

**THE ROLE OF THE INTERNATIONAL ORGANIZATION FOR MIGRATION  
(IOM) IN THE PREVENTION OF HIV-INFECTIONS AMONG MOBILE AND  
VULNERABLE POPULATIONS (MVPs) AND POTENTIAL EMIGRANTS IN  
BEITBRIDGE.**

by

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To you all, may the LORD continue to bless you in abundance and I wish you a success in your endeavours.

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**DECLARATION**

I declare that *THE ROLE OF THE INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM) IN THE PREVENTION OF HIV-INFECTIONS AMONG MOBILE AND VULNERABLE POPULATIONS (MVPs) AND POTENTIAL EMIGRANTS IN BEITBRIDGE* is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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## **ABSTRACT**

This study assessed the role of the International Organization for Migration (IOM) in HIV-prevention among mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge. A mixed-method approach, which combines quantitative and qualitative approaches, was used in this action research. A total of 20 in-depth face-to-face interviews were conducted with key informants and 56 self-administered questionnaires were completed by MVPs and potential emigrants in Beitbridge. The study found that a number of effective strategies are currently being implemented as a preventative measure by the IOM within MVPs and potential emigrants' communities in Beitbridge. At the same time, however, in order to ensure sustainability of these HIV-prevention initiatives, the IOM must promote long-term synergies with other strategic partners throughout the project cycle. It is recommended that, the IOM strategically position itself by moving a step further from being the sole provider of emergency humanitarian support towards devising sustainable and durable solutions among MVPs and potential emigrants.

### **Key concepts**

HIV and AIDS, International Organisation for Migration (IOM), mobile and vulnerable populations (MVPs), and potential emigrants.

## **STUDENT DETAILS**

**THE ROLE OF THE INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM) IN THE PREVENTION OF HIV-INFECTIONS AMONG MOBILE AND VULNERABLE POPULATIONS (MVPs) AND POTENTIAL EMIGRANTS IN BEITBRIDGE**

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## LIST OF ACRONYMS AND ABBREVIATION

AIDS	Acquired Immune-Deficiency Syndrome
AU	African Union
ASEAN	Association of South-East Asian Nations
BRSC	Beitbridge Reception and Support Centre
CARICOM	Caribbean Community Secretariat
CoN	Commonwealth of Nations
CRC	Convention on the Rights of the Child
CSO	Central Statistics Office
CSW	Commercial Sex Workers
DAAC	District AIDS Action Committee
DEVAW	Declaration on the Elimination of Violence against Women
DSS	Department of Social Services
FBO	Faith Based Organizations
FGM	Female genital mutilation
FI	Food Items
FST	Family Support Trust
GBV	Gender Based Violence
HIV	Human Immuno-Deficiency Virus
ICAS	Interagency Coalition on AIDS and Development
ID	Immigration Department
IDP	Internally Displaced Population
IEC	Information Education and Communication
IFPRI	International Food Policy Research Institute
IGO	Inter-governmental Organization
IO	Immigration Official
IOM	International Organization for Migration
ITO	Informal Transport Operator
JICA	Japan International Cooperation Agency
LA	Local Authority

MoESC Ministry of Education, Sports & Culture

MoHA Ministry of Home Affairs

MoHCW Ministry of Health and Child Welfare

MoPSLSW Ministry of Public Service, Labour and Social Welfare

MoWAGCD Ministry of Women Affairs, Gender and Community Development

MoYIEC Ministry of Youth, Indigenous and Employment Creation

MVP Mobile and Vulnerable Population

NAC National AIDS Council

NBCSPST National Behavioural Change Strategy for Prevention of Sexual Transmission of HIV

NFI Non-Food Items

NGO Non-governmental Organization

OAS Organization of American States

OVC Orphaned and Vulnerable Children

PHAMSA Partnership on HIV and Mobility in Southern Africa

UE European Union

UN United Nations

UNAIDS Joint United Nations Programme on HIV/AIDS

UNDESA United Nations Department of Economic and Social Affairs

UNDP United Nations Development Program

UNFPA United Nations Population Fund

UNIFEM United Nations Development Fund for Women

UNGPID United Nations Guiding Principles on Internal Displacement

UNSC United Nations Security Council

USA United States of America

RENEWAL The Regional Network on HIV/AIDS, Livelihoods and Food Security

SADC Southern African Development Countries

SAMP Southern African Migration Project

SCN Save the Children Norway

SIRDC Scientific and Industrial Research and Development Centre

STI Sexually Transmitted Infection

SPSS	Statistical Package for the Social Sciences (SPSS)
SSA	Sub-Saharan Africa
VCT	Voluntary Counselling and Testing
WEF	World Economic Forum
WHO	World Health Organization
WSF	World Social Forum
ZDHS	Zimbabwe Demographic and Health Survey Report
ZIM	Zimbabwe Institute of Management
ZRP	Zimbabwe Republic Police
ZIMRA	Zimbabwe Revenue Authority

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## **CHAPTER 1**

### **SITUATING THE RESEARCH PROBLEM**

#### **1.1 INTRODUCTION**

Two of the most crucial social issues facing the world today have been characterized by the United Nations as Acquired Immuno-deficiency Syndrome (AIDS) and the international migration patterns of millions of people in resource poor countries (ICAS 2011). Human Immuno-deficiency Virus (HIV) and AIDS remain a global health challenge with vast social and economic dimensions. sub-Saharan Africa still bears an inordinate share of the global HIV burden. The epidemics in sub-Saharan Africa vary considerably, with southern Africa still the most severely affected. An estimated 11.3 million (10.6 million–11.9 million) people were living with HIV in southern Africa in 2009, nearly one third (31 percent) more than the 8.6 million (8.2 million – 9.1 million) people living with HIV in the region a decade earlier (Joint United Nations Programme on HIV/AIDS (UNAIDS) Report on the Global AIDS Epidemic, 2010: 28). Globally, 34 percent of people living with HIV in 2009 resided in the 10 countries in southern Africa; 31 percent of new HIV infections in the same year occurred in these 10 countries, as did 34 percent of all AIDS-related deaths. About 40 percent of all adult women with HIV live in southern Africa (ibid).

Sub-Saharan Africa remains the region most heavily affected by the HIV epidemic although twenty-two countries in the region have shown signs of decline in HIV incidence rate by more than 25 percent between 2001 and 2009. In sub-Saharan Africa, where the majority of new HIV infections continue to occur, an estimated 1.8 million (1.6 million–2.0 million) people became infected in 2009; considerably lower than the estimated 2.2 million (1.9 million–2.4 million) people in sub-Saharan Africa newly infected with HIV in 2001. This trend reflects a combination of factors, including the impact of HIV prevention efforts and the natural course of HIV epidemics (ibid). In Zimbabwe, the main behavioural change appears to have been a reduction in the

proportion of men with casual partners, while condom use with non-regular partners has remained high since the late 1990s.

By 2009, the overall growth of the global AIDS epidemic appeared to have stabilized. The annual number of new HIV-infections has been steadily declining since the late 1990s and there are fewer AIDS-related deaths due to the significant scale-up of antiretroviral therapy over the past few years. Although the numbers of new infections has been falling, levels of new infections overall are still high, and with significant reductions in mortality the number of people living with HIV worldwide has increased (UNAIDS Report on the Global AIDS Epidemic, 2010).

Evidence of the decreasing incidence of new HIV-infections in countries most severely affected in Africa is linked to change in sexual behaviour among the sexually active age groups. The UNAIDS Report on the Global AIDS Epidemic (2010) details a statistically significant decline of 25 percent or more in HIV prevalence among young pregnant women attending antenatal clinics since 2008. Five countries in the sub-Saharan region namely Botswana, South Africa, United Republic of Tanzania, Zambia, and Zimbabwe showed a significant decline in HIV prevalence among young women or men in national surveys.

### **1.1.1 Migration as a catalyst for the spread of HIV and AIDS**

As a global challenge, the epidemiology of HIV and AIDS can be closely linked to the process of migration. Migration has been a catalyst in the rapid spread of HIV in southern Africa. It is argued that the spread of HIV and AIDS is likely to be accelerated in a situation of large-scale migration (Anarfi 1993:46) and that the spread of infectious diseases that are transmitted from person to person will follow the movement of people (Decosas, Kane & Anarfi 1995:826). In the region, the HIV and AIDS epidemic has had a devastating social and economic impact. In sub-Saharan Africa, HIV has been the source of disintegration of the once integral social fabric of the African cultures, with

breadwinners the economic productive age group being the most infected thereby reducing the productive capacity in both the private and public sectors (Zawaira 1999:25). In linking human mobility and the epidemiology of HIV and AIDS, it is important to note that different forms of migration lead to different social and geographical forms of migrant 'community', and thus to different causes and cultures of risk (Crush, Frayne & Grant 2006:22).

Zimbabwe is one of the sub-Saharan countries severely affected by the HIV epidemic. High levels of mobility among the populace in Zimbabwe being characterized by prolonged spousal separation caused the disintegration of the cultural social fabric of many families and the emerging of one of the recently identified key drivers of HIV namely multiple concurrent sexual partnerships outside formal marriages and cross generational sex among the potential emigrants, and internally displaced populations (IDPs) (referred to in this study as mobile and vulnerable populations – (MVPs). Given the high rate of HIV-prevalence in the sub-Saharan region, MVPs and potential emigrants are particularly vulnerable to HIV-infections.

### **1.1.2 Global decline in the new HIV infections**

The UNAIDS Report on the Global AIDS Epidemic (2010) points to a global decline in the new HIV infections. Dedicated efforts to promote and support coordination among international agencies and other partners working in the global response to HIV are producing clear and impressive results on a global scale. The incidence of HIV infection declined by 19 percent between 1999 and 2009 globally; the decline exceeded 25 percent in 33 countries, including 22 countries in sub-Saharan Africa. But while parts of the world experienced significant and encouraging decreases in HIV incidence between 2001 and 2009, during the same period the incidence increased by more than 25 percent in seven countries, including five in Eastern Europe and Central Asia (ibid:64).

Behaviour change is the most important factor accounting for these encouraging declines in new HIV infections in many countries. Among young people, noteworthy drops in HIV incidence have been associated with a significant positive trend (for either or both sexes) in important behaviour indicators, including increased condom use, delayed sexual debut, and reductions in multiple partnerships (ibid).

Correct and consistent condom use has been found to be greater than 90 percent effective in preventing transmission of HIV and other sexually transmitted infections. By 2009, major successes in HIV prevention had been achieved in concentrated epidemic countries that have devoted substantial programming efforts and funds to prevention among people at higher risk of exposure to HIV. Too often, however, prevention responses still do not focus on these key populations (ibid).

Addressing sexual behaviour to prevent the sexual transmission of HIV remains one of the key priorities in addressing HIV. The vast majority of people newly infected with HIV in sub-Saharan Africa are infected during unprotected heterosexual intercourse (including paid sex) and onward transmission of HIV to newborns and breastfed babies. Having unprotected sex with multiple partners remains the greatest risk factor for HIV in sub-Saharan Africa.

### **1.1.3 Global responses to HIV and AIDS**

The World Economic Forum (WEF) and the World Social Forum (WSF) held key sessions on AIDS and its global implications in Porto Allegre, Brazil in 2003. The United Nations Security Council (UNSC) held its first debate on AIDS in January 2000. This was the first time health as a development issue was scrutinized. Subsequent to this, the UNSC organized two more public debates on AIDS by the end of 2002 (UNAIDS, 2002: 11). The relationship between the HIV and AIDS epidemic and migration was recognized by the UN during the General Assembly Special Session on HIV and AIDS in June 2001.

The HIV and AIDS epidemic has provoked responses from national governments, UN agencies, international organizations (IOs), non-governmental organizations (NGOs), faith-based organizations (FBOs) and inter-governmental organizations (IGOs). The IGOs responded by joining hands with other global partners to provide care and support, reduce risks and vulnerability to HIV-infection and alleviate the impact of the epidemic through the implementation of specific programmes targeting specific groups for example potential emigrants, mobile and vulnerable populations (MVPs).

#### **1.1.4 HIV-prevention among the mobile and vulnerable populations in Zimbabwe**

In Zimbabwe, continued economic decline characterized by high levels of unemployment and the increase in political violence prior to the June 27, 2008 presidential run-off are some of the major causes of the increase of internal displacements and irregular migration to neighbouring countries. In addition, the 2005 government-sanctioned initiative to clean up the cities, code named Operation Restore Order (Operation Murambatsvina), left thousands of families displaced from their homes and their sources of livelihoods destroyed. These developments led to a massive exodus of Zimbabweans to neighbouring countries in search of employment and better living conditions. In situations where livelihoods and homes are destroyed, many individuals are left with few options and are susceptible to resorting to risk behaviours, for example young women and girls finding themselves coerced into sex to gain access to basic needs such as food, shelter and security as a risk survival strategy which exposes them to HIV-infection.

In trying to address the situation in Zimbabwe, the IOM responded quickly to the HIV epidemic among the potential emigrants and MVPs, leading the way in providing care and support in form of basic needs for human survival in form of distribution of food and non-food items, provision of transitional shelters, mobile health facilities, information awareness raising on HIV and AIDS, capacity building and sensitization workshops within the MVPs and potential emigrants communities to the affected. As an inter-governmental organization, the IOM is committed to the principle that humane and orderly migration benefits migrants and society. The IOM acts with its partners namely

United Nations Development Program (UNDP), United Nations Population Fund (UNFPA), World Health Organization (WHO), UNAIDS and United Nations Development Fund for Women (UNIFEM) and donors in the international community to assist in meeting the operational challenges of migration, to advance understanding of migration issues, to encourage social and economic development through migration and to uphold the human dignity and well-being of migrants (IOM, 2002).

The increase in awareness raising, imparting of knowledge and new skills among the MVPs and potential emigrants during the prevention-initiatives influences behaviour change among the targeted audiences through encouraging safe sexual practices and assist in the prevention of transmission of HIV-virus. Such grassroots community-based initiatives among the MVPs and potential emigrants would need to be well co-ordinated among the partners and integrated into the existing health development packages and other bodies working in this field.

## **1.2 MIGRATION TRENDS, HIV AND AIDS**

The relationship between migration and HIV and AIDS is complex. Although many people think that migrants mainly bring HIV when they enter countries, evidence usually shows the opposite, suggesting that migrants are more vulnerable than local populations to HIV infection. The structure of the migration process comes into play when trying to define the possible linkages between mobility, HIV and AIDS (IOM, 2002:1).

### **1.2.1 Global migration trends, HIV and AIDS**

Globally, the migration flows of today are being driven by many forces, namely the emerging of the global village, social, economic and political unrest among the individual countries also caused more people to be on the move in the 21<sup>st</sup> century compared to any other point in the history of mankind. The global estimates indicates that there are now

almost 191 million people living outside their place of birth, which is about three per cent of the world's population up from 2.9 percent in 1990 (United Nations Department of Economic and Social Affairs (UNDESA), 2006:1) This means that roughly one out of every thirty-five persons in the world today is a migrant.

### **1.2.2 Regional migration trends, HIV and AIDS**

Southern Africa has a long history of cross-border migration, particularly for employment purposes, with the main destination being South Africa. Income disparities and the persistence of poverty have resulted in flanking countries such as Lesotho, Malawi, Mozambique, Swaziland, Zambia and Zimbabwe being sources of labour migration to South Africa for almost a century. Although some of the characteristics and mechanisms that typified migration in colonial southern Africa still remain, there has also been a paradigm shift in the nature of migration trends as a result of the end of apartheid era in South Africa. Currently, Botswana, Namibia and South Africa are becoming the main destination of the labour migrants while Malawi, Mozambique, Zambia and Zimbabwe being the migrant sending (IOM & SAMP, 2005).

Several migration trends have been identified in the region since the end of the apartheid era in South Africa, the main trends being: intra-regional cross border trade, feminization of cross border migration, restructuring of traditional contract labour migration and emergency of irregular migration within the continent.

### **1.2.3 Migration trends and HIV and AIDS in Zimbabwe**

In Zimbabwe, migration has become a common coping strategy for many households and breadwinners under stress due to underperformance of the formal economy. Since the beginning of the 21<sup>st</sup> century irregular movement of people with main destination being South Africa due to unemployment levels increased significantly. Whilst there is no reliable data on the number of undocumented Zimbabweans staying in South Africa, the

Republic of South Africa Government (2010) estimated the total number of migrants at one million and five hundred thousand are living in South Africa, but only 275,000 had applied to be regularized through Zimbabwe Documentation Process (ZDP) by the 31<sup>st</sup> of December 2010 deadline, and the department has so far only issued permits to just over half of them.

In trying to respond to the socio-economic and political challenges bedeviling the country since the beginning of the 21<sup>st</sup> century, many Zimbabwean women, as the primary income earners of their families, have resorted to cross-border trade. These new migration trends cause breakdown of families due to prolonged spousal separation leading to burgeoning of multiple concurrent sexual partnerships and cross generational sex, which facilitates the spread of sexually transmitted infections (STIs) and HIV among the migrants.

Zimbabwe, like most sub-Saharan countries, is at the epicentre of the HIV and AIDS pandemic. Data from the Ministry of Health and Child Welfare has shown a gradual decline in HIV prevalence among adults aged 15 – 49 years from 23.7 percent in 2001 to 14.3 percent in 2009 owing to change in sexual behaviour coupled with prevention interventions by the government, other non-state actors and the support from the international community (Zimbabwe Millennium Development Goals Report, 2010:32). This fall in the prevalence rate, if sustained, should result in an improvement in life expectancy in the future.

Although Zimbabwe has experienced a decline in HIV prevalence in adults aged 15-49 years from 23.7 percent in 2001 to 14.3 percent in 2009 the latest figure still represents one of the worst HIV-infection prevalence in sub-Saharan Africa. HIV and AIDS remains the largest cause of mortality among the productive age group 15 – 49 years, with an estimated 3,000 deaths recorded per week. As a result of the pandemic, life expectancy has declined from 61 years in 1990 to 39 years in 2007 with females being disproportionately more affected than males thus emphasising the gender dynamics and increased vulnerability among women (WHO, 2007).

In Zimbabwe, the HIV trends have proven that almost half of all new HIV-infections are perceived to be occurring among the age group aged 15-24 years, with high incidences being recorded among the female adolescents as compared to male counterparts (UNFPA, 2004; ZDHS, 2006).

UNICEF (2006) estimated that one in every four children in Zimbabwe have lost one or both parents due to HIV and AIDS, leading to an estimated figure of 1.6 million orphans by the end of 2006. Given the above statistics, the HIV epidemic has not only dire economic consequences, but is a cross-cutting social problem which has pervasive consequences.

### **1.3 RESEARCH PROBLEM**

Since the mid-1990s there has been an increase in the number of Zimbabweans attempting to leave Zimbabwe for neighbouring countries mainly to South Africa and Botswana using illegal exit and entry points. The economic challenges characterized by high levels of unemployment and the increased cases of political violence experienced in Zimbabwe prior to the harmonized June 27, 2008 presidential run-off as well as the 2005 Operation Restore Order (Operation Murambatsvina) and the Fast-Track Land Reform Programme which was implemented by the government between 2000 and 2002 (although with some current isolated eviction reports) stand out as some of the major causes of high population mobility (both internal and external) which led to an increase of vulnerability and risky sexual practices exposing disadvantaged populations to HIV-infections. Operation Restore Order has led to disruption of HIV and AIDS related services particularly administering of antiretroviral drugs treatment (ART), home based care and prevention programmes among the affected and infected populations (Tibaijuka, 2005:39). Furthermore, given lack of supportive mechanisms among the affected populations, Tibaijuka projected in her report that Operation Restore Order might contribute to the increase in new HIV transmission, higher infection rates and a more

rapid progression of the disease in the medium to long-term if the situation continues unchecked (ibid).

Given the above background, one can safely say that during the first decade of the 21<sup>st</sup> century factors such as increased population mobility, family disintegration and an increase in number of women turning to sex work as a survival strategy are likely to have increased the frequency of unsafe sex thereby recording an increase in new HIV-infections in Zimbabwe. (United Nations General Assembly Report (UNGASS), 2006-2007). Zimbabwe's decade long economic malaise and political violence has acted as a spur for migrants to seek employment and better living conditions in neighbouring states, with South Africa remaining the destination of choice for most, because of its large economy, proximity and easy access. This exercise left many families without any option but to resort to risk behaviours which expose them to HIV as one of the survival coping mechanism.

Poverty, food insecurity, lack of legal protection, discrimination, social exclusion and exploitation are some of the main factors that can have a negative impact on the health of MVPs and their access to health services (IOM, 2007:27). The breakdown of social networks and institutions stemming from migration reduces community cohesion, weakening the social norms that regulate sexual behaviour, leading to risky behaviours and increased exposure and vulnerability to HIV-infection among the MVPs and potential emigrants. Likewise in Zimbabwe, many push factors contributing to migration, such as an unbalanced distribution of resources, high unemployment levels, socio-economic instability and political unrest, as well as their status and mobility patterns also play key role in determining their vulnerability to HIV-infection of migrants.

Researches and evaluations have generally been conducted with projects that provide insight to global migration flows on the risks and realities of HIV-infections among the irregular migration. However, there are some gaps especially in the sub-Saharan Africa given the developments on push and pull factors to migration flows compared to any other region. Not much has been done in terms of HIV-prevalence among the MVPs and potential emigrants in Zimbabwe.

Given the above background, this research assesses the role of the International Organization for Migration (IOM) in HIV-prevention among the MVPs and potential emigrants in Beitbridge and to determine the effectiveness of HIV-prevention activities undertaken by the IOM. Furthermore, the research identify gaps and advice on what needs to be done to enhance the existing IOM's awareness raising initiatives in preventing and reducing HIV-infections among the MVPs and potential emigrants in Zimbabwe. The linkages that exist between MVPs and the HIV-prevention and how it relates to IOM's prevention and awareness raising activities will be highlighted.

