

**DISCUSSION
AND LESSONS
LEARNED**



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Current Approaches

Current HIV/AIDS prevention programming for migrant fishermen and related populations can be conceptually framed as two concentric layers. The core goal of this programming is to promote healthy behaviors among specific populations using targeted outreach interventions. The broader goal focuses on promoting changes in the surrounding environment to support the ability of fishermen and related populations to practice healthy behaviors. In all, there are three distinct goals - promoting healthy behaviors, creating an enabling environment, and increasing access to health services. These goals and their component strategies mutually support each other and constitute the current framework for this type of programming, which is graphically illustrated below.

Under this current framework, the core goal is to **promote healthy behaviors** among fishermen, sex-workers, seafood processors and housewives. Targeted outreach interventions are the main mechanisms in accomplishing this. The success of outreach is reliant on three main

considerations: the tailoring of appropriate messages to target groups, the ability of interventions to effectively communicate these messages to groups, and the ability to reach target groups with these interventions and messages.

Creating an enabling environment establishes supportive mechanisms that encourage and assist fishermen and related populations to practice healthy behaviors. The success of this approach is contingent on implementers' ability to develop strategies to address factors in the surrounding environment that limit the ability of these groups to pursue healthy behaviors, and promote positive changes.

Increasing access to health services mutually supports the other two strategies by alleviating immediate concerns of health, which may overshadow HIV/AIDS prevention interventions, and, in turn, gains the trust of target beneficiaries, which leads to the ability to provide HIV/AIDS interventions. Although this strategy is

intended to act as a supportive intervention, in many cases, especially when there is a significant migrant community present, it has come to the fore, taking precedence over other components.

Although these three goals can be defined separately, the strategies utilized are integrated to a large degree. For example, volunteer systems assist all three components in some way, and outreach is used to communicate about other health issues besides HIV/AIDS. Thus, it is generally acknowledged that although HIV/AIDS prevention is the primary goal in most cases, it cannot be addressed as a solitary issue, or by using a single approach.

In acknowledging this, it is essential that implementers strengthen their current programming so that component strategies are not only effective separately, but also contribute to the other components as a means of attaining the ultimate goal of HIV/AIDS prevention. Accordingly, it is important to draw out lessons from interventions about what works, what is still weak, and how to focus future programming. Although each implementer is at a different level in the understanding of their site, and the depth and breadth of interventions varies, as do outcomes, there are lessons learned on current effective approaches and viable strategies that can be drawn from all sites.

In the following sections, divided by goal and component interventions, the discussion synthesizes this programming as a whole rather than referring back to each particular site. Source communities are included in this discussion implicitly, and are referred to specifically in the subsequent section - Future Directions. In the Conclusion and the Future Directions section, recommendations are provided on how this type of programming could be strengthened and developed further.

Promoting Healthy Behaviors

Generally, the focus of programming has shifted from promoting behavior change among fishermen as a primary strategy, to more comprehensive programming for the migrant community as a whole. While broader coverage was initially part of most project designs, the

shortcomings encountered in providing direct outreach to fishermen, in combination with migrant communities' level of need, have contributed to implementers shifting the focus of outreach and other interventions more on related populations.

