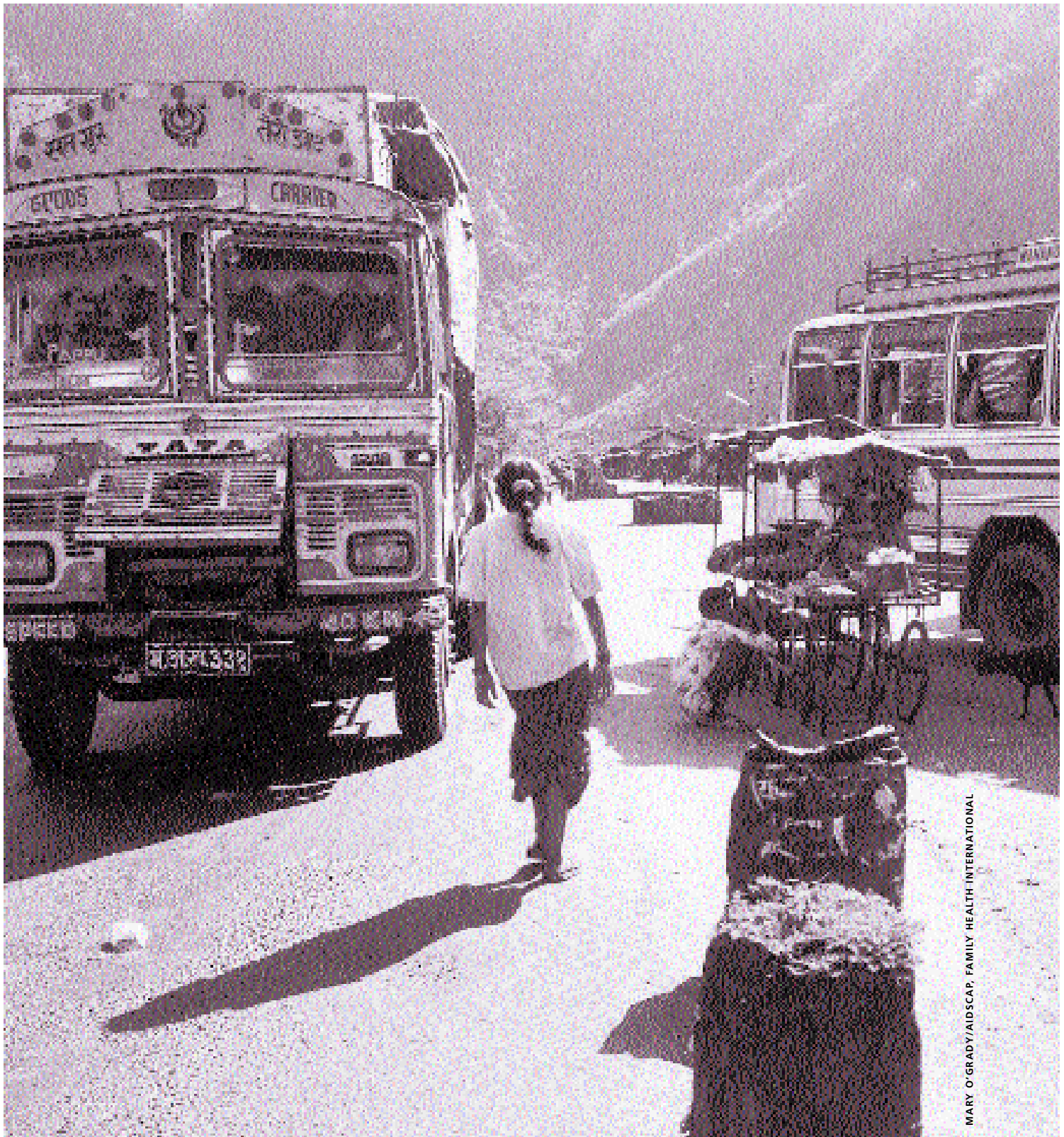


More HIV infections will be prevented sooner if programmes strategically select locations with the greatest potential for HIV transmission.



MARY O'GRADY/AIDSCAP, FAMILY HEALTH INTERNATIONAL

A BUSY HIGHWAY INTERSECTION IN NEPAL NEAR THE INDIAN BORDER PROVIDES AN ENTRY POINT FOR REACHING VULNERABLE GROUPS VIA CROSS-BORDER HIV PREVENTION PROGRAMMING.

# **INITIATING CROSS-BORDER HIV/AIDS-PREVENTION PROGRAMMES: PRACTICAL LESSONS FROM ASIA**

<b>210</b>	<b>INTRODUCTION</b>
<b>211</b>	<b>IMPLEMENTING CROSS-BORDER PREVENTION PROJECTS</b>
<b>221</b>	<b>CONCLUSION</b>
<b>221</b>	<b>AUTHORS</b>
<b>221</b>	<b>ACKNOWLEDGEMENT</b>
<b>222</b>	<b>REFERENCES</b>
<b>224</b>	<b>APPENDIX I</b>
<b>229</b>	<b>APPENDIX II</b>

## INITIATING CROSS-BORDER HIV/AIDS-PREVENTION PROGRAMMES: PRACTICAL LESSONS FROM ASIA

### INTRODUCTION

Seroprevalence data from a number of countries in Asia show that there tend to be higher levels of HIV and sexually transmitted infections (STIs) in provinces with international border crossings than in other provinces.<sup>1</sup> Tens, sometimes hundreds of thousands of people cross these borders every year, stopping in nearby towns to rest and relax (see Appendix II). Studies conducted during the 1990s led to the growing recognition that border towns tend to be higher-risk environments for HIV and STIs, in part because of an atmosphere of remoteness from normal legal and cultural restrictions that encourages visitors to engage in risk behaviours they might not necessarily practice in their home communities.<sup>2-7</sup>

By 1998 a number of agencies in Asia had started implementing HIV-prevention programmes at border crossings to reach mobile populations in transit to other parts of the region. Implementing programmes in these border locations presents unique challenges that mainstream HIV/AIDS-control programmes do not regularly face. For example, multiple languages are used in cross-border sites; most of the population

at any given time is en route to somewhere else; and, fewer government health and social services are available in these sites than in provincial capitals or other trade towns not located on borders.