### **1.3.1 The role of the IOM in Beitbridge**

This study was carried out in Beitbridge, with IOM Beitbridge Reception and Support Centre (BRSC) as the nucleus. Beitbridge is a busy border town located in the southern part of Zimbabwe in Matabeleland South Province, about 584 kilometers from Harare the capital city. The town lies just north of the Limpopo River about one kilometer from the border post which forms the political border between South Africa and Zimbabwe. The busiest border site in sub-Saharan Africa, Beitbridge has a lot of male and female informal traders, truck drivers, commercial sex workers and irregular migrants crossing to South Africa on daily basis. Based on the Zimbabwe population census figures of 2002, Beitbridge town had a stable population of 22,387 but the number has more than trebled because of heightened economic activity owing to 2010 FIFA World Cup and its proximity to South Africa. The population is dominated by the local Venda people who are also found across the international border in the Vhembe District of the Republic of South Africa. Furthermore, in 2003 the Beitbridge town had a transient population of more than 150 000 persons (IOM & Care International, 2003:29). The town has an estimated 2,570 houses in formal settlements primarily accommodating government officials and mid-level private sector staff and 3,000 in informal settlements (Muleya [Herald, 14 March Article], 2011). Formal-settlement dwellings are mainly two to three roomed brick houses, while those in the informal settlements are among the worst mud houses in Zimbabwe (ibid). The major source of local employment in Beitbridge is government departments mainly customs and immigration, the uniformed services as

well as formal and informal vending. Several thousand truckers cross the border monthly. The area has many of sex workers, with many transient sex workers coming outside Beitbridge as far away as Bulawayo, Harare, Masvingo, Chiredzi and Mutare (IOM & Care International, 2003:29).

### **1.3.2 Returned Zimbabweans from South Africa between 2006 and 2007**

A substantial number of undocumented migrants were deported back to Zimbabwe between 2006 and 2008 from South Africa, where upon return some are forced to depend on limited resources and adverse coping mechanisms, with some being coerced into sex as a gateway in gaining access to basic needs required for human survival e.g. food and shelter which makes them vulnerable to HIV-infection. Since the beginning of the 21<sup>st</sup> century South Africa has recorded a significant increase of undocumented Zimbabwean migrants. The increasing number of Zimbabweans migrating to South Africa can also be deduced by the number of those who are deported back to Zimbabwe. According to the IOM's BRSC for returnees, since its opening in May 2006, over 12,000 Zimbabwean returnees have passed through Beitbridge per month. In January 2007, these figures rose to more than 21,400 returnees and by August 2008 a total 252,588 returnees passed through the IOM reception centre (Press release, Southern Africa Humanitarian Crisis, Zimbabwe, 2008).

### **1.3.3 Support provided to the returned migrants in Beitbridge**

The support provided to returned migrants at the BRSC includes immediate food support, basic health care and referrals for further treatment, transport assistance, information on safe migration and information on HIV and AIDS and gender-based violence (GBV). Returned migrants also report protection cases to protection officers and migration advisors. The child centre located within the BRSC provides unaccompanied children with accommodation, and psycho-social support. Regular trainings and meetings are conducted between the government of South Africa and Zimbabwe officials on both sides of the border focusing on best practices when assisting MVPs.

Since the opening of the centre up to the end of August 2008; 252,588 returned migrants have requested and received some form of assistance from IOM in Beitbridge. From May to August 2008; 249,283 were given a hot meal and 188,456 food packs were issued. One hundred and ninety seven thousand , six hundred and thirty five returned migrants were assisted with transport back home and 623 protection incidents were reported of which 66 were rape cases, 129 physical assaults, 13 sexual abuse and 104 had their documents confiscated (IOM Beitbridge Reception and Support Centre Report, 2009). Upon return, women and adolescent girls are destitute and forced to depend on limited coping mechanisms thereby making them prone to further sexual violence, abuse and exploitation and to engage in commercial sex work furthermore exposing them to HIV infection. Thus, the MVPs are at great risk of contracting HIV-infections and other STIs.

In Zimbabwe it is widely recognized that population mobility increases vulnerability to HIV-infections, both for migrants and their partners at home due to long time separation of spouses and limited access to health information and services during time of mobility when individuals often are forced to change sexual habits due to the circumstances in which they find themselves.

#### **1.4 PURPOSE OF THE STUDY**

Despite the IOM's commitment to play an active role in the prevention of the spread of HIV and AIDS among the MVPs in Zimbabwe, there are some shortcomings in the prevention strategies which might be addressed through broad-based stakeholder involvement. Besides responding to the immediate needs of the MVPs and potential emigrants the researcher found little if any documentation or literature regarding the role played by the IOM at grassroots level in Zimbabwe to prevent the spread of HIV and AIDS. Therefore this study sought to establish the role of the IOM in HIV-prevention among the MVPs and potential emigrants in Beitbridge and to determine the

effectiveness of HIV-prevention activities undertaken by the IOM. In addition, the study explores the future role of the IOM in the prevention of the spread of HIV and AIDS.

The objectives of the study were to:

- Investigate the types of awareness-raising activities on HIV-prevention conducted by the IOM amongst mobile and vulnerable populations and potential emigrants in Beitbridge;
- Establish the effectiveness of these activities in raising awareness of HIV-prevention among the MVPs and potential emigrants;
- To explore the future role of the IOM in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants;
- To suggest ways in which existing HIV awareness-raising activities among MVPs and potential emigrants may be enhanced.

## **1.5 RESEARCH QUESTIONS**

The study sought to answer the following questions:

- 1) What are the types of awareness raising activities utilized by the IOM in its HIV-prevention activities among the MVPs and potential emigrants in Beitbridge?
- 2) How effective is the awareness-raising of HIV-prevention among MVPs and potential emigrants in Beitbridge?
- 3) What needs to be done to further enhance the IOM's existing awareness-raising activities in preventing and reducing HIV infections among the MVPs and potential emigrants?
- 4) What are the future role and responsibilities of the IOM in enhancing identified activities to prevent HIV-infection among MVPs and potential emigrants?

## **1.6 OVERVIEW OF THE RESEARCH METHODOLOGY**

In line with the research objectives, a mixed research methodology, which combines quantitative and qualitative approaches during different phases of the research process, was selected for this action research study. A form of methodological triangulation was employed in this study in that the researcher developed both qualitative and quantitative data collection instruments in form of a semi-structured interview schedule and a self-administered questionnaire. A total of 20 in-depth face-to-face interviews were conducted with MVPs, potential emigrants and key informants from NGOs and government ministries (refer to Table 3.1b in Chapter 3). To complement the in-depth interviews, the researcher developed a self-administered questionnaire to collect quantitative data. A total of 60 questionnaires were distributed amongst the MVPs and potential emigrants registered with the IOM in Beitbridge and a total of 56 completed questionnaires were returned (refer to Table 3.1a in Chapter 3). The questionnaire was designed in such a way that it was user friendly, quick, precise and easy to complete, with several questions involving a choice of tick or X boxes, with a minimum amount of written responses.

Strydom (2001:24) defines ethics as a set of widely accepted moral principles which offer rules and behavioural expectations about the most correct code of conduct towards experimental subjects and respondents. The research protocol was based on a number of key principles related to ethics and protection. In order to give the respondents an opportunity to express themselves freely, research methods that they felt most comfortable with were chosen. The information revealed in the interviews was kept confidential in that no name or identifying feature of the respondents was used in the study report. In all the interviews conducted no personal questions which would reveal personal characteristics were asked. All the questions were strictly related to the role of the IOM in HIV-prevention among MVPs and potential emigrants in Beitbridge. The researcher used the Statistical Package for the Social Sciences (SPSS) to perform the descriptive statistical analyses, the tests, the analysis of variance, and the correlation.

## **1.7 CONTRIBUTION OF THE STUDY**

The study has the potential to develop and improve the current IOM's HIV and AIDS awareness-raising activities among the MVPs and potential emigrants in Zimbabwe by identifying the gaps in their current programmes and activities. Addressing HIV and AIDS and mobility is critical and fits well within the mandate of the IOM which is the only international agency dealing with the entire spectrum of MVPs during all phases of mobility in southern Africa. The government and other stakeholders dealing directly with the MVPs and potential emigrants may also use these findings to formulate appropriate policies and specific intervention strategies in addressing risks associated with irregular migration in relation to HIV-prevention.

## **1.8 DELINEATIONS AND LIMITATIONS**

This study was restricted to only one research site, namely the IOM Beitbridge Reception and Support Centre (BRSC). This site is one of the areas covered by the IOM's programmes with the MVPs and potential emigrants<sup>1</sup>. Therefore these research findings cannot be generalized to all IOM programmes dealing with the MVPs and potential emigrants in Zimbabwe. The targeted respondents might have perceived needs in relation to IOM's awareness-raising activities in HIV-prevention hence their response might differ significantly from other respondents from other communities who are not part of the scope of this research study.

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<sup>1</sup> Besides the Beitbridge Reception and Support Centre, in Zimbabwe the IOM is currently assisting the MVPs and potential emigrants in Plumtree, Trenance, Killarney, Nyamukwarara, Mugondi, Vhalahela, Fairfields, Mutanda and Odzi.

## 1.9 DEFINITION OF KEY TERMS

- **Child** – For the purposes of the study, a child is defined as a person under the age of 18 years as outlined in the United Nations Convention on the Rights of the Child (Art. 1, UN Convention on the Rights of the Child (CRC), 1989).
- **Child abuse** - Abuse to a child is anything that individuals or institutions do, or fail to do, that directly or indirectly harms the child or damages his or her prospects for life or healthy development.
- **Commercial sex workers** - These are people who sell their bodies sexually as a means of earning an income for survival.
- **Deportation** - The act of a State in the exercise of its sovereignty in removing a non-national from its territory to his or her country of origin or a third state after refusal of admission or termination of permission to remain (IOM Glossary on Migration, 2011: 27).
- **Displaced person** – A person who flees his or her State or community due to fear or dangers for reasons other than those which would make him or her a refugee. A displaced person is often forced to flee because of internal conflict or natural or man-made disasters (ibid: 29).
- **Emigration** - The act of departing or exiting from one State with a view to settle in another. International human rights norms provide that all persons should be free to leave any country, including their own, and that only in very limited circumstances may States impose restrictions on the individual's right to leave its territory (IOM Glossary on Migration, 2004).
- **Emigrant** - A person undertaking emigration.

- **Female genital mutilation (FGM)** - The cutting of genital organs for non-medical reasons, usually performed at a young age. It can include partial or total cutting, removal of genitals and stitching for cultural or other non-therapeutic reasons (IOM Glossary on Migration, 2011:38).
- **Gender** - Refers to the set of roles, responsibilities, constraints, opportunities, and privileges of women and men in any context. Those attributes are learned and socially constructed, changeable over time and can vary within and between cultures. The concept of gender is relational and refers not simply to women or men but to the relationship between them (IOM Glossary on Migration, 2011:42).
- **Gender-based Violence** - Any act that results in, or is likely to result in, physical, sexual or psychological harm or suffering to a person due to his or her gender, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Art. 1, Declaration on the Elimination of Violence against Women, 1993).
- **Humanitarian assistance** - Aid that addresses the needs of individuals affected by crises. This assistance is provided in accordance with the humanitarian principles, particularly the principles of humanity (human suffering must be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women and the elderly; the dignity and rights of all victims must be respected and protected), neutrality (humanitarian assistance must be provided without engaging in hostilities or taking sides in controversies of a political, religious or ideological nature), and impartiality (humanitarian assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race or religion. Relief of the suffering must be guided solely by needs and priority must be given to the most urgent cases of distress) (IOM Glossary on Migration, 2011:47).

- **Illegal entry** – Act of crossing borders without complying with the necessary requirements for legal entry into the receiving State (Article 3 (b), UN Protocol against the Smuggling of Migrants by Land, Sea, and Air, supplementing the UN Convention against Transnational Organized Crime, 2000).
- **Internally Displaced Persons (IDPs)** – Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residents, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violation of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border (referred to and mobile and vulnerable populations (MVPs) throughout the study) (UN Guiding Principles on Internal Displacement, 1998).
- **Irregular migrant** - A migrant who entered a country illegally and remains in that country in violation of that host country's immigration laws. The term 'irregular' is preferable to 'illegal' because the latter carries a criminal connotation and is seen as denying migrants' humanity.
- **Irregular migration** - Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries it is entry, stay or work in a country without the necessary authorization or documents required under immigration regulations. From the perspective of the sending country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfil the administrative requirements for leaving the country (IOM Glossary on Migration, 2011:54).
- **Migration** - The movement of a person or a group of persons, 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, economic migrants, and persons moving for other purposes, including family reunification (IOM Glossary on Migration, 2011:62-63).

- **Orphan** - A child, both of whose parents are known to be deceased. In some countries, a child who has lost one parent is called an orphan.
- **Orphans and vulnerable children** - According to the United Nations' Children's Fund (UNICEF), an orphan or vulnerable child is any child who has lost one or both parents, lives in a household where at least one adult died within the past 12 months, lives in a household where at least one adult was seriously ill for at least three months during the past 12 months, or lives in a household headed by a child (where the head of household is under 18 years old).
- **Umalayisha (plural: omalayisha)** - These are Zimbabwean male informal transport operators but with South African citizenship who mostly use South African registered vehicles to transport migrants and goods to and from South Africa. They also transport unaccompanied goods and children. Their work is facilitated by their use of a combination of trust, deceit and violence. Most of their vehicles have heavily tinted windows. Omalayisha is not original Ndebele but Zulu, the equivalent in Ndebele would be umathwala/omathwala.

## **1.10 OUTLINE OF THE DISSERTATION**

**Chapter 1** describes the background to the study, including the research problem, purpose of the study, research questions and definition of key terms used.

**Chapter 2** discusses the literature review undertaken for the study with reference on the linkages between migration and HIV and AIDS in sub-Saharan Africa. The chapter also further examines the global and regional efforts in addressing HIV and AIDS in

migration settings and Zimbabwe's initiatives responding to the migration challenges and HIV and AIDS. Literature relating to socio-cultural responses to HIV and AIDS among mobile and vulnerable populations (MVPs) and potential emigrants with specific reference to harmful cultural practices, beliefs and myths that foster the spread of HIV and AIDS was also consulted.

**Chapter 3** outlines the research design used in the study, data-collection procedures, sampling design and procedures, measurement of variables, data analyses, and ethical considerations.

**Chapter 4** presents the data analysis, interpretation and summary of the findings.

**Chapter 5** discusses conclusions and makes recommendations for long term sustainable strategies and interventions for the IOM in Beitbridge. The chapter also highlights recommendations for policy makers and makes suggestions for further research.

## **1.11 SUMMARY**

This chapter introduced the study and discussed the problem, purpose and objectives of the study. The researcher formulated the research questions to be answered and defined the key terms.

**Chapter 2** covers the literature review conducted for the study.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

AIDS and the international migration patterns of millions of people in resource poor countries have been characterized by the UN as two of the most crucial social issues facing the world today (ICAS 2011). While being a migrant in and of itself is not a risk factor, certain activities and conditions that are present throughout the process of migration considerably increase vulnerability to HIV and AIDS (ibid).

In trying to address the main objective of the study, the researcher consulted literature from various sources with a focus on the linkages between migration, HIV and AIDS in sub-Saharan Africa. The researcher further examines global and regional efforts in addressing HIV and AIDS in migration settings and Zimbabwe's initiatives responding to migration challenges, HIV and AIDS. Literature relating to socio-cultural responses to HIV and AIDS among MVPs and potential emigrants with specific reference to harmful cultural practices, beliefs and myths that foster the spread of HIV and AIDS was also consulted.

#### **2.2 MIGRATION AND HIV/AIDS**

The relationship between migration, HIV and AIDS is complex. Although many people think that migrants mainly bring HIV when they enter countries, evidence usually shows the opposite, suggesting that migrants are more vulnerable than local populations to HIV infection. The structure of the migration process comes into play when trying to define the possible linkages between mobility and HIV and AIDS (IOM, 2002: 1).

There is evidence of a link between HIV and AIDS and the process of migration (Brummer 2002; Maphosa 2005; JICA/IOM 2004; Mudungwe 2005). According to Brummer (2002), migration has been the catalyst for the spread of HIV. Cross border migrants are among the more vulnerable groups to HIV infection. Rates of infection also tend to be higher along main transport routes and in border regions. Studies indicate that migration and mobility does not only increase the vulnerability of migrants themselves to HIV and AIDS but also that of their partners at home (Thiam, Perry & Piche, 2004).

During the migration process and their stay in the country of destination migrants encounter situations and engage in behaviours that increase their vulnerability to HIV infection. The situations migrants experience and the behaviours they engage in during and after the migration process are influenced by the migrants' characteristics such as sex, age, marital status, educational level and even ethnicity (Brummer, 2002). Undocumented migrants are especially vulnerable to HIV infection because of their 'invisibility' during and at the end of the migration process (Maphosa, 2004). This 'invisibility' often translates into exploitation, harassment, exclusion and powerlessness. The social construction of gender and sexuality underlines the HIV vulnerability of mobile populations (JICA/IOM, 2004). Mobile women, particularly those who migrate for economic reasons, are considered an anomaly to be brought under control especially through shaming behaviour (Gaidzanwa, 1998). This is because mobile women generally act outside the control of men or encroach into traditionally male domain of being breadwinners. Maphosa (2005) explains that in parts of Matabeleland South, *dabulaphu* (crossing the border through illegal crossing points) has traditionally been done by male adults and often used to emphasize masculinity. The increasing feminization of migration, especially through means that have traditionally been perceived as a test of masculinity, constitutes a threat to men and increases the risk of exposure to HIV to these women.

### **2.2.1 HIV and AIDS in sub-Saharan Africa**

Sub-Saharan Africa remains the region most heavily affected by the HIV epidemic (although twenty-two countries in the region have shown signs of decline in HIV incidence rate by more than 25 percent between 2001 and 2009) (UNAIDS Global Report, 2010). Out of the total number of people living with HIV worldwide in 2009, 34 percent resided in ten countries of southern Africa (UNAIDS Global Report 2010). The vast majority of people newly infected with HIV in the region are infected during unprotected heterosexual intercourse. Having unprotected sex with multiple partners remains the greatest risk factor for HIV in the region. New HIV-infections among children due to mother-to-child transmission of HIV are also significant in the region (UNAIDS Global Report 2010).

The epidemiology of HIV and AIDS can be closely linked to the process of migration. Migration has been a catalyst in the rapid spread of HIV in southern Africa. It is argued that the spread of HIV and AIDS is likely to be accelerated in a situation of large-scale migration (Anarfi, 1993:46) and that the spread of infectious diseases that are transmitted from person to person will follow the movement of people (Decosas, Kane & Anarfi, 1995:826).

Since the discovery of the HIV virus, it is estimated that 25 million people had died globally by the end of 2008. This has brought profound demographic and social challenges and untold suffering in the severely affected countries (UNAIDS/WHO 2008:31). The most recent global epidemiological data has shown a significant decline in HIV-infection rates in specific countries. Although there are some positive indicators from some countries, sub-Saharan Africa continues to bear a disproportionate share of the global burden of HIV with 35 percent of HIV infections and 38 percent of AIDS deaths in 2007 (UNAIDS/WHO, 2008:32). In addition, globally 67 percent of people living with HIV are from the sub-Saharan region. In sub-Saharan Africa, the HIV and AIDS epidemic has had a devastating social and economic impact. HIV has been the source of disintegration of the once integral social fabric of African cultures, with breadwinners

from the economic productive age group being the most infected thereby reducing the productive capacity in both the private and public sectors (Zawaira, 1999:25).

In Southern Africa, the linkages between HIV and AIDS and migration are close and complex. Crush and Dodson (2006) has highlighted four key ways in which migration is tied to the rapid spread and high prevalence of HIV and AIDS in sub-Saharan Africa:

- There is a higher rate of infection in ‘migrant communities’, which are often socially, economically and politically marginalized;
- Migrants’ multi-local social networks create opportunities for mobile sexual networking;
- Migration per se can encourage or make people vulnerable to high-risk sexual behaviour;
- Migration makes people more difficult to reach through interventions, whether for preventive education, condom provision, HIV testing, or post-infection treatment and care.

There are many factors that contribute to the vulnerability of migrants to HIV infection. The breakdown of social networks and institutions stemming from migration reduces community cohesion, weakening the social norms that regulate sexual behaviour, leading to risk behaviours and increased exposure to HIV infection (IOM, 2007).

In sub-Saharan Africa, there is substantial empirical evidence of the link between HIV and AIDS and migration (Crush & Dodson, 2006; Crush & Tevera, 2010; IOM, 2007). Research conducted in sub-Saharan Africa has found that the incidence of HIV has been found to be higher near roads and highways, and amongst people who either have personal migration experience or have sexual partners who are migrants (Van Schaik, 2003:100). Border towns represent areas with high rates of HIV prevalence, being places where transients such as truck drivers encounter a more stable local population, and which are by definition remote from nationally centralized HIV and AIDS intervention programs (Wilson, 2000). Refugees and MVPs have also been found to be especially

vulnerable to HIV-infection, often as part of the same disruption that caused them to migrate. (There is another school of thought which differs from the above argument, and contends in all the regions where HIV is spreading, it is most predominant in urban areas, with an estimated urban-rural ratio of 36:1 in sub-Saharan Africa. The reasons for this geographical differentiation relate to the concentration of high-risk behaviour, as well as those cities and large towns are often the first entry point of the virus into a country [Webb, 1997:11-12]).

In linking human mobility and the epidemiology of HIV and AIDS, it is important to note that different forms of migration lead to different social and geographical forms of migrant 'community', and thus to different causes and cultures of risk (Crush, Frayne & Grant 2006:22). As an example, where single-sex labour migration is regularized and formalized as in the South African mines, migrant communities and an associated migrant culture has developed as highlighted by Campbell (2003). Sex and sexuality are integral components of such cultures, including commercial or 'transactional' sex and heterosexual as well as homosexual relations, in addition to sex with a female partner at home.

Other forms of mobility disrupt or prevent the formation of any stable, place-based community. People with multiple 'homes', or who spend a lot of their time away from or between homes, lead lives of contingent encounters and short-term relationships, whether economic, social or sexual (Crush et al, 2006:21). This encourages high-risk sexual behaviour, including obtaining sex on a commercial basis. In Zambia, for example, it has been argued that low-income men living away from home for one or more months per year are more than twice as likely to die from HIV related illness as men living at home (Chapoto & Jane, 2008).