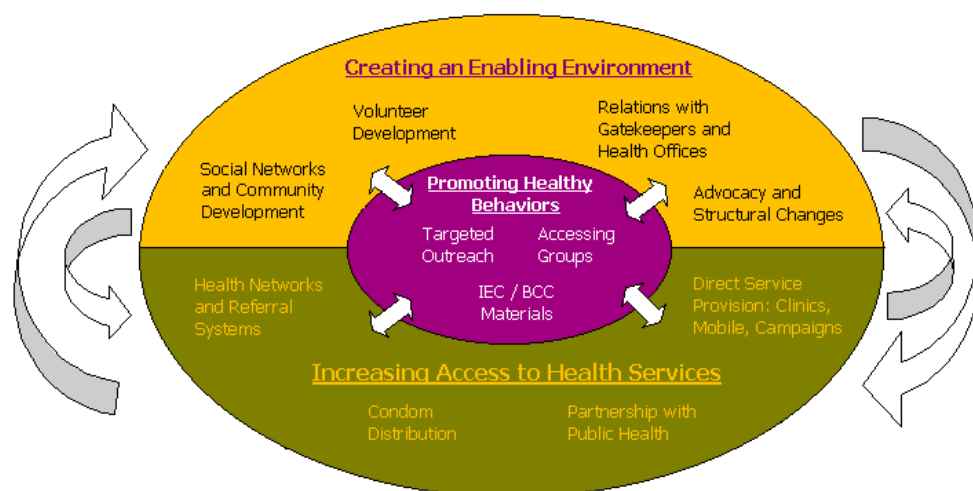
Although behavior change is considered a primary strategy, outreach to fishermen and related populations is one of the weaker components in current programming. The ability to contact fishermen and seafood processors is inconsistent, and effective techniques are not always applied even when implementers have access to these populations. Increasingly, implementers are developing more outreach curriculums specifically for these populations, and, overall, IEC materials are highly targeted. Yet, these strategies have not reached their full potential, as most implementers stop short of integrating IEC materials and outreach as part of a broader, focused communication strategy.

In order to increase effectiveness, behavior change strategies need to be considered more broadly than as a set of education activities given to fishermen and related populations. Behavior change promotion requires a communication strategy that integrates highly targeted materials, messages and activities, and delivers them through appropriate and effective channels to these groups.

Targeted Outreach

- Utilizing targeted, participatory techniques to teach fishermen and related populations to assess and personalize their risk of HIV/AIDS is more effective than using lecture or standard curriculums.
- Fishermen and related populations respond positively to visual materials used in activities that accurately reflect their ethnicity, lifestyle/sub-culture and circumstances.
- Outreach activities that are presented in the language of the participant and use targeted and appropriate visual materials are most accessible to fishermen and related populations, as demonstrated by high levels of interaction.

Figure N - Current Programming Framework



Currently, in this type of programming, direct outreach is the primary tool in implementers' behavior-change strategy, targeting fishermen, sexworkers, seafood processors and housewives with activities. Although, some implementers have developed or adapted curriculums to better target these groups, the level of targeting used in outreach activities is inconsistent overall.

Fishermen and related populations are characteristically mobile migrants who work in occupations that constitute their social environment, meaning that their type of work influences all aspects of their life, including their identity and behavior. Accordingly, interventions need to be highly targeted to each group specifically, as each group has certain characteristics and circumstances that contribute to their vulnerability to HIV/AIDS. Although there are common factors that make different groups vulnerable, such as inconsistent condom use, the causes that increase vulnerability are specific to each group, such as why there is inconsistent condom use. It is this aspect of behavior change where outreach activities need to be more specifically targeted to each group.

Accessing Fishermen and Related Populations

- Timing outreach campaigns to coincide with fishermen's patterns of mobility, such as docking patterns or seasonal migration, can assist in increasing access to fishermen.
- Outreach curriculums and activities that are flexible, simple and concise are necessary to accommodate migrant laborers' limited availability of time.
- Laborers on the docks and members of the broader community, including senior or former fishermen, can play a significant role in arranging outreach activities.
- Drop-in centers that provide incentives, such as recreational activities or counseling and referral services, create opportunities for outreach activities by attracting fishermen to a centralized location.

- Conducting activities during special events, such as at the hospital during health exams for registering migrant workers or in the migrant community on cultural holidays and festivals, can provide opportunities for mass communication activities.

Practical factors have also detracted from the effectiveness of direct outreach interventions. The inability to gain regular access to beneficiaries, for one, is a weak point that has a negative impact on outreach. The high mobility among fishermen, regular turnover of sex-workers and the controlled environment of seafood processing factories, have limited implementers' ability to reach these populations consistently, provide follow-up activities or monitor interventions' impact.

