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SAFAIDS

Sexual health and mobile and migrant populations

Mary Haour-Knipe & Danielle Grondin

Now, at the start of the 21st century, one of every 35 persons worldwide is an international migrant. If all international migrants lived in the same place, it would be the planet's fifth biggest country. The world saw 80 million people migrate in relation to labour in 2001; there were also 10-15 million undocumented migrants who crossed borders. In 2002, 22 million people were refugees and internally-displaced persons, while another 4 million persons were trafficked for labour and sexual exploitation purposes. In addition, each year almost 700 million travellers also cross international boundaries.¹

People move from one place to another for many reasons. Some migrate to join family members. Others, such as airline personnel, truckers, people serving in uniformed services, petty traders, and sex workers, travel for professional reasons. Many people move in search of economic opportunities. Yet others are pushed by war, human rights abuses, ethnic tensions, violence, famine and persecution.

Movement may be voluntary or forced. It may be temporary, seasonal (e.g., during harvests), permanent or circular (returning home repeatedly). Categories shift: people intending to migrate permanently may change their minds and return home; people intending to stay only a short time may settle permanently; students or tourists entering countries legally may become undocumented migrants when their visas expire; undocumented migrants may have their status regularised; and refugees and internally-displaced persons may be able to return to the communities from which they fled, as they are currently doing in Angola and Afghanistan for example.

Though the reasons for people's mobility differ, the risks and vulnerabilities that they encounter to their sexual health are similar, as are the approaches to deal with them.



Mobile solutions for mobile people

Photo: Sara A. Holtz

Individual risk and social vulnerability

Risk factors to sexual health are both individual and social. Like other people, migrant and mobile people have a responsibility to take care of their own health. However, their behaviour is often different when they are away from home and the social norms that guide and control behaviour in stable communities. Some people may indeed choose to leave home specifically so that they can more comfortably practise a stigmatised profession (e.g., sex work). When they travel without partners, and because of loneliness or as a result of social pressure, some migrants and travellers may engage in behaviours that put them at risk of undesired pregnancies or STIs. People who move from a conservative society to one perceived to be more liberal may be ill-equipped to deal with sexual freedom: they may not understand the norms or limits in the new society, and how to protect themselves in that context. Such cultural misunderstandings cause difficulties for women but also for men; more than one immigrant or male traveller who has misperceived sexual codes and ground rules has ended up being accused of rape.

For most migrants, daily life is dominated by priorities other than sexual health. Refugees worry about missing family members or mourn their dead. Newly-arrived immigrants are concerned about food, housing and finding a way to earn a living. Mobile workers, such as miners and truckers, may see far more imminent danger in their work environments than in the hypothetical risks of HIV/STIs. People travelling, fleeing danger, or pursuing a dream through migration are understandably reluctant to deal with the possibility of an illness that would slow them down. They may delay thinking about a health symptom until it becomes a problem that is impossible to ignore. An immigrant girl may come for a first antenatal consultation only when she is at an advanced stage of pregnancy; a trucker may present at a clinic only when an STI is very painful, and a would-be migrant in transit may find out about his HIV-positive status only when he has advanced AIDS.

Ill-adapted migration policies

Thus risk factors such as social pressure, cultural naiveté and more immediate priorities increase migrants' vulnerability to sexual and reproductive ill health. Other social factors operate less directly, by putting people in situations where risk behaviours are more likely to take place. Poverty, powerlessness, lack of respect for human rights, distrust of foreigners and marginalization drive discrimination and exploitation, creating risk situations in which people have very little individual choice at all.

Ill-adapted migration policies are behind many of the social factors that increase the vulnerabilities and sexual and reproductive health risks of migrants. Such policies may, in fact, seriously undermine public health policies. For example, policies encouraging labour migration of single people force them to migrate without their partners; this may increase their recourse to casual sex and thus the risk of HIV/STI infection. These policies affect not only the sexual health of the mobile people but also that of their partners and spouses, children, other family members left behind, and even entire communities.

The special vulnerability of women and children

The last 10 years have seen an increased feminisation of migration; women currently represent about 50% of the 175 million worldwide migrants estimated by the International Organization for Migration. Individual and social factors create special risk factors for women. For example, women travelling alone may have little choice but to sell sex for survival, or to establish partnerships in transit or at their destinations in order to gain access to protection. Refugee and internally-displaced women without male partners may similarly find themselves unprotected. In addition, they may have been exposed to rape as a weapon of war, or to rape in camps, where sexual violence is one outcome of male boredom, depression and substance abuse. The risk of sexual violence also increases in gender-segregated and unregulated sectors of the economy, for example, for female traders, domestic workers and sex workers.

The trafficking of human beings has been a lucrative trade for centuries, but recent opportunities created by globalisation – combined with tightening restrictions on immigration and labour migration – have contributed to an increase in the numbers of persons smuggled and trafficked. Women and female children and adolescents are particularly vulnerable to trafficking for sexual exploitation. UNICEF estimates that about 1 million children are forced into the sex trade every year worldwide. In countries of the European Union, there are numerous indications that unaccompanied (or separated) children and adolescents from Eastern Europe and the Balkans are being trafficked. Persons trafficked for sexual exploitation face significant risks to their mental and reproductive health, such as sexual violence, unwanted and unsafe pregnancy and motherhood, unsafe abortion, and HIV/STIs. Sexual exploitation of children often means that children will give birth to children if contraception – including emergency contraception – and safe legal abortion are unavailable.

Approaches used

It has often been pointed out that it is not migration or mobility itself, but rather the situations encountered and the behaviours expressed that increase vulnerability and risks for mobile and migrant populations. The *patterns* of mobility discussed in the first section of this article define the conditions of the journey and its potential subsequent impact on health (regular or irregular, forced or voluntary migration). Migration *status* usually defines access to health and social services. Efforts therefore can and should be made to improve the access of mobile and immigrant populations to health promotion, care and support.

Measures needed to *reduce risks* for mobile populations are the same as for any other group. They include provision of health education and information, voluntary counselling and testing, family planning and antenatal care, and STI treatment. Peer education is a particularly important approach for such populations, as is active outreach that will ensure that information and services offered are not only language- and culture-appropriate but also "user friendly" (understandable, accessible, welcoming, easy to use).

Measures to reduce vulnerability are even more important. These are attempts to go beyond addressing individual behaviour change to address the social factors sketched out above. Some measures to decrease sexual violence, for example building latrines where women can get to them safely, are relatively simple. Other approaches may require more fundamental reorganization. These include measures to reduce the frustration that leads to violence, or the factors that drive discrimination, lack of respect of rights and exploitation. They also include efforts to change migration policies that directly or indirectly promote behaviour that has a negative impact on sexual health.

Two fundamental programming bases are important for reducing migrants' risks and vulnerability: 1) use of a rights-based approach – based on the principle that migrants have a right to health, thus to information and services – and 2) involvement of migrant communities. Leaders and representatives of migrant and mobile groups know their needs and how to meet them. At the same time, governments are responsible for including health and immigration authorities in the definition of priorities and development of policies of inclusion rather than exclusion. Rights and responsibilities for both migrant and host communities must be balanced. Governments may have difficulties, however, in programming for target groups such as irregular migrants. It is here that international organizations and NGOs can play crucial and complementary roles of advocate, spokesperson, and link between stakeholders. Such supra-national agencies can also facilitate essential cross-border and cross-continental initiatives that link countries of origin, transit, destination and return.

What is needed

Much remains to be done in this field. The evidence base concerning migrant health in general, and migrant sexual health specifically, needs to be improved. Programmes are far too often put into place in the absence of baseline assessments, and priorities are far too often donor- rather than needs-defined. Programmes are far too often unevaluated, and knowledge about lessons learned remains unshared.

Addressing the pattern and status factors that may enhance vulnerability for migrant and mobile populations poses challenges for migration health management and for policy formulation. It also poses complex medical, legal and ethical questions. Should diseases posing a public health risk not be treated as migrants travel? Should treatment available to national citizens be offered to people who may not stay in a country? Should a migrant with a health condition that will be expensive to treat be excluded from a health programme or be rendered inadmissible to a country? How can we provide services for one community without providing services for another?

In sum, addressing the sexual and reproductive health needs of mobile and migrant populations poses complex challenges and fundamental questions about balancing individual rights and responsibilities, and the rights and responsibilities of nations. ♦

¹. Source of data cited in this paragraph: International Organization for Migration, International Labour Organization, United Nations High Commissioner for Refugees and World Tourism Organization.