The gender dynamics of migration lead to differences between men and women in terms of their risk of exposure to HIV (MacPhail, Williams & Campbell, 2002:331-342). While 'on the road,' women are especially vulnerable to exploitation and harassment, which can include sexual assault. In Malawi, for example, for women and girls who undertake cash-

earning piecemeal work (*ganyu*) beyond the confines of the village are particularly at risk as transactional sex is increasingly incorporated into *ganyu* contracts (Bryceson & Fonseca, 2005).

### **2.2.2 Push factors to HIV-prevalence in sub-Saharan Africa**

No single factor, biological or behavioural, determines the spread of HIV infection (UNAIDS, 2002:25). Saaiman and Kriel (1991:161) identify a range of factors associated with the spread of HIV and AIDS. These include poverty, illiteracy, rising unemployment, cultural beliefs and practices, sexual behaviour, myths and perceptions, economic devastation, political manoeuvring, and other forces, "... which the individual hardly understands, let alone controls" (ibid).

A long history of migration and the attendant breakdown of social cohesion characterised by family disintegration among the African cultures are some of the key push factors explaining the high HIV-prevalent rates in sub-Saharan Africa (Zawaira 1999:25). Globally, the migration flows of today are being driven by many forces, inter alia, the emerging of the global village, and the social, economic and political unrest in many countries which has caused more people to be on the move in the 21<sup>st</sup> century than at any other point in the history of mankind. The global estimates indicate that there are now almost 191 million people living outside their place of birth, which is about three percent of the world's population up from 2.9 percent in 1990 (UNDESA, 2006:1) This means that roughly one out of every 35 persons in the world today is a migrant.

With particular reference to sub-Saharan Africa, Gennrich (2004:7) and Zawaira (1999: 26) argue that past employment practices and apartheid laws have contributed significantly to the spread of HIV. The social devastation caused by migrant labour and the apartheid laws, which prevented families from settling as families near their places of work increased the risk of exposure to HIV.

HIV is clearly linked to certain patterns of human behaviour, especially sexual behaviour, and as such is an essentially biological and socio-cultural phenomenon (Helman, 1997: 346). Social behaviour such as promiscuity, pre- or extra-marital sexual relations, homosexuality (both male and female), and transactional sex are associated with the spread of HIV and AIDS (Helman, 1997:149-153; Webb, 1997:18). Young women, who have strong economic or consumer needs, are often exposed to risk. They may partner older men for greater protection and support, or engage in sexual intercourse for exchange of status items, such as cash, cars or cell phones. Promiscuity is often perceived as the outcome of a combination of behavioural and contextual/economic factors (Gennrich, 2004:7).

### **2.3 CULTURE, MYTH AND BELIEFS THAT FOSTER THE SPREAD OF HIV AND AIDS**

The influence of culture, religion, myths and beliefs on sexual behaviour is complex at both individual and societal levels. In different societies, cultural practices and traditions abound that were adaptive and fulfilled important functions in the past that may, today, carry serious health and welfare risks. Cultural beliefs and myths about AIDS in some African communities influence the risk behaviour and foster the spread of HIV and AIDS.

#### **2.3.1 Gender and sexuality**

Gender inequality is a critical factor in the spread of HIV in Africa, in how people are cared for when they are sick, in what happens when they die and who inherits what (Jackson, 2002:87). Research reflecting global AIDS epidemic trends reveal that men have more opportunity to contract and transmit HIV compared to women due to cultural practices which gives men more power to determine the circumstances of sexual intercourse. In the context of gender inequality, male attitudes and behaviours are

currently the crux of the HIV and AIDS problem, whether men are heterosexuals, homosexuals or drug injectors (UNAIDS, 2000). Essentially, widespread stereotypes of masculinity, 'machismo' and what it means to be a 'real man' encourage male dominance over women, risk-taking and promiscuous sex. In many African cultures, ideals of manhood include strength, courage and dominance and, critically, accept men as having an uncontrollable sex drive that lets them off the hook of responsibility.

Furthermore, the African traditional patriarchal societies have long endorsed multiple partnerships for men in the form of polygamy and other sexual freedoms within prescribed limits. WHO surveyed men and women in 18 countries around the world and found that, in all, men acknowledged a higher number of sexual partners than women.

### **2.3.2 Culture and religion**

The influence of culture and religion on sexual behaviour is complex at both individual and societal levels. In different societies, cultural practices and traditions abound that were adaptive and fulfilled important functions in the past that may, today, carry serious health and welfare risks. With regard to HIV and STIs transmission, practices and traditions that are risky include:

- Sexual practices, mostly practiced in the African cultures such as ritual cleansing, also known as widow cleansing, and levirate union (inheritance of a wife by the deceased husband's brother), are associated with the spread of HIV and AIDS. It is believed that "to be purged of the 'evil forces' assumed to have caused the death of a spouse, the widow or the widower is 'cleansed' through the act of sexual intercourse with a relative of the deceased this practice is widespread in many countries" (Helman, 1997:359). The practice of the levirate, for instance in some areas in Zambia and Zimbabwe the woman is supposed to become the brother's wife, even though her husband may have died of AIDS and she has

HIV. In Zambia the widow has sex with the brother in a linked cleansing ceremony;

- According to Helman (1997:152, 325), marriage patterns that permit extra-marital relations, polygamy, frequent divorces, or the exchange of partners may all contribute to the spread of the virus;
- Initiation rites in parts of Malawi which involves adolescent girls being secluded for training to be a wife, training that includes having sex with an anonymous man selected from the community.

The culture of silence that surrounds sex education in most African cultures is also a contributory factor to the spread of HIV and AIDS in the sub-Saharan Africa. In most countries in sub-Saharan Africa, sex education e.g. promotion of condom use among the youth in primary and secondary schools is regarded as a taboo, exposing youth to sexual practices before they know much about the consequences and how to protect themselves. In Zimbabwe in particular, the Ministry of Education, Sports and Culture Policy prohibits sex education that seeks to promote the use of condoms as a preventive measure to HIV infection within the primary and secondary education system. Mass media adverts, especially on television, contribute to the myth that 'sex is cool' and a normal part of any casual relationship (Gennrich, 2004:12).

Female Genital Mutilation (FGM) is widely practiced among African cultures. FGM is a procedure that involves the partial or total removal of the external female genitalia. In most of the African countries especially in West and Central Africa, this initiation is being generally performed without anaesthesia by traditional elders, in some cases for pay. FGM has health consequences that include haemorrhage, shock, pain, infection, psychological and sexual problems, and difficulties during child birth as well as a high risk for HIV transmission (Collymore, 2004:1; Helman,1997:326).

### **2.3.3 Myths about HIV and AIDS**

Myths about HIV and AIDS and the associated fears can undermine attempts to identify, treat and control the disease and to offer its victims the care and compassion they deserve. Thus the moral and ideological attitudes of a society towards AIDS are just as relevant to its control as the search for an effective vaccine. In the United States of America (USA), the discourse on AIDS defines the victim as the ultimate “other, alien, antisocial, unnatural, dangerous and threatening their disease is a manifestation of their inner moral evil and/or mental illness” (Helman, 1997:348).

One of the most pernicious and dangerous myths in circulation in Zimbabwe is that having sex with an old woman or a virgin cures a man of HIV and AIDS. The consequences of this fallacious belief are simply that a deadly virus is passed on to an innocent child or young woman. The increasing number of rape victims who are babies and children would seem to be associated with this myth (Jones, 2004:16-37).

The belief exists that HIV and AIDS is just another colonial way of oppressing black people, calling it the ‘American idea to destroy sex’, and in defiance continue indulging in a risky life style behaviour that will expose them to HIV infection (Gennrich, 2004:7). Another myth is that women mostly infect men with HIV (ibid:13). The fact is that women are more vulnerable to HIV and more likely to get sick more quickly than men through biological factors that make them more susceptible to infection because they have a larger surface area of genital mucous membranes than men.

### **2.3.4 Beliefs about HIV and AIDS**

Cultural representations of AIDS are blend of medical and indigenous beliefs, as a physical disease, and, for example, a punishment for sinful behaviour (Helman, 1997:348). The belief that HIV is a punishment for sinful behaviour appears to be widespread. In Indonesia, it is believed that HIV is a curse from God and sinners catch

the disease. African-Americans in the USA regard AIDS as punishment for sin a result of breaking religious and moral laws, especially those against homosexuality or extra-marital sex (Knust, 2003). In Botswana, some traditional healers see it as just a folk illness caused by the breaking of certain sexual taboos; others blame the disease on a sent sickness, or sorcery, due to envy because a person infected with HIV has been bewitched (Helman, 1997:349). This leads the victim's family to consult a voodoo priest to confirm this and find someone to blame for being responsible. Some people will avoid an AIDS sufferer like the plague for fear of being infected by mere touching. Such erroneous beliefs make it difficult for HIV-positive people to openly seek help early from the hospital. They delay seeking treatment and die from loneliness and fear of stigma, and rejection.

In Africa, some cultural and religious beliefs insist that women should obey their husbands at all times and that men naturally need more than one sexual partner. Accepting polygamous marriages, for example, makes it difficult for wives to insist on their husbands' faithfulness or to refuse unsafe sex, even within marriage. Violent or exploitative relationships experienced by women and children also contribute to the spread of HIV in some places (Gennrich, 2004:13).

The spread of HIV and AIDS is thus associated with secrecy, prejudice, ignorance, fear, denial and late presentation of signs and symptoms of the infection presented by many infected persons (ibid:7).

## **2.4 THE ROLE OF INTERNATIONAL AGENCIES IN ADDRESSING HIV AND AIDS**

Numerous initiatives are being taken by United Nations (UN) agencies, international organizations and inter-governmental organizations to control or combat the HIV and AIDS epidemic at global and regional levels among the potential emigrants, mobile and vulnerable populations (MVPs). The UN, the IOM and Southern African Development

Community (SADC) countries regional research papers on global migration trends, and HIV and AIDS are highlighted in this section.

#### **2.4.1 Global initiatives in addressing HIV and AIDS**

The relationship between migration, HIV and AIDS epidemic was recognized by the United Nations during the General Assembly Special Session on HIV and AIDS in June 2001. Former United Nations General Secretary, Kofi Annan, during the General Assembly Special Session on HIV/AIDS in June 2001 declared that:

For there to be any hope of success in the fight against HIV/AIDS, the world must join together in a great global alliance. The Declaration of Commitment on HIV/AIDS is the culmination of a year-long process of awareness, engagement and mobilization. My great hope is that it signals the emergence of a response to this deadly disease — by Governments, multilateral organizations, the private sector and civil society — that could soon match the scale of the epidemic itself.

As a result of the above a position paper on HIV and AIDS and Migration was produced at the eighty-fourth session of the IOM General Assembly in October 2002. All countries attending the General Assembly concurred that HIV and AIDS remains a global health challenge with extraordinary social and economic dimensions.

#### **2.4.2 The African Summit on HIV and AIDS**

In April 2001, the African Summit on HIV and AIDS, tuberculosis and other related infectious diseases was held in Abuja, Nigeria. The former UN General Secretary, Kofi Annan issued a global call to action in the fight against AIDS (UNAIDS, 2002:11). Annan welcomed the commitments of African Heads of State or Government at the Abuja special summit in April 2001, particularly their pledge to set a target of allocating

at least 15 percent of their annual national budgets for the improvement of the health sector to help to address the HIV epidemic; and recognizing that action to reach this target, by those countries whose resources are limited, will need to be complemented by increased international assistance (UNAIDS, 2001:8). He further pointed out that HIV and AIDS has since been a prominent item on the agenda of summits and decision-making forums organized by the regional and international bodies like the G7 and G8 nations, the Organization of American States (OAS), the African Union (AU), the Commonwealth of Nations (CoN), the European Union (EU), the Association of South-East Asian Nations (ASEAN), and the Caribbean Community Secretariat (CARICOM).

### **2.4.3 HIV and AIDS in Zimbabwe**

Zimbabwe, like most Southern African countries, is at the epicentre of the HIV and AIDS pandemic. Since the beginning of the 21<sup>st</sup> century, Zimbabwe has witnessed a gradual decline in HIV prevalence in adults aged 15-49 years from 23.7 percent in 2001 dropped to 18.1 percent in 2007 (Zimbabwe Demographic Health Survey [ZDHS] Country Report; UNGASS, 2008–2009). Government of Zimbabwe Millennium Development Goals Report (2010:32) estimates for 2009 revealed a further decline in the adult prevalence rate to 14.3 percent. Significant declines are also evident in the HIV prevalence rate for pregnant women dropping from 25.78 percent in 2002, to 21.3 percent in 2004, further down to 17.7 percent in 2006 and finally to 16.1 percent in 2009 (UNGASS, 2008 – 2009). The decline in the incidence of HIV in pregnant young women (15-24 years of age) typically reflects a similar decline in HIV and AIDS incidence in general. In 2002, the prevalence for this age group was estimated to be 20.8 percent, but declined thereafter, falling to 17.4 percent in 2004, 12.5 percent in 2006, and 11.6 percent in 2009 (ibid:10). The gradual decline in HIV prevalence has been attributed to a change in sexual behaviour including delayed sexual debut, decreased in the number of sexual partners, increased correct and consistent condom use as well as other interventions by the government, other local players and the support from the international community (ZDHS, 2007). It is expected that the incidence will continue on the downward trend as

Zimbabwe government in partnership with local and international partners continue to scale up prevention efforts in the HIV-negative population, thus leading to the reduction in new infections. If the scaling up of treatment is strengthened Zimbabwe will record a reduction in new infections, which may translate into lower transmission rates and thus reduced incidence among the general population (Government of Zimbabwe Millennium Development Goals Report, 2010:32).

The high prevalence rate is attributed among other issues to mobility among the Zimbabweans seeking better economic opportunities within the SADC region and beyond due to under-performance of both private and public sectors witnessed since the end of the 20<sup>th</sup> century (IOM, 2007). A high level of mobility among the populace in Zimbabwe is characterized by prolonged spousal separation which has caused the disintegration of the cultural and social fabric of many families. Multiple concurrent sexual partnerships outside formal marriages and cross generational sex have been identified as key drivers of HIV in Zimbabwe (National Behavioural Change Strategy for Prevention of Sexual Transmission of HIV, 2006 – 2010).

In Zimbabwe, the current HIV trends indicate that almost half of all new HIV-infections are perceived to be occurring among the youth (between 15 and 24 years), with high incidences being recorded among the female adolescents as compared to male counterparts (UNFPA 2004; ZDHS, 2007).

## **2.5 THE ROLE OF THE IOM IN THE PREVENTION OF HIV AND AIDS**

The IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an inter-governmental body, the IOM acts with its partners in the international community to assist in meeting the operational challenges of migration, to advance understanding of migration issues, to encourage social and economic development through migration and to uphold the human dignity and well-being of migrants (IOM, 2007:1). IOM's mandate allows it to work with migrants, refugees, displaced persons and others in need of migration services or assistance.

Migrants are generally more vulnerable to HIV infection at their destination. This is often the case with men who work far from home and live in men-only camps. For others, the greatest risk occurs in transit, as with women who trade sex as a survival strategy. As for countries of origin, partners of migrant workers have been shown to be at increased risk of infection when the latter return from working in countries with high HIV prevalence or the former engage in risk behaviours as a survival strategy (IOM, 2002:1).

Universally, migrants are very often faced with poverty, discrimination and exploitation, alienation and a sense of anonymity, limited access to social, education and health services, separation from families and partners, and separation from the socio-cultural norms that guide behaviour in stable communities. Many of the underlying factors sustaining mobility, such as an unbalanced distribution of resources, unemployment, socio-economic instability and political unrest, are also determinants of the increased risk of migrants and their families to HIV infection (ibid). A key characteristic of migrants is that because of their mobility, and status as non-nationals, they may fall through the cracks of governments' responsibilities in countries of origin, transit, destination and return. It is in such instances that international institutions like the IOM play an important role in preventing and protecting migrants and mobile populations.

### **2.5.1 The IOM's approach in addressing HIV and AIDS**

In its programme to address migration, HIV and AIDS, the IOM supports a global approach with a focus on advocacy, policy guidance and definition of best practices; regional and country level initiatives with harmonization of approaches with other partners working in the global response to HIV among the mobile populations and potential emigrants.

The IOM works to prevent and counter the misinformation, misunderstanding and stigmatization that continue to foster the perceived relationship between migration and

the initiation and/or propagation of HIV and AIDS. The organization takes a multi-pronged, rights-based approach to address specific HIV-related vulnerabilities of mobile populations, through programs of capacity building, service delivery, advocacy and policy developments (IOM, 2007:2). These strategies create a positive environment for dealing with HIV and AIDS in a holistic manner, where issues such as discrimination and xenophobia are addressed, and where migrants receive the best possible health promotion and health-care services. The IOM works within a rights-based framework to increase the access of migrants and mobile populations to HIV prevention, care, support and treatment, as well as to assist countries on management of the health impacts of population mobility (ibid:1). In terms of a multi-stakeholder approach, the IOM works with international organizations (IOs), governments, non-governmental organizations (NGOs) and key actors from all countries in developing regional and cross-regional strategies to address HIV risks and vulnerabilities of migrants and mobile populations.

The IOM's response to HIV and AIDS epidemic addresses migrants throughout all stages of their journey: before they leave; as they travel; in communities and countries where they stay; and after they return home. Effective HIV-prevention programmes among mobile populations require a thorough understanding of migrants' cultural backgrounds and social practices.

In trying to adhere to the international standards in addressing migration, HIV and AIDS, the IOM's projects and programmes are developed in consultation with the beneficiaries themselves, and in partnerships with other stakeholders with the governments, NGOs and other IOs working in the field of HIV and AIDS and migration.

### **2.5.2 The IOM HIV and AIDS activities framework**

The organization's activities are structured under the following strategic objectives:

- Decrease risk of HIV exposure among mobile populations and labour migrants;
- Advocate for universal access of migrants to HIV care and treatment;

- Support governments to manage the health impacts of migration and population movements;
- Address the HIV needs and vulnerabilities of mobile populations in emergency settings.

In 2007, the IOM implemented HIV programmes in twenty-two countries. These included Colombia, Croatia, Mauritania, Myanmar, Somalia, South Africa, Thailand and Zimbabwe. HIV projects constitute an integral element of the IOM migration health activities, and incorporate a range of activities such as:

***Advocacy and policy dialogue***

- Increasing international understanding and recognition of the vulnerability of migrant populations to HIV and AIDS through UN theme groups, governments and NGOs;
- Building networks and organizing national and international events with a wide range of stakeholders to build consensus around priorities, policies and actions related to migration, HIV and AIDS;
- Advocating for the protection of migrants' rights, including access to health promotion information, to decent working and living conditions, and for access to care and support for migrants living with HIV and AIDS;
- Supporting policy development on the national, regional and global levels that will reduce the vulnerability of migrants to HIV infection;
- Advising governments and employers concerning HIV-related immigration policies.

***Capacity-building and mainstreaming***

- Assisting governments and regional structures to address migration in national and regional strategic HIV and AIDS action plans and programmes;

- Assisting governments and NGOs to integrate or mainstream HIV and AIDS and migration issues into humanitarian and development planning, budget allocations, and programme implementation;
- Assisting governments, the private sector and trade unions to address the underlying factors that make migrants particularly vulnerable to HIV infection;
- Facilitating and building capacity on the ground for voluntary confidential HIV counselling and testing for people on the move;
- Assisting governments and NGOs in training peer educators, outreach workers and healthcare personnel in the HIV and AIDS-related needs of migrants.

### ***Research and information dissemination***

- Carrying out baseline assessments of HIV-related risks associated with migration;
- Providing written and oral HIV and AIDS information to migrants;
- Commissioning and coordinating research in the area of HIV and AIDS and migration in order to inform policy formulation and programme development;
- Collecting, reviewing and disseminating information about migration, HIV and AIDS;
- Identifying and generating technical updates and best practice documents on HIV and AIDS prevention and access to care for migrants.

Given the IOM's years of experience in dealing with migration globally, the organization is exclusively placed to become a leader in the prevention of HIV-infection among MVPs and potential emigrants in Zimbabwe. The challenges include ensuring access to HIV and AIDS prevention, care and support for migrants around the world, and working to reduce the factors that make migrants particularly vulnerable to HIV infection.

The UN (UNAIDS, 2002:11-13) and the IOM (2001) share similar concerns about the problems and challenges caused by HIV and AIDS pandemic and call for:

- More resources to fight AIDS and ensure that a wide range of prevention programmes are available to all;
- At least 90 percent of young people to have access to information, education and services necessary to develop the life skills needed to reduce their vulnerability to HIV, the rate of HIV infection among young people in most affected countries, and the proportion of infants born with HIV;
- Anti-discrimination and human rights protection for people living with HIV and AIDS and for vulnerable groups;
- Participatory programmes to protect those affected by HIV and AIDS;
- Women to be empowered as an essential part of reducing vulnerability to HIV;
- National strategies to strengthen health care systems and address factors affecting the provision of HIV-related drugs, including affordability and pricing, and make treatment and care for people with HIV and AIDS as fundamental to the AIDS response and its prevention.

This Declaration of Commitment on HIV and AIDS was adopted unanimously and serves as a benchmark for global action (UNAIDS, 2002:12-13).

The IOM has been providing humanitarian assistance services in Zimbabwe to vulnerable returned migrants deported from neighbouring countries of South Africa and Botswana since May 2006. The IOM Beitbridge Reception and Support Centre (BRSC) offers a range of services to returnees including safe migration advice, medical treatment, protection, food, counselling, and voluntary transport assistance back to their respective place of origin. HIV prevention activities are an integral component of the IOM assistance to MVPs and potential emigrants in Zimbabwe.

## **2.6 SUMMARY**

This chapter discussed the literature reviewed on HIV and AIDS, global and regional initiatives in prevention of HIV infections in migration settings. The IOM Zimbabwe and

SADC's regional initiatives on HIV and AIDS among migrants and MVPs were also explored. In-depth analysis of the role of the IOM in promotion and prevention of the spread of HIV and AIDS among potential emigrants, MVPs was consulted. In addition, literature focusing on Zimbabwe's initiatives responding to migration challenges, HIV and AIDS as well as socio-cultural responses to HIV and AIDS among MVPs and potential emigrants with specific reference to harmful cultural practices, beliefs and myths that foster the spread of HIV and AIDS was also consulted.