In March 1998 a workshop jointly organized and sponsored by Family Health International's (FHI's) Asia Regional Office, based on work performed during the AIDS Control and Prevention (AIDSCAP) Project, and the Joint United Nations Programme on HIV/AIDS (UNAIDS) Asia-Pacific Intercountry Team (APICT) was held in Mae Sai, Thailand, to share experiences among agencies implementing cross-border programmes in Asia. Judging by the geographical sites represented by project staff, a definition of "cross-border" in the context of HIV prevention can be stated as "a land, sea or river connection between two countries where significant border crossing occurs."

The prevention programmes are usually carried out in linked settlements (see Table 1) populated by people who are involved in the cross-border trade. They target those who are travelling to places near or far in search of economic opportunity—a population largely unserved by mainstream HIV/AIDS programmes.

FIGURE 1

Examples of Linked “Cross-Border” Settlements in Asia

Type of Linked Settlement	Regional Example
Over Land	Poipet–Aranyaprathet (Thailand–Cambodia) Raxaul–Birgunj (India–Nepal) Bauwet–Moch Bai (Cambodia–Vietnam)
Over Sea	Merauke–Mahachai (Cambodia–Vietnam)
Over River	Mae Sai–Taichilek (Thailand–Myanmar) Huay Sai–Chiang Kong (Laos–Thailand)
Over Land And Sea	Sao Tong–Klong Yai (Cambodia–Thailand)

A “sister-city” approach to prevention programming is evolving in these linked settlements, based on the hypothesis that HIV-prevention messages and services will have greater impact if they are reinforced on both sides of a border. This assumption follows the basic communication principle of repeating messages through different media, but also reflects the understanding that public health problems such as HIV are not avoided by crossing a border.

This case study is a summary and synthesis of information from the agencies that have had actual experience in designing, implementing and evaluating cross-border HIV-prevention programmes. As a first attempt to chart the essential steps in mounting such a prevention effort, it draws on state-of-the-art experience from the projects that have pioneered this work and may serve as a practical guide to other agencies wishing to begin on their own. A much larger and wider effort will be needed in the coming years as the number of border crossings increases in Asia and elsewhere.

**IMPLEMENTING CROSS-BORDER PREVENTION PROJECTS**

**1. Listing cross-border locations**

*Why?* The number of border crossings in Asia seems to change by the month. While some close (temporarily), more open than close. With each new bridge, paved road or port, opportunities for cross-border movement increase. Therefore, it is important to try to establish a working list of international border crossings to serve as the “universe” of possible sites for a project. This list need not be exhaustive. Indeed, listing some unofficial sites might jeopardize the welfare of refugees. It should, however, include the major cross-border junctions where a significant number of people engage in daily economic activity across borders.

*How?*

- First, list the sites that meet the criteria for a cross-border location. Try to categorize the basic nature of the site from information available from common knowledge

(e.g., official/unofficial, land/sea/river crossing, large/medium/small size).

- Be creative about finding reliable sources of information. Include recent migrants, local government officials (particularly health officials) and representatives of nongovernmental organizations (NGOs) that may have development projects in border areas. Trips to the perimeter of the country are often useful and necessary. Look for published lists of cross-border sites (e.g., from the national immigration authority).
- Having an international airport should not be a criterion for selection because the higher-priority sites are land or water crossings. (In Asia, HIV is concentrated among the lower- and middle-income segments of society. Those who travel by air either have higher incomes or travel infrequently and are, therefore, at considerably lower risk of transmitting HIV to large numbers of people.)
- Cross-border sites are not only contiguous land borders; rivers or seas can connect “sister” port towns. Port cities that regularly receive international seafarers should always be included in a list. (However, “rest and recreation” sites that receive foreign navies a few times a year are not necessarily places where HIV flourishes and should not receive priority attention unless they meet other criteria described in this case study.)

## 2. Selecting sites for a formal assessment

**Why?** Once a pool, or “universe,” of cross-border sites is assembled, a subset needs to be selected for more in-depth assessment. The list of potential sites is usually too large to enable efficient assessment.

Selecting the preferred sites requires making a judgment on the relative importance of each site for the regional HIV epidemic—current or future. Please note that this step occurs before the on-site assessment. Thus, the selection of priority sites should be made based on secondary information that can be obtained easily.

### **How?**

- In the absence of more specific data, sites with larger populations should be selected because they have greater potential for STI and HIV spread. This is because a local economy must reach a certain size in order to sustain overnight accommodations, commercial sex establishments and a wide selection of drinking establishments and to offer people some anonymity to engage in (usually) illegal activities—all hallmarks of cross-border HIV epidemics.
- If existing data show that a particular site has a tradition of nonmarital sex and a known STI or HIV problem, clearly that site is a priority for selection. Some of the key proxy information to look for is included in the following checklist:
  - Do people cross the border for commercial sex?
  - Is there a well-established nightlife or entertainment sector?
  - Are drugs and alcohol available or traded?
  - Is the site on a major truck route?
  - Is the site a major port for deep-sea fishing vessels or sea transport?
  - Is there evidence that women are welcomed aboard ships in port to engage in commercial sex (the “boat climber” format for commercial sex)?

- Do employers in the area want and employ migrant labour?
- Are there large numbers of soldiers or police in the area?
- Do men outnumber women?
- Are there legal differences between the two countries that stimulate cross-border movements (e.g., availability in one country of gambling, cheap alcohol, drugs, sexual services, pornography)?
- Is there a rapid change in the social environment that could create risk (e.g., sexual experimentation by youth, separation of families)?
- Are government welfare services or medical services weak?
- Is there significant trading of goods and services?
- Is the cross-border site a good-sized town and not just a “pass-through” point to another larger town?
- If a site has already been assessed within the past several years, reports of these assessments and their authors should be consulted as part of site selection and prioritization. Search for previously conducted studies about the sites that might be relevant (e.g., studies of drug use, trade, transportation, infrastructure development).
- A site that has some government or NGO HIV-prevention services may still be considered a priority if these services are weak or very limited in coverage. If a comprehensive prevention programme has already been mounted in a particular site, however, that site should be a low priority for new intervention.
- Sites that pose a security risk should be included and assigned relatively high priority in the list, because HIV tends to thrive in environments that encourage other forms of risk behaviour, such as gambling, organized crime, commercial sex and smuggling. Many of these activities occur in remote border areas because it is usually more difficult for authorities to police such sites. However, one must recognize the increased risk to project staff in such an environment and take this into account during design and implementation phases.