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Mobile populations: addressing HIV among truckers

It has been known for a long time that people whose jobs require them to travel a lot, such as truckers, traders, seafarers, army personnel etc. are extremely vulnerable to HIV and STIs. In the case of truck drivers, overnight stays away from home, less social control, long waiting periods in ports and border stations, the availability of commercial sex, and other factors work together in creating this vulnerability. In various countries of the world, mainly in South Asia, South Africa and Western Africa, projects have been set up to increase HIV/AIDS awareness among truckers and their occasional sexual partners, and teach them about the importance of consistent condom use. In Burkina Faso, West Africa, a local union of road freight personnel took up the challenge. One of its activities was the development of an "infotaining" audiocassette named *Radio Psamao*. In South Africa, several roadside container clinics for HIV/AIDS education and treatment of STIs were set up by the road freight industry. The following two articles describe these interventions.



Photo: Wade Hatler

Audiotape entertainment for long-distance truck drivers in West Africa

Salifou Compaoré

In 1998, the Family Health and AIDS (FHA) project developed a programme that mainly focused on the reinforcement of condom distribution and promotion along the axes of migration (i.e., the main roads) in the area. This programme, *Prévention du SIDA sur les Axes Migratoires de l'Afrique de l'Ouest (PSAMAO)*, developed activities targeting long-distance truck drivers, sex workers, seasonal workers and other mobile populations in Benin, Burkina Faso, Côte d'Ivoire, Mali, Niger and Togo. PSAMAO's main goal is to increase HIV awareness through the development of communication campaigns and creation of communication tools. One tool developed to educate truck drivers was an informational audiocassette entitled *Radio PSAMAO*.

Why use an audiocassette?

In 2000, discussion groups with truckers in Burkina Faso evaluated existing and potential communication materials. The truckers favoured the concept of an audiocassette combining entertainment and information on HIV/AIDS, which they could listen to while on the road. They recommended combining music, sketches and spots adapted to their taste and needs. Based on this information, PSAMAO decided to produce a cassette that would simulate a radio transmission with several sections and two radio presenters. The cassette was then to be distributed to long-distance truck drivers in the six countries involved in the project.

During previous communication campaigns targeting truck drivers, the focus was on condom use. *Radio PSAMAO* aimed to encourage the truckers to also recognise STI symptoms, seek treatment and use condoms consistently. Specific objectives were to:

- ❖ increase the truckers' risk perceptions concerning STIs and their severity (symptoms, complications)



A booklet used by peer educators to educate roadside sex workers

- ❖ alert them to the fact that STIs favour the transmission of HIV
- ❖ emphasize the necessity of protecting oneself
- ❖ raise awareness on the importance of seeking professional treatment instead of self-medication
- ❖ encourage voluntary counselling and testing for HIV.

Family Health and AIDS

Radio PSAMAO is part of a sexual health promotion campaign aimed at long-distance truck drivers and sex workers in West Africa, which has been carried out in the framework of Family Health and AIDS (FHA), a regional initiative funded by USAID. This programme is jointly planned and executed by five institutions. Population Services International (PSI) is also involved in the PSAMAO project; PSI is an American NGO specialised in behaviour change communication and social marketing of condoms and health services. PSI executes programmes in more than 60 countries.

Some of the products of the PSAMAO project include:

- ❖ a logo and regional slogan, "Roulez Protégé" (Drive Protected), both widely promoted and well-known
- ❖ *Radio PSAMAO* educational cassettes
- ❖ the video films *Roulez Protégé* for truck drivers and *Amah Djah-foule* for sex workers for use in group meetings
- ❖ a network of 68 road-side advertisement-boards to sensitize truckers on the road
- ❖ a network of more than 550 peer educators in 6 countries.

Other activities implemented by PSAMAO include research, media campaigns (radio and television spots), peer education training, social marketing of condoms, printing and distribution of educational materials (posters, leaflets) and promotional gadgets (T shirts, caps, key rings, stickers, etc.)

In Central Africa, similar activities are being carried out through PSAMAC, a migration project comparable to PSAMAO, in Cameroon, Chad and the Central African Republic.

More information: <http://www.fha-sfps.org>

Careful selection of messages

A communications agency was hired to produce the cassette in French and local languages (Moré, Dioula, Mina, Fon, Haoussa and Bambara). The production process lasted more than six months because the selection of appropriate messages had to be done carefully for this largely illiterate and less educated target group. The social marketing programme Population Services International assisted with this.

The project communicated the gist of the messages to the agency, which in turn called upon scriptwriters for the sketches. The sketches were sent to the project partners in the different countries for their opinions and contributions, so as to take into account specific cultural sensitivities. Two "radio presenters" were selected on the basis of their voice qualities to serve as cassette disc jockeys. The cassette also featured three sketches played by professional actors well-known in Côte d'Ivoire and seven songs on AIDS sung by famous African artists, including Meiwey and Tiken Jah Facoly from Côte d'Ivoire, Black So Man from Burkina Faso, King Mensah from Togo, Madou from Benin and Le Groupe Rage from Mali. All these artists gave up their copyrights so that the project could use the songs for free.

The cassette was pre-tested with a group of 200 truckers in Côte d'Ivoire of different nationalities; this led to an adaptation of the messages. *Radio PSAMAO* was then finalised and produced in French. The second step

consisted of translating the cassette into local languages, so that all the versions had the same content. Local versions are currently being produced in Cameroon under the PSAMAC project.

In September 2001, 15,000 copies of the cassette were distributed to truck drivers at main truck stops in the six countries involved in the PSAMAO project. In Niger, the cassette is also being used by rural radio stations, as it is seen as a meaningful addition to their low-budget programming. Given the good quality of the production, the cassette has even been duplicated illegally by street vendors and sold to the local population.

Evaluation

The efficiency of the communication material was measured in Côte d'Ivoire in August 2002 with the help of 385 truckers who regularly drive on major roads leading to bordering countries. The goal of the

evaluation study was to determine the intervention's success, as measured by the penetration of the messages among the target population and their level of retention of the gist of the messages. The study showed that 21% of the interviewed truck drivers had listened to the cassette and 9% owned the cassette. Almost all the respondents had memorised the prevention messages regarding STIs and the importance of testing.

The interviewed truckers mentioned that there were not enough cassettes available. In fact, most of them had not received a copy and expressed the wish of greater distribution of *Radio PASAMO*. The cassette will most likely be re-released during the next project period after September 2003. ❖

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Roadside Wellness Centres in South Africa – mobile health services for mobile people

Paul Matthew

In South Africa, national HIV prevalence rates grew from 0.8% in 1990 to 22.4% in 1999. By the end of 2001, an estimated five million South Africans were living with HIV/AIDS and 1600 people were contracting HIV daily. Long-distance truck drivers and their sexual partners were found to be especially vulnerable population groups. To counteract the spread of HIV/STIs among its mobile personnel, the South African road freight industry set up several mobile health clinics along the main roads of the country. The project is carried out by the Learning Clinic, a local NGO.

Truck drivers travelling the national long-haul freight routes in South Africa are away from their homes, families and friends for long periods of time. Many of the truckers encounter sex workers and other women who exchange sex for money or presents at truck stops and along major trucking routes and are tempted to start relationships with these women.

Urgent need for interventions

As a result of the depressed economy, the commercial sex market is growing in South Africa and unfortunately so is the rate of HIV/STIs due to unprotected sex with several partners. A study conducted at five truck stops in the heavily affected region of KwaZulu-Natal in 2000 with men who visited sex workers found high levels of HIV prevalence (56%) among both truck drivers and sex workers. Two-thirds of the men reported having an STI in the previous six months. Condom use was not very high; almost a third of the truckers reported never using condoms with sex workers, while less than half reported always using condoms. According to this study, the truck drivers and their partners need:

- ❖ information about HIV/STIs and condom use
- ❖ condom distribution at truck stops, toll plazas, work places and border posts
- ❖ peer education by truck drivers and sex workers to spread positive messages
- ❖ provision of syndromic STI treatment and HIV counselling at strategic points along major trucking routes (e.g., through mobile clinics).

The Learning Clinic was appointed to be the project manager for two major anti-AIDS projects within the road freight industry, "Trucking against AIDS" and "Focus on AIDS", sponsored by the National Bargaining Council for the Road Freight Industry (NBC) and the Road Freight Association (RFA), respectively.

Roadside Wellness Centres

As truck stops are an ideal spot for HIV prevention activities, with the possibility of reaching both truck drivers and sex workers, the Learning Clinic introduced the first Roadside Wellness Centre in 2000 at Beaufort West (along Route N1). By June 2003, more centres had been established near several main roads and border posts in South Africa: Harrismith, Port Elizabeth Truckers Inn, Ventersburg, Tugela, Beit Bridge Border Post and Komatipoort. The N7 route was under investigation as a new site.

