Toolkit for HIV prevention

among mobile populations
in the Greater Mekong Subregion

PART ONE
The approach: five critical components of an effective program

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

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Glossary

Capacity building. Strengthening people's capacity to determine their own values and priorities, and to organise themselves to act on them. This is the basis for development (Oxfam).

Community. In this toolkit, the term 'community' can refer to a community of people with a shared range of interests and reasons to live and work together for mutual benefit. This might be a local community, such as the members of a rural village. But it might also mean a more transient community, such as the 'community' of fishermen in a particular port, or the 'community' of workers in a construction company, who might move from place to place, but who also live and work together as a community associated with the company.

Community development. The process through which people work together to improve their lives and the choices they are able to make. This results in improvements in social capital and economic development. It also involves people in gaining control over all aspects of their environment. These include physical, social, cultural, ethical, legal, political and resource features of their environment.

Community health volunteers. These people represent the general community, rather than a specific occupation group or age group. Community Health Volunteers are natural primary care givers in their communities. They might include Traditional Birth Attendants, injectors and housewives. All of these people can receive training and support to perform their voluntary work more effectively. They can be involved in providing basic health care, promoting community participation in development workshops, disseminating messages about health and development, and broader aspects of community development.

Community participation. Members of communities participate in processes of development. These might include education or health workshops, community mapping, planning and responding to community wide challenges, such as HIV. Community participation can be encouraged, not just allowed to happen. People who participate can be involved in identifying problems and needs, taking on responsibilities in planning and management, and evaluating the effectiveness of their own community's development strategies.

Front line social networkers. These are people whose daily work and other activity involves interactions with many others. They might be people who work at a shop, beer stall, petrol pump or other places that don't at first appear to have much to do with HIV. But their interactions with others make them ideal educators. For example, while truck drivers come and go from a local village, the Frontline Social Networkers are there all the time. They can be trained in HIV and Development, and supported to maintain an ongoing role as educators of the truck drivers. (See comparison with 'Peer Educators' below).

HIV-resilient community. An HIV-resilient 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
 undertake analysis of the challenges
 able to talk about HIV in their communities.

Participatory learning and action. This is two things. First, it is a concept. The concept describes the way community members can participate in analysing what is going on in their own lives and in finding solutions to challenges they identify. In this concept, the participation of community members is more important than the involvement of outsiders: the expertise lies in the community. Second, it is a set of group exercises. The group exercises have been used by others to promote participatory learning and action. They have been so successful in so many parts of the world that their methods are now often grouped together in manuals and used as set programs in participatory learning and action.

Peer educators. These are educators who are themselves part of a defined 'peer group'. This might mean a group of 'youths', 'truck drivers' or 'fishermen' or another defined group. Selected members of that group are trained in HIV prevention (or other relevant issues) and taught the skills of being an interactive educator. They then go out into their own communities and act as Peer Educators. They are usually very successful at this, because their own life experience provides them with good understanding of the barriers their own peers face to learning, and HIV and Development, and the barriers they face to changing their behaviour. Most HIV prevention programs involving Peer Educators ensure that there is follow-up after initial training, so that the Peer Educators remain up to date with understanding of the nature of the HIV epidemic, they can exchange experiences and lessons learned, and they can over the long term learn to support each other to become even more effective at what they do.

Preface to the complete toolkit

Purpose of the toolkit

This is a toolkit for managers and implementers of HIV prevention programs in locations where there is an association between mobility and HIV vulnerability. It outlines how HIV transmission can be prevented among mobile people as well as among people who live in stable communities affected by mobility.

The toolkit will be used by people who already have some experience in HIV prevention and are now ready to address the specific challenges of working with mobile populations. It is not a complete textbook for people new to HIV

prevention. It assumes that program managers already know about HIV, know how to facilitate participative educational processes, and know how to work with people in local communities. For these program managers, the toolkit presents useful guidelines that will help them to ensure that all aspects of effective HIV prevention programs are occurring in their location.