**Chapter 3** describes the research design and methodology of the study.

## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter describes the research design, data-collection procedures, sampling design and procedures, data analysis and ethical considerations. The stages identified by Johnson (1994) guided the selection of the research method, arranging research access, developing the research instruments, collecting the data, pulling out of the investigative phase, and ordering the data.

An exploratory and descriptive study (Denzin & Lincoln, 2000:22) was undertaken with the aim of assessing the role of the International Organization for Migration (IOM) in HIV-prevention among the mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge, and to determine the effectiveness of HIV-prevention activities undertaken by the IOM.

#### **3.2 THE RESEARCH DESIGN**

A research design may be described as a blueprint or detailed plan for the conduct of a research study (Thyer, 1993:94). In planning for any research, researchers need to specify firstly the exact purpose of the investigation and translate it into specific objectives that will allow them to select the most appropriate way of collecting data. In accordance with the research objectives, a mixed research methodology, which combines quantitative and qualitative approaches during different phases of the research process, was selected for this action research. Johnson and Onwuegbuzie (2004:17) define a mixed research method as the class of research where the researcher mixes or combines qualitative and

quantitative research techniques, methods, approaches, concepts or languages into a single study. Elements of action research were also employed. Action research (also known as participatory research) is a form of research whereby the researcher actively involves the participants in order to solve a problem or achieve a learning objective (Hofstee, 2006:127). A semi-structured interview questionnaire was designed to capture qualitative data through in-depth interviews, and a self-administered questionnaire was designed to capture quantitative data by means of a survey.

### **3.2.1 Quantitative research methodology**

Burns and Grove (2001:30) define a quantitative descriptive research design as “an accurate portrayal or account of the characteristics of a particular individual, situation or group”. The survey design is the most commonly used descriptive method. It gathers data at a particular time with the intention of describing the nature of existing conditions, identifying standards against which existing conditions can be compared, or determining the relationships that exist between specific events (Cohen & Manion, 1994:98-100).

### **3.2.2 Qualitative research methodology**

A qualitative research methodology aims to describe events, perceptions, experiences and views of people and what lies at the core of their lives. Qualitative approaches are linked to the subjective nature of social reality and they provide insights from the perspective of the participants, enabling the researcher to see events as their informants do (Harris, 1976:6). In other words, qualitative research methodology helps the researcher to examine the experiences, feelings and perceptions of the study rather than immediately imposing a personal framework that might distort the ideas of the informants.

### **3.3 THE DATA COLLECTION METHODS**

A form of methodological triangulation was employed in this study in that quantitative and qualitative data were collected by means of a semi-structured interview schedule for in-depth interviews and a structured questionnaire for the survey.

In order to provide background information for use in developing the assessment tools, an interview guide with five broad questions was developed and administered to selected key informants (representatives from the Department of Immigration, the Department of Social Services (DSS), the Ministry of Health and Child Welfare (MoHCW) and three NGOs operating in Beitbridge) who were not part of the final research sample. The researcher then developed both qualitative and quantitative data collection instruments in form of a semi-structured interview schedule and a self-administered questionnaire.

#### **3.3.1 Face-to-face interviews**

A semi-structured interview schedule was developed by the researcher to collect qualitative data. Qualitative research is a "way of knowing" and learning about different experiences from the perspective of the individual. Unlike quantitative methods which assume that "truth" is objective and can be empirically revealed, qualitative research follows a naturalistic paradigm based on the notion that reality is not predetermined, but constructed by research participants (Polit, Beck & Hungler). Qualitative research empowers participants because they are not merely reacting to the researcher's questions but have a voice to guide the study. In the above context, the interviews with the key informants were semi-structured so as to reveal the feelings, thoughts and intentions of individuals (Blummer, 1977:234). In addition, interviews proved to be an effective way of collecting qualitative data using open-ended questions, thereby giving room for clarity and more time for participants to respond to the questions in their own words rather than forcing them to choose from fixed wording and sequence of presentation like in quantitative research.

The researcher originally planned to conduct 40 interviews with key informants. Due to the unavailability of representatives and study constraints this figure had to be reconsidered. Ultimately, 20 in-depth face to face interviews were conducted with key informants in Beitbridge (see Table 3.1b). All interviews were conducted by the researcher. The language used for the interviews was English. Given the sensitivity of the area of study the researcher was only able to capture the information in writing rather than using other methods like tape recorders.

The interviews covered broad areas such as: forms of abuse experienced by MVPs and potential emigrants in Beitbridge which might put them at risk of contracting HIV; available support services provided by the IOM; types of HIV-prevention activities conducted by the IOM; the efficiency and effectiveness of these activities in HIV-prevention; ways in which existing HIV-prevention activities may be enhanced.

Employing a qualitative method allowed the researcher to:

- Collect the primary data in a flexible, non-structured way that allowed emergence of new information and interpretations of role of the IOM in HIV-prevention among MVPs and potential emigrants;
- Interact with the research subjects, in most of the cases, at their own work place;
- Obtain a more realistic and hands-on feel of the world that cannot be experienced in the numerical data and statistical analysis used in quantitative research.

Follow-up interviews were conducted by the researcher with three participants to validate findings and reliability of the results.

### **3.3.2 Self-administered questionnaire**

The researcher developed a self-administered questionnaire to collect quantitative data. The questionnaire was designed in such a way that it was user friendly, quick, precise and

easy to complete, with several questions involving a choice of tick or X boxes, with a minimum amount of written responses. The questionnaire was designed to gather quantitative data at a particular point in time with the intention of describing the nature of existing conditions (Cohen & Manion, 1994:83).

A self-administered questionnaire is the best form of data collection for a survey design. It has the potential for reaching respondents who live at widely displaced addresses or abroad, is the cheapest way of data collection, offers anonymity and respondents can complete the questionnaire when it is convenient for them and check personal records, if necessary (Neuman, 1997:141).

The questionnaire was divided into four sub-sections: general information; description of the current role of the IOM and its effectiveness in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants, personal beliefs among the MVPs and potential emigrants regarding the spread of HIV and AIDS and the last part describes the possible future role of the IOM in the prevention of the spread of HIV and AIDS.

The general information included the demographic data (age, gender, formal education etc), the duration of stay in Beitbridge (number of months, number of years), and background in the place of origin (attending school, employed, unemployed, etc). The second part of the questionnaire consisted of three main questions with statements related to the extent to which (1) HIV and AIDS messages were included in the IOM activities within the MVPs and potential emigrants communities (during distribution of food and non-food items, livelihoods programmes, irregular and safe migration activities, etc), (2) HIV and AIDS prevention activities organized by the IOM in the MVPs and potential emigrants communities, and (3) aspects of HIV and AIDS addressed within IOM programmes. The third part of the questionnaire consisted of statements describing personal beliefs about the spread of HIV and AIDS among the MVPs and potential emigrants, and the last part covered the possible future role of the IOM in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants.

A total of 60 self-administered questionnaires were distributed among the MVPs and potential emigrants registered with the IOM in Beitbridge. Fifty six completed questionnaires were returned.

The fieldwork for the study took place between May and December 2010.

### **3.3.3 Advantages and disadvantages of qualitative and quantitative instruments**

The researcher experienced a number of advantages of applying both quantitative and qualitative methods in this action research study. Quantitative methods ensured high levels of reliability of gathered data. Qualitative method allowed for obtaining more in-depth information about the role of the IOM in HIV-prevention activities among the MVPs and potential emigrants. The use of different research methods allowed building on the strengths of each method and minimizing their weaknesses. The weaknesses of the quantitative method, such as failure to provide information about the context of the situation, inability to control the environment, and pre-determined outcomes, were compensated by interaction with the research participants during interviews, learning about the context, and uncovering new research themes.

The weaknesses of the qualitative method, such as departing from the original objectives of the research, excessive subjectivity of judgment, and high requirements for the experience level of the researcher, were compensated by clearly stating the research problem, and cross-checking with the results of the statistical analyses.

### **3.3.4 Validity**

The content validity of both quantitative and qualitative research instruments was ensured by carefully formulating the questions and statements for the research tools to include all components of the conceptual framework. The questionnaire developed for quantitative research was shared with two experts from the National AIDS Council (NAC) and the

IOM research department. Feedback was received from the experts and necessary changes were made in line with the comments raised. The in-depth semi-structured interview schedule for key informants was shared with the experts from the Zimbabwe Institute of Management (ZIM) and the IOM for their comments. If the research instruments measure all the components of the variables in question, a researcher can be confident that the instruments have a high content validity (Polit & Hungler, 1991:375).

### **3.3.5 Reliability**

No statistical reliability test of the research instruments was conducted. However, the self-administered data collection instrument was pre-tested at Hopley farm with MVPs and potential emigrants who were not part of the final research sample. The in-depth semi-structured interview schedule was pre-tested with two IOM implementing partners and other service providers working in Hopley farm. A follow-up in-depth semi-structured interview with three participants to validate the findings and reliability of the results was done. The completed research instruments were given to the research supervisor for review and comments. The research was authorized by the IOM Chief of Mission. Polit and Hungler (1991:367) refer to the reliability of an instrument as the degree of consistency with which it measures the attribute it is supposed to measure.

## **3.4 SAMPLING STRATEGY**

The difference between quantitative and qualitative methods is captured in the underlying logic of sampling approaches. As the purpose of each strategy is different, the techniques for sampling will differ.

### **3.4.1 Purposive sampling**

The sample for the in-depth interviews was drawn from Beitbridge, which is located less than a kilometre from the border post between Zimbabwe and South Africa with the setting being the IOM Beitbridge Reception and Support Centre (BRSC). Non-probability purposive sampling (Cohen & Manion, 1994:88) was used to select 40 key informants for the semi-structured in-depth face-to-face interviews in Beitbridge for convenience. Of the selected 40 participants, 16 were from the MVPs and potential emigrants (interviewed as they visited the BRSC centre), and 24 key informants were selected from active NGOs working with MVPs and potential emigrants, the police's victim friendly unit officials, health care workers, social services officers, immigration officials, IOM partners and IOM migration advisors in Beitbridge. Due to the unavailability of representatives and study constraints this figure had to be reconsidered. Ultimately, 20 in-depth face to face interviews were conducted with key informants in Beitbridge (see interview breakdown in Table 3.1b).

In contrast with probability sampling, non-probability purposive sampling is not a product of a randomized selection processes. All key informants were selected on the basis of their in-depth knowledge of the MVPs and potential emigrants, their accessibility, as well as the purposive personal judgment of the researcher. This type of non-probability purposive sampling allows the researcher to select interviewees whose qualities, experiences or knowledge permit an understanding of the IOM's role in HIV-prevention among the MVPs and potential emigrants, and are therefore valuable.

### **3.4.2 Systematic probability sampling**

The sample size in a survey design depends on the nature of the data to be collected and the type of statistical tests the researcher wishes to conduct (Oppenheim, 1992:77). The sample for the self-administered questionnaire was drawn from Beitbridge with the IOM BRSC as the nucleus. The IOM had a total of 300 MVPs and potential emigrants above

18 years registered in 10 groups/clusters, each having 30 names. This register with ten groups/clusters was used as a sample frame for the self-administered questionnaire. Systematic probability sampling was used to select 60 participants from the 300 MVPs and potential emigrants in the 10 groups/clusters with every fifth person, starting from the first from each cluster selected. In a probability sample, every element in the population has the same probability or chance of being included (Lemeshow, Hosmer, Klar & Lwanga, 1990:65-68; Bless & Higson-Smith, 1995:34). This equal probability depends on the availability of the sample frame or list of the elements of the population representing the characteristics of the sample. Systematic or interval sampling is based on the selection of elements at equal intervals, starting with a randomly selected element on the sample frame (Bless & Higson-Smith, 1995:27).

Burns and Grove (2001:367) refer to inclusion criteria as characteristics that must be present for the element to be included in the sample and exclusion criteria as exceptions to the inclusion criteria. Furthermore, the researcher must provide logical reasons for the inclusions and exclusions. To be included in the self-administered category, participants had to:

- appear on the IOM groups/clusters registers to ensure that the responses are coming from people specifically referred to as MVPs and potential emigrants;
- have a minimum of formal primary education and able to read and write. People with no education were excluded because the researcher wanted people who could read and write so that they could express themselves on paper;
- be above 18 years of age to ensure that they were of a sexually active and marriageable age and were likely to have had experiences that could contribute to the study.

### **3.4.3 List of sampled respondents for the study**

In any survey design, the sample size depends on the nature of the data to be collected and the type of statistical tests the researcher wishes to conduct (Oppenheim, 1992:77).

Tables 3.1a and 3.1b below gives a summary of the respondents who were included in the quantitative self-administered questionnaire and in the qualitative in-depth semi-structured interviews with the key informants respectively:

**Table 3.1a: Distribution of targeted respondents for the self-administered questionnaire**

<b>Respondent Category</b>	<b>Target Sample Size</b>
Women (18 years and above)	30
Men (18 years and above)	30
<b>Total</b>	<b>60</b>

**Table 3.1b Distribution of targeted respondents for the semi-structured interviews**

<b>Respondent Category</b>	<b>Target Sample Size</b>	<b>Conducted Interviews</b>
Zimbabwe Republic Police	2	1
Immigration Official	1	1
ZIMRA Official	1	0
Commercial sex workers	2	0
Hospitality industry (lodge/hotel & bars)	2	1
Umalayisha (Informal Transport Operators)	1	1
Ministry of Health and Child Welfare	1	1
Ministry of Education, Sports & Culture	1	1
Local Authority Official	1	1
Ministry of Youth	1	1
Ministry of Women Affairs, Gender and Community Development	1	1
Ministry of Public Service, Labour and Social Welfare	1	1

District AIDS Action Committee (DAAC)	2	1
IOM Reception & Support Centre Officials	2	1
Family Support Trust	1	1
Lutheran Development	1	0
Save the Children Norway	1	1
Mobile and Vulnerable Populations (men and women)	10	3
Potential emigrant in Beitbridge (men and women)	6	3
Other NGOs operating in Beitbridge	2	0
<b>TOTAL</b>	<b>40</b>	<b>20</b>

The self-administered questionnaire, with a written instruction, was distributed to the respondents at the BRSC during the monthly sessions and the researcher collected all questionnaires soon after completion, while those not able to fill-out the questionnaire at the BRSC were given a self-addressed return envelope to post the questionnaire back. A total of 60 participants received a self-administered questionnaire. Bless and Higson-Smith (1995:54) warns of the risk of a low response rate with mailed questionnaires.

### **3.5 ETHICAL CONSIDERATIONS**

Strydom (2001:24) defines ethics as a set of widely accepted moral principles which offer rules and behavioural expectations about the most correct code of conduct towards experimental subjects and respondents. All forms of protocol were observed before conducting interviews.

The research protocol was based on a number of key principles related to ethics and protection. In order to give the respondents an opportunity to express themselves freely, research methods that they felt most comfortable with were chosen.

In all interviews, respondents were asked if they were satisfied with the time set aside for the interview and the location of the interview. Before conducting an interview the researcher clearly highlighted the purpose of the interview and the participants were not forced to share personal experiences that they feel were uncomfortable to discuss. The information revealed in the interviews was kept confidential in that no name or identifying feature of the respondents was used in the study report. In all the interviews conducted no personal questions which would reveal personal characteristics were asked. All the questions were strictly related to the role of the IOM in HIV-prevention among MVPs and potential emigrants in Beitbridge.

All attempts were made to prevent respondents' expectations from being raised, although this was a difficult challenge to overcome. Respondents were told from the outset and at the conclusion of the interview that the IOM will use the data derived from this study as guidelines for enhancing its HIV-prevention activities among the MVPs and potential emigrants in Zimbabwe through formulating appropriate interventions. Furthermore, the government and other stakeholders dealing directly with the MVPs and potential emigrants might also use the findings to formulate appropriate policies and specific intervention strategies to address risks associated with irregular migration in relation to HIV-prevention. A summary of the findings will be made available to the participants on request.

### **3.6 DATA ANALYSIS**

The quantitative method allowed the researcher to collect the data from the respondents in a numerical format. The researcher scrutinized and compared the returned questionnaires to see the response patterns and any abnormalities in the completion of the questionnaire. The respondents were consistent in the completion of the various items and no questionnaire was discarded. Each questionnaire was then assigned a number and the answers were coded and captured on the computer. The researcher used the Statistical Package for the Social Sciences (SPSS) to perform the descriptive statistical analyses, the

tests, the analyses of variance, and the correlation analysis (Norusis, 1999). Data cleaning involved:

- Checking whether the denominators were tallying;
- Checking the validity of each option entered into the computer system;
- Checking for inconsistencies in either data collection or capturing.

Data from the in-depth interviews and secondary data sources were organized thematically and then content analyzed.

### **3.7 SUMMARY**

The research design, data-collection instruments, sampling design and procedures, data analysis and ethical considerations were discussed in this chapter. The data from the semi-structured interviews and self administered questionnaires was collated and analysed and the findings are given in Chapter 4.

## CHAPTER 4

### DATA ANALYSIS AND INTERPRETATION

#### 4.1 INTRODUCTION

An exploratory and descriptive survey research design was used to assess the role of the International Organization for Migration (IOM) in HIV-prevention among the mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge and to determine the effectiveness of HIV-prevention activities undertaken by the IOM. A mixed-method approach was used to collect qualitative and quantitative data by means of in-depth interviews and self-administered questionnaires. The field research was conducted between May and December 2010.

A total of 20 in-depth face-to-face interviews were conducted with MVPs, potential emigrants and key informants from non-governmental organizations (NGOs) and government ministries (Ministry of Labour and Social Services (MoLSS), Ministry of Home Affairs (MoHA) (represented by the Zimbabwe Republic Police (ZRP) and Immigration Department), Ministry of Health and Child Welfare (MoHCW), Zimbabwe Revenue Authority (ZIMRA) and customs officials. Respondents also included Umalayisha (informal transport operators) and representatives from the hospitality industry; IOM's implementing partners and the IOM staff at Beitbridge Reception and Support Centre (BRSC). The interviews covered broad areas in line with the objectives of the study.

A total of 60 self-administered questionnaires were distributed among the MVPs and potential emigrants registered with the IOM in Beitbridge. Fifty-six (n=93%) completed questionnaires were returned. The researcher believes that the high response rate can be attributed to the researcher's personal contact with most of the respondents (Polit & Hungler, 1991:193), and the concern of the respondents with the question of HIV and AIDS. The questionnaires were distributed to the respondents during the community-

based activities as well as at the BRSC during monthly refresher HIV-prevention and awareness raising sessions (with the representatives from the MVPs and potential emigrants). The researcher collected all questionnaires soon after completion, while those not able to fill-out the questionnaire at the BRSC were given a self-addressed return envelope to post the questionnaire back.

## **4.2 QUALITATIVE DATA ANALYSIS**

Analyzing qualitative data consists of three parts: noticing, collecting and thinking interesting things (Seidel, 1998). Jorgensen (1989:107) defines data analysis as the breaking up, separating, or disassembling of research materials into pieces, parts, elements, or units. With facts broken down into manageable pieces, the researcher sorts and sifts them, searching for types, classes, sequences, processes, patterns or wholes. The aim of this process is to assemble or reconstruct the data in a meaningful or comprehensible fashion.

All interviews were conducted by the researcher himself, and were conducted in English. Given the sensitivity of the topic the researcher was not allowed to tape record live interviews with key informants. This forced the researcher to rely on a detailed field diary to make notes of all discussions during interviews with the key informants. In order to overcome shortfalls that might arise, the researcher made use of the detailed field diary notes to produce a corpus to guide the analysis. After every interview, besides information collected in the interview guide and the detailed diary, a summary form was completed detailing the time and place of interview; duration of each interview and aspects of the contents and emerging issues.

All the interview transcripts and detailed field diary notes were read by the researcher and coded in the style of a grounded theory approach to data analysis (Glaser & Strauss, 1967). While developing initial categories for data analysis, open coding was done, followed by systematic selective coding in line with the interview guide and the

objectives of the research. At the end of the coding process categories and headings (presented below) were generated from the data. All data gathered from the key informants were accounted for under these headings.

The key informants were selected based on their role in working with the IOM in addressing the needs of the MVPs and potential emigrants in Beitbridge. Three MVPs and three potential emigrants were selected for interviews and represented the direct beneficiaries of the IOM project. In order to enhance validity of the findings and reliability of the results, follow-up interviews were conducted with three selected key informants who were not part of the original sample. In addition, post interview feedback from the key informants complemented the data analysis.

In terms of the research objectives, the interview schedule covered broad areas such as: forms of abuse experienced by MVPs and potential emigrants in Beitbridge which might put them at risk of contracting HIV; HIV-prevention activities conducted by the IOM amongst the target group; available support services provided by the IOM; the effectiveness of these activities in raising awareness on HIV-prevention; identifying gaps in HIV-prevention initiatives; and what needs to be done to enhance existing awareness raising initiatives among the MVPs and potential emigrants in Beitbridge.

#### **4.2.1 Demographic characteristics**

The respondents' demographic profile covered personal details: age, gender, formal education, time in Beitbridge and background in the place of origin.

- **Gender**

Of the total number of key informants interviewed, 60% (n=12) were female and 40% (n=8) were male.

- **Key informants**

Forty percent (n=8) of the total number of the key informants interviewed were government employees, while 30 percent (n=6) were from civil society organizations, the hospitality industry and informal transport operators. The remaining 30 percent (n=6) represented the MVPs and the potential emigrants in Beitbridge as indicated in Table 4.1.

**Table 4. 1 Distribution of respondents for the semi-structured interviews (n=20)**

<b>Respondent category</b>	<b>Frequency</b>	<b>Percentage</b>
Gender		
Male	8	40%
Female	12	60%
Workplace		
Government ministries	8	40%
NGOs	4	20%
Hospitality industry	1	5%
Informal transport operators	1	5%
Mobile and vulnerable populations	3	15%
Potential emigrants	3	15%

#### **4.2.2 Forms of abuse and risk behaviours experienced by MVPs and potential emigrants**

Responses revealed that MVPs and potential emigrants were subject to various forms of abuse, and a range of perpetrators were identified. The vulnerable position of MVPs and potential emigrants also rendered them susceptible to various risk behaviours.