The centres were established to undertake HIV/AIDS awareness education, primary health care, STI treatment through syndromic management and condom distribution to truck drivers spending an overnight rest stop in town. These services were also made available to their occasional sex partners (mainly sex workers), who are usually members of the local community. Each centre consists of two modified six-metre containers. One container is fully equipped with medications; a nurse undertakes health-care programmes and counsels patients suffering from STIs. The second container is equipped to undertake awareness and education training on the health consequences of having unprotected sex with several partners.

Trusting relationship

Truck drivers are invited to attend group education sessions, which last for approximately 45 minutes. Topics include: basic information on HIV/AIDS/STIs; prevention, care and support; the link between tuberculosis and other opportunistic diseases and HIV/AIDS; and abuse of women. In 2002, over 30,000 people received information about HIV/STIs and an estimated 350,000 condoms were distributed. While the main focus of the medical container is to provide syndromic STI treatment, it also includes a basic

medication stock with headache tablets, vitamins, etc. In 2002, over 7300 people received treatment at the clinics (including sex workers); more than 3200 (44%) were treated for an STI.

At first the drivers were sceptical about the programme and it took a while to build up a trusting relationship. They are encouraged by a coordinator based at the clinic to attend the training and afterwards visit the medical site if necessary. A fair amount of outreach is needed to convince them of the usefulness of the services; however, as soon as they experience the non-judgemental environment, the truckers tend to spread the word about the clinics and come around freely.

Sex workers and the truckers' other sex partners are also welcome to visit the Roadside Wellness Clinics for awareness, education and health-care programmes. There is no huge difference in motivating the drivers and sex workers to visit the educational sessions, although it seems that sex workers are more approachable due to their attitude towards the subject of HIV/AIDS. To encourage them to practise safer sex, workshops are held at the container clinics. Their programme consists of HIV/STI awareness and education and the importance of using condoms at all times.

Truck drivers usually visit the Roadside Wellness Centres between the hours of 5 and 12 p.m. Women's workshops are therefore conducted during daylight hours when truckers normally do not patronise the clinics. Some clinics have different operating times because of factors such as border-post operational times.

Future dreams

The increased number of clinics since 2000 is due to partnerships between the two original sponsors with the Health Department of Port Elizabeth and several Provincial Departments of Health in Free State, Western Cape and KwaZulu-Natal. These partnerships have proved invaluable in expanding the network to offer the freight industry's workforce a wider choice of Roadside Wellness Centres, where health-care programmes and condoms are available.



Truck drivers: a highly vulnerable population group

Photo: Roel Burgler

The Learning Clinic's long-term vision is to have a comprehensive network of clinics along national routes and at all border posts in South Africa. A computer system has been instituted to link all the container clinics. Drivers are given a personal number for use at the centres (no names are required). In this way, the truckers' progress can be traced throughout South Africa, regardless of which clinic they choose to use. What we hope to accomplish with the computer system is to have numbers available in terms of illnesses, prescribed medications and the truckers' history of use of these centres. This information will help the project managers to determine if a clinic is still viable in the specific area, if it is being used optimally or should be relocated, etc. ♦

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Special Article

HIV/AIDS and the military: fighting the war against HIV/STIs

Nel van Beelen

The armed forces in many high-prevalence countries are especially vulnerable to STIs, including HIV. Various contributory factors include the young age of many soldiers, their related high levels of sexual activity, a military culture that promotes risk-taking, and uses the purchasing of sex as part of bonding among soldiers, the high availability of commercial sex near army camps, and last but not least, the lengthy periods of time during which soldiers are away from home. This combination of factors leads to situations in which soldiers purchase sex from sex workers in the vicinity of their camps. Often these sexual encounters are not protected by condom use.

The military has been traditionally concerned about STIs and has promoted condom use for a long time. There are data indicating that the prevalence of HIV and STIs among military personnel is higher than among the average population in many countries. For example, data from a rural blood bank in Mozambique showed that 39% of military blood donors were HIV-positive, compared to 15% of non-military donors. Almost 75% of

the HIV-infected soldiers also tested positive for syphilis. Estimates of HIV prevalence among the military in Angola and the Democratic Republic of the Congo range between 40 and 60%. UNAIDS estimates that during periods of peace, STI rates among the armed forces are generally 2-5 times higher than in comparable civilian populations. The difference can be even greater in times of conflict.

In light of these high rates of HIV/STIs among military personnel, it is urgent to design effective intervention programmes for this population. Many governments realise that, given the high costs of caring for HIV-infected soldiers and their families by military health services, it is essential to invest in HIV prevention.

The UNAIDS response

In 2000, the United Nations (UN) identified HIV/AIDS as a growing security threat. UNAIDS established the UNAIDS Office on AIDS, Security and Humanitarian Response (SHR), which adopted a Strategic Action Plan in 2002. This "Strategic Action Plan for HIV/AIDS interventions among uniformed services with a special emphasis on young recruits" was designed as a generic model to support governments in formulating interventions. The overall aim is to provide selected countries with the necessary resources and support in order to initiate an effective and durable HIV/AIDS programme for uniformed services, in particular, young recruits.

Components of the Strategic Action Plan are:

- ❖ Generic guidelines aimed at UNAIDS staff, implementing partners and national entities to guide them in the formulation of projects.
- ❖ A guide to peer education training, to be published in 2003, that covers basic information for the training of trainers, peer educators and other persons directly involved in training.
- ❖ A guide designed to provide an overview of HIV/AIDS/STI programming options for planners.

Although military personnel are highly susceptible to HIV/STI infections as a group, the structure of the military also offers a unique opportunity for HIV/AIDS prevention and education: large audiences living in a disciplined, highly-organized setting. In various countries, such as Ethiopia, Kenya and Thailand, special prevention, counselling and training programmes have been set up for this group.

Ethiopia: training the army on HIV/AIDS

In October 2001, the UN Mission in Ethiopia and Eritrea (UNMEE), together with the Ethiopian army, organised a two-week training course for HIV/AIDS educators who mainly work for the Ethiopian National Defence Forces. One training goal was to develop a five-year strategic plan for HIV/AIDS control in the armed forces. The training activities are part of a UN requirement to establish a task force on HIV/AIDS to plan for prevention and control of the disease wherever it has peace-keeping forces. The training, attended by 24 soldiers and two UNMEE staff, will create an initial cadre of peer trainers to lead other members of the armed forces in developing anti-HIV/AIDS action plans. Similar trainings have also been conducted in Eritrea.

Kenya: voluntary and anonymous testing and counselling

Between 50-60% of all beds at the Kenyan Armed Forces Memorial Hospital are occupied by military men and women with HIV/AIDS-related infections and at least 6-10 soldiers die each week as a result of AIDS. In response, the Kenyan government set up an AIDS Control Unit at the Department of Defence. The Kenyan army operates 16 Voluntary Counselling and Testing (VCT) Centres where soldiers can be tested anonymously for HIV. Sixty-four counsellors, including three who are open about their

What concrete actions should be taken?

Approaches addressing risk behaviour

- ❖ Prevention education, including training of armed forces' medical and nursing staff, and regular briefing of the troops with specific HIV-related information.
- ❖ Condom education and distribution. Education must be explicit and repeated to be effective.
- ❖ Promotion and availability of STI treatment.
- ❖ Voluntary Counselling and Testing services, with regular encouragement.

Approaches addressing underlying vulnerability factors

- ❖ Changes to posting practices, including an emphasis on maintaining family life. Examples include shortening tours of duty away from home, and finding ways of helping soldiers to bring their families with them if long-term postings are unavoidable.
- ❖ Changes to military culture in order to make soldiers more skilled in understanding risks and taking personal responsibility for both one's own health and that of others.
- ❖ Changes to military attitudes towards civilian populations. If military attitudes to civilians place greater value on protection, providing security, communication, compassion and understanding, these qualities will also help improve the military response to HIV/AIDS.

Partnerships with the civilian sector

- ❖ Close collaboration with non-military actors, e.g. the Ministry of Health or other civilian health authorities. For example by having full participation of appropriate military officials in the civilian National AIDS Programme or by having health-system officials participate directly in training, prevention education and care for the military.

Acceptance and care of HIV-positive military staff

- ❖ Creation of a non-stigmatizing and non-discriminatory environment within the military population for those who are HIV-positive. This must begin with full confidentiality for HIV testing.
- ❖ Make sure that HIV-positive individuals be given every opportunity to carry out the tasks for which they have been trained and which they are still fit to perform.
- ❖ Care and support for soldiers living with HIV/AIDS, including continuity of care for them and their families as they return to civilian life.

