



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

Preparing for the implementation of IOM's health promotion projects across southern Africa.

Photograph - Mpho Khwezi



BASELINE ASSESSMENT



A CONSOLIDATED REPORT OF FINDINGS FROM AN ASSESSMENT ON HIV-RELATED KNOWLEDGE, ATTITUDES, BEHAVIOURS AND PRACTICES OF WORKERS IN THE FISHING, MINING AND AGRICULTURAL SECTORS IN MOZAMBIQUE, NAMIBIA, SOUTH AFRICA, SWAZILAND AND ZAMBIA.

Pretoria, March 2009

ACKNOWLEDGEMENTS

IOM would like to thank the following partners in southern Africa for facilitating and carrying out the assessment in their respective sites:

Walvis Bay Multi Purpose Centre Trust – **Namibia**
TEBA Development – **Mozambique and Lesotho**
Hoedspruit Training Trust – **South Africa**
Royal Swaziland Sugar Corporation – **Swaziland**
Comprehensive HIV/AIDS Management Programme – **Zambia**

In particular all their researchers that undertook the field work.

IOM would like to extend particular thanks to the local communities and stakeholders who participated, including the migrants who gave their time and shared their experiences.

Special thanks to the Swedish International Development Agency (SIDA) for financially supporting IOM's Partnership on HIV and Mobility in Southern Africa (PHAMSA) programme.

The report was written by Stephanie Bleeker, for IOM Pretoria.

Publisher:

International Organization for Migration, Regional Office for Southern Africa (IOM Pretoria)
PO Box 55391
Arcadia
0007
Republic of South Africa

tel **(+27) 12 342 2789**
fax **(+27) 12 342 0932**
email **phamsa@iom.int**
website **www.iom.org.za**

TABLE OF CONTENTS

1	Executive Summary	08
2	Introduction	11
2.1	Mobile populations and HIV in southern Africa	11
2.2	IOM's Partnership on HIV and Mobility in southern Africa	13
2.3	Rationale of the Assessment	14
3	Methodology	15
3.1	Study design	15
3.2	Mini survey	15
3.3	Focus group discussions	16
3.4	Field data collection and management	16
3.5	Stakeholder involvement	17
3.6	Data Analysis	17
4	Findings and Analysis	18
4.1	Socio-demographic characteristics of respondents	18
4.2	Environmental factors	21
4.3	Knowledge, attitudes, behaviours, practice and perceptions	22
4.4	Risk and vulnerability within the context of mobility and migration	26
4.5	Relationship between gender and HIV risk and vulnerability	28
5	Conclusions	29
5.1	General	29
5.2	Limitation of the assessment	29
5.3	Socio demographic information	29
5.4	HIV knowledge, attitudes, behaviours and perceptions	30
5.5	HIV risk, vulnerability within the context of migrants and mobility	30
5.6	HIV risk, vulnerability and gender	30
5.7	Environmental factors	31

6	Recommendations for planning and prioritized actions	32
6.1	Recommendations with respect to content	32
6.1.1	Knowledge on HIV and AIDS	32
6.1.2	Prevention of HIV	32
6.1.3	HIV testing	33
6.1.4	Stigma reduction	33
6.1.5	Gender	33
6.1.6	Running effective workplace programmes	33
6.1.7	Tuberculosis	34
6.1.8	Male circumcision	34
6.2	Recommendations with respect to the PHAMSA Pilot Projects	34
6.2.1	Focus and strengthening of PHAMSA Pilot Project	34
6.2.2	Information system	35
6.3	Strengthening of future assessments	35
6.3.1	Methodology and data collection	35
6.3.2	Building research capacity	35
6.4	Future research agenda	36
6.4.1	Conduct additional mapping exercise	36
6.4.2	Issues related to sexual behaviour	36
	References	37
	Annex I	38
	Rationale for the baseline assessment	
	Annex II	39
	Interview guide: Baseline Survey for PHAMSA Partners	

TABLES

Table 1	Summary of key data from findings of the baseline assessment	9
Table 2	HIV and AIDS estimates statistics southern Africa	11
Table 3	PHAMSA Pilot Project objectives	14
Table 5	Implementing Partners PHAMSA Pilot Project	14
Table 6	Sample of target groups	15
Table 7	Field data collection	16
Table 8	Involved stakeholders	17

FIGURES

Figure 1	Three level approach to address vulnerability	13
Figure 2	Gender distribution	18
Figure 3	Age of respondents	19
Figure 4	National or foreign workers	19
Figure 5	Education level of mobile workers	20
Figure 6	Type of relationship of mobile workers	20
Figure 7	Work status of mobile workers	21
Figure 8	Location of living	21
Figure 9	Frequency of home visits of workers	22
Figure 10	HIV knowledge	23
Figure 11	Beliefs on HIV	24
Figure 12	HIV testing	25
Figure 13	Occurrence of transactional sex and forced sexual activity	26
Figure 14	Condom use	27
Figure 15	Perceptions on condoms	27
Figure 16	Gender values	28

A BBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretrovirals
BCC	Behaviour Change Communication
CHAMP	Comprehensive HIV/AIDS Management Programme
FHI	Family Health International
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with HIV and AIDS
HIV	Human Immune Virus
HTT	Hoedspruit Training Trust
IEC	Information, Education, Communication
IOM	International Organization for Migration
IP	Implementing Partner
KAP	Knowledge, Attitude, Behaviour and Practice
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MoU	Memorandum of Understanding
NGO	Non Governmental Organization
OVC	Orphans and other children made vulnerable by HIV and AIDS
PHAMSA	Partnership on HIV and Mobility in Southern Africa
PLHIV	People Living with HIV
PMTCT	Preventing Mother-to-Child Transmission
PRA	Participative Rural Appraisal
RSSC	Royal Swaziland Sugar Corporation
SADC	Southern Africa Development Community
SCC	Social Change Communication
(S)GBV	(Sexual) Gender Based Violence
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV and AIDS
VCT	Voluntary Counselling and Testing
WBMPCT	Walvis Bay Multi Purpose Centre Trust

GLOSSARY OF TERMS

Baseline Assessment	A process of collecting data prior to implementation of the project, to develop targeted interventions and develop frameworks for monitoring of project progress and evaluation of impact of project's activities (Source: IOM Partners Pack)
Behavioural Change Communication	An interactive process with communities (as integrated with an overall programme) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours. (Source: Family Health International).
Beneficiaries	Direct recipients of the project's services or/and products. Those social groups within whose domain the results of a development measure are intended to take place. (Source: GTZ)
Concentrated HIV epidemic	Where HIV is concentrated in groups with behaviours that expose them to a high risk of HIV infection e.g. intravenous drug users. (Source: UNAIDS 2008)
Contract workers	A worker who is employed by a company that is contracted to provide certain services to the mother organisation. The worker may be employed as a permanent, temporary or seasonal worker. (Source: IOM 2007)
Drivers of the HIV epidemic	The term driver relates to key factors that increase people's vulnerability to HIV infection. (Source: UNAIDS 2008)
Environmental Drivers of the HIV epidemic	The term environmental driver relates to the context within which an individual or a community lives that can increase HIV vulnerability. Examples could include access to health services, lack of recreational activities, living and working conditions. (Source: UNAIDS 2008)
Executing Agency	An organization responsible for the overall management and execution of programme objectives and activities and have a much bigger responsibility in the entire cycle of the programme (Source: IOM Partners pack)
Gender	Refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (i.e. society's idea of what it means to be a man or woman). These attributions can change over time and from society to society (Source: IOM Gender manual)
Gender based violence	Any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. (Source: UN Declaration on the Elimination of Violence against Women 1993)
Generalise HIV Epidemic	Where adult HIV prevalence among the general adult population is at least 1% and transmission is mostly heterosexual (Source: UNAIDS).
Focus Group Discussions	A structured and facilitated conversation held with a particular group (e.g. local and foreign seagoing personnel, spouses of migrant mineworkers) to explore people's opinions and experiences of specified issues of interest e.g. condoms use; transactional sex etc. (Source: IOM Partners Pack)
Implementing Partner	An organization responsible for implementation of specific components of a project. (Source: IOM Partners Pack)
Individual Drivers	The term individual driver relates to behaviour and practices over which a person has control. Strategies to address these factors include IEC, promotion of condoms, VCT faithfulness and partner reduction (Source: UNAIDS).
Informal sampling	Convenience or common sense rather than mathematical reasoning (Source: USAID 2006)
Intended Outcome	Intended direct effects of the project-benefits which will be derived from the project by beneficiaries (Source: IOM Partners Pack).
HIV Risk	Is defined as the probability that a person may acquire HIV infection. Certain factors create, enhance and perpetuate risk such as unprotected sex with a partner whose HIV status is unknown, multiple unprotected sexual partnerships (Source: UNAIDS).
HIV Vulnerability	Vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These may include (i) personal factors such as the lack of knowledge and skills required to protect oneself; (ii) factors pertaining to the quality and coverage of services, such as inaccessibility of services due to distance, cost and other factors; (iii) societal factors such as social and cultural norms practices, beliefs and laws that stigmatize and disempowers certain populations (Source: UNAIDS).
Key informants interviews	Formal (structured) or informal conversations held with individuals who, by virtue of their status have some influence on the project and its beneficiaries. These could be opinion leaders such as community leaders, or programme implementers such as peer educators (Source: IOM Partners Pack).

GLOSSARY OF TERMS

Migrant	The term applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospects for themselves or their family (Source: IOM 2007).
Migrant worker	A person, who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national. (Source: IOM 2007) The term migrant worker have different meanings and connotations in different parts of the world. The United Nations definition is very broad, essentially including anyone working outside their home country. In other instances, the term has a specific connotation that work will be low paid. The term can also be used to describe someone who migrates within a country in order to pursue work such as seasonal work.
Migration	A process of moving, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people and economic migrants (Source: IOM 2007).
Mini Survey	A rapid, snap shot survey looking at people's knowledge and understanding of particular issues of interest such as HIV and gender (USAID 2006).
Mobile Population	People who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons (Source: IOM 2007).
Mobile Worker	A person whose nature of work requires them to move from one area to the other, cross border or within a country (Source: IOM 2007).
Monitoring	The continuous follow-up of activities to ensure that they are proceeding according to plan and are on schedule and/or to signal the need for adjustment. It keeps track of and registers achievements, personnel utilisation, use of supplies and equipment, and the money spent in relation to the resources available, so that if anything goes wrong immediate corrective measures can be taken (Source: World Bank).
Output	Direct result of the activities that are implemented within the framework of the project-it is a description of the value of the services/ products produced by the project within the framework of the project (what the project will be responsible for delivering). (Source: IOM Partners Pack)
Permanent employee	A worker employed in a permanent position that is critical to the day-to-day running of the organization all year round. These may include foremen, human resources and administrative personnel (Source: IOM 2007).
Probability Sampling	Each unit in the population has an equal chance of being selected for the sample (Source: USAID 2006)
Remittance	Monies earned or acquired by migrants that are sent back to their country of origin. (Source: BBC migrants glossary)
Seasonal worker	A migrant worker whose work by its character is dependent on seasonal conditions and is performed only during part of the year. (Source: IOM 2007)
Social Change Communication	A process of public and private dialogue through which people define who they are, what they want, what they need and how they can act collectively to meet those needs and improve their lives. It supports processes of community-based decision making and collective action to make communities more effective and it builds more empowering communication environments. (Source: Communication for Social Change Consortium).
Sexually Transmitted Infection	Disease resulting from bacteria or viruses and often acquired through sexual contact. Some STIs can also be acquired in other ways (i.e. blood transfusions, intravenous drug use, mother-to-child transmission). The term 'STI' is slowly replacing 'STD' (sexually transmitted disease) in order to include HIV infection. Most STIs, like HIV, are not acquired from partners who are obviously ill, but rather through exposure to infections that are asymptomatic or unnoticeable at the time of transmission (Source: UNAIDS)
Structural Drivers of the HIV epidemic	The term structural driver relates to the structural and social factors, such as poverty, population mobility, gender inequality and human rights violations that are not easily measured that increase people's vulnerability to HIV infections (Source: UNAIDS).
Temporary worker	A worker employed on a short-term basis, to perform any kind of job as required by the employer. They are also often referred to as casual workers (Source: IOM 2007).
Vulnerability	Conditions determined by physical, social, economic and environmental factors or processes, which increase the susceptibility of a community to the impact of something harmful.

1 EXECUTIVE SUMMARY

Southern Africa, which has the highest prevalence rates of HIV globally, also experiences high levels of population movement. The link between mobility and HIV is an important dimension of the region's epidemic. Many of the same factors that influence the spread of HIV, such as unbalanced distribution of resources, unemployment, political instability and conflict, also drive migration in the region. Migrants are vulnerable to HIV infection for several reasons, and also face obstacles to accessing care and support services if living with the virus. The circumstances of movement, whether voluntary or involuntary, legal or irregular, affect the risk of HIV infection for migrants. A better understanding of the link between HIV and population movement in southern Africa is essential to develop effective AIDS intervention strategies.

Against this background, IOM established the *Partnership on HIV and Mobility in Southern Africa* (PHAMSA). The overall objective of PHAMSA Pilot Projects is to build capacity in the region to implement comprehensive HIV programmes that aim to reduce vulnerability to HIV and to mitigate the impact of AIDS among migrant and mobile workers, their families and the communities with which they interact through behavioural and social change interventions.

This report is a consolidation of the findings from baseline assessments carried out by IOM's PHAMSA Pilot Projects implementing partners in Lesotho and Mozambique (TEBA Development), Namibia (Walvis Bay Multi Purpose Centre), South Africa (Hoedspruit Training Trust), Swaziland (Royal Swaziland Sugar Corporation) and Zambia (CHAMP and Global Development Alliance companies). It reviews the HIV-related knowledge, attitudes, behaviours and practices of labour migrants working in the fishing, commercial agriculture and mining sectors. The aim of these assessments is two-fold:

- *Capacity building of implementing partners:* Conducting a baseline assessment has been a learning process for PHAMSA and the implementing partners and capacitated them to gain

or strengthen research experience and contributes to the objective of a learning organisation. This baseline exercise is an opportunity for the partner to understand the project target group and consider some of the associated difficulties in regards to accessing them, promoting a culture of data collection by using monitoring and evaluation and research skills in order to develop tools to assess their progress.

- *Baseline for future interventions:* The findings of this assessments serve as a baseline for future interventions that meet the basic needs of migrant workers, and mobile communities, measuring changes in knowledge and behaviour over time and strengthen the programme design of the current pilot projects.

The assessments were conducted among fishermen, commercial farm workers and mineworkers, their families and the people they interact with. Data was gathered and focussed on the following areas: socio-demographic information; HIV knowledge, attitudes, behaviours, and perceptions; HIV risk and vulnerability within the context of mobility and migration; the relationship between gender and HIV; environmental factors, such as location of living, transport, recreation, access to services; and current knowledge, acceptability and perceived impact of existing interventions and programmes. In one site – Walvis Bay - focus group discussions are also conducted.

The sample included: 100 people from Leribe district, Lesotho; 100 people from Três de Fevereiro Village, Mozambique, 96 seafarers from four fishing companies in Walvis Bay, Namibia; 202 workers on Richmond Citrus Estate, Hoedspruit, South Africa; 142 contract/seasonal farm workers on Mhlume Sugar Estates, Swaziland; 182 temporary workers of a mining company, Zambia; and 232 seasonal workers and the surrounding community at a cotton ginnery in Zambia.