The ability to secure sufficient time and a suitable environment for conducting activities has also been inconsistent, often resulting in disruptions or participatory activities being reduced to lecture sessions. Having a limited understanding of the functioning of the seafood industry appears to be a major contributing factor in not being able to identify opportunities to access fishermen and other laborers more consistently. Implementers have generally tried to overcome barriers to access by reaching fishermen and seafood processors through social networks in the community, and by establishing drop-in centers. At some locations, implementers have identified periods when fishermen are more available or likely to have their shore leave, such as during the full moon period, and provided activities then. Yet, little has been done to encourage business owners to integrate HIV/AIDS and health interventions into the work environment, including providing a designated time and location for activities.

IEC & BCC Materials

- IEC materials that use easy to understand terms and common language, including common vernacular, are most effective for fishermen and related populations with low-education levels. Pre-testing of materials with target-beneficiaries should always be a part of the development process to ensure that IEC materials use appropriate language.

- Using participatory processes when developing IEC materials is essential. Learner-generated materials are the highest expression of this, however, close guidance is necessary to avoid redundancy of already existing materials.
- IEC materials that use images that reflect the ethnic, cultural and sub-cultural identities of the target group being addressed, and accurately depicts their environment, elicits interest and helps to clarify understanding.
- Mediums that are less reliant on written materials such as audiotapes or videos are ways of overcoming barriers of literacy and can easily incorporate ethnic minority languages.

Every implementing organization uses and distributes IEC/BCC materials. Some implementers produce materials specifically for the project and some borrow materials from other organizations, including from source countries. Organizations that produce their own materials generally abide by best practices in the development process. Although the materials that have been developed are of high quality, not enough implementers evaluate a material's effectiveness after it has been distributed.

There are two main concerns regarding the IEC/BCC materials currently being used with migrant fishermen and related populations. First, there has been a heavy reliance on written materials even though it is known that these groups have low literacy levels. Second, ethnic minority groups from Myanmar have their own languages, yet these are hardly represented in materials. More implementers are starting to develop videos on VCD, as well as audiotapes and other mediums that are less reliant on written materials. The benefit of these types of materials is that they are accessible to low literacy groups, and are easy to dub, which allows greater representation of ethnic languages.

Another way to improve IEC effectiveness would be to develop materials that concentrate on specific behaviors that make people vulnerable to HIV/AIDS rather than presenting general information or multiple topics, and incorporate

these as part of focused outreach campaigns. For example, some of the specific issues that IEC/BCC materials could focus on include: condom use in "sweetheart relationships", the dangers of penis enhancement, and the effects of drunkenness. These types of materials could then be used in conjunction with outreach to lead or support activities. Some implementers have done this to a degree, but using a focused and integrated communication strategy, currently, is not common practice.

Regarding distribution, there is a need for improved strategies to take into account the way that materials will be viewed: will cartoon books be more likely to be viewed on the boat or on land, and is it better to distribute videos to community members and shop keepers to show to fishermen or give it to fishermen directly? Effective distribution strategies could be identified through better monitoring and evaluation.

Creating an Enabling Environment

All implementers currently understand that knowledge alone will not result in HIV/AIDS prevention. Accordingly, in all of the programming, implementers attempt to influence healthy behaviors among migrant fishermen and related populations by "creating an enabling environment". To achieve this goal, implementers attempt to make changes in the local environment to remove structural barriers that restrict the ability to practice healthy behaviors, and to develop social structures that encourage, support and reinforce the practice of healthy behaviors.

