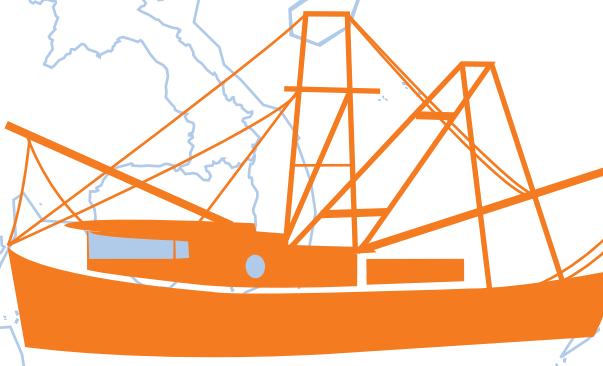
Protecting People on the Move:



Applying Lessons Learned in Asia to Improve HIV/AIDS Interventions for Mobile People

USAID

fhi Family Health International

Impact Implementing AIDS Prevention and Care Project

Acknowledgement

This document was developed by Family Health International and authored by David Lowe and Caroline Francis.

Thanks to Sara Hersey, Robert Kelly and Nigoon Jitthai for useful comments and to FHI and its regional and local implementing partners particularly in Nepal, Vietnam, Cambodia, Lao PDR, and Thailand who commit to providing quality services to mobile and migrant people and for sharing their experiences and lessons learned on which this document is based.

ISBN: 974-94322-6-6

This document was developed with the funds from the United States Agency for International Development (USAID) through the Implementing AIDS Prevention and Care (IMPACT) Project (Cooperative Agreement HRN-A-00-97-00017-00).

This document is printed with the support of the Canada South East Asia Regional HIV/AIDS Programme (CSEARHAP) (www.csearhap.org), which is funded by the Canadian International Development Agency (CIDA).

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communications
FHI	Family Health International
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use or Injecting Drug User
NGO	Non-government Organization
STI	Sexually Transmitted Infections
VCT	Voluntary Counseling and Testing

Protecting People on the Move:

Applying Lessons Learned in Asia to Improve HIV/AIDS Interventions for Mobile People

Key Definitions

What is mobility and migration?

Mobile people are those who move from one place to another, temporarily, seasonally or permanently for either voluntary or involuntary reasons. It is a broad term that describes the full range of mobility, from short-term movement (e.g. truck drivers) to longer term or permanent relocation.

Migrant is a more specific term that is used for those mobile people who take up residence or remain in another place for an extended period of time, including seasonal migrants. ***Internal migrants*** move from their homes to other places within the same country. ***External migrants*** are people who cross international borders and live in a foreign country.

External migrants can have ***legal status,*** which means the host government permits them to stay or work, or they may be ***undocumented,*** which means they do not have official documents to allow them to stay in the host country.

Mobility may be ***voluntary***—for work or exploration purposes for example—or it may be ***involuntary,*** as a result of coercion, trafficking, or poverty.

People affected by mobility
People who are **not** mobile may also be vulnerable to HIV and its impacts. For example, those who live in places mobile people pass through or settle may be at risk of infection through interactions with mobile people. When mobile people return home with HIV infection, their source community may experience the impacts of the disease.

Refugees and displaced people
This document does not specifically deal with the special HIV prevention needs of refugees and people who are displaced by natural disasters, war and political events. However, some of the information presented here may be adapted for use with these groups.

— Compiled from
The United Nations Task Force on
Mobility and HIV Vulnerability Reduction.
Strategy on Mobility and HIV Vulnerability Reduction
in the Greater Mekong Subregion, 2002-2004.

Mobility and HIV/AIDS

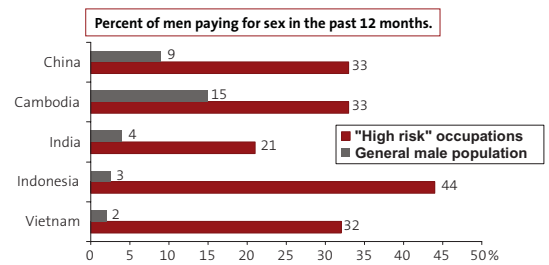
In today's world, people are on the move more than ever before. Recent figures count some 170 million migrants currently living outside their country of citizenship. Even greater numbers of people move within their own countries or travel temporarily every year. The reasons people move are varied—some voluntary, some not. They include socio-economic motives, occupational pursuits, exploration, exploitation and displacement as a result of conflict, disaster, or national policies.

While mobility is not a definitive risk factor for HIV/AIDS, some mobile people are especially vulnerable to the disease. Factors such as loneliness, separation from regular partners, higher income, peer pressure, and freedom from the control of families and social norms encourage mobile people to take risks—like engaging in unsafe sex or illicit drug use—that leave them vulnerable to HIV. Sexual health and HIV/AIDS education, health services, and commodities may be rendered inaccessible as a result of cultural and linguistic barriers, unfamiliarity with the area, undocumented or "hidden" status, or the simple unavailability of such services or products in the area. Even when services do exist, they are often targeted to local populations, with few resources directed to mobile people.

Mobile people may be marginalized, and subject to discrimination, exploitation and harassment at various stages of the mobility process. They may have little social or legal protection, and little participation in the host community. All of these factors increase a person's vulnerability to HIV and augment the challenges of living with HIV/AIDS.

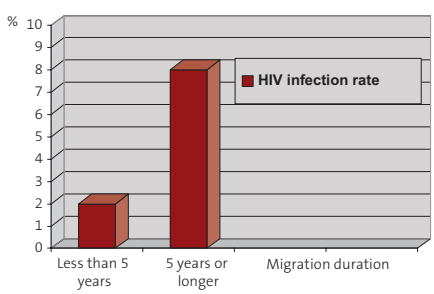
Some studies suggest that mobile male populations tend to be at higher risk than the general male population and that the vulnerability is also related to the length of migration.

Mobile men tend to be at higher risk than the general male population.



Notes: High risk occupations include truck drivers, police and sailors.
Sources: National BSS; Bui Pham, et al 2001; Riono2001; Parish, Laumann et al 2003

The longer the migration period, the more they become vulnerable



Source: New ERA. 2002

Experiences from the Field

Family Health International (FHI) is a recognized leader in HIV/AIDS prevention, care and support efforts around the world. Through USAID-funded global initiatives such as AIDSCAP and IMPACT Projects, FHI and its partners have targeted those who are most vulnerable to the disease. FHI's work with mobile people in Asia began since early 1990s, with HIV/AIDS prevention programming and surveillance among truckers in India and Nepal. Since then, FHI has pioneered a number

of regional and single-country mobility and HIV/AIDS initiatives across South and Southeast Asia. In this document, we recount some of our experiences, lessons and themes that have emerged from over a decade of mobility and HIV/AIDS programming in the Asian region.

Understanding the Mobility Process

Population movement is complex and dynamic. Understanding how it works and how it changes provides a starting point in planning, implementing and refining mobility and HIV/AIDS interventions.