Hereunder is a summary of the key findings, followed by conclusions and recommendations for action:

TABLE 1 – SUMMARY OF KEY FINDINGS

FINDINGS	CONCLUSIONS	KEY RECOMMENDATIONS
GENERAL		
<ul style="list-style-type: none"> Under-reporting of sensitive and personal issues Limited accessibility of the respondents Sample selection was not always specified, in terms of size, inclusion criteria, and location Informal sampling was used instead of probability sampling making analysis difficult. Data collectors had little research experience, and training they received prior to data collection was not adequate to prepare them for the job. Questionnaires were not always pre-tested, not adequately filled out, and data was missing Basic research capability of implementing partners 	<ul style="list-style-type: none"> Lack of research experience e.g. no pre-test of the questionnaire, information provision by the respondents was not maximised. Supervision and monitoring of data collection process, incl. interviewers, needs improvement Due to the culturally-sensitive nature of some of the questions, under-reporting is likely. Lack of information on purpose of the sample size; usage of methodology; inclusion criteria for respondents selection; and geographical areas The design of the assessment does not allow the findings for an elaborate statistical analysis and generalisation to a larger population group Difficult to access the respondents Capacitated partners strengthen research skills 	<ul style="list-style-type: none"> Organize feedback session on findings of this study Identify human and institutional capacity building needs to improve services and strengthen the programme. Investigate and share tools and training materials that can help partners to strengthen research capacity Develop and implement a training, monitoring and supervision package to support implementing partners, training supervisors and data collectors Schedule consultative workshops at country level
SOCIO DEMOGRAPHIC INFORMATION		
<ul style="list-style-type: none"> 1054 (M:708, F:346) migrants, mobile populations, families and community members participated Most respondents were between 20-39 yrs. Ninety four percent of the respondents were internal migrant workers. Fifty eight percent of the respondents attended 5-14 yrs of school and 16% not more than 4 yrs. Most respondents are either married or in a long term relationship. The employed respondents either have a temporary contract, are seasonal or permanent workers. 	<ul style="list-style-type: none"> The education level indicates that people have basic reading and writing skills. The findings do not show that many respondents were involved in casual partnerships or multiple concurrent partnerships. 	<ul style="list-style-type: none"> Fine-tune project indicators according to baseline outcomes at country level Adjust and fine-tune monitoring and evaluation framework and include updated project indicators. Establish information system on listing volunteers/migrants and mobile workers, to collect information on who is receiving services, type of services and need for follow up.
HIV KNOWLEDGE, ATTITUDES, BEHAVIOURS, AND PERCEPTIONS		
<ul style="list-style-type: none"> Respondents have a basic level of awareness and knowledge on HIV and the modes of transmission, Respondents express a high prevalence of misinformation, misconceptions and myths about HIV. Seventy eight percent of the respondents believe that PLHIV can live normal and healthy lives. Respondents express the importance of knowing their HIV status. Fifty one of the respondents have tested for HIV before. However, almost twenty six percent of the respondents are not willing to test if an HIV test is offered to them. 	<ul style="list-style-type: none"> The knowledge gap contributes to stigmatizing beliefs. Such myths and misconceptions add to perpetuating risky sexual practices and stigma towards PLHIV The findings show that there is reason to be concerned about people's beliefs and attitudes about HIV and AIDS. Stigmatising beliefs and attitudes are still prevalent and need to be addressed. Little data was collected on other STI/TB 	<ul style="list-style-type: none"> Include information of HIV, AIDS, STI and reproductive health, in the behaviour change communication/ social change communication activities as planned in the pilot projects, including peer group discussions and IEC materials. Formation and facilitation of support groups for PLHIV Investigate tools and training on addressing stigma, and inclusion and empowering of PLHIV Conduct more research on sexual knowledge, attitudes and practises including sexual gender based violence, men having sex with men, risk taking sexual behaviour
HIV RISK AND VULNERABILITY WITHIN THE CONTEXT OF MOBILITY		
<ul style="list-style-type: none"> Respondents have a basic understanding on HIV vulnerability issues. Risky sexual behaviour, such as non consistent condom use, is prevalent Knowledge about condoms is widespread; however, respondents express many misconceptions about perceptions and beliefs on condom use. A frequently reported belief is that condoms take away the sexual pleasure. One third of the migrants are of the opinion that sex is much safer with a condom. 	<ul style="list-style-type: none"> The knowledge on issues related to HIV, AIDS and vulnerability needs to be strengthened. Prevalence of risky sexual behaviour. Issues related to men having sex with –men, sexual practices are not included in this assessment. Respondents state that the relation between prevention of HIV and male circumcision is unclear and needs to be addressed Perceptions and beliefs relating to condoms are a barrier to consistent correct condom use and needs to be addressed 	<ul style="list-style-type: none"> Develop skills in prevention, risk reduction and life skills. Advocate and facilitate the availability/ accessibility of condoms at working site and information on condom use Organize sensitization meetings at the working sites including HIV and STI prevention; Organize community dialogue to encourage openness about HIV and AIDS; to dialogue on risks, vulnerability; and to inform individuals on available HIV prevention methods and treatment services.

TABLE 1 – SUMMARY OF KEY FINDINGS		
FINDINGS	CONCLUSIONS	KEY RECOMMENDATIONS
HIV RISK AND VULNERABILITY WITHIN THE CONTEXT OF MOBILITY		
<ul style="list-style-type: none"> Ninety seven respondents confirmed to have engaged in transactional sexual relationships. Sexual violence is prevalent, and not exclusive to women 		<ul style="list-style-type: none"> Set up counseling services to deal with questions, concerns, re HIV prevention, treatment, care; referral to VCT and sexual and reproductive health services; and (legal) advice and referral of cases of sexual/gender based violence. Create a position of trust and appoint a person who will become the point of contact within the company Develop IEC materials including prevention messages, testing information (VCT, STI and TB screening) and sexual and reproductive health issues Organize and facilitate peer based communication sessions on past and present individual behaviour; HIV risk; the importance of testing; treatment possibilities. Always include PLHIV Facilitate and support increased access to VCT and psychological services for migrant and mobile populations. Include male circumcision in IEC materials
HIV RISK, VULNERABILITY AND GENDER		
<ul style="list-style-type: none"> Gender stigmatizing and discriminatory beliefs are prevalent amongst the respondents. Findings show that respondents believe that women need to be pressurised a little to have sex. A prevalent belief is that women who carry a condom are sleeping around, while it is believed that it is acceptable for a woman to initiate condom use with her partner. 	<ul style="list-style-type: none"> Rights of women are not respected and therefore perpetuate the low socioeconomic status of women and increase their vulnerability. Prevalence of female discriminating beliefs can make women vulnerable to sexual violence. 	<ul style="list-style-type: none"> Address consistently gender related issues (incl. gender based violence) in the planned programme interventions Organize and facilitate gender training and mentoring programme Organize sensitization meetings at the working sites including gender related issues and prevention on GBV Future research agenda may include issues related with sexual and gender based violence
ENVIRONMENTAL FACTORS		
<ul style="list-style-type: none"> Thirty three of the respondents live in housing provided by their employer or rent accommodation themselves. Most of the workers live in a single sex unit. Weekly or monthly visits by respondents. 	<ul style="list-style-type: none"> The respondents visit their homes on a regular basis, most of the respondents are reunited with their family once a week or once a month. In spite of the scope of this assessment, in due course of the development of this assessment not all topics were included in the final questionnaire. 	<ul style="list-style-type: none"> Conduct a mapping exercise on the accessibility of (SR) health services, VCT; support services for PLHIV; Conduct mapping exercise of recreational activities; workplace policies and programmes at each project site; Link new activities with existing activities/ of the partners Involve employers, trade unions, relevant community support organizations whenever possible in the Project. Create recreational opportunities at work sites Take stock of existing workplace policy Inform migrant about existing workplace policy Ensure condoms are available at workplace settings.

2 INTRODUCTION

2.1 MOBILE POPULATIONS AND HIV IN SOUTHERN AFRICA

Throughout history, population movement has been an important factor in the epidemiology of infectious diseases, including HIV. In southern Africa, where livelihoods are greatly based on mobility and the search for income opportunities in different locations and sectors in order to achieve economic independence, mobility has played a significant role in the spread of HIV. This is especially due to the seasonal nature of work within sectors that employ migrant workers such as agriculture. A number of

factors, all linked to mobility, contribute to HIV vulnerability and risk in southern Africa. These include poverty and economic marginalisation, different strains of HIV, high rates of sexually transmitted infections and other opportunistic infections (such as Tuberculosis), sexual networking and patterns of sexual contact, including high levels of multiple concurrent sexual partners, and the role of core groups such as sex workers. See table (UNAIDS 2007 & WHO 2008).

TABLE 2: HIV AND AIDS ESTIMATES STATISTICS SOUTHERN AFRICA

	NO OF PEOPLE LIVING WITH HIV	ADULTS AGED 15-49 HIV PREVALENCE RATE	ADULTS AGED 15 AND OVER LIVING WITH HIV	WOMEN AGED 15 AND OVER LIVING WITH HIV	DEATHS DUE TO AIDS	CHILDREN AGED 0-14 LIVING WITH HIV	ORPHANS AGED 0-17 DUE TO AIDS	% OF PREGNANT WOMEN RECEIVING TREATMENT TO REDUCE MTCT
Lesotho	270.000 250.000- 290.000	23.2 [21.9 – 24.7%]	250.000 240.000- 270.000	150.000 [140.000- 160.000]	23.000 [20.000 – 27.000]	18 000 [6900 – 34.000]	97.000 [88.000- 110.000]	5.1%
Mozambique	1.800.000 1.400.000- 2.200.000	16.1 [12.5- 20%]	1.600.000 1.300.000- 2.000.000	960.000 [590.000 1.300.000]	140.000 [100.000 -200.000]	140.000 [57.000- 310.000]	510 000 [390 000- 670 000]	3.4%
Namibia	230 000 110.000- 360.000	19.6 [8.6 -31.7%]	210.000 99.000- 340.000	130.000 [54.000- 220.000]	17.000 [7.800- 27.000]	17.000 [5.800- 40.000]	85.000 [42.000- 120.000]	25%
South Africa	5.500.000 4.900.000- 6.100.000	18.3 [16.8 – 20.7%]	5.500.000 4.900.000 – 6.100.000	3.100.000 2.800.000- 3.400.000	320.000 [270.000- 380.000]	240.000 [93.000- 500.000]	1.200.000 [970.000- 1.400.000]	14.6%
Swaziland	220.000 150.000- 290.000	26% M:20% F:31%	210.000 140.000- 270.000	120.000 [70.000- 180.000]	16.000 [10.000 -3.000]	15.000 [25.000- 32.000]	63.000 [45.000- 77.000]	11.9%
Zambia	1.100.000 1.100.000- 1.200.000	17.0 [15.9 – 18.1%]	1.000.000 950.000- 1.100.000	570.000 [540.000 – 610.000]	98.000 [77.000 – 120.000]	130 000 [53.000 – 250.000]	710.000 [630.000- 830.000]	4%

TABLE 2: HIV AND AIDS ESTIMATES STATISTICS SOUTHERN AFRICA

	PREVALENCE OF TB, PER 100.000	INCIDENCE OF TB PER 100.000	CAUSE SPECIFIC MORTALITY RATE FOR TB AMONG HIV-PEOPLE PER 100.000	CAUSE SPECIFIC MORTALITY RATE FOR TB AMONG HIV+ PEOPLE PER 100.000	% OF YOUNG WOMEN AND MEN, 15-24YS, CORRECTLY IDENTIFY WAYS TO PREVENT HIV	% OF WOMEN & MEN, 15-24YS, USING CONDOMS LAST TIME THEY HAD SEX WITH CASUAL PARTNER	% OF HIV-INFECTED WOMEN AND MEN RECEIVING ART
Lesotho	513	635	42	47	M: 48% F:50%	na	14%
Mozambique	624	443	63	54	M: 33.0% W:20%	W:29.0% M:33.0%	9%
Namibia	658	767	54	41	na	na	35%
South Africa	998	940	84	134	na	na	21%
Swaziland	1084	1155	94	184	na	na	31%
Zambia	568	553	56	46			37%

Three key issues link mobility and HIV: a) mobility can make people vulnerable to high-risk sexual behaviour; b) mobility makes people more difficult to reach, whether for prevention education, condom provision, HIV testing, or post-infection treatment and care; and c) migrants' multi-local social networks create opportunities for sexual networking. The transient nature of migrant's lives puts them at risk. The longer they spend away from home, the more likely it is that some will indulge in casual, high risk sex. Population mobility and migration contribute to the phenomenon of concurrent sexual partnerships, which is one of the main drivers of the HIV epidemic in southern Africa (Dodson and Crush, 2002). Because migrants and mobile workers are regularly separated from their regular partners, some engage in short or long-term sexual relations with non-regular partners.

Gender plays an important role in the interface between migration and HIV in southern Africa. The social construction of gender and sexuality underlies HIV vulnerability of migrants and mobile workers (IOM, 2007). Gender norms and values are central to shaping sexual behaviour, and affect men's and women's vulnerabilities and HIV-related risk. Most migrants are men who move to urban areas and leaving their wives behind in rural areas. However, increasingly, women are also migrating. Many of them move from rural to urban areas in order to achieve economic and social independence (UNFPA, 2006, Crush et al, 2005.). Women's vulnerabilities and risk to HIV are due to several factors including:

- *poverty*, which makes women less economically and socially independent than men, and can push them into risky behaviour such as transactional sex or sex work;
- *cultural norms*, which define women as the primary care-givers;
- *sexual norms* which encourage passivity, modesty, innocence and sometimes ignorance in sexual matters;

- *violence against women*, including coerced sex;
- *lack of legal protection and property rights*;
- *displacement*;
- *greater physiological susceptibility to the virus*; and
- *female genital mutilation*. (Singh, 2007)

Lack of education can restrict women to working as informal traders sector or domestic workers, and also puts them in danger of resorting to more vulnerable means of income generation such as sex work. These forms of employment subject women to poor working conditions, including abuse or harassment.

Men's vulnerabilities and risk to HIV are also fuelled by several factors, including:

- *poverty*, which pushes boys and men into sex work;
- *long distance employment*;
- *cultural norms*, which encourage a denial of risk;
- *sexual norms*, which encourage men to be the dominant partner in economic, social, and intimate relations, including sometimes having many sexual partners;
- *homophobia and taboo surrounding homosexuality*, which forces men who have sex with men to keep their behaviour secret and deny their risk;
- *incarceration*, which makes it hard for incarcerated people, the majority of whom are males, to protect themselves from unsafe sex; and
- *single sex working environments* which contribute significantly to male notions of masculinity and sexuality (Singh, 2007).

Next to the boredom and loneliness of work, many male migrant workers endure dangerous and unpleasant working conditions and living conditions, to which they might respond with exaggerated "*masculinity*" and sexual bravado (Campbell, 2003). Male migrants often subscribe to gender norms that

prize multiple sexual partnerships. Another significant source of HIV transmission is unprotected sex between men, especially those working and living in predominantly male environments (IOM, 2003).

2.2 IOM'S PARTNERSHIP ON HIV AND MOBILITY IN SOUTHERN AFRICA

Addressing HIV and population mobility fits within the mandate of the *International Organization for Migration* (IOM). IOM works through the entire spectrum of migration and during all stages of mobility. IOM uses a rights-based, public health and participatory approach to bring HIV prevention and access to care and support to migrant and mobile populations. Since 2004, IOM has been implementing the *Partnership on HIV and Mobility in Southern Africa* (PHAMSA) programme. The programme has grown and expanded over the years, with the current cycle ending in 2010.

The main aim of the programme is to reduce the vulnerability of migrants and mobile populations to HIV and AIDS in the *Southern African Development Community* (SADC) region through establishing partnerships with key stakeholders. IOM advocates for a holistic approach that looks at the contextual causation of HIV infection, rather than focusing on individual behaviour. Individuals live and work within a broader environment in which there are things they can and cannot control, all of which have an impact on behaviour and practices (Campbell, 2003). This requires a multi-level approach that aims to reduce individual risks by addressing individual and environmental factors whilst also taking into account structural issues that increase HIV vulnerability (see Figure 1).

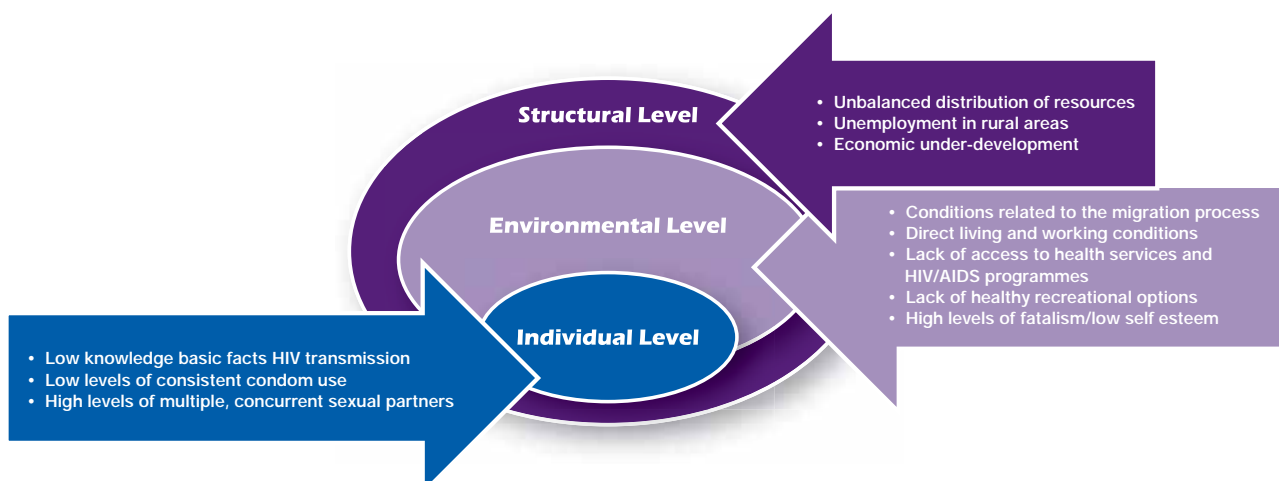


Figure 1: Three-level approach to addressing HIV vulnerability

The PHAMSA programme consists of four inter-related, programme components:

- 1 Advocacy for Policy Development** Which advocates for national policies that acknowledge the HIV vulnerabilities and risks within the context of population mobility and migration.
- 2 Research and Learning** component aims to generate new knowledge and increase understanding of HIV dynamics of labour migration in southern Africa.
- 3 Regional Cooperation and Technical Coordination** component broadly aims to support development and implementation of projects that addresses HIV and mobility issues, across the region and beyond.
- 4 Pilot Projects** component seeks to demonstrate a model for effective interventions that aims to reduce HIV incidence and impact of AIDS among migrants, mobile workers, their families and those they interact with through on-the-ground implementation of HIV interventions and enhance programme capacity in the region, see Table 3 and 4, which outlines the objectives and outputs of the PHAMSA's pilot projects and IPs

TABLE 3 – PHAMSA PILOT PROJECT II OBJECTIVES

<p>1. To build capacity in the region to implement comprehensive HIV programmes as guided by the PHAMSA project model</p>	<ul style="list-style-type: none"> • Strengthened capacity of IPs to develop programmes in targeted migrant communities • Increased capacity of IPs to run programmes and deliver services to migrant and mobile populations (IPs able to run the programme without PHAMSA support) • Organisations interacting with migrant and mobile populations have access to tools and methods on how to roll out the PHAMSA pilot project model
<p>1. To reduce vulnerability to HIV and to mitigate the impact of AIDS among migrant and mobile workers, their families and the communities with which they interact through behavioural and social change intervention</p>	<ul style="list-style-type: none"> • Increased knowledge and understanding of HIV and AIDS among migrant and mobile workers, their families and the communities with which they interact • Improved attitudes towards HIV, AIDS and SRH among migrant and mobile workers, their families and the communities with which they interact • Improved health seeking behaviour (including behaviour related to sexual and reproductive health) among migrant and mobile workers, their families and the communities with which they interact supported by a conducive environment • Improved mitigation of the impact of AIDS on migrant and mobile workers, their families and the communities in which they interact

Beneficiaries are labour migrants and mobile populations in commercial agriculture, fisheries, informal cross border trade, and mineworkers and their families.