### *Sexual abuse*

Umalayisha, (informal transport operators) were cited among the perpetrators of sexual abuse. Women and children were the most frequent targets of this abuse. Sexual abuse among the MVPs and potential emigrants is also perpetrated by their partners, neighbours, relatives and fellow emigrants, and the host community. The general feeling among key informants was that the gender imbalances characterised by unequal power relations, unfair distribution of resources force more women and girls to engage in sexual risk behaviour due to poverty exposing them to HIV-infection. Although umalayisha were mentioned by most of the respondents as the perpetrators of sexual abuse among the MVPs and potential emigrants, this could not be followed up with the umalayisha for security reasons. The operations of the umalayisha is well coordinated and facilitated by their use of a combination of trust, deceit and violence with most of their vehicles heavily tinted windows as a way of hiding their operations.

### *Psychological abuse*

In addition to physical abuse, the MVPs and potential emigrants were also subjected to various forms of psychological abuse in the form of verbal abuse and harassment mainly perpetrated by those who are tasked with guaranteeing protection of the MVPs and potential emigrants, with the host community members being the main perpetrators. Name-calling was identified as the most common form of psychological abuse. A key informant from one of the NGOs working directly with the MVPs and potential emigrants told of the complaints in this regard:

*Some of the complaints we received during our work with the MVPs is the issue of stigma and discrimination in form of name-calling. For example they are being labelled homeless people, sex workers....*

### ***Access to resources***

Most of the MVPs and potential emigrants had no security to land tenure, access to clean water and sanitation facilities. Some of the host community members deny the MVPs access to community resources such as land, water and sanitation. One government respondent explained how they had to intervene to assist:

*In some areas, the MVPs are being denied access to community resources by the host community. In one of the communities we intervened as ministry to make sure they have access to community boreholes and land for ploughing*

### ***Risk behaviour***

Many of the MVPs and potential emigrants end up engaging in risk behaviours as a survival strategy, for example prostitution and unprotected sex. The plight of the MVPs and potential emigrants was encapsulated by one respondent:

*These people [MVPs and potential emigrants] don't have a permanent and comfortable place to stay; they don't have the land rights and ownership of the place they are staying right now. They don't have a constant source of livelihoods except handouts being extended to them by the well wishers and donors. What do you think they can do for survival? A number of them you see them at night loitering around soliciting for sex in order for them to survive. We need to do something if we are serious in addressing the spread of HIV pandemic.*

MVPs and potential emigrants, given their situation of vulnerability, are being coerced into sexual “relationships of convenience” so that they can have access to better living conditions, thereby exposing them to HIV-infection. One key informant explained:

*In the last month (October 2010) a total of three different cases of sexual abuse were reported, of which the victims were two women and a young girl who were forced into sexual relationships for them to have access to a better*

*living condition, given the fact that all of them had no decent shelter and source of income.*

Besides being coerced into sexual relationships as a survival strategy, some of the MVPs and potential emigrants voluntarily engage in prostitution and unprotected sex risking their lives to contracting HIV.

### ***Vulnerability of women and girls***

Key informants interviewed revealed that in most instances of violence, women and girls were the easy targets. This was explained by a representative from one of the NGOs working directly with the MVPs and potential emigrants:

*Women and girls are vulnerable in the sense that physically they cannot fight back to the perpetrators who are mostly men, who are perceived to be stronger.*

This was also observed by a respondent from a government institution:

*In our culture, women and girls are described as the “weaker sex” who could easily be taken advantage of. The situation of the MVPs and potential emigrants further exposes them to any form of abuse especially sexual form.*

MVPs and potential emigrants experience multiple violations of their rights. The study revealed various forms of abuse and risk behaviours experienced by the MVPs and potential emigrants. Sexual abuse was identified as the most common form of abuse being experienced among the MVPs and potential emigrants. The vulnerability of the MVPs and potential emigrants also forces them to engage in risk behaviour as a survival strategy exposing them to HIV-infection. The majority of victims are women and girls. However, it is worth noting that although the highest number of the MVPs and potential emigrants experienced different forms of abuse that exposes them to HIV-infection,

others voluntarily engage in risk behaviours e.g. prostitution thereby exposing themselves to the risk of HIV-infection. One key informant described these activities:

*At night you can see some of the MVPs and potential emigrants loitering around near beer halls and the dark streets soliciting for sex. This kind of behaviours exposes them to HIV-infection because sometimes they might have unprotected sex in exchange for more money.*

#### **4.2.3 Support services provided by the IOM to MVPs and potential emigrants**

The IOM is currently implementing a number of programmes within the MVPs and potential emigrants' communities in Beitbridge, with an emphasis on addressing their immediate needs as well as trying to raise awareness on HIV and AIDS. The programmes presented by the IOM are addressing existing gaps in HIV-prevention activities targeting the MVPs and potential emigrants. An informant from a government department acknowledged the role played by the IOM:

*The government really appreciates the IOM project targeting the MVPs and potential emigrants here in Beitbridge. Imagine these people are very mobile, they come from different backgrounds with no source of livelihood, as government we thank the IOM's project of providing food handouts.*

#### ***Supply of food and non-food items***

The IOM provides basic food baskets with items required for human survival (mealie-meal, cooking oil, beans, salt, sugar, etc) in response to the immediate needs of the target group. They also provide non-food items in form of clothes, blankets, pots and water reservoirs. These items go some way in preventing people from having to engage in risk behaviours such as transactional sex in order to survive as expressed by a key informant from the NGO sector:

*The non-food items like clothes, blankets, cooking utensils provided by the IOM to the MVPs and potential emigrants honestly plays a crucial role in*

*changing their lives towards the better. This support prevents them from loitering in the streets soliciting for sex in order to survive.*

The value of this assistance was also expressed by one of the MVPs:

*Pandakauya kuno ndanga ndisina pekutangira. Upenyu hwangu hwanga hwaguma chaiko, vana ivava hapana chandaikwanisa kuvapa. Ndanga ndafunda zvekutoita zvechipfambi kuti ndirarame. Ndinotenda hangu nemoyo wese basa reIOM. (When I came here I had nowhere to start. My life was idle, with nothing to give to my kids. I was about to engage into prostitution for a living. I personally want to thank the IOM for coming to my rescue).*

The testimonies provided by the MVPs and potential emigrants are evidence that the supply of food and other basic needs contribute towards reduction of new incidents of HIV-infection among the MVPs and potential emigrants as it reduces the risk of the MVPs and potential emigrants in engaging in risk behaviours which might expose them to HIV.

#### ***Dissemination of HIV/AIDS messages during distribution of food and non-food items***

The IOM used the food and non-food items distribution time as a strategic platform to disseminate key HIV and AIDS related information. The food and non-food distribution is also accompanied by an edutainment package in form of drama with key messages centred on HIV-prevention followed by distribution of brochures and fliers with key HIV and AIDS messages.

One of the potential emigrants explained how they were subjected to HIV and AIDS messages before being given food:

*Tisati tapiwa mafuta, beans, upfu, hembe, mapoto, tinoona drama rinonakidza uye richitipa rudzidziso maererano nezvechirwere chanetsa chaizvo*

*chemukondombera rinoitwa neCorridors of Hope. Macondom anenge aripo zvakare kune avo vanenge vachimada.* (Before receiving food from the IOM, we watch an edutainment drama from Corridors of Hope with key messages on HIV pandemic. Condoms are also distributed during the process).

### ***Provision of mobile health facilities, temporary and transitional shelter***

The IOM also provides support services in form of temporary and permanent shelter and mobile health services. One respondent describes her predicament and explained how she was assisted with shelter:

*Ini pakapaziwa imba yangu ndanga ndichigara mumaplastics nevana vangu vana. Nerubatsirwo rweIOM ndakapiwa tent pakutanga, tikazonzi foromai zvitina tokupai cement, mawindow, madoor frames uye nemarata. Takaita saizvozvo, tikabva tavakirwa dzimba dzemarata. Nhasi ndinofara chaizvo.* (When my initial home was destroyed I started staying in one room made of plastics with my four kids. With the help of the IOM initially I was given a tent, and we were told to mould bricks so that they can provide other building materials in form of cement, door frames, window frames and roofing sheets. We moulded bricks and the IOM provided us with other inputs and my house was constructed. Today I am happy with the support I received from the IOM).

The provision of mobile health services and shelter improved the quality of life among the MVPs and potential emigrants in Beitbridge. The value of the IOM support was explained by the representative from NGOs interviewed. In showing appreciation and support of the programme one of the interviewee from the government stated:

*The support provided by the IOM in form of free health assistance and shelter improved the quality of life among the MVPs and potential emigrants. We need other development players to emulate this.*

The long term provision of basic food basket and basic requirements for human survival in form of clothes, blankets, water and sanitation facilities, transitional to semi-permanent shelter among the targeted population by the IOM is another effective way of addressing some of the risk factors which exposes the MVPs and potential emigrants to HIV and AIDS.

Mainstreaming of key HIV messages among these activities plays a very important role in addressing knowledge gaps, promotes behaviour change among the MVPs and potential emigrants.

#### **4.2.4 HIV-prevention activities**

##### ***HIV and AIDS workshops***

The workshops being implemented by the IOM equip the MVPs and potential emigrants with skills and knowledge on HIV-related issues. A local authority interviewee who took part in some of these workshops explained:

*Between June and July 2010 in partnership with the IOM we organized four workshops on behaviour change, ethical issues, cultural disbeliefs and misconceptions surrounding HIV and AIDS. The community is very interested in these workshops as they come in large numbers and are actively involved in the proceedings*

Key informants believed that the workshops on HIV and AIDS organized by the IOM were crucial as they increase awareness, knowledge and sensitize the community on key issues affecting people in their day-to-day living. Some of the key messages focused on: HIV transmission, correct and consistent use of condoms, risk behaviours, behaviour change and effective nutrition for people living with HIV. Information, Education and Communication (IEC) materials were distributed during these workshops. Role plays, small group discussions and plenary sessions are some of the training methods used

during workshops to encourage effective participation and two way interactive communication with the participants. A key informant representing one of the NGOs working directly with the MVPs explained the strategy used to engage the target group:

*In order to involve the MVPs and potential emigrants and to evaluate their level of understanding, we task them to come up with role plays during workshops to evaluate their level of understanding on the discussed issues. This proves to be very effective method to engage them in whole discussion.*

### ***HIV and AIDS community road shows***

Community-based road shows were used as a strategy by the IOM to raise awareness on HIV and AIDS and appeared to be one of the most popular and effective strategies for reaching the youth. Typical comments were:

*IOM uses different models to pass on the message to different targeted age groups. I attended one of the road shows organized in this community targeting the youth. That event was entertaining as well as educating. The youth were very active on stage as well as in disseminating HIV-prevention messages.*

*Combining educating and entertaining activities in form of road shows is very interesting for the young people. In October 2010 I participated in one of the thrilling road shows organized by the IOM in our community. All the youth were very excited about the event and they effectively contributed to the HIV related issues being discussed.*

Generally, youth can be actively involved on issues affecting them if they are consulted in the process. Entertainment provided during the road shows attracts more young people thus reaching a wider audience in the dissemination of IEC materials.

### ***Income generating activities***

Besides provision of shelter and other services responding to the immediate needs of the MVPs and potential emigrants, the IOM has moved a step further to implement short to long-term income generating projects aimed at improving income levels among the MVPs and potential emigrants thereby preventing the spread of HIV, as revealed by one of the interviewees from one of the organizations working with the IOM:

*Livelihoods programmes being implemented by the IOM in form of gardening, sewing, candle making, brick moulding, carpentry and welding improved the quality of life among the MVPs and potential emigrants.*

The livelihood initiative is one of the key strategic areas in addressing HIV in that the income levels of the MVPs are improved resulting in better living conditions.

An interviewee, who was a beneficiary of one the programmes, explained the way in which the livelihood programmes had assisted her:

*With the income generated from sewing, I am able to look after my family, paying school fees for my kids and to buy basic needs I want.*

The livelihoods initiative being implemented by the IOM is a step towards establishing durable solutions to the needs of the MVPs and potential emigrants. Livelihood enhancement responds to the medium to long-term needs of the beneficiaries as it boosts income levels thereby reducing their chances of engaging in risk behaviours which exposes them to HIV-infection.

#### **4.2.5 Efficiency and effectiveness of the HIV-prevention activities**

The general feeling among key informants was that the HIV-prevention activities being spearheaded by the IOM are effective given the number of MVPs and potential emigrants

benefited from the distribution of food and non-food items, medium to long-term income generating activities and the shelter provision projects. The IOM initiatives respond to the immediate, medium and long-term needs of the targeted beneficiaries thereby reducing the risks that might expose them to HIV-infection.

Responses from government department representatives indicate that the income generating activities of the IOM have led to a change amongst youth (which, as a sexually active groups are prone to risk behaviours). With many of them actively involved in income generating activities they are kept occupied most of the time, leaving them with little or no time to engage in risk behaviours which might expose them to HIV-infection.

Besides the provision of the basic requirements needed for the human survival as one of the effective ways of addressing HIV-prevention, key informants also believed that the HIV and AIDS workshops targeting different age groups, road shows, dramas and role plays initiated during distribution of food and non- food items also played a central role.

The IOM also trains peer educators as a strategy to bring about behaviour change. A key informant commented on the high numbers of youth participating in IOM initiatives:

*There is a significant change in behaviour among the youth, shown by the high numbers who are actively participating in the workshops and community based HIV-prevention initiatives in the form of peer education, drama performances on public gatherings.*

The IOM projects, in the form of workshops, road shows and livelihoods interventions have encouraged community involvement. There has been an increase in the number of HIV-prevention programmes organized by the communities themselves in the form of support groups, peer education and the establishment of herbal gardens. The encouragement of community involvement is aimed at establishing ownership and sustainability of programmes when the IOM exits.

#### 4.2.6 Gaps identified and how to enhance the existing HIV-prevention activities

Although the key informants have indicated positive changes brought by the IOM's HIV-prevention activities among the MVPs and potential emigrants, a number of areas in which the existing HIV-prevention activities could be enhanced were identified:

- Some of the key informants interviewed emphasized the need for creating synergies and strengthening support systems from other stakeholders e.g. the government and the private sector. In order to create long-term sustainability of the project, permanent government institutions need to play an effective role in the project. Local authority representative interviewed remarked:

*IOM is doing a very good job; however, this type of support interventions needs to be supported by resident government structures to ensure continuation and sustainability when the IOM exit.*

In order to address this gap, the local government structures need to be capacitated in order to play an effective role in the mainstream of the project.

- The need for a comprehensive approach in programming through the involvement of the host communities as well as other members who do not qualify for the IOM selection criteria for the MVPs to ensure ownership and sustainability of the projects. During interviews with the key informants, host community was revealed among the abusers of the MVPs and potential emigrants. Since the onset of the project some of the influential key structures within the community were not involved hence the creation of hatred and sabotage from the hosts. In order to redress this, government representatives interviewed emphasized the need to mainstream the community key structures into the day-to-day running of the project so that they feel consulted and be part and parcel of the initiative. One of the interviewee stated:

*When we started the project, I think the IOM only concentrated on addressing the immediate needs of the beneficiaries keeping a deaf ear to the host community. This was an oversight since the community structures feel not consulted and involved in the day-to-day running of the project. This will gradually create acrimony which might lead to name-calling, stigma and discrimination.*

- Interviews with the key informants revealed the gap in policy and legislation framework recognizing the existence of the MVPs and potential emigrants in line with the 2009 Kampala Declaration. The general feeling among interviewees was in support of the need for the government to come up with policy reforms which recognize the rights and needs of the MVPs and potential emigrants in Zimbabwe. The policy framework will be used in advocating for sustainable and durable solutions for the MVPs and potential emigrants which will go a long way in supporting HIV-prevention initiatives. One of the potential emigrants interviewed has this to say:

*Kutaura chokwadi, tinosangana nerusarura rwakaoma mukugara kwedu. Dai hurumende yationawo sevanhu vakafanana nevanwe vose. (Truly speaking we come across with discrimination in our community. We urge the government to enact policy/legislation which recognizes us as a human being just like anyone else).*

- The need to gradually move from addressing the immediate needs of the MVPs and potential emigrants through the development and implementation of long-term durable and sustainable solutions for the MVPs and potential emigrants, like the setting up of livelihoods support structures, provision of permanent shelters, clean water and sanitation facilities with financial support from the government. Although the interviewees applauded support from the IOM in responding to the immediate needs of the MVPs and potential emigrants as well as showing positive

steps in the long-term initiatives, the general feeling was that the government has to chip-in with support rather than leaving everything to the donors. In support of the above representative from the NGO interviewed has this to say:

*Our government is too relaxed, they should play a leading role and the donors will complement, but on the ground it's the other way round. This needs to be corrected if we want to witness sustainable initiatives with support from all the community structures.*

## **4.3 QUANTITATIVE DATA ANALYSIS**

### **4.3.1 Respondents' profile**

The respondents' profile was described in terms of their demographic characteristic (gender, age, formal education, duration of stay in Beitbridge, and background in the place of origin).

### **4.3.3 Respondents' demographic statistics**

- **Gender**

Of the total number of the returned completed questionnaires, 52 percent (n=29) were from female respondents, and 48 percent (n=27) from male respondents.

- **Age in years**

The respondents' ages were distributed as follows: 18 – 24 years represented 46 percent (n=26), 25 – 34 years represented 43 percent (n=24), 35 – 44 years represented 9 percent (n=5) and above 55 years represented 2 percent (n=1). Ages between 18 – 24 and 25 – 34 represented the highest number of the respondents respectively as shown in Figure 4.2.

- **Formal education**

The levels of education of the respondents were distributed as follows: none 6 percent (n=3), primary level 14 percent (n=8), secondary level 48 percent (n=27), tertiary college 25 percent (n=14) and university level 7 percent (n=4). The highest number of the respondents reached at least secondary education (form 4) (Referred to Ordinary Level in this study).

- **Period of stay in Beitbridge**

Of the respondents, 2 percent (n=1) stayed for more than 48 months in Beitbridge, 5 percent (n=3) stayed for 36 to 47 months in Beitbridge, 25 percent (n=14) stayed for 25 – 35 months, 41 percent (n=23) stayed for 13 to 24 months, 22 percent (n=12) stayed for 7 to 12 months, while 5 percent (n=3) stayed below six months. While some respondents had been staying in Beitbridge between 25-35 months, the largest number had been there for 13-24 months.

- **Background in place of origin**

Of the total number of the respondents, 34 percent (n=19) were still going to school, 21 percent (n=12) were formally employed while 11 percent (n=6) were informally employed, 32 percent (n=18) were not working and 2 percent (n=1) did not specify their background position in the place of origin prior to coming to Beitbridge. The largest group comprised respondents of school-going age (who were attending school), while the second largest group of respondents had been unemployed in their place of origin.

**Table 4. 2 Demographic characteristics (n=56)**

<b>Characteristics</b>	<b>Frequency</b>	<b>Percentage (%)</b>
<b>Gender</b>		
Male	27	48%
Female	29	52%
<b>Age in years</b>		
18-24	26	49%
25-34	24	43%
35-44	5	8%
45-54		
55+	1	1%
<b>Highest level of education</b>		
None	3	5%
Primary level	8	14%
Secondary level	27	48%
Tertiary level	14	25%
University level	4	7%
<b>Time of stay in Beitbridge</b>		
0-6 months	3	5%
7-12 months	12	21%
13-24 months	23	41%
25-35 months	14	25%
36-47 months	3	5%
48+ months	1	1%
<b>Background history</b>		
Going to school	19	34%
Formal employment	12	21%
Informal employment	6	11%
Not working	18	32%
Other	1	2%

#### **4.4 CURRENT IOM ACTIVITIES IN HIV-PREVENTION AMONG MVPS AND POTENTIAL EMIGRANTS IN BEITBRIDGE**

The questions asked in this section describe the current role of the IOM and its effectiveness in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants in Beitbridge. In line with the study objectives, three main questions were put to the respondents:

- (1) How often are HIV and AIDS messages included in the IOM's activities within the MVPs and potential emigrants' programmes;
- (2) How often are HIV and AIDS initiatives organized by the IOM in the MVPs and potential emigrants' programmes;
- (3) How often are the aspects of HIV and AIDS addressed within the IOM programmes.

For all the questions, the respondents were asked to use a three-point scale (not at all, occasionally and constantly) to rate the IOM's current HIV-prevention initiatives among the MVPs and potential emigrants.

##### **4.4.1 HIV and AIDS messages**

The researcher asked the respondents to rate the extent to which HIV and AIDS messages were included in the following six IOM initiatives among the MVPs and potential emigrants in Beitbridge:

- 1) Distribution of food items
- 2) Distribution of non-food items
- 3) Livelihood programmes
- 4) Irregular migration and safe migration programmes
- 5) Safe migration workshops
- 6) Outreach activities

Irregular migration and safe migration programmes was the activity where HIV and AIDS messages were constantly included as indicated by 37 percent (n=21) of the respondents, followed by outreach activities with 13 percent (n=7), safe migration workshops with 9 percent (n=5), distribution of food and non food items recorded 2 percent (n=1) respectively while livelihood programmes did not include any HIV and AIDS messages.

Of the total respondents, 91 percent (n=51) indicated that HIV and AIDS messages were occasionally included during the safe migration workshops, followed by 85 percent (n=48) during distribution of food items, 85 percent (n=48) during distribution of non-food items, 85 percent (n=48) in outreach activities, 61 percent (n=34) during irregular and safe migration programmes, 43 percent (n=24) in livelihoods programmes and 9 percent (n=5) in safe migration workshops. The highest number of respondents shows that the IOM's HIV and AIDS prevention messages were occasionally included in the activities.

Livelihoods programmes were the highest activity where HIV and AIDS messages were not included at all as indicated by 56 percent (n=32) of the respondents, followed by distribution of food items and non-food items respectively recording 13 percent (n=7) and lastly outreach activities and irregular and regular migration recording 2 percent (n=1).