Understanding the mobility process is a crucial first step for planning, implementing, and refining mobility and HIV/AIDS initiatives. The International Organization for Migration (IOM) has devised a particularly useful framework for understanding the mobility process, which is highlighted below. We have added elements that need to be further understood in order to assess levels of vulnerability and to develop appropriate interventions.

Source – the place where people originate. It is important to understand why people leave and/or return, what relationships they maintain at home while they are away, and who fulfills their roles once they leave. Implementers should also strive to identify the HIV prevalence in the source community, the kinds of HIV/AIDS services available, and the levels of HIV/AIDS knowledge and risk behaviors among mobile people and other members of the community.

Transit – the places people pass through. Understanding how mobile people travel, how they behave and how they interact with others while traveling is important in gauging their level of vulnerability. It is critical to understand how long people stay in the transit point and what opportunities exist to reach them; how they behave and interact with others in transit and those who live in transit points; what health services exist in the area(s) and whether or not they can access them. Ascertaining the existence or likelihood of a local HIV/AIDS epidemic also will help to prioritize intervention sites.

Destination – where people reside, either for the short or long term. Understanding the mobile person's living and working conditions in the new place, the responses of the host community, risk behaviors of the populace, and the availability or accessibility of STI/HIV/AIDS services is crucial for developing or refining appropriate interventions.

Return – the communities to which people return. Learning about mobile people's families and social networks and their access to resources is crucial here. One needs to understand the changes that have occurred in mobile people's lives, and the conditions they find upon their return. Also important is ascertaining the HIV/AIDS knowledge levels of the populace; protective behaviors; the attitudes towards those living with or affected by the disease; and the prevention, care, treatment and support needs of the community.

Since population movement is fluid, effective HIV/AIDS responses ideally should address the particular needs and vulnerabilities of

mobile people at each stage of the mobility process. In practice, however, it may be necessary to confine interventions to one or a few strategic sites due to priority setting and funding limits.

Identifying Risk Environments and Vulnerable Populations

Strategic information can tell us which mobile populations are at risk and why; how best to work with them; and which geographic areas are epicentres of risk behaviors and HIV.

Research is important. It helps us select sites, discern the needs and vulnerabilities of mobile and stationary populations, identify HIV risks and impacts in targeted areas, and design effective interventions. FHI has utilized a variety of different research methodologies for our work with mobile people. They include behavioral and epidemiological surveillance; knowledge, attitudes and practices (KAP) surveys; participatory action research (PAR); participatory learning and action (PLA) approaches; mapping; ethnographic research; and situation assessments. To gather information on hard-to-reach populations, like mobile people, a variety of qualitative and quantitative approaches seem to work best. Research that can be done rapidly, at various times over the project cycle, and in a manner that is sensitive to the needs, concerns and well-being of mobile people, is ideal.

Prioritizing Sites

When gathering information on potential sites, it is important to note that some environments fuel the spread of HIV or create conditions that make mobile people and host populations more vulnerable to HIV. These places should be given priority in choosing sites for interventions. They can be described in the following ways:

Hot spots – are specific sites such as border towns, urban economic hubs, and large work sites (e.g. mines) that have high levels of HIV infection and the potential for rapid and widespread HIV transmission. Hot spots bring together mobile people from a wide range of places, and usually have entertainment and sex establishments where HIV risk behaviors take place. Hot spots can be destination points for some mobile people and transit points for others.

Risk zones – the risk of HIV can exist in a zone through which large numbers of mobile people pass. On a highway, for example, there may be a number of places where risk behaviors occur, including truck stops, bus stations and marketplaces. Because people are mobile, the risk of infection is often not confined to just one or a few sites, but can exist at many places in a risk zone. The type of risk behaviors and the extent to which people engage in them vary from one place to another within the zone. Understanding what kinds of risk practices occur in different places along a risk zone will facilitate the identification of priority intervention sites.

Identifying Intervention Sites in Nepal

In Nepal, FHI studied how people moved between Nepal and India to identify important intervention sites. Some 600,000 to 1.3 million Nepali males migrate each year to different places in India for seasonal and long-term work. While many of these people travel to and from border areas, others leave their interior Nepali communities to find employment in a few large Indian cities. Such movement is especially pronounced in the far western region of Nepal. By understanding how people move, and when and where they travel, FHI was able to identify important intervention sites, and exclude other areas where movement was low.

"I'm not afraid of AIDS, I'm afraid of no sex"

Socheat (false name), a 21-year old motor taxi driver in the border area of Koh Kong, Cambodia, makes his point passionately. "People living in Koh Kong do not fear AIDS," he cries. "They fear not having sex."

Socheat is not alone. CARE International's participatory research with Khmer motor taxi drivers in Koh Kong found that many of these men had an inadequate knowledge of STIs and HIV/AIDS, and engaged in high-risk behaviors that left them vulnerable to the disease. To better understand their health needs, CARE outreach workers met with various motor taxi drivers and discussed their lives, their work, and their leisure pursuits. The drivers detailed their health concerns and their dreams for the future. They also elaborated on their knowledge of HIV/AIDS, their use of condoms, and their STI/HIV/AIDS education needs. CARE used the information to develop HIV/AIDS prevention activities in the FHI-sponsored Border Areas HIV/AIDS Prevention Project, or BAHAP. Over the course of the project—between 1998 -2000—motor taxi drivers became key sources of STI and HIV/AIDS information for their peers, families and customers.

Major construction sites – the development of roads, dams and other large projects can have major impacts on the surrounding communities. HIV prevalence rates may rise dramatically as a result of increased trade, transport and mobility of populations, if the latter is accompanied by risk practices.

Source communities – people in source communities may have little knowledge of HIV/AIDS, nor the life skills necessary to protect themselves from the virus. The burden of caring for mobile people who return with HIV/AIDS also may be beyond the community's capabilities and resources.

Studying the pattern of movement of mobile people—where they come from, where and how they move, and where and how long they stay—will help us determine potential intervention sites. Deciding where to intervene may also be ascertained through an examination of STI and HIV/AIDS rates in specific areas. By assessing the levels of infection among both mobile people and the local populations, and examining the extent to which risk behaviors are occurring, one can begin to assess the impact of HIV/AIDS and the potential for HIV spread.

Before the final site selection is made, however, it is important to look at some practical issues that will undoubtedly affect the ease by which we introduce or implement project interventions. These issues may include:

- The degree to which local stakeholders support the initiative, and the extent to which they cooperate with one another and with us;
- The existence of implementing partner agencies or groups working in STI/HIV/AIDS prevention, care and support, or other related areas and the services they provide;
- The potential for changing the environment through policy and advocacy interventions;
- The capacity levels of the implementers, and the ability to provide technical assistance to those at the site; and
- The degree to which the interventions are sustainable following the end of the project funding cycle.

While the decision on where to intervene may not be based solely on these factors, thinking about them will help identify possible barriers and facilitate potential solutions.

It is important to note that each site is different. Care needs to be taken to examine why an intervention is needed in a particular site. Remember that **not all sites where mobile people transit or live are risk areas for HIV.**

Identifying Vulnerable Populations

Learning about the HIV/AIDS needs of mobile people

Assessing the HIV/AIDS prevention, care and support needs of mobile people is not always easy. Mobile people may be difficult to access or identify, particularly if they are internal migrants, transient movers or undocumented workers. There also may be limited statistics or other

research that describes their risk behaviors or outlines the prevalence of STIs and HIV/AIDS in their communities.