Partners include organisations involved in the targeted sectors, plus technical experts, intergovernmental organisations, and governments. The PHAMSA partnership strategy is to develop and strengthen partnerships on an ongoing basis and to establish links with organisations that have specific expertise and or skills, have access to a key group and add value to the programme.

PHAMSA currently has 5 IPs implementing the PHAMSA Pilot Projects:

TABLE4: IMPLEMENTING PARTNERS PHAMSA PILOT PROJECTS

Comprehensive HIV/AIDS Management Programme (CHAMP) is a private, non-profit Zambian organisation dedicated to combating the HIV epidemic in Zambia. Since its inception in 2002, CHAMP has grown from a small team to 75-member staff. CHAMP has earned a reputation as a leading organization in HIV responses, particularly in workplace and community programmes. It is currently conducting initiatives with some of the largest companies in Zambia. CHAMP has undertaken activities in 39 districts in all 9 provinces of Zambia.

Hoedspruit Training Trust is a NGO that seeks to empower commercial farm workers and their families with a greater sense of responsibility for their personal health, spiritual and educational development. It cares for and educates in life skills and empowers people infected with and affected by HIV in the citrus farming area. Hoedspruit Training Trust covers Maruleng Municipality, with a focus on commercial and game farms in the Hoedspruit area in a radius of ± 30 kms, with a population of ± 140,000.

Hlokomela project developed out of the partnership with IOM and coordinates various health and educational development initiatives for 38 local agricultural businesses associated with the Hoedspruit Training Trust.

Royal Swaziland Sugar Corporation (RSSC) is one of the largest employers in Swaziland, employing more than 3.600 permanent employees with operations in Mhlume and Simunye and a population of about 30.000 people comprising mainly of employees and their dependents, contract workers and the community of Mhlume and Simunye Sugar Estates. RSSC currently provides IEC activities; peer education programmes; condom distribution; care and support for employees with HIV; support groups and facilitates VCT and access to ARVs.

TEBA Development is an NGO arm of TEBA Limited, a service organisation primarily responsible for the recruitment of mineworkers for the South African mining industry. TEBA Development has been active in providing home-based care for ex-mineworkers who retired due to ill-health and life-threatening conditions such as HIV and AIDS, TB, cancer etc. The programmes of TEBA Development are implemented within communities from where mineworkers are recruited.

Walvis Bay Mutli Purpose Centre Trust (WBMPCT) provides information, education and communication to inform local communities about HIV and AIDS. The centre also provides care and support to community members affected by the disease, and facilitates condom distribution. It is covering the population of Walvis Bay.

2.3 RATIONALE OF THE ASSESSMENT

Following the inception of the PHAMSA Pilot Projects, and prior to the implementation of the project activities, all IPs conducted baseline assessments at designated sites. These assessments were initiated at an induction workshop where partners expressed a need to gather basic data on mobile communities living and working in the target areas.

The baseline assessments were conducted during the months of November 2007 - February 2008. This report is a consolidation of all the assessments conducted by the IPs. The assessment was aimed at assessing HIV and AIDS related knowledge, attitudes and practises within the targeted migrants and mobile workers.

The assessment also looked at socioeconomic and cultural issues impacting on HIV and AIDS (e.g gender norms).

The findings provide baseline data against which interventions can be applied, monitored and evaluated, through measuring changes in knowledge and behaviour over time. This information will be used to strengthen the design of existing PHAMSA pilot projects and to develop future interventions. Conducting the baseline assessment has been a learning process for both PHAMSA and its IPs. This experience has built the research capabilities and capacity in IPs thereby contributing to organizational development and institutional growth. See Annex I for the terms of reference of this consolidated report.

3 METHODOLOGY

3.1 STUDY DESIGN

A total of 7 baseline assessments were conducted by the five PHAMSA IPs in six countries: i.e. Namibia (NAM), Lesotho (LES), Mozambique (MOZ), South Africa (RSA), Swaziland (SWA) and two in Zambia (ZAM). The partners are working with

migrants, mobile workers, their families and the communities they interact with in the mining, agriculture and fishing sectors. Table 5 outlines the sample sizes for each site:

	LOCATION	IMPLEMENTING PARTNER
100 persons; 58 male, 40 female respondents of mineworkers and people from the Leribe district	Lesotho	TEBA Development
100 persons; 32 Male, 68 female mineworkers and people from mining communities from Trés de Fevereiro Village, Xai Xai District	Gaza Province, South-western Mozambique,	TEBA Development
96 male seafarers of 4 fishing companies Cadilu Fishing, Tunacor Fishing, Benguella Fishing and NAMSOV Fishing enterprises	Walvis Bay, Westcoast, Namibia	Walvis Bay Multi Purpose Centre
202 persons; 124 male, 78 female workers on the commercial citrus farm, Richmond Citrus Estate, Hoedspruit	Limpopo Province, South Africa	Hoedspruit Training Trust
142 persons; 98 male, 41 female contract/seasonal farm workers on Mhlume and Simunye Sugar Estate. 298 interviews were conducted, 142 analysed	Swaziland	RSSC
182 male seasonal and temporary mineworkers in a copper mine	North-western Province, Zambia,	CHAMP
232 seasonal workers employed in cotton ginning	Eastern Province Zambia	CHAMP

An IOM study on mobile populations and HIV and AIDS in the southern African region provides a characterisation of mineworkers and farm workers regarding HIV vulnerability (IOM, 2005).

Mineworkers often have a transient lifestyle. Their HIV-related vulnerabilities are exacerbated by poor living and working conditions. Mines are often located in remote and inhospitable areas, employing workers drawn from distant communities. Typically the workers are young men from rural areas, who work in dangerous stressful conditions and live in single sex hostels with easy access to casual sex partners and alcohol. These settings offer limited social support and little opportunities for intimacy. The intangible risk of HIV is a low priority compared to the daily odds of being injured in the mine. Opportunities for leisure are few, which makes drinking and sex with casual partners some of the few recreational activities available. Mining communities also tend to have a less developed health infrastructure and available facilities are under-utilized due to workers’ lack of familiarity with the area (Campbell, 2003).

The living and working conditions of **agricultural farm workers** place them at risk of HIV-related vulnerabilities. Because of the informal nature of their contracts they are not adequately protected

by existing labour laws and very often their human rights are violated. Farm workers, especially seasonal workers often live in compound accommodation, tents or shacks that are unhygienic, overcrowded and lacking privacy; casual and commercial sex is common on or near most commercial farms; most farms do not have access to primary health care services, including HIV programmes or STI services. The sector employs many irregular workers who can be reluctant to access health services for fear of revealing their work status to the authorities and risking deportation. The seasonal nature of farm work also increases mobility; recreational facilities are often inadequate or not present at all and income levels are strikingly unequal between men and women.

3.2 MINI SURVEY

Mini surveys were used to gather the baseline data. Mini surveys allow for collecting data under resource-constrained environments and under time limitations. To gather information from the migrants and their community, a generic structured questionnaire was developed by PHAMSA and its implementing partners. At country level the questionnaire was adapted to the local context and translated into the relevant language(s). The participants were assured of anonymity and required to give informed consent before participating in the survey, see Appendix II.

Some implementing partners used probability sampling and others used informal sampling to select the respondents. The sample sizes of the assessments were relatively small. Coverage was enough for analysis, but the findings cannot be used for elaborate statistical analysis due to the small sample sizes.

The purpose of the assessments was to gather information about the following areas:

- Socio-demographic information of the targeted mobile workers
- HIV knowledge, attitudes, behaviours, and perceptions among mobile populations
- HIV risk and vulnerability within the context of mobility and migration
- Relationship between gender and HIV risk and vulnerability
- Environmental factors: location of living, transport, recreation, access to services
- Current knowledge, acceptability and perceived impact of existing interventions

Due to the limitations of the methodology and research capacities amongst the implementing partners, not all the issues were adequately covered. Except for the Walvis Bay Multi Purpose Centre Trust (WMPCT), all IPs could only do the mini survey. Issues such as acceptability and perceived impact of existing

interventions were not explored as they required additional research methodologies such as key informant interviews and focus group discussions.

3.3 FOCUS GROUP DISCUSSIONS

The Walvis Bay Multi Purpose Centre Trust used focus group discussions as a secondary tool to collect information to understand the impact of the seafarers' vulnerability on their spouses and, in turn, to understand how the spouses' vulnerability affects the lives of the seafarers. This information was used to validate the findings of the mini survey. The discussions were carried out with 10 seafarers who are permanently employed and spouses (long-term or married) of seafarers. Groups were selected purposively from the programme area sites and on the vessels. A discussion guide was used to ensure that the data collected is consistent with the purpose of the project.

3.4 FIELD DATA COLLECTION AND MANAGEMENT

The surveys were conducted between November 2007 and February 2008. The Zambian project started a little later and the assessment was conducted between May and July 2008. Each IP recruited and trained fieldworkers. Per location the data collection process varies considerably, see Table 6 hereunder:

	RSA	LES	MOZ	NAM	SWA	ZAM M	ZAM C
No of collectors	2	5 (M:2,F:3)	10	7	10	6(M:6)	8 (M:4, F:4)
Type of collectors	University students	Field workers	University students	Youth club, support group, community	Form 5 students	Health workers/ peer educators	Health workers/ peer educators
Research experience	No	Yes	No	No	No	Yes	Yes
Interview/research training attended	Yes, 3 days	No	No, 1 day orientation	Yes	Yes, 2 days	Yes, 2 days	Yes, 2 days
Duration of data collection	3 days	4 days	NA	10 days	10 days	5 days	4 days
Monitoring and supervision	By HTT	By TEBA	Coordinator & community leaders	Community mobilizer, workplace health educator	Acting project coordinator and the community development manager	IOM research officer and field coordinators	IOM research officer and field coordinator
Training materials	NA	NA	NA	PHAMSA partners pack	NA	Yes, in-depth training pack prepared	Yes in-depth training pack prepared
Evaluation forms	NA	NA	NA	Yes, post test	NA	Informal post data collection team evaluation	Informal post-data collection team evaluation

NA: not available

3.5 STAKEHOLDER INVOLVEMENT

The model for interventions used by PHAMSA focuses also on the contextual factors that drive the HIV epidemic. Therefore, the context in which the targeted migrant communities are working and/or living was looked at. It was therefore essential to include other stakeholders. While conducting the baseline assessment, implementing partners engaged and partnered with the following

organizations and companies; see Table 7. The stakeholders were informed about the project by means of formal letters followed by private consultations. The consultations provided stakeholders with information about PHAMSA and identified the role stakeholders could play in the project.

TABLE 7: STAKEHOLDERS INVOLVED DURING ASSESSMENT PROCESS

SA	Farm owner, farm workers, Nompilos
LES	Leribe district authorities, Nat. AIDS Commission, PSI, New Start, Ex-mineworkers and allies
MOZ	Local government, community leaders and religious leaders, Amigos dos naturais de Novungene, AMIMO
NAM	Ministry of Fisheries and Marine resources, Mission to seafarers, Bengulla Fishing Company, Cadilu Fishing Company, Tunacolor Fishing Companies
SWA	Companies contracted to RSSC, department within RSSC working with seasonal and temporary workers
ZAM/MINE	IOM partners, CHAMP, Mining company
ZAM/ COTTON	IOM partners, CHAMP, Grinning company local government

NA: not available

3.6 DATA ANALYSIS

Data was collected through the survey questionnaires, focus group discussions, and key informant interviews. Interviews were conducted between November 2007 and July 2008. Data capturing, analysis, and presentation was done by the five implementing partners with the support of the PHAMSA team. Basic statistical methods were used to analyse the data. PHAMSA designed a Microsoft Excel data entry tool to collect the data. A deductive method of data entry was used, which involves the use of a predetermined classification scheme that is followed by the coder.

The raw data were organised by means of frequency tables. This characterised the populations and distribution of responses,

allowing for descriptive analysis. Uni-variant and multi-variant analysis was used to determine frequency distribution and percentages of responses of participants. In this mini-survey it was desirable to obtain measures of the central tendency, using the arithmetic average. Data on the various variables were summarised using tables. Qualitative data from key informants and focus group discussions were analysed in themes corresponding to the key variables in the structured questionnaires. The data of the Zambia assessments were entered in a SPSS data base. Frequencies were run for all questions. Data were disaggregated according to sex, age, education, nationality and other categories relevant to the site.

4 FINDINGS AND ANALYSIS

This assessment primarily serves as a baseline for measuring the impact of the PHAMSA Pilot Projects at seven sites in southern Africa.

The assessment provides a snapshot to indicate the HIV and AIDS-related knowledge, attitudes, practice and behaviours of migrant and mobile workers, their spouses and the community they interact with. A total of 1054 respondents were included in the mini-survey. For the sake of presentation and visibility, no gender segregation is used: details of disaggregated findings can be found in individual site reports. This consolidated report does not aim to compare the different sites, since the context and target groups are so diverse. The findings are presented in percentages and rounded off to the nearest number. The figures provide an overall indication of the findings.

No information is presented regarding theme 5 and 6 of the assessment since the topics covered were already elaborated (see pg 16). The issues not covered are: environmental factors such as the mapping of recreational facilities, access to services, health statistics, mapping of existing programmes, and the perception of the respondents of these programmes

4.1 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

In total, 1054 people were interviewed at seven sites. Sixty-seven per cent are men, 32% are women, and 5 respondents did not specify their sex. In Mozambique, in the migrant community of Trêz de Fevereiro, more women than men took part in the survey. This is due to the fact that the wider population is included and many of the males have migrated to look for economic opportunities, mainly in South African mines.

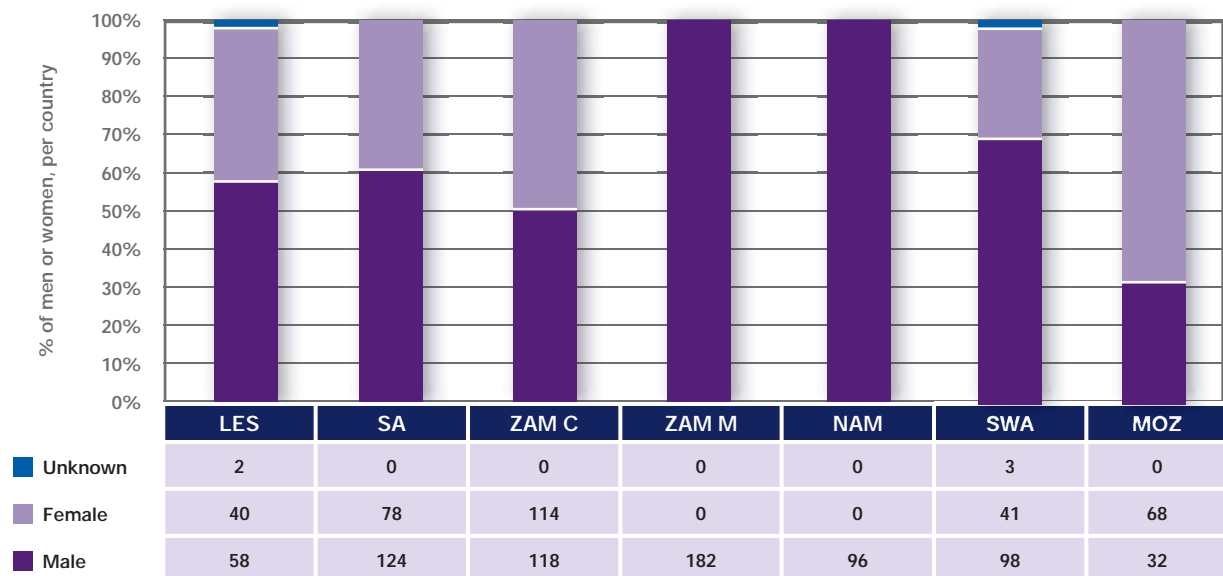


Figure 2 – Gender distribution

Figure 3 shows that the majority of those interviewed are between 20-39 years. The highest percentage is between 30-39 years. As expected, the target population is relatively young and in the reproductive age.

