

Asian Development Bank and UNDP

Toolkit for HIV Prevention among mobile populations in the Greater Mekong Subregion

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World Vision Australia & The Macfarlane Institute

**TA 5881-REG: Preventing HIV/AIDS Among Mobile
Populations in the Greater Mekong Subregion**

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INTRODUCTION

Purpose of the toolkit

This is a toolkit to guide the management and implementation of HIV prevention programmes for mobile populations in the Greater Mekong Subregion. It will be used by people and organisations who already have some experience in HIV prevention, and are now ready to address the specific challenges of working with mobile populations. Specifically, the toolkit addresses ways to work with mobile groups of construction workers, truck drivers, seafarers and migrant sex workers.

While the toolkit supports HIV prevention amongst mobile population groups, it also recognises that HIV is transmitted through interaction between mobile or migrant groups and the more stable communities they pass through, live in or return to. The toolkit therefore strongly recommends that effective HIV prevention will occur only when there are programmes for mobile groups *and* for the more stable communities with whom they interact. All advisers to the development of the toolkit were concerned that implementing programmes *just* for mobile populations can easily lead to stigma and discrimination against mobile people, along with denial of the relevance of HIV to stable populations. The combined effect of these two outcomes is an environment in which HIV is *more* likely to be transmitted.

The toolkit outlines what needs to occur in effective HIV prevention programmes in specific locations. In most locations, there will be local communities with many people who are not mobile, alongside people who are mobile. In some locations, there will only be mobile groups. For example, at a road construction site, or on a ship at sea, there will only be mobile workers. In these cases, the toolkit will be used to design HIV prevention programmes just for those mobile workers.

The toolkit was initiated by the Asian Development Bank and the UNDP South East Asia HIV and Development Project, as part of a technical assistance programme, *ADB TA 5881 – HIV/AIDS and mobility in the Greater Mekong Subregion*.

Five critical elements of HIV prevention programmes for mobile population groups

The toolkit specifies five critical elements that must be included for an HIV prevention programme to be effective in reducing the association between HIV and mobility. However, the users of the toolkit will have their own experiences and resources, and these can be used to determine exactly *how* each critical element of the programme will be implemented. In this way, the toolkit prescribes what must be achieved but allows flexibility in how it will be achieved.

The five critical elements of an effective HIV prevention programme are outlined here. After each critical element has been implemented, the outcomes will be:

1. *A Task Group is formed and active.* There will be a multisectoral group of people who will oversee the development of HIV prevention programmes in the specific locality in which the toolkit will be used. This might be an existing group which agrees to use the toolkits, or a group formed by programme managers who will use

the toolkit. At construction sites, this might be a group formed by the construction company.

2. *There is local capacity to implement the HIV prevention programme.* The users of the toolkits will have worked to build the capacity of locally based people to run the programme. The resulting programme will have been implemented with maximum commitment, understanding of needs and possibilities, and likelihood of sustainable support for ongoing HIV prevention even after the programme is completed.
3. *The local situation and needs of mobile groups are understood.* A situation analysis will have been conducted to ensure that the HIV prevention programme takes account of the specific nature of the local context and the specific nature of the mobile people who are present in that context.
4. *The local community is taking visible steps towards becoming “HIV resilient”.* HIV resilient communities can support behavior change for their own community and for the mobile populations with whom they interact. They do not discriminate against mobile people or people living with HIV, and they do not exclude those groups from community participation, because they understand that this can lead to increased HIV transmission. They understand how the HIV epidemic is evolving in their own locality. They understand how this is influenced by changes in socio-economic development and by changes in systems of mobility (e.g. the introduction of new roads, ports, technologies or economic choices). They know what to do to improve development so that it reduces people’s vulnerability to HIV.
5. *Mobile people have received support for behavior change.* Mobile people will be informed about HIV transmission, have access to resources they might need to prevent HIV transmission (such as condoms), have personal support for behavior change from their own peers or from Frontline Social Networkers, and have access to services that enable diagnosis and treatment of sexually transmissible infections (STIs).

A flexible approach to HIV prevention programming

Each of the five critical elements of an HIV prevention programme is an essential outcome of the programmes designed using the toolkit. But there are many ways to reach each objective. The exact path chosen by programme managers will depend on the nature of the local context, the needs of mobile groups who are present in that context, and their own experience and available back-up support. These factors will all differ in each situation. The toolkit is therefore presented in a brief format that enables its users to decide for themselves how each objective will be achieved.

The toolkit does not indicate how to create an enabling policy environment, provide care and support for people living with HIV, or achieve sustainable socio-economic development. While these processes are important, they are beyond the scope of this toolkit. Many of these issues will be addressed through complementary programmes, including the ASEAN Joint Action Programme for Mobility and HIV, 2002-2004. The ASEAN programme will ensure

that governments create enabling policy environments and begin to address development issues affecting mobile people's vulnerability to HIV.

Evidence base for the contents of the toolkit

The contents of the toolkit are based on experiences of good practice in HIV prevention. These include:

- Global experience of what is required for effective HIV prevention programmes, as outlined in the UNAIDS Best Practice Collection document, *Innovative approaches to HIV prevention: selected case studies*.
- The HIV prevention experience of the writers of the toolkit, from World Vision Australia and The Burnet Institute, who have implemented their own programmes and supported the design, implementation and evaluation of others' programmes in the region.
- The HIV prevention experience of governments and NGOs working on HIV prevention in the Greater Mekong Subregion, who have experience in specific contexts, and who made suggestions on the content of the toolkits and the way they can be used.
- An understanding of the factors affecting mobility and HIV vulnerability, collated as part of the same Technical Assistance programme that produced the toolkits. In this case, research about factors affecting mobility was collated by the Mobility Study of the Asian Research Centre for Migration. The report outlines typologies of different mobile groups and the communities with whom they interact in each GMS country.
- Experience in using development strategies to reduce the vulnerability of mobile people to HIV. This experience has been developed and collated by UNDP South East Asia HIV and Development Project (UNDP-SEAHIV). That project has worked closely with the producers of the toolkit to provide guidance and support, and has facilitated collaboration between the toolkits producers and development specialists in each GMS country.
- Guidance and advice from the UN Regional Task Force on Mobile Populations and HIV Vulnerability, which brings together governments, NGOs, UN groups, multilateral agencies, donors and researchers to support development of more effective responses.
- Field testing of the toolkits in the countries in which they will be used, which resulted in understanding of the needs of different mobile groups and the requirements of different local contexts, and led to changes in the content of the toolkits.
- The *Regional Strategy on Mobility and HIV Vulnerability Reduction in the Greater Mekong Subregion 2002-2004*, a consensus statement of all key stakeholders outlining what needs to occur to prevent further HIV transmission associated with mobility.
- The WHO booklet, *Beyond 2000: responding to HIV/AIDS in the new millenium*.

TASK GROUP

Desired outcome

A task group is formed and active.

This will be a group of people who will oversee the development of HIV prevention programmes. The group will

- decide what needs to happen
- support the implementation of the programme
- ensure that the programme is relevant and helpful to the local community
- ensure that the programme is relevant and helpful to the mobile group who are presently in the community
- monitor and evaluate the programme and its impacts

The toolkit allows for a flexible approach to forming a task group. The members who make up that group might be different people in each location where the toolkit is used. There might be an existing group which agrees to use the toolkits, or the programme managers who will use this toolkit might have to form a new group specially for this purpose. But there must be a locally based group to oversee the HIV prevention programme.

Why this outcome is important

Experience of HIV educators indicates that when HIV education programmes have engaged local people as planners and facilitators, communities report that this has been more useful than just HIV education done by outsiders. When HIV education is run by outsiders, this can reinforce the community's view that the problems of HIV are only relevant to outsiders.

The need for a local task group was reinforced through the testing of this toolkit. The establishment of the task group allowed for local participation, identification of the local situation and issues relating to HIV and mobility, and participation in planning and implementation of activities of the programme.