Given the above analysis, irregular migration and safe migration campaigns and workshops recorded the highest number of HIV-prevention messages due to the different strategies being used to conduct the activities. The road shows, drama and role plays are being organized to raise awareness on the dangers and risks associated with irregular migration and advantages of safe migration. During these activities, IEC materials on HIV and AIDS designed to target different age groups were disseminated. The IOM should continue to use road shows, drama, role plays and workshops as effective platforms to engage the MVPs and potential emigrants on HIV and AIDS related issues.

On the other hand, the least dissemination of HIV and AIDS messages on activities such as livelihoods and distribution of food and non-food items can be attributed to the emergency nature of the programme. The activities put much focus on responding to the emergency needs of the MVPs and potential emigrants with a limited scope addressing their vulnerability to HIV-infection. There is need for the IOM to effectively mainstream HIV and AIDS messages in the programmes responding to the immediate needs of the MVPs and potential emigrants, this can be done through capacity building of the IOM's emergency relief team, hiring gender and HIV and AIDS experts or partnering with other organizations specializing already working on HIV and AIDS-related programmes.

**Table 4. 3 Inclusion of HIV and AIDS prevention activities among the MVPs and potential emigrants in Beitbridge**

IOM activities	Rating of the inclusion of HIV and AIDS messages (n=56)		
	Constantly	Occasionally	Not at all
Distribution of food items	1 (2%)	48 (85%)	7 (13%)
Distribution of non-food items	1 (2%)	48 (85%)	7 (13%)
Livelihoods programmes		24 (43%)	32 (57%)
Irregular migration and safe migration programmes	21 (37%)	34 (61%)	1 (2%)
Safe migration workshops	5 (9%)	51 (91%)	0 (0%)
Outreach activities	7 (13%)	48 (85%)	1 (2%)

#### 4.4.2 HIV and AIDS activities

The respondents were asked to rate activities on HIV and AIDS prevention, using the three-point scale (not at all, occasionally and constantly). The relevant activities were: (1) HIV and AIDS workshops, (2) HIV and AIDS seminars, (3) HIV and AIDS awareness

campaigns, (4) HIV and AIDS counselling, (5) HIV and AIDS training of care givers, (6) HIV and AIDS edutainment activities, (7) Establishing and supporting HIV and AIDS support groups, (8) Treatment of opportunistic infections among the MVPs and potential emigrants, (9) Voluntary, HIV and AIDS testing and (10) Access to health facilities in the MVPs communities (mobile clinics).

Of the respondents, 36 percent (n=20) indicated that the IOM constantly organize activities promoting access to health facilities in the MVPs communities, followed by treatment of opportunistic infections among the MVPs and potential emigrants with 29 percent (n=16), HIV and AIDS awareness campaigns 5 percent (n=3), while HIV and AIDS edutainment activities and HIV and AIDS trainings for care givers recorded 4 percent (n=2) respectively.

Of the respondents, 91 percent (n=51) indicated that HIV and AIDS prevention workshops were occasionally organized by the IOM targeting the MVPs and potential emigrants in Beitbridge, followed by HIV and AIDS seminars and HIV and AIDS trainings for care givers recording 88 percent (n=49) respectively, HIV and AIDS awareness campaigns 82 percent (n=42), establishing and supporting HIV and AIDS support groups 75 percent (n=42), carrying out treatment of opportunistic infections 66 percent (n=37), providing health facilities in the MVPs communities and conducting HIV and AIDS edutainment activities 64 percent (n=36) respectively, providing voluntary HIV and AIDS testing 52 percent (n=29) and HIV and AIDS counselling 48 percent (n=27) recording the least. See Table 4.4 below.

A number of aspects relating to HIV and AIDS that are not addressed within the IOM programmes were identified: HIV and AIDS counselling 52 percent (n=29), voluntary HIV and AIDS testing 48 percent (n=27), HIV and AIDS edutainment activities 32 percent (n=18), establishing and supporting HIV and AIDS support groups 25 percent (n=14), HIV and AIDS awareness campaigns and HIV and AIDS seminars recording 13 percent (n=7) respectively, HIV and AIDS workshops and HIV and AIDS trainings for

care givers 9 percent (n=5) respectively, and treatment of opportunistic infections among the MVPs and potential emigrants 5 percent (n=3). Refer to Table 4.4 below.

Strengths and shortcomings of the IOM's HIV and AIDS activities were identified. The findings shows that the IOM needs to continue building the strengths identified on the use of workshops to sensitize and raise awareness among the MVPs and potential emigrants on HIV and AIDS key messages. However, it was also noted that some of the key HIV-prevention activities in form of voluntary counselling and testing, training of care givers, edutainment activities, establishment of support groups and treatment of opportunistic infections are not adequately addressed within the IOM programmes. In order to have a comprehensive package in addressing these gaps, the IOM should enter into strategic partnerships with other organizations with technical expertise in the identified area. These partnerships will allow the IOM to concentrate on their area of expertise while the identified organizations will bring their technical-know-how to fill-in the gaps.

**Table 4. 4 Rating HIV and AIDS prevention activities addressed by the IOM among the MVPs and potential emigrants in Beitbridge**

Activities	Rating of HIV and AIDS activities addressed by the IOM among the MVPs and potential emigrants in Beitbridge (n=56)		
	Constantly	Occasionally	Not at all
HIV and AIDS workshops		51 (91%)	5 (9%)
HIV and AIDS seminars		49 (87%)	7 (13%)
HIV and AIDS awareness campaign	3 (5%)	46 (82%)	7 (13%)
HIV and AIDS counselling		27 (48%)	29 (52%)
HIV and AIDS training for care givers	2 (4%)	49 (87%)	5 (9%)
HIV and AIDS edutainment activities	2 (4%)	36 (64%)	18 (32%)
Establishing and supporting HIV and AIDS clubs		42 (75%)	14 (25%)
Treatment of opportunistic infections among the MVPs and potential emigrants	16 (29%)	37 (66%)	3 (5%)
Voluntary HIV and AIDS counselling		29 (52%)	27 (48%)
Access to health facilities in MVPs communities	20 (36%)	36 (64%)	

#### **4.4.3 Aspects of HIV and AIDS addressed within the IOM programmes**

The respondents were asked to rate aspects of HIV and AIDS addressed within the IOM programmes, using the three-point scale (not at all, occasionally and constantly). The relevant aspects were: (1) Cultural beliefs and practices that fuel HIV and AIDS, (2) Risk behaviours among the MVPs that tend to drive HIV and AIDS, (3) Sexual practices that expose to HIV, (4) Mode of transmission of HIV and AIDS, (5) High risk group and vulnerable group to HIV-infection, (6) Meaning of AIDS, (7) Ethical issues related to HIV and AIDS, (8) Care of HIV and AIDS patients, (9) Professional issues related to HIV and AIDS, (10) Prevention of HIV and AIDS, (11) Socio-economic issues that are drivers of HIV and AIDS, (12) Mobility/Irregular migration and HIV and AIDS, (13) Poverty and HIV and AIDS, (14) Safer sex practices and HIV and AIDS.

Of the respondents, 41 percent (n=23) indicated that the IOM constantly address aspects of mobility/irregular migration and HIV and AIDS, followed by high risk group and vulnerable group to HIV infection recording 38 percent (n=21), risk behaviours among the MVPs that tend to drive HIV and AIDS 27 percent (n=15), mode of transmission of HIV 25 percent (14), sexual practices that expose to HIV 23 percent (n=13), meaning of AIDS 21 percent (n=12), safer sex practices and HIV and AIDS 9 percent (n=5), prevention of HIV and AIDS 7 percent (n=4), poverty and HIV and AIDS, and socio-economic issues that are drivers of HIV and AIDS recorded 1 percent (n=1) respectively. See table 4.5 below.

Of the respondents, 93 percent (n=52) indicated that aspects of HIV and AIDS prevention are occasionally addressed within the IOM programmes, followed by safer sex practices 91 percent (n=51), poverty and HIV and AIDS and care of HIV and AIDS patients indicated 86 percent (49) respectively, socio-economic issues that are drivers of HIV and AIDS 84 percent (47), meaning of AIDS 79 percent (n=44), cultural beliefs and practices that fuel HIV and AIDS 77 percent (n=43), mode of transmission of HIV and AIDS 75 percent (n=42), risk behaviours among the MVPs that tend to drive HIV and AIDS, and sexual practices that expose to HIV recorded 73 percent (n=41) respectively, high risk

group and vulnerable group to HIV infection 61 percent (n=34), mobility/irregular migration and HIV and AIDS 59 percent (n=33), ethical issues related to HIV and AIDS 48 percent (n=27), and professional issues related to HIV and AIDS 5 percent (n=3).

A number of aspects relating to HIV and AIDS that are not addressed within the IOM programmes were identified: professional issues related to HIV and AIDS 95 percent (n=53), ethical issues related to HIV and AIDS 52 percent (n=29), cultural beliefs and practices that fuel HIV and AIDS 23 percent (n=13), socio-economic issues that are drivers of HIV and AIDS 14 percent (n=8), care of HIV and AIDS patients 13 percent (n=7), poverty and HIV and AIDS 11 percent (n=6), sexual practice that expose to HIV and high risk group and vulnerable group to HIV infection recorded 1 percent (n=1) respectively. See Table 4.5 below.

Activities focusing on HIV prevention, risk behaviours, mode of transmission, poverty and HIV and AIDS, socio-economic issues that are drivers of the HIV transmission, messages linking mobility and irregular migration proved to be the most popular and effective among the respondents. This can be linked to the simplified IEC materials developed in English and two vernacular languages (Shona and Ndebele) and occasionally disseminated to the MVPs and potential emigrants during different foras. The IOM should continue to build on the strengths associated with the use of simplified IEC materials with key HIV messages as an effective preventative measure.

On the other hand, a number of aspects relating to HIV and AIDS are not adequately addressed by the IOM for e.g. professional issues related to HIV and AIDS, cultural beliefs that tend to fuel HIV and AIDS, ethical issues, sexual practices that expose to the HIV-infection and care of HIV and AIDS patients.

**Table 4. 5 Aspects of HIV and AIDS addressed within the IOM programmes**

Activities	Rating of HIV and AIDS aspects addressed in main IOM's prevention activities among the MVPs and potential emigrants (n=56)		
	Constantly	Occasionally	Not at all
Cultural beliefs and practices that fuel HIV and AIDS		43 (77%)	13 (23%)
Risk behaviours among MVPs that tend to drive HIV and AIDS	15 (27%)		41 (73%)
Sexual practice that expose to HIV	13 (23%)	41 (73%)	2 (4%)
Mode of transmission of HIV and AIDS	14 (25%)	42 (75%)	
High risk group and vulnerable group to HIV infection	21 (38%)	34 (60%)	1 (2%)
Meaning of AIDS	12 (21%)	44 (79%)	
Ethical issues related to HIV and AIDS		27 (48%)	29 (52%)
Care of HIV and AIDS patients		49 (87%)	7 (13%)
Professional issues related to HIV and AIDS		3 (5%)	53 (95%)
Prevention of HIV and AIDS	4 (7%)	52 (93%)	
Socio-economic issues that are drivers of HIV and AIDS	1 (2%)	47 (84%)	8 (14%)
Mobility/irregular migration and HIV and AIDS		23 (41%)	33 (59%)
Poverty and HIV and AIDS	1 (2%)	49 (87%)	6 (10%)
Safer sex practices and HIV and AIDS	5 (9%)	51 (91%)	

## **4.5 PERSONAL BELIEFS ABOUT HIV AND AIDS**

The respondents' personal beliefs about HIV and AIDS were described in terms of the most commonly held myths, misconceptions and stereotypes surrounds HIV and AIDS transmission. In responding to the questions, the respondents were asked to rate their responses using the five-point likert scale, ranging from (Strongly Agree-SA, Agree-A, Undecided-U, Disagree-D, Strongly Disagree-SD). The questions rated by the respondents were: 1) HIV is transmitted by sharing hands with an infected person, 2) HIV is transmitted by seating next to infected person, 3) HIV is transmitted by sleeping in the same blanket, 4) HIV is cured by having sexual intercourse with a virgin, 5) Having sexual intercourse with an old woman cures AIDS, 6) Having sex with a young child can cure HIV, 7) HIV is caused by promiscuity and 8) Healthy looking person cannot be HIV positive. The results of the ratings are presented in Table 4.6.

### **4.5.1 Respondents' personal beliefs**

Of the respondents, 52 percent (n=29) strongly disagree with the view that HIV is transmitted by seating next to an infected person, HIV is transmitted by sleeping in the same blanket with infected person respectively, followed by HIV is transmitted by shaking hands with an infected person 46 percent (n=26), HIV is cured by having sexual intercourse with a virgin 43 percent (n=24), having sexual intercourse with an old woman cures AIDS 41 percent (n=23), having sex with a young child can cure HIV 38 percent (n=21), healthy looking person cannot be HIV positive 20 percent (n=11) and HIV is caused by promiscuity 16 percent (n=9).

The results showed that, 48 percent (n=27) disagree with the view that HIV is transmitted by shaking hands with an infected person, followed by HIV is transmitted by seating next to an infected person 43 percent (n=24), HIV is transmitted by sleeping in the same blanket with the infected person 41 percent (n=23), HIV is cured by having sexual intercourse with a virgin 39 percent (n=22), having sex with a young child can cure AIDS

34 percent (n=19), healthy looking person cannot be HIV positive 21 percent (n=12) and HIV is caused by promiscuity 18 percent (n=10).

Of the respondents, 45 percent (n=25) were undecided with the view that healthy looking person cannot be HIV positive, followed by having sexual intercourse with an old woman cures AIDS, having sex with young child can cure AIDS and HIV is caused by promiscuity 27 percent (n=15) respectively, HIV is cured by having sexual intercourse with a virgin 16 percent (n=9), HIV is transmitted by sleeping in the same blanket with infected person 5 percent (n=3), HIV is transmitted by shaking hands with an infected person and HIV is transmitted by seating next to an infected person recording 4 percent (n=2) respectively.

Of the respondents, 23 percent (n=13) agree with the view that HIV is caused by promiscuity, followed by healthy looking person cannot be HIV positive 9 percent (n=5), HIV is cured by having sexual intercourse with a virgin, having sexual intercourse with an old woman cures AIDS, having sex with young child can cure HIV, HIV is transmitted by shaking hands with an infected person, HIV is transmitted by seating next to infected person and HIV is transmitted by sleeping in the same blanket with the infected person recorded 1 percent (n=1) each respectively. Of the total responses, 16 percent (n=9) strongly agree with the assertion that HIV is caused by promiscuity, followed by a healthy looking person cannot be HIV positive recording 5 percent (n=3).

The respondents recorded a high general understanding of the commonly held myths and misconceptions and stereotypes centred on HIV and AIDS. Besides, the IOM activities, it is important to note that the national awareness raising activities being flighted on national television and radio stations focusing on stigma and discrimination has a role to play in raising awareness of the general public. However, the IOM should continue to address these myths and misconceptions through the use of different methodological strategies among the MVPs for e.g. using drama, role plays and peer education.

**Table 4. 6 Personal beliefs about HIV and AIDS**

Statements	Rating of personal beliefs about HIV and AIDS (n=56)				
	Strongly agree	Agree	Undecided	Disagree	Strongly disagree
HIV is transmitted by shaking hands with an infected person		1 (2%)	2 (4%)	27 (48%)	26 (46%)
HIV is transmitted by seating next to an infected person		1 (2%)	2 (4%)	24 (43%)	29 (51%)
HIV is transmitted by sleeping in the same blanket with infected person		1 (2%)	3 (5%)	23 (41%)	29 (52%)
HIV is cured by having sexual intercourse with a virgin		1 (2%)	9 (16%)	22 (39%)	24 (43%)
Having sexual intercourse with an old woman cures AIDS		1 (2%)	15 (27%)	17 (30%)	23 (41%)
Having sex with young child can cure AIDS		1 (2%)	15 (27%)	19 (34%)	21 (37%)
HIV is caused by promiscuity	9 (16%)	13 (23%)	15 (27%)	10 (18%)	9 (16%)
Healthy looking person cannot be HIV positive	3 (5%)	5 (9%)	25 (45%)	12 (21%)	11 (20%)

## **4.6 THE FUTURE ROLE OF THE IOM IN THE PREVENTION OF THE SPREAD OF HIV AMONG MVPS AND POTENTIAL EMIGRANTS**

In this section, the views of respondents on the future role of the IOM in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants were explored. The respondents were asked three main questions. The first question consisted of statements on the steps to be taken by the IOM in the prevention of HIV and AIDS. The second question consisted of statements on the role that the IOM should play in the prevention of the spread of HIV and AIDS. The last question was an open-ended question that requires personal feelings on other role that respondents think the IOM should play in the prevention of the spread of HIV and AIDS.

The respondents were expected to evaluate each statement of the first two questions using the five-point likert scale, from (Strongly Agree-SA, Agree-A, Undecided-U, Disagree-D, and Strongly Disagree-SD). The answers to the open-ended question were also quantitatively analyzed. The results of the findings were presented as a general and specific steps or actions to be taken by the IOM in the prevention of HIV-infection among the MVPs and potential emigrants.

### **4.6.1 General steps or actions to be taken by the IOM**

All statements centred on steps to be taken by the IOM in its efforts to address HIV and AIDS among the MVPs and potential emigrants. The respondents were expected to evaluate each statement using the five-point likert scale, from (Strongly Agree-SA, Agree-A, Undecided-U, Disagree-D and Strongly Disagree-SD). The following statements were asked:

- 1) IOM should make available ARVs to the MVPs and potential emigrants infected with HIV;

- 2) IOM should conduct regular workshops with the MVPs and potential emigrants on HIV and AIDS issues;
- 3) IOM should provide food dietary requirements to the MVPs and potential emigrants living with HIV;
- 4) IOM should provide more medicine and other health care supplies (bleach, soap, gloves, etc);
- 5) IOM should provide training of family members to take care for the sick;
- 6) IOM should provide emotional support for the sick family members;
- 7) IOM should provide emotional support for the care giver;
- 8) IOM should address ethical issues concerning HIV-prevention among the MVPs and potential emigrants;
- 9) IOM should discuss HIV and AIDS issues with MVPs outside food distribution programmes.

Of the respondents, 52 percent (n=29) strongly agree with the view that the IOM should conduct regular workshops with MVPs and potential emigrants on issues related to HIV and AIDS, followed by the IOM should address ethical issues concerning HIV-prevention among the MVPs and potential emigrants 45 percent (n=25), IOM should further discuss HIV and AIDS issues with MVPs outside food distribution programmes 39 percent (n=22), IOM should make available ARVs to the MVPs and potential emigrants infected with HIV 29 percent (n=16), IOM should provide training of family members to take care for the sick 10 percent (n=5), IOM should provide emotional support for the sick family members and IOM should provide emotional support for the care giver recorded 7 percent (n=4) respectively. IOM should provide food dietary with requirements to the MVPs and potential emigrants living with HIV 5 percent (n=3) and IOM should provide more medicine and other health care supplies recording 4 percent (n=2). The results of the ratings were analyzed and presented as in Table 4.7.

The number of respondents who agree with the action/steps to be taken by the IOM in prevention of HIV and AIDS varied from 48 percent to 84 percent. The results showed that 84 percent (n=47) of the respondents agreed with the assertion that the IOM should

provide more medicine and other health care supplies, followed by the IOM should make available ARVs to MVPs and potential emigrants infected with HIV as well as providing training of family members to take care for the sick recording 71 percent (n=40) respectively, IOM should provide emotional support for the sick family member 63 percent (n=35), IOM should further discuss HIV and AIDS issues with the MVPs outside food distribution programmes/times 61 percent (n=34), IOM should provide emotional support for the care giver 59 percent (n=33), IOM should provide food dietary with requirements to the MVPs and potential emigrants living with HIV 57 percent (n=32), while IOM should conduct regular workshops with the MVPs and potential emigrants on HIV and AIDS issues and addressing ethical issues concerning HIV-prevention among the MVPs and potential emigrants recorded 48 percent (n=27) respectively.

Of the respondents, 38 percent (n=21) were undecided with the view that IOM should provide food dietary requirements to the MVPs and potential emigrants living with HIV, followed by the IOM should provide emotional support for the care giver 32 percent (n=18), the IOM should provide emotional support for the sick family member 29 percent (n=16), IOM should provide training of family members to take care for the sick 18 percent (n=10), lastly the IOM should provide more medicine and other health care supplies 13 percent (n=7).

Of the respondents, those who disagree with the action to be taken by the IOM varied between 1 percent and 7 percent. The results showed that 7 percent (n=4) of the respondents disagree with the view that the IOM should address ethical issues concerning HIV-prevention among the MVPs and potential emigrants, followed by the IOM should provide training of family members to take care for the sick family members, IOM should provide more medicine and other health care supplies and the IOM should provide emotional support for the care giver recorded 1 percent (n=1) respectively.

Generally the responses from the respondents have shown the relevance of the IOM's activities in HIV-prevention among the MVPs and potential emigrants. IOM should continue to strengthen its role and action at community and family levels. The

involvement of the MVPs and potential emigrants in the community based HIV-prevention initiatives for e.g. using workshops, awareness raising campaigns in form of road shows, proved to be one of the effective methods of HIV-prevention. Besides conducting workshops, the IOM should also play a part in providing moral support to the infected MVPs and potential emigrants through the provision of trainings; this can be possible through strengthening networks with the government line ministries, the civil society organizations and the community leadership in order to promote ownership and guaranteeing sustainability of the programme.