Strategies for creating an enabling environment currently being used include working with gatekeepers and local health authorities, low-level advocacy, the development of volunteers, and the fostering of social networks. The effectiveness of these strategies, however, has been limited, as implementers sometimes lack a clear understanding of the mechanism of such strategies. The link between the strategy and the goal of reducing the target groups' vulnerability to HIV/AIDS may be tenuous, or not well understood, and implementers' may employ strategies without knowing how to affect the intended

result. For instance, assumptions are made that creating a sense of belonging and an increased sense of self-esteem will contribute to more consistent condom use. How social networks and related strategies actually lead to such outcomes, however, has not been clearly identified yet.

An underlying weakness that hampers these strategies is that often they were initially developed to support outreach activities, such as to gain access to target groups, rather than as elaborated strategies with objectives of their own. Over time, though, either through an organic evolution or systematic adjustments made by implementers, these supportive activities are becoming strategies. For example, volunteer networks have expanded beyond the original intention of peer education and now provide referral linkages and community health.

Looking at the strategies employed under this goal in a broader sense, there is a lingering question as “to what greater end are these component strategies leading?” In other words, are implementers aiming at creating lasting changes, such as would be articulated under a broader goal of community development, or, are these interventions more stop-gap approaches? Is the strategy intended to simply support outreach interventions, or is it an articulated strategy in and of itself?

Relations with Gatekeepers and Health Offices

- Establishing basic relationships with authorities, owners and employers, or at least securing their trust, facilitates access to fishermen, seafood processors and sexworkers.
- Access to fishermen, seafood processors and sex workers is greatly facilitated when a health officer accompanies or introduces field staff.
- The most effective way of gaining a formal audience/introduction, or engaging health officials and business owners in planning or activities, is through previously existing meetings (e.g. Provincial AIDS Committee or Fisheries Association).

- After a formal introduction, more direct and informal contact with gatekeepers, such as boat or factory owners and karaoke proprietors, builds trust that can lead to regular access to target groups.

- Providing HIV/AIDS activities for groups of gatekeepers, such as boat owners, builds trust, as it provides them a benefit.

In order to work successfully at any site where there are migrants present, implementers have found it essential to establish relations with local government, especially health officials, as well as those who control access to target beneficiaries, such as employers. The primary objective of these relationships has been to allow access to hard-to-reach populations. As essential as these relationships are, implementers have learned some difficult lessons about working with local authorities and gatekeepers.

The most essential relationship, and the one that should be developed first, is with local health officials at the PHO, hospitals, and health centers. Health officers can greatly facilitate access to hard-to-reach populations by assuring gatekeepers (employers, local government and community leaders) that activities are solely health oriented, which is especially important considering the legal implications of undocumented migrant populations or sex workers. Although health officers are usually willing to assist in providing introductions to gatekeepers to facilitate access, once access is granted, health officers' participation in activities may be inconsistent, depending on timing, their specific responsibilities and their workload.

In the case of gaining permission to work at the ground level, the local sub-unit of government needs to be approached directly (sometimes the Tambon Administrative Office, and sometimes the village headman). This requires starting at the top of the hierarchy at the provincial level, then moving down and gaining approval at each level. The Thai government is highly decentralized, yet every level wants to make sure permission has already been granted from the higher level, however, the different levels do not necessarily communicate with each other. It takes energy and time, but is a necessary process.

Overall, the strategy for working with gatekeepers is currently based on gaining access to target populations and relationship building. However, employers are generally reluctant to waste their employees' productive time to allow for HIV/AIDS education, with some exceptions. Owners that do allow activities provide inconvenient times, such as, immediately after fishermen have finished work and are exhausted, or during lunch break in crowded factory lunchrooms. What this strategy lacks is a way of approaching gatekeepers that might encourage them to understand the value of HIV/AIDS prevention. Improved cooperation would then provide better access for in-depth activities, and integration of HIV/AIDS interventions into the work place.