Program managers who are completely new to HIV prevention will require further assistance to use this toolkit. They may require some training in the methods of participative education. They may find it useful to become part of a network of HIV prevention workers in their own country. They may find it useful to work alongside others who are running their own HIV prevention programs as a way of learning what is required. These types of assistance are available in each country of the Greater Mekong Subregion (GMS), through national AIDS programs and through HIV prevention programs designed to address the associations between mobility and HIV vulnerability.

The two parts of the toolkit

The toolkit is in two parts:

Part 1—The approach: five critical components of an effective program

Part 2—Country resources

Part 1 outlines the five components that are essential for effective HIV prevention programs. It defines the desired outcome of each of these five components, so that program managers can easily see what needs to be done. But it allows for flexibility of approaches, so that program managers can decide *how* they will reach each outcome.

Part 2 is a collection of resources other agencies have used when implementing the five critical components outlined in the first part. These resources were used in field testing of the toolkit and found to be effective. The resources will be useful in providing better understanding of some ways of meeting the outcomes of the five critical components, as they provide practical directions rather than discussion of concepts. They can be used as they are, adapted to ensure they are more relevant for use in specific locations, or they can be replaced with other resources that program managers have prepared themselves or received from others.

A flexible approach to HIV prevention

The toolkit outlines five critical components of effective programs. But it allows for flexibility in how each of these critical components is implemented. This flexibility is important. Programs in each location will have to be designed to meet the needs of people in that location. This might require different sorts of activities, use of materials in different languages, and collaboration with different types of local groups already active or interested in HIV prevention. Thus, while all five critical components are important, the way outcomes might be achieved will vary from place to place.

The flexible framework is also important because the toolkit will be used by many people who already have experience in HIV prevention. It represents a collation of what is known about what works best in HIV prevention in the countries of the Greater Mekong Subregion. It does not attempt to be a completely new approach to HIV prevention. Rather, what is new in this toolkit is the way it summarises a complete set of lessons learned about what works and what does not work in HIV prevention. Readers can quickly gain a simple but comprehensive overview of what is required for effective programs.

These lessons have been provided by many people and agencies working in HIV prevention. The toolkit is written so that each agency can now use it as a reference point, but continue to use its own preferred methods to implement each critical component.

HIV prevention and the involvement of people living with HIV

Global experience indicates that the involvement of people living with HIV can vastly improve the effectiveness of HIV prevention programs. People living with HIV have direct experience of the reasons for HIV transmission and with the consequences of HIV infection. Their perspectives, when voiced, can help other people to develop a much deeper understanding of the nature of the HIV epidemic in their own locations.

Ideally, all programs developed using this toolkit will find ways to involve people living with HIV. But in some locations this will be impossible. Access to blood tests that enable people to find out whether they have HIV is limited in some places, so there might not be anyone locally who knows they have HIV.

However, in all countries it is now possible to talk with organisations that have worked to promote peer support groups for people living with HIV. It is essential that program managers of new HIV prevention programs talk with those organisations to find out how collaboration might make it possible to have some involvement of people living with HIV in the new program.

The need to work with mobile groups and stable communities together

The toolkit was designed to outline HIV prevention requirements for specific groups of mobile people. It was field tested with one or more of these groups in each country of the Greater Mekong Subregion:

construction workers
truck drivers
fishermen
migrant sex workers.

While the toolkit was tested with these groups, it will also be useful for programs to prevent HIV transmission among other types of mobile people.

Most importantly, the toolkit recommends that programs to prevent HIV transmission must *simultaneously* work with mobile groups *and* the stable

communities with whom they interact. This is not a flexible requirement: it is essential.

All advisers to the development of the toolkit were concerned that implementing programs *just* for mobile populations can easily lead to stigma and discrimination against mobile people, while leaving stable communities thinking they themselves do not have to worry about HIV. 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 programs 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 be mobile groups only. 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 programs just for those mobile workers.

A contract for HIV prevention for construction workers

For HIV prevention programs at construction sites, the toolkit will be used by agencies sub-contracted to implement the HIV prevention program, while the construction company itself continues to focus on construction. A set of *draft terms of reference* is included in Part 2 of the toolkit, for incorporation into a standard contract. As the exact content of contracts varies from country to country, varies according to the size and duration of the construction project, and varies according to the funding source for the project, no 'standard contract' is included. However, to assist with preparing a contract for a specific purpose, an *example of a possible contract* is also included.