**Table 4. 7 General steps or actions to be taken by the IOM**

Actions to be take by the IOM	General rating of actions to be taken by the IOM (n=56)				
	Strongly agree	Agree	Undecided	Decided	Strongly disagree
Make available ARVs to MVPs and potential emigrants infected with HIV	16 (29%)	40 (71%)			
IOM should conduct regular workshops with MVPs and potential emigrants on HIV and AIDS issues	29 (52%)	27 (48%)			
IOM should provide food with dietary requirements to MVPs and potential emigrants living with HIV	3 (5%)	32 (57%)	21 (38%)		
IOM should provide more medicine and other health care supplies	2 (4%)	47 (83%)	7 (13%)		
IOM should provide training of family members to take care for the sick	5 (9%)	40 (71%)	10 (18%)	1 (2%)	
IOM should provide emotional support for the sick family member	4 (7%)	35 (62%)	16 (29%)	1 (2%)	
IOM should provide emotional support for the care giver	4 (7%)	33 (59%)	18 (32%)	1 (2%)	
IOM should address ethical issues concerning HIV-prevention among the MVPs and potential emigrants	25 (45%)	27 (48%)	4 (7%)		
IOM should discuss HIV and AIDS issues with MVPs outside food distribution times	22 (39%)	34 (61%)			

#### **4.6.2 Specific role to be taken by the IOM**

Respondents had to indicate which role or actions should be taken by the IOM in the prevention of the spread of HIV and AIDS. The respondents were expected to evaluate each statement using the five-point likert scale, from (Strongly Agree-SA, Agree-A, Undecided-U, Disagree-D, and Strongly Disagree-SD)

- 1) Educating the MVPs and potential emigrants on risk behaviours that expose them to HIV and AIDS;
- 2) Educating the MVPs and potential emigrants on harmful cultural and traditional beliefs and practices that expose people to HIV infection;
- 3) Educate the MVPs and potential emigrants on the mode of HIV transmission;
- 4) Advocate for availability of ARVs to MVP communities;
- 5) Scale up prevention of HIV and AIDS programmes;
- 6) Advocating for establishment of satellite health services in mobile and potential emigrants communities;
- 7) Advocating for the availability of free anti-retroviral drugs among the MVPs and potential emigrants communities;
- 8) Addressing professional issues related to HIV and AIDS.

Of the respondents, between 50 percent (n=28) and 100 percent (n=56) strongly agree with the above statements. The respondents strongly agree as follows that the IOM should educate the MVPs and potential emigrants on risk behaviours that expose them to HIV and AIDS recording 100 percent (n=56), followed by advocating for the availability of free anti-retroviral drugs 95 percent (n=53), advocating for establishment of satellite health services in the MVPs and potential emigrants communities 93 percent (n=52), educating the MVPs and potential emigrants on harmful cultural and traditional beliefs and practices that expose people to HIV-infection 91 percent (n=51), educating the MVPs and potential emigrants on the mode of HIV transmission and advocate for the availability of ARVs recorded 89 percent (n=50) respectively. While scaling up prevention of HIV and AIDS programmes and addressing professional issues related to HIV and AIDS recorded 82 percent (n=46) and 50 percent (n=28) respectively.

Of the respondents, between 5 percent (n=3) and 43 percent (n=24) only agree with the above statements, the respondents agree as follows that the IOM should address professional issues related to HIV and AIDS, followed by scaling up prevention of HIV and AIDS programmes 18 percent (n=10), educating the MVPs and potential emigrants on the mode of HIV transmission and advocate for availability of ARVs respectively recording 11 percent (n=6), educating the MVPs and potential emigrants on harmful cultural and traditional beliefs and practices that expose people to HIV-infection 9 percent (n=5), advocating for establishment of satellite health services in the MVPs and potential emigrants communities 7 percent (n=4), while 5 percent (n=3) indicated advocating for the availability of free anti-retroviral drugs among the MVPs and potential emigrants.

Of the respondents, only 7 percent (n=4) were undecided regarding the IOM's role in addressing professional issues related to HIV and AIDS as indicated in the Table 4.8.

The IOM should continue to play a leading role in the HIV-prevention initiatives addressing behaviour change, cultural and traditional practices that are harmful through organizing targeted workshops, road shows, training of peer educators and health workers. Although the respondents have indicated the need for the IOM to provide ARVs, their capacity in providing the service is compromised. Although the IOM in partnership with other lobby and pressure groups advocate for the availability of the ARVs, the organization does not have competent structures and equipment in line with the minimum standards being referred to by the World Health Organization (WHO) guidelines. The organization can only provide resources and other support services to the established structures within the Ministry of Health and Child Welfare (MoHCW) to effectively roll-out the programme.

**Table 4. 8 Specific role to be played by the IOM in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants**

IOM should play an active role in:	General rating of actions to be taken by the IOM (n=56)				
	Strongly agree	Agree	Undecided	Decided	Strongly disagree
Educating MVPs and potential emigrants on risk behaviours that expose to HIV and AIDS	56 (100%)				
Educating MVPs and potential emigrants on harmful cultural and traditional beliefs and practices that expose people to HIV infection	51 (91%)	5 (9%)			
Educate MVPs and potential emigrants on the mode of HIV transmission	50 (89%)	6 (11%)			
Advocate for availability of ARVS to MVPs communities	50 (89%)	6 (11%)			
Scale up prevention of HIV and AIDS programmes	46 (82%)	10 (18%)			
Advocating for establishment of satellite health services in MVPs and potential emigrants communities	52 (93%)	4 (7%)			
Advocating for the availability of free anti-retroviral drugs among the MVPs and potential emigrants communities	53 (95%)	3 (5%)			
Addressing professional issues related to HIV and AIDS	28 (50%)	24 (43%)	4 (7%)		

#### **4.6.3 Open ended question - Personal feelings on other role that respondents think the IOM should play in the prevention of the spread of HIV and AIDS.**

There were similarities between the answers generated from the open-ended question and the results presented above. Of the respondents, 61 percent (n=34) indicated that the IOM should:

- Scale up HIV-prevention workshops focusing on behaviour change among the MVPs and potential emigrants in partnership with the responsible government ministries and the community structures to ensure continuity and community ownership and sustainability of the programme when the IOM withdraw funding;
- Conduct information awareness raising activities in form of community based road shows promoting active involvement of the most affected youth in the MVPs and potential emigrants communities;
- Work closely with the print and electronic media in promoting the rights and needs of the MVPs and potential emigrants in line with the HIV and AIDS prevention activities;
- Encourage correct and constant condom use among the MVPs and potential emigrants' communities.

Of the respondents, 30 percent (n=17) indicated that the IOM in partnership with the civil society organizations should play a leading role in lobbying the responsible government ministries to:

- Come up with national strategies addressing risk factors that expose the MVPs and the potential emigrants to HIV-infection;
- Scale-up support to the income generating projects (IGPs) targeting the MVPs and potential emigrants as a positive step towards durable solutions in addressing HIV-prevention among the target groups;
- Provide free or subsidized medical support among the MVPs and potential emigrants through scaling up mobile clinics.

Of the respondents, 9 percent (n=5) indicated that the IOM should set up community based support structures to support people living with HIV and families affected with HIV and AIDS among the MVPs and potential emigrants communities. IOM should emulate support structures being used by other organizations in HIV-prevention for example setting up of community support groups for the people living with HIV, setting up of horticultural gardens within the MVPs and potential emigrants' communities. Furthermore, the IOM should also create social networks for the support groups through linking them with other permanent community structures thereby guaranteeing community support and ownership of the initiative as well as reduces stigma and discrimination.

#### **4.7 SUMMARY**

This chapter covered the data analysis and interpretation of the respondents' views on the effectiveness and shortcomings of the IOM's role in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants in Beitbridge.

In **Chapter 5** the conclusions of the study are summarized by focusing on the research questions. Specific recommendations are then made resulting from the findings of the study.

## **CHAPTER 5**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

This chapter presents the conclusions and recommendations regarding the role of the International Organization for Migration (IOM) in the prevention of HIV-infections among the mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge. The major findings of the study are presented and some recommendations for long-term sustainable strategies are made. The current strategies and interventions of the IOM at the Beitbridge site are summarised and further recommendations which have relevance for policy and practice are made. Certain limitations of the study are then briefly underlined.

#### **5.2 SUMMARY OF THE MAJOR FINDINGS**

The vulnerability of mobile populations is increasingly recognised as an important dimension in relations to HIV and AIDS (IOM/UNDP/UNAIDS, 2002:138). Findings of the study reveal that poverty, gender inequality and cultural beliefs and practices are key drivers which render the MVPs and potential emigrants at Beitbridge vulnerable to high risk behaviours and sexual abuse. These have short, medium, and long-term implications for effective prevention strategies in general, and for the IOM as the sole provider of emergency humanitarian support at this site.

The IOM's current HIV-prevention strategies range from humanitarian responses to broad-based durable solutions: distribution of food and non-food items, HIV-prevention workshops, distribution of IEC materials with key HIV-prevention messages, edutainment activities, provision of mobile health clinics, the provision of temporary and transitional shelter and income generating activities. The findings of the study indicated that, in responding to the challenges and effects of HIV and AIDS, a number of effective

strategies are currently being implemented by the IOM within the MVPs and potential emigrant communities in Beitbridge. These initiatives could, however, be improved by the creation of long-term synergies with relevant governmental and non-governmental stakeholders in supporting sustainable and durable solutions in the form of broad-based livelihoods programmes.

### **5.2.1 Poverty as major push factor for risk behaviours**

There is a high correlation between HIV-infection and poverty, and the spread of HIV infection is strongly associated with poverty and unemployment (Zawaira, 1999:26). The study found that poverty is the main push factor exposing large volumes of the MVPs and potential emigrants in Beitbridge to engage in risk sexual behaviours. While many factors contribute to the worsening of HIV, it emerged from the study that poverty appears to be the single most significant cause that pushes the MVPs and potential emigrants into sexual risk behaviours. A significant number of the respondents for self administered questionnaire were unemployed and living below the poverty datum line with no secure or regular source of income to support themselves and their families. Most of the MVPs and potential emigrants engage in risk behaviours such as transactional sex because there are no immediate viable alternatives through which they can support themselves, family members and some cases, their extended families.

Responses to the immediate needs of the target groups by the IOM to address the gaps in food security among MVPs and potential emigrants include the provision of basic food baskets with items required for human survival (mealie-meal, cooking oil, beans, sugar, etc) in response to the immediate needs of the target groups. Non-food items in the form of clothes, blankets, kitchen utensils and water resources are also provided. Addressing food security appears to be an effective measure in preventing the MVPs and potential emigrants from having to engage in risk behaviours such as transactional sex as a survival strategy. Food aid is, however, a temporary measure. The IOM needs to engage with the MVPs and potential emigrants in formulating an exit strategy promoting self reliance. If not managed and addressed in time, the food programme might create a dependence

syndrome which might derail efforts by the IOM in HIV-prevention when IOM withdraws. It is therefore important for the IOM in partnership with the government and non-governmental stakeholders to come up with effective broad-based poverty reduction strategies among the MVPs and potential emigrants in Beitbridge so as to reduce the push factors, at the same time addressing the basic needs for human survival which might put them at risk of engaging in risk behaviours exposing them to HIV-infection.

### **5.2.2 Gender inequality and HIV**

Gender inequality is one of the critical factors in the spread of HIV in Africa (Jackson, 2002:87). Responses indicated that there were significantly more females than males among the MVPs and potential emigrants. Gender imbalances are characterized by unequal power relations, unfair distribution, access to, and control of, community and family resources and are one of the driving forces exposing women and girls to sexual abuse and HIV-infection. The gender dynamics of HIV and AIDS exposed in the study should be central in guiding and influencing HIV and AIDS strategies implemented by the IOM among the MVPs and potential emigrants.

In the context of gender inequality, male attitudes and behaviours are currently the crux of the HIV and AIDS problem, whether men are heterosexuals, homosexuals or drug injectors (UNAIDS, 2000). In many African cultures, ideals of manhood include strength, courage, and dominance and, critically accept men as having an uncontrollable sex drive that lets them off the hook of responsibility. The study findings found that men often resort to physical force to control resources leaving their female counter-parts without control over resources thereby forcing them to engage in risk behaviour exposing them to HIV as a survival strategy.

In order to address gender inequality and its consequences, the IOM needs to reinforce gender education awareness raising programmes, inter-alia, through creating long-term synergies with the line government ministries and community leadership who are the

custodians of our culture. The IOM should mainstream legal aspects of the law vis-à-vis the Sexual Offences Act Chapter 9:21 (Act number 8 of 17 August 2001) through highlighting its provisions and referral procedures to ensure swift provision of services within the stipulated timeframe.

If well supported, workshops on gender mainstreaming will empower the MVPs and potential emigrants in particular women and girls and the community at large so that they can stand up and challenge the perpetrators through reporting the cases timeously to guarantee swift legal recourse.

Men and women are affected and infected differently. Comprehensive effective interventions and HIV awareness raising strategies of the IOM and other stakeholders must include specific programmes which take these differences into account and address the circumstances and needs of men and women separately. Because women are more vulnerable to HIV infection than men, for both biological and socio-cultural reasons, gender issues are an integral component of IOM programmes. The rights, needs and concerns of female migrants, in particular young girls, should be specifically addressed in the IOM programmes.

The findings revealed that the MVPs and potential emigrants were subjected to various forms of abuse and a range of perpetrators were identified. Sexual abuse was cited by the key informants as the worst form of abuse prevalent among the MVPs and potential emigrants with primary targets being young women and girls. Umalaysha (informal transport operators) were cited as the main perpetrators of sexual abuse among the MVPs and potential emigrants. Lack of well supported social and economic empowerment opportunities among the MVPs and potential emigrants is one of the factors which put women and girls at risk of being sexually abused by the Umalaysha. The IOM workshops and awareness-raising programmes could be extended to the Umalaysha and other potential abusers in order to inform them of the dangers and risks associated with sexual abuse with a view to bringing about behavioural change.

### **5.2.3 Cultural beliefs and practices in relation to HIV and AIDS**

The study found that while some of the respondents were knowledgeable about HIV and AIDS and possessed positive attitudes towards prevention, a number of respondents were unaware of the way in which cultural beliefs and practices and myths about AIDS influenced risk behaviour and fuelled HIV and AIDS. A pervasive example of a cultural practice that fuels HIV is the ritual cleansing that requires a family member of a deceased person to have sexual intercourse with the widow or widower. If the deceased died from AIDS-related causes and has infected the partner, the family member that observes this cultural practice will be exposed to the infection.

One of the most pernicious and dangerous myths in circulation in Zimbabwe is that having sex with an elderly woman or a virgin cures a man of HIV and AIDS. The consequences of this belief are simply that a deadly virus is passed on to an innocent child or woman. The increasing number of rape victims who are babies and children would seem to be associated with this myth (Jones, 2004:16-17). Some of the MVPs and potential emigrants still believed that a healthy looking person cannot be HIV positive. While sexual practices and risk behaviour that expose people to HIV infection, and ethical issues related to HIV and AIDS are occasionally addressed in the IOM programmes, cultural beliefs and practices that fuel HIV and AIDS are not adequately addressed in these programmes. The IOM must address these issues more openly as many MVPs and potential emigrants could be at risk through ignorance while upholding cultural beliefs and practices. Open discussion must be encouraged to address the different cultural understandings and traditions of the MVPs and potential emigrants, and different platforms for dialogue must be promoted to create awareness as well as encourage community participation in HIV and AIDS prevention programmes.

### **5.3 RECOMMENDATIONS FOR CURRENT IOM INITIATIVES**

While the IOM is predominantly geared for emergency responses, there is an increasing recognition that HIV and AIDS issues must be addressed more forcefully in its programming.

#### **5.3.1 Regular activities and awareness raising campaigns**

The study found that the targeted workshops on HIV and AIDS focusing on various thematic areas organized by the IOM were crucial as they raise awareness and sensitize the community on key issues affecting people in their day-to-day living. Community-based road shows were also used by the IOM to raise awareness on HIV and AIDS and appeared to be one of the most popular and effective strategies for reaching the youth. Regular workshops, seminars, awareness campaigns and edutainment activities should be an integral aspect of the IOM's HIV-prevention strategy. It is also important for the IOM to streamline HIV and AIDS messaging in other activities targeting the MVPs and potential emigrants, for example in safe migration, human trafficking and human smuggling workshops.

#### **5.3.2 Tailoring messages for specific target groups**

HIV-prevention programmes must take cognizance of the needs of diverse audiences. For example, specific discussion topics targeting different age groups in the HIV and AIDS information awareness package will ensure a more effective delivery of key and relevant messages.

### **5.3.3 The use of vernacular language for communication**

The majority of the MVPs and potential emigrants in Beitbridge had attained some degree of formal education (primary or secondary level) prior to coming to Beitbridge. The level of education has a bearing on the strategy to use when designing workshops and edutainment activities. The relatively high literacy levels among the MVPs and potential emigrants justify the use of structured workshops on HIV and AIDS by the IOM as an effective strategy in HIV prevention. However, it should be also noted that the use of vernacular language for community workshops (as opposed to English) may provide a friendlier environment and be more conducive to effective interactive participation among participants.

### **5.3.4 HIV and AIDS support groups**

The initiation of HIV and AIDS support groups in and around the MVPs and potential emigrants' communities is important for people living with HIV to meet together and share experiences, promote interaction, positive support and encouragement. This will create long-term bonding and a comfort zone for people with the same needs. Support groups also have the potential to address the stigma and discrimination associated with HIV and AIDS.

### **5.3.5 The use of current platforms**

Food and non-food items distribution time is utilized by the IOM as a platform to disseminate key HIV and AIDS messages, and to distribute male and female condoms. Food distribution is accompanied by an edutainment package in the form of drama with thematic areas centred on HIV-prevention. The selection of the food distribution time to conduct drama and distribution of IEC materials with key HIV-prevention messages has proved to be an effective platform to reach out to significant numbers of MVPs and potential emigrants as highlighted by the key informants.

### **5.3.6 Permanent health facilities and shelter**

The IOM provides mobile health facilities, transitional and permanent shelter to the MVPs and potential emigrants as one of their strategies to address HIV-prevention through responding to the health and shelter needs of the targeted communities in Beitbridge. Addressing health and shelter needs addresses some of the risk factors which expose the MVPs and potential emigrants to HIV and AIDS. In order to have a long-term effect, however, the IOM must initiate advocacy with the local authorities and the relevant government ministries for residential and commercial land rights and ownership in support of the MVPs and potential emigrants. Furthermore, to ensure access to health facilities the IOM has to partner with relevant government ministries and other stakeholders in constructing a permanent referral clinic to cater for the MVPs and potential emigrant communities.

### **5.3.7 HIV-prevention through livelihoods projects**

The livelihoods initiative being implemented by the IOM is a step towards establishing durable solutions to the needs of the MVPs and potential emigrants. Livelihood enhancement responds to the medium to long-term needs of the beneficiaries as it boosts income levels thereby reducing their chances of engaging in risk behaviours which exposes them to HIV-infection. Although there is a positive shift in focus from humanitarian responses to durable and sustainable solutions within humanitarian settings there is need for the IOM to come up with a broad-based action plan supported and endorsed by the government and other non-governmental stakeholders. The livelihoods initiative as one of the key strategic areas in addressing HIV requires technical back-up in order to improve the income levels of the MVPs which will, in turn, result in better living conditions.

#### **5.4 RECOMMENDATIONS FOR POLICY AND PRACTICE**

The following recommendations are being made to assist all stakeholders to scale up HIV-prevention measures among the MVPs and potential emigrants in Beitbridge:

- A multi-sectorial approach is required to steer the process of addressing HIV among the MVPs and potential emigrants. No single individual organization or agency has the capacity to deal exclusively with the identified challenges faced by the MVPs and potential emigrants. There is need for synergies to be established between different stakeholders who have competencies in addressing HIV in migration settings. These players include relevant government ministries, selected UN agencies, inter-governmental and non-governmental organizations, faith-based organizations, community-based organizations and the community leadership. It is also imperative to ensure the participation of the MVPs and potential emigrants themselves in the formulation and implementation of the directed interventions;
- The IOM should incorporate host communities in the mainstreaming of HIV-prevention initiatives given their central roles in commanding access, control and ownership of existing community resources to which the MVPs and potential emigrants are generally denied access;
- There is need for coordination among various stakeholders in executing HIV-prevention activities and to formulate clear and efficient referral and support systems that ensure comprehensive services are delivered to the MVPs and potential emigrants;
- The IOM should play a leading role in advocating for policy and legislation guidance and defining best practices that recognizes the existence of the MVPs and potential emigrants in line with the African Union 2009, Kampala Declaration. The policy framework will be used in promoting sustainable and

durable solutions supporting HIV-prevention initiatives. The IOM should further advocate for the government of Zimbabwe to take the lead in designing national strategies addressing risk factors that exposes the MVPs and the potential emigrants to HIV-infection;

- The IOM should formulate a comprehensive strategy addressing sustainable development and durable solutions targeting the MVPs and potential emigrants as part of their exit strategy;
- There is need for the stakeholders to come up with effective and comprehensive poverty reduction strategies among the MVPs and potential emigrants, not only in Beitbridge but also the major MVPs and potential emigrants source areas so as to reduce the push factors, at the same time addressing the basic needs for human survival which might put them at risk of engaging in risk behaviours exposing them to HIV-infection. This would include technical and financial support for viable and sustainable income generating projects targeting individuals at community level;
- The IOM, in partnership with the government and non-governmental organizations, should develop specific programmes protecting the rights of women and girls, for example income-generating initiatives targeting women, and capacity building workshops focusing on women's empowerment;
- The IOM should work closely with the print and electronic media in championing the rights and needs of the MVPs and potential emigrants in line with the HIV and AIDS prevention activities;
- Although the IOM is primarily geared towards emergency responses it needs to address HIV and AIDS issues more regularly and aggressively in its programming in order to educate and inform the MVPs and potential emigrants to prevent the spread of HIV. This is in line with the concern with HIV-prevention programmes

as part of the global action in fighting HIV and AIDS (UNAIDS, 2002:11-12) and (IOM 2001:5).

## **5.5 LIMITATIONS OF THE STUDY**

This study has highlighted numerous issues that impact on the role and intervention strategies of the IOM in the prevention of HIV-infections among MVPs and potential emigrants in Beitbridge. As this study was restricted to only one research site, namely Beitbridge, the research findings cannot be generalized to all the IOM programmes dealing with the MVPs and potential emigrants in Zimbabwe. The findings, however, may provide some context for any proposed prevention strategies and provide a solid basis for the effective programming of targeted and practical responses to minimize incidences of new HIV-infections among the MVPs and potential emigrants.

Bearing in mind the limitations of the study, the researcher recommends that:

- A broader study among the MVPs and potential emigrants in Zimbabwe be commissioned for a comprehensive and well coordinated national approach to the prevention of HIV and AIDS.