Having the local task group gave all communities a sense of ownership of the HIV prevention programme. It was effective in providing easy access to knowledge of the local situation from the perspective of local people and mobile people. It ensured that there was good understanding of local situations, and this led to identification of what might work and what might not work.

If there is no attempt to form a local Task Group, then an HIV prevention programme could be run. But it would be run entirely by outsiders or just one or two of the locally present people. This would mean it could be based on limited and possibly inaccurate knowledge of the local situation and people's needs. It would be based on pre-conceived ideas of what is going to work, rather than developed in a way that is tailored to local needs. It would not result in local ownership or sustainability of the programme or its outcomes. It would be

more difficult to implement activities, and more difficult to overcome barriers to implementing activities.

When there is a local group of people directly involved, there is a much higher chance that the HIV prevention programme will be based on local needs, and that it will be effective. The programme is also much more likely to be sustainable in the long term as the local people develop their own understandings of HIV, mobility, and solutions to problems they identify.

Flexible alternatives to forming a local task group

The exact way to form a task group, and who should be included in that task group, will be different in each different situation. The group should be should small enough to work effectively, and large enough to include people with various interests and understandings.

The local task group will need to be developed in accord with national and local requirements. The name of the group will match those requirements. For example, it might be called a *Village Health Team*, or *District AIDS Committee*. In some places, a group will exist already. The programme manager should then work with the existing group. In other places, the HIV prevention programme will work with mobile workers from a particular mobile company, such as a road construction company. In these places, the Task Group might be a group of people from within that company, so that the Task Group moves with the workers, who are the participants in the HIV prevention programme.

The group might include

- Local leaders
- Representatives of local departments or organisations implementing HIV prevention programmes
- Mobile people presently in the community
- Employers of mobile people

Suggested steps for group formation

1. Advocacy. Approach the people who could be involved, to explain what the HIV prevention programme is about, and to seek their involvement.
2. Meet with all those who have consented to be members, and explain to them the purposes and the methods of the HIV prevention programme.
3. Present to the Task Group the policy framework that indicates there is a need for this programme. This might, for example, include presenting the National HIV/AIDS Strategy, workplace policies, or statistics on HIV or STIs for your country.
4. Work with the Task Group over the life of the HIV prevention programme, to follow the rest of the guidelines of this toolkit:
 - conduct training to build capacity

- conduct a situation analysis
- work to build an HIV resilient community
- promote behaviour change for specific mobile population groups

Field testing and other lessons learned about forming task groups

The toolkits were field tested with each mobile group, and the field testing experiences are reported in the Case Studies prepared by the four Country Co-ordinators. These are available as reference guides for others wishing to design and implement an HIV prevention programme using the toolkit. Some extracts from the Case Studies about forming Task groups are presented here to illustrate how the toolkits were developed and how they can be used differently depending on who is available join each Task Group.

In **Myanmar** the Task Group was called a Village Health Team. This group developed a Vision Statement, outcomes for the group, and a list of responsibilities for the members. Each one had to assist with the preparation of a village health plan to combat HIV/AIDS and other health problems, provide leadership in the implementation of the plan and monitor the activities conducted.

The members stated that after writing their Vision Statement and having understood who they were, what they were addressing, and where they were going, they felt more organised than ever before. They also mentioned that they were motivated and committed to moving forward with activities to improve their lives in the future.

In **Cambodia** the Task Group was formed after many meetings with local representatives and it consisted of officials as well as representatives from the mobile groups in the city. The following quotations illustrate some members' impressions of the Task Group and its value.

“ I've been providing HIV/AIDS education to sex workers in the area for a long time, but something like mobility has never been a topic of our discussion, although I heard how it contributed to the epidemic...I hope through my role in this new task group, I will learn something about it and help prevent my community from further HIV infection ...”

Community Outreach Worker of Phum Thmey

“ When I came to the first meeting with a big group of people from different backgrounds and from different places, I was very shy and simple. I did not know what I could give to the group or what I was expected to do. But while the discussion continued I realised I had a lot to tell and I did. Eventually, I ended up being a member of the newly established Task Group on Mobility and HIV and later on I had lots to do...”

Sex Worker Representative, Sihanouk Ville

In **Lao PDR** a member of the Task Group from the Education Department said, “ In the past we were implementing HIV prevention activities in such a way that intended only to inform people about HIV and how to prevent transmission. There was no sign of a continuum. there was a lack of follow-up, and there was no evaluation of behaviour change. Hearing about the

toolkit, especially when talking about building HIV resilient communities, I feel that this is a new way and it will be useful for our country..”

In **China** a member of the task group recommended to present the national policy and strategy for HIV prevention and mobility, so that it is clear there is an official framework within which the Task Group can operate.

“Global experience has shown the following elements to be among those central for effective national HIV prevention efforts: community involvement in programme and intervention development, and building upon the will of groups and individuals to contribute to national HIV prevention efforts; ”

*Innovative approaches to HIV prevention: selected case studies
UNAIDS Best Practice Collection, Geneva, 2001*

“Following a recent review of successful community-based projects and activities (UNAIDS, 1999), a further set of principles has been identified outlining some of the factors that need to be taken into account if community-based prevention activities are to be effective. These include:

- ***engaging the community through existing organizations, groups and structures for education and support;***
- ***building partnership and trust through communication, networking and collaboration;***
- ***including people with HIV and AIDS at all stages of the process so as to enhance visibility and benefit from their skills and experiences;***
- ***creating an accepting community environment in which HIV and AIDS are acknowledged to be everyone’s concern.***
- ***Beyond these principles, community-based approaches need to make certain that resources are directed towards community capacity-building in order to ensure sustainability.”***

*Innovative approaches to HIV prevention: selected case studies
UNAIDS Best Practice Collection, Geneva, 2001*

“There is no one formula for effective community mobilization. If there is a common denominator of all effective mobilization efforts it is a sense of opportunism – of capitalizing on people’s energies and commitments, on available resources, and on situations that can help move a group of people – a community – to achieve a common purpose – a shared purpose understood by all.”

Larsen HJ, Narain JP. Beyond 2000: responding to HIV/AIDS in the new millennium. New Delhi, World Health Organisation, 2001

Reference List

Country specific National HIV/AIDS Strategy

Strategy on Mobility and HIV Vulnerability Reduction in the Greater Mekong Subregion (2001-2004)

UNDP/UNOPS, South East Asia HIV and Development: A website at the service of HIV and Development: Remarks on role, strategy and effective (June 2001)

FAO/UNAIDS: Sustainable Agriculture/Rural Development and Vulnerability to the AIDS Epidemic, FAO and UNAIDS Joint Publication (1999)

UNDP HIV and Development Programme: Strengthening Community Responses to HIV/AIDS (2000)

CAPACITY BUILDING

Desired outcome

There is local capacity to implement the HIV prevention programme, using participatory approaches and making decisions about exactly what should occur in the programme in each particular location.

The programme manager needs to design and implement a capacity building programme to train locally based people, who will then implement the HIV prevention programme.

Why this outcome is important

The required capacity building is of three types:

- building people's capacity to understand HIV transmission and prevention
- building capacity to facilitate participatory approaches
- building capacity to undertake programme design and implementation.

Each of these three types of capacity building is important because

- The people running an HIV prevention programme need to know about HIV themselves, or they will make mistakes.
- The processes to be used in the HIV prevention programme rely on use of participatory methods. People who are not familiar with these methods will not be able to use them. People who are familiar with these methods but have not had experience as facilitators often fail to generate effective community participation and involvement.
- The toolkit presents very flexible guidelines about what should happen in each HIV prevention programme. The people who implement the programme therefore need to have their own capacity to make judgements about what is appropriate for their own local context. They also need capacity to plan and manage their own programme, so that it becomes effective in supporting behaviour change.

Flexible alternatives to capacity building

The toolkit allows for a flexible approach to capacity building. This is important because people's needs for capacity building vary enormously. Some will already have all the skills needed, while others will have very few such skills.