### 3. Conducting a preliminary rapid assessment and prioritization

**Why?** There are few agencies delivering cross-border prevention activities in Asia and not enough comprehensive programmes to cover all sites adequately. Thus, prioritization is particularly important in order to avoid wasted effort. More HIV infections will be prevented sooner if programmes strategically select locations with the greatest potential for HIV transmission. Some objective basis for this prioritization is needed to ensure that resources are directed to the most important locations. The data collected to make these decisions also will help funding agencies understand the need for and goals of cross-border projects.

**What?** The term “rapid assessment” is frequently used to describe data collection in a number of sites before a final location is chosen for an HIV-prevention project. Such an assessment need not be a complex and expensive behavioural survey. Enough is known about the context of HIV epidemics to allow efficient collection of

the relevant data from observation and interviews with a few key informants.

The main difference between rapid assessments and larger, more formal surveys is time. Depending on the site, a rapid assessment can range from one to two weeks.

In a rapid assessment, a trained team uses a set of methodological tools to efficiently gather information about a site. The methods may be qualitative, quantitative or both, but are often mostly qualitative. They include in-depth interviews, mapping, observation, collection of secondary data, taking photographs, videotaping and focus group discussions.

#### ***How?***

- The rapid assessment should provide data on the number of sexual-risk access points, contextual features that support risk, general volume of persons in the cross-border area, the dearth or abundance of HIV/STI-prevention resources and political support for a prevention project.
- To the extent possible, use local people as data gatherers. This does not mean, however, that outside people cannot fully participate in the assessment.
- Training is particularly important when the local people have little or no experience in gathering data. Consider training needs when determining how long the rapid assessment will last.
- To the extent possible, conduct the assessment on both sides of the border.
- Consider what will happen in a cross-border site where you conduct a rapid assessment but do not decide to implement a project. How will it affect the people at the site?

Can the information collected during the rapid assessment be used advantageously to serve that community?

- Prioritize among sites that have been assessed. From the assessment results, an informed decision can be made about where to begin action among several potential sites. Clearly the sites with greater risk environment and fewer HIV-prevention resources should be given top priority.
- Appendix I provides one framework for conducting a rapid assessment. Another set of guidelines has been published by the UNAIDS APIC Task Force on Migrant Labor and HIV Vulnerability.<sup>8</sup>

#### **4. Preparing the intervention programme**

***Why?*** The rapid assessment may provide the data necessary for prioritizing and selecting sites, but it will not yield enough in-depth information about the cross-border community to design a complete intervention programme. For this, a more involved pre-intervention technical assessment is needed.

***What?*** Approaches designed to maximize the opportunity for community input include Participatory Rural Appraisal (PRA) and Participatory Learning and Action (PLA). Such approaches tend to be long term and in-depth. An agency that uses one of them should assume that it will start an intervention programme at the site—to justify the investment and also to be responsive to community expectations.

Several shorter-term methods have been used to design cross-border HIV interventions in Asia, including assessments by multidisciplinary technical teams. These methods are

focused, direct and rely on a small group of (usually outside) experts.

Some of the advantages and disadvantages of these types of approaches to designing interventions are described briefly below. Implementing agencies must weigh the advantages and disadvantages and select one approach or a combination of both. Field experience to date is not sufficient to recommend one method over another.

**How?** (1) *PLA: Participatory Learning and Action*. PLA evolved out of the participatory rural appraisal approach developed for analyzing agro-ecosystems. Many of the PLA methods are derived from social anthropology and include visualized information exchange among members of a community. For example, members of a community draw maps showing where people meet, and stones or other objects are placed on the maps to indicate areas of high and low HIV risk. A variety of other tools are used to gather information, including time lines of influential community events, family lines and trend analysis.<sup>9</sup>

In the context of HIV, the PLA technique requires particularly skilled guidance from facilitators because of the myths and prejudices that surround HIV/AIDS. While a participatory approach allows more community input, it can also allow those with discriminatory tendencies to dominate group discussion. The facilitator needs to guard against these tendencies and try to ensure that false or bigoted information is exposed and rejected by the group. Despite this hazard, the final result of a successful PLA exercise should be a more profound understanding of the dynamics of HIV/STI risk in the cross-border community,

more community investment in a solution and greater sustainability once external assistance ends.

(2) *Multidisciplinary technical assessment*.

In this approach an outside group of technical specialists visits a series of communities and, by reviewing data and holding discussions with local key informants, makes some determination of the level of risk in the environment. If team members consider the site worthy of a prevention programme, they recommend certain general strategies. Then local implementing agencies are given funding to operationalize those strategies.

While the factors that lead to HIV-risk behaviour are many and complex, the mechanics of prevention can be basic and straightforward. Therefore, having outside technical experts design a plan that applies behaviour change and STI-care strategies that have proven effective in other border areas can save valuable time in mounting a prevention effort.

Such early action may, in fact, be more important than long-term sustainability because of the explosive nature of HIV epidemics in Asia. The early period of very high infectivity (first three months after infection) followed by a long period of low infectivity means that a community can become saturated fairly rapidly unless the most susceptible sex networks are “immunized” by individual, group and structural interventions. On the other hand, if such immunization can be accomplished early in an epidemic, the result will be a rapid decline in new cases.

Thus, if HIV prevention is the primary goal of a cross-border project, a technical planning team might be more efficient than PLA. However, if long-term community health development is the goal, PLA may provide a broader base for future programming.

