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New Delhi, 9-11 December 1998**

Provisional agenda item 5

Migration and HIV/AIDS

EXECUTIVE SUMMARY

Every year there are around 120 million people moving voluntarily from one country to another or within their own country, plus another 38 million refugees and internally displaced persons. HIV and other STDs have been shown to spread more rapidly as populations become more mobile. The number of migrants living with HIV remains unknown. However, preliminary information indicates that a large number of migrants engage in HIV risk behaviour related to sex or drug use. At the same time, most tend to be more vulnerable than local populations to the risk of HIV infection because of their living and working conditions – poverty, powerlessness, precarious family situations, and inadequate access to health services.

A review of available information from the regions (Annex 1) makes it clear that when it comes to AIDS and migration, there are major policy, programme and information gaps. These gaps make effective planning and intervention difficult.

Policy issues pertinent to migrants and AIDS include:

1. the need to view migration as a continuum in which interventions are planned for all stages – place of origin, transit and destination
2. the need to anticipate and take prompt steps in advance of large population movements due to conflicts, opening of borders etc.
3. the need to review restrictive migration laws whose protectionist approaches limit effective AIDS prevention, care and support
4. the need to review human rights violations which contribute to migrants' vulnerability to HIV infection, such as discriminatory policies associated with HIV screening as grounds for refusing mobility.
5. Interventions related to migrants and AIDS that are in urgent need of implementation include:
6. education and condom promotion for HIV prevention through media, outreach activities, in the workplace, etc.
7. improving access to health care that comprises HIV/AIDS and STD services, including through mobile and outreach services
8. voluntary HIV counselling and testing with full respect for confidentiality
9. reducing socioeconomic vulnerability to HIV by improving quality of life through the workplace and in living conditions.

In order to develop effective intervention policies and strategies, action-orientated research is required. The focus of research should be on risk-taking behaviour and vulnerability to HIV. Research can also be used as a tool to monitor progress in and evaluate outcomes and impact of implementing policies and interventions.

UNAIDS, its cosponsors and other UN agencies are increasingly involved in advocating and supporting collaboration at regional and country level to improve the response to the problem of migration and HIV/AIDS.



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I. INTRODUCTION

A. Scope of the HIV epidemic and migratory movements

1. The June 1998 *Report on the Global HIV/AIDS Epidemic* (UNAIDS and WHO) estimates that over 30 million people, or one in every 100 adults between 15 and 49 years of age, are living with the human immunodeficiency virus (HIV). Close to six million of them became infected in 1997 – this represents a rate of some 16 000 new infections a day. Furthermore, over 90% of all people with HIV infection or AIDS live in a developing country. Concurrently, and also in the developing world, huge numbers of people are on the move. An estimated two to four million people voluntarily leave their country of origin each year, a number dwarfed by the 16 million people moving from rural to urban settings within their own countries (the latter estimate excludes China and its “floating population” of an estimated 80 to 100 million people - migrants who move around on a regular seasonal basis or temporarily). Added to these are 18 million people who have fled their own countries as refugees and another 20 million thought to be internally displaced, having left their community for another within their own country.
2. Both the HIV epidemic and migration are thus occurring in the same populations. Some evidence indicates that migration increases people’s vulnerability to becoming infected with HIV. Previously, governments’ main concern was that incoming migrants might bring HIV with them. Today, however, while this scenario still occurs, there is increasing recognition that migrants may be more vulnerable than non-mobile populations to acquiring HIV infection and that others may acquire the virus from migrants when the latter return to their respective homes.

B. Links between HIV transmission and migration

3. Human migration, whether voluntary or involuntary, may result in the spread of HIV infection both to those who migrate and to members of the communities which receive migrants, as well as to individuals in the country of origin, if a migrant returns infected. Exposure to HIV usually occurs through sexual contact, but in the context of migration it can also occur through the sharing of infected equipment for injecting drug use (both licit and illicit) in transit areas; the use of infected blood supplies in refugee camps; and unsafe health practices which migrants may seek out when they distrust or are denied access to standard medical care.
4. In transit areas, migrants may have increased opportunities for risk-taking behaviour. Booming sex and drug businesses within the local economy through which migrant populations pass or move to may be devoted to activities that increase the risk of HIV transmission. Migrants in transit may trade or sell sex for goods, services, physical security and/or cash in order to survive. Such so-called “survival sex” occurs in border areas in many regions of the world. In addition, AIDS education, STD services and condoms are usually not available to migrant populations. What was a relatively lower-risk activity (sex with condoms) in the migrant’s place of origin becomes a very high-risk activity (sex without condoms) – in terms of HIV - in a transit area. In addition, the extremely constrained social environment in transit areas, where an illegal or undocumented migrant

has few safer alternatives or is unable to exert negotiation, can increase the risk of HIV transmission.

5. Because of the high mobility of people in these areas, it is difficult to provide prevention programmes and health services which serve them effectively.
6. Once they have arrived at their destination, migrants may experience problems in adapting to a new environment. This can influence their mental and physical health, and sexual behaviour. High-risk behaviour such as sex with multiple partners, whether in the context of the sex trade or in casual sex, is not solely the result of migration. It is also a function of being separated from family, from a regular sex partner, the concentration of migrants in one place, and the stresses and vulnerabilities associated with the migration process. There is a strong need for money to buy necessities or on which to subsist while waiting for employment. The anonymity of being a foreigner, especially in transit areas, can increase sexual activities. If the new environment is exclusively male, sometimes this enhances the potential for sex between men. Exposure to HIV may occur if unsafe sex is practised. Even if women are present, migrants may have difficulties integrating into a new culture and meeting women in their new environment.
7. Migrants tend to occupy a relatively vulnerable position in the receiving society, although this is less the case with migrants who have skills, education and secured employment. This holds especially true for refugees, displaced persons and undocumented migrants. They may, in fact, represent the most vulnerable of all migrant groups with respect to HIV infection, in that they are forced by circumstances into unsafe working conditions and accommodations and may be exploited for meagre wages. They lack money to buy health services or are unable to access local services due to their legal status.
8. Much of the policy concern about admission of migrants centres on whether they are likely to become a burden on health and social services in receiving countries. In contrast, little attention has been paid to the economic dangers of ignoring the health needs of these workers – a major oversight given their economic contribution to receiving countries. Since the majority of migrants are men in the prime of their earning potential as well as their reproductive life, HIV could have devastating social and economic effects, should a large number of this sizeable earning population cease contributing to society.