The programme manager must therefore make an assessment of the capacity building needs of those who will be involved in the final three sections of the toolkit: situation analysis, building HIV resilient communities, and supporting individual behaviour change.

In some cases, for example where a local community group is already working on community development issues using participatory methods, it might not be necessary to build capacity in each required area. The local community group, for example, might already know how to plan programmes, how to use PLA methods and how to facilitate focus groups. In these

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cases, the programme manager should make an informed decision on what capacities are already available, and what capacities need to be further developed.

In some cases, the local community might already be running and HIV prevention programme, but does not yet work specifically to meet the needs of mobile population groups. In these cases, the programme manager should make an informed decision on what capacities are already available, and what capacities need to be further developed.

Each specific community will have different experiences with participatory approaches in education. To build capacity to implement an HIV prevention programme, the programme manager might have to spend time explaining why participatory approaches are important, and how they work. This might need to occur before, or as part of, any specific training in skills needed to implement the programme.

Programme facilitators are encouraged to use their own training resources in the development of these capacity building processes. The most useful processes for capacity building are the same as the processes to be used later in working with construction workers and local community members: participatory learning and action, focus group discussions, and other interactive learning processes.

One example of a training curriculum is provided as **Appendix A**. This was developed for and used successfully in the Myanmar field testing of the toolkits.

Suggested steps for capacity building

The steps to be taken are:

- ❑ Conduct a training needs assessment
- ❑ Develop training curricula and lessons plan based on the needs assessment
- ❑ Conduct capacity building training

Capacity building for the Task Group members and local volunteers will need to occur at the very beginning of the programme. This will build their capacity to:

- 1) understand HIV transmission and prevention
- 2) use participatory learning and action methods
- 3) facilitate focus group discussions
- 4) conduct surveys
- 5) plan a programme
- 6) communicate
- 7) identify appropriate resources
- 8) select and recruit peer educators and frontline social networkers
- 9) motivate communities, provide social leadership, work as a team, and manage group actions.

Once they have these capacities, the Task Group and local volunteers can undertake the situation analysis (see next section of the toolkit).

After the situation analysis is complete, they can work to build the capacity of peer educators and frontline social networkers. It is important to allow sufficient time to build these capacities before implementing the rest of the programme. Some of the Task Group and local volunteers will assist the programme manager to conduct training sessions.

Capacity building for peer educators and frontline social networkers will build capacity in:

1. participatory learning and action methods
2. focus group discussions
3. life skills approaches to HIV prevention
4. communication skills

Field testing and other lessons learned about capacity building

During field testing, participants in the capacity building sessions appreciated the opportunity to learn new skills. Most had never used PLA methods before, but they found them easy to learn and apply. Many reported that they would use their newly acquired skills in their community work. In Lao PDR the outcome of the training was that the Local Task Group members greatly increased their knowledge of HIV/AIDS, PLA, focus group discussions and planning methods.

Training sessions were organised according to the local situation and the requirements of the participants. In Cambodia the sessions were conducted in a local nightclub. In Vietnam the fishermen who were trained said that the participatory methods used were easy to learn and use. They also mentioned that these methods were suitable for those who are illiterate.

In Myanmar a curriculum was developed for the Village Health Team (name of the Local Task Group in Myanmar) and for volunteers. This curriculum is attached as **Annex X**, as an example of the type of programme to be used. In Lao PDR the participants who successfully completed the training received certificates from the trainer. The use of certificates is a type of motivator that a programme manager may consider using to acknowledge the efforts of the participants.

In the design and implementation of a HIV prevention programme using the toolkits it will be necessary to allow adequate time to undertake capacity building and Allowance should also be made for refresher courses and follow up of those trained.

“Community participation also means building capacities in communities to advocate and bring about the political, social and economic changes, as well as to improved access to health and information services that will enable them to participate more fully in national efforts.”

Larsen HJ, Narain JP. Beyond 2000: responding to HIV/AIDS in the new millenium. New Delhi, World Health Organisation, 2001

“At the programme/project level, the following factors are central to programme success ...(list includes)

- *the provision of training in skills for communication*
- *the participation of target groups at all stages of design, implementation and evaluation*
- *the monitoring of programmes / projects at all stages of development and implementation.”*

*Innovative approaches to HIV prevention: selected case studies
UNAIDS Best Practice Collection, Geneva, 2001*

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Pre programme HIV/AIDS Knowledge survey questionnaire
10 ways to help someone prevent HIV. California Partners Study II, see: <http://www.caps.ucsf.edu/projects>

Family Health International (FHI), HIV risk behavioral surveillance surveys (BSS): Methodology and issues in monitoring HIV risk behaviors, The AIDS Control and Prevention (AIDSCAP) project funded by USAID.

UNICER/EAPRO: Securing a Future-Mekong Children and HIV/AIDS (2000)

UNOPS/UNDP-Southeast Asia HIV & Development: People's Development – A Community Governance Tool (2001)

SITUATION ANALYSIS

Desired outcome

The local situation and needs of mobile groups are understood.

The situation assessment will answer the following questions:

- How is HIV transmission most likely to occur in this locality?
- How are mobility and HIV transmission associated in this locality?
- What are the characteristics of mobile people here, and how are different groups of mobile people more or less vulnerable to HIV? (consider short term or long term placement here, origins of mobile people, who they travel with, how easy is it for them to interact with local people, languages used, what is culturally appropriate, and so on)
- What other things are already happening in this locality that will influence HIV transmission (e.g. other programmes, health service provision)?
- Who, in this locality, can positively influence the behavior of mobile people to avoid HIV transmission?
- What will help create an enabling environment so that mobile people find it easy to change their behaviour to avoid HIV transmission?
- What will make it hard for people to change their behaviour in this locality?

The programme manager and the Task Group on HIV and Mobility will conduct the situation analysis and then prepare a plan of action to reduce HIV transmission for mobile people. The plan of action will take account of the answers to the above questions, so that the programme responds to existing needs.

Why this outcome is important

It is important to understand the real situations people face in preventing HIV transmission.

Many HIV prevention programmes have been ineffective because the people implementing the programmes assumed that they understood what other people needed. It is easy to make assumptions about the answers to the questions listed above.

Conducting a situation analysis means that the programme manager and the Local Task Group can assess the real situation. They can use the findings of the situation analysis to ensure the HIV prevention programme is based on the right assumptions. They can determine what the real situations are and, therefore, what needs to occur in an effective HIV prevention programme in this location or amongst this group of mobile people.

People involved in conducting situation analyses have often found that the process builds their own motivation, commitment and sense of ownership of the HIV prevention programme. Going out into the community and interacting with people means that the programme implementers build rapport with community members, develop understanding of

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the local culture or cultures, build understanding of the problems faced by different people, and build a much deeper understanding of how to design their own effective programmes.

HIV is often a sensitive issue to discuss in communities. It involves talking about issues not normally talked about. The situation analysis can be the first stage of building trust between the educators and the rest of the community. It can give the community members and mobile people a sense of value, because their first interaction with the educators is when they are asked to give their own opinions and talk of their own experiences. It can also be the first stage of supporting the local community members in identifying their own problems and finding their own solutions to those problems.

Flexible alternatives to situation analysis

The toolkit allows for a flexible approach to conducting a situation analysis. Programme managers can choose what methods they will use.

Alternatives might be:

- A situation analysis has already been done before this HIV prevention programme commences. In this case, the Task Group could just consider the results of that previous situation analysis. It will be important to ensure that members of the Task Group discuss the information available to them, and consider directly what this implies for the new HIV prevention programme. Because situations change, especially situations affected by mobility, it will be important to conduct at least some independent follow-up activities to update understanding of the current situation.
- No specific situation analysis has been conducted for HIV prevention, but community organisations have collected data for other reasons. This data can be collated and reviewed, so that there is no need to collect data again in order to find out some aspects of the local situation.
- A rapid assessment of the current situation in this location or with this group of mobile people, to take place before the rest of the HIV prevention programme begins.
- A more complex situation assessment, using multiple techniques, which might have different components that take place at different stages of the HIV prevention programme.