## SIDEBAR 1

---

### **Nepal-India Project Creates Cross-Border Partnerships for HIV Prevention**

One promising example of a cross-border HIV/AIDS prevention project began in 1995, when a clinic offering sexually transmitted infection (STI) treatment and other health services opened in the Indian town of Raxaul and started linking its services with those of a Nepali organization across the border.

This collaboration grew out of research conducted by Family Health International's (FHI's) AIDS Control and Prevention (AIDSCAP) Project, which found high levels of HIV-risk behaviour among truck drivers and their assistants along trucking routes in India and Nepal. Concerned about protecting its workers from HIV, the Transport Corporation of India (TCI) decided to establish the Raxaul clinic, one of a network of 16 clinics run by its Bhoruka Public Welfare Trust throughout India.

Raxaul was chosen as the site for the cross-border intervention because it is on the main road to Nepal's capital city of Kathmandu and consequently the most important entry point from India into Nepal and because of its proximity to AIDSCAP activities in the town of Birgunj. There the NGO General Welfare Pratisthan (GWP) was already providing HIV/AIDS and STI prevention outreach to truck drivers and their sex partners as part of the AIDSCAP programme along the major trucking routes in Nepal's central region.

Several major highways converge at Birgunj and Raxaul. Some 2,000 truck drivers pass through

these towns daily, often stopping for one or two days to load and unload trucks and to rest. The transient nature of life in such towns creates many opportunities for HIV-risk behaviour, but the open Nepal-India border also offers unique opportunities for cross-border interventions.

AIDSCAP's first cross-border project, funded by the United States Agency for International Development's (USAID) Asia and Near East Bureau (ANE), wove together the STI treatment and prevention services offered by the Bhoruka AIDS Project (BAP) in Raxaul with the outreach services of GWP in Birgunj. The staff of BAP, GWP and the Lifesaving and Lifegiving Society (LALS), a Nepali NGO that provides technical assistance in human resource development to GWP, worked together to match project goals, strategies and approaches. As a result, outreach workers from India and Nepal found it easy to coordinate their activities.

Frequent visits and communication among field staff were essential to successful collaboration. BAP, GWP and LALS staff members also participated in joint training workshops, and GWP invited BAP staff to participate in training sessions at its office in Hetauda, just an hour's drive north of the border.

Field workers from the three groups even crossed the border to work regularly with each other on Indian-Nepal outreach teams. BAP staff helped their GWP counterparts improve outreach to Indian men in Birgunj, while GWP educators talked to Nepali sex workers in Raxaul.

---

The Bhoruka AIDS Project was able to use or adapt many of the communication materials developed for the AIDSCAP programme in Nepal. Only a few changes (identified by focus group participants) were required to make the Nepal programme's logo, "Dhaaley Dai," acceptable to Indian audiences. Using similar materials created a seamless prevention environment at the Raxaul-Birgunj border, where thousands of people received consistent messages about HIV and STIs as they travelled back and forth.

Perhaps the most important aspect of the BAP-GWP collaboration was the joint STI referral system. Because people were often reluctant to visit Birgunj's only and highly visible STI clinic, GWP outreach workers used cards printed in Nepali and Hindi to refer men and women in need of STI services to BAP's general clinic just across the bridge. From 1995 to 1997, the clinic served an average of 50 clients a day. Almost one out of four clients receiving treatment was from Nepal.

GWP and BAP also worked together to organize a consultative board consisting of representatives of local organizations, clubs and government agencies. The board provides advice and keeps members informed about project activities, building vital community and government support for cross-border interventions.

The pilot project has not yet been evaluated. However, in surveys conducted to evaluate the AIDSCAP programme in Nepal, both sex workers

and their clients reported increased condom use. In fact, the proportion of sex workers who said that their most recent client had worn a condom increased from 35 per cent in 1994 to 61 percent in 1996, while there was no significant increase in reported condom use by sex workers in similar areas that had not benefited from the AIDSCAP programme. Nearly 82 per cent of clients with STI symptoms in the project area reported seeking treatment, compared to only 50 per cent in other areas.

Surveys of truckers in Raxaul also revealed some indications of behaviour change and an increased level of awareness about the risk of HIV. An analysis of the results, however, led to the conclusion that the Bhoruka AIDS Project alone was too small to have the necessary impact on HIV-risk behaviour and transmission among the large population of truckers and their partners along India's National Highway 28A.

Expanding cross-border prevention efforts to reduce HIV-risk behaviour among large mobile populations will require more of the kind of long-term international partnerships created in Raxaul and Birgunj. This collaboration continues with funding from the USAID's ANE Bureau and technical assistance from FHI, and it has been expanded to three additional border crossings between India and Nepal. It has also served as inspiration for a number of planned cross-border projects sponsored by other organizations along the India-Bangladesh border.

## 5. Implementing the interventions

**Why?** It is reasonable to ask why this additional section on implementing interventions is needed—why not simply apply the current state-of-the-art in HIV prevention to cross-border settings?

Because of the unique challenges of cross-border programmes described earlier, unique adaptations to the intervention strategy are required. The experience of the cross-border programmes in Asia provides important guidance in many areas that other guidelines may not address.

The next section lists some of these special attributes of interventions during the start-up phase of cross-border programmes. Since the implementation of these programmes in Asia is still nascent, it is premature to suggest lessons for successful (and unsuccessful) implementation.

**How?** (1) Forge local partnerships between agencies across borders. The most successful projects have started locally and gradually sought the support of national governments.

- Work with local agencies on both sides of the border. (See Sidebar 1.)
- Initiate contact at the provincial or district level first; *do not try to begin at the national level*. Build relationships between local NGOs before forging government-to-government collaboration.
- Plan to evolve toward a mixture of both government and NGO programme management.
- Include non-HIV programme areas of priority to local governments, such as assistance with repatriation of illegal aliens or orientation on immigration policies and differences in laws when crossing a border. Explore ways to incorporate these issues into the design of the intervention package.