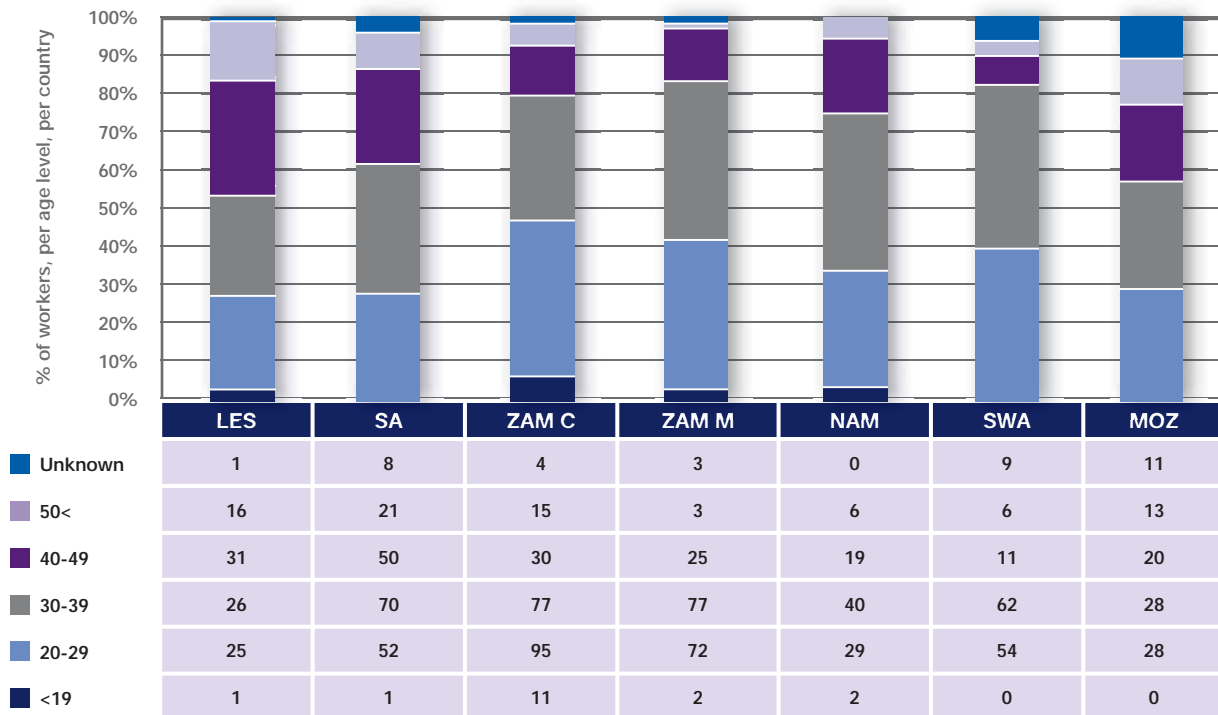


Figure 3 – Age of respondents

Most (94%) of the respondents are internal migrants; the percentage of foreign workers is small. The foreign workers are mainly from neighbouring countries, for instance Mozambican migrant workers in Zambia.

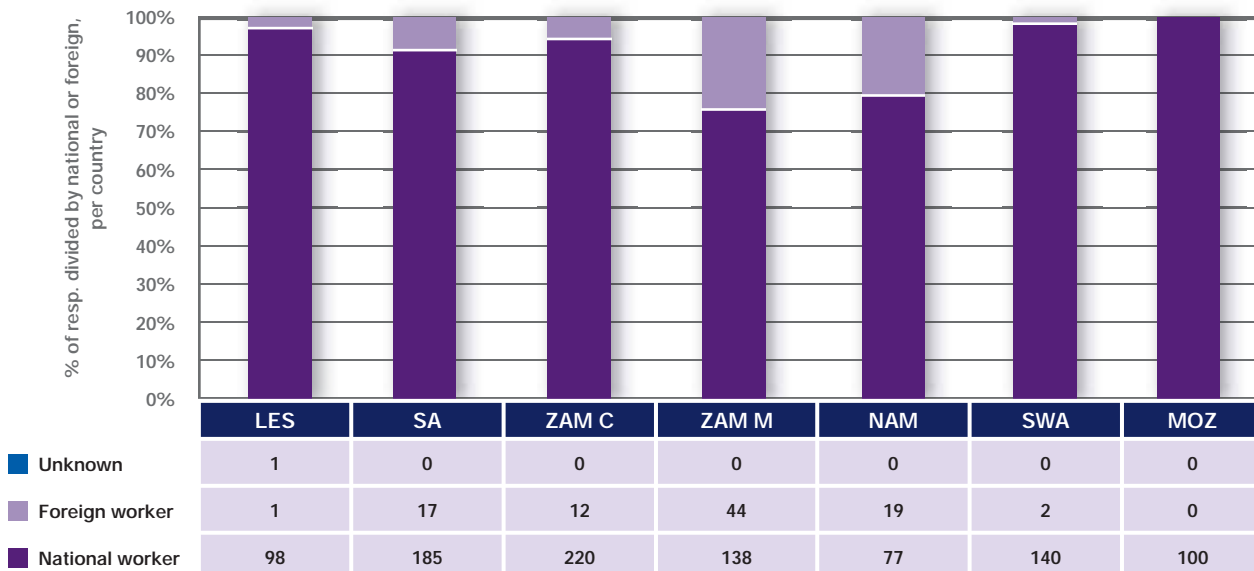


Figure 4 – National or foreign workers

As Figure 5 shows, the majority of the respondents (58%) finished between 5 and 14 years of education and have been through secondary school. 16% of respondents have attended school for 0 to 4 years. In the Walvis Bay study, no information

is collected about the education level of the fishermen. In Swaziland, Mozambique, Zambia and South Africa, in total 17% of the respondents did not indicate their education level.

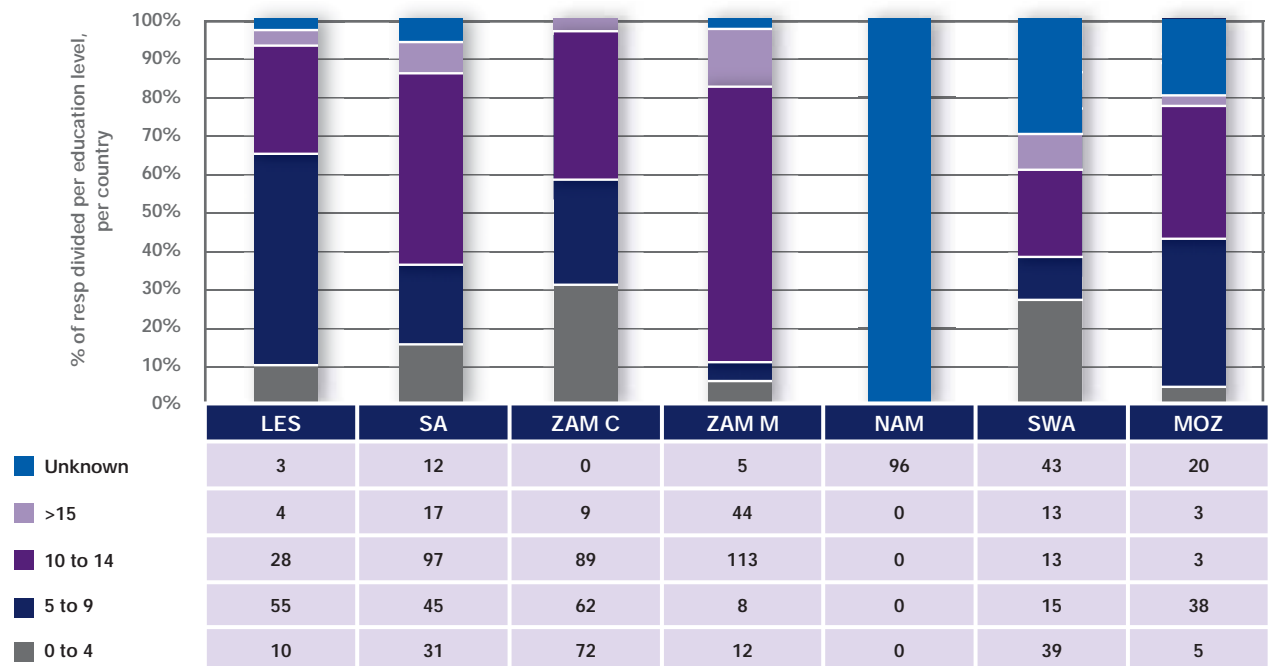


Figure 5 – Education levels of respondents



Figure 6 Types of relationships of respondents

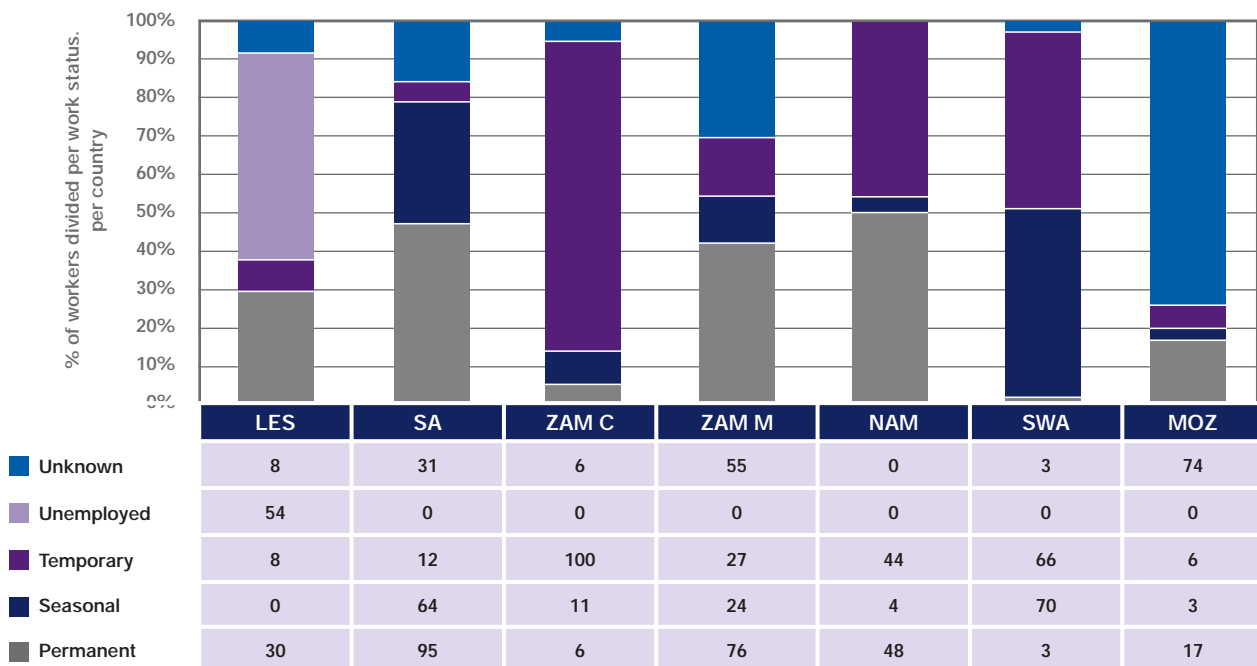


Figure 7 – Work status of respondents

Figure 7 outlines that most respondents are either on a temporary contract (25%), permanent workers (25%) or seasonal workers (17%).

accommodation sourced by themselves (33%). Only a small group commute (5%), or squat (8%) with friends.

4.2 ENVIRONMENTAL FACTORS

As Figure 8 illustrates, 33% of the migrant workers live in accommodation provided by their employer or in rented

A quarter (26%) of workers who lives in employer provided accommodation stay in single sex units. However, 50% of the respondents did not answer this question.