Suggested steps for situation analysis

- Hold a special meeting of the local Task Group, and ask that group to generate lists of answers to the questions listed in the first paragraph above, by using PLA methods.
- Conduct the *Pre-Programme Survey* amongst mobile people, to find out what they already know about HIV.
- Conduct PLA exercises with groups of mobile people, to find their answers to the above questions.
- Gather statistics and other recorded data from local health departments and others who might collect information about the local community or mobile groups.

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- Hold meetings with other groups running programmes or providing health services in this locality. Ask them to help you make more complete answers to each of the above questions.
- Write a report summarising what you have learnt from the above steps. This report should include:
 - The process you used
 - The list of points outlining why this locality is an important place to work on HIV with construction workers
 - The outcomes of the Task Group PLA exercise
 - The outcomes of the construction workers PLA exercise
 - The summary of results of the *Pre-programme survey*
 - A summary of what you learn through discussions with representatives of other groups running programmes
 - The conclusions drawn by the Task Group on what should now occur to prevent further HIV transmission amongst construction workers the local community.
- Present your findings and recommendations to the Task Group and other interested people for discussion on how the rest of the programme should proceed. This discussion should identify priorities for the local programme to prevent HIV transmission.
- Based on the findings and the discussion, prepare a Plan of Action to indicate how the next three sections of the guidelines will be implemented.

Lessons learnt about situation analysis, from field testing and other sources

The two methods used to gather information were the pre-test survey and the use of Participatory Learning and Action techniques. These included mapping, trend analysis, causal diagrams and focus group discussions. Both the Task Group members and the Country Co-ordinators gave the following reasons for conducting the situation analysis using these methodologies:

- It was a means of engaging the mobile group and local communities in a non-threatening environment to share their knowledge and understanding of the local situation. As HIV is usually a sensitive topic to raise with groups who are not HIV positive, it is usual to experience resistance if programme implementers only provide education sessions on HIV prevention without any opportunity for interaction.
- Doing the situation analysis involved the local people, buildt trust and confidence It also gave people a sense of value, as they saw outsiders who were willing to come and ask their opinions and listen to the information that they have about their local area.
- It allows participants to identify the particular issues of vulnerability to HIV in their area and allows them to identify their own solutions to these issues.

In Cambodia

“The information gathered from the situation analysis tells us a lot of things about how our community is affected by mobility and HIV. I think we are now having a better idea of what and how we can do things better in the future...”

Head of Provincial AIDS Office, Sihanouk Ville

“When one thinks about AIDS here, the first thing that usually comes to one’s mind is a condom. But from these PLA exercises we can see that there are many more things to consider..”

A sex worker, Phum Thumey

In countries or locations where secondary sources of data are scarce, such as in Lao PDR, the application of a simple tool such as PLA was useful for gathering information. The pre and post-test survey among the mobile group is also useful as a means to measure the immediate impact of the programme activities on behaviour change.

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UNOPS/UNDP, South East Asia HIV and Development, Population mobility and HIV vulnerability in South East Asia, an assessment and analysis

Vietnam Seafarers Research Team: Rapid Assessment of Seafarer vulnerability to HIV/AIDS and drug abuse

UNAIDS AP ICT Taskforce on Migrant Labour and HIV vulnerability: Guidelines for rapid applied research on mobile populations for planning and implementing STD/HIV/AIDS Prevention and Care (January 1998, Bangkok)

UNICER/EAPRO: Securing a Future-Mekong Children and HIV/AIDS (2000)

UNOPS/UNDP, Southeast Asia HIV & Development: People’s Development – A Community Governance Tool (2001)

FHI/AIDSCAP: HIV risk behavioral surveillance surveys (BSS), methodology and issues in monitoring HIV risk behaviors

Sample list of voluntary counseling and testing services from Cambodia.

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BUILDING HIV RESILIENT COMMUNITIES

Desired outcome

The local community has adapted to the presence of HIV, and taken the first steps towards becoming “HIV resilient”.

A community that is HIV resilient will be able to draw on its own capacity to

- prevent further transmission of HIV
- minimise the impact of the HIV epidemic, including
 - health impact of HIV
 - social impact of HIV
 - development impact of HIV

It takes a long, long time for a community to be able to achieve all these outcomes. More time than is available for a single HIV prevention programme. But an HIV prevention programme, even in the short term, can help a community to take the first important steps.

The toolkit recommends that the HIV prevention programme should focus on achieving these important first steps. It suggests some practical short term outcomes. Then the local community will be moving towards becoming “HIV resilient”.

After the HIV prevention programme, the community members will:

- know about HIV
- have a sense of ownership of their own responses to HIV
- acknowledge that HIV is important for this community
- be talking about HIV in helpful ways that don’t lead to panic and stigma
- be aware of the association between HIV and mobility
- be working with mobile people in action to slow down the epidemic, without creating stigma and discrimination against mobile people
- be aware that people living with HIV can contribute to more effective HIV prevention programmes, and be taking steps to make possible their participation
- be developing strategies to ensure provision of resources and services, including
 - access to condoms for those who need them
 - access to counseling and HIV testing
 - access to STI diagnosis and treatment

Why this outcome is important

HIV affects every community. However, it is possible for each community to become “resilient” to the HIV epidemic. This means that the community will adequately respond to the problems caused by HIV, so that the virus and related illness do not destroy the community. Even though there is HIV present, the community will continue to survive and develop. It is important that the HIV prevention programme does not lead communities into thinking they should isolate construction workers, or marginalize them from full participation

in community affairs. An HIV resilient community will be resilient to HIV, not resilient to the positive impacts of mobility and socio-economic development.

The term “resilience” is used to indicate that communities require more than just information about HIV. They need to become “resilient”, in a similar sense to the way a car tyre might be resilient to rocks on the road. The tyre running over a rock does not burst, but it bends a little to adjust to the presence of the stone, later returning to its original shape. In a similar way, communities can adapt to the presence of HIV. Similar words which might also be used include “tolerance”, “recovery”, “overcome”, “adaptation”, “coping mechanisms” and “societal resistance”.

Building HIV resilient communities recognises that mobile people, while themselves vulnerable to HIV, are also part of a broader community while they are present. Preventing HIV transmission therefore requires involvement of the broader community as well as the mobile people. Building HIV resilient communities promotes general awareness about HIV, and ensures there will be community understanding and support for special HIV programmes and services for mobile people.

In the long term, a community that is resilient to HIV will be able to draw on its own capacity to

- prevent further transmission of HIV
- minimise the impact of the HIV epidemic, including
 - health impact of HIV
 - social impact of HIV
 - development impact of HIV

UNAIDS recommends the following processes should be used in communities faced with the challenge of HIV. These processes would be important first steps towards building HIV resilient communities:

- *engaging the community* through existing organizations, groups and structures for education and support
- *building partnership* and trust through communication, networking and collaboration
- *including people with HIV and AIDS* at all stages of the process so as to enhance visibility and benefit from their skills and experiences
- creating an *accepting community environment* in which HIV and AIDS are acknowledged to be everyone’s concern.

While these may be difficult to achieve in the short term, this section of the toolkit outlines the steps that can be taken to ensure the community is moving in the right direction.

To become HIV resilient, communities require support to undertake analysis of challenges they face, and to find sustainable solutions to the problems they identify. The solutions often require partnerships with construction company managers, construction workers, other communities, governments, the private sector and civil society organisations. The solutions require initiatives in prevention of HIV transmission, creation of an enabling environment, and facilitation of development for communities and construction workers.

This toolkit is mainly concerned with helping communities and mobile people to prevent further transmission of HIV. It is not possible to prevent transmission of HIV unless the community as a whole is able to talk about the epidemic in ways that help its members to support each other in making changes. This occurs only when the community is able to address the whole range of issues that will make it resilient to HIV. It will require discussions between community members and construction workers, rather than either group of people working on their own.

Once the community has taken the first steps, it might be useful to consider activities that will help with community development. For example, helping the community to address issues of poverty, food security within an HIV epidemic, or sustainable livelihoods for people directly affected by HIV (those with HIV, and their family members).