## **5.6 CONCLUSION**

The IOM, as a leading organization in responding to migration challenges, plays a crucial role in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants. The comparative advantage enjoyed by the IOM compared to other organizations in having access to the MVPs and potential emigrants in Beitbridge is a unique opportunity to devise all-inclusive HIV-prevention programmes targeting the MVPs and potential emigrants. Given the study findings, the IOM needs to strategically

position itself by moving a step further from being the sole provider of emergency humanitarian support towards formulating and implementing sustainable and durable solutions among the MVPs and potential emigrants, particularly with regard to the prevention of HIV infections.

Building on its success, the IOM should continue organizing workshops, seminars, and awareness raising initiatives targeting the MVPs and potential emigrants as a successful preventive measure for the spread of HIV.

In order to ensure long-term sustainability and durability the IOM must promote long-term synergies with other stakeholders like relevant government ministries, NGOs and community based organizations in the implementation of activities addressing HIV and AIDS among the MVPs and potential emigrants.

In trying to adhere to the international standards in addressing migration and HIV and AIDS, IOM's MVP's and potential emigrants' projects and programmes should be closely developed in consultation with the beneficiaries, in partnership with the relevant governments ministries, local community structures and non-governmental organizations working in the field of HIV and AIDS and migration. Involvement of stakeholders in all phases of the project cycle guarantees sustainability.

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## APPENDIX 1

### LETTER OF CONSENT

15 May 2010

Flat 21 Birdcage Walk  
178 Herbert Chitepo Avenue  
Harare

Dear Sir/Madam,

**Re: Request for participation to a study**

I hereby request your participation to the study entitled “*The role of the International Organisation for Migration (IOM) in the prevention of HIV-infections among mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge*” by completing the attached questionnaire and by returning the completed questionnaire using the enclosed self-addressed and stamped envelope or personally deliver to the researcher.

The research study is undertaken in partial fulfilment towards the degree of Masters in Social Behaviour Studies in HIV/AIDS offered by the Department of Sociology, University of South Africa (UNISA). Your participation to the study is optional and the return of the completed questionnaire will be considered as your consent to participate to the study.

The questionnaire does not include any personal information and the returned questionnaire will be handled with confidentiality. The results will be presented in such a way that the information will not be trace back to the individual participants.

IOM might use the results of this study as guidelines in enhancing its activities in preventing HIV-infection among mobile and vulnerable populations and potential emigrants in Zimbabwe through formulating specific interventions. Furthermore, the government and other stakeholders dealing directly with the mobile and vulnerable populations and potential emigrants might also use the findings to formulate appropriate policies and specific intervention strategies to address risks associated with irregular migration in relation to HIV-prevention. A summary of the findings will be made available to the participants on request.

Kindly be informed that I remain at your disposal should you have any further questions concerning the questionnaire, please do not hesitate to contact me on +263 772 956 624, or email: [nyararaik@yahoo.com](mailto:nyararaik@yahoo.com)

I look forward to your participation.

Yours sincerely

Nyararai Kwenda (Mr)

Student for Masters in Social Behaviour Studies majoring in HIV/AIDS (UNISA)

**APPENDIX 2**

**INTERVIEW CONSENT FORM**

**(FOR KEY INFORMANTS)**

I have been told that this interview is about a research study entitled “*The role of the International Organisation for Migration (IOM) in the prevention of HIV-infections among mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge*” with Beitbridge Reception and Support Centre as the nucleus. I have been told that I will not be forced to share my experiences and that if I refuse to participate, it will not negatively affect me. I have also been told that if I agree to participate, I will not be forced to share something that I feel uncomfortable discussing. I also know that I have the full right to stop this interview at any time without providing an explanation. I understand that the information that I reveal in this interview will be kept highly confidential by the researcher conducting this study. I hereby agree to participate in this interview of my own will and interest. I submit that I have not been forced or coerced (emotionally and physically) to take part in this interview, and that my consent to this is wholly my own decision.

Date ..... Signature or Mark .....

I hereby state that I have explained to the respondent the details about this interview and the terms of his/her participation. I have, in a language understood by this researcher, explained that consent to participate in this interview is totally voluntary and that he/she can resign or withdraw consent at any point of time or opt out of the interview without need of approval or an explanation. I have made it clear that the respondent is free to reveal or share such information as he/she is comfortable with and that there will be no pressure or force to him/her to share or reveal more than he/she wants to. I hereby understand that whatever is revealed by the respondent during this interview has to be treated with the utmost confidentiality and cannot at any cost be revealed to any other person except with the consent of the respondent, and I promise to honour this requirement.

Date ..... Signature or Mark .....

## APPENDIX 3

### INTERVIEW GUIDE FOR KEY INFORMANTS

#### INTRODUCTION

My name is Nyararai Kwenda, currently studying Masters in Social Behaviour Studies majoring in HIV/AIDS offered by the Department of Sociology, University of South Africa (UNISA). In partial fulfilment of the requirements of Masters' degree, each student is required to carry out a research study in any topic relating to HIV and AIDS. My research topic focuses on *“The role of the International Organization for Migration (IOM) in the prevention of HIV-infections among mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge”*.

In your position, I believe you may have some information or have heard of things that have happened in this area that might help my investigation. Anything you say would be treated in the utmost confidence and you would not be identified as the source of anything that you tell me. IOM might use the results of this study as guidelines in enhancing its activities in preventing HIV-infections among MVPs and potential emigrants in Zimbabwe. Further, the government and other stakeholders dealing directly with MVPs and potential emigrants might also use the findings to formulate appropriate policies and specific intervention strategies to address risks associated with irregular migration in relation to HIV-infection a summary of the study will be made available to you on request.

Would you be prepared to talk to me? I expect the interview to take about 30 minutes. There would be no obligation on your part to answer all the questions that I ask you and there may be some questions that you do not know the answer for or do not have an opinion about. Let me begin by asking you some general demographic questions.

**CONSENT (FOR INTERVIEWER TO FILL IN; NOT READ OUT TO RESPONDENT)**

I Nyararai Kwenda confirm that I have read out the introduction above and that the respondent interviewed for this questionnaire gave his/her full consent to be interviewed.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

The objectives of the study are to:

- Investigate the types of awareness-raising activities on HIV-prevention conducted by the IOM amongst mobile and vulnerable populations and potential emigrants in Beitbridge;
- Establish the effectiveness of these activities in raising awareness of HIV-prevention among the MVPs and potential emigrants;
- To explore the future role on the IOM in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants as perceived by the interviewed key informants and the MVPs and potential emigrants;
- Based on the findings, suggest ways in which existing awareness-raising activities may be enhanced.

In terms of the research objectives outlined above, the interview schedule covered broad areas such as:

1. Forms of abuse experienced by MVPs and potential emigrants in Beitbridge which might put them at risk of contracting HIV;
2. HIV-prevention activities conducted by the IOM amongst the target group; available support services provided by the IOM;
3. The effectiveness of these activities in raising awareness on HIV-prevention; identifying gaps in HIV-prevention initiatives;
4. What needs to be done to enhance existing awareness raising initiatives among the MVPs and potential emigrants in Beitbridge.

Record time end.....

Closing

I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know of importance to my research study?

Thank you again.

## APPENDIX 4

### LETTER OF REQUEST

Flat 21 Birdcage Walk  
178 Herbert Chitepo Avenue  
Harare

23 March 2010

The Chief of Mission  
International Organization for Migration (IOM)  
142 King George Road  
Avondale  
Harare

Dear Sir/Madam

**Ref: Request to conduct a research study**

My name is Nyararai Kwenda, currently studying Masters in Social Behaviour Studies majoring in HIV/AIDS offered by the Department of Sociology, University of South Africa (UNISA). In partial fulfilment towards the requirements of Masters' degree, each student is required to carry out a research study in any topic relating to HIV/AIDS. I hereby request permission to conduct my research study entitled "*The role of the International Organisation for Migration (IOM) in the prevention of HIV-infections among mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge*" at IOM's Beitbridge Reception and Support Centre.

The objectives of this study are:

- Investigate the types of awareness-raising activities on HIV-prevention conducted by the IOM amongst mobile and vulnerable populations and potential emigrants in Beitbridge;
- Establish the effectiveness of these activities in raising awareness of HIV-prevention among the MVPs and potential emigrants;
- To explore the future role on the IOM in the prevention of the spread of HIV and AIDS among the MVPs and potential emigrants as perceived by the interviewed key informants and the MVPs and potential emigrants;
- Based on the findings, suggest ways in which existing awareness-raising activities may be enhanced.

Research instruments in the form of self-administered questionnaires and face-to-face interviews with selected key informants namely MVPs and potential emigrants, implementing partners, NGOs and key government ministries working with IOM in Beitbridge.

The research instruments to be used in this study do not reflect any personal questions which reveal personal characteristics and the returned questionnaire will be handled with confidentiality. The results will be presented in such a way that the information will not be trace back to the individual participants. No individual identities will be used in any report or publication resulting from the research. Study information will be coded and kept confidential at all times. Only the researcher will have access to the information.

IOM might use the results of this study as guidelines in enhancing its activities in preventing HIV-infection among mobile and vulnerable populations and potential migrants in Zimbabwe through formulating specific interventions. Furthermore, the government and other stakeholders dealing directly with the mobile and vulnerable populations and potential migrants might also use the findings to formulate appropriate policies and specific intervention strategies to address risks associated with irregular migration in relation to HIV-prevention. A summary of the findings will be made available to the participants on request.

I hope that this request will meet your approval. Kindly be informed that I remain at your disposal should you have any further questions concerning this research study, please do not hesitate to contact me on +263 772 956 624, or email: [nyararai@yahoo.com](mailto:nyararai@yahoo.com).

Sincerely,

Nyararai Kwenda (Mr)

Student for Masters in Social Behaviour Studies majoring in HIV/AIDS (UNISA)

**APPENDIX 5:**

**SELF ADMINISTERED RESEARCH QUESTIONNAIRE**

Qre No \_\_\_\_\_

**(SHOULD BE POSTED TO THE RESPONDENT TOGETHER WITH THE  
LETTER OF CONSENT)**

**SECTION A: GENERAL INFORMATION**

Please answer all the questions below by placing a cross (X) at the relevant block or space provided except where specific information is required.

**Demographic data**

**1. Gender**

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

**2. Age in years**

18 – 24	<input type="checkbox"/>
25 – 34	<input type="checkbox"/>
35 – 44	<input type="checkbox"/>
45 - 54	<input type="checkbox"/>
55+	<input type="checkbox"/>

**3. Formal Education**

None	<input type="checkbox"/>
Primary Level	<input type="checkbox"/>
Secondary Level	<input type="checkbox"/>
Tertiary College	<input type="checkbox"/>
University level	<input type="checkbox"/>

Other (specify).....

**4. How long have you been staying in Beitbridge?**

0 – 6 months

7 – 12 months

13 – 24 months

25 – 35 months

36 – 47 months

48+

Other specify.....

**5. Background in the place of origin**

Going to school

Formal employment

Informal employment

Not working

Other specify .....

**SECTION B**

**Current IOM activities in HIV-prevention among MVPs and potential emigrants in Beitbridge**

Note: Please answer questions 1 to 3 below using the following key:

1: Not at all 2: Occasionally 3: Constantly

Answer each statement by placing a cross (X) in the block under the corresponding key.

**For example**

Activities	1	2	3
Distribution of food items	X		

**Question 1.**

**How often are HIV and AIDS messages included in the following IOM activities within the MVPs and potential emigrants' communities?**

<b>Activity</b>	<b>1</b>	<b>2</b>	<b>3</b>
Distribution of food items			
Distribution of non-food items			
Livelihood programmes			
Irregular migration and safe migration programmes			
Safe migration workshops			
Outreach activities (specify)			

**Question 2.**

**How often are the following HIV and AIDS activities organized by IOM in your community?**

<b>Activities</b>	<b>1</b>	<b>2</b>	<b>3</b>
HIV and AIDS workshops			
HIV and AIDS seminars			
HIV and AIDS awareness campaign			
HIV and AIDS counselling			
HIV and AIDS trainings of care givers			
HIV and AIDS Edutainment activities			
Establishing and supporting HIV and AIDS support groups			
Treatment of opportunistic infections among the MVPs and potential emigrants			
Voluntary, HIV and AIDS counseling			
Access to health facilities in MVPs communities (mobile clinics)			

**Question 3.**

**How often are the following aspects of HIV and AIDS addressed within IOM programmes?**

<b>Activities</b>	<b>1</b>	<b>2</b>	<b>3</b>
Cultural beliefs and practices that fuel HIV and AIDS			
Risk behaviours among MVPs that tend to drive HIV and AIDS			
Sexual practices that expose to HIV			
Mode of transmission of HIV and AIDS			
High risk group and vulnerable group to HIV infection			
Meaning of AIDS			
Ethical issues related to HIV and AIDS			
Care of HIV and AIDS patients			
Professional issues related to HIV and AIDS			
Prevention of HIV/AIDS			
Socio-economic issues that are drivers of HIV and AIDS			
Mobility/Irregular migration and HIV and AIDS			
Poverty and HIV and AIDS			
Safer sex practices and HIV and AIDS			

**SECTION C:****YOUR PERSONAL BELIEF ABOUT HIV AND AIDS**

**Note:** Answer question in Section C and D by using the following keys: SA: Strongly Agree; A: Agree; U: Undecided; D: Disagree; SD: Strongly Disagree

Evaluate each statement by placing a cross (X) in the block under corresponding key

**Question 1**

<b>Statements - I believed that:</b>	<b>SA</b>	<b>A</b>	<b>U</b>	<b>D</b>	<b>SD</b>
HIV is transmitted by shaking hands with an infected person					
HIV is transmitted by seating next to infected person					
HIV is transmitted by sleeping in the same blanket					

HIV is cured by having sexual intercourse with a virgin					
Having sexual intercourse with an old woman cures AIDS					
Having sex with a young child can cure HIV					
HIV is caused by Promiscuity					
A Healthy looking person cannot be HIV positive					

**SECTION D**

**FUTURE ROLE OF IOM IN THE PREVENTION OF THE SPREAD OF HIV AMONG MVPs AND POTENTIAL EMIGRANTS**

Evaluate each statement by placing a cross (X) in the block under corresponding key

**Question 1.**

<b>Actions to be taken by IOM</b>	<b>SA</b>	<b>A</b>	<b>U</b>	<b>D</b>	<b>SD</b>
Make available ARVS to MVPs and potential emigrants infected with HIV					
IOM should conduct regular workshops with MVPs and potential emigrants on HIV and AIDS issues					
IOM should provide food with dietary requirements to MVPs and potential emigrants living with HIV					
IOM should provide more medicine & other health care supplies (bleach, soap, gloves, etc) to care givers					
IOM should provide training of family members to take care for the sick					
IOM should provide emotional support for the sick family member					
IOM should provide emotional support for the caregiver					
IOM should address ethical issues concerning HIV – prevention among the MVPs and EP					
IOM should discuss HIV and AIDS issues with MVPs outside food distribution times					

**Question 2.**

<b>IOM should play a leading role in</b>	<b>SA</b>	<b>A</b>	<b>U</b>	<b>D</b>	<b>SD</b>
Educating MVPs and potential emigrants on risk behaviours that expose them to HIV and AIDS					
Educating MVPs and potential emigrants on harmful cultural and traditional beliefs and practices that expose people to HIV infection					
Educating MVPs and potential emigrants on the mode of HIV transmission					
Advocating for the availability of ARVs to MVP communities					
Scale up prevention of HIV and AIDS programmes					
Advocating for the establishment of satellite health services in mobile and potential emigrants communities					
Advocating for the availability of free anti-retroviral drugs among the MVPs and potential emigrants communities					
Addressing professional issues related to HIV and AIDS					

**What other role do you think IOM should play in the prevention of HIV among MVPs and potential emigrants?**

## APPENDIX 6:

### PERMISSION TO CONDUCT A STUDY

06-JUL-2011 11:48 FROM 707

TO Nyararai

P.001/001



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

**Our Ref: IOM/HRE/034/10**

Harare, May 3, 2010

Mr. Nyararai Kwenda  
Flat 21, Birdcage Walk  
178 Herbert Chitepo Avenue  
Harare

Dear Nyararai Kwenda

**Re: Permission to conduct a research study on the IOM HIV-prevention programme**

Reference is made to your letter dated 23 March 2010 in connection with your request to conduct a research study entitled "*The role of the International Organisation for Migration (IOM) in the prevention of HIV-infections among mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge*" using the IOM Beitbridge Reception and Support Centre (BRSC) as your primary research site. I am very glad to inform you that your request has been approved. Hopefully this study will not only enable you to complete your Masters degree but will also benefit the IOM in the implementation of better strategies in HIV-prevention among the mobile and vulnerable populations and potential emigrants in Zimbabwe.

I wish you the best in your studies. Should you require any support don't hesitate to contact IOM officials in Beitbridge.

Yours sincerely,

**Marcelo Pisani**  
Chief of Mission,

---

International Organization for Migration (IOM)  
142 King George Road, Avondale, Harare  
P.O. Box 2570, Harare, Zimbabwe  
Tel: (263) 4 335048, 335044, 303514. Fax: (263) 4 335055. E-mail: [iomharare@iom.co.zw](mailto:iomharare@iom.co.zw)

TOTAL P.001

## APPENDIX 7: ETHICAL CLEARANCE CERTIFICATE



Department of Sociology  
College of Human Sciences  
5 April 2011

**Proposed title:** The role of the International Organization for Migration (IOM) in the prevention of HIV-infections among mobile and vulnerable populations (MPVs) and potential emigrants in Beitbridge

**Principal investigator:** Nyararai Kwenda (Student number 42545889)

**Reviewed and processed as:** Class approval (see paragraph 10.7 of the UNISA. Guidelines for Ethics Review)

**Approval status recommended by reviewers:** Approved

The Higher Degrees Committee of the Department of Sociology in the College of Human Sciences at the University of South Africa has reviewed the proposal and considers the methodological, technical and ethical aspects of the proposal to be appropriate to the tasks proposed. Approval is hereby granted for the candidate to proceed with the study in strict accordance with the approved proposal and the ethics policy of the-University of South Africa.

In addition, the candidate should heed the following guidelines:

- To only start this research study after obtaining informed consent
- To carry out the research according to good research practice and in an ethical manner
- To maintain the confidentiality of all data collected from or about research participants, and maintain security procedures for the protection of privacy
- To work in close collaboration with his supervisor and to record the way in which the ethical guidelines as suggested in her proposal has been implemented in his research
- To notify the committee in writing immediately if any change to the study is proposed and await approval before proceeding with the proposed change
- To notify the committee in writing immediately if any adverse event occurs.

Approvals are valid for ONE academic year after which a continuation must be submitted.

Kind regards

D Gelderblom (Prof)  
Chair: Department of Sociology  
Tel + 2712 429 6301



University of South Africa  
Pretter Street, Muckleneuk Ridge, City of Tshwane  
PO Box 392 UNISA 0003 South Africa  
Telephone: +27 12 429 3111 Facsimile: +27 429 12 429 4150  
[www.unisa.ac.za](http://www.unisa.ac.za)

## APPENDIX 8: NOTE FROM EDITOR

05-JAN-2012 11:35 FROM 707

TO Nyararai

P.001/001

### NOTE FROM EDITOR

#### TO WHOM IT MAY CONCERN

This is to certify that I edited Nyararai Kwenda's master's dissertation on **The role of the International Organisation for Migration (IOM) in the prevention of HIV-infections among mobile and vulnerable populations (MVPs) and potential emigrants in Beitbridge** for language and content.

Yours sincerely



**Dr. Gerald Chikozho Mazarire**

TOTAL P.001

## APPENDIX 9: LETTER FROM UNISA

06-JUL-2011 11:48 FROM 707

TO Nyararai

P.001/001



Stud nr/no: 425545889  
Enq/Navrae: M&D Examination Coordinators  
M&D Eksamenkoördineerders  
Tel: 012 441-5500/5501/5498/5499  
Fax/Faks: 012 429-8119

Mr N Kwenda  
21 Birdcage Walk  
178 Herbert Chitepo Avenue  
HARARE  
Zimbabwe

2011-06-06

Dear Mr Kwenda

With reference to previous correspondence, I have pleasure in informing you that your supervisor has consented to your submitting the dissertation for examination.

I have pleasure in informing you that the following **amended title** has been approved for your projected dissertation of limited scope for the degree of MA in Social Behaviour Studies in HIV/AIDS: **THE ROLE OF THE INTERNATIONAL ORGANISATION FOR MIGRATION (IOM) IN THE PREVENTION OF HIV-INFECTIONS AMONG MOBILE AND VULNERABLE POPULATIONS (MVPS) AND POTENTIAL EMIGRANTS IN BEITBRIDGE.**

For purposes of examination, three copies, bound between soft covers with a glued spine, must be submitted. The copies must be addressed to The Registrar, for attention **Record Management Centre, M & D section**, [Tel (012)429-3057, (012)429-3506, (012)429-3150 or (012)429-3486], or they may be handed in personally at the counter, Level 2 in Block B, Theo van Wijk Building (use the Gold Fields entrance)\*.

The enclosed *ProQuest Information and Learning (University Microfilms Inc)* agreement form must be completed in all its detail and must accompany the abovementioned examination copies.

### Regarding submission dates the following rules apply:

- If submission takes place after 15 June a student will only graduate in April/May of the following year;
- if submission takes place after 30 November graduation will only take place in September of the following year;
- if submission takes place after 5 March a student will graduate in September and have to reregister and pay the full tuition fees;
- if you are not currently a registered student, submission will not be allowed.

Please note that, **after the examination has been completed** and **after** any corrections that the examiners might request have been effected, a student must, before the degree can be awarded, submit the text in **electronic format** and the same text in a further **two additional copies** of the accepted dissertation, namely two spine-glued hard cover copies, reflecting the full title of the dissertation and your name on both the cover and spine of the bound copies. See \* above for the address.

Yours faithfully

for REGISTRAR  
/cp062011-1



University of South Africa  
Preller Street, Muckleneuk Ridge, City of Tshwane  
PO Box 392 UNISA 0003 South Africa  
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150  
[www.unisa.ac.za](http://www.unisa.ac.za)

TOTAL P.001