How was this toolkit produced?

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 program, *ADB TA 5881 – HIV/AIDS and mobility in the Greater Mekong Subregion*.

The technical assistance project was managed by World Vision Australia, and implemented by a regional technical assistance (TA) team including country coordinators in each of the participating countries: Cambodia, Lao PDR, Myanmar, PR China and Vietnam.

This team collaborated closely with other agencies working in each country, incorporating their experiences and educational materials, so that the toolkit is based on direct experiences with HIV prevention. Development of the toolkit occurred in five stages:

exploration of resources available in each country
first drafting of the toolkit
pre-testing and revision
field testing in five locations in the GMS
dissemination.

The final format of the toolkit is based on feedback from the people who used it and from others in each country. The production of a toolkit in two parts ensures that it meets the different needs expressed by users during the field testing:

the need for a concise summary of critical components of effective HIV prevention programs (Part 1)

the need for more detailed materials for use as optional resources in each country (Part 2).

Chapter 1. Introduction

This first part of the toolkit outlines the approach to HIV prevention. It specifies five components that are essential for effective HIV prevention programs. It defines the desired outcome of each of these five components, so that program managers can easily see what needs to be done. But it allows for flexibility of approaches, so that program managers can decide *how* they will reach each outcome.

Five critical components of HIV prevention programs for mobile population groups

This part of the toolkit identifies five critical components that must be included for an HIV prevention program 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 component of the program 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 program are outlined in the flow chart on page . 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 programs in the specific locality in which the toolkit will be used. This might be an existing group that agrees to use the toolkits, or a group formed by program 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 program*. The users of the toolkits will have worked to build the capacity of locally based people to run the program. The resulting program will have been implemented with maximum commitment, understanding of needs and possibilities, and likelihood of sustainable support for ongoing HIV prevention even after the program 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 program 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 behavioural 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 socioeconomic 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 behavioural 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 behavioural 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 program is an essential outcome of the programs designed using the toolkit. But there are many ways to reach each objective. The exact path chosen by program 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 socioeconomic development. While these processes are important, they are beyond the scope of this toolkit. Many of these issues will be addressed through complementary programs, including the ASEAN Joint Action Program for Mobility and HIV, 2002–2004. The ASEAN program 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 programs, 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

programs and supported the design, implementation and evaluation of others' programs 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 program 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.

Experience in the use of mapping assessments to conduct a rapid situation assessment of the mobility system, to profile the people involved and the interactions between those on the move and communities they come in contact with, and to identify HIV vulnerability factors. This methodology has been developed and tested by the UNDP South East Asia HIV and Development Project (UNDP–SEAHIV) and has been documented in *The Impacts of Mapping Assessments on population movement and HIV vulnerability in south East Asia* September 2001.

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 millennium*.

Flow chart of the critical components

Chapter 2. 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 programs. The group will:

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

Why this outcome is important

Experience of HIV educators indicates that when HIV education programs 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 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 program.

Having the Task Group gave all communities a sense of ownership of the HIV prevention program. 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 Task Group, then an HIV prevention program 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 possible 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 program 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 program will be based on local needs, and that it will be effective. The program 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 Task Group

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

The Task Group will need to be developed in accordance 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 program manager should then work with the existing group. In other places, the HIV prevention program 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 the company, so that the Task Group moves with the workers, who are the participants in the HIV prevention program.

The group might include:

local leaders
representatives of local departments or organisations implementing HIV prevention programs
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 program 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 program.
3. Present to the Task Group the policy framework that indicates there is a need for this program. 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 program, 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 behavioural 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 five Country Coordinators. These are available as reference guides for others wishing to design and implement an HIV prevention program 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 to 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 meeting 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 behavioural 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 program 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:

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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 mobilisation. If there is a common denominator of all effective mobilisation 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

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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)

FA0/UNAIDS: Sustainabile Agriculture/Rural Development and Vulnerability to the AIDS Epidemic, FAO and UNAIDS Joint Publication (1999)

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

Chapter 3. Capacity building

Desired outcome

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

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

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 program design and implementation.