C. Definition of “migrant”

9. In this discussion paper, a broad definition of migrant has been used. Migrants are here defined as voluntary or economic migrants, as well as refugees, displaced persons, and additional individuals who move for other compelling reasons. Thus, the word “migrant” in this paper means anyone who migrates across international or internal borders.

II. Policy Issues Related to Migrants and HIV/AIDS

10. Four policy issues related to migrants and HIV/AIDS need urgent attention by the international community. These are (1) recognizing that migration is not a single event but a process or

continuum; (2) taking early steps to avert increases in HIV spread; (3) harmonizing different laws and regulations on migration; and (4) examining the effects of restrictive laws that violate human rights while increasing vulnerability to HIV. Each issue is briefly described below.

A. Migration as a continuum

11. For policy-makers involved in planning or implementing interventions related to migrants and HIV/AIDS, the most useful view is that migration is a continuum with different stages, rather than an event or a one-time activity. The three basic stages of migration are: the point of origin, the transit period and the destination. For each stage, critical analysis is needed, for example on why migrants leave, how they earn a living while travelling, the social and financial relationships they maintain during transit and at their destination, and their legal status at destination.
12. Apart from analysing different stages in the continuum, it is important to consider the different specific categories and motivations of migrants and the influence of *time*. Movement can be abrupt, as in the case of a person who traverses several continents in a few hours by jet plane, or as slow as the progress of people moving on foot and stopping for weeks or months along the way. In addition, much migration is *cyclical*, with people leaving and returning to their place of origin one or more times, sometimes frequently. A final and crucial factor is that of *legal status in relation to the different stages in the continuum*. This, more than anything else, may determine what happens to a migrant at home, in transit or at destination, and can have a powerful influence on his or her vulnerability to HIV/AIDS.
13. When all these factors are taken into account, policies can be adopted and interventions planned for all three stages. In this way, policy directives and the design of intervention activities on migratory issues will be better adapted to the continuously evolving situation and needs of migrant populations, and thus more likely to be effective. When migration is viewed broadly, this can also have a positive impact on the number of collaborating ministries/agencies, the scale and design of implementation and sources of funding.
 - *Point of Origin* – Place, Reason and Situation: e.g., where migrants come from (and often where they return to), why they leave, what relationships (social, financial, etc.) they maintain while away
 - *Transit Period*– e.g., the places through which migrants pass, the means of transportation, how they maintain their livelihood while travelling
 - *Destination* – e.g., where they are going, or intend to go, legal status and living conditions at their destination

For example, once a policy of focusing on migration as a continuum is adopted, it is crucial to plan interventions at all the places of origin, transit and destination.

For example, addressing the *continuum* in its response to HIV/AIDS and migration, the Railways Administration of China has been implementing multiple interventions at different points of migration. As part of this strategy, the Railways Administration distributes HIV/AIDS prevention information to its staff and railway passengers throughout the transportation routes. Many of the migrants belong to the floating labour force population. Railways are also setting up drop-in health/counselling centres at pilot stations. (*China Responds to AIDS, China Ministry of Health and UNAIDS China*)

B. Early warning and advanced preparation

14. A second policy issue is the need to analyse situations and prepare ahead of time when it seems likely that a new migratory movement is imminent. Certain situations and factors can serve as early warnings of significant migration or internal mobility. Therefore, situation assessments should be conducted and, when these factors are detected, plans to cope with migration and implement AIDS-related interventions should be prepared as early as possible. Similarly, once migration begins, AIDS-related interventions should start as soon as possible, without waiting for high HIV rates to begin appearing. Lessons have been learned from these warning situations. For example, the migration and refugee situations in South-East Asia should have warned policy-makers and others to prepare for population movement in Eastern Europe *before* the emergence of the newly independent states.
15. Among the more recent situations leading to or influencing population movement and mobility are:
- increased availability of air transport and cross-border roads
 - growing international or crossborder trade and commerce
 - deregulation of trade practices and promotion of regional free trade (European Union, North American Free Trade Agreement, World Trade Organization, etc.)
 - opening of borders
 - conflict situations and wars.
16. These have occurred most notably in South-East Asia, Eastern European countries and the Commonwealth of Independent States (CIS), Southern Africa, and Economic Free Zones along China's east coast, and have resulted in increased population movement, including movement of groups with higher HIV risk or vulnerability, such as refugees, sex workers and injecting drug users.

C. Legal frameworks

17. A third item that should be included in policy dialogue is that of State laws. Some laws restrict migrants' mobility while others deal with quality-of-life issues (including HIV/AIDS prevention and care) and can have a positive effect.
18. In recent years, States have been adopting more laws and regulations to control the movement of persons into their territories. The legalities of moving from one country to another are thus a patchwork, although international conventions on trade, commerce, health and human rights have attempted to harmonize or encourage the adoption of similar principles and practices among States. National policy-makers need to work within and between countries to negotiate and collaborate in this process.
19. Second, there has been some, but not sufficient, attention to the public health implications of migration and AIDS. As long as illegal and undocumented migration continues to be viewed only in relation to security and national interests, public health will be neglected. It is clear that countries

must increase efforts to provide social and health services targeted to the needs of migrants, including their need for HIV prevention. One way in which policy-makers can achieve or facilitate this is by approving appropriate laws and regulations.

D. Interface between human rights, migration and HIV/AIDS

20. Finally, there are policy issues at the interface between human rights, migration and AIDS. Among the rights in question are the ones relating to free circulation, requesting and obtaining asylum, and being accompanied by family members. Failure to respect these rights can have unanticipated effects on public health, including the health of migrants. For example, many States do not allow migrants to be accompanied by their family members. The resulting isolation may increase their vulnerability to HIV and unwittingly contribute to the spread of the epidemic. Again, in the case of refugees, compulsory HIV testing as a requirement for asylum¹ may result in some members of one family being granted asylum but not all, breaking up the family and increasing vulnerability to HIV.
21. In spite of the fact that the course of the HIV pandemic has a demonstrated relationship to human mobility, there has been little specific policy development focused on this relationship. Based on internationally recognized guidelines, regional offices of international agencies should promote and assist countries to draft policy statements on migrants' HIV risk and vulnerability which would lead to applied research, planning and programming with the objective of risk and vulnerability reduction.
22. Among the ways of responding to this policy consideration is to develop an intercountry framework for collaboration on issues of relevance to countries on the same migration route.