Source: AIDS and the military, UNAIDS Point of View, May 1998.

positive HIV status, have been trained. Military medical staff have also attended a tuberculosis management course to aid in screening all TB patients for HIV and all HIV patients for TB. Condoms are now available and easily accessible in the barracks.

Thailand: reducing the incidence of HIV

The Royal Thai Army was one of the first armed forces that made a serious attempt to curb the spread of AIDS among its personnel. UNAIDS is currently developing a best practice publication based on the Thai example. A behavioural change intervention focusing on consistent condom use, and reducing brothel patronage and the use of alcohol at a Thai army base, showed that it is possible to decrease the number of new HIV/STI infections. Young conscripts who received intensive HIV education were followed from their entrance into the army in 1993 to May 1995. Compared to control groups of conscripts who did not receive the education, they were seven times less likely to catch an STI. During this period, the incidence of HIV was halved among the participating soldiers.

Examples like these can be found everywhere. Unfortunately, there are also negative responses. Several countries demand HIV testing of their new recruits and refuse any applications from HIV-infected soldiers, claiming that "we need healthy soldiers; people with HIV

cannot fight¹. Other countries dismiss soldiers and officers who are found or suspected to be HIV-positive, or remove them from active service. According to UNAIDS, HIV testing in military settings was carried out in some form by 93% of 62 countries that were examined in a 1995 survey. Forty-three countries stated that they impose mandatory testing. UNAIDS and other international organizations strongly oppose compulsory testing.

Conclusion

Although members of the armed forces are highly vulnerable to HIV/STIs, the very nature of the military's

hierarchical organization creates opportunities for interventions. Governments and military leaders are increasingly seizing this opportunity to contribute to the fight against AIDS among their armed forces. However, they should not take the "easy road" and conduct mandatory testing of their soldiers; rather, they should encourage the establishment of high-quality VCT services for their personnel, along with other HIV/AIDS prevention, care and support activities. ❖

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Philippines

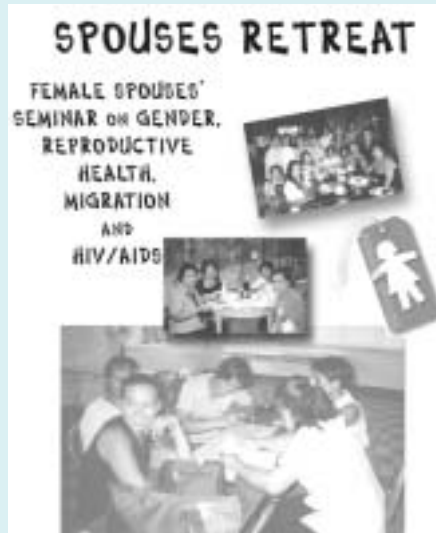
Education programme for wives of seafarers

After Indonesia, the Philippines are the second seafaring nation in the world. Seafarers are away from home for considerable periods of time, leaving their wives and children behind. With support from the Ford Foundation, the Philippine NGO ACHIEVE started a two-year HIV prevention intervention for wives of Filipino seafarers in 2001, as part of a comprehensive migrant community HIV/AIDS programme comprising pre-departure HIV education and post-return support for HIV-infected migrants and their families. The programme, called "Facilitating Change in Women's Lives: Education and Capacity Building for Female Spouses of Seafarers", was implemented in three areas: Davao City, Antique Province and Metro Manila. ACHIEVE worked in partnership with existing support NGOs, spouses associations and women living with HIV/AIDS in implementing the programme.

The programme aimed to raise the women's awareness and increase their knowledge of migration, gender, sexuality and health issues, particularly HIV/AIDS. A series of consultation workshops to assess the women's training needs was conducted in the communities. The workshops revealed that the seafarers' spouses wanted information on reproductive health issues, STIs, HIV/AIDS and sexuality. They also wanted to build their skills in communication, assertiveness, home management and leadership. Modules developed in consultation with key leaders of the partner organizations were used to conduct seminars and skills-building workshops focused on gender, sexuality, reproductive health, HIV/AIDS and migration issues. Given the sensitive and complex issue of condom use, a special skills training on assertive communication and a safer sex workshop were included in the programme. Sixty women from the three communities took part in the activities.

Following completion of the first phase of trainings, five key leaders and potential trainers from each community underwent training of trainers in May 2002. This training was meant to build and enhance their skills in transferring their newly-acquired knowledge to their peers. It was also intended to facilitate discussions that would deepen their understanding of gender, sexuality and reproductive health issues within the context of migration.

Phase 2 of the programme is being implemented through December 2004. Two manuals were published in March 2003: *Taking control: a life skills guidebook for female spouses of*



Material used for workshops with spouses of seafarers

migrant workers (FSMWs) and A discussion guide for FSMWs on gender, reproductive health, migration and HIV/AIDS. One component of Phase 2 is the distribution of the two manuals and the collection of feedback from users. The life skills manual, a collation of the contents of the skills training workshops, is meant primarily for the women. The training manual, which documents the trainer's training, is intended to be used as a resource material in future trainings, workshops and similar initiatives that may be embarked on by ACHIEVE or its partner organizations for non-migrating partners, not just of seafarers, but also of other migrant workers. ❖

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Mexico/USA

Cross-border care programme for HIV-infected Mexicans

Hundreds of thousands of Latin Americans cross the Mexico-US border each year in search of work in the United States. Among them, Mexicans are the largest group. HIV infection trends in Mexico seem to follow two patterns. The urban infected population is seen primarily in cities along the US-Mexico border and other large cities and is composed mainly of men. The rural infected population comprises primarily women, whose infection is usually attributed to their migrant husbands. Along the border, HIV prevention projects have sprung up to raise awareness on HIV among Latinos on both sides of the border.

The Binational AIDS Advocacy Project, also known under its Spanish-language acronym PROCABI, has set up HIV-related services for Mexicans in the Californian city of San Diego and the Mexican city of Tijuana, near the US border. Prevention education activities are carried out, support groups for HIV-infected Mexicans have been set up, and other services are offered such as psychological and legal support. In both cities, a drop-in centre for migrants offers a confidential and secure location where HIV-infected migrants can receive services and counselling and where they can meet with other infected people. ❖

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HIV/AIDS awareness for migrant communities in the rural hills of Nepal

Nirmala Sharma

Nepal has begun to move away from being a low HIV prevalence country to having a documented concentrated epidemic among female sex workers and injecting drug users. As seen in other low-to-medium prevalence countries in Asia, there is a real danger that HIV will spread rapidly from these highly vulnerable groups to the general population. One of the "bridging populations" identified in this regard are Nepalese labour migrants, who frequently move between Nepal and neighbouring India. Special programmes in the source areas are necessary to make them and their partners more aware of HIV/AIDS.

Bajhang and Doti Districts are among the more remote districts of the Far Western Development Region (FWDR) of Nepal. These districts are characterized by a lack of NGOs, negligible infrastructure and insufficient reach of government programmes. Essential resources for local people's employment and livelihood are very much lacking and both districts do not produce enough food to feed their population. Also, there are high gender inequality and low literacy rates, especially among women (12%).

Given the problems described above, there is a high rate of migration, primarily among men (adolescents and adults), who leave their villages in search of jobs to support their families. A study conducted by CARE-Nepal revealed that 80-90% of households from the FWDR have at least one male migrating for work. Most of them are from low-caste strata. Anecdotal evidence suggests that a large concentration of Nepalese men from the western districts migrate to Indian cities such as Bangalore, Delhi and Mumbai.

Many migrant workers visit sex workers during their stay abroad. Having multiple sex partners and lack of condom use puts them at risk of HIV/STI transmission. Migrants are also vulnerable to infection due to their non-resident status in the host country, leading to inadequate access to awareness programmes, condom supplies and STI services. Therefore these men do not have preventive skills and knowledge to protect themselves against HIV/STIs. Similarly, the low social status of their female sexual partners, either their wives or sex workers, puts these women at risk of infection.

Hidden cases

The National Centre for AIDS and STI Control stated that 2800 cases of HIV were detected in Nepal by June 2003. Each month the average number of new cases is about 27. However, there are many more undetected cases; it has been suggested that the estimated number of people living with HIV/AIDS is almost 60,000 and the overall adult HIV prevalence rate 0.5%. A study on HIV/STI prevalence among selected villages in Doti District revealed that 10% of migrants were HIV-positive at random blood sampling. All of them had been to Mumbai for work. Among the tested men, 27-29% also suffered from some kind of STI.

A baseline study done by CARE-Nepal in 1999 demonstrated that most village men and women had insufficient knowledge on HIV/AIDS. Moreover, many health-care providers were also unaware of modes of transmission and prevention methods. There was a strong social stigma attached to HIV/AIDS among those who had heard about the disease, and no system in place to support HIV-infected people and their families.