Volunteer Development

- It is effective to utilize different types of volunteers with different roles at the same site such as: “eyes and ears”, IEC materials distribution, arranging outreach activities, distribution of condoms and contraception, and peer educators.
- Over time, implementers develop and adapt volunteer systems to appropriately suit the character of the populations present and the dynamics of the site.
- Clearly elaborating the role of volunteers facilitates matching appropriate people to those roles, including considerations of gender, social position and ethnicity.
- The most effective volunteers have some or all of these preferred characteristics: the ability to speak Thai, a stable presence at the site and/or documentation, are from the same ethnic group as target populations, are respected or have standing in the community, or have had some previous relevant experience (such as being a paramedic or a fisherman).
- On-going, tiered trainings for volunteers that continually lead to a higher level of responsibility will result in developing a small group of effective peer-trainers.

Volunteers are an essential element of this programming, yet their role and effectiveness varies. Part of what influences the success of a volunteer system seems to be whether there is a clear understanding of the role of volunteers and whether appropriate people are being recruited for those roles. Oftentimes, volunteer networks have been initiated based on the ideal that volunteers will be peer educators. However, it has been found that this role is not always appropriate for volunteers, largely due to the social dynamics and high mobility of fishermen, and the restrictive social environment that migrant populations and sex workers find themselves in. Once this is realized, implementers have used an organic process to adapt and find the appropriate role for volunteers.

Part of the organic process of developing volunteer networks is through on-going training and increased responsibilities. Through this process, volunteer networks have evolved into higher-level strategies, such as assisting with health referrals, or providing home-based care. However, it seems that although there are strategies for retaining and developing volunteers, not enough implementers recognize volunteers as part of a broader strategy to promote community development and civil society. Implementers need to recognize the long-term strategies that volunteers contribute to, and develop volunteers accordingly.

Social Networks and Community Development

- It is necessary to assess the composition of a migrant community to identify those who have the most direct contact and influence over fishermen, and social networks that can be tapped into and developed.
- Implementers invest in developing and supporting social networks when community capacity-building is an articulated objective.
- Drop-in centers can act as a social focal point for fishermen and migrant communities.

Although the strategy for social networking is not clearly articulated in a way that can be easily replicated, the objective is clear: to develop social structures in the migrant community as a way of supporting HIV/AIDS prevention, and promoting community development and health. This strategy could also be articulated as a strategy to support behavior change by providing social alternatives to risky behaviors. Social networks have manifested in different ways in this programming, but in most cases are simply extended volunteer networks, peer educators, or event-oriented activities such as sports days and community clean-ups. There is a distinction to be made, however, between volunteers and social networks: members of a social network provide a social function that contributes to the broader objective of community development, whereas a volunteer provides a service that fulfills a specific role or objective.

Ranong is the one site where social networks have been fully developed. The social networks established have drawn on members of the community who have some social standing or strategic function, such as community leaders, community benefactors, former fishermen and housewives. By supporting these people with knowledge and skills, members of these social networks have, in turn, provided a social benefit to fishermen and the community. In some cases, this benefit has been directly related to reducing vulnerability to HIV/AIDS, such as providing social alternatives to risky behaviors, or HIV/AIDS education and condoms; in other cases it has been less obvious, such as provision of health services, or providing personal counseling. The success and ability to replicate this strategy, though, may be contingent on the presence of an established migrant community with long-standing members.

The communication linkage to source communities could be considered an offshoot of the social networking idea, as it provides motivation for practicing safer behaviors. The underlying premise of this strategy is that in the absence of community, maintaining a linkage to their home community can reinforce motivation for these behaviors. The drawback to this strategy is that

it is labor intensive and it is difficult to correlate an evident benefit unless matched to a broader scheme such as life planning and investment. Recently, implementers have introduced community drop-in centers that provide recreation and act as a focal point to access services. At Rayong, the drop-in center acts as a formal point to send and receive communications as well. The strong response by communities and fishermen to drop-in centers indicates that this is a promising development under this strategy.

Advocacy and Structural Changes

- Advocating for procedural changes is a quick and effective way of addressing specific problems that restrict access to services.
- Participating in multi-sector coalitions at the local level that include public health offices, local governments, business owners, NGOs, and CBOs, facilitates gaining support of migrant issues at all levels.
- Exposing government figures, health officials and the public to the situation of migrants is an essential element of advocacy.