III. Interventions Related to Migrants and HIV/AIDS

23. In addition to the review of policies described in the preceding section, it is urgent to implement interventions relevant to migration and HIV which cover prevention, care and supportive environments. Preparation for these interventions should start as soon as the early-warning situations are detected. Implementation among migrant populations should begin as early as possible.

A. Education and condom promotion for HIV prevention

24. The basic principles of HIV prevention targeted at migrant populations are not much different from prevention activities designed for other populations. Such interventions must include ways of

¹ The International Organization for Migration (IOM) supports the policy guidelines issued by the United Nations High Commissioner for Refugees (UNHCR) in March 1988, as well as the UNAIDS Policy on HIV Testing and Counselling) of August 1997. The UNHCR guidelines state that "refugees and asylum seekers should not be targeted for special measures regarding HIV infection and that there is no justification for screening to be used to exclude HIV positive individuals from being granted asylum" (UNHCR Health Policy on AIDS, 15 February 1988).

increasing HIV-related awareness, knowledge and skills (condom use, decision-making, negotiation); access to the means of prevention, especially condoms and clean needles and syringes; and relevant services (e.g., treatment of sexually transmitted diseases [STDs] and HIV/AIDS counselling). A combination of approaches must be used to reach migrants, including peer education, outreach programmes, small media, mobile health services and integration of AIDS interventions into existing non-health services, such as job training and legal services.

25. The design and selection of combined approaches must be tailored to the needs of each migrant population group. For example, condom distribution and AIDS education for truck drivers and sex workers whom they visit must be carried out by mobile, versatile teams working along the truck routes. Drug treatment, needle exchange, AIDS education and drug-prevention education should be provided to mobile populations in the areas of high drug use prevalence. Outreach programmes for mobile construction workers are feasible only if they function in the evening. In addition, the AIDS education materials used for them should be audio-visual, or, if printed, predominantly illustrated with comics and pictures. AIDS education and skills training for young women in the migrants' families should begin in the place of origin or as soon as they arrive at transit or destination sites where they are pressured to exchange sex for cash, goods, job opportunities or physical security. The AIDS education and condom distribution for refugees should be integrated into the camps' communication system (possibly multilingual) and into health and non-health services where possible, making use of outreach work involving camp staff and refugee volunteers. While interventions should begin without delay, occasional rapid assessments among migrant populations may help to elicit additional information needed to tailor the interventions and messages. Involvement of some migrants in the process of intervention is highly recommended.
26. Protection of human rights, including children's rights, and confidentiality are very important elements of implementing such interventions. Collaboration with local authorities and local leaders can help to reinforce and sustain these efforts to protect rights. In addition, local communities may provide some health and social services, such as non-formal education or schooling, to migrant populations. Non-governmental organizations (NGOs) and, in some cases, the business sector are enthusiastic and effective in the provision of AIDS-related interventions and relevant services.

B. Health care, including HIV/AIDS and STDs

27. International and national migration programmes should guarantee access to primary health care, in addition to services relating to HIV and sexually transmitted diseases. Governments should gather information and develop action programmes aimed specifically at migrants, including those living with HIV or AIDS. Whenever possible these efforts should be approached within a regional framework in order to address crossborder issues of health-service provision. The latter requires close collaboration between governments at national and local levels, in addition to support from international bodies.
28. Migrant populations have difficulty in gaining access to health and support services during and after migration. This is particularly true for illegal and undocumented migrants. It is crucial to integrate care for HIV/AIDS and STDs into health services at one and the same site. Most migrant populations, particularly highly mobile labourers and refugees, will have neither the opportunity nor

the resources to visit more than one service site. Since seeking formal help or treatment for illness may result in an illegal migrant being detained or expelled, few are willing to take such a risk – with the result that small problems turn into overt and major ones. If it is not possible to modify restrictive laws or regularize the migrant's official status, NGOs can offer specially designed services through mobile or outreach teams that offer the needed care .

29. Guidelines on services relating to health and HIV/AIDS are available and have been adopted by the United Nations system. UNAIDS has published a document in its Best Practice series entitled *Refugees and AIDS*. Guidelines on this subject, which are applicable to refugees and other migrant populations, describe how to ensure a safe blood supply, condom availability and supply materials for universal medical precaution, such as gloves, prevention education and counselling, as well as access to safe injection supplies, health services and comprehensive care for people living with HIV/AIDS.

C. Voluntary counselling and testing

30. Many States use mandatory testing for HIV as a condition of admissibility. UNAIDS' stated position is that it does not support mandatory testing of any groups of people.
31. All testing for HIV infection should be voluntary, conducted with the informed consent of the individual to be tested, and confidential counselling should be offered to all those tested. This policy is consistent with previous positions taken by the World Health Organization and with the intent of the International Health Regulations, and reaffirms the 1988 UNHCR Health Policy on AIDS. Moreover, voluntary counselling and testing have proven effective as an HIV prevention measure, by influencing behavioural change among people engaging in high-risk activities.

D. Improving working and living Conditions that intensify vulnerability to HIV

32. "...migrants are viewed as people who because of their living circumstances, poverty and socio-cultural situation in a host country may be vulnerable to disease of all sorts including STDs and HIV." *Edna Oppenheimer, Methodologies of Cross-Border Analysis of Clandestine Migrant Populations, May 1997*
33. It is well known that vulnerability to HIV is often greatest when people find themselves living and working in conditions of poverty, powerlessness and social instability. Separation from family and one's familiar socio-cultural norms; isolation and loneliness; a sense of anonymity that offers more sexual freedom; and inadequate financial resources make migrants more vulnerable to engaging in behaviour that puts them at risk of HIV infection. Loneliness, frustration and peer pressure combined with easy access to drugs can make it hard for migrants to resist injecting drugs. The search for living quarters, for cash to survive or for protection from physical violence can force family members of migrants into commercial sex work or sexual exploitation.
34. These working and living conditions that increase vulnerability call for special action. In countries receiving economic migrants, employers should be actively involved in improving the quality of life

of their employees, especially for migrants working in isolated situations such as logging camps, plantations and mines. Participation is needed from private and public sectors (including health authorities and large infrastructures that employ migrants) and trade unions, to assess and then improve their living and working conditions. In order to reduce vulnerability and modify the circumstances that foster a risk-taking environment, it is important to educate all participants about the health and social needs of migrants, including those related to HIV. Efforts must be coordinated between countries where migrants originate, transit and settle in order to harmonize policies, activities and exchange of information.