Flexible alternatives to building HIV resilient communities

Experience of HIV educators indicates that it takes a long, long time to build HIV resilient communities. But in the short term, significant steps can be taken that lead to this long term outcome. There is no set way to build an HIV resilient community, but there are important processes that can help.

Participatory processes can be used to engage members of the community in discussion about HIV. These processes can be used in ways that help the community move towards being HIV resilient. It is the participatory approach that makes a difference. Helping people to talk about HIV with each other is far more useful than just informing them about HIV.

Without community ownership and a shared commitment to long term change, HIV prevention programmes can result in denial of HIV, stigma against those perceived to be at risk, and marginalization of mobile people and those who interact with them. All of these outcomes result in further HIV transmission.

So the primary task of a short term programme is to promote community discussion, acceptance of HIV, and acceptance that HIV is a problem for the whole community, not just for those who might be at high risk. Exactly how an HIV prevention programme can facilitate community discussion is flexible, and the objective can be met in many different ways.

Suggested steps for building HIV resilient communities

Five strategies are suggested to help communities become resilient to HIV. The programme manager, working with the local Task Group, will need to ensure that all five strategies are in place.

1. ***Raising awareness about HIV.*** This requires two key steps:
 - Promoting understanding about HIV, through dissemination of information, using culturally appropriate methods. These might include mass campaigns and distribution of

educational materials throughout the whole community. **Examples of educational materials are included in the toolkit (in the section on *HIV resilient communities*).**

- Generating community discussion about HIV. Through discussion, the community will not only learn the facts about HIV, but will also begin to develop its own solutions to the problems caused by the HIV epidemic. Community discussion can be started using Participatory Learning and Action (PLA) exercises with groups of people likely to have a big influence on how the community talks to itself. **PLA exercises to generate community discussion about HIV are included in the toolkit (in the section on *capacity building*).**

2. *Ensuring people have access to condoms.*

An HIV resilient community will ensure that all sexually active people have affordable access to condoms on a sustainable basis. Social marketing of condoms ensures that the community understands the value of condom use, and that condoms are easily available for those who need to use them. In all the countries of the Greater Mekong Subregion, there is now an organisation responsible for social marketing of condoms. The programme facilitator can ask the condom social marketing agency to become active in programme location. Where this is not possible, the Task Group should discuss ways to make sure condoms are available in the community through a variety of outlets. This will ensure that the HIV resilient community does not depend on construction workers to provide condoms for use in all circumstances.

3. *HIV counseling, testing and referral services.*

In an HIV resilient community, anyone concerned that they might have HIV will be able to obtain voluntary counseling and testing. If these services are not already available, the Task Group and the local Health Department should discuss what can be done to make such services available.

4. *STI diagnosis and treatment.*

STI stands for “sexually transmitted infection”. If STIs are correctly diagnosed and treated, then HIV transmission is much less likely to occur. In an HIV resilient community, services will be available for STI diagnosis and treatment, or at least referral services will be available. If these services are not already available, the Task Group and the local Health Department should discuss what can be done to make such services available.

5. *Participation of people living with HIV.*

Communities that enable people living with HIV to participate in HIV programmes, and in other community affairs, are more likely to develop deep understanding of the nature of the HIV epidemic and what works to slow it down. The most useful starting point is to support the development of small networks of people living with HIV. If these groups do not exist in the local community, the Task Group should discuss what can be done to develop such groups. Ideally, people living with HIV should be represented on the Task Group and involved in the training and education.

Lessons learnt about building HIV resilient communities, from field testing and other sources

- The Case Studies of the field testing reported that the combination of awareness and education activities, along with the identification of services such as STI testing and treatment, HIV counseling, testing and condom distribution provides a comprehensive package for the prevention of HIV through behaviour change. It was recognised by the Country Coordinators that the toolkits will help to minimise the impact of the HIV epidemic among communities and mobile groups in locations where they live and work.
- The building of resilient communities facilitates the collective responses of a group or a community to preventing HIV. In static communities where there is good integration of the mobile group into the local population, it is possible to integrate this with the section on Promoting Behaviour Change. Examples where these two sections were integrated include Sihanouk Ville, where the toolkit was used amongst sex workers, and in Duwei, where the toolkit was used in fishing villages.
- In locations where the situation is more dynamic, such as when the toolkit is used with road construction workers and truck drivers, it may be useful to have separate sections for the local community and for each mobile group. The Cambodia Case Study provides a good example of an approach that integrates the two sections.
- An example of what can be done by a community to make sure condoms are available comes from the field testing in Myanmar. The Local Task Group proposed the setting up of a village health revolving fund to support health activities including condom promotion and distribution. This is an example of the local community taking responsibility to prevent the spread of HIV in their location. To establish this fund they requested a loan from a local NGO as seed funding to establish a small business – chicken raising – in order to have money to start up the health revolving fund.
- In Lao PDR, participants in the activities to build a resilient community stated that the toolkit gives a whole context and process for dealing with HIV transmission among mobile groups alongside development related problems.

“Behaviour change will not occur without a significant change in the social and political environment in the wider society. Unequal gender and power relations, taboos on frank and open communications about sex, and stigma and discrimination are particularly significant obstacles to an effective response. If stigma and fear around HIV/AIDS persists, the epidemic will remain hidden. Only clear, candid information about how HIV is and is NOT transmitted will alleviate unnecessary fear and discrimination.”

Larsen HJ, Narain JP. Beyond 2000: responding to HIV/AIDS in the new millennium. New Delhi, World Health Organisation, 2001

Reference list

Samples of health education materials from the GMS countries

National AIDS Standing Bureau, Socialist Republic of Vietnam: Provincial AIDS Committee Guidelines: Guidelines on how to organize a HIV/AIDS counseling network and its activities

Border Areas HIV/AIDS Prevention (BAHAP), Family Health International (FHI): When the Stars are Up: Life and work of Sex Workers in Koh Kong, CARE International in Cambodia, June 2000

Family Health International(FHI), CARE: Work, Life and Sex Among Motor Taxi Drivers in Koh Kong, Cambodia (June 2000)

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UNICER/EAPRO: Securing a Future-Mekong Children and HIV/AIDS (2000)

UNOPS/UNDP-Southeast Asia HIV & Development: People's Development – A Community Governance Tool (2001)

UNICEF: Promoting Health, Resilience and Psychosocial Development in Children and Youth affected by AIDS, A child friendly community schools approach (2001)

PROMOTING BEHAVIOUR CHANGES FOR MOBILE PEOPLE

Desired outcome

Mobile people have received support for behavior change.

Mobile people will

- be informed about HIV transmission
- have personal support for behavior change from their own peers or other people with whom they interact
- have access to resources they might need to prevent HIV transmission (such as condoms or syringes), and
- have access to services that enable diagnosis and treatment of sexually transmissible infections (STIs).

To prevent HIV transmission associated with mobility, it is important to work directly with mobile people. However, HIV prevention programmes that just focus on mobile people can lead others to believe they are not themselves at risk (i.e. lead to community denial of HIV). They can also draw attention to mobile people's vulnerability to HIV, but accidentally create stigma, and then cause discrimination, against mobile people. It is therefore essential that there also be work with the broader community, including those who are not mobile.

Why this outcome is important

General awareness about HIV is not sufficient on its own to bring about behavior change.

Vulnerability to HIV depends on people's place within a community. Mobile people can be vulnerable to HIV because they are marginalized, lack access to services and regular HIV programmes, are separated from their regular partners, and are distant from their families. They might be from a different culture, speak different languages, or be unfamiliar with the local area. They might sometimes have high disposable incomes in comparison to the local community, and have recreation time with little to do. All these factors influence whether they are likely to undertake behaviors which enable HIV transmission. In the long term, an HIV prevention programme will have to help people find ways to address all these factors.

Mobile people need special support to help them to make behavior changes. This can overcome the barriers to behavior change that are specifically relevant to them.