- As projects mature, involve higher levels of governments.
- Inform and get approval from military/border police early.
- (2) Identify and engage the key stakeholders in cross-border towns/ports.
- Once local cross-border partnerships have been formed, move beyond implementing agencies to link the following on both sides, as appropriate:
  - private sector (clinics, pharmacies, transport companies, fishing companies)
  - commercial sex establishments (with consistent condom-only policies)
  - local border officials (customs/police)
  - immigration officials
  - port health officials
  - branch offices of the Ministry of Defence (reaching men)
  - publicity/media channels (local radio, television, advertisers)
  - mass organizations (political support, connections)
  - UN agencies (expertise, resources)
  - political parties (funding)
  - universities (evaluation, capacity building)
- (3) Establish a project advisory committee.
- Identify individuals on both sides of the border from the NGO, government and commercial sectors who can provide guidance and support to the implementing agencies.
- Include representative(s) from local organizations for migrant workers.
- Convene regular meetings of the advisory committee to review obstacles, progress and plans. (The advisory committee should be used as a “sounding board” to suggest what is realistically possible and what is not and to help interpret why activities do not proceed as planned.)

## 6. Evaluating the programme

**Why?** Evaluation is an essential component of all programmes, but it is particularly important for cross-border projects because of the special challenges they face. The high mobility of populations in border areas is perhaps the most formidable challenge, since effective behaviour change communication (BCC) requires repeated contacts. The many languages and dialects spoken in border areas may mean that BCC messages are not fully absorbed, or only by the full-time resident population. And the relative absence of social and legal controls in border areas means that risk is a way of life and that attempts to modify norms may have little impact on mobile populations.

These examples are just some of the attributes that distinguish border areas from the average provincial or district capital or trade town. The implication is that what worked elsewhere in HIV prevention may not fully apply in cross-border settings. Therefore, in this formative phase of cross-border programming, evaluation systems are needed to objectively monitor trends in self-risk perception and risk behaviour over many years. The information they provide will be useful to programme planners and implementers and to the funding agencies that are investing an increasing amount of resources in this strategy for regional HIV prevention.

**What?** The following bimodal approach to evaluating cross-border HIV-prevention programmes is recommended:

(1) Use quantitative data-collection tools to track risk behaviours over time among certain subgroups of the community.

(2) Use qualitative methods to assess the environment of risk in the community at large.

This approach is recommended because changes in risk behaviour have proved to be one of the more reliable indicators of prevention programme impact in Asia.<sup>10</sup> While behaviour change itself does not necessarily protect one from HIV in all cases, there is a strong correlation between behaviour change and trends in STI and HIV in countries with extensive data.<sup>11</sup> Process data from programme implementation, such as number of persons reached, condoms distributed and posters displayed, are important for monitoring implementation. However, these data do not always provide convincing evidence of programme impact.

**How?** Monitoring changes in behaviour among a large population over time can provide reliable evidence that communities are changing in response to project interventions. Some of the recommended indicators include:

- self-reported number of sex partners in the previous six months
- self-reported patronage of commercial sex industry in the previous six months
- self-reported condom use with different types of partners
- self-reported STI symptoms and treatment-seeking behaviour
- self-assessment and assessment of others' risk of contracting HIV
- ability to identify effective methods to prevent HIV transmission.

Data collection to measure these and other indicators should be conducted just

before the prevention programme begins to establish a baseline and repeated once a year.

#### SIDEBAR 2

---

##### **Subgroups at Risk of HIV Infection in Cross-border Areas**

A behavioural survey should be conducted among different subgroups of the cross-border community, depending on their proximity to the HIV transmission network:

##### **Highest risk groups**

For example: full-time sex workers, motorcycle taxi drivers, border military or police, transport workers, boat crews.

##### **Bridge between highest risk groups and general population**

For example: border traders, freelance sex workers, travelling salesmen.

##### **General population**

For example: married women, adolescents.

---

The behavioural surveillance survey (BSS) approach, created by Family Health International, has been applied in a variety of settings in Asia and may be an appropriate tool for sub-regional programme evaluation of cross-border projects.<sup>12</sup> A core questionnaire and standard methodology already have been developed for the BSS and are described in several handbooks.<sup>13,14</sup>

While the BSS presents quantitative data on risk behaviour in the cross-border population, other evaluation data are needed on the context of risk in the community. This is because some border towns have an

“atmosphere” of risk that facilitates reckless behaviour and, possibly, HIV transmission.<sup>15</sup>

Some of the contextual dimensions that should be investigated (using qualitative data collection methods) include:

- Interaction between the resident population and the mobile populations who travel through a border town
- Self-perception when in or outside the border area (e.g., sense of anonymity, freedom from legal or social controls)
- Behaviours and attitudes of powerful authorities that may encourage or discourage risk behaviour
- Increase or decrease in institutions and policies that encourage or discourage risk behaviour.

Manuals for using qualitative methods to collect data for HIV-prevention programmes are available.<sup>16</sup>

## **7. Leveraging Local Resources and Sustainability**

*Why?* Despite the increased attention to Asia as the area with potentially more future HIV infections than any other region, it is very likely that grant funding for HIV-prevention programmes will continue to decline indefinitely. While loan funds may increase for some time, these funds will be managed by national prevention programmes that may consider border sites a lower priority than large cities. Thus, agencies planning new cross-border interventions need to include plans for sustainability right from the start. As data are being collected during the pre-implementation phase, special attention needs to be given to the capability of the community

to mobilize indigenous resources to eventually underwrite much of the prevention costs. If that capacity does not exist, it must be built as part of the intervention.

**How?** To invest in, and then sustain, HIV-prevention interventions can be particularly challenging in remote cross-border areas. Travel and communication costs are much higher on average for cross-border projects than for programmes in large cities and other more accessible areas. World Vision has attempted to address the sustainability challenge by integrating HIV prevention into its general development work along the border between Thailand and Myanmar. This integration achieves some economies of scale. Other programmes are considering a “prevention marketing” strategy to deliver prevention materials and supplies to at-risk mobile populations through social marketing. Cost-recovery is possible through the collection of modest clinic fees, as is done on the India-Nepal border. However, the most successful HIV-prevention work is achieved through sustained interpersonal communication with trained outreach workers, and this usually requires outside support.