Implementers' advocacy skills are developing rapidly; however, most efforts are still low-level and opportunistic. Some implementers have been able to successfully push for procedural changes in the health system to improve migrants' access to specific health services, however, there has been little in the way of promoting comprehensive and systematic changes to improve access to health services for the whole migrant community. Although implementers are communicating more amongst themselves through formal and informal networks, they still lack the coordination and skills required to formulate and advocate for significant policy changes, such as establishing a migrant health system or reforming migrant policy.²² Moreover, implementers have not focused advocacy efforts on influencing policies that affect the enabling environment. For example, the ability to use foreign personnel from neighboring countries has been complicated by regulations related to visas.

Similarly, implementers have approached owners and employers to request access for activities and to change certain practices, such as withholding migrants' registration cards. However, there has been little effort to encourage integrating HIV/AIDS interventions into the structure of the work place. This partly seems to do with a lack of capacity to approach the industry in this way, and partly because implementers fear that if owners respond negatively, they will be denied access to target groups. Implementers need to develop skills to approach and negotiate with owners to present these types of recommendations proactively.

Implementers have approached public servants with low-level advocacy activities, such as providing site visits and having public events that show migrants respecting and contributing to Thai society, and there has been some positive media coverage through newspapers and television. Although some opportunism is necessary, these efforts generally do not seem connected to an elaborated, broader advocacy strategy.

Increasing Access to Health Services

All implementers have found that to effectively reach fishermen requires working with the surrounding community as well. When implementers approach these communities, however, it becomes clear that migrants have many pressing concerns that require attention, especially health. Without first dealing with these most immediate needs, it is difficult to gain migrants' trust, which is prerequisite to providing HIV/AIDS interventions. Implementers have come to realize this and have adjusted their programming accordingly, making access to health services a significant component of their activities.

Through a range of interventions and strategies, implementers at the various sites have been able to increase access to health services for migrant fishermen and related communities. These strategies include basic linkages and referral systems, condom distribution, networks of community health volunteers, and direct provision of services through community and

mobile clinics. Many of these services focus on a specific element of health, such as reproductive health or maternal and child health. Other interventions simply attempt to provide greater access to all health services. Overall, these interventions are effective; yet, the health needs of the migrant community always seem to exceed the level of services provided.

Migrants express a set of preferences in service provision according to certain considerations, such as language and attitude of the providers. Perhaps the strongest factor influencing utilization of a health facility by migrants, though, is the location of services. Accordingly, strategies that improve access to health services or provide services directly have been successful when they are sensitive to migrants' fears of exposure and possible arrest by police. It has been demonstrated that the best locations for provision of services are within migrant communities or near workplaces. Similarly, condom distribution is also more successful when strategies are employed that diminish shyness while increasing the convenience of access.

Beyond the inherent benefits of health, these interventions have also facilitated trust building, which has provided an access point for HIV/AIDS interventions, and set the foundations for community development. These secondary yet valuable benefits of health interventions raises a question as to why health interventions are not the primary strategy, with HIV/AIDS as a component strategy, rather than the other way around as it stands currently. This is especially illustrated in the case of PLHA, where the provision of basic health provides an immediate benefit to those who are suffering symptoms of HIV/AIDS. Lastly, the systems being used to increase access to health, such as community health networks, provide a foundation for community development that should not be disregarded.

Community Health Networks, Referral and Linkages

- Training health volunteers in symptom identification and treatment of basic health conditions, including distribution of contraceptives, can greatly improve the general health of the migrant community.

²² The repealing of pregnancy as an exclusionary condition in the registration's health exam was strongly influenced by an advocacy network for migrant workers.