“While information is critical to behaviour change, there is substantial evidence to show that information alone is ineffective in changing behaviours. Integrated approaches involving advocacy, education, voluntary counselling and testing, provision of condoms and STI services have met with considerable success.”

Larsen HJ, Narain JP. Beyond 2000: responding to HIV/AIDS in the new millenium. New Delhi, World Health Organisation, 2001

Flexible alternatives to facilitating behaviour change

Mobile people who are vulnerable to HIV require four types of support:

- provision of information
- direct personal contact which supports behaviour change
- availability of resources
- access to services

As with other sections of this toolkit, there is no set way to provide each of these types of support. The toolkit, in the next section, outlines what might occur in an HIV prevention programme. But exactly what is done will depend on local situations, the capacity of programme managers and task groups, and the mobile people's own previous exposure to HIV prevention programmes.

Suggested steps for building HIV resilient communities

Four types of support are required:

- provision of information
- direct personal contact which supports behaviour change
- availability of resources
- access to services.

1. *Provision of information.*

Provision of information through education materials which include specific information relevant to their own sexual and drug using behaviors. This might be different to the information provided to the whole community. These might have to be adapted to the languages and cultures of the mobile people working in each location.

The Task Group should develop an education campaign to ensure that all mobile workers know about HIV and how to prevent HIV transmission. This might include use of education materials, videos, radio, posters, public lectures or community events. A reference list of some suitable IEC materials, used in the field testing of the toolkit, is included as an annex to the toolkit.

2. *Direct personal contact which supports behaviour change.*

Direct personal contact, through which mobile people can talk with people who understand their behaviors and the difficulties in changing them. This can be the result of

- Peer Education, through which people learn together with others like themselves.

- Regular contact with Frontline Social Networkers, who are well informed about HIV, what is required for behavior change, and how to support mobile workers undertaking behavior change.
- Peer educators. Support for behavior change can be provided by “Peer educators”. These are mobile workers who have been trained to support behavior change amongst their own peers, who are other construction workers. The Task Group will need to develop a plan to train peer educators and then to support their education work. The main methods used by peer educators are Participatory Learning and Action (PLA) and Focus Group Discussions.
- Frontline Social Networkers. Support for behavior change can also be provided by “Frontline social networkers”. These are people who are not mobile people, but who interact with them through work or recreation activities. Frontline Social Networkers for mobile workers such as construction workers could be cyclo or taxi drivers, waitresses, shopkeepers or other people who regularly talk with construction workers. The Task Group will need to develop a plan to train frontline social networkers and then to support their education work. The main methods used by Frontline Social Networkers are face to face discussions with individuals and distribution of condoms. The training for capacity building will have to ensure that Frontline Social Networkers learn about communication skills and basic knowledge about prevention of HIV transmission. The Task Group will need to develop a plan to ensure condoms are available for use by Frontline Social Networkers.

3. *Availability of resources.*

This might be as simple as explaining where mobile people can buy condoms in this location. In some cases, it might include making condoms available in the workplace, especially at construction sites or in dormitories.

- Condoms in the workplace. Special efforts need to be made to ensure that mobile people know where to find condoms, how to buy them and how to use them. The programme facilitator and the Task Group will devise a strategy to ensure that mobile people have access to condoms. In the short term, this might include free distribution of condoms (paid by the programme). Later, the construction company might agree to provide condoms, or to make sure they are available at affordable prices on a sustainable basis.
- Clean needles and syringes. Some mobile people inject drugs, either for pleasure or to help them cope with difficult work. These people will need access to clean injecting equipment, otherwise HIV will be rapidly transmitted between those who inject drugs, and then to their sexual partners.

4. *Access to services.*

Mobile people require access to HIV testing and counselling, and to STI diagnosis and treatment.

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A short term programme will need to ensure these services are available, affordable, and accessible to mobile people. It will need to ensure that existing services are able to meet the needs of people who speak different languages and come from different cultures to the local culture. It might set up mobile clinics at construction sites, or outreach services from existing health clinics. It might find other ways to ensure that mobile people receive referrals and can gain access to existing services.

In the field testing of the toolkits, one programme developed a list of all available health services in the local area. They then printed 10,000 copies of this list, to distribute to mobile workers so that they knew what services are available and how to access them.

Lessons learnt about behaviour change, from field testing and other sources

The four steps together provide a comprehensive package of strategies. They support behaviour change by providing knowledge about HIV prevention along with other essential means. This was welcomed during field testing by truck drivers, fishermen, and construction workers. Some of them had received information about HIV prevention before but had not had access to services. The services, and peer support, are important components of an enabling environment for safe sexual behaviours.

In Cambodia one outreach worker's testimony of her experience with the toolkits shows how desirable the toolkit is.

“My experience with the toolkit field-testing programme was wonderful. I was involved in all stages of the programme from the beginning till the end... I've learned a lot of things from WV, the local Task Group and many others... I am happy to be able to help people in my own community to think about their life, their future and what to do to get rid of the AIDS problems... I am also proud of being part of the bigger programme, the regional Programme on Preventing HIV among Mobile Populations in the GMS... I would say this is a great yet challenging initiative, which has never been introduced into our community before... I am sure others will agree with me in saying that we've seen significant changes happening in our community during and following the field-testing. For example, active participation of community members including mobile groups in the whole process of planning and implementation ... full support from the local Task Group, the mobile populations as well as the local government... I hope the programme will be extended further with expansion into care and support for people living with HIV/AIDS as well.”

Community outreach worker, Sihanouk Ville

In Vietnam the Country Coordinator identified and trained a small group of Peer Educators and Frontline social networkers to work with fishermen and sex workers. The fishermen were able to discuss HIV prevention during their long trip at sea, as well as distribute IEC materials.

In Vietnam the fishermen and local task group suggested the setting up of a fisherman's club for recreation activities. They use it as a place to display IEC materials and as a place for fishermen to meet peer educators.

In Laos the truck drivers suggested erecting an HIV education board at the Bus Station to display HIV information. They also prepared a box of HIV leaflets for drivers to take and read during their trips.

“Even those who might have made safe choices and taken precautions to prevent HIV infection may find themselves limited by communication skills in another country and be frustrated by difficult access to local resources and services such as buying condoms and seeking treatment for STIs.”

Larsen HJ, Narain JP. Beyond 2000: responding to HIV/AIDS in the new millennium. New Delhi, World Health Organisation, 2001

“The correlation between HIV and sexually transmitted infection

- *The predominant mode of transmission of both HIV and other STI agents is sexual, although other routes of transmission for both HIV and other STI agents is sexual, although other routes of transmission for both include blood, blood products, donated organs of issue, and from an infected woman to her foetus or newborn infant*
- *Many of the measures taken for preventing the sexual transmission of HIV and other STI agents are the same, as are the target audiences for these interventions*
- *Access to STI clinical services are important for people at high risk of contracting STIs and HIV, not only for diagnosis and treatment but also for education and counselling.*
- *There is a strong association between the occurrence of HIV infection and the presence of certain STIs, making early diagnosis and effective treatment of such STIs an important strategy for the prevention of HIV transmission.*
- *Trends in STI incidence and prevalence can be useful early indicators of changes in sexual behaviour and are easier to monitor than trends in HIV seroprevalence.”*

Larsen HJ, Narain JP. Beyond 2000: responding to HIV/AIDS in the new millennium. New Delhi, World Health Organisation, 2001

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Bruce Parnell & Kim Benton: Facilitating sustainable behaviour change, a guidebook for designing HIV programs (1999)

UNOPD/UNDP, Southeast Asia HIV & Development: Sang Fan Wan Mai Youth Group: Tiny steps by youth to battle the AIDS crisis (2001)

UNAIDS, Condom Social Marketing: Selected Case Studies (2000)

USING THE TOOLKIT WITH SPECIAL MOBILE GROUPS

The toolkit shows how to implement an HIV prevention programme in locations where there are mobile people. In some cases, the toolkits will be used to design HIV prevention programmes for specific groups of mobile people. The groups are

- construction workers
- truck drivers
- fishermen
- migrant sex workers.