#### **CONCLUSION**

While HIV has spread rapidly in some Asian countries, it appears that the pervasive urban and rural epidemics that many countries in sub-Saharan Africa are experiencing will not materialize in this region of the world.<sup>17</sup> Nevertheless, for future decades HIV will continue to be a serious public health threat to Asians. Accordingly, regional prevention programmes need to concentrate their limited resources in the areas most vulnerable to

HIV/AIDS epidemics. Analysis of the distribution of HIV in parts of Asia suggests that areas with busy land-border crossings and international fishing ports have higher levels of STI and HIV than other trade areas. Because of the volume of people who travel to and through these towns and ports, the implications for widespread transmission of HIV are enormous. Similarly, the implications for cost-effective reductions in new HIV infections are also great.

An increasing number of NGOs and funding agencies are recognizing this border-crossing epidemic-spread phenomenon and are steering resources to the geographical perimeter, instead of the centre, of societies. The March 1998 Mae Sai meeting of the agencies with the most experience conducting this work in Asia was remarkable for the commonality of approaches and strategies that had evolved independently. This case study outlines the essential elements of a cross-border programme based on the practical experience of NGOs that implement such programmes. This experience can be summed up in a few simple words: “Select carefully, start locally, plan broadly.”

#### **AUTHORS**

**Tony Bennett**, AIDS Control and Prevention (AIDSCAP) Project, Family Health International, Bangkok, Thailand

**Kathleen Henry**, Sidebar 1, AIDSCAP, Family Health International, Arlington, Virginia, USA

#### **ACKNOWLEDGEMENT**

This case study is based on the proceedings of a participatory workshop of 40 individuals representing cross-border HIV-prevention projects in multiple sites of South-East Asia

as of March 1998. The workshop was jointly organized by the Asia Regional Office of Family Health International's Implementing AIDS Prevention and Care (IMPACT) Project, funded by USAID's Asia/Near East Bureau, and the UNAIDS Asia-Pacific Intercountry Team Office, both based in Bangkok. FHI collaborated with UNAIDS to adapt the proceedings for this FHI/UNAIDS Best Practices in HIV/AIDS Prevention Collection case study.

#### REFERENCES

1. Family Health International, Asia Regional Office. A regional cross-border HIV/AIDS prevention response in East Asia. Seminar proceedings. Bangkok, Thailand, January 1996.
2. Jenkins C. Final report: Behavioural risk assessment for HIV/AIDS among workers in the transport industry, Papua New Guinea. AIDSCAP/Family Health International, Bangkok, 1994.
3. Pramualratan A, Somrongthong R, Jindasak K, Saetiow S. Assessment of the potential for spread and control of HIV among cross-border populations along the Thai- Cambodian border. AIDSCAP/Family Health International, Bangkok, 1995.
4. Rao A, Sundararaman R, Shrestha BK. Report of the study team for the assessment of the AIDS situation on the trucking routes between Nepal, India and Bangladesh. AIDSCAP/Family Health International, Kathmandu, 1995.
5. Simbulan NP, Gomez DC, Tayag JG, Imperial RH. Formative research on the seafaring population: Philippines final report. AIDSCAP/Family Health International, Manila, 1996.
6. CARE International/Laos. Three provinces focus group project. Project report. AIDSCAP/Family Health International, Bangkok, 1995.
7. Programme for Appropriate Technology in Health (1995). Rapid ethnographic assessment: Strategic planning for AIDS prevention in five Indonesian cities. AIDSCAP/Family Health International, Bangkok, 1995.
8. UNAIDS-APICT Task Force on Migrant Labor and HIV Vulnerability. Guidelines for rapid research on mobile populations: For planning and implementing STD/HIV/AIDS prevention and care. APICT/UNAIDS, Bangkok, January 1998.
9. Jakakaran RI. PLA: Participatory learning and action. User guide and manual. New Delhi, India: World Vision, 1996.
10. Nelson K, Celantano D, Eiumtrakol S, et al. Changes in sexual behaviour and a decline in HIV infection among young men in Thailand. *N Engl J Med*, 1996; 335(5):297-303.

11. Brown T. The relationship of HIV and STD declines in Thailand to behaviour change—a synthesis of existing studies. Draft monograph. UNAIDS, Geneva, 1997.
12. Mills S, Ungchusak K, Srinivasan V, et al. Assessing trends in HIV risk behaviours in Asia. *AIDS*, 1998; 12(suppl B):S79–S86.
13. Family Health International, AIDS Control and Prevention Project. HIV risk behavioural surveillance surveys (BSS): Methodology and issues in monitoring HIV risk behaviours. Summary from the workshop “HIV risk behavioural surveillance: country examples, lessons learned, and recommendations for the future,” Bangkok, Thailand, August 11-14, 1997. Family Health International, Bangkok, 1998.
14. Family Health International, AIDS Control and Prevention Project. Application of a behavioural surveillance tool. AIDSCAP Evaluation Tool Module Series, module no. 4. Family Health International, Arlington, VA, 1995.
15. Bennett T. An aura of risk. In: Second technical consultation on transnational population movements and HIV/AIDS in Southeast Asian countries. Proceedings of a seminar in Chiang Rai, Thailand. Asian Research Centre for Migration, Bangkok, May 1997.
16. Family Health International, AIDS Control and Prevention Project. Qualitative evaluation research methods. AIDSCAP Evaluation Tool Module Series, module no. 5. Family Health International, Arlington, VA, 1996.
17. Chin J, Bennett A and Mills S. Primary determinants of HIV prevalence in Asian-Pacific countries. *AIDS*, 1998; 12(suppl B):S87–S91.

## APPENDIX I

### RAPID ASSESSMENT: GUIDELINES FOR CROSS-BORDER PROJECTS

**Introduction and Rationale** Using statistical methods, epidemiologists have determined that mobility is an independent risk factor for HIV infection where HIV is prevalent. The same relationship should hold for other STIs, even where HIV is not prevalent. Thus, it is important for prevention programmes to develop services for mobile individuals.