Leaving for work to India

Targeting men and their families

CARE-Nepal, in collaboration with Family Health International (FHI), started the migrant community programme in February 2002 to reduce HIV/STI-related risk behaviours among vulnerable population groups through community-based interventions. The programme is carried out in several communities in the Doti and Bajhang Districts. CARE-Nepal is implementing the programme with two local NGOs: the Nepal Red Cross Society and Samajik Bikash Samuha (Social Development Group). These NGOs increase their reach by mobilising community associations, such as youth groups and migrant wives groups, in the fight against AIDS. The main focus of the programme is on behaviour change through massive awareness creation and increasing the accessibility of condoms at the community level.

In order to sustain activities, emphasis has been given to building organizational capacity through CARE's technical assistance to local NGOs, district health offices and health posts in close coordination with district and village development committees (political bodies at the district and village levels).

"News from home"

The programme mainly targets migrant men and their wives. The migrant workers are given orientation on HIV/AIDS and STIs, which includes education on how to prevent infection. The men are approached on an individual and group basis by peer educators trained under the programme before leaving for work to India. Attempts are also made to follow up through education at their destination sites. A small cloth bag containing leaflets on HIV/STIs, along with personal messages from the organization and the migrants' wives, is sent by mail or given to other men going to the same place. The

package, named *Gaon ko Raiwar* (News from Home), is meant to remind the men to take precautions while abroad. By June 2003, about 300 such packages had been sent to men at their work destinations. The response from quite a few migrants was quite encouraging. The men seemed to feel happy to receive letters and sexual health-related information.

A drop-in centre (DIC) at a bus stop entry point to one village in Doti District was established as a part of the programme activities. The DIC operator provides education, does condom promotion, and distributes IEC materials regularly. From the DIC, a counsellor catches up with migrant men emerging from the bus and before they proceed home. He talks to them about HIV/AIDS and STIs and hands over a small cloth bag named *Sano Upahaar* (A Small Gift) as a welcoming present. This bag contains a few condoms, leaflets on HIV/STIs, information on the places where condoms are available, etc.

Women

The migrants' wives have formed 146 groups who have been trained in both project districts. Every group has a peer educator group leader, who is approached regularly by the community facilitators of the partner organizations. They encourage and update the women with information on IEC tools and impart skills for sharing the information with their fellow group members. The group members are given a thorough orientation on HIV/AIDS and STIs, modes of transmission and ways to prevent diseases with the aim that they will educate more women in their villages. They are also expected to discuss and negotiate safer sex with their husbands when they return home.

Other activities of the community programme are:

- ❖ HIV/STI education for school teachers, female community health volunteers, school-going adolescents, participants of non-formal education groups, members of Youth Action Groups (YAG), key stakeholders and leaders in the community.
- ❖ Messages displayed in public places through wall paintings and billboards.
- ❖ Celebrations on HIV/AIDS Day and Condom Day (AIDS rallies).
- ❖ Community-based condom distribution centres

(social marketing) in all project communities. These centres are functioning very well and there are clear indications that condom use is on the increase.

- ❖ Training of health-care providers (government health centres/local NGOs) on STIs and case management through the syndromic approach, and on HIV/AIDS.
- ❖ Training of traditional healers on referring patients to STI treatment facilities and other health services.

Lessons learned

One of the major lessons we have learned is that women play an important role in the dissemination of information to their fellow villagers and their husbands. These women have become more aware of the dangers of HIV/AIDS and are more conscious of the virus and its transmission.

We have also experienced the importance of social mobilization by reaching out to local community groups through our network of partner NGOs. The partner NGOs are more capable now of managing HIV/AIDS projects at the local level. Also, their staff are more motivated to carry out such projects, which leads to more interactions and acceptance at community levels. Due to this social mobilization many people seek HIV/AIDS-related information now and are willing to disseminate this information to others.

Another lesson is that men can be persuaded to change their behaviours and practice safer sex more effectively by involving fellow men from within their villages. Any programme should give special attention to men since it is difficult for women (wives) to initiate talk about STIs and HIV/AIDS and ask their husbands to use condoms when they come home during holidays.

Other lessons learned are that it is necessary to involve local government bodies, and that a drop-in centre can be very useful in terms of increasing accessibility to services and information to the targeted people. Finally, we have found that traditional healers are important in terms of referring people to health institutions for special care e.g., STI treatment. Therefore it is essential to include them in such programmes as key persons for service delivery. ❖

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Research Notes

The impact of family housing on HIV transmission among mining communities in South Africa

Hirut Gebrekristos & Mark Lurie

Early in the history of the AIDS epidemic, there was great interest in migration and HIV/AIDS. In particular, the public health community was interested in mapping the routes of HIV infection in hopes of containing the epidemic. Similarly, governments have been and to some degree continue to be interested in migration and AIDS. The consequence of government interest has had implications for immigration in the form of travel restrictions and mandatory HIV testing. Over the years, the AIDS and migration issue has moved away from viewing the immigrant/migrant as a carrier of HIV to trying to understand how the conditions of migration facilitate HIV infection.

Several studies have shown that the migrant labour system – marked by the disruption of families and stable sexual relationships – increases the risk of HIV transmission. This issue is especially significant in South Africa where there are both high levels of movement and migration as well as high prevalence of HIV/AIDS. The mining communities in South Africa are some of the worst affected areas in the world.

Labour migration, the backbone of the South African mining industry, has a long historical presence in the most remote communities in southern Africa. South Africa has both cross-border and internal contract migration. Cross-border migrants have traditionally come from neighbouring southern African nations. Migrants coming from Lesotho, Mozambique, Malawi, Botswana, and Swaziland represent the majority of international



mine workers in South Africa. The migrant labour system in South Africa is a type of migration marked by circular patterns of movement from rural homes to work areas. This process of circular migration started as early as 1889 when the diamond mines, providing contracts of limited duration, began to house their labour force in single-sex hostels. The labour force returned home once their contract ended. Other mining sectors adopted this same strategy soon after. Although restrictive laws have been eliminated in post-apartheid South Africa, labour migration continues to be of circular nature.

Visiting home and HIV transmission

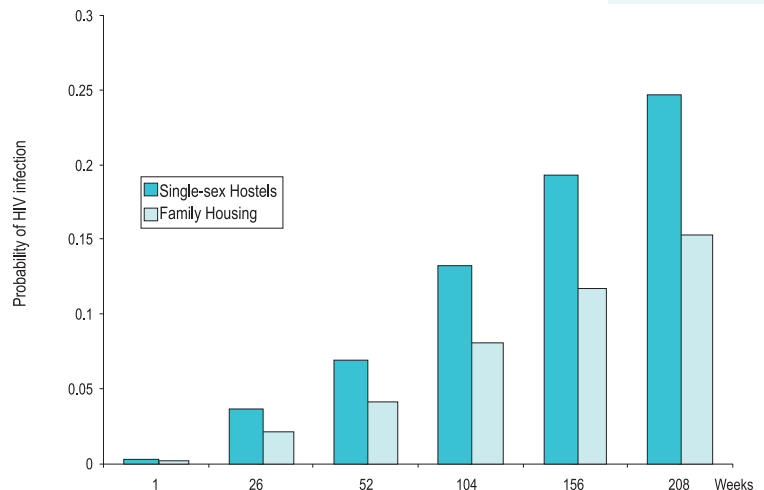
The literature highlights two distinct, but related reasons for why the migrant labour system in South Africa encourages risky sexual behaviour. The first is the separation of familial and stable sexual relationships. The second is the presence of commercial sex in mining towns. The circular nature of the migrant labour system in South Africa is not only circular with regards to labour, but it has also developed circular forms of sexual networks between rural areas and labour centres. Miners have sexual partners at the labour centres while continuing a long-distance relationship with their regular partners back in the rural areas. Although less is known about the miners' partners, there is some evidence that they also have other sexual partners while their husbands are away.

The two most common migration arrangements for South African miners are those where the men are able to return home two to four times a year and those where the men are able to return every month. In a study comparing the prevalence of HIV among men in the two migration arrangements and their respective partners against non-migrating men and their partners, Lurie et al found that the prevalence of HIV infection is lower when men spend more time at home with their partners.¹ The study also illustrates that the partners of the migrants who come home more (once a month) have the highest HIV prevalence when compared to the other partner categories. This suggests that increased visits within the context of migration could have a negative impact on partners. This may be because migrants continue to engage in casual sex while also returning home more frequently thereby putting their partners at greater risk. At the same time, the data indicates that the lowest HIV rates are found among couples that remain together year round, which suggests that establishing family-style housing may dramatically decrease the incidence of HIV among migrants and their partners.