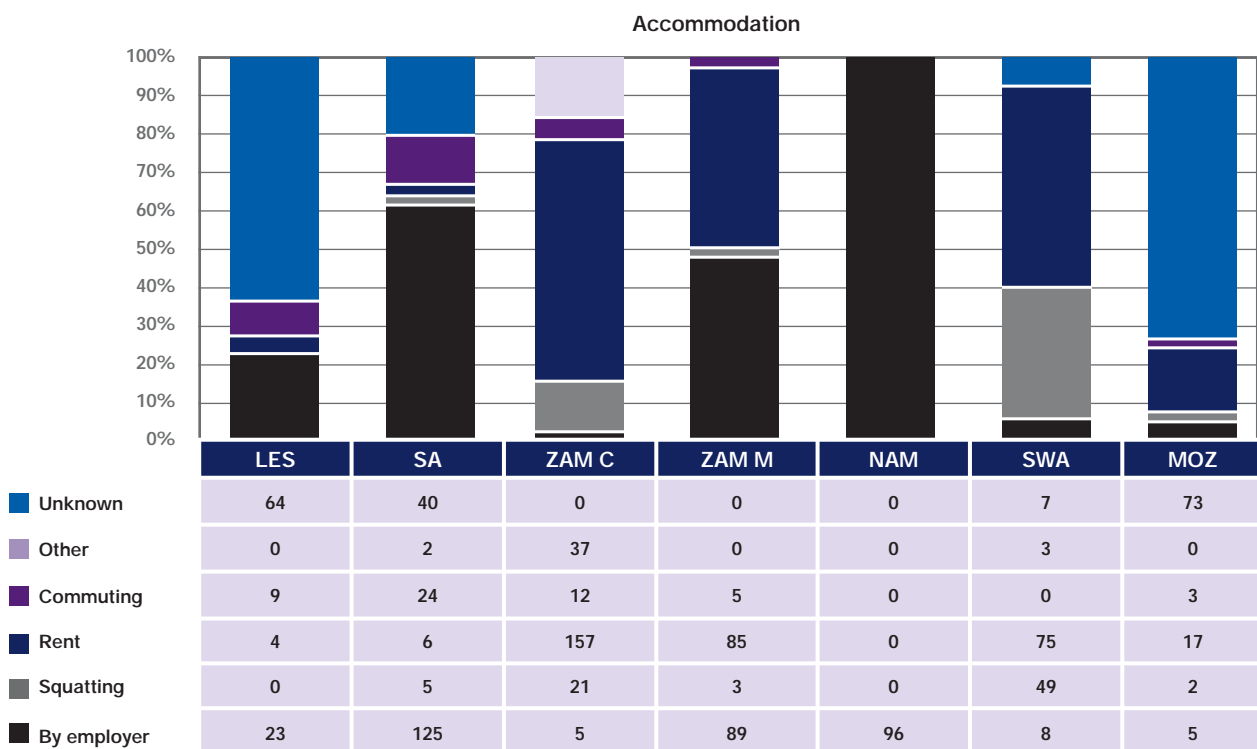


Figure 8 – Location of living

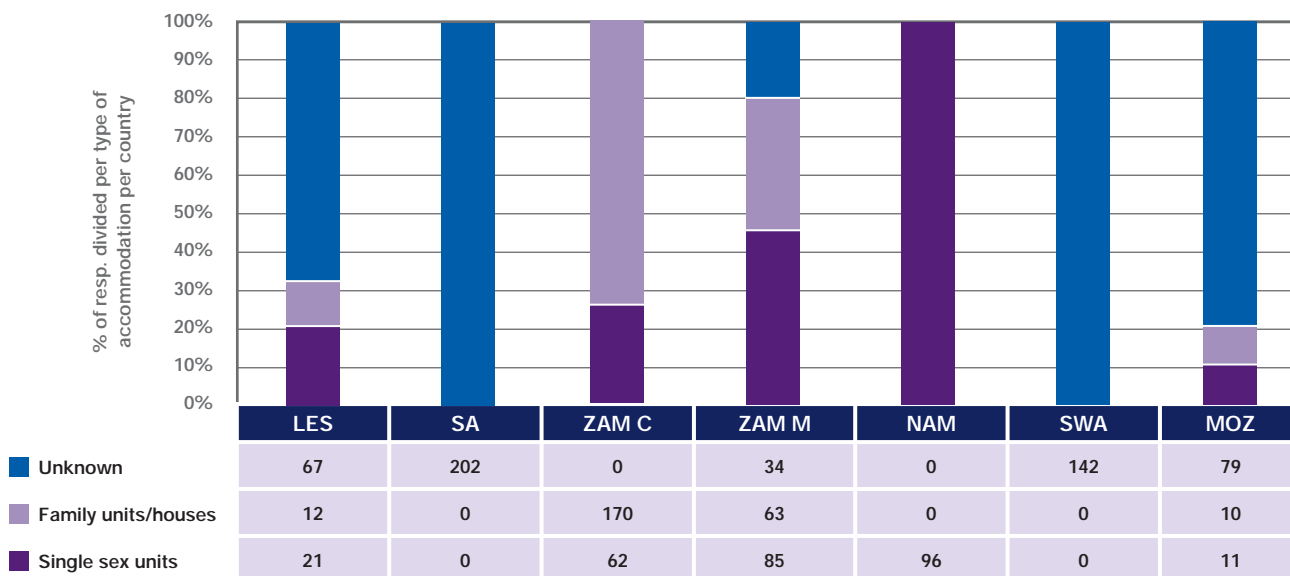


Figure 8 – Location of living

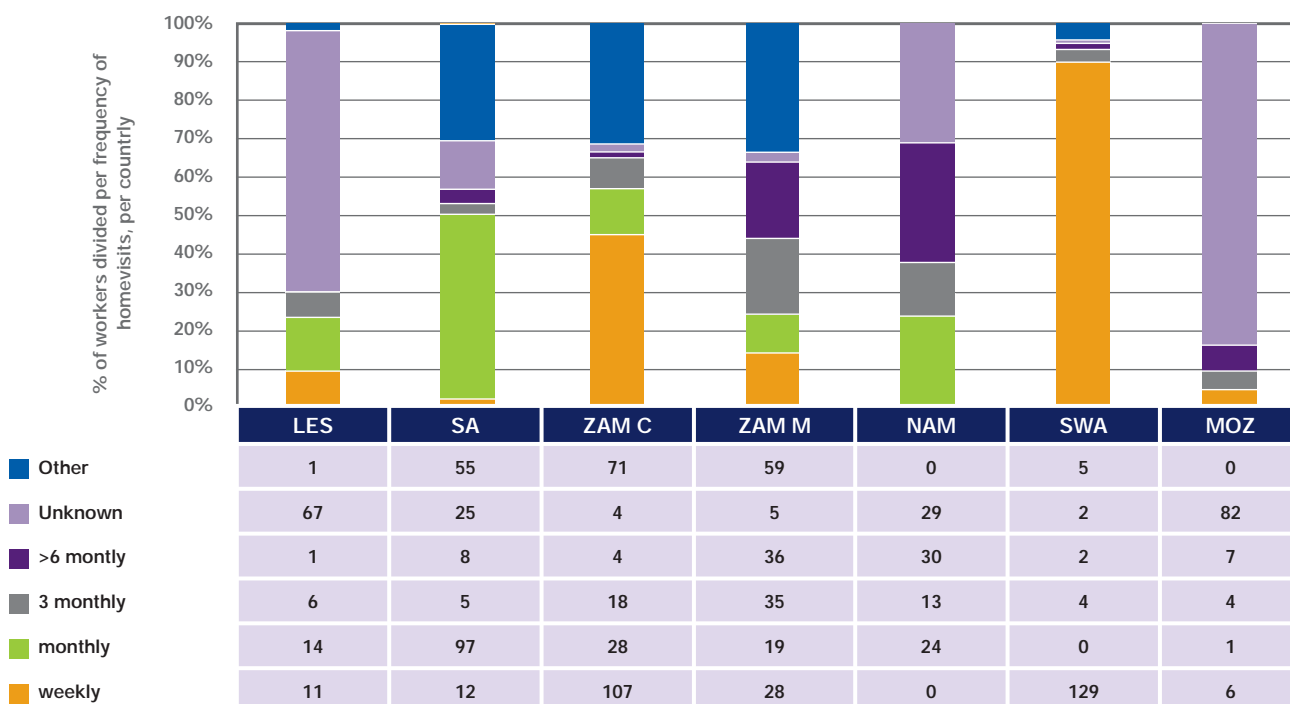


Figure 9 – Frequency of home visits of workers

4.3 KNOWLEDGE, ATTITUDES, BEHAVIOURS, PRACTICE AND PERCEPTIONS

Respondents display a fair level of knowledge on HIV and AIDS. Most migrants have heard of HIV and STIs. There is also some understanding of the modes of HIV transmission amongst those who responded.

However, as Figure 10 below illustrates, respondents also presented with high levels of misunderstanding, misconceptions and myths about HIV. These findings indicate a considerable gap in knowledge and understanding.

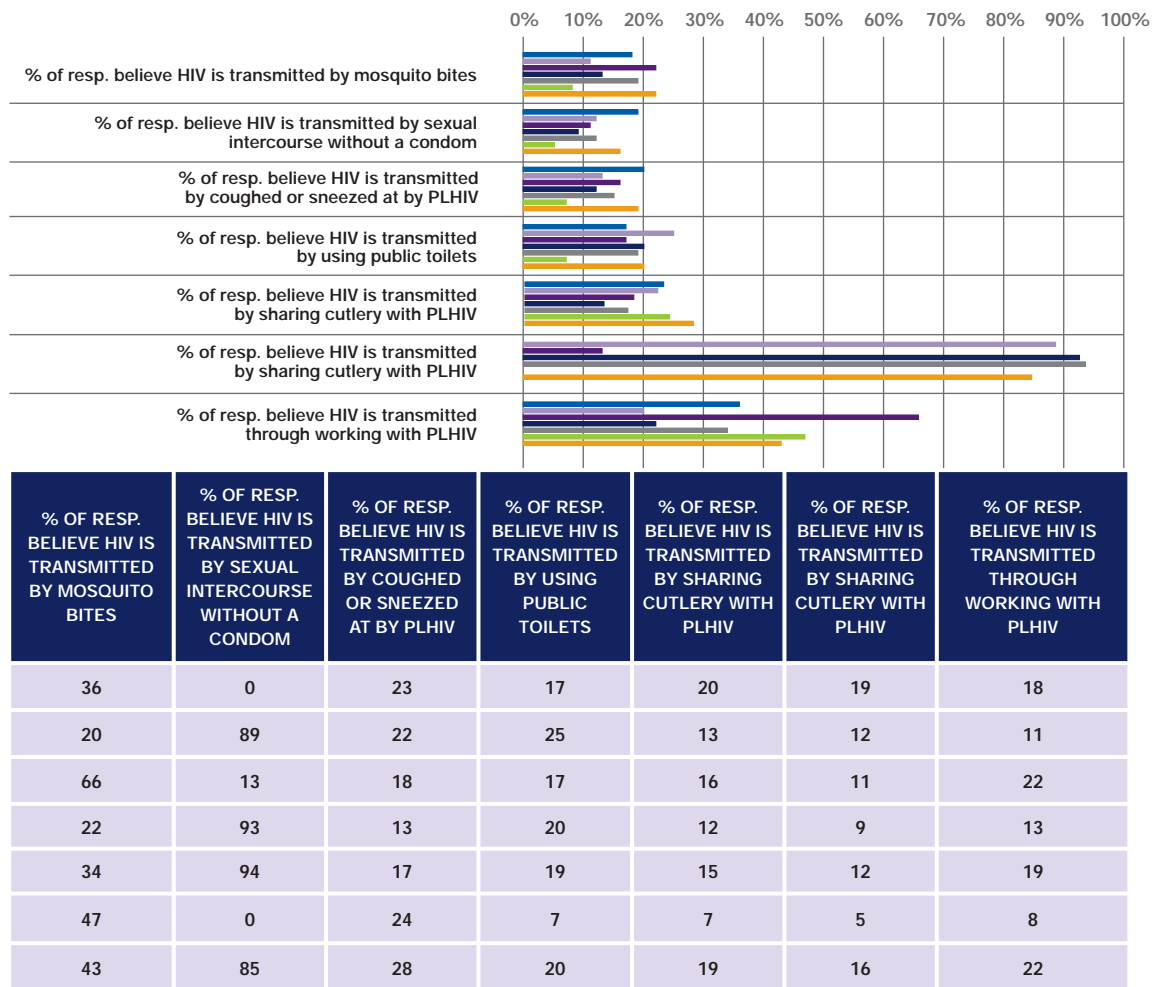


Figure 10 – HIV Knowledge

More than 16% of respondents believe that HIV can be transmitted through working with someone who is HIV positive, coughed or sneezed at (21%), sharing public toilets (18%), sharing cutlery with someone who is HIV positive (15%), and, believe that HIV can be transmitted through mosquito bites (36%).

attitudes and beliefs that may be stigmatising and discriminatory, but also those that may lead to myths and misconceptions about HIV and AIDS. These findings show that there is reason to be concerned about people's beliefs and attitudes in as far as HIV is concerned.

HIV related attitudes and beliefs are explored to get a sense of the level of acceptance of PLHIV and assess the prevalence of

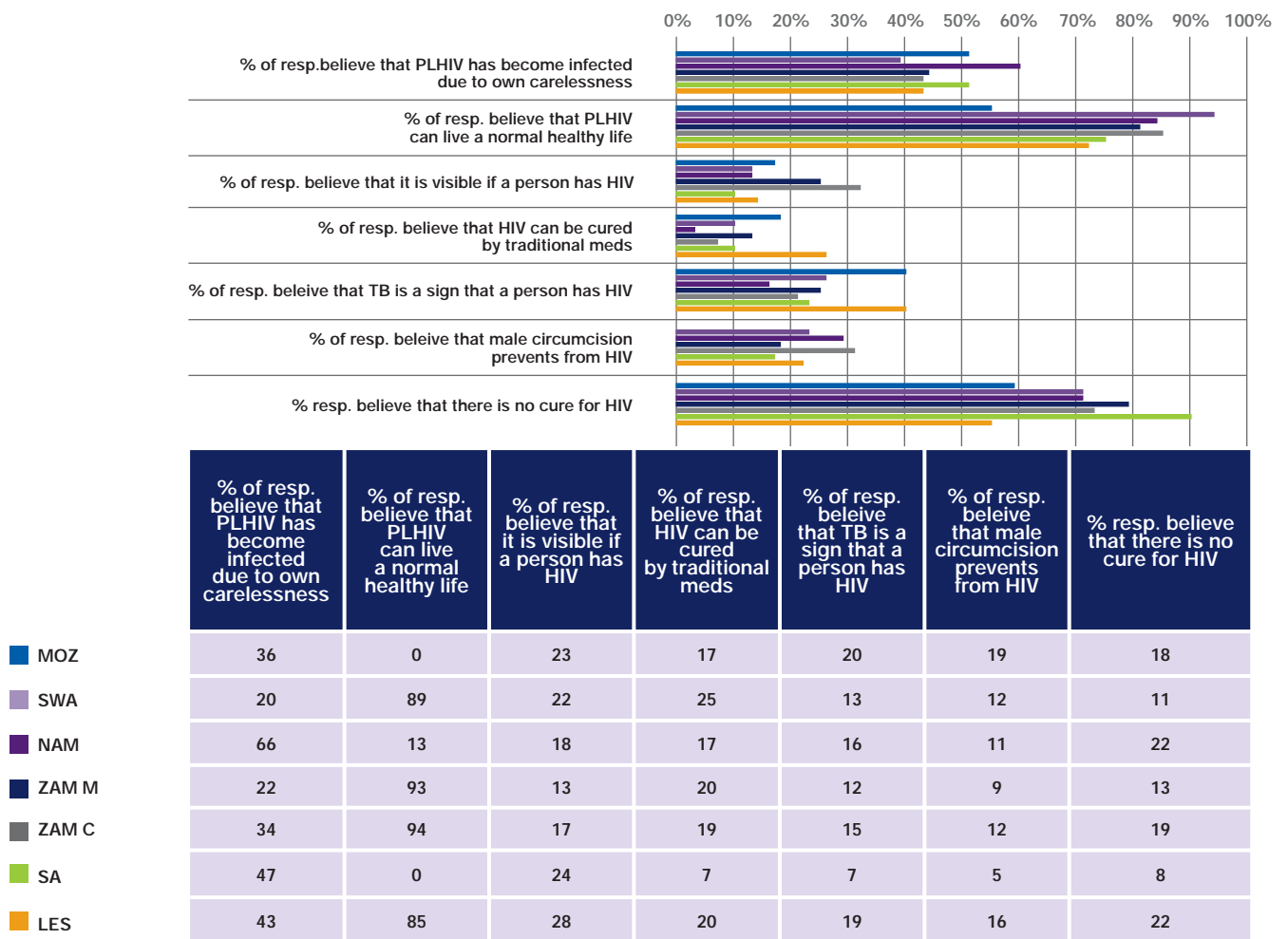


Figure 11 – Beliefs on HIV

Questions about HIV-related attitudes and beliefs were asked to get a sense of the level of stigma, as well as the existence of set beliefs that may lead to myths and misconceptions about HIV and AIDS. The findings indicate that there is cause to be concerned about beliefs and attitudes relating to HIV.

Figure 11 outlines positive and negative attitudes and beliefs relating to HIV and AIDS. These reflect the knowledge gap indicated in Figure 10 above. Respondents hold many stigmatising beliefs. Nearly half of respondents believe that people with HIV (PLHIV) have become infected because of their own carelessness (47%) and almost 27% associate TB with HIV. On the other hand, 78% of respondents consider that PLHIV can live normal healthy lives.

A considerable number are of the opinion that HIV can be cured by traditional medicines and that circumcision is 100% effective as an HIV prevention method. Twenty percent of respondents indicated that male circumcision can reduce HIV infection.

As Figure 12 shows, 82% of the respondents agree that it is important for people to know their HIV status and 51% say that they have been tested for HIV. There is a level of unwillingness to test, and the reasons for this are beyond the scope of this assessment. 26% of all respondents said that they will not take an HIV test if one were offered to them. Of the respondents who answered this question, approximately 25% do have access to testing facilities within their communities or workplaces.

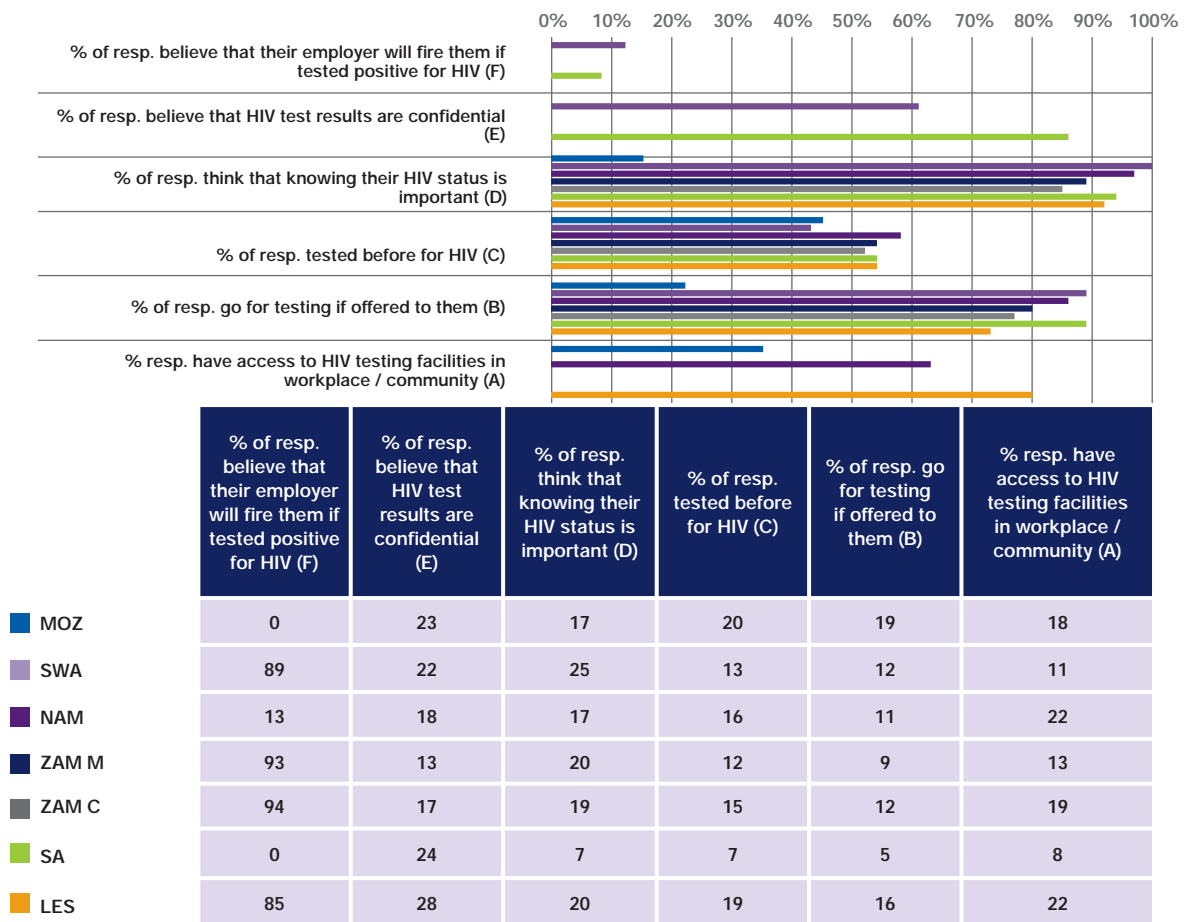


Figure 12 – HIV testing

4.4 RISK AND VULNERABILITY WITHIN THE CONTEXT OF MOBILITY AND MIGRATION

Figure 13 below shows the levels of risky sexual behaviour. A considerable number of respondents did not respond to questions relating to sexual behaviour. 74 respondents reported that they have engaged in sex with a commercial sex partner; 110 respondents said to have been engaged in casual sex; and

97 persons reported that they have engaged in transactional sexual relationships. As reported by the respondents, the level of sexual violence is high. Eighty-seven respondents reported that they have experienced forced sex. This is not exclusive to females. Male respondents also reported that they have been forced to have sex.