Each of these three types of capacity building is important because

The people running an HIV prevention program need to know about HIV themselves, or they will make mistakes.

The processes to be used in the HIV prevention program 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 program. The people who implement the program 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 program, so that it becomes effective in supporting behavioural 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 program 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 behavioural 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 programs, how to use PLA methods and how to facilitate focus groups. In these cases, the program 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 program, but does not yet work specifically to meet the needs of mobile population groups. In these cases, the program 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 program, the program 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 program.

Program 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 mobile 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 in Part Two. 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 program. This will build their capacity to:

- understand HIV transmission and prevention
- use participatory learning and action methods
- facilitate focus group discussions
- conduct surveys
- plan a program
- communicate

identify appropriate resources
select and recruit Peer Educators and Frontline Social Networkers
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 program. Some of the Task Group and local volunteers will assist the program manager to conduct training sessions.

Capacity building for Peer Educators and Frontline Social Networkers will build capacity in:

participatory learning and action methods
focus group discussions
life skills approaches to HIV prevention
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 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 Task Group in Myanmar) and for volunteers. This curriculum is presented in Part Two, as an example of the type of program 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 program manager may consider using to acknowledge the efforts of the participants.

In the design and implementation of a HIV prevention program 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 millennium. New Delhi, World Health Organisation, 2001

"At the program/project level, the following factors are central to program success …(list includes):

the provision of training in skills for communication
the participation o***f target groups at all stages of design, implementation and evaluation***
the monitoring of programs/projects at all stages of development and implementation."

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

Reference list

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Lewis, M (2000). Focus Group interviews in Qualitative Research: A Review of the Literature. Action Research E-Reports, 2. Available at: http://www.cchs.usyd.edu.au/arow/002.htm. First published, 1995, The Author: Health Science Education, Faculty of Health Sciences, University of Sydney

World Vision Australia and World Vision Vietnam, Pre and Post Training Questionnaires for HIV/AIDS Knowledge, revised edition, May 2001.

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)

Chapter 4. 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 programs, health service provision)?
Who, in this locality, can positively influence the behaviour 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 program 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 program 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 programs have been ineffective because the people implementing the programs 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 program manager and the Task Group can assess the real situation. They can use the findings of the situation analysis to ensure the HIV prevention program 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 program in this location or among 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 program. Going out into the community and interacting with people means that the program implementers build rapport with community members, develop understanding of 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 programs.

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. Program managers can choose what methods they will use.

Alternatives might be:

A situation analysis has already been done before this HIV prevention program 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 program. 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 program begins.

A more complex situation assessment, using multiple techniques, which might have different components that take place at different stages of the HIV prevention program.

Suggested steps for situation analysis

Hold a special meeting of the 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-Program Survey* among mobile people, to find out what they already know about HIV.

Conduct PLA exercises (mapping, causal diagrams, trend analysis, health ranking, wealth ranking etc) with groups of mobile people, to find their answers to the above questions.

Conduct a specific *Mapping assessment* to analyse the relationships between mobility and HIV vulnerability in the location of the new program. Mapping

assessments have been carried out at national level in all countries in which this toolkit will be used. Those involved in the national mapping can assist with planning of local mapping.

- Gather statistics and other recorded data from local health departments and others who might collect information about the local community or mobile groups.
- Hold meetings with other groups running programs 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-program survey*
  - a summary of what you learn through discussions with representatives of other groups running programs
  - the conclusions drawn by the Task Group on what should now occur to prevent further HIV transmission among mobile workers and the local community.
- Present your findings and recommendations to the Task Group and other interested people for discussion on how the rest of the program should proceed. This discussion should identify priorities for the local program 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 Coordinators 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 program implementers only provide education sessions on HIV prevention without any opportunity for interaction.
- Doing the situation analysis involved the local people and built 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.