An appeal for family housing

Based on this data, we examined how changing single-sex hostels into family-style housing would impact the HIV/AIDS epidemic. Using a mathematical model, we

were able to estimate the impact of establishing family housing on HIV transmission. This type of modelling has been used widely to understand the effectiveness of risk reduction interventions, condom use, and vaccines. Although there are many challenges to modelling the complex sexual relationships in the migrant labour environment, the model indicates that family housing has the possibility of reducing the impact of HIV/AIDS among mining communities in South Africa. Because family housing would provide the structural support to change migrants' risky sexual behaviour, we estimate that the family housing intervention can bring about a 41% reduction in HIV transmission.



Probability of HIV infection under single-sex hostels and family housing
The single-sex hostel bar represents the probability of becoming infected with HIV under the existing conditions and the family housing bar represents the probability of becoming HIV-infected given family housing. Family housing consistently yields lower values of HIV transmission than single-sex hostels².

Efforts to stabilize the workforce by providing migrants with permanent residence near the mines have historically been minimal. Most efforts discriminated against unskilled labourers and also international migrants. Although living arrangements and options are more diverse for miners than they have been in the past, family housing continues to be limited for miners. The high cost associated with family-style housing is often cited as a reason for continuing with single-sex hostels; however, the potential positive impact that family housing has on decreasing HIV transmission among migrants may outweigh any cost that is incurred by the industry and the state. ♦

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For editorial reasons, most references are left out of the article. A full bibliography is available from the authors.

Notes

1. Lurie, M, Williams, B, Mkaya-Mwamburi, D, Garnett, G, Sturm, AW, Sweat, MD, Gittelsohn, J, and Karim, SA. The Impact of Migration on HIV-1 Transmission in South Africa. *Sexually Transmitted Diseases* 2003, 30(2):149-155.
2. Gebrekristos, H. *Implications of Family Housing on HIV/AIDS Among Migrants in South Africa*. Yale University, Department of Epidemiology and Public Health, Master's Thesis, 2001.

Crossing national and sectoral boundaries in HIV/AIDS strategies – experiences from South-East Asia

Lee-Nah Hsu & Jacques du Guerny

As the saying goes, in a globalized world, "no virus is more than 24 hours away by plane". The recent emergence of SARS is a stark reminder of this unpleasant truth. We want goods and services, as well as people, to move efficiently around the world, but unaccompanied by diseases or infections. Unfortunately, societies and human beings tend to prefer to respond to crises, whether epidemics, floods or famines, rather than take action to prevent them.

However, crisis responses tend to be short-lived and limited to localised territories. It is thus not surprising to note difficulties encountered in responding to slow-moving epidemics such as HIV. Not only do people have difficulties perceiving such a long-lasting process, but established institutions are generally not designed to respond to longer-term systemic situations. This is due to factors such as territorial mandates (both spatial and sectoral) and personal ambitions that lead many people to sacrifice the common good for short-term personal gains.

When HIV was identified 20 years ago, it was first perceived to be a disease limited to gay or drug-addicted people. However, it did not take long for those working in the international arena to wake up to the fact that we were facing a global pandemic; in response, a Global Programme on AIDS was established under WHO. In contrast, the reaction of many national governments was both to acknowledge and deny this global dimension by attempting to control the movement of perceived potential HIV carriers so that HIV/AIDS presumably would not get a solid foothold in their own countries. Eventually, more and more governments began to recognize that, despite their previous claims, their own populations harboured HIV – the "few cases" were no longer limited to foreigners or national citizens who had been abroad. They admitted that the virus was moving across borders and that containment efforts at border entry points could not address the actual pattern through which HIV was spreading within countries.

Failed containment strategies

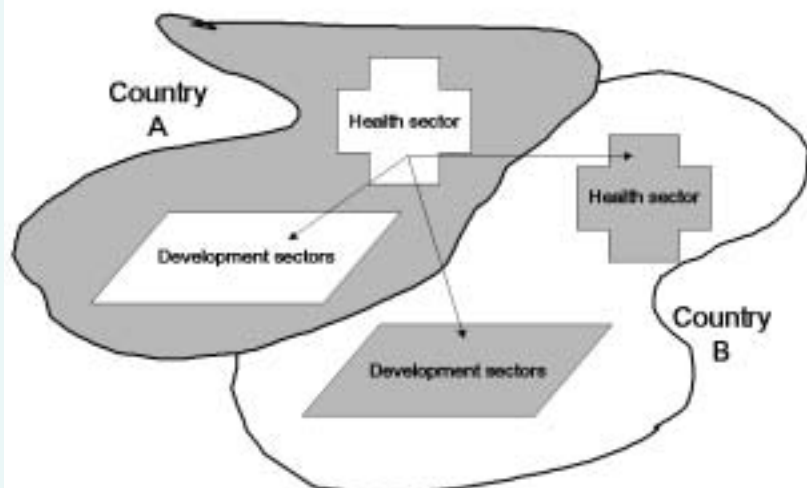
In South-East Asia, several countries attempted containment strategies, juggling with contradictions such as requiring HIV tests for visa approvals for students or migrant workers, but not for diplomats or tourists. In these cases, politics or business interests opposed public health interests. A well-known exception to this approach was Thailand, which responded to the HIV threat by reducing the vulnerability of those who could be in contact with "outsiders" (e.g., the 100% condom use strategy in brothels), reconciling both business and public health interests.

Nowadays, national AIDS programmes in that region are aware that there are new opportunities for the spread of HIV infection because of the increasing economic integration of their countries. For example, improved roads and transport infrastructure for Asian highways, coupled with economic disparities, are making zones of economic growth and opportunity irresistible destinations for millions of people. The forces of development are reshaping the societies and economies of the region. It is within such a context that national responses to HIV/AIDS must prevent the epidemic from spreading out of control.

Multisectoral collaboration

Economic integration is accompanied and fuelled by the movement of millions of people across international borders in search of economic opportunities. Communities and households are exposed to forces that overwhelm traditional resilience systems and create new vulnerabilities, leading to greater risks of exposure to HIV infection. For example, traditional crops can become impossible to market if rural farmers cannot compete with lower-priced agricultural products coming in from other areas. This results in out-migration and possible sex work to gain an income. In order to respond proactively to these new challenges, health-based strategies need to build partnerships with other development sectors as allies both in- and outside of the country (Figure). The boundaries that must be broken down are both administrative and geographic in nature; they also include boundaries between sectors.

From such a perspective, national AIDS programmes should encourage development sectors, such as agriculture, public works, law enforcement and the military, to reduce vulnerabilities and strengthen community resilience. For example, when a new road links rural communities to towns, young women may leave villages to engage in sex work while young men leave to find jobs in the cities, especially in construction but also in the sex trade. The agricultural sector can help



The health sectors of countries A and B should not only collaborate with each other, but also with development sectors

communities prevent this by introducing income-generating crops for the new markets opened up by the improved road networks: young women and men may thus have other options than the sex trade.

Such a strategy demonstrates the need to shift away from dealing mainly with "high risk groups", such as sex workers, drug users or migrant workers, to adopting a *systems* approach, in which programmes link the origin, transit and receiving communities of mobile people. They can then begin to address the different vulnerabilities of people who pass through the different communities and of people who interact with them. For example, a rural farmer's wife who stays behind to look after children and elderly family members, while her husband goes to town to seek employment during the idle farm season, would be at risk of HIV infection if her husband has unprotected sexual relations in town. If sex workers or migrant workers are targeted in isolation, other vulnerable populations, like the farmers' wives, are ignored and only a partial response to HIV vulnerability is developed.

An enabling environment

To move effectively into broader HIV/AIDS strategies, national responses need an enabling environment to negotiate with other countries and with multiple sectors within the country. Contrary to what many people think, this goal is achievable, as shown in South-East Asia. On 5 November 2001, a Summit of the heads of State of the Association of South-East Asian Nations (ASEAN) adopted a Declaration in which they decided to "*intensify and strengthen multi-sectoral collaboration involving all development ministries and mobilising... a wide range of non-governmental organizations, the business sector,*

media, CBOs, etc." They also resolved to "*strengthen regional mechanisms... to support joint regional actions...to reduce the vulnerability of mobile populations to HIV infection...and promote innovative inter-sectoral collaboration to effectively reduce socio-economic vulnerability and impact...*"

The formal language of the Declaration expresses awareness at the highest political levels of the need to be pragmatic by expanding actions beyond health strategies while joining forces regionally. The Declaration also represents a statement of commitment to support activities in this new direction. The ASEAN countries and the People's Republic of China have developed a regional strategy to reduce mobility-related HIV vulnerabilities. They agreed to collaborate not only through national AIDS programmes, but also through Ministries of Public Works and Transport, Ministries of Labour, Ministries of Rural Development, and NGOs. Such collaboration utilizes the expertise and networks of each partner. The challenge is now in implementation! ♦

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More information: *Towards borderless strategies against HIV/AIDS*, www.hiv-development.org/publications/borderless-strategies.htm; and *Brunei, Indonesia, Malaysia, Philippines, Singapore cluster country consultation on migrant workers' HIV vulnerability reduction: pre-departure, post-arrival and returnee reintegration*, www.hivdevelopment.org/publications/BIMPS-Report.htm.