- Various avenues of referral, such as through volunteer networks and drop-in centers, contributes to increased use of health services.
- Community health volunteers should be either volunteers who have been active a long time and have proved themselves reliable, someone who has had previous medical background, or is a respected person in the community.
- Training community health volunteers in problem solving and community assessment, as well as health care related skills, can lead to developing community leaders and project assistants.

The most basic intervention that improves health of migrant fishermen and related populations is referral and linkages to health providers. These services are based on intermediaries assisting members of the migrant community to navigate the logistics of accessing health services, including but not limited to providing transportation, filling out forms, and translation. Mostly, field officers and networks of trained volunteers provide referral and linkage services.

Community health networks are the next level of this sort of intervention, where volunteers actually provide some type of health service. Usually, community health networks have developed from basic volunteer networks that have received on-going training and support. These networks are usually comprised of volunteers who have been active for a significant period and have received commensurate training. The level of their responsibility and their activities depend on the training they receive and their intended role as defined by the implementer. For example, a community health volunteer may provide contraception pills, or home-based care. One consideration that seems to have been omitted in this strategy is incorporating traditional healers into health networks. Considering that traditional healers play a prominent role in the health of migrant communities and are often the first contacted when a migrant suffers an ailment, these people could play an important role in this strategy.

Although community health networks suffer attrition common among volunteer systems, they usually suffer lower rates of turnover because these long-standing volunteers have already shown themselves to have a stable presence and strong commitment. In these cases, volunteers who remained active have received training not only in health provision, but also in community development skills, such as research, IEC development, and counseling / problem solving skills. Once volunteers have reached a certain level of training and demonstrated themselves, a few implementing organizations have even supported them to either become active in community development, or to act as project assistants. Rightfully, community health networks should be considered a long-term investment, and with the addition of systematic monitoring, could assist in follow-up on proper / full course treatment for certain diseases such as DOTS for TB or treatment for STIs. This sort of system could then potentially be expanded to incorporate ARV treatment when finally made available for migrant populations.

Condom Distribution

- Distribution through outreach activities ensures that proper use is demonstrated and practiced, and allows for discussion on conditions and behaviors that may compromise a condom's effectiveness.
- Distribution strategies rely on people in regular contact with fishermen and sex-workers to provide condoms, such as esteemed members of the community, other laborers, motorcycle taxi drivers, karaoke women, and bar proprietors.
- Distribution strategies attempt to make condoms more accessible closer to the time or place fishermen are likely to engage in sexual behavior by placing distribution boxes at locations where fishermen may go prior to seeking commercial sex, such as barber shops, food stalls/bars and snooker halls.
- Although not pervasive, emphasizing the other functions of condoms beyond prevention of disease, such as being a spontaneous

and effective form of contraception with no side effects, has been a way of promoting condom use among couples.

- Promotion and provision of KY jelly among sexworkers who are open about their occupation has proven a positive step in encouraging regular condom use with these women and their partners.

Increasing condom use is a standard objective in every project, and making condoms readily available is a key mechanism. Although distribution strategies vary somewhat, most implementers primarily rely on direct distribution to target beneficiaries, including fishermen, sex workers, housewives and other laborers. Some implementers supplement distribution through various types of volunteers and distribution boxes. Of note is the fact that although social marketing has proved an effective tool in the region, implementers primarily rely on the free distribution of condoms, and only one site currently uses this strategy.²³ Moreover, although the total numbers of condoms being distributed is impressive, there is very little systematic monitoring of condom use, such as identifying trends in usage among various categories of sexual partners.

Most condom promotion campaigns for fishermen primarily focus on promoting condom use with sex-workers. This is an essential approach, but some caution is required. The focus on commercial sex tends to neglect non-commercial sex and ambiguous relations such as "sweethearts". This is of concern as many indirect sex workers, such as karaoke women, do not perceive themselves as sex-workers, nor necessarily do their clients. Moreover, there is still a stigma attached to condoms that affects condom use between couples and long-standing relationships including married couples that this sort of promotion reinforces. A strategy needs to be developed and promoted that encourages condom use between all sex partners, and that identifies an end-point where it is safe to stop using condoms.²⁴ Faced with

the possibility of never being able to safely have sex again without a condom may evoke a counter-productive response among targeted groups.