Figure 13 Occurrence of transactional sex and forced sexual activity

Most respondents know that consistent condom use minimises the chances of HIV infection, however on average only 15% report that they ‘always’ use condoms when they have sex, and 22% indicate that they ‘sometimes’ use condoms. According to Figure 15 below condom availability does not seem to be a major problem. 37% of respondents indicate that they can always get condoms if they need them.

One of the common beliefs about condoms is that they take away sexual pleasure (44%). Although 84% of the respondents agree that sex is safer with a condom.

36% of all respondents believe that free condoms are of bad quality. 45% of respondents believe that if a woman carries a condom it means she is “sleeping around”, and 72% believe that it is acceptable for a woman to initiate condom use with her partner.

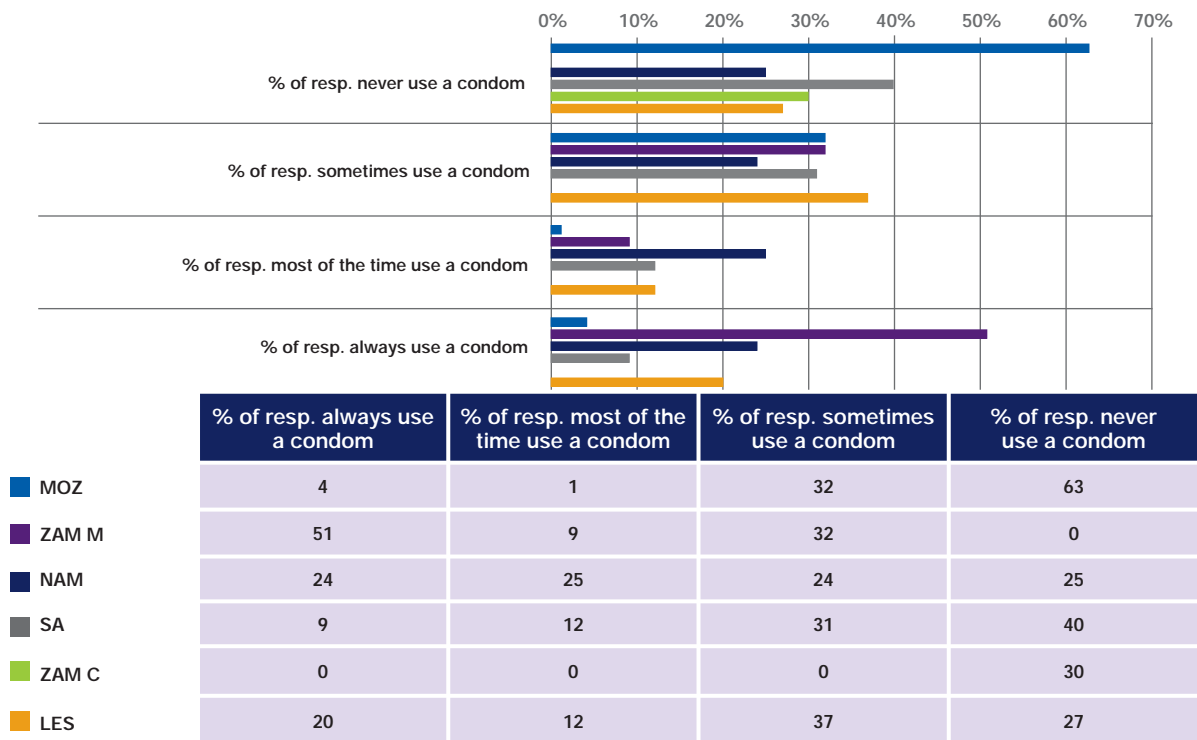


Figure 14 – Condom use



Figure 15 Perceptions on condoms

4.5 RELATIONSHIP BETWEEN GENDER AND HIV RISK AND VULNERABILITY

Almost 44% of the respondents believe that women should not hold the same job as men at the same rate of pay. Respondents hold strong beliefs that men should have control over decisions made in relationships and that a man may beat his spouse if she disobeys him (31%). Almost 19% of respondents believe that

it is acceptable for men to have more than one sexual partner, and more than 80% believe that women should only have one partner. Many also believe that women sometimes need to be pressurised a little to have sex (34%).

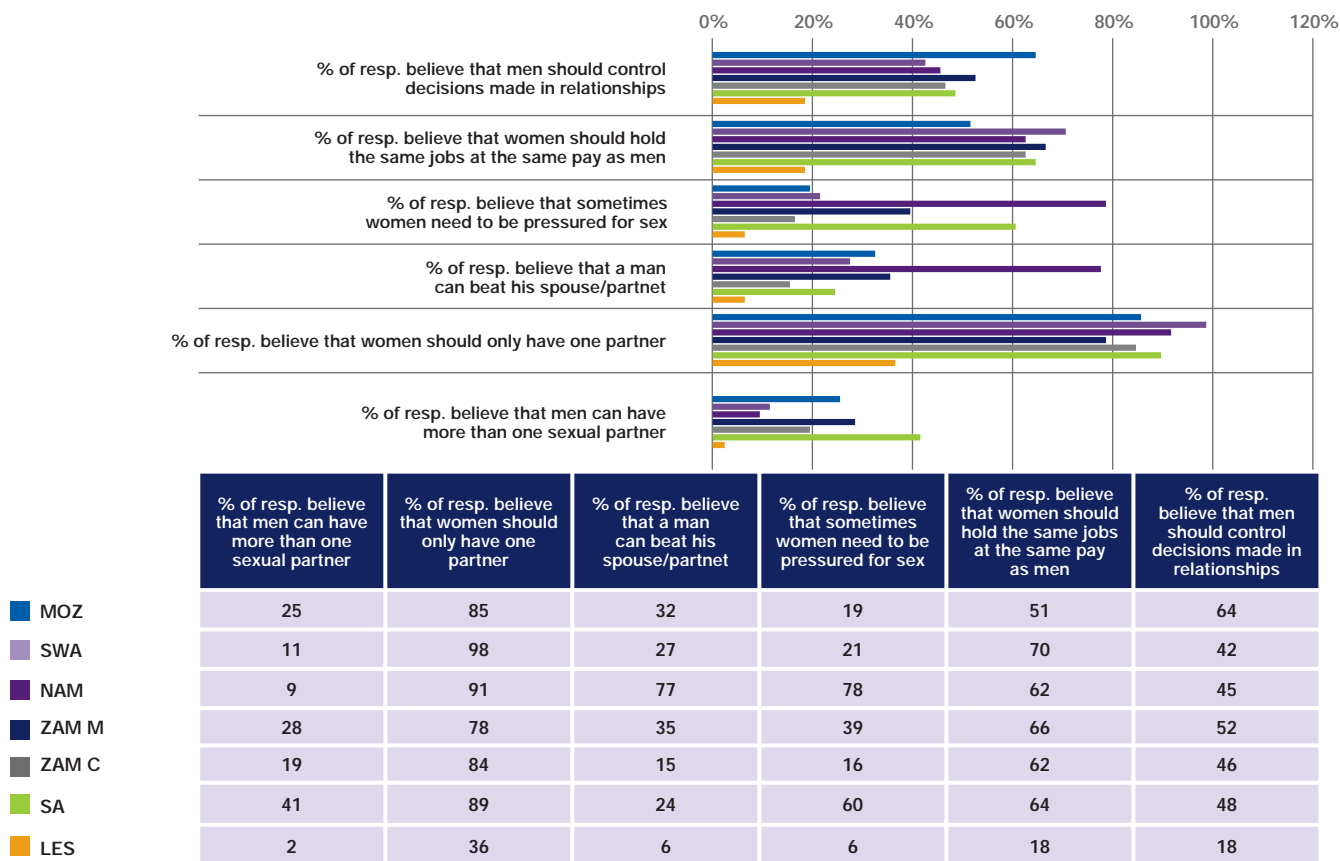


Figure 16 – Gender values

5 CONCLUSION

5.1 GENERAL

The findings from these assessments provide a range of useful information to strengthen the implementation of the PHAMSA Pilot Projects component. General conclusions and conclusions per theme of the assessment are presented below. In addition, the outcome of the assessments was subject to a number of limitations, which are summarised hereunder.

5.2 LIMITATION OF THE ASSESSMENT

The findings from this study cannot be used to generalise about the wider population groups covered by the PHAMSA pilot projects. Furthermore, the assessment findings cannot be used for elaborate statistical analysis, due to the sampling technique. However, given the intended use of the findings of this assessment – programmatic design and areas for implementation - the general trends and tendencies are useful.

With the exception of Zambia, the country-specific assessments fall short on information on how the sampling was determined including size, respondent selection, inclusion criteria and specific geographical areas that are included. The majority of the partners used purposive, informal sampling known as convenience sampling. This was used due to difficulty in accessing the respondents. Only those easily reached by interviewers were included in the sample.

From the individual country reports it was evident that the interviewers who collected the data had a diverse profile and level of training. Overall, the interviewers had limited research experience and were not always adequately prepared for the job. For interviewers themselves it can be difficult to talk about sex, especially with an older person. Interviewers have to be extremely careful in wording sensitive questions to obtain accurate answers. As a result, questionnaires were not adequately filled out, data was missing and it is assumed that due to inadequate interview techniques, information provided by the respondents was not maximised. Furthermore, the biases which are inherent to researching sensitive issues had a negative impact on the findings. The research capacity of most PHAMSA implementing partners was basic; therefore they could not provide sufficient supervision to the interviewers and oversee the data collection process. The advantage of a mini survey is that the number of non sampling errors tends to be low. Each requires only a few interviewers who tend to be better trained and supervised than interviewers used for larger surveys. However in this assessment

the interviewers were not sufficiently trained and therefore omissions occurred and the number of non sampling errors is relatively high. Also in terms of data analysis and reporting the IPs need to be capacitated. This assessment was therefore a capacity building opportunity for the partners.

Due to the culturally-sensitive nature of some of the questions, under-reporting is likely to have occurred. This also relates to issues regarding sexual risk-taking practices, sexual activity and stigmatizing attitudes, about which respondents might feel obligated to give socially acceptable responses, rather than answers that reflect their actual attitudes and beliefs. A large percentage of the sample neglected to answer a number of questions, particularly those relating to their socio economic status, with incomplete, or insufficiently filled in questionnaires as a result.

Accessibility of the respondents in some cases was difficult. The unpredictable docking times of the vessels, the long, early and late working hours of the workers presented a major challenge; and impeded data collection.

The assessment aimed to include 6 areas of data collection. However, the type of survey is not appropriate to collect a lot of data, covering a wide range of topics. Therefore in the process of the development of the questionnaire it was decided to leave objective 5 (environmental factors) and 6 (awareness of existing programmes) out.

Not all implementing partners pre-tested the questionnaires/ interviews therefore omissions in the questionnaires and interviews could not be tackled before the data collection commenced. Some topics covered in the questionnaire, such as gender roles, stigma towards PLHIV, sexual behaviour, gender based violence could have been topics for focus group discussions.

5.3 SOCIO DEMOGRAPHIC INFORMATION

The majority (67%) of the 1054 respondents are male. Most of the respondents are relatively young, between 20-39 years and are in the midst of their reproductive life. Of the total group most (94%) were nationals working in the fisheries, commercial agriculture or residing in mine-sending communities. The majority (58%) finished between 5 to 14 years of formal education, and only sixteen percent attended between 0-4 years school. Overall, the level of education is basic however people can read and

write, which is important for the development of IEC materials. The majority of the respondents are either married or are in a long term relationship. The findings do not show that many respondents are involved in casual partnerships or multiple concurrent partnerships, however, since the assessment did not cover this information and this particular question was often not answered, conclusions are difficult to draw from this. The respondents work either on a temporary contract, are seasonal workers or are permanent workers.

5.4 HIV KNOWLEDGE, ATTITUDES, BEHAVIOURS AND PERCEPTIONS

There is a fair level of knowledge about HIV and modes of transmission. However, the findings show that there is reason to be concerned about people's beliefs and attitudes about and towards HIV and AIDS. The respondents display high levels of misunderstanding, misconceptions and myths relating to HIV. The knowledge gap contributes to stigmatising beliefs. Such myths and misconceptions contribute to perpetuating risky sexual practices and stigma towards PLHIV. However, most of the respondents believe that PLHIV can live normal healthy lives. This indicates encouraging attitudes towards PLHIV, but stigmatising attitudes still need to be addressed in programmes. The assessment did not investigate attitudes towards other related infectious diseases such as TB and STIs, and further research into this area is recommended.

The majority agrees that it is important for people to know their HIV status and more than half indicate that they have tested for HIV. However, there is also an unwillingness to test, for reasons that are beyond the scope of this assessment. Almost half of the workers said that they will not take an HIV test if offered to them.

Respondents hold many stigmatising beliefs. Nearly half of respondents believe that people with HIV have become infected because of their own carelessness. This belief could lead to negative and unsympathetic attitudes towards PLHIV. It could also mean that people know that it is their own risky behaviour that leads to HIV infection, or it may be a stigmatising statement that may fuel negative attitudes towards people living with HIV. Over a quarter of the respondents associate TB with HIV and this might mean that people know of the clinical association, or it may be a statement that may label everyone who has TB as being HIV positive. Many respondents believe that PLHIV can

live normal healthy lives. This indicates positive attitudes towards people living with HIV, but stigmatising beliefs and attitudes are still prevalent and need to be addressed. A considerable number of respondents believe that HIV can be cured by traditional medicines and that circumcision is 100% effective as an HIV prevention method. This needs to be considered during future project design. It is clear that the issue of circumcision is still unclear and needs to be looked at more closely (i.e. how is it promoted within IEC) to help people understand that circumcision is not an HIV prevention method in itself. Some respondents believe that HIV infection is not possible if the man is circumcised. This is a worrying belief as it may imply that people believe that if you are circumcised you do not need to practice safer sex through methods such as condom use.

5.5 HIV RISK, VULNERABILITY WITHIN THE CONTEXT OF MIGRANTS AND MOBILITY

A basic theoretical understanding of the issues around HIV vulnerability does exist, however, this knowledge is not in-depth, and it has not led to positive changes in sexual behaviour. For example, knowledge about the benefits of using male condoms are widespread, however misperceptions and beliefs relating to condoms are a barrier to consistent and correct condom use. One of the most frequently reported beliefs is that condoms reduces and eliminates sexual pleasure. Only one third of the respondents believe that sex is much safer with a condom.

The issue of male circumcision is unclear and needs to be looked at more closely – many people do not understand that circumcision is not a failsafe protection method. Regarding casual and commercial sexual relationships, no conclusions can be drawn from these findings since so many people did not answer the question. A number of respondents confirmed to have engaged in transactional sexual relationships. The assessment shows that the level of sexual violence is high and it is not exclusively women who are the victims and men the perpetrators.

5.6 HIV RISK, VULNERABILITY AND GENDER

Respondents - both men and women - hold gender-stigmatising and discriminatory beliefs. Findings indicate that women's rights are not respected and this factor could perpetuate the low socio-economic status of women and increase their vulnerability to HIV. The findings show some gender inequality in as far as sexual practices are viewed. While some practices might be acceptable for men, it is different for women. These beliefs promote

risky sexual practices amongst men, while they increase HIV vulnerability amongst women.

For example, respondents believe that sometimes women need to be pressurised a little to have sex, which means women are vulnerable to sexual violence. One conflicting finding is that most people believe that a woman who carries a condom is sleeping around. This is gender stigmatising and means that women have limited power over their sexual practices. But on the other hand it is reported that it is acceptable for a woman to initiate condom use with her partner.

This survey did not study in detail men-who-have-sex-with-men, and this should be researched in future assessments.

5.7 ENVIRONMENTAL FACTORS

Many of the respondents live in housing provided for by their employers (33%) or rent accommodation by themselves (33%).

Of the reported data, 26% of the workers live in single sex units. Overall, it can be stated that the respondents visit their homes once a week or once a month. No correlation can be made between the type of accommodation and the frequency of home visits in the assessments.

In spite of the scope of this assessment, not all topics were included in the final questionnaire. No information was collected on recreational activities of the migrants and mobile communities; access to (sexual and reproductive) health services; access to VCT facilities; available workplace policies and services; and health seeking behaviour of mobile workers. Furthermore, no information was collected regarding the current knowledge, acceptability and perceived impact of existing interventions and programmes. The perception on involvement of people living with AIDS (GIPA principle) in future programme interventions and support services for PLHIV was also not assessed. Therefore no conclusion and response can be drawn on these issues.

6 RECOMMENDATIONS FOR PLANNING AND AUTHORISED ACTIONS

The sections hereunder summarize a number of recommendations for the PHAMSA Pilot Project and IPs.