Annex 1 provides more specific information and regional examples of working and living conditions that increase the vulnerability of migrants to HIV infection.

IV. Research Issues

A. Risk and vulnerability assessment

35. In order to develop effective intervention policies and strategies, more research is required. Any research undertaken on migration and HIV/AIDS must be action-oriented. Given the nature of migration, related research should also address crossborder issues, as well as those internal to a country.

36. The following two subject areas are proposed as priorities for research that will support evidence-based policies and practices in the area of migration and HIV.

a. Focus on risk-taking behaviour

37. The linkage between migration and HIV can be inferred from existing studies of highly mobile groups, such as truck drivers, and from rural-urban migration studies. However, studying only highly mobile occupational groups does not capture all the risk behaviours and risk factors involved in the migration process. Outside of specific studies on the sex trade and sex tourism, few studies have examined the risk-taking behaviour of migrants with respect to HIV, including engaging in commercial sex, casual sex and injecting drug use. Moreover, the limited data available does little to explain the determinants of the risk-taking behaviour that resulted in infection.

38. Greater knowledge of risk behaviours and their determinants must be obtained if effective prevention programmes are to be developed to prevent the spread of HIV during the migratory process. It is crucial not to overlook factors that contribute to the risk of becoming HIV infected. Ultimately, specific types of behaviour engaged in during the migration process put migrants at risk of acquiring HIV. Sex without using condoms is one example. Finally, breaking the data down by age, sex, occupation and other socio-demographic factors, will make it easier to understand how the various factors contribute to the HIV risk.

b. Focus on vulnerability to HIV

39. As described earlier, becoming a migrant can intensify an individual's vulnerability to HIV infection as migrants may be less able to control their actions to prevent HIV. The following are some of the key issues relating to HIV vulnerability and migration that should be considered when conducting research prior to designing vulnerability-reduction programmes:

- Demographic profile of migrants and linkages to HIV vulnerability
- Opportunities for literacy education, continuation of formal education, skills training for alternative employment for all members of migrant families
- Social norms values in relation to the status of women, sexual exploitation of children, and commercial sex
- Social norms and values in relation to status of women, sexual exploitation of children and commercial sex
 - Socio-economic conditions and legal status of migrants in places of origin, transit and at their destination
 - The societal effects of migration on the public health of the countries of origin, transit and destination
 - Working and living conditions, levels of assimilation, acceptance of the local population
 - Accessibility of health services and social support systems.
 - Health issues that affect migrants, including access to health, HIV/AIDS and STD services, including voluntary counselling and testing, health information, barriers to seeking treatment, cultural biases, use of traditional/alternative healing, and availability of support mechanisms (familial, religious, welfare, etc.).

B. Monitoring of interventions

40. Research is also a tool to monitor progress in implementing policies and other interventions. The results of these can feed back into and improve the policy-making and intervention design process. Evaluating outcomes or impacts of selected policies and other interventions such as HIV prevention can provide evidence of, for example, a reduction in the spread of HIV, an alleviation of AIDS impact, and an improvement in migrants' quality of life. In addition, these research results are useful not only to justify spending of funds and continuation of political commitment, but also serve to identify best practices or lessons learnt for large-scale expansion and adaptation in other sites. Planning and preparation for monitoring and evaluation should be effected as early as possible.

V. Efforts of the United Nations System

41. Migration and HIV/AIDS vulnerability is seen as an important issue by the United Nations system. UNAIDS Cosponsors and other United Nations bodies, especially at subregional and country levels, are currently engaged in activities which address this issue. For example, the West African Initiative on HIV/AIDS is sponsored by the World Bank and UNAIDS, as well as contributions

from the Canadian and German Governments. Also, in collaboration with the United Nations Development Programme (UNDP), the Initiative is helping to strengthen associations of people living with HIV. In Asia, the United Nations Children's Fund (UNICEF) is implementing projects of applied research on mobile populations and HIV/AIDS vulnerability in the sub-region, together with AIDSCAP and the Ford Foundation. In China, UNDP and UNICEF are addressing HIV prevention among migrant labourers through education and communication programmes. A number of other projects in the region are being sponsored and supported by UNAIDS Cosponsors through the United-Nations Theme Group on HIV/AIDS. One example is a project for truck drivers and sex workers in India and Nepal (see Annex 2).

42. The last two meetings of the United Nations Inter-Agency Advisory Group (IAAG) on AIDS have examined the issues of HIV and migration, as well as HIV in emergency situations. Both topics involve movements of people, either within countries for economic or political reasons, or across borders, for similar reasons. At the IAAG meeting, many representatives of participating United Nations agencies referred to work being undertaken on migration, with implications for HIV/AIDS. A number of agencies also expressed a willingness to continue this work, including the Food and Agriculture Organization of the United Nations (FAO), the International Labour Organisation (ILO), the International Organization for Migration (IOM), UNDP and the World Trade Organization (WTO).
43. On the subject of HIV/AIDS in emergency and conflict situations, IAAG members noted the importance of examining socio-economic determinants behind the behaviours of refugees and displaced persons in order to develop appropriate responses. The need to examine the implementation of existing guidelines, as well as the monitoring and evaluation of interventions, was also noted. Overall, there was a recognized need to further enhance strategic planning and to adopt a systemic approach in this area, especially to mainstream HIV issues at the national level, with the goal of enhancing the preparedness of governments during emergency and conflict situations.
44. UNAIDS continues to strengthen its work with the United Nations system and other partners in the areas of advocacy, promotion of shared programming principles and strategies, and identification and dissemination of best practices. Currently, the issue of migrants and refugees is part of the "difficult-to-reach and vulnerable populations" programme component in the UNAIDS Workplan for 1998-1999.
45. The International Organization for Migration and UNAIDS are producing a joint publication on migration and HIV/AIDS. In addition, for the past couple of years, the UNAIDS Intercountry Teams (ICTs) have concentrated their efforts on facilitating and strengthening collaboration between intercountry and regional bodies on cross-border issues, migration and mobility. Several projects have been initiated to increase the understanding of migration and mobility and to propose strategies for reducing vulnerability and risks associated with these factors.
46. In addition to its overall focus on brokering regional partnerships in support of responses to HIV/AIDS, especially between United Nations agencies, countries, institutions and regional bodies, the Asia-Pacific Intercountry Team in Bangkok is facilitating intercountry collaboration and regional dialogue on migration and drug use, two issues with particular relevance for the region.