Refugee youth education in Kyrgyzstan

Chikako Minei

Sexual and reproductive health care has only recently been recognised as an essential service for refugees and existing programmes frequently lack the knowledge and funds to carry out multicultural interventions. Several years ago, UNHCR and UNFPA designed a project on HIV/AIDS awareness for Tajik refugees in Kyrgyzstan in co-operation with the Kyrgyz Family Planning Alliance (KFPA), the implementing agency since 2001. This programme proved to be very successful and is currently being expanded to other areas of the country and other target groups.

The Kyrgyz Republic (Kyrgyzstan) gained independence from the USSR in 1991 and is now a member of the Commonwealth of Independent States (CIS). Situated in the north-eastern part of Central Asia, Kyrgyzstan has borders with Kazakhstan, Tajikistan, Uzbekistan and China. Its population numbers 5 million people, of whom 64% are Kyrgyz, 14% Uzbek and 13% Russian. Islam (75%) and Russian Orthodoxy (20%) are the major religions.

As a result of the 1992-95 civil war in neighbouring Tajikistan and continued internal chaos in Afghanistan, thousands of people fled to Kyrgyzstan in search of refuge. In 2000, a small number of Chechen asylum-seekers began arriving in Kyrgyzstan fleeing from internal conflict as well. In June 2003, there were 6644 Tajik refugees, 759 Afghan refugees and 521 Chechen asylum-seekers registered with the Department of Migration Services (DMS) under the Ministry of Foreign Affairs. Refugees in Kyrgyzstan experience problems in the socio-economic sphere, particularly with respect to access to social services, education and other benefits. The vast majority are unemployed and lack a stable source of income.

HIV/AIDS awareness project for refugee youth

Over the past few years, HIV/AIDS has become a critical issue in Kyrgyzstan, although it is still a low-prevalence country. In April 2003, there were 349 registered HIV cases in the country. However, the estimated number is much higher than the officially registered cases. It is important to note that, so far, no refugees have been reported HIV-positive and it is vital to maintain this favourable situation. In August 2001, UNHCR, UNFPA and KFPA implemented a joint pilot HIV/AIDS awareness project to preserve the reproductive health of refugees. The project focused on Tajik refugee youth aged 14-20 years in northern Kyrgyzstan, who have little or no opportunity to receive information and education on HIV/AIDS and reproductive health through the national system. In addition, the project worked to reduce STI infections and to encourage family planning.

Implementation arrangements were taken step by step. Before the pilot was carried out, KFPA conducted a survey to estimate the youth's level of knowledge on HIV/AIDS and reproductive health. The survey showed that they did not have sufficient and correct information on the subject.



Many young women do not receive sufficient information on reproductive issues

Photo: Mark Read (markread.photo@virgin.net)

Initial lack of acceptance

At the beginning of the pilot project, refugee parents were reluctant to allow their children, particularly daughters, to participate in the programme. According to their cultural values, it was shameful to show and provide contraceptives such as condoms to children and many parents considered the subject of sexual health an unnecessary and unwanted topic. One solution to change these attitudes was to involve refugee leaders in the programme and educate them on the advantages of youngsters having knowledge of their bodies and sexual health. KFPA contacted local NGOs to identify refugee leaders in local communities. Programme staff visited the leaders and explained the project's aims and how the organization planned to conduct the programme.

Initially, the leaders expressed their disapproval due to the taboos surrounding the subject matter. In the end, persevering clarifications by KFPA staff motivated them to attend meetings in 2002. After attending these consultations, the leaders positively influenced refugee parents to permit their children to attend the sessions. In 2002, the parents also participated in separate meetings, which eventually resulted in greater understanding of, and support towards, the KFPA project.

From the lessons learned during the pilot project, all parties realised that working with leaders has significant importance since they have direct influence on and authority in the refugee communities. Involving them in the programme and educating them about HIV/AIDS built trustworthy relationships between the leaders and the programme staff, so that KFPA could smoothly provide seminars and trainings to refugee youth. A post-project survey, conducted after the refugees participated in consultations and trainings, demonstrated a significant improvement in their knowledge on HIV prevention and reproductive health.

Expansion

During the pilot project, KFPA had received many requests from the local population to participate in such a project. Given the success of the pilot initiative, a follow-up project took place in 2002. This project was implemented with three important changes. First, it was expanded to the southern part of

Kyrgyzstan, in areas with large refugee populations; second, local people were encouraged to participate in the programme as well. Finally, the targeted age group was extended to 35 years. In 2002, a small number of Kyrgyz people, comprising 3% of the total beneficiaries, attended consultations/trainings with the refugees.

Several full-day meetings were organised for two different age groups: 14-20 years and 21-35 years. Approximately 20-25 refugee and local youth participated in each meeting. Many young people attended several of these consultations. For increased effectiveness, consultations were conducted in the Kyrgyz language only since the vast majority of Tajik refugees are ethnic Kyrgyz and they speak the language fluently. During the consultations, several handouts (brochures and booklets on HIV/AIDS prevention and awareness, reproductive health and family planning, etc.) in Kyrgyz and Russian were distributed.

Peer education

Each consultation was based on peer education and led by three trainers – an experienced KFPA trainer and two refugee trainers who had been selected and trained during the 2001 pilot project. The meetings were conducted for male and female groups separately, and were taking into account the participants' varied religious and ethical values and different cultural backgrounds. The dominant religion of Tajik refugees is Islam and, in general, there is no discussion on sexuality among them. All participants were Muslims.

During the consultations, KFPA and the refugee trainers received a considerable number of questions regarding these subjects, a clear proof of interest and the importance of the issue for refugee populations who had not had an opportunity to receive information about sexual health issues before. As a result of the programme, refugee youth became more interested in subjects such as HIV prevention and awareness, contraceptive methods and other issues related to sexuality.

Approximately 1400 refugees benefited from the projects in 2001 and 2002 during four training workshops and 59 consultations throughout Kyrgyzstan. We feel that this programme has had a significant impact, not only on the refugee participants, but also on their communities and local populations. The participants can act as resource persons and peer educators and provide further information and education to those who have not had such an opportunity. This could be the first step toward mobilizing their communities on the issue of HIV/AIDS.

Positive attitudes

After implementation of the second project, many participants expressed a positive attitude towards the programme and a better understanding of the subject. More importantly, they expressed their wish to continue the programme in the near future. As a result, KFPA decided to continue its activities for refugees in 2003. The target group of the new project includes Afghan refugees and Chechen asylum-seekers in Bishkek and its suburbs. Tajik refugees in Chui (north) and Osh (south) provinces who have not been involved in the programme in the last two years will be provided with seminars and consultations as well.

In total, there will be 26 consultations provided throughout the country in 2003, and community focal points will be set up in 16 villages with a high refugee population. Work will have to be done to break down the socio-cultural barriers that still affect the full acceptance of these projects by some groups in the beneficiary communities. To this end, KFPA will work directly with refugee leaders from the early stage of project implementation. ♦

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Reproductive health services for internally displaced people in Sri Lanka

Atula Nanayakkara & Samantha Guy

While there are indications that reproductive health services are starting to become more available in certain conflict-affected settings, people displaced within their own countries are often unable to access such services. With the assistance of Marie Stopes International, an international NGO that supports initiatives to improve reproductive and sexual health, Population Services Lanka (PSL) has carried out a project to provide integrated reproductive health care to communities affected by armed conflict in the northern and eastern parts of Sri Lanka.

Sri Lanka has experienced armed conflict for over two decades since the Liberation Tigers of Tamil Eelam (LTTE) launched a civil war against the Sri Lankan government with the aim of establishing an autonomous Tamil state in the Northeast of the country. According to Human Rights Watch, the war has claimed over 64,000 lives and displaced more than one million people. In February 2002, the government of Sri Lanka and the LTTE signed a Memorandum of Understanding for a long-term ceasefire. By 2003, more than 230,000 internally displaced people (IDPs) had spontaneously returned to their home villages but an estimated 800,000 remained scattered throughout the country. Despite the ceasefire, continued outbreaks of violence cause ongoing displacement.