6.1 RECOMMENDATIONS WITH RESPECT TO CONTENT

6.1.1 Knowledge on HIV and AIDS

Communities at all sites have a basic theoretical understanding of issues relating to HIV and AIDS, but this knowledge needs to be more in-depth. Information on HIV, AIDS and STIs and basic knowledge of sexual and reproductive health should be included in behaviour change/social change communication activities. This should be supported through peer group discussions and through the development of culture-specific, localised IEC materials. There is a need to address the misconceptions that people hold regarding modes of HIV transmission. Interventions should also focus on spouses of migrant workers and the community members.

PRIORITISED ACTION ON KNOWLEDGE ON HIV, AIDS AND STIS

- Include information on HIV, AIDS, STIs and reproductive health in behaviour change/social change communication activities.
- Organise and facilitate peer group discussions on HIV, AIDS, STI and sexual and reproductive health knowledge.
- Development of IEC materials, including basic facts on HIV, AIDS, STIs and sexual and reproductive health.

6.1.2 Prevention of HIV

Although most people state that having one sexual partner is a method of preventing HIV infection, the low perception of risk indicates a need to increase knowledge of HIV transmission, and to reinforce behaviour change in the following areas:

- Mutual faithfulness among partners;
- HIV VCT;
- Support positive living and decrease the incidence of new HIV infections; and
- Correct and consistent condom use.

As an initial step, communication interventions designed to increase knowledge on prevention should be implemented. Respondents need assistance in developing skills in prevention, risk reduction and life skills (making healthy choices, resisting negative peer pressures (including those that are gender-based, and minimizing harmful behaviours). Advocacy is needed for accessible condoms at work sites.

There is need for sensitisation meetings at the work sites. These should include HIV and AIDS prevention, STI, and gender related issues including prevention of (sexual) and gender based violence (SGBV). Different communication methods can be used. These include: community dialogue to clarify and correct misconceptions about HIV transmission and to encourage openness about HIV and AIDS; dialogue on risks and vulnerability; inform individuals of available HIV prevention methods and treatment services; peer education; SCC/BCC involving particular focus group discussions. This method of reaching people should be used widely to help workers learn more about HIV and AIDS, particularly relating to prevention of infection and service provision. Sessions should be planned at a time which is suitable for migrant workers. The employer should facilitate and encourage such gatherings.

Education should be extended into communities close to the work site. Each company should appoint a focal person whom workers can trust and who is their point of contact to address questions, concerns and clarification on issues relating to HIV and STI prevention; where they can access information and referrals to services (STI and SRH services, counselling and testing, legal support in case of gender based violence).

PRIORITISED ACTION ON PREVENTION OF HIV

- Develop skills in prevention, risk reduction and life skills.
- Advocate and facilitate for the availability and accessibility of condoms at work site, coupled with information about correct condom use and the importance of consistency (including with regular partners/spouses).
- Organise sensitization meetings at the work sites or after working hours including HIV and STI prevention; gender related issues and prevention of SGBV.
- Organise community dialogue to encourage openness about HIV and AIDS; dialogue on risks and vulnerability; and to inform individuals on available HIV prevention methods and treatment services.
- Create a position of trust and appoint a person who will become the point of contact within the company to address questions, concerns and issues relating to HIV and referral on sexual and reproductive health and cases of sexual and gender based violence.
- Development of IEC materials including prevention messages, and education of reproductive health issues.

6.1.3 HIV testing

The overall reported testing rate of migrant and mobile communities needs to be improved. As a starting point, risk-perception needs to be increased through use of peer based communication methods that encourage open and frank discussions on past and present individual behaviour and the importance of testing. HIV testing sites can be entry points for other services such as care and treatment, counselling, PMTCT, medical examination and to increase openness and reduce stigma. Access to health and psycho-social services for migrant and mobile populations should be increased. It is important to consider how to support and promote VCT and treatment access and with which partners.

PRIORITISED ACTION ON HIV TESTING

- Include information on HIV testing, STIs and TB screening in behaviour change communication/social change communication activities.
- Development of IEC materials, including testing information and information on nutrition to bolster the immune system.
- Organise and facilitate peer-based communication sessions to encourage open frank discussions on past and present individual behaviour; HIV risk; the importance of testing; treatment possibilities. Include where possible people living with HIV.
- Facilitate and support increased access to VCT and psychological services for migrant and mobile populations.

6.1.4 Stigma reduction

Companies and farms should create an enabling environment for PLHIV to be open about their status and fully participate in the working process without discrimination or stigmatisation. Programmes aiming to reduce stigma PLHIV should be implemented, for example, community dialogue on how HIV and AIDS affect everyone and how to address the issue. Support groups for people living with HIV and AIDS should be formed and facilitated and PLHIV should be actively involved in work-related activities (e.g. peer meetings). The belief that people who have HIV have become infected because of their own carelessness is stigmatising and needs to be considered when developing implementation plans and social change communications.

PRIORITISED ACTION ON STIGMA REDUCTION

- Facilitate community dialogue on effects of HIV on PLHIV, their families, and the people they interact with.
- Formation and facilitation of support groups for PLHIV.
- Involve PLHIV in programme development and activities.
- Investigate tools and training to address stigma and empowering PLHIV.

6.1.5 Gender

Gender-related issues including GBV should be mainstreamed into all future programme design and implementation. Currently, gender issues are acknowledged by the programme but not addressed in a consistent manner. A gender training and mentoring programme should be implemented to address this. Understanding gender dynamics and how they impact HIV vulnerability needs to be central in all interventions, since gender, sexuality, and HIV are so intertwined. It is also critical to change culturally-defined understandings of masculinity to create a community that respects the rights and needs of both men and women. These beliefs need to be explored further through focus group discussions and included in IEC materials and messages. Programmes need to tackle gender stereotyping, promote women's rights and sensitize men against sexual violence, especially in an all male working and living environments.

PRIORITISED ACTION ON WORKPLACE PROGRAMMES

- Inform employees about existing workplace policies and programmes on HIV and AIDS.
- Take stock of existing workplace policies.
- Ensure condoms are available at workplace settings.
- Set up counselling services to deal with questions, concerns, HIV prevention, treatment, care and cases of gender based violence and appoint person of trust.

6.1.6 Running effective workplace programmes

The workplace is a convenient setting for HIV activities and workplace-based interventions have been proved to be effective. These include: work based awareness programmes and HIV counselling in the workplace; provision of ARV drugs to HIV positive employees and referral to health facilities. The ILO code of good practice, outlines 10 action points related to the workplace: HIV Recognition of HIV/AIDS as a workplace issue; non-discrimination; gender equality; healthy work environment; social dialogue; screening for purposes of employment; confidentiality; continuing the employment relationship; prevention, care and support (ILO, 2001)

The issue of leadership needs to be addressed by companies. Senior management should be more active and vocal in its support of workplace strategies, which need to move from the surface level to become part of the culture of an organisation. Many companies have initiated HIV workplace programmes but in general too few people are making use of them. This is due to various factors including trust, stigma and the fact that employees might not be aware of what services are available. Early action in educating workers on HIV prevention is essential if the serious economic and social consequences of AIDS for companies are to be avoided.

PRIORITISED ACTION ON TUBERCULOSIS

- Inclusion of Tuberculosis prevention and treatment messages in IEC materials.
- Facilitate and support access to Tuberculosis screening and treatment.
- TB support groups?

6.1.7 Tuberculosis

TB is an increasingly important issue in southern Africa among migrants and mobile populations, particularly in the mining sector. PLHIV are at greater risk of developing TB than other opportunistic infections. In southern Africa it is estimated that 50-80% of tuberculosis patients are HIV-positive. Drug resistant TB and especially TB with resistance to both first and second line anti-TB drugs can spread rapidly in communities of PLHIV resulting in high mortality rates. In this assessment, 27% of the workers associate HIV with TB. This could indicate that people know of the clinical association, or that they label everyone who has TB as being HIV positive. Therefore, particular emphasis should be placed on including information in IEC materials on community-based strategies to identify undetected cases, ensure early referrals for screening and treatment, and support treatment adherence.

PRIORITISED ACTION ON MALE CIRCUMCISION

- Include circumcision in IEC materials to help people understand that circumcision is not an HIV prevention method per se.
- Focus Group Discussions about male circumcision – to inform, and collect data about existing beliefs and attitudes.

6.1.8 Male circumcision

There is a great deal of misunderstanding on the issue of male circumcision and it needs to be looked at more closely, particularly on how it is promoted, to help people understand that circumcision is not an HIV prevention method per se.

6.2 RECOMMENDATIONS WITH RESPECT TO THE PHAMSA PILOT PROJECTS

As the IOM study on mobile populations and HIV/AIDS in the southern African Region (2003) concludes, programmes that train peer educators in the workplace and that distribute IEC materials and condoms are extremely important. Researchers emphasise that these efforts should always go together with the protection of basic human rights and improving the living and working conditions of mobile workers. As already included in the PHAMSA project design, also the spouses and regular partners of migrants and mobile populations should be reached with HIV prevention and care messages. It is important to create a climate that encourages disclosure and openness about HIV infection.

6.2.1 Focus and strengthening of PHAMSA Pilot Project

Per country, PHAMSA should be clear on its strength and niche and consider the following: what are the strengths of the IPs; what can it achieve within a framework of a company/business/farm/community; what can other stakeholders contribute; what are the specifics of the target group. This should be outlined or if already available, updated. Since context, actors and needs are diverse a local approach is necessary.

It is essential to have a good working relationship with the companies/farms and communities PHAMSA works with, in order to create circumstances and an environment that enable behaviour change and social change. If possible, a consultative mid-term workshop should be facilitated to gain stakeholder buy-in and input into the development of effective implementation strategies based on the baseline assessment findings.

The provision of entertainment and recreational facilities at companies, mines, and on farms are important elements in the projects. Recreational activities especially sport, but also video, enable workers to use spare time constructively and safely. Fostering a sense of belonging within the broader community (via church groups, support and youth clubs) can help build self esteem and counter risky behaviour.

The PHAMSA pilot project should increase the uptake of VCTs by males and females; increase visits to the clinic for SRH treatment; increase uptake of condoms; and decrease the reported number of concurrent sexual partners.

PRIORITISED ACTION FOCUS PHAMSA PILOT PROJECT

- Schedule mid-term workshops at country level.
- Identify human and institutional capacity-building needs to improve services to migrants and mobile communities.
- Investigate tools and training to address stigma, and the inclusion and empowering of PLHIV.
- Organise and facilitate life skills training.
- Identify areas for service expansion and service delivery improvement.
- Link new activities with existing activities/programmes of IPs e.g. use trained peer educators.
- Involve employers, trade unions, relevant community support organisations and SWs whenever possible in the PHAMSA Pilot Project.
- Facilitate the development of recreational opportunities at work sites.

6.2.2 Information system

In order to generate data for project monitoring and evaluation, there is need to establish an information monitoring system. PHAMSA could set up or identify clusters or groups of migrant labourers at the work site. This will help in monitoring which person is receiving services, type of services and any need for focused follow-up by volunteers. Furthermore, such information will assist in subsequent surveys (for example, in sampling and determining service delivery gaps) and producing corresponding listings of volunteers/migrants and mobile workers responsible for each of the clusters or groupings. In order to monitor the programme effectively during the coming years, it may be necessary to develop specific checklists or data collection forms for each indicator.

PRIORITISED ACTION ON INFORMATION SYSTEMS

- Establish information system on listing volunteers/migrant workers, to collect information on who is receiving services, type of services and need for follow up.

6.3 STRENGTHENING OF FUTURE ASSESSMENTS

6.3.1 Methodology and data collection

For the next assessment, statistical software such as Epi Info or SPSS should be used for analysis. In this assessment Zambia used SPSS for data collection and analysis. This assessment was conducted by more experienced data collectors than at other sites and therefore analysis was more advanced. The better quality of data collection and analysis and the trained collectors strengthened the findings.

Respondents should be selected according to clusters using purposive sampling, population proportional to size. Minimum sample sizes should be obtained for each site to enable future measurement of changes over time. Clear inclusion criteria should be outlined for the sample selection and the exact location of the assessment.

One of the main lessons learned from this assessment is the importance of establishing a clear understanding of the availability and accessibility of the target group. For example, it would be better to collect the baseline data either before, or after the seasonal shut down of the fishing sector, during the 'low' season of the farm workers, or the employer can provide (paid) time off for the workers who participate in the assessment.

PRIORITISED ACTION METHODOLOGY AND DATA COLLECTION

- Use statistical software such as Epi Info or SPSS for analysis.
- Select respondents using probability sampling, sample proportional to population size, and outline clear inclusion/exclusion criteria.
- Ascertain a clear understanding of the availability and accessibility of the target group during the planning stage of the assessment.
- Conduct a pre-test run of the questionnaires.
- Conduct focus group discussions to elaborate on specific topics.

6.3.2 Building research capacity

Developing any system of behavioural data collection should begin with a careful preliminary assessment of the existing situation. The assessment should have several development stages: a literature review of existing behavioural studies and data sources in the country, a rapid assessment of risk behaviours, and mapping of where the risk is and who is at risk. The research capacity of IPs needs to be strengthened to enable a collection of valid behavioural data that can be used for statistical analysis. Going through the process of conducting these baseline assessments is the start of this process.

PHAMSA and its partners should ensure strong preparation and training of data collectors in the assessment methodology. Since the assessments are about sensitive issues, interviewers need to build rapport with migrants and mobile workers and should cope with their bias themselves. However, at the same time they should remain totally scientific in their approach. They need to be trusted, and they must not show any emotional reactions to the responses. Therefore, a training pack, monitoring and supervision programme should be developed to support these interviewers. They need to be aware of the full scope of the exercise (including how the baselines fit in with the PHAMSA project cycle), build strong interview techniques and have to learn how to apply non-threatening and culturally sensitive ways of probing and eliciting information. When selecting data collectors, their demographics (gender and age), languages, and experience should be considered.

PRIORITISED ACTION ON BUILDING RESEARCH CAPACITY

- Organise feedback sessions with the implementing partner on findings of the previous baseline assessments.
- Develop and implement a baseline toolkit, including protocol, training manual, monitoring and supervision details to support implementing partners, training supervisors and data collectors.
- Organise training before next assessment/review/survey for partners.
- Investigate and share tools and training materials that can help partners to strengthen research capacity.

6.3.3 PHAMSA Pilot Project Indicators

The indicators which will be used for monitoring and evaluation should be clearly defined. Existing indicators should be adjusted to determine zero measurement.

Indicators may include the following which are internationally recognised¹: 1) Disaggregation by gender; 2) Percentage of people with advanced HIV infection receiving antiretroviral combination therapy; 3) Percentage of companies which have HIV workplace policies and programmes; 4) Percentage of women and men aged 15-49 who had sex with more than one partner in the last twelve months, of all people surveyed aged 15-49 who report being sexually active in the last twelve months; 5) Percentage of women and men aged 15-49 reporting the consistent use of a condom with non-regular sexual partners in the last year.

PRIORITISED ACTION ON PROJECT INDICATORS

- Align indicators according to baseline outcomes at country level.
- Adjust the Monitoring and Evaluation (M&E) framework and include updated project indicators, including internationally recognised indicators in M&E framework.

6.4 FUTURE RESEARCH AGENDA

6.4.1 Conduct additional mapping exercise

For logistical reasons, limited data were collected on environmental factors that can exacerbate the HIV vulnerability of migrants and mobile populations, such as single sex hostels and limited home leave, dangerous working conditions, boredom and loneliness, lack of social cohesion, poor living conditions, seasonal mobility, and lack of access to health care facilities. Further research should be conducted to collect data on existing recreational activities for migrants and mobile workers; access to (sexual and reproductive) health services; access to voluntary counselling and testing facilities; review of health records, baseline data on condom distribution and accessibility, support services for PLHIV; knowledge, acceptability and perceived impact of existing interventions and programmes; the perception on involvement of people living with AIDS. It is also recommended that a mapping exercise on what businesses/companies are doing to promote HIV awareness in their organisation and available workplace policies and services.

PRIORITISED ACTION ON THE ADDITIONAL MAPPING EXERCISE

- Conduct a mapping exercise on existing recreational activities, access to (sexual and reproductive) health services, access to and quality of VCT facilities, review of health records, baseline data on condom distribution and accessibility, support services for PLHIV, the perception on involvement of PLHIV.
- Conduct a mapping exercise on existing activities to promote HIV awareness and workplace policies and services in businesses/companies.
- Collect data on the current knowledge, acceptability and perceived impact of existing interventions and programmes.

6.4.2 Issues related to sexual behaviour

Various issues related to sexual practices need further research. For instance, unprotected anal sex with men and women are risk taking behaviour and should be addressed in the IEC materials. The issue of men-having-sex-with-men has not been included in this assessment – partly because the topic is highly sensitive, especially in countries where this practice is illegal. Previous research and anecdotal evidence show that there are sexual relationships between men at migrant receiving sites, especially in single sex working and living environments, as well as of male rape. Little is known about the character of these relationships and what possible role they play in the transmission of HIV.

The relationship of alcohol and substance abuse and risk taking sexual behaviour should be assessed.