Time and flexibility are essential to allow us to learn about the needs of mobile people. Research methods that encourage mobile people to express their own views, experiences and perceptions are ideal. Participatory methods, such as Participatory Learning and Action (PLA), can provide opportunities for mobile people to discuss and analyze issues that are important to them, and identify solutions that respond to these issues. To facilitate these interactions, the establishment of trust is crucial, but may prove difficult if mobile people are unable, afraid or too busy to talk to project implementers. In these cases, it may first be necessary to collect information on key problems in the community, and identify possible entry points. Implementers may find it preferable to gather supplemental information from others who are in contact with mobile people and can identify their needs and vulnerabilities. Repeated contacts with mobile people—at times and places that are convenient to them—also will facilitate trust and allow for more comprehensive interactions. However, with highly mobile groups, recurring exchanges may be difficult to achieve.

Other data collection methods—particularly those that can rapidly generate useful information—provide alternative opportunities to learn about the lives of mobile and stationary populations. In Lao PDR, FHI trains outreach workers to conduct a simple monthly assessment of the size of the population of prostitutes in the intervention sites when they conduct outreach activities. This allows the program to monitor changes in the number of prostitutes and the turnover rate which help us to estimate the number of outreach workers that are needed and how often we need to start repeating BCC educational themes. Where resources and time permit, FHI advocates the use of both qualitative and quantitative approaches to identify vulnerable populations. Existing data about the site and/or the target populations should be used to establish or augment what we know. However, one must be careful that any research—new and existing—avoids making assumptions about mobile people's vulnerabilities and needs, and involves them meaningfully in the development of interventions that seek to improve their lives.

Targeting most vulnerable groups

Research conducted by FHI and its partners across Asia note that some mobile and stationary groups may be more vulnerable to HIV/AIDS than others. **Mobile women,** who make up an increasing proportion of mobile population groups in Asia, are often more vulnerable than their male counterparts. These women, as well as **women partnered with mobile men,** may have little access to sexual health services, and may lack the negotiating power to prevent unwanted and unsafe sex during travel and at their destination. Some may be subjected to sexual violence or exploitation. For women living with HIV and AIDS, unequal access to HIV/AIDS treatment and care, and the challenges of caring for others and running the household, further increase the difficulties of coping with the consequences of the illness.

By ensuring that gender considerations are incorporated into the project assessment and design, we can identify the sometimes hidden vulnerabilities of women, particularly those that may not be mobile themselves but who have mobile male partners. Incorporating positive

Some Research Highlights

- In Thailand, seafarers draw **social maps** that detail the number and kinds of boats at the dock; the numbers of crew; and the ethnic backgrounds of the crewmembers. The Program for Appropriate Technology in Health (PATH)—through funding provided by FHI—has used the information to roughly determine the size of the fishermen population and the extent of their program reach among an extremely mobile population group.

- **Surveillance data** in Lao PDR found that not all cross border migrants traveling from this low prevalence country to higher prevalence Thailand were at risk for HIV. The research—funded by FHI and implemented by Chulalongkorn University and the National Committee for the Control of AIDS Bureau in Lao PDR (NCCAB)—pinpointed source, transit and destination areas, occupations, migration flows, risk behaviors and points of access.

- Vulnerable men who have sex with men (MSM) have been identified in Vietnam through a **"capture-recapture" research methodology.** This approach allows us to estimate the size of hidden or difficult-to-reach populations. It works by first "capturing" the target group in one area by giving them an educational brochure and counting the numbers of brochures distributed during that time period. Two weeks later, the researchers return to the same area at the same time and "capture" a second sample of people. By equating the two samples, the size of the population can be estimated.

Are all mobile people equally at risk for HIV?

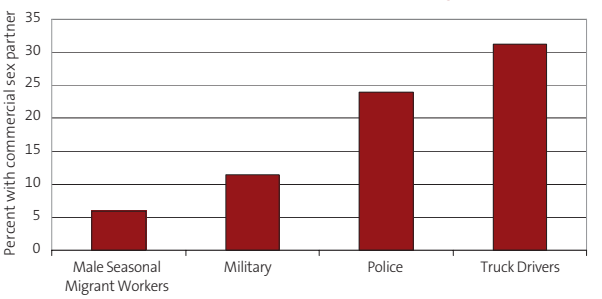
It is often assumed that all mobile people and those living in border areas are at high risk for HIV. Behavioral surveillance in Lao PDR has shown that only 6% of mobile male seasonal laborers report having a commercial sex partner in the past 12 months, compared to 12% of military personnel, 24% of police and 31% of truck drivers. While the majority of HIV cases in Lao PDR are linked to mobile men working in Thailand, this data indicates that Lao truck drivers are a high priority group, but male seasonal migrants are not. Similarly, behavioral surveillance in Cambodia indicates that military personnel at border sites have fewer commercial sex partners compared to national military personnel. Such statistics suggest that we should not make assumptions about who is at risk. Where possible, existing research results should be examined or small scale studies conducted before interventions are introduced.

gender roles and relationships in our messages and materials—and equipping women with the life skills necessary for the protection of their sexual health—is crucial to make our interventions more effective, and to stimulate communities to respond to wider issues of gender inequality. In the case of female migrants, it also may be necessary to focus our education and advocacy efforts on various gatekeepers—such as brothel owners, police officers, and agents—to make the mobility process safer for these women.

Besides mobile women, **undocumented migrants** may be particularly vulnerable to HIV. They may be forced into unsafe working and living conditions and be exploited for meager wages in their destination countries. They may speak a different language and hail from a different cultural background. Most importantly, undocumented migrants often lack the power, resources and access to information and services to protect themselves and their partners from the impacts of HIV/AIDS. Accessing and working with undocumented migrants is difficult; in some cases, interactions with undocumented migrants may have negative implications on themselves and on program implementers. Approaching undocumented migrants with sensitivity is crucial. So too is creating, facilitating and advocating for an environment that –

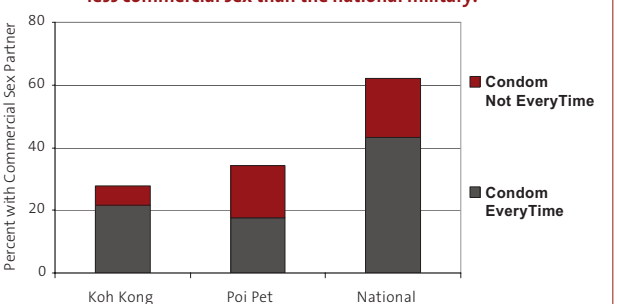
- Addresses the factors that increase the vulnerability of undocumented migrants;
- Increases access to essential information, commodities, services and programs; and
- Empowers undocumented workers to respond to the impacts of HIV/AIDS.

Male seasonal migrants from Lao PDR had fewer commercial sex partners than other male groups.