> ***"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, Cambodia*
>
> ***"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, Cambodia*

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 program activities on behavioural change.

Reference list

ADB/UNDP TA report on Mobility and HIV/AIDS in the Greater Mekong Subregion, Asian Research Centre for Migration, World Vision Australia and Macfarlane Burnet Centre for Medical Research (2001)

UNOPS/UNDP, South East Asia HIV and Development: The Impact of Mapping Assessments on Population Movement and HIV Vulnerability in South East Asia (September 2001)

UNOPS/UNDP, South East Asia HIV and Development, Population mobility and HIV vulnerability in South East Asia, an assessment and analysis, (2000).

Vietnam Seafarers Research Team: Rapid Assessment of Seafarer vulnerability to HIV/AIDS and drug abuse, (2000)

UNAIDS APICT 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)

UNICEF/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 counselling and testing services from Cambodia (Source: World Vision Cambodia 2001).

Chapter 5. 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
- undertake analysis of the challenges
- able to talk about HIV in their communities.

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 program. But an HIV prevention program, even in the short term, can help a community to take the first important steps.

The toolkit recommends that the HIV prevention program 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 program, 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 programs, 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 counselling 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 program does not lead communities into thinking they should isolate mobile workers, or marginalise 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 socioeconomic 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 programs 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 organisations, 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 employers of mobile people, the mobile workers, other communities especially those from which the mobile workers come from, 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 mobile 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 mobile 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 during 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 programs can result in denial of HIV, stigma against those perceived to be at risk, and marginalisation 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 program 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 program 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 program manager, working with the 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. A list of IEC materials available in each country is presented in Part Two.

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. Other programs that get people talking are peer education and youth programs. A list of appropriate PLA exercises and a simple manual is included in Part Two.

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 program facilitator can ask the condom social marketing agency to become active in program 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 is able to make condoms easily accessible for mobile workers in their community.

3. HIV counselling, testing and referral services

In an HIV-resilient community, anyone concerned that they might have HIV will be able to obtain voluntary counselling 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.

Communities that enable people living with HIV to participate in HIV programs, 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 counselling, testing and condom distribution provides a comprehensive package for the prevention of HIV through behavioural 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 Behavioural change. Examples where these two sections were integrated include Sihanouk Ville, where the toolkit was used among sex workers, and in Dawei, 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.

An example of what can be done by a community to make sure condoms are available comes from the field testing in Myanmar. The 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.

Defining and translating the term ‘Resilient Community’ to ensure local understanding when implementing the toolkits. Each country used different metaphors and terms that were appropriate in their language and culture. Some examples are presented below.

In Cambodia resilience was described in terms of the difference between a dry leaf and a wet leaf. The dry leaf will catch fire easily whereas a wet leaf will smoulder as it has sufficient water to prevent it from igniting and being totally destroyed. The wet leaf also has received the right nutrients for it to grow in its environment and therefore can withstand adverse condition more readily than a poorly nourished leaf.

In Lao PDR one group described 'resilient' in the following way:

There are three types of people in any given community: people without HIV or AIDS, people at risk of HIV, people with AIDS. A resilient community makes these three groups live together, care and support each other. A resilient community promotes ownership in the struggle against AIDS in the community.

A resilient community = a community that fights together against AIDS.

"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 (See list in Part Two)

National AIDS Standing Bureau, Socialist Republic of Vietnam: Provincial AIDS Committee Guidelines: Guidelines on how to organise a HIV/AIDS counselling 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)

UNICEF, UNAIDS: Salt, Sea and Sex: Shore Leave, Seafarers, drugs and HIV/AIDS video (2000)

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)

Chapter 6. Promoting behavioural changes for mobile people

Desired outcome

Mobile people have received support for behavioural change.

Mobile people will:

- be informed about HIV transmission
- have personal support for behavioural 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 programs 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 behavioural change.

Vulnerability to HIV depends on people's place in a community. Mobile people can be vulnerable to HIV because they are marginalised, lack access to services and regular HIV programs, 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 behaviour which enables HIV transmission. In the long term, an HIV prevention program will have to help people find ways to address all these factors.