PRIORITISED ACTION ON ISSUES RELATED TO SEXUAL BEHAVIOUR

- Conduct more research on sexual practises among mobile populations including sexual and gender based violence, men having sex with men, other risk taking sexual behaviour.
- Include data collection on the prevalence, knowledge and attitudes regarding sexually transmitted infections in future assessments.
- Include data collection on alcohol and substance abuse and link it to risk taking sexual behaviour.

¹ Monitoring and Evaluation Toolkit. WHO et al 2006

REFERENCES

- Campbell, C
2003
Letting them Die: Why HIV prevention programmes often fail. Oxford, James Currey.
- Crush, J. et al
2005
Mobility Migration, STDs and AIDS: an Essay on sub Saharan Africa. In G. Herdt (ed), *Sexual Cultures and Migration in the case of AIDS.* Oxford, Clarendon.
- Dodson, B. and Crush, J.
2003
Mobile Deathlihoods: migration and HIV/AIDS in Africa. Paper for the UNAIDS project 'AIDS in Africa: Scenarios for the future'.
- International AIDS Alliance.
2006
Building Blocks Africa wide briefing notes. International AIDS Alliance. London.
- International Labour Organization
2001
Code of practice on HIV/AIDS and the world of work. ILO. Rome
- International Organization for Migration
2008
Partners Pack, A guide to being an IOM/PHAMSA Implementing Partner. IOM. Geneva
- International Organization for Migration
2007
Briefing note on HIV and labour migration in South Africa. IOM. Geneva
- International Organization for Migration
2005
HIV/AIDS, Population Mobility and Migration in Southern Africa. Defining a research and policy agenda. IOM. Pretoria.
- IOM/SafAIDS/UNAIDS
2003
Mobile Populations and HIV/AIDS in the Southern African Region. IOM/SafAIDS/UNAIDS. Pretoria.
- SafAIDS/UNAIDS
2008
The eastern and southern African AIDS monitor factsheet. SafAIDS. Pretoria.
- Sighn
2007
Paradoxical Payoffs: Migrant women, informal sector work and HIV/AIDS in South Africa. *New Solutions: A Journal of Environmental and Occupational Health Policy: NS, 17 (1-2), 71-81.*
- UNAIDS
2008
2008 UNAIDS' Terminology Guidelines. UNAIDS. Geneva
- UNAIDS
2007
AIDS Epidemic Update Regional Summary. Sub Sahara Africa. UNAIDS. Geneva
- UNAIDS
2006
Report on Global AIDS Epidemic. UNAIDS. Geneva.
- United Nations Population Fund
2006
The State of the world population 2006. A Passage to Hope: women and International Migration. UNFPA. New York.
- USAID
2006
Conducting Mini Surveys in Developing Countries. USAID. Washington.
- WHO
2008
World Health Statistics 2008. WHO. Geneva.
- WHO
2008
Global Tuberculosis Control. Surveillance, planning, finance. WHO. Geneva.
- WHO
2006
Monitoring and Evaluation Toolkit. HIV/AIDS, Tuberculosis and Malaria. WHO. Geneva.

ANNEX I - RATIONALE FOR THE BASELINE ASSESSMENT

WHY ARE WE DOING IT?

- a) We want to know the level of HIV knowledge, related attitudes, behaviours, practices and perceptions among migrants and mobile populations, their families and communities they interact with.
- b) Assess perceived HIV risk and vulnerability within the context of mobility and migration
- c) Assess their understanding of the relationship between gender and HIV
- d) Assess knowledge, acceptability and perceived impact of existing interventions and programmes (e.g. workplace policies and programmes)
- e) Be able to evaluate the impact of PHAMSA supported interventions in increasing knowledge and understanding of HIV and AIDS, behaviour change and coping strategies (we should be able to measure any shift made by PHAMSA in terms of HIV/AIDS awareness, knowledge, behaviour change)
- f) Use the assessment results to develop questions, hypotheses and propositions for further testing (to feed in to the PHAMSA research agenda)

WHAT DO WE WANT TO KNOW?

1. HIV/AIDS knowledge, Attitudes and Perceptions

- a) We want to know if the beneficiaries have ever heard of HIV and AIDS (What is HIV, what is AIDS etc...)
- b) Have they received any information on HIV and AIDS, and how have they received such information (through radio, attended workshops/training, read in the papers, from a pamphlets etc.) SCC
- c) Do they know how HIV is transmitted and how you can prevent yourself from being infected
- d) Do they know about VCT, and what is their perception on going for VCT and where they can access it
- e) Do they think using a condom can prevent HIV- have they used a condom before
- f) What myths do they have about HIV – (is witchcraft,)
- g) Do they know someone who is HIV positive or have died of AIDS?

2. HIV AND MOBILITY

- a) **How they understand the link between HIV and Mobility**
 - i. Do they consider themselves migrants or mobile
 - ii. Are migrant populations more vulnerable to HIV and why?
 - iii. Should there be special programmes for migrant workers, and how should they be structured

3. HIV AND GENDER

- a) Are men and women affected differently by HIV and how so?
- b) Do they think women are more vulnerable to HIV and why?
- c) Do they know of any cultural practices that increases woman's vulnerability to HIV?
- d) Levels of concurrent sexual partnerships
- e) Traditional practices?

4. ENVIRONMENTAL FACTORS:

- a) Where do you live? Who do you live with
- b) Transport
- c) Recreation
- d) Access to services: health, social, legal

5. HIV/AIDS PROGRAMMES

- a) Does the target group know of any programmes are currently addressing HIV and AIDS
- b) How have they benefited from that?
- c) How do they think they can be improved
- d) Do they know about the programmes

How will we get the information (methodologies and tools)

- a) Mini surveys- questionnaire
- b) Key informant interviews- interview schedule
- c) Focus Group Discussion – Discussion questions
- d) Some PAR tools- e.g. Service mapping
- e) Review of health records- to get baseline data on condom distribution, VCT, STI etc.

Who

- a) Namibia-Local and Foreign fishermen in Walvis Bay; service providers and other stakeholders)
- b) Swaziland- Migrants and seasonal workers employed by RSSC, Peer educators at RSSC; Contractors and their employers; community members of the Mhlume and Simunye Estates; service providers)
- c) Mozambique, Xai Xai- spouses of mineworkers (ex and current; potential new recruits; community leaders; service providers)
- d) South Africa: Farm workers, including seasonal and contract workers in Hoedspruit
- e) Lesotho: Mine workers, ex-mine workers and community of Leribe district
- f) Zambia: Seasonal and temporary mine workers in the copper mines of the Northern Province; seasonal workers working in the cotton farms in the Eastern province

ANNEX II - INTERVIEW GUIDE: BASELINE SURVEY FOR PHAMSA PARTNERS

TO BE COMPLETED AT THE END OF THE INTERVIEW

001	Name of PHAMSA Partner	
002	Name of interviewer	
003	Date /Time	
004	Country	

INFORMED CONSENT

Say: "My name is I am working for the International Organization for Migration. We are carrying out interviews in _____ in order to plan programs in your community. We are trying to understand people's attitudes, knowledge and behaviour regarding HIV and AIDS.

This interview should take about X. Some of the questions in this interview are very personal, since they are related to sexual relationships and sexual practices. These questions may be difficult to answer. However, anything you tell us will be completely confidential as your name will not be written on this form, and will never be used in connection with any of the information you disclose.

You may refuse to answer any question and can stop the interview at any time. However, your honest answers to these questions will help us to better understand what people think, say and do. We would greatly appreciate your help in responding to this survey.

The survey will take about 30 minutes. Are you willing to participate?"

012 SIGNED BY INTERVIEWER ONLY:

(Signature of interviewer, certifying that the respondent gave verbal consent to participate in the interview)

Inclusion criteria:

Say: "Before I continue I want to clarify a few things"
(Each partner to define their inclusion criteria)

	YES	NO
Are you between the ages of x and x		
Are you (nationality)		
Do you speak x?		

Say: "We are now ready to start the interview."

CIRCLE RESPONSE CODES THROUGHOUT

Background information

	QUESTION	RESPONSES	CODE	SKIP TO
05	Record sex of the respondent	Male Female	1 2	
06	In what month were you born?	_____(Month) No response Do not know	 98 99	
07	In what year were you born?	_____(Year) No response Do not know	19 98 99	
08	In what country were you born?	Fill in most likely answers Other (specify) _____ No response Do not know	1 2 3 4 97 98 99	
09	Which country does your family come from?	_____ No response Do not know	1 98 99	
010	What is the highest level of school you have completed? (read all responses and record one)	Never attended school Did not complete primary school Primary Secondary Higher No response Don't Know	1 2 3 4 5 98 99	
011	Are you currently employed (If "no" Skip to question no. 016)	Yes No No Response Don't know	1 2 98 99	
012	Are you a (read all, circle one)	Permanently employed Temporarily employed Seasonally employed Other_____	1 2 3 4	
013	What is your job			
014	Where do you live when you are working	Workplace Renting locally Commute daily from home Squatting with friends Other_____	1 2 3 4 5	
015	What kind of accommodation provided by your employer do you stay in	Single-sex hostel Family units Other_____	1 2 3	

I'm now going to ask you some questions about HIV

	KNOWLEDGE OF STIS, HIV AND AIDS	RESPONSES	CODE	SKIP TO
016	Have you ever heard of diseases that can be transmitted through sexual intercourse?	Yes	1	
		No	2	
		No response	98	
		Don't know	99	
017	Have you ever heard of HIV or the disease called AIDS?	Yes	1	cont
		No	2	Skip to Q031
		No response	98	cont

018	(read all responses and record yes or no for each answer Can you get HIV from.....	Yes(1)	No (2)	Don't know (98)	NR (99)
A	(Prompt) : Can you get HIV from working with someone who has HIV (Prompt): Yes or No				
B	(Prompt) : Can you get HIV from Eating food cooked by someone who has HIV(Prompt): Yes or No				
C	(Prompt) : Can you get HIV from Sharing plates, forks or glasses with someone who has HIV(Prompt): Yes or No				
D	(Prompt) : Can you get HIV from Using public toilets(Prompt): Yes or No				
E	(Prompt) : Can you get HIV from Being coughed or sneezed at by someone who has HIV(Prompt): Yes or No				
F	(Prompt) : Can you get HIV from Having sexual intercourse without a condom(Prompt): Yes or No				
G	(Prompt) : Can you get HIV from a mosquito bite(Prompt): Yes or No				
019	(read all responses and record yes or no for each answer Can you reduce your chance of getting HIV by:	Yes(1)	No (2)	Don't know (98)	NR (99)
A	(Prompt) Can you reduce your chance of getting HIV by: Taking a shower after sex (Prompt): Yes or No				
B	(Prompt) Can you reduce your chance of getting HIV by Being circumcised(Prompt): Yes or No				
C	(Prompt) Can you reduce your chance of getting HIV by Wearing a condom every time you have sex (Prompt): Yes or N				
D	(Prompt) Can you reduce your chance of getting HIV by Having only one sexual partner (Prompt): Yes or No				

The following questions ask about your beliefs and attitudes regarding HIV and other infections. I will ask you if you agree or disagree with the following statements.

		AGREE (1)	DISAGREE (2)	DON'T KNOW (98)	NR (99)
020	People who have HIV have become infected because of their own carelessness. (Prompt): Do you Agree or Disagree?				
021	People with HIV can live normal healthy lives (prompt): do you agree or disagree				
022	You can tell by looking at someone if they have HIV (Prompt): Do you Agree or Disagree?				
023	HIV can be cured through traditional medicine.				
024	TB is always a sign that someone has HIV (Prompt): Do you Agree or Disagree?				
	You can't get HIV if you are circumcised(prompt)- do you agree or disagree				
025	There is no cure for HIV. (prompt)- do you agree or disagree				

Please answer yes or no to the following questions

	(HIV TESTING)	YES(1)	NO (2)	DON'T KNOW (98)	NR (99)
026	Do you think that it is important to know your HIV status? (Prompt): Yes or No				
027	Have you ever been tested for HIV? (Prompt): Yes or No				
028	Would you go for an HIV test now if one were offered to you? (Prompt): Yes or No				
029	Do you think that the result of an HIV test is confidential? (Prompt): Yes or No				
030	Do you think that your employer would fire you if you tested positive for HIV? (Prompt): Yes or No				

	RELATIONSHIP STATUS & SEXUAL HISTORY	RESPONSES	CODE	SKIP TO
031	Which of the following best describes your current relationship status? (read all responses and record applicable answers) *Single means you are not in any relationship **by short- term partner we mean someone you have been in a relationship with for between 1 and 6 months ***by long term partner we mean someone you have been in a relationship with for more than 6 months, but have not married	*Single **Short-term-partner ***Long-term partner Married Divorced Widowed Engaged in more than one relationship Other No response	1 2 3 4 5 6 7 97 98	
032	Have you ever had *sexual intercourse? * by sexual intercourse we mean vaginal or anal sex with your husband/ wife or any other partner(Prompt): Yes or No	Yes No No response	1 2 98	→ cont → Skip to 039 → cont
033	Have you had sexual intercourse in the past 12 months? (Prompt): Yes or No	Yes No No response	1 2 98	→ cont → 039 → cont

034	I would like you to think about the sexual partners you have had in the past 12 months. Have you had sexual intercourse with...			
A	Your spouse, someone you were/are living with, or were/are in a relationship with? (Prompt): Yes or No	Yes No No response	1 2 98	
B	Commercial partners, with whom you had sex in exchange for money(Prompt): Yes or No ?	Yes No No response	1 2 98	
C	*Casual sexual partners? By casual sexual partners we mean someone you are not married to, or are not in a relationship with, and whom you did not pay. (Prompt): Yes or No	Yes No No response	1 2 98	
035	Has anyone ever forced you to have sex even though you did not want to? (Prompt): Yes or No	Yes No No response	1 2 98	→ cont → skip to 037 → cont
036	Who forced you to have sex? (read all responses and record all that apply)	My husband/boyfriend Person from the local community My supervisor Other (specify) _____ No response Do not know	1 2 3 97 98 99	
037	Has a person ever given you money, food, gifts, job, clothing or any favour in exchange for sex? (Prompt): Yes or No	Yes No No response	1 2 98	→ cont → Skip to 039 → cont
038	Who gave you money, housing, food, gifts, clothing and/or any favour in exchange for sex? (read all responses and record all that apply)	My husband/boyfriend Person from the local community My supervisor Other (specify) _____ No response Do not know	1 2 3 97 98 99	

	CONDOMS	YES(1)	NO (2)	DON'T KNOW(98)	NR (99)
039	Have you ever had heard of condoms (Prompt): Yes or No (If No, Skip to Q050)				
040	Have you ever used a condom? (Prompt): Yes or No				
041	Did you use a condom the last time you had sex? (Prompt): Yes or No				
042	Have you used a condom in the past 6 months? (Prompt): Yes or N				
043	Have you ever used a female condom? (Prompt): Yes or No				

	Do you Agree or Disagree with the following statements.....	AGREE (1)	DISAGREE (2)	DON'T KNOW(98)	NR (99)
044	Condoms take away sexual pleasure (prompt- do you agree or disagree)				
045	Sex is safer with a condom (prompt- do you agree or disagree)				
046	If a woman carries a condom it means she is sleeping around(prompt- do you agree or disagree)				
047	Women can initiate condom use with their partners(prompt- do you agree or disagree)				
048	Free condoms are bad quality(prompt- do you agree or disagree)				
049	Female condoms are better than male condoms(prompt- do you agree or disagree)				

	GENDER ROLES AND NORMS Do you Agree or Disagree with the following statements.....	AGREE (1)	DISAGREE (2)	DON'T KNOW (98)	NR (99)
050	It is ok for men to have more than one sexual partner (prompt- do you agree or disagree)				
051	It is ok for a woman to have more than one sexual partner (prompt- do you agree or disagree)				
052	A man may beat his spouse/partner if she disobeys him (prompt- do you agree or disagree)				
053	Sometimes women need to be pressured a little to have sex (prompt- do you agree or disagree)				
054	Women should be able to hold the same jobs at the same pay as men(prompt- do you agree or disagree)				
055	Men should have control over decisions made in relationships (prompt- for example, whether to marry, whether to have sex, how many children to have etc.) (prompt- do you agree or disagree)				

CONCLUSION

Say: "We have now come to the end of the interview. I know we have covered some personal issues and I want to thank you very much for agreeing to answer these questions.

I would once again like to reassure you that the information gathered in this survey will not be linked directly back to you. Your name and other identifying details have not been recorded.

Thank the respondent again for his/ her participation.

*Now that the interview has been successfully completed, remember to fill in questions 001, 002, and 003 on the cover page.

Implementing Partners:

Walvis Bay Multi Purpose Centre Trust – **Namibia**

TEBA Development – **Mozambique and Lesotho**

Hoedspruit Training Trust – **South Africa**

Royal Swaziland Sugar Corporation – **Swaziland**

Comprehensive HIV/AIDS Management Programme – **Zambia**

IOM Regional Office for Southern Africa

PO Box 55391 Arcadia 0007 Pretoria South Africa

tel +27 (0)12 342 2789 fax +27 (0)12 342 0932

email phamsa@iom.int

www.iom.org.za