Source: Lao PDR BSS conducted by FHI and NCCA, 2000-2001

Cambodian military at border areas had less commercial sex than the national military.

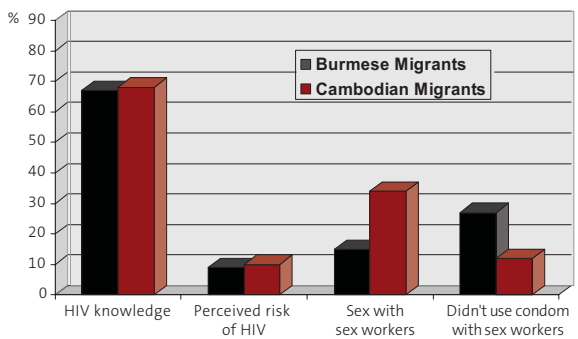


Sources: Border Area BSS conducted by FHI, OPTA and NCHADS, 1999-2000
Cambodia BSS conducted by NCHADS with FHI, 1999

Another group, often overlooked by HIV/AIDS and mobility implementers, are **internal migrants.** Across Asia, men and women move within their home countries for short or long term periods. Large cities and major work sites frequently attract internal migrant workers from the provinces. Away from the social restrictions in their source community, internal migrants may engage in risk practices that leave them vulnerable for HIV. They may bring HIV/AIDS home to their source communities, often without even knowing it. Reaching internal migrants is difficult, as they may not be easily identified among the general population. Such difficulties may be overcome by concentrating on workplaces (e.g. construction sites or factories) or occupations with high numbers of internal migrants.

Like the groups mentioned above, there are undoubtedly many other mobile people who are vulnerable to the impacts of the disease. Recognizing that particular groups of mobile people have unique vulnerabilities is important. However, we must not assume that all female mobile groups, undocumented migrants and internal mobile populations will equally be at risk for HIV/AIDS. Remember that **not all mobile people are vulnerable to HIV/AIDS, nor are particular groups in different areas equally at risk.** One needs to conduct assessments to learn about the HIV/AIDS prevention, care and support needs of mobile people, and the contextual risk factors in the areas where we work.

Doing the same job at the same site doesn't make them at equal risk.



Source: Apichat C., Wathinee B, and Patama Y. Baseline Survey for PHAMIT Project. Thailand. 2004

To target or not to target . . .

Targeting particular high-risk mobile groups, such as sex workers, injecting drug users and undocumented workers, is an important way to stem the spread of HIV and protect vulnerable groups from acquiring the infection. However, targeting proves difficult when mobile people engage in multiple risk behaviors, like unsafe sexual activities and injecting drug use. Targeting can stigmatise vulnerable populations. Being mobile may mean that particular high-risk groups are also hard to reach, especially if they travel outside of the geographic confines of the project. Complex networks between mobile and stationary populations may place less vulnerable people at risk for the disease. And numerous secondary populations—who may influence or motivate the mobile people we work with—may also need to be targeted. In these cases, it may be more advantageous to target the whole area or situation, rather than particular populations. Broadly focused interventions have the advantage of reaching both the mobile population(s) and the people

Multiple risks, multiple needs

Interventions for IDUs often ignore the risk of IDUs acquiring and spreading HIV infection through sexual activity. And programs concentrating on sexual transmission need to examine whether injecting drug use is a risk for HIV in the areas where mobile people reside. A study of IDUs in Surabaya, Indonesia showed that 80% of IDUs were having sex with female sex workers, and the vast majority were not using condoms.

It is important not to assume that the target population has only one risk for HIV. Interventions for mobile populations who inject drugs must also incorporate activities that highlight the risk of infection from sexual activity.

with whom they interact. Depending on the geographical coverage, these interventions can also respond to people on the move. However, care needs to be taken not to target too broadly as the project may lose focus and end up targeting people who are not at significant risk. And if resources are limited, a concentrated prevention effort needs to focus on those who are most vulnerable, as effective interventions with these groups will have the greatest impact on reducing HIV/AIDS.

Promoting Partnerships

Engaging in mobility and HIV/AIDS work is impossible without strong multisectoral partnerships. Partnerships can facilitate access to hard-to-reach people and places. Working collectively can bring about policy improvements and help to create more supportive environments for mobile people. Partners can draw upon diversified resources and encourage "buy in" from stakeholders to make interventions more effective and sustainable.

Perhaps more than anything else, partnerships are the key component of successful mobility and HIV/AIDS interventions. Partners will be as diverse as the mobile people themselves, and can include government authorities, NGOs, community groups, media, the private sector, migrant associations, brothel and entertainment place owners, police officers, and others. Mobile people are our most important partners, and should be involved meaningfully in the planning, implementing and monitoring of mobility and HIV/AIDS interventions. The nature of mobility and HIV/AIDS programming also may require that partners hail from sectors including but not limited to health, and come from different geographical regions or different sides of an international border.

Networking with organizations, groups and individuals who have a stake or interest in the project is a necessary first step in consolidating partnerships. In some cases, intensive advocacy efforts will be needed to secure a partner's involvement and/or support. It is crucial to plan for partnership building at the start of a program, and to allocate proper resources for these efforts.

Local level **project advisory committees** can assist in building partnerships. Local partnerships will help increase access of mobile people to local services, and create a climate of acceptance for our work. Obtaining the support of those in authority, like local government officials and police officers, can reduce harassment and discrimination and facilitate a more enabling environment. In some cases, the inclusion of non-HIV priority areas will build trust and cooperation among local officials and gatekeepers. In Cambodia and Thailand, the FHI-sponsored "Prey Veng – Rayong Operation on Migration Dynamics and AIDS" (PROMDAN) initiative assisted a local community group with its sanitation campaign. Although this was not part of the project's main activities, it responded to the community's needs, increased the trust and acceptance of its members, and prompted their involvement in the program.

For small scale mobility projects, it may be best to build relations with **local stakeholders** first before obtaining support at the provincial or national levels. That is, start locally, and gradually seek the support of provincial and national governments as needed. For large scale

regional initiatives that cross a number of borders, it will be necessary to engage national government support at an early stage. Memoranda of Understanding (MOUs) between target countries may already exist; such agreements may highlight intra-government support for mobility and HIV/AIDS interventions and thus facilitate our work.

Employers of mobile people are other key partners, as they can ultimately allow or restrict access to their workers. Some of these people, especially those who are employing undocumented migrants or treating their workers harshly, may be reluctant to collaborate in our programs. Gaining an understanding about their business environment, and learning what may motivate them to undertake social action is paramount. In some cases, access to mobile people may be dependent on the focus of our programming. We may be pressed to concentrate on health education, treatment and support efforts, rather than on other rights-based actions, such as improving working conditions or changing policies. Here, actively involving employers and managers in the project can have benefits that extend beyond the health of the workers to the overall enabling environment. If this is impossible, programmers can also liaise with other organizations, associations and groups to address factors that contribute to the HIV vulnerabilities of mobile people.

Overall **sustainability** of mobility and HIV/AIDS interventions is dependent on the ability and inclination of our partners to carry on the activities. By actively securing partners' support and involvement, and providing resources for them to understand the issues and carry out the activities, we can enhance the longevity of our initiatives.