Regional HIV-prevention programmes in Asia are becoming more interested in mobile populations because these individuals may not have equal access to national prevention programme services. In addition, population movement in Asia is on the rise, due to the expanding infrastructure of paved roads, bridges and ports. This increased movement is expected to increase the spread of HIV.

By virtue of their movement, mobile populations are difficult to reach with sustained interventions for STI diagnosis and treatment and interpersonal communication to assess risk and choose behavioural options to reduce personal risk. Mobility is also a vague term, since everyone in society is mobile to some degree. For the purpose

of this discussion, the following distinction is made. Mobile populations are of two types:

- (1) Migrants, who change residence (legally or illegally) for a significant duration (many months or years).
- (2) Other mobile populations, such as those with mobile occupations, who do not change their formal residences.

Although both groups are vulnerable to HIV/STI due to lack of access to quality prevention services—and the social disruption of moving—it is proposed that the second group plays the more significant role in fuelling the regional HIV epidemic. This is because certain HIV “breeding grounds” in the region are disproportionately located in cross-border market towns and international fishing ports. These cross-border junctions serve as gathering places for Asian men and women with mobile occupations and cash incomes. While migrants may pass through these locations only once, those with mobile occupations pass through them regularly and repeatedly.

Despite the substantial investment in HIV/AIDS prevention resources in Asia, few of these resources reach the cross-border sites because of their remoteness, the lack of recognition of their epidemiological

significance and the priority national AIDS programmes place on serving mainstream populations. In addition, the need for programmes that cross borders means that these sites fall into a political vacuum, outside of the mandate of most national and bilateral programmes. Recently, however, regional HIV-prevention programmes are beginning to design prevention projects for mobile populations—especially those that cross national boundaries. To inform the design process, these projects need more information on the context of risk and the potential modes of intervention.

This case study defines a proposed methodology for conducting a rapid assessment of cross-border locations originally prepared in response to a request by the APIC/UNAIDS Task Force on Migrant Populations and HIV Vulnerability.

#### **Data Collection: Community Context**

The epidemiological data suggest that some contextual factor or set of factors render cross-border sites “flammable” for HIV. Thus, a rapid assessment must collect certain information on the general community setting in order to help sketch a risk profile. This information should enable planners to prioritize sites for the pilot projects that are to follow the assessments. The major method of data collection is key informant interviews with individuals who have a broad knowledge of the site and have been in residence for some time. In addition, the team will use observation and mapping to describe the locations and interaction of various establishments or sites that facilitate sharing of sex partners.

#### **Key Informant Interviews**

Key government administrative officials

- chief district officer, mayor
- chief of police
- chief of immigration
- chief government health officer.

Knowledgeable long-term residents

- retired governor, district chief, mayor
- beauty salon owners (female)
- bar or nightclub owners.

The items for the discussion guide should be adapted for different types of informants, and not all questions should be asked of each respondent. Reliable information on the following core items should be obtained:

- age of town; factors behind development status
- number and location of ports, landing docks
- number and location of bus depots, truck stops
- number and location of fresh markets
- number and location of health service outlets (including pharmacies)
- number and location of places with overnight accommodations by price/room
- number and location of places that serve hard liquor
- number and location of commercial sex access points by type (e.g., brothels, karaoke lounges, massage parlours)
- number and location of places that sell/distribute condoms
- number and locations of parks, locations for “cruising” for commercial sex partners and men who have sex with men
- number of gambling dens
- local slang terms for above locations, commercial sex, STI, drunken behaviour

- size of population (of sexually active age):
  - in residence
  - in transit
- passing through without staying overnight
- male-to-female ratio (of those of sexually active age).

Based on this information, the data collection teams will begin to construct a crude map of the site and plot the key landmarks. Next, a thorough walk-through is conducted to fill in locations of other sites that were overlooked by the key informants. Photographs should be taken during the day and night of important gathering places where risk behaviour or commercial sex negotiation take place; STI service outlets; and border crossing junctions, such as bridges, checkpoints, ports and piers.

#### **Data Collection: Populations of Special Interest**

It is necessary to have some concept of hierarchy of risk to ensure that the most vulnerable are the focus of the assessment. Time does not allow a general survey and evaluation of risk for all persons in cross-border communities. Besides, much is already known about vulnerability in the Asian context. Although behaviour is the most important determinant of risk, certain occupations create circumstances leading to very high risk of infection.

**Occupations for Men:** These include occupations in which there are prolonged periods in close proximity with other male co-workers, followed by a short burst of freedom to socialize with women (e.g., deep-sea fisherman, logger, miner, military recruit).

**Occupations for Women:** These include occupations in establishments whose primary customers are men (e.g., brothel

worker, masseuse, karaoke lounge hostess, barber shop attendant, snooker hall marker, dance hall hostess).

Secondary levels of risk are associated with the following:

**Men:** Occupations involving itinerant travel, such as trader, salesman, transport worker or border police.

**Women:** Wife or girlfriend of the men in any of the male occupations described above.

A rapid assessment of such short duration must rely on key informants who know about the populations of special interest described above. It is not necessary to conduct sample surveys of these populations to measure knowledge and behaviour. Their vulnerability is already well established. Instead, the data collection team should collect information from individuals who have resided in the cross-border location long enough to have a good understanding of population movements, gathering places and prevention opportunities. Approximately one person each should be interviewed from the following groups:

- older sex worker who has been in town at least one year (one for each of the predominant linguistic groups, or about 3 persons)
- fishing boat captain (in port towns)
- foreman (logging, mining, construction, fishery company)
- daytime market vendor (female)
- nighttime market vendor (female)
- local commuter transport worker: motorcycle taxi
- local commuter transport worker: cycle, rickshaw
- local commuter transport worker: boat or ferry.

The discussion guide will vary by type of key informant, but the essential information from all groups should lead to a composite impression of the risk environment of the town at large.