47. With the goal of providing a forum for identifying priorities and opportunities for collaborative policy and programme action in Asia-Pacific, two task forces have been established in the areas of migration and drug use, respectively. The principal objective is to accelerate and expand efforts to tackle issues of vulnerability to HIV infection, as they relate to migration and migrant labour, and drug use, at country, subregional and regional level, notably through the development and strengthening of technical resource networks. The Asia-Pacific ICT is also supporting rapid applied research on HIV vulnerability and migrant labour in the region, as well as subregional consultations focusing on cross-border issues and the coordination of intercountry and subregional responses to HIV and drug use, among other issues.
48. In this context, there is and will be a strengthening of policy dialogue and advocacy in areas such as human rights, trafficking of women and children and child labour. Special attention is also being paid to large-scale development projects and labour-intensive commercial activities with their attendant population movements, the plight of ethnic minorities, sex workers, and the vulnerability of specific mobile populations such as fishermen, seamen, truckers and domestic workers, as well as that of young people in the informal work sector. Partners in advocacy and assessment have included AIDSCAP, the Ford Foundation, GTZ, UNDP, UNICEF, the United Nations Population Fund (UNFPA), the World Bank and the World Health Organization (WHO), among others.
49. In partnership with GTZ, WHO, the World Bank and other players, UNAIDS is facilitating the development of research and intervention programmes on migration, mobility and HIV/AIDS in West Africa. With the accumulation of evidence on the increased risk and impact of HIV infection on immigrant and mobile populations in the region, public health authorities in countries of Asia-Pacific have recognized the need to work at an intercountry level to develop appropriate prevention, care and support strategies and policies. To do so, collaboration between national AIDS programmes, researchers and NGOs has led to the elaboration of an action-research programme involving seven countries: Burkina Faso, Côte d'Ivoire, Ghana, Mali, Niger, Senegal and Togo. In most of these countries, field teams have elaborated plans of action with local communities, focusing on three programmatic phases: situational analysis, transformation in the contexts of risk and vulnerability, and evaluation of the impact of these actions. While some of these projects are located in important market towns along international trade routes, others have been elaborated in frontier regions characterized by a high intensity of border crossings. Through this programme, UNAIDS will help identify strategies and develop methods of work on migration and mobility, to be widely disseminated at both national and regional levels.
50. A recently formed Cluster Team for the Caribbean intends to address the issue of mobility in the Caribbean. Although not yet elaborated, this programme will include research on immigrants, sex work and tourism.

51. The following areas should be considered for further attention within the United Nations system:

- Advocate for the importance of migration and HIV/AIDS vulnerability, and promote national governments, NGOs and international bodies in dealing with policy issues, implementing interventions and conducting research.
- Continue to work with cosponsors, other UN bodies, international agencies, NGOs and national governments to promote adherence to the various international conventions and agreements that are designed to protect the basic human rights of migrants, especially women and youth, in addition to rights and non-discrimination in the context of accessing social, economic and health services.
- Through the process of national strategic planning at country level and based on experiences from sub-regions and countries and internationally recognized guidelines, migration and HIV/AIDS should be developed as a component in the National AIDS Plan just as migration is a crucial programme of the national socio-economic development plan.
- Develop as early as possible and strengthen existing regional and cross border programmes with and for migrant population including refugees through strengthened collaboration with the Cosponsors, IOM, UNHCR, FAO, ILO and other bodies of the United Nations as well as grass roots oriented network of migrants groups to develop a common strategic partnership on HIV/AIDS and migration.
- In collaboration with specialized agencies and its cosponsors, UNAIDS should develop technical guidelines, demonstration intervention projects and identify best practice on migration and HIV/AIDS vulnerability.
- Support situation assessment, operational and evaluation research linking mobility and HIV and STD.

It is suggested that the UNAIDS Secretariat, Cosponsors, other UN bodies and partners continue discussion and action on the issue of migration and AIDS and seek to work within the priorities of this area.

ANNEX 1

Current Situation of Migration and HIV/AIDS in Selected Regions

West and Central Africa

1. Population movements are substantial in this region, which encompasses Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, the Democratic Republic of Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau,
2. Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone and Togo. For example, approximately five million migrations took place between 1988 and 1992 in the West African countries of Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger and Senegal – an area whose combined population of persons aged 15 and over equals only 26 million.
3. Temporary migrants and seasonal workers, many moving to coastal states, predominate in mobile populations in West and Central Africa. They are usually young single men with low levels of education, migrating from rural areas without partners. A study conducted by CARE in Mali and Niger in 1991 found that 50% of migrants reported having had sexual contacts at their destination. Only 63% of migrants from Mali reported knowing how to use condoms, compared with 10% of Nigerians. Less than 10% reported using them. Paradoxically, more than 50% of Malian migrants questioned in the study reported having had a STD compared with 4% of the Nigerians. A similar study in Ghana in 1993 found that the majority of migrants reported sexual contacts at their destination in the previous month, a substantial number of which were with casual partners.
4. Of the highly mobile population groups in this region, the two of particular concern are truck drivers and itinerant traders. Truck drivers have ready access to commercial sex workers and multiple partners along transport routes. They can be infected and spread STDs over long distances during travel. Truck drivers frequently travel to areas with high HIV prevalence. Multiple sex partners en route are not uncommon, as was discovered in a 1993 study in Cameroon which found that 62% of truck drivers had had at least one partner during their last trip; 64% of them reported commercial sex partners. Similarly, a 1992 study of truck drivers in Burkina Faso found that 54% reported having had at least one sexual contact during their trips, while 14% reported having had many contacts. When this latter study was repeated in 1993, the proportion declaring sexual contacts during travel decreased significantly.
5. Itinerant trading is a major economic activity for women in this region. Many of these women face an increased risk of HIV and STD infection since their trading activities often involve travelling long distances without their families, and sometimes selling sexual services to supplement trading activities and obtain merchandise from farmers. In a survey of female itinerant traders, 38% reported extramarital relationships for economic reasons. Many were compelled by circumstances to enter into sexual liaisons when they travelled away from home. Trading sex in return for staying

with a local man during travel was reported to be preferable to sleeping in the open with the risk of being assaulted and robbed.