Trialing Model Interventions

Over the past 10 years, FHI and its partners have piloted various mobility and HIV/AIDS prevention, care and support model interventions. Here we describe some of the pros and cons of each approach, as well as our overall successes and lessons learned.

Prevention, Care and Support Begins and Ends at Home

Implementing comprehensive prevention, care and support initiatives in source communities allows us to respond to the vulnerabilities of mobile people before they leave their homes, and helps us to mitigate the impact of HIV/AIDS when mobile people return.

Pre-departure programming

Across Asia, mobile people hail from source communities that are coping with issues that extend far beyond HIV/AIDS. Often economically depressed, these communities may be plagued by natural or human disasters, loss of labor, and a lack of health and other essential services. Residents may have little knowledge of various health issues, including HIV/AIDS, nor the life skills necessary to protect themselves from the virus. The burden of caring for those with HIV/AIDS also may be beyond the community's capabilities and resources.

Protecting people before they leave is one way to reduce the impact of HIV/AIDS on source communities. **HIV/AIDS pre-departure programs** aim to equip potential migrants with HIV/AIDS knowledge and skills in an effort to promote safer mobility on transit and at destination. Comprehensive pre-departure programs also prepare potential migrants for the stresses of the mobility process and life in the destination area. Program components of a comprehensive pre-departure program may include:

- Outreach that provides –
  - Information about the migration process, and how to migrate "safely"
  - Orientation about life in the destination area/country, e.g. its culture, rules and regulations, working and living conditions
  - Information on the basic rights of the migrant worker
  - Health and hygiene awareness training
  - Basic skills and language training, pertaining to the new job or the local language in the destination area
  - Financial management
  - Sexuality and sexual health information
  - Life skills
  - Condom promotion
- HIV voluntary counseling and testing (VCT)
- Mass and small media campaigns that promote STI/HIV/AIDS awareness, positive health behaviors, as well as realistic images of mobility
- Income generation schemes for stationary populations in the labor-depleted source community
- Partnering with other organizations for community development initiatives

Pre-departure programs are practical for a number of reasons. If mobile people from one source community travel to number of different destinations at different times, they will be much easier to reach in their place of origin. When agents assemble large numbers of mobile people to work in particular industries, such as domestic work and seafood processing, implementers can work with these agents to put together pre-departure training and orientation packages. And in particularly impoverished source communities, or in those suffering natural hardships, almost everyone can be characterized as a potential migrant in need of assistance.

Identifying potential mobile people in source communities, however, is often difficult. Carrying out careful assessments and/or working with employers, agents and returnees will help us identify those on the move. Unless the numbers of mobile people are significant, however, it may not be justifiable to initiate pre-departure interventions. In some cases, targeting both mobile and stationary populations may be necessary, particularly if there is a high risk of HIV positive returnees to the community, or when the HIV prevalence rates in the area are significant. Targeting those who remain in the community enables them to take steps to protect themselves from HIV infection, especially when their partners return. Raising awareness of HIV/AIDS in source communities can also be used to create an enabling environment that will be accepting and supportive for people infected and affected by the illness.

Reintegration programming

Returning to one's home community, sometimes after many years away, is understandably hard. Returnees may need economic, income generation and/or investment assistance; help reintegrating into familial and social roles; and support in the area of their health. Health needs will be especially pronounced should the returnee come home with HIV. Providing comprehensive HIV/AIDS prevention, care and support interventions is necessary to protect the onward transmission of HIV to family members and partners; to provide crucial care, treatment and support services to those infected and affected by the virus; and to reduce stigma and discrimination in the source community. Facilitating the creation of networks of other returnees also can provide support for those experiencing reintegration hardships. And partnering with others to provide additional assistance, such as income generation or savings schemes, may help community members to mitigate the impacts of the disease.

Working in Hot Spots and Risk Zones

Reaching mobile men and women in areas where they are most at risk for HIV/AIDS is paramount for reducing the spread and impact of HIV/AIDS.

Across Asia, there are a number of hot spots, risk zones and other destination areas where the risks for HIV/AIDS abound. FHI focuses much of its resources on the strengthening of national behavioral and biological surveillance systems that allow us to identify important HIV/AIDS hot spots, and help us to document trends in HIV/AIDS prevalence and risk behavior. Over the past 10 years, FHI has worked with national governments to include mobile populations in their surveillance systems, and to cover more and more locations where mobile people travel and reside. In Lao PDR, for example, FHI collaborated with the National Center for HIV, AIDS, and STIs to expand the surveillance system to remote northern areas of the country, where cross-border movement to and from China and Myanmar is more likely than other parts of the country.

Epidemiological data and other operational research have helped FHI and its partners to develop tailored interventions in hotspots, risk zones and other destination areas. In Indonesia, HIV/AIDS awareness and condom promotion campaigns have been conducted among vulnerable seafarers in port areas, such as Merauke (Irian Jaya) and Belawan (North Sumatra). Ports are difficult environments to work in because of the diverse ethnic backgrounds of their inhabitants, the short time seafarers are stationed there, and the seafarers' preoccupation with things other than HIV/AIDS education during their stay. In 2000-2001, PATH, with support from FHI and local port authorities, responded to these challenges by conducting simple, short educational and condom promotion sessions to fishermen in places that were important to them, such as in their boats or at port entertainment venues. Condoms were made available at hotels, guesthouses and other high-risk areas frequented by seafarers and their partners. Multilingual educational materials—especially billboards and posters placed throughout the port area, and comic books that provided entertainment to the fishermen during long periods at sea—supported and reinforced the sometimes limited face-to-

All Sites are not Created Equal

In 1997-2000, the Border Areas HIV/AIDS Prevention Project (BAHAP), implemented by CARE International, targeted mobile people at cross-border hotspots between Thailand, Lao PDR, Vietnam and Cambodia. Tay Ninh (Vietnam) and Svay Rieng (Cambodia) were chosen as one implementation site. It soon became clear, however, that those who were most vulnerable to HIV/AIDS did not stay in the border areas, but moved inland to Phnom Penh, Cambodia and Ho Chi Minh City in Vietnam. These cities were the real hotspots—not the relatively sleepy areas along the border. When identifying "hotspots," do not forget to conduct careful situational assessments and other operational research to select risk environments.

Safe Highways/ Safe Cities/ Safe Migration: Highway clinics for mobile people

In Nepal, mobile people at risk of HIV transmission are reached through clinics along the Mahendra Highway. Static clinics at truck parks along the highway and STI/VCT integrated mobile clinics set up by STI clinic teams traveling on the highway are utilized by female prostitutes and their clients (including truck drivers and their assistants, rickshaw-pullers, industrial laborers, migrant laborers, military and police personnel). This has helped increase accessibility to STI/VCT services for most-at-risk groups that travel along these routes.

face communications. PATH also worked with other target groups—such as prostitutes and port authorities—to promote safer sexual activities.