The core components of the discussion guide should include the following content:

- size of the population of coworkers, peers
- frequency of turnover (average duration of stay)
- common destinations when leaving this site
- trend toward increase or decrease in population of peers
- common languages spoken in group
- most pressing need/hardship of group right now (financial, legal, environmental, health, etc.)
- previous STI/HIV-prevention services received (when, what type, by whom)
- current need for prevention services by type (STI, condoms, information, incentives to change behaviour)
- sources of condoms (with price range)
- sources of STI treatment (with price range)
- interest in becoming a peer educator/leader
- recommendation of other key informants.

#### **Data Collection: Service Infrastructure**

To obtain more information on the health-seeking behaviours of the mobile populations and the range of services available, both STI and non-STI certain key informants will be interviewed, such as the following:

- private clinic physician (one male, one female)
- pharmacy drug seller (one male, one female)
- government health office official (one male, one female)
- traditional healers.

The information to be collected from these individuals includes, but is not limited to, the following:

- most common complaints/conditions of patients seen
- any patients with STIs or concerns about STI, by type
- about how many persons with STI-like complaints seen per week or month
- what service is provided to these individuals
- local terms used for different STI-like conditions
- how STI is diagnosed
- how treatment is prescribed
- the most common treatment for (1) genital ulcer, (2) genital discharge, (3) abdominal pain
- need for additional training on STIs
- need for additional equipment/supplies for STI management; who should provide these
- most popular service outlets for STIs (by name and location)
- volume of sales of over-the-counter STI drugs by type
- volume of sales of post-coital contraceptive (Postinor)
- demand for abortion
- volume of sales of condoms by brand, price per piece.

#### **Data Collection Team Composition**

The research team may vary in size and other parameters but must include the following attributes:

1. literate, multilingual speakers of the predominant languages used in the site

2. male and female data gatherers (minimum: one each) with quantitative and qualitative data-collection skills
3. team supervisor (one minimum)
4. local counterpart (ideally, one female and one male)
5. time enough to spend overnights in the site inclusive of one Friday-Saturday night combination.

**Field logistics** It is proposed that the assessment be conducted over a period of six consecutive days. A team of five individuals should be able to collect the requisite data in that time. The assessment report should be prepared in the week immediately following the assessment and should include maps and photographs to illustrate the context of the risk dynamics of the site.

Essential equipment and support services include:

- evidence of previous contact with local officials and official, written permission to collect data in the site
- a one-page description of purpose of visit and names of team members and organizational affiliation
- most recent road maps of the districts and provinces surrounding the site
- discussion guides with topics for key informant interviews
- checklists to aid in mapping site locations
- grid paper for map sketches
- notepads for field notes
- tape recorder, tapes, spare batteries
- camera, print film, spare batteries
- locally-rented transportation and driver.

#### REFERENCES (APPENDIX I)

1. Decosas J, et al. Migration and AIDS. *The Lancet*, 1995; 346:826–29.
2. Wagner HU, et al. In-country migration and HIV-1 infection in a rural Ugandan community. Paper presented at the European Conference on Tropical Medicine, Hamburg, Germany, October 1995.
3. Kane F, et al. Temporary expatriation is related to HIV-1 infection in rural Senegal. *AIDS*, 1993; 7:1261–1265.

## APPENDIX II

TABLE A

**Selected Border Crossings in Asia\***

(Note: All crossing points are official or officially endorsed)

Names of "Linked" Border Towns	Type of Crossing	Estimated Person-Crossings Per Year
<b>Thailand–Laos</b>		
Chiang Khong–Huaysai	River ferry	
Chiang Saen–Huaysai	River ferry	
Nongkhai–Vientiane	Bridge	830,000 (1996)
Nakorn Panom–Savannakhet	River ferry	
Chong Mek–Pakse	River ferry	350,000 (1996)
<b>Cambodia–Thailand</b>		
Choam Ksan–Nam Yin	Land	
Samrong–Kap Choeng	Land	
Polpet–Aranyaprathet	Land	
Koh Kong–Klong Yai	Land, speed boat, sea vessel	300,000
Kompongsm–various ports	Sea vessel	
<b>Thailand–Myanmar</b>		
Mae Sai–Takilek	Bridge	Hundreds of thousands
Mae Sot–Myawadee	Bridge	Tens of thousands
Ranong–Kawthawng	Ferry and land	Tens of thousands
<b>Thailand–Malaysia</b>		
Satun–Padang Besar	Land	
Sungai Kolok–Kota Bharu	Land	
<b>Cambodia–Vietnam</b>		
Svay Rieng–Tay Ninh	Land	110,000
Takeo–Chao Doc	Land	
Kompongsm–various ports	Sea vessels	

TABLE A (CONTINUED)

Names of "Linked" Border Towns	Type of Crossing	Estimated Person-Crossings Per Year
<b>China–Laos</b>		
Mengla–Mohan	Land	
Jiangcheng–Phongsaly	Land	
<b>Laos–Vietnam</b>		
Savannakhet–Quang Tri	Land	22,000 (trucker-trips)
<b>China–Myanmar</b>		
Ruili–Muse	River vessel	
Mengding–Chin Shwe Haw	River vessel	
<b>China–Vietnam</b>		
Dongxing–Mong Cai	Land	
Pingxiang–Dong Dang	Land	Approximately 2 million
Tianbao–Ha Giang	Land	100,000 (1995)
Jingping–Jinshuihe	Land	124,000 (1995)
Hekou–Lao Cai	River vessel	200,000 (1990)
<b>Nepal–India</b>		
Birgunj–Raxaul	Land	
Nepalgunj–Bharaich	Land	
Biratnagar–Dharbanga	Land	
<b>India–Bangladesh</b>		
Calcutta–Benapole–Jessore	Land	
Silchar–Syhlet	Land	
<b>Bangladesh–Myanmar</b>		
Chittagong–various ports	Sea vessels	
Mongla–various ports	River and sea vessels	
<b>Philippines–Indonesia</b>		
General Santos City–Manado	Fishing boats	
<b>Indonesia–Thailand</b>		
Mereuke–Samut Prakan	Fishing boats	

\*Much of the information in this table is derived from the Asia Research Centre for Migration publication *Maps of International Borders between Mainland Southeast Asian Countries and Background Information Concerning Populations Movements at those Borders* (February 1998).