Mobile people need special support to help them to make behavioural changes. This can overcome the barriers to behavioural 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 ser vices have met with considerable success."***
>
> *Larsen HJ, Narain JP. Beyond 2000: responding to HIV/AIDS in the new millennium. New Delhi, World Health Organisation, 2001*

Flexible alternatives to facilitating behavioural change

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

provision of information
direct personal contact which supports behavioural 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 program. But exactly what is done will depend on local situations, the capacity of program managers and Task Groups, and the mobile people's own previous exposure to HIV prevention programs.

Suggested steps for promoting behavioural change among mobile groups

Four types of support are required:

provision of information
direct personal contact which supports behavioural 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 behaviour. This might be different from 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 in Part Two of the toolkit.

2. Direct personal contact which supports behavioural change

Direct personal contact, through which mobile people can talk with people who understand their behaviour 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, know what is required for behavioural change, and how to support mobile workers undertaking behavioural change.

Peer educators. Support for behavioural change can be provided by 'Peer educators'. These are mobile workers who have been trained to support behavioural change among their own peers. 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), Focus Group Discussions and one-to-one contact.

Frontline Social Networkers. Support for behavioural 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 program 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 program). 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.

A short term program 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 program 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 behavioural change, from field testing and other sources

The four steps together provide a comprehensive package of strategies. They support behavioural 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. Services and peer support are important components of an enabling environment for safe sexual behaviour.

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 program was wonderful. I was involved in all stages of the program 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 program, the regional Program 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 program 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 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 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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National AIDS Standing Bureau, Socialist Republic of Vietnam: Provincial AIDS Committee Guidelines: How to plan and implement a Peer Education Program for Injecting Drug Users

World Health Organization: STI/HIV: Guidelines for HIV/AIDS, STI, and Behavioural Risk Factors Surveillance, Pacific Island Countries and Areas, 2000

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

UNDP, Better Safe than Sorry: Preventing HIV/AIDS among mobile populations in the Greater Mekong Subregion (2001)—CD available in Khmer, Lao, Vietnamese and English

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

Chapter 7. Using the toolkit with special mobile groups

The toolkit shows how to implement an HIV prevention program in locations where there are mobile people. In some cases, the toolkits will be used to design HIV prevention programs 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 program manager is forming a Task Group as part of a program for fishermen, then the relevant section to consider here will be ‘FISHERMEN – Task Group’.

Construction workers

The toolkit will be used to inform development of HIV prevention programs for construction workers from specific companies. These companies will provide sub-contracts to HIV program managers, to design and implement HIV prevention programs 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 in 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 the company and from provincial or district levels, rather than having members from 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 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 life of the construction project. It is important, therefore, to facilitate interaction between the community and the construction workers, and the 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 an integrated program working with multiple mobile groups in the same program.

Capacity Building

The development of capacity building programs 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 programs for the workers. At one field testing site in Yunnan Province, the workers were organised into three work shifts, which impacted on how HIV prevention activities were scheduled.

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 participatory education sessions and or IEC materials.

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 is that they are seasonal workers. This results in a high turn over of workers. For such projects, capacity building will have to be an ongoing component rather than a one time activity.

Building an HIV-resilient Community

When construction programs 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 counselling and testing will be determined by the program manager and the Task Group according to the local situation. This may require the HIV prevention program 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 Behavioural 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 program 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 behavioural change, it will be necessary to recruit and train Peer Educators who are part of the company.

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 provide HIV prevention information and to support behavioural change.

List of References

UNOPD/UNDP Southeast Asia HIV & Development: Indonesian Overseas Contract workers' HIV knowledge, a gap in information (2000)

Truck drivers

The nature of truck drivers' work requires them to be on the move constantly, driving to and from destinations that are either long or short journeys in a country or across borders. This presents unique challenges when developing HIV prevention programs 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 found that implementing HIV programs was best done at truck stopping sites.

Task Group

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

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

Capacity Building

In a program working with truck drivers the capacity building strategies will focus on the community members involved in the 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 training sessions included one-to-one mentoring and demonstrations of how to discuss sexual behaviour and HIV prevention 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 appropriate program activities.