The government aims to provide primary health care and basic curative medicine for all Sri Lankans at their nearest health institution. However, this approach effectively excludes vast number of IDPs who are settled in informal camps and communities or in remote areas. Most IDPs have limited or no means of transportation, which also affects their ability to access government services. In response to the needs of the displaced population, PSL began working in IDP communities in 1995 and currently provides clinic and outreach services in six regions of the country (Vavuniya, Puttalam, Anuradhapura, Trincomalee, Ampara and Mannar). This programme is part of the Marie Stopes International Global Partnership Initiative and supported by DFID and the European Commission.

Overall, the majority of the people served by the programme are Tamils. The vast majority of those served by the Mannar, Vavuniya and Trincomalee clinics are Tamils. The majority served by the Puttalam and Ampara clinics are Muslims and the majority served by the Anuradhapura clinic are Sinhalese. There are significant cultural and religious differences between these groups; Tamils are generally Hindus and are Tamil-speaking, as are the Muslims. Most Sinhalese are Buddhists and speak Sinhala.

Stationary and mobile clinics

Prior to establishing services among the displaced populations, extensive consultations were held with communities at refugee welfare centres and in resettlement areas, with local and international agencies, and with relevant government officials at the national, regional and district levels. In addition to stationary clinics situated in main towns, mobile clinics were set up to facilitate access to the greatest number of people. The mobile units based at each of the clinics serve a radius of 60 km, ensuring that the teams cover no more than 120 km in a round trip. At the height of the conflict this was an essential measure to ensure the clinic teams' safety. In addition to clinic staff, community health promoters from the IDP communities are attached to each clinic.

In the initial stages of the project, many clients came mainly for primary health care services, reflecting the poor health status of the IDPs. However, this provided the opportunity to reach a much wider audience for reproductive health, including typically hard-to-reach target groups such as adolescents and men. All the team members were trained with a strong reproductive health focus, which meant that during general health treatments they could identify clients who might be in need of reproductive health services. Services provided through the stationary and mobile units include antenatal and postnatal care, a full range of temporary and permanent family planning methods, and the prevention and management of STIs.

In addition to service delivery, the programme includes extensive health education that covers nutrition, recognising and conserving clean water, disease transmission, gender awareness, family life education, contraception, pregnancy and STIs including HIV. IEC activities are undertaken in a range of settings, including schools around the camps and with a variety of beneficiaries, including female community health volunteers, young people and community leaders. The community health volunteers are supported by the government but PSL also undertakes training and capacity building with them.

Lessons learned

PSL has implemented the programme in line with international best practice, following guiding principles laid out in *Reproductive health in refugee situations*, a field manual produced by the Inter-Agency Working Group on Reproductive Health in Refugee Situations. These principles include: community participation, quality of care, integrated services and IEC activities.

Community participation underpins the programme and has been essential to its successful development. A number of approaches have enabled PSL to achieve effective community participation. Setting up and training Health Committees in each IDP camp/settlement allowed the committees to become a key voice of the IDP community. The committees enable PSL teams to receive crucial feedback regarding IDP needs, including appropriate operating times for each community (e.g., for Muslim communities Sunday is an appropriate day to access services, while this is not the case for other IDP communities).

A second major feature of the programme is the identification and training of Community Health Promoters (CHPs) from IDP communities. These educators play a major role in raising awareness of reproductive health and acting as co-ordinators for the outreach service teams. The CHPs receive initial training covering basic health and first aid, maternal and child health, and reproductive health information. The modules

are prepared in collaboration with the Ministry of Health. Through the initial training programme and regular refresher training sessions conducted by PSL, the CHPs build up a great deal of knowledge on reproductive health care, general primary health care, hygiene and sanitation. They will take this knowledge with them when they are able to move back to their areas of origin, along with any training materials they have used during their attachment to the programme.

Another important facet of the programme is the inclusion of all the affected communities including the local host population. In many settings, agencies are mandated to serve a particular group of people, often to the exclusion of communities in the vicinity. This can cause resentment and lead to an increase in tensions. In addition, excluding sections of the community, particularly in situations of ethnic conflict, can lead to suspicion and repercussions for service providers. Thus, PSL developed its programme to ensure the inclusion of all the communities, including the local host population.

Services are provided in a manner that is appropriate to all clients, whether at stationary clinics or mobile settings. The PSL project teams comprise medical and other staff from host and IDP communities to ensure the linguistic and cultural appropriateness of service delivery. In addition, this contributes to a reduction in ethnic tensions between the communities as well as offering a model of how ethnic differences can be overcome.

Working towards sustainability

In many conflict settings, fighting may continue for decades, making it very difficult for displaced populations to return home. Projects are therefore rarely short-term and consideration should be given from the outset to the longer term impact and sustainability of interventions. PSL has established a financially, socially and culturally sustainable programme through:

- ❖ close collaboration and coordination, including provision of training, with both government and NGOs to prevent gaps in services and avoid duplication
- ❖ charging locally appropriate service fees with provision of subsidised fees to ensure accessibility to all
- ❖ employing staff, particularly CHPs, from the IDP community to ensure the cultural appropriateness of services and to ensure continuation of health provision on eventual return to home
- ❖ providing reproductive health services within an integrated health setting to allow clients to seek out reproductive health services in a confidential setting, thereby increasing acceptability. ❖

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- ❖ *Population mobility and AIDS* (2001) is a UNAIDS Technical Update (16 p.). It is available in English, French, Spanish and Russian. Order information: UNAIDS Information Manager, 20 avenue Appia, CH-1211 Geneva 27, Switzerland, e-mail: unaids@unaids.org. Also available online: www.unaids.org/publications/documents/specific.
- ❖ *HIV prevention and care in resource-constrained settings: Handbook for the design and management of programs* (2002) a Family Health International publication, offers one chapter (No. 10) on programmes for mobile populations and their partners. Available online: www.fhi.org/en/HIVAIDS/Publications/HIVAIDSPreventionCare.htm.
- ❖ *Mobile populations and HIV/AIDS in the Southern African region* was launched by IOM and UNAIDS in May 2003. This review outlines HIV/AIDS vulnerability factors, policies, and programmes across eight Southern African countries concerning: military personnel; transport, mine, construction and agricultural workers; informal traders; domestic workers; refugees and IDPs. Hardcopies are US\$ 32; order through IOM website: www.iom.int. Also available online: www.sarpn.org.za/documents/d0000365/index.php.
- ❖ *Spaces of vulnerability: migration and HIV/AIDS in South Africa* (2002), published in the Migration Policy Series of the Southern African Migration Project, explains the relationship between mobility and the spread of HIV/AIDS. Available online: www.queensu.ca/samp/publications/policyseries/Acrobat24.pdf.
- ❖ Various publications on HIV/AIDS and mobility/mobile population groups in English and South East Asian languages can be found at the website of the UNDP South East Asia HIV and Development Programme (SEAHIV): www.hiv-development.org.

- ❖ *A Toolkit for HIV prevention among mobile populations in the Greater Mekong Subregion* was published by UNDP SEAHIV and Asian Development Bank in 2001 to guide the management and implementation of HIV prevention programmes. The toolkit addresses ways to work with mobile groups of construction workers, truck drivers, seafarers and migrant sex workers. Available online: www.hiv-development.org/publications/tool-kit.htm.
- ❖ Several organizations (UNDP-SEAHIV/UNESCAP/UNAIDS/SMA/CIDA) developed a computer-based training tool for the maritime industry (mainly targeting seafarers) which can be used by maritime training institutions. The CD ROM *HIV/AIDS: Be Safe Not Sorry* is available on request to hivsea@undp.or.th.
- ❖ CARAM-Asia (Coordination of Action Research on AIDS and Mobility), an international network of organizations in 11 countries in South and South East Asia, published a seven-part booklet series on the issue of pre-departure, post-arrival and reintegration programmes for labour migrants in 2002. For more information: <http://caramasia.gn.apc.org>.
- ❖ *Research for sex work* is an annual publication on HIV prevention and health promotion for sex workers. The 2002 issue was on the theme of "Health, HIV and sex work: the influence of migration and mobility". It is online available in English and Spanish: www.med.vu.nl/hcc.
- ❖ The theme of *Sexual Health Exchange* 2000/2 was "The influence of conflict and war on sexual and reproductive health." In that edition several articles can be found on the health of refugees and internally displaced people, including country examples from Kenya, Lebanon, Mexico, Sudan, Tanzania, etc. Available online: www.kit.nl/exchange.
- ❖ The Reproductive Health Outlook website offers links to organizations and resources that address reproductive health for refugees: www.rho.org/html/refugee_links.htm.

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