6. For some years now, there has been significant mobility of young women in the region for commercial sex. However, observers also note a relatively new phenomenon of young refugee women, particularly from Liberia and Sierra Leone who engage in “survival sex” in the night clubs of urban centres such as Accra, in Ghana.
7. Infected migrants may introduce HIV into their home environment through sexual contact with their partners. In the region of Ziguinchor, Senegal, where 82% of men aged between 20 and 40 migrate each year, a study reported that migration was the only sociological factor significantly associated with acquiring HIV. None of the married women reported casual partners, whereas 22% of married men and 50% of non-married men with regular partners reported having sexual contacts with casual partners. In such circumstances, it is concluded that many men contracted HIV infection during their seasonal migration. These men have the potential to transmit infection to their wives or regular partners on returning to their villages. The circular nature of migration and frequent home visits can put people at risk at both ends of the migratory movement.
8. A recent situational assessment of frequent cross-border movement between rural regions was carried out in a West African initiative and included Burkina Faso, Ghana and Togo. This project reflects many of the issues associated with migration and HIV/AIDS and gives support to the prevention recommendations made for migrant populations.
9. The populations of these regions share similar cultural characteristics and community ties, and are, to a certain extent, economically interdependent. In addition to specific economic activities, such as those of traders, vendors at local markets, truck drivers and seasonal agricultural workers, people regularly cross borders to seek health care. As in other countries, however, HIV/AIDS programmes rarely reach these border regions.
10. The following describes the results of an analysis to determine the overall context of risk and vulnerability in the border regions, and the local community needs in terms of prevention and care of STD and HIV/AIDS:

Preliminary results show a pattern of a greater number of sexual partners and higher exposure to STDs, particularly among professions where mobility is essential (traders, truckers). While no specific health services in both prevention and care are directed at these populations, they appear fairly well integrated into local communities. Both at the community and political level, there are opportunities to address these populations in integrated intervention programmes.

It is significant that both the cost of health services and the perception of quality determine where migrants seek health care. Migrant patients cross borders mostly into Ghana, where health services cost the least among the three countries (Burkina Faso, Ghana and Togo). Migrants return to their home countries due to financial conditions, lack of proper immigration documents and ill health, including HIV/AIDS. There are no health programmes designed specifically for cross-border migrants in the three countries. Health facilities are generally poorly equipped, drugs are not always available and STD/HIV control is poor.

It was found that important opportunities exist for reinforcing prevention messages at certain border points and in the health services visited. Periodic meetings for ministries of health and other stakeholders, to share information and develop appropriate linkage and strategies to improve the health of migrants, are highly recommended.

East and Southern Africa

11. Countries in this region include Angola, Botswana, Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Somalia, South Africa, Sudan, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.
12. In East Africa, a great deal of migration is non-voluntary. Conflicts in the Sudan and the Horn of Africa region have resulted in large numbers of refugees and internally displaced persons. The United Nations High Commission for Refugees estimates that there were approximately 1.3 million refugees from and in eastern African countries in 1997. These migrant populations tend to be heavily concentrated in rural camps and holding areas. In addition to this involuntary migration, the past 10 years have seen the rapid growth of urban populations, mainly as a consequence of rural-to-urban migration.
13. In Southern Africa, the largest flows have lately been non-voluntary migration in Angola and economic migration to South Africa. There are an estimated 150 000 Angolan refugees and 1.2 million internally displaced Angolans, most of whom are women, children and the elderly. In South Africa, by contrast, most migrants are likely to be unaccompanied young men seeking seasonal work.
14. Since HIV prevalence rates are now high in almost all countries of East and Southern Africa, the concern that migrants may introduce the virus into areas of low prevalence is no longer an appropriate focus for public policy. Instead, the concern now is that migrants may be vulnerable to acquiring the infection during migration.
15. While there is little data available on HIV prevalence rates in refugees in East Africa, recent studies indicate that this group may be vulnerable. To date, few focused interventions have been made to prevent the spread of HIV among refugee populations. In the large refugee camps in the region, the primary focus has been to provide safe water, and adequate food and shelter. Efforts to provide preventive health education have been implemented only recently or are just beginning.
16. In 1998, among the 350 000 people employed in the gold mines in South Africa, approximately 95% were migrants, either internal or international, and the majority were housed in hostels. While there is little data available on the HIV rates in these populations, there is evidence of a high proportion of STDs. Where information on HIV exists among some mobile populations, it is alarming. A 1995 study of construction workers in rural Lesotho, which furnishes large numbers of migrant workers to South Africa, found an HIV prevalence of 5.3% in construction workers compared to 0.8% among villages of similar gender and age profiles.

South-East Asia

17. The Mekong region of South-East Asia includes the countries of Cambodia, China (with emphasis on the southwestern provinces of Yunnan and Guangxi), Laos, Myanmar, Thailand and Vietnam. (Note: unlike the other regions described herein, it does not cover refugees as a specific group.)
18. During the 1980s, the rising affluence of Japan and the Newly Industrialized Economies (NIEs) converted them into attraction poles for migrant workers from the less prosperous countries of South-East Asia. Although many of the migrants ended up in irregular situations, the Asian NIEs and Japan began to provide an alternative destination for workers from countries such as the Philippines and Thailand. From 1990 to 1994, 72% of Thai migrant workers found employment in other Asian countries. The average annual number of migrant workers from the South-East Asia region received in Indonesia between 1990 and 1994 was 118 000 while the Philippines received 471 000 (United Nations, 1998).
19. The emergence of new sources of migrant workers, such as China, Myanmar and Vietnam, has further increased the dynamism of labour migration in South-East Asia. However, the recent economic problems that are affecting the region have already led to the expulsion of migrant workers from certain countries. Moreover, there is a real possibility that the measures being taken might dampen further migration, despite the fact that foreign workers may still be needed to perform tasks that nationals are not prepared to undertake.
20. China now has internal population movements on a large scale, with between 80 and 100 million people travelling within the country. Many of these are the so-called "floating population" or surplus rural labourers, who travel in search of work. On a much smaller, though fast-growing scale, increasing numbers of Chinese citizens are travelling outside the country. Much of the concern about HIV transmission related to international travel centres on traffic between Yunnan province and the countries of Laos, Myanmar and Vietnam.
21. Travel between the countries of this region is increasingly facilitated by new highways, growing trade and tourism, economic policies which make countries more open than previously, and relaxation of requirements for travel documentation. In many border communities, men outnumber women. This gender disparity and the fact that many men migrate alone create an unusually high demand for commercial sex. As a consequence, women in these cross-border areas are at increased risk of acquiring HIV because their sexual partners may be mobile men who are engaging in unsafe sex. In such areas, prevention and treatment programmes have proven to be difficult.
22. International tourism, internal travel and interaction with the sex industry have been identified as some of the factors responsible for the rapid spread of HIV in some neighbouring countries. Young women join or are forced into the sex industry in order to send money home to support their families. When they finish their work in the sex industry, most women return home to their place of origin, bringing home any STDs they contracted, including HIV. In many countries, HIV prevalence rates among commercial sex workers are very high, such as in Cambodia, where 39.3% tested positive for HIV in 1997 (UNAIDS/WHO Report on the global HIV/AIDS epidemic, June 1998).