Building an HIV-resilient Community/Promoting Behavioural change

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

It is difficult to get truck drivers to participate in training programs so the recommended approach is to train a network of Frontline Social Networkers at the identified stopping sites in 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 where trained as Frontline Social Networkers. They discovered that most effective strategy was to talk to truck drivers when they finished their meals. At this time, they were more relaxed and willing to talk and receive 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 of sexually transmitted infection. 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 behavioural change among the truck drivers.

List of References

UNOPS/UNDP Southeast Asia HIV & Development: Cambodia HIV Vulnerability Mapping, Highways one and five (2000)

UNOPS/UNDP Southeast Asia HIV & Development: HIV Vulnerability and population mobility in the northern provinces of the Lao PDR (2000)

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

UNOPS/UNDP Southeast Asia HIV & Development: HIV Vulnerability Mapping, Highway One, Vietnam (2000)

Fishermen

There are many 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 come from all over the country, including inland areas. Those who are at sea for many months will stop at other ports in either their own country or in other countries in the region.

A program for fishermen will need 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 to meet their needs.

Task Group

The members of a Task Group will have to be from the port community where the program 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 also responsible for fishermen. 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 program is located in the home villages of the fishermen then it is more feasible to have them participate in the Task Group. This was the case in the field testing in Myanmar.

Capacity Building

For programs 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 program among the fishermen, and the participants in that project facilitated the selection and training of the Peer Educators for the HIV prevention program.

Situation Analysis

It is critical when working to prepare an HIV prevention program among fishermen to determine where they come from, the length of time they spend at sea, the ports they visit and their risk behaviour 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 differ in each case.

Building an HIV-resilient community

The most successful HIV prevention programs 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 program, so that they become aware of the need for preventing HIV.

In Myanmar, World Vision has programs among fishermen based in their home villages. They have worked successfully with wives of fishermen to develop their own strategies to change behaviour. 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 program 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 Behavioural 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 program will have to have a strategy to have Peer Educators 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 programs 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 trying 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 References

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.

Sex workers who have migrated from other parts of their own country are also vulnerable. They might have to travel alone, and do not have the support of their families and friends.

Task Group

The migrant sex workers usually stay in a community for a short time—approximately 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 program for Peer Educators among this group has to take account of this.

Situation Analysis

When developing a program 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 programs.

Building an HIV-Resilient Community/Promoting Behavioural change

In Cambodia an integrated model of Building Resilient Communities and Promoting Behaviour Change among 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 programs in the local community.

If using the toolkit in a fully funded program, 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 counselling skills. For each program this will be determined in the feasibility/design stage, depending on the location and the specific mobile group involved. In remote rural areas, more provision to support service delivery will be required than in urban or port locations where services are already established.

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

CARE/FHI: When the stars are up: Life and work of sex workers in Koh Kong (2000)

Conclusion

These guidelines on how to implement an effective HIV prevention program for mobile workers were produced as part of a Technical Assistance project to the Asian Development Bank and UNDP. They were developed in consultation with governments, international organisations and NGOs in the Greater Mekong Subregion.

The methods used in the guidelines are consistent with UNAIDS best practice. (as outlined in the UNAIDS Best Practice Key Materials 2001 publication, *Innovative approaches to HIV prevention*.) They are also consistent with the experience of the toolkit designers from World Vision Australia and the Burnet Institute.

The contents of the toolkit has been field tested in five countries of the Greater Mekong Subregion. The field tests were reported as case studies. When using the toolkit, it will be helpful to read the case studies, which are included in the CD ROM accompanying the toolkit. They provide examples of how the toolkit has been used in different locations. The case studies for Lao PDR and People's Republic of China reported on field experiences among truck drivers and construction workers. Case studies for Vietnam, Myanmar and Cambodia reported on field testing among fishermen and migrant sex workers.

As the HIV epidemic continues to evolve, so does understanding of the complex components that make effective responses possible. The approach presented in this toolkit is part of that evolution of understanding. Programs designed using this toolkit will take the whole process an important step further.