Besides port areas, HIV/AIDS hotspots may include workplaces that attract large numbers of mobile people. FHI/Indonesia has targeted vulnerable "mobile men with money" by focusing on workplace environments in the natural resource, transportation and manufacturing sectors. Working directly with companies has important advantages: the company can act as a "key influential" on employee behavior, and company support affords implementers with unique access to the client population. In the Indonesian case, FHI and its partners provide technical and financial assistance to local NGO; these organizations then train companies to set up and run their own HIV/AIDS programs. Companies assume all of the programmatic costs, including the training costs provided by the local NGOs. After training, companies can do the following:

- Train key staff to integrate HIV/AIDS prevention messages into existing human resource and communications programs
- Educate workers about HIV/AIDS, and distribute condoms and educational materials
- Refer workers to available STI, VCT and care and support services
- Develop policies on HIV/AIDS prevention and treatment

One hundred and ten company teams have currently received training, and over 550,000 migrant workers have been reached. Over 6,000 member companies of the Indonesian Employers Association received HIV/AIDS program start up tools between 2004 and 2005. Through collaboration with the Ministry of Manpower, prevention programs will be provided to an additional 1,000 companies over the next four years.

Like some large workplaces, border areas across Asia often show high rates of HIV and risk behavior. HIV/AIDS interventions are especially needed in areas where there are no HIV projects, a large target population, high HIV prevalence (either locally or among mobile people), and engagement in risk practices. In some border areas, people move through quickly and there may be insufficient people at risk to target. Other challenges include the remoteness of the border location, the cultural and language differences of the populations that pass through them, and the tendency of these areas to have less developed health care infrastructure and limited services. These and other factors must be weighed before beginning interventions in border sites.

In areas like highway rest areas and ports where target populations are only accessible for short periods of time, creative HIV/AIDS prevention strategies can help us extend our reach and impact. Mobile health units and health education teams that go to the target groups—rather than vice versa—are crucial. Multilingual, culturally-appropriate messages and materials that appeal to the people we work with and respond to their needs and desires also can help to increase awareness and effect behavior change. So too can intensive mass media campaigns focusing on risk environments along the mobility continuum.

Identifying where risk behaviors occur can allow us to direct our interventions in places where they can have the greatest impact.

For some mobile people—such as undocumented migrants—prisons and detention centers constitute their home away from home. Epidemio-logical and behavioral research suggests that interventions in prisons—where risk behaviors like unprotected sex and injecting drugs also take place—can do much to reduce the vulnerabilities of mobile people and augment the impact of HIV/AIDS on the larger community.

Creating Linkages through Cross-border Interventions

Often, working in one place has little impact. This is especially true when mobile people cross borders on a regular basis. Accordingly, FHI and its partners had piloted cross-border interventions at busy border crossings across South and Southeast Asia.

Consistent and complementary HIV/AIDS prevention, care and support strategies —implemented on both sides of a border— can greatly enhance the effectiveness of our programs.

Adjoining cross-border communities need to be considered as a single, extended town due to the interaction between the populations on both sides. Connections can be made by linking services, using consistent materials and messages, developing a branded communications strategy, and conducting joint outreach activities. Interventions on both sides of the border gain community support and acceptance if collaboration between field staff from the neighboring towns is evident. Educational messages and materials need to be produced in all the major languages spoken at the border area, and to respond to the needs and wants of our target populations.

Cross-border interventions often focus on isolated and remote sites. As local partners may have limited experience with mobility and STI/HIV/AIDS interventions, a high level of technical assistance and management support is essential.

Implementation of multi-site interventions is complex and challenging, and the level of difficulty is not usually anticipated. Effective management and a high level of coordination are essential. Clear understanding of the roles and responsibilities of each organisation is needed for multi-agency and multi-site interventions. A skilled and experienced project manager overseeing all sites is needed.

Barriers to implementing cross-border interventions need to be anticipated and addressed during program planning and implementation. For example, staff may hail from different cultural, linguistic and ethnic backgrounds; restrictions on cross-border movements may hinder collaboration between project implementers; and foreign-language materials and messages may not be allowable in particular border areas. Try to anticipate and respond to these challenges at the earliest opportunity!

Contiguous Programming at Source and Destination

Cross-border programming is one way to link interventions that respond to people on the move; another, more comprehensive approach attempts to link HIV/AIDS prevention, care and support efforts in source communities and destination areas, no matter where they are located. The latter is called "source-destination programming." FHI piloted source-destination interventions in Cambodia and Thailand, namely in the PROMDAN initiative, implemented by PATH; and along highways in Nepal and India.

In source-destination programs, attempts are made to create connections between the source and destination areas as people leave, travel to new places, and return to their home villages and cities. Potential migrants participate in education sessions on HIV/AIDS, pre-departure preparation, and condom awareness and negotiation. Members of the source communities—particularly the partners, spouses and family members—also may take part in HIV/AIDS assertiveness and condom promotion discussions. In the case of PROMDAN, income generation and small investment schemes were set up among stationary populations in labor-depleted source communities to improve their livelihoods and well-being. Attempts also have been made in PROMDAN to improve the quality of available health services, particularly for STI treatment and VCT, and to improve access to these services among both mobile people and their stationary partners.

As mobile people travel to destination areas, linkages are established between the destination site and the source community as a way to further decrease HIV/AIDS vulnerabilities and risks. HIV/AIDS prevention and risk reduction messages are continued and reinforced in the destination area. Drop in centers—such as the one established in Rayong, Thailand under PROMDAN—provide opportunities for migrant fishermen to congregate in a central location for rest and recreation, health referral and/or treatment, and education. PROMDAN has also focused on improving the quality of life of fisherman, and strengthening the bonds between them and their loved ones in their home community by:

- Facilitating family communications via a "post card" mail system, whereby PROMDAN staff have assisted fishermen and their family members to prepare and send correspondence;
- Promoting a saving scheme for fishermen to generate more savings and to send it home;
- Advocating for improvements in the living and working conditions of migrant fishermen in Thailand; and
- Promoting dialogue between the Thai and Cambodian governments regarding immigration issues and the protection of migrants' human rights.

While not all of these activities have been equally successful, they do form innovative ways in which to respond to mobility and HIV/AIDS issues. Evidence also suggests that the quality of life of mobile and stationary populations can be improved by addressing a broad range of factors that contribute to the HIV/AIDS vulnerabilities of these people.

Source-destination programming has obvious benefits; however, it must be noted that these programs are practical only if a large number of mobile people at the destination site come from one or a small number of source communities. If they originate from many source communities or travel to a number of destination areas, it is not practical to target all the different source/destination communities. If this is the case, it might be necessary to limit the intervention to the place where an intervention is most feasible, which could be source, transit and/or destination points, and then to partner with organizations working in other areas.

Fostering National and Regional Responses

Scaled up interventions among mobile people in key sites in Asia are needed to have an impact. Integration of HIV mobility interventions within national AIDS programs, which are linked regionally, is needed to increase coverage.

With people on the move from one place to another, HIV epidemics are rarely confined to just one place. This means HIV and mobility interventions will be more effective if they take a regional and national focus.