Eastern Europe

23. Until the mid-1990s, most of the countries of Eastern Europe appeared to have been spared the worst of the HIV epidemic. In the last few years, however, the former socialist economies have seen the number of HIV infections rise approximately six-fold. Some 150 000 adults and children in the region are currently estimated to be living with HIV infection, a significant increase over the estimate made at the end of 1992. The pattern began to change in 1995 in several of the countries of the former Soviet Union. Belarus, Moldova, the Russian Federation and Ukraine have all registered spectacular growth in HIV infection rates over the last three years, most of it related to unsafe drug injecting.
24. The break-up of the Soviet Union and the formation of independent states in the early 1990s have created a shift in migration patterns in the countries of the Commonwealth of Independent States (CIS). Repatriation of various ethnic groups was one consequence. These groups include all those who formerly had their own republic within the Soviet Union,
25. Russian speakers and many previously deported peoples. For reasons which include forced displacement, the number of refugees and internally displaced persons has grown on a massive scale.
26. Between 1989 and 1996, there were more than 900 000 refugees, 1.1 million internally displaced persons, and 4.2 million repatriates in the CIS. Environmental degradation has also resulted in hundreds of thousands of ecological migrants. In addition, legal and illegal transit migration increased. Between 500 000 and one million illegal migrants, particularly Afghans, Iranians, and Iraqi Kurds, are estimated to be living in the Russian Federation alone. Emigration, largely to the CIS, has increased dramatically from countries with ongoing armed conflict, such as Armenia, Georgia, and Tajikistan.
27. With some notable exceptions, the greatest number of current migrants in this region, encompassing Central and Eastern Europe and the Commonwealth of Independent States, have moved for economic reasons. In stark contrast to most of the other regions described in this document, the age composition of today's migrant population in the CIS is very similar to that of the general population.
28. At the same time, changes in government policies and increased openness in many aspects of society have influenced migration flows. Details of the influence of these developments on HIV/AIDS and other sexually transmitted diseases is only beginning to be understood.

Mexico and Central America

29. In Central America (comprised of Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua and Panama) and Mexico, most of the migration and population movement is toward the north. The majority of migrants are seeking better economic opportunities, mostly in the United

States, and to a lesser extent in Mexico and Canada. Most migrants are young men who have little education or specialized training and may be illiterate.

30. Migrants originating in Central American countries move north to Mexico, which is becoming a major transit country. From Mexico, many will move on to seek better opportunities in the United States. Mexican migrants in the United States include both permanent residents and temporary migrants who may have legal or illegal status. According to United States Government sources, in 1996 some three per cent of the United States population – about seven million people – were born in Mexico. Of these, 2.7 million were estimated to be unauthorized migrants. Between 80 and 90 per cent of these migrants are male, mostly single or unaccompanied, between 15 and 34 years of age.
31. Few studies on migration and HIV have been conducted in Central America. The epidemic is in the incipient stage in Central America, with the exception of Honduras which has a high incidence based on heterosexual transmission. Honduras accounts for more than half of all AIDS cases reported in Central America. The establishment of United States military bases in Honduras in the 1980s and the proliferation of textile factories that employ high proportions of women are possible factors contributing to the high rate of HIV infection in the country. The information available is far from complete, however, as there is reason to believe that there may be serious under-reporting in countries such as Nicaragua.
32. With the established northward migratory pattern, some studies conducted in southern parts of Mexico point to vulnerabilities of migrants originating from Central America. A study of commercial sex workers in Chiapas, in southern Mexico, found that most originated from Central America. While none was found to be HIV-positive, 37% had STDs. This finding corresponds to trends observed following the increase of commercial sex along international routes which connect countries. Reporting of rural cases of HIV/AIDS has begun.
33. For both Mexico and Central America, the migratory flow is northward to the United States, where HIV prevalence is higher. In Mexico, 25% of people reported to be living with AIDS in rural regions have a history of temporary migration to the United States. These rural workers, most of whom are young men, carry the infection back to their communities when they return. If the trend toward the ruralization of the epidemic in Mexico continues – as a result of internal and international migration – the impact on women's health in rural areas will be dramatic.
34. Among people reported to be living with AIDS in Mexico, 10% have consistently had a history of residence in the United States. A higher proportion of men in the age group from 25 to 45 has been observed, corresponding to the migratory profile for the region. The occupational profile has changed remarkably, with the proportion of non-manual wage-earners, workers, craftsmen, peasants and farm-workers increasing since 1987.

ANNEX 2

UNAIDS and Cosponsor Projects on HIV/AIDS and Migration in Three Subregions

1. Listed here are a number of projects and activities on HIV and migration in which UNAIDS and its Cosponsors are involved in three subregions: Asia, South and Central America and West Africa. Some of these projects are research-based, and may lead to initiative-based projects. This list is indicative rather than exhaustive.
2. In addition to the projects mentioned in the following tables, the “Great Lakes Initiative on HIV/AIDS” has been launched in the East Africa subregion. This regional initiative focuses on mobile populations and HIV/AIDS.
3. The Great Lakes Initiative includes Burundi, Democratic Republic of Congo, Kenya, Rwanda, Tanzania and Uganda. Activities will concentrate on the main road axes and comprise situation analyses, the development of a subregional strategy on HIV prevention, condom promotion, STD treatment and increasing resource availability. A cross-border surveillance system for HIV/AIDS and STDs will be developed, as well as a network for the exchange of information. In addition, a joint programme on HIV/AIDS prevention will be specifically set up for refugees and displaced populations.
4. UNAIDS, WHO, the World Bank and other partners are currently collaborating on several initiatives in Southern Africa, as well. Migration and HIV/AIDS are an important component of many of these initiatives.
5. There is currently little information available on the subject of migration and AIDS in the East European context. However, one project focuses on migrant sex workers moving between the Czech Republic and Germany. Preliminary discussions have also taken place on a “Black Sea initiative” which would address migration and AIDS.