For each of these groups of mobile people, this section outlines some of their characteristics and suggests what needs to occur if the toolkits are to be used with these groups. The information is presented under the same headings as used in each section of the toolkit. Readers should refer to that section and consider what is said here. For example, if a programme manager is forming a local Task Group as part of a programme for fishermen, then the relevant section to consider here will be “FISHERMEN – Local Task Group”.

CONSTRUCTION WORKERS

The toolkit will be used to inform development of HIV prevention programmes for construction workers from specific companies. Those companies will provide sub-contracts to HIV programme managers, to design and implement HIV prevention programmes for their own workers.

Task Group

For a construction project that is involved in building roads there is a need to consider forming a Task Group within the company. The Task Group might include participation of district or provincial level HIV or health authorities, depending on the size of the project.

Road construction workers move along the route being developed. They do not relate to local communities for very long. It is important to remember this when forming a Task Group. The Task Group might have members from within the company and from provincial or district levels, rather than having members from more local community organisations, as these will not move along with the construction workers.

Construction workers at ports or dam sites will be in a static location for the length of the construction project. In this case, a local Task Group can be formed that includes the construction workers along with representatives of the local community. The local community members will interact with the construction workers during the whole life of the construction project. It is important, therefore, to facilitate interaction between the community and the construction workers, and the local Task Group will be an effective starting point.

At port locations there will also be other mobile groups such as truck drivers, fishermen and migrant sex workers. This allows for the development of integrated programme working with multiple mobile groups within the same programme.

Capacity Building

The development of capacity building programmes for construction workers will need to be in appropriate languages. It will be necessary to work with the management of the Construction Company to negotiate the most suitable time to run capacity building programmes for the workers. At the field testing site in Yunnan Province, the workers were organised into three shifts. This would have to be taken into consideration when scheduling programme activities with workers.

Situation Analysis

Construction workers might be migrants from other provinces or from other countries. In collecting information, it will be important to find out the place of origin of the construction workers. It will be important to identify which languages are best understood by the workers. These are the languages that should be used for information and for participatory education sessions.

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During the field testing it was noted that groups of workers often travel together from their home district or province, and some even bring their wives who get jobs as cooks at the construction site.

Another characteristic of migrant construction workers discovered during the field testing is that there is a high turnover of workers, as many of them come to the new location as seasonal workers. For projects that do have a high turnover of workers capacity building will have to be an ongoing component rather than a one time activity.

Building an HIV Resilient Community

When construction programmes are located in remote areas there will be a need to assess how to ensure that workers have access to resources and services relating to HIV prevention. How best to provide access to condoms, STI diagnosis and HIV counseling and testing will be determined by the programme manager and the local Task Group according to the local situation. This may require the HIV prevention programme to include the provision of condoms and provision for medical or nurse practitioners to provide health/STI checks and counselling for employees.

For port and dam construction sites it is expected that there will be local services in existence that can be accessed by the construction workers. The project manager will need to check that these local services are willing to see migrant workers and have staff who can communicate with them if they speak different languages.

Promoting Behaviour Change

IEC materials are more acceptable when they have been developed for specific groups. To date little has been developed for construction workers so any programme proposing to do HIV prevention with this group will need to source or develop relevant and culturally appropriate IEC materials.

Construction workers often live at the construction sites and have high earnings. They will travel to local towns for entertainment in their free time. To ensure that construction workers have direct and ongoing personal contact which supports behaviour change, it will be necessary to recruit and train peer educators who are part of the company and can move when the rest of the workers move.

In static construction sites such as port or dams, direct personal contact could be through a network of Frontline Social Networkers. These are people who interact with the construction workers, such as cyclo/taxi drivers, waitresses and bar owners. They can be trained to ensure that they are able to provide support for behaviour change.

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TRUCK DRIVERS

The nature of their work requires truck drivers to be on the move, driving to and from destinations that are either long or short journeys within a country or across borders.

This presents unique challenges when developing HIV prevention programmes for truck drivers. Options vary and each project will have to determine what will be the most appropriate approach. It is possible to work through the transport companies, private or government owned, or to work at locations where the drivers stop.

In Vietnam, World Vision has found that implementing such programmes is best done in truck stopping sites. These are visited far more often than the transport company offices, which truck drivers may only visit once a month on pay day.

Task Group

Truck drivers are constantly travelling along major highways and tend to have their regular favourite stopping places where they eat, rest, wash and refuel their trucks.

The local Task Group for a programme that relates to truck drivers should include people from the local communities at identified truck stopping sites.

Capacity Building

In a programme working with truck drivers the capacity building strategies will focus on the community members involved in the Local Task Group and on those people chosen to be Frontline Social Networkers. In the World Vision Vietnam project for truck drivers in Central Vietnam, it was important to implement follow up training for local community members and Frontline Social Networkers. These follow up training sessions included one to one mentoring and demonstrations of how to discuss sexual behaviour and HIV prevention methods with the drivers.

Situation Analysis

Data will need to be collected about where the truck drivers come from, their destinations and the places where they stop along the route. There are short and long haul drivers, and the length of the haul determines the length of time they are away from home. Strategies to work with long haul drivers will be different, as they are away from home for longer periods. They may have a few days of waiting at border crossings, or at ports, unloading and loading goods. This is when they have time for entertainment.

At the stopping sites along the route, drivers usually only stop long enough to eat and refuel before moving on. Understanding the travelling habits of the truck drivers will be necessary in order to plan programme implementation.

Building an HIV Resilient Community/ Promoting Behaviour Change

Truck drivers usually have young men as assistants, so programmes should aim to include them in education activities.

It is difficult to get truck drivers to participate in training programmes so the recommended approach is to train a network of Frontline Social Networkers at the identified stopping sites within the project location. This strategy worked successfully in the World Vision Truck Drivers project in Vietnam. Waitresses, tollgate attendants, restaurant owners and petrol pump attendants were trained as Frontline Social Networkers. They discovered that of all their strategies the best time to talk to the drivers and assistants was when they had finished their meal and before they set out on the road again. In this brief period they were most relaxed and open to talking and receiving information about HIV prevention.

After receiving IEC materials the same drivers would return on their next trip to ask questions and request more materials. Some wanted more information about where to get condoms or where to go for treatment. A rapport developed between the drivers and the Frontline Social Networkers. A relationship of trust developed, and this enabled the Frontline Social Networkers to encourage behaviour change amongst the truck drivers.

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APAC-VHS Chennai: Prevention of STD/HIV/AIDS along the highway. An innovative initiative (1999)

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FISHERMEN

There are many different types of fishermen. Some go to sea for a few days at a time, others for a few weeks or months. Some will work from their home ports while others may come from other locations to find work at large fishing ports, as is the case with fishermen in Myanmar who work in Myeik but from all over the country, including inland areas. Those who are at sea from many months will stop at other ports in either their own country or in other countries in the region.

A programme that intends to work with fishermen will have to do an assessment in the location chosen to determine the type of fishermen and their travel patterns. This will be important to the design of activities appropriate to meet their needs.

Task Group

The members of a local Task Group will have to be from the port community where the programme is based. The management of the port and some owners of large fleets of boats can be invited to be members of the group. In Vietnam the fishermen are organised through the Farmer's Union which is a mass organisation. In the field testing of toolkits among fishermen in Vietnam, the Farmer's Union member was the key person involved in organising the fishermen and arranging for the field testing staff to work with them.

If a programme is located in the home villages of the fishermen then it is more feasible to have them participate in the Local Task Group. This was the case in the field testing in Myanmar.

Capacity Building

For programmes with fishermen, building capacity of Peer Educators requires special attention to the planning of the training and follow up sessions. Times will have to be arranged around their fishing trips to coincide with their days in port. Since they will want to rest and relax during these shore leave times it will be important to get the support of local authorities who can ensure their participation. In Vietnam this was facilitated by the Farmer's Union member. In Myanmar, World Vision already had a programme among the fishermen, and the participants in that project facilitated the selection and training of the peer educators for the HIV prevention programme.