Because mobile people often cross borders, the involvement of national AIDS programs in HIV mobility programs is essential. National programs need to include HIV prevention and care and support for mobile populations in their existing programs. This will result in a broader level of reach to widely scattered target groups than can be achieved by solely relying on NGOs. The involvement of large NGOs that have the capacity to coordinate multi-country projects can also help.

National AIDS programs in source and destination countries need to work together. Strong advocacy is usually needed to obtain government involvement, especially in destination countries that usually give low priority to foreigners, particularly when they are undocumented migrants. Policies that deal with undocumented migrants and trafficking can usually be more effectively addressed at the national and regional levels by international NGOs, donors and governments, rather than by individual projects.

The risk of HIV infection among mobile people is not just a health issue. Other government departments can take action to help reduce the vulnerability of mobile people to HIV. For example, schools can educate students about the realities of mobility; HIV prevention schemes can be integrated into major road construction projects; and legal recognition of foreign migrants can help to reduce their isolation and marginalization. Ministries, such as Labor, Interior, Defense, Transport, Public Works and Education all have a role to play by including HIV policies and programs within their mandates.

Can we scale up?

At present, interventions in Asia targeting mobile people reach only a minority of those at risk for HIV. If projects are to have an impact on HIV transmission, they will need to operate on a large enough scale to effectively reach these populations. Small-scale projects for large target groups are unlikely to have animpact. If projects can scale-up over the coming years, it may be possible to form coalitions or networks of people and programs that help to reduce the HIV vulnerabilities of mobile people and mitigate the impact of AIDS in a wide range of locations.

Creating a more Enabling Environment for Mobile People

Comprehensive mobility and HIV/AIDS programs must address factors that marginalize mobile people and make them vulnerable to HIV/AIDS and its impacts.

Fostering a more enabling environment is vital in HIV/AIDS and mobility programming. Not only do we need to address the factors that contribute to the HIV vulnerabilities of mobile people, we must also try to increase their access to essential information, commodities, services and programs, and support both mobile and stationary populations to respond to the HIV/AIDS crisis and to mitigate its impacts. No single intervention can address all the complex social and economic factors associated with why people move and what places them at risk for HIV and its impacts. However, a better balance is needed between interventions that focus entirely on risk reduction and those programs that attempt to reduce the HIV/AIDS vulnerabilities of mobile people and to mitigate the impacts the virus has on their lives.

Obviously the kinds of strategies we use to create more enabling environments are specific to the needs of our target populations and to the local context. In some areas, we might conduct advocacy with governmental officials, business owners and other "gatekeepers" to sensitize them to the aims of our programs and to garner their support. We might provide specific training to health providers and bring mobile people to the health services as a way to increase their access. We might use community-based and participatory approaches to allow mobile people to assess their own vulnerabilities and to develop solutions appropriate to their needs. And we might partner with other organizations, groups and institutions to promote the human rights of mobile people and those with whom they interact.

Whatever we do, we need to have a clear idea, before we start our programs, on what we mean by the enabling environment, and what measures we will use to assess change. Understanding the contextual factors and the needs of the people with whom we work should help us clarify our aims. Making realistic project projections on what we can achieve is crucial. It takes a long time and many helping hands to affect lasting changes in the broader environment. Here it is important to identify small changes that might be achieved over the course of the project—like increased availability of condoms, or more supportive attitudes among local government officials—and then partnering with other groups and organizations affect deeper, more substantial change.

Promoting Healthy Behaviors in Mobile Populations

Mobile people have special needs and vulnerabilities that may limit their abilities to access, or benefit from, more conventional HIV/AIDS prevention, care and support approaches. Flexible and creative solutions are often needed. For example,

- **Face-to-face interpersonal communications** are generally more effective with mobile people when they are participatory; when outreach workers hail from similar ethnic, cultural and/or linguistic backgrounds; and when activities or learning curricula are flexible, simple and concise. Conducting outreach at times and places that are convenient to mobile people is crucial. Intensive outreach may be possible in particular situations, e.g. when fishermen are in port for rest and relaxation; when seasonal laborers return home to harvest rice; and when prostitutes have rested between clients.

- **Drop-in centers** that provide opportunities for rest and relaxation, counseling and referral services, may also create opportunities for further outreach by attracting mobile people to a centralized location.

- **Support materials,** whether they are leaflets, comic books, or resource manuals, must accurately reflect the backgrounds, lifestyles and circumstances of the mobile people with whom we work. All materials must be available in languages that are accessible to mobile populations, in formats that are culturally appropriate, and presented in ways that respond to the special needs of some groups, e.g. low literate audiences. Support materials should also be appealing and respond to the needs and wants of our target populations. Comic and story books, for example, might entertain seafarers during long periods at sea, while audiotapes—with HIV/AIDS prevention, care and support messages between songs—might appeal to long distance truck drivers. Remember that all materials should be created in conjunction and/or extensively pre-tested with our target audiences.

- **Branding materials and messages** in cross-border interventions or contiguous programming will ensure the consistency of our communications and will reinforce behavior change and healthy lifestyles.

- **Media campaigns**—though expensive—have the potential of reaching large numbers of mobile people over broad areas. Remember, however, that messages may need to be in multiple languages and/or include appropriate graphics.

- **Special HIV/AIDS educational events** can be conducted at times and places where large numbers of mobile and stationary populations congregate.

- **Conventional peer education** approaches may not be viable with highly mobile groups. Using "frontline social networkers," "secondary peers," and other "gatekeepers" who are more stable may be more appropriate and allow for greater monitoring of interventions. If a peer education strategy is being used, be realistic about what the educators can and cannot do, and what kinds of training and support may be required. It may be necessary to train large rosters of peer educators if the turnover is high.

- Identifying **gate keepers** who have the most contact with, or the most influence on, our target populations is a crucial way to build social support for behavior change. It is also important to sensitize

A Creative Solution

In India and Nepal, staff from the Boruka Cross Border Intervention Project found that they could not effectively use truck drivers as peer educators because these people were constantly on the move. That's when the staff came up with a creative solution. They recruited and trained 'secondary peers'—parking lot supervisors and mechanics at the border crossing. These secondary peers were in more frequent contact with truck drivers than the drivers were with each other. And they could be more easily supported and monitored than their peer truck driver counterparts.

stationary communities to ensure greater understanding and acceptance of mobile people, and to involve them in developing solutions to respond to HIV/AIDS and mobility issues. Working with various partners may allow us to do more comprehensive programming or scale up our activities.

- **Barriers to health services** (be they issues of cost, language, cultural differences, stigma, or distance) need to be identified at the start of the interventions, along with strategies that seek to address these barriers. In some instances, capacity building measures may have to be directed to health workers in order to make the services more acceptable and user-friendly. In other cases, mobile or satellite health services, and/or comprehensive referral systems, may be needed to facilitate access and foster acceptance.

- **Innovative strategies,** such as STI periodic presumptive treatment or mobile/satellite VCT centers may be appropriate with some mobile groups, provided there is extensive technical and material support, and provided these activities are part of a comprehensive behavior change communications (BCC) strategy.

Evaluating the Success of our Responses

Rigorous evaluation and documentation of mobility and HIV/AIDS programming is needed.