Inventory of Projects on HIV/AIDS and Migration (West Africa)

<i>Projects</i>	<i>Activities</i>	<i>Countries, regions concerned</i>	<i>Type of migrants</i>	<i>Time-frame</i>	<i>Contributing sources</i>	<i>Implementing agencies</i>	<i>Linkages with NGOs</i>
Action-research project on migration and HIV/AIDS in Burkina Faso	Situation analysis, IEC, condoms	Koupela	Travellers, salesmen, sex workers	Initial phase: 12/97 to 11/98	UNAIDS/ World Bank	Country team, NACP	Local CBOs
Action-research project on migration and HIV/AIDS in Côte d'Ivoire	Situation analysis, condoms, training STD	Ferkessedougou	Truck drivers, bar/hotel owners, sex workers	Initial phase: 11/97 to 11/98	UNAIDS/ World Bank	Country team, NACP	Local CBOs
Action-research project on migration and HIV/AIDS in Mali	Situation analysis, IEC, condoms	Sikasso	Truck drivers, sex workers	Initial phase: 1/98 to 11/98	UNAIDS/ World Bank	Country team, NACP	Local CBOs and NGOs
Action-research project on migration and HIV/AIDS in Niger	Situation analysis, IEC, condoms, community mobilization	Gaya	Travellers, truck drivers, local community, sex workers	Initial phase: 11/97 to 11/98	UNAIDS/ World Bank	Country team, NACP	Local CBOs
Action-research project on migration and HIV/AIDS in Senegal	Situation analysis, IEC, condoms, community mobilization	Train route, Tambacounda, Thies	Truck drivers, salesmen, railroad employees, sex workers	Initial phase: 10/97 to 11/98	UNAIDS/ World Bank	Country team, NACP	Local CBOs
Study on cross-border migration, sexual health and HIV/AIDS: Burkina Faso, Ghana and Togo	Study on social characteristics sexual behaviour, KABP, health	Border regions of the three countries	Salesmen HCWs and patients, sex workers, local community	8/97 to 8/98	UNAIDS, GTZ, CIDA*	Local NGOs, health services, ACTION AID	CARE
Document synthesizing the pilot project on migration and HIV/AIDS	Literature review on migration and AIDS, analysis of the pilot projects			Done: 8/97	UNAIDS/ World Bank	All CCIPs, consultant (Cheikh I. Niang)	

* CIDA = Canadian International Development Agency

Inventory of Projects on HIV/AIDS and Migration (Asia)

<i>Projects</i>	<i>Activities</i>	<i>Countries, regions concerned</i>	<i>Type of migrants</i>	<i>Time-frame</i>	<i>Contributing sources</i>	<i>Imple-menting agencies</i>	<i>Linkage s with NGOs</i>
Bhoruka AIDS Programme, Raxaul Main Road	IEC, STD	India, Nepal	Truckdrivers sex workers	Started: July 1995 Ended: July 1998	APICT/UNAIDS, UNICEF, UNDP, Indian Institute of Health Management, FHI, AIDSCAP	Bhoruka Public Welfare Trust, General Welfare Pratishtan (GWP)	NACO *
Rapid Assessment and Action-Research Project Among Migrant Populations	Action-research project, workshops, IEC	Nepal and Indo-Nepal frontier	Internal migrants, daily-wage earners		UNAIDS, SCF/US, USAID, Plan International-Nepal	NCASC *	
Prevention among migrant labourers through education/communication programmes	IEC, condoms, STD	China	Migrant labourers		UNDP	9 government-sector academic institutions	
Potential for spread of HIV/AIDS on the Lao-Vietnamese border		Laos Vietnam			UNAIDS	UNDP UNICEF WHO	
North Sulawesi/Southern Mindanao collaboration on HIV/AIDS prevention		Indonesia Philippines					
Second technical consultation on transnational population and HIV/AIDS		South-East Asian countries				GTZ SEAMEO-Tropmed WHO	
Approaches to applied research on mobile populations and HIV/AIDS vulnerability		South-East Asia, East Asia			UNAIDS	AIDSCAP Ford Foundation UNICEF	
Awareness building on HIV/AIDS for female migrant workers	IEC	Sri Lanka	Women	10/98	SLBLE* SPDF; UNFPA	SLBLE	

* SLBLE = Sri Lanka Bureau of Foreign Employment

* NACO = National AIDS Control Organization

* NCASC = National Centre for Aids and STD Control

*Inventory of Projects on HIV/AIDS and Migration
(South and Central America)*

<i>Projects</i>	<i>Activities</i>	<i>Countries, regions concerned</i>	<i>Type of migrants</i>	<i>Time-frame</i>	<i>Contributing sources</i>	<i>Implementing agencies</i>	<i>Linkages with NGOs</i>
Campaign of HIV/AIDS and STD prevention in Central American truck drivers	IEC, condoms, support network	Costa Rica, Guatemala, El Salvador, Honduras, Nicaragua, Panama	Long-distance truck drivers and their companions	1996		ILPES *	CONFESIDA *
Campaign of HIV/AIDS and STD prevention in Central American truck drivers	IEC, condoms, support network	Mexico	Long-distance truck drivers and their companions	1998	USAID		
Action-research on migration, sexual commerce and STD/HIV/AIDS in the southern border of Mexico	Situation analysis, IEC, condoms	Tuxtla Gutiérrez Comitan Ciudad Hidalgo	Sex workers		WHO		
Study on truck drivers		Most countries of the region			Dutch Government		
Epidemiological research		Border between Guatemala and Honduras					
Study on the impact of an educational programme in Mexico		Morelos Guanajuato			CONASIDA*		

* CONFESIDA = Central American Confederation of NGOs against AIDS

* ILPES = Latin American Institute for Prevention and Education in Health

* CONASIDA = The Mexican National Agency for AIDS Control and Prevention