Situation Analysis

It is critical when working to prepare an HIV prevention programme among fishermen to determine where they come from, the length of time they spend at sea, the ports they visit and their risk behaviours for STI and HIV.

It is also important to do an analysis of the community at the major ports they visit, and from their home port, as the risks may be different in each case.

Building an HIV resilient community

The most successful HIV prevention programmes will work with the communities where fishermen come from as well as with the ports they visit during their fishing trips. It will be important to ensure that local communities interact with the fishermen and with the programme, so that they become aware of the need for preventing HIV.

In Myanmar, World Vision has programmes among fishermen based in their home villages. They have worked successfully with wives of fishermen to develop their own strategies to change behaviours. In one village, housewives organised drinking parties in their own area so that the men did not go into the city and visit brothels on the way home.

In port locations there will also be other mobile groups such as truck drivers, sex workers and in some places construction workers, factory workers or tourists. In such locations an integrated programme could be considered to address HIV prevention and mobile groups. In Hai Phong City, Vietnam, this is the case, with an NGO project focussing on mobility and HIV vulnerability.

Promoting Behaviour Change

Peer educators among fishermen can provide the most effective method of direct personal contact through which to share information and provide advice on HIV prevention. The programme will have to have a strategy to have PEs for as many fishing boats as possible. They will be able to talk to the fishermen while they are at sea.

Frontline Social Networkers can also be involved in HIV prevention programmes in ports. The people to train as Frontline Social Networkers can be selected from staff of the restaurants and bars that fishermen visit for entertainment.

From experience of working with fishermen, many NGOs report that some fishermen inject drugs. It will be necessary to provide information on the risks of HIV transmission through sharing of injecting equipment. Harm reduction strategies, such as ensuring clean needles are accessible and affordable, can be used in these situations. Harm reduction is an attempt to reduce the health consequences of injecting drugs, rather than try to stop people using drugs altogether. The most important health consequence can be HIV infection, which can be avoided so long as drug users don't share injecting equipment.

List of Reference

Cambodia seafarers research team: Rapid assessment of seafarer vulnerability to HIV/AIDS and drug abuse, CARE, CRC and NCHAD (2000)

UNAID/UNICEF: Video on Shore leave, Seafarers, drugs and HIV/AIDS (2000)

MIGRANT SEX WORKERS

Migrant sex workers are a vulnerable group. They are usually very young, do not know the local language, are in debt to those who arranged their passage and also have to pay expenses to the brothel owner. As undocumented migrants they have no right to health or social welfare services.

Even sex workers who have migrated from another part of their own country can be very vulnerable. They might have traveled alone, and do not have the support of their families and long term friends.

Task Group

The migrant sex workers usually stay in one community for six months. It is possible to form a Task Group with local members and include representatives of the sex workers or those who are working with them, such as the Women's Union in Vietnam. As some migrants may not speak the local language, representatives will have to be chosen who can communicate with the local community.

Capacity Building

Working to build capacity among migrant sex workers will require having staff who can speak their native language and the development or resourcing of materials in their language. Many migrant sex workers are illiterate, so the capacity building programme for Peer Educators among this group has to take account of this.

Situation Analysis

When developing a programme for migrant sex workers it is important to know where they come from, who organised work for them, how they came, the length of time they stay in one place, how often they return home, and who is managing them. Their education levels, their local language skills and their access to local health services also need to be ascertained. All these factors will influence their vulnerability to HIV, and their ability to participate in HIV prevention programmes.

Building an HIV Resilient Community / Promoting Behaviour Change

In Cambodia an integrated model of Building Resilient Communities and Promoting Behaviour Change amongst migrant sex workers was developed. The migrant sex workers are living and working in a community where services and information are available, and they can be reached through HIV prevention programmes within the local community.

If using the toolkits in a fully funded programme, a budget may be required to support the development and implementation of services and community based activities such as income generation activities (as proposed in the China Case Study), training for local health staff in STI/HIV prevention and treatment, and training of local health staff in counseling skills. For each programme this will be determined in the feasibility/design stage, depending on the

location and the specific mobile group involved. In remote parts of China and Lao among construction workers, more provision to support service delivery will be required than in port locations such as Hai Phong, and Sihanouk Ville.

List of References

CARE International (Cambodia): Dangerous Places, a discussion of the process and finds of PLA research with policing in Svay Rieng, Cambodia (2000)

CARE/FHI: When the stars are up: Life and work of sex workers in Koh Kong (200)

Appendix (A)

Training Curriculum for Capacity Building of Village Health Team and Volunteers

Learning Objectives	Learning Message	Teaching-Learning		Time (Min)
		Activities	Material	
At the end of the training, the participants would be able to:				
1. review the existing problems and consequences of HIV/ transmission in the village.	<ul style="list-style-type: none"> - Introduction to the course - Problems of HIV/AIDS in the village <ol style="list-style-type: none"> 1. Health Problems 2. Social Problems 3. Development Problems 	<ul style="list-style-type: none"> - Introductory talk - Group discussion - Review of PLA exercises - Feed back discussion 	<ul style="list-style-type: none"> -White board -Flip charts -PLA records 	90
2. recall the mode of HIV transmission and preventive measures.	<ul style="list-style-type: none"> - Determinants of HIV transmission <ol style="list-style-type: none"> 1. Agent (HIV) 2. Reservoir 3. Mode of exit 4. Mode of transmission 5. Mode of entry. 6. Vulnerable host - Preventive Measures - Proper use of condom 	<ul style="list-style-type: none"> - Brain storming - Feed back discussion - Energizing game - Demonstration - Individual practice 	<ul style="list-style-type: none"> -White board -Flip charts -Demonstration material 	90
3. set up specific planning objectives of community actions against the problems.	<ul style="list-style-type: none"> - Importance of setting objectives - Characteristics of a specific objective 	<ul style="list-style-type: none"> - Lecture-discussion - Group Assignment - Plenary discussion 	<ul style="list-style-type: none"> -White board -Flip charts -Exercise books 	360
4. decide relevant activities to be carried out by the VHT members.	<ul style="list-style-type: none"> - Micro-project activities <ol style="list-style-type: none"> 1. VHT management activities 2. Community groups support activities 3. Services activities 	<ul style="list-style-type: none"> - Group Assignment - Plenary discussion - Case review - Concept game - Feed back discussion 	<ul style="list-style-type: none"> -White board -Flip charts -Exercise books -Material for game 	360

5. identify resources required for implementation of village health activities.	<ul style="list-style-type: none"> - Resources for community activities <ol style="list-style-type: none"> 1. Appropriate technical skills 2. Community groups and volunteers 3. Fund for community actions 	<ul style="list-style-type: none"> - Group Assignment - Plenary discussion - Feed back discussion 	<ul style="list-style-type: none"> -White board -Flip charts -Exercise books 	180
6. discuss the concepts of community health.	<ul style="list-style-type: none"> - Definition of "Health" - Health Promotion, Prevention, Care, and Rehabilitation 	<ul style="list-style-type: none"> - Lecture-discussion - Brain storming 	<ul style="list-style-type: none"> -White board -Flip charts -Exercise books 	90
7. discuss social leadership and team work.	<ul style="list-style-type: none"> - Organizing Community - Initiation and leading the group activities - Team work 	<ul style="list-style-type: none"> - Material for game - Brain storming - Case review - Concept game - Feed back discussion 	<ul style="list-style-type: none"> -White board -Flip charts -Material for game 	120
8. determine necessary education message that would motivate the fishermen and others for behavior change	<ul style="list-style-type: none"> - Health education and communication - Appropriate Health message - Message regarding the men's concerns with their family affairs - Message regarding village development - Winding-up 	<ul style="list-style-type: none"> - Lecture-discussion - Group discussion - Brain storming - Concept game - Feed back discussion 	<ul style="list-style-type: none"> -White board -Flip charts -Exercise books -Material for game 	240