Direct Service Provision and Partnerships with Public Health

- Migrant fishermen, seafood processors, and related migrant communities utilize health services more when they are located in areas that are accessible and discrete, such as in their community or immediate work area.
- Mobile health services are an effective way of increasing migrant communities' access to health services.
- Certain types of services for migrant populations, such as reproductive health, family planning, and especially STI treatment, require a discrete system that avoids embarrassment, especially for youth.
- The number of clients using a community or mobile clinic increases when supported by referral systems and community volunteer networks.
- Partnerships with the PHO, hospitals and other health providers can facilitate procedural changes and increase the level of services available to make health services more accessible to migrants.
- Partnership with the PHO and hospitals can lead to greater accountability for the health of migrant populations by public health providers.

A couple of implementers have established community health clinics for migrant communities at their sites. These clinics provide either basic prevention services or specialized services, such as reproductive health, and are mostly staffed with personnel of the same nationality as the clients. Most clinical services,

²³ The introduction of social marketing at Ranong was partially motivated by a shortage of condoms.

²⁴ One strategy would be to emphasize consistent condom use for at least two months in a monogamous relationship until both people in the relationship receive VCT and learn the results. The ability to use this strategy, however, is contingent on the availability of appropriate VCT to these populations, which also requires having care and support, and other social support mechanisms already in place.

such as STI and HIV testing, are provided through the local hospital, but this does not limit their ability to treat, using syndromic management for STIs when necessary, or provide counseling. The benefit these services provide migrant communities is undeniable, yet clinics still find that the communities' needs surpass what these clinics can provide. Moreover, there is a lingering question as to whether by providing these services NGOs are not relieving the PHO of their responsibility to provide health for all of the public.

In response to this and as part of a broader goal of increasing access to health services to migrant communities, implementers have developed partnerships with local health officials as part of a strategy to make the PHO more attentive to and eventually responsible for the health of all migrants. This has often been difficult as the commitment level of health offices to migrants is inconsistent, and often these offices are already over-burdened with providing health to the Thai population. Accordingly, success of this strategy has seemed to partially coincide with timing, such as having the right Head Officer in charge at the time or coinciding with a mandate from the government to address certain health issues.

A major shortcoming of partnering with health providers is that implementers often enter these partnerships without a clear strategy or idea of what the outcome will look like in advance. At Mahachai, for example, although there is discussion with public health officials about developing and integrating a migrant health system as part of the government's public health system, what such a system looks like or how it would operate has not been articulated. Without a clear idea of the result, health officials will waiver in their commitment and they will pursue goals of convenience, potentially resulting in outcomes that may be disadvantageous, such as what occurred in the placement of the new clinic in Ranong. This strategy could greatly benefit from a coordinated effort between all implementers and the PHO to develop a migrant health system that can be integrated into the current health system and remain sustainable.

Conclusion

The current framework being used has had some success, however, there are some lingering questions about its effectiveness and sustainability. A primary and underlying question not yet addressed is whether this framework, as it currently stands with outreach as a central component, is the most effective strategy to use for mobile and hard to reach populations, such as fishermen and related populations.

There are two main drawbacks to the current framework. First, it seems that implementers' reliance on direct outreach has had limited success due to a lack of strategies to accommodate fishermen's high mobility or the fishing industry's work environment; and, second, the emphasis on outreach and supportive interventions has distracted from efforts to influence broader, lasting changes. In other words, using this framework, HIV/AIDS and health interventions have remained primarily focused on gaining access to populations. In this regard, a criticism could be leveled that the current framework focuses too strongly on "reducing risk" of individuals, to the detriment of making systematic changes in the surrounding environment.