Do our interventions change the behaviours of mobile populations and those with whom they interact? Can we affect behavior change and promote healthy lifestyles among people who frequently move in and out of our intervention sites? What kinds of activities or interventions best meet the needs of mobile people? Do our interventions cover a significant proportion of those who are most vulnerable in a particular target area?

Unfortunately, most evaluations of mobility and HIV/AIDS projects in South and Southeast Asia have focused on process indicators rather than on outcomes. The dearth of rigorous evaluation data makes it difficult to judge the effectiveness of our interventions and the degree of behavior change among the people with whom we work. Size estimation of mobile populations—many of whom are hard to reach—has not been widely done, nor systematically implemented. In continuing and improving HIV/AIDS services to high-risk mobile people, rigorous evaluation and documentation of mobility and HIV/AIDS programming should be integrated at least to selected interventions, site and mobile groups for future lessons learned.

References

Allan Beesey. *Moving Forward, Looking Back: The Dynamics of Migration and Mobility and HIV/AIDS Vulnerability.* CSEARHAP, a program executived by CARE/Canada, PATH/Canada and the Canadian Society for International Health, with funding by the Canadian International Development Agency (CIDA), Bangkok. 2004. (unpublished document)

Brahm Press. *Untangling Vulnerability: A Study on HIV/AIDS Prevention Programming for Migrant Fishermen and Related Populations in Thailand.* Raks Thai Foundation for Rockefeller Foundation – Southeast Asia Office. Bangkok. 2004.

Thang D. Bui, Chi K. Pham, Thang H. Pham, Long T. Hoang, Thich V. Nguyen, Thang Q. Vu, and Roger Detels. Cross-sectional Study of Sexual Behaviour and Knowledge about HIV among Urban, Rural, and Minority Residents in Viet Nam. *WHO Bullentin*; vol 79(1); 2001; 15-21.

Cambodia's National Center for HIV/AIDS, Dermatology and STDs (NCHADS). Behavioral Surveillance Survey, Phnom Penh. 1999.

CARE International. *BAHAP: Activities and Outputs of the Border Areas HIV/AIDS Prevention Project*. With support from Family Health International (FHI) and the United States Agency for International Development (USAID). Bangkok. 2000.

Catrin Evans. *Vulnerability to HIV/AIDS in Asia: A Situation Analysis and Responsive Assessment, with a Special Focus on Mobile Populations, Trafficking, Sex Work, and People Living with HIV/AIDS.* CARE/Asia Regional Management Unit. Bangkok. 2003. (draft)

Chulalongkorn University, Lao PDR's Center for HIV/AIDS/STI and Family Health International. *Migration to Thailand and its Potential Contribution to an HIV Epidemic in Lao PDR.* With support from the United States Agency for International Development (USAID). Vientiane. 2005.

David Lowe and Siriporn Yongpanichkul. *Evaluation of PROMDAN: The Prey Veng-Rayong Operation on Migration Dynamics and HIV/AIDS Intervention.* Program for Appropriate Technology for Health (PATH) and Family Health International (FHI). Bangkok. 2003 (unpublished document).

Directorate of Communicable Disease Control and Environmental Health, Ministry of Health and Central Bureau of Statistics, Indonesia. *Behavioral Surveillance Survey 2004.* Jakarta. 2004.

Family Health International (FHI). *A Regional Cross Border HIV/AIDS Prevention Response in East Asia: Seminar Proceedings.* AIDSCAP Project. Bangkok. 1996.

Family Health International (FHI). *What Drives HIV in Asia? A Summary of Trends in Sexual and Drug Taking Behaviors.* Bangkok. 2001.

International Organization for Migration (IOM). *World Migration 2005: Costs and Benefits of International Migration*. Geneva. 2005.

Office of Population Technical Assistant Team (OPTA), Cambodia's National Center for HIV/AIDS, Dermatology and STDs (NCHADS), and Family Health International (FHI). *Indochina Border Area Behavioral Surveillance Survey 1999-2000.* Bangkok. 2001.

Cambodia's National Center for HIV/AIDS, Dermatology and STDs (NCHADS) and Family Health International (FHI). *Behavioral Surveillance Survey 1999*. Phnom Penh. 2000.

Ivan Wolfers. *Programs for mobile populations and their partners*. In: Lamptey P, et al. (Eds) HIV/AIDS Prevention and Care in Resource Constrained Settings: A Handbook for the Design and Management of Programs. Family Health International (FHI). Arlington, VA. 2002.

Jacques du Guerny and Lee-Nah Hsu. *Population Movement, Development and HIV/AIDS: Looking Towards the Future*. UNDP. Bangkok. 1999.

Jeanine Bardon and Wassana Em-Im. *BAHAP: Border Area HIV/AIDS Project*. External Review Document. Family Health International (FHI). Bangkok. 2000. (unpublished document)

Lao PDR's National Committee for the Control of AIDS Bureau, Lao PDR's HIV/AIDS Trust and Family Health International (FHI). *Behavioral Surveillance Survey 2000 – 2001*. Vientiane. 2003.

Lao PDR's National Committee for the Control of AIDS Bureau and Family Health International (FHI). *HIV Surveillance Survey and STI Periodic Prevalence Survey 2001*. Vientiane. 2003.

Nepal's Central Bureau of Statistics. *Population Census*. Kathmandu. 2001.

Tony Bennett. *Initiating Cross-border HIV/AIDS Prevention Programmes: Practical Lessons from Asia*. In: Makinawa B, O'Grady M (Eds). HIV/AIDS: FHI/UNAIDS Best Practices in Prevention Collection. Family Health International (FHI) and UNAIDS. Arlington, VA. 2001.

UNAIDS. *Population Mobility and AIDS*. UNAIDS Technical Update. Geneva. 2001.

UNDP. *Multisectoral Responses to Mobile Populations' HIV Vulnerability: Examples from People's Republic of China, Thailand and Viet Nam*. Bangkok. 2003.

UN Regional Task Force on Mobility and HIV Vulnerability Reduction. *Strategy on Mobility and HIV Vulnerability Reduction in the Greater Mekong Subregion*. UNDP. Bangkok. 2001.

William L. Parish, Edward O. Laumann, Myron S. Cohen, Suiming Pan, Heyi Zheng, Irving Hoffman, Tianfu Wang and Kwai Hang Ng. Population-based Study of Chlamydial Infection in China: A Hidden Epidemic. *JAMA*. 2003; 289(10); 1265-73.

World Health Organization (WHO). *Reduction of HIV Transmission in Prisons*. WHO/HIV/2004/05. TR/05/158. Geneva. 2004.

World Vision/Australia and the Macfarlane Institute. *Toolkit for HIV Prevention among Mobile Populations in the Greater Mekong Subregion*. Asian Development Bank and UNDP. Bangkok. 2002.

Family Health International
Asia and Pacific Department
19th floor, Tower 3, Sindhorn Building
130-132, Wireless Road
Lumpini, Phatumwan,
Bangkok 10330
Thailand
Tel: 66-2-263-2300
Fax: 66-2-263-2114
www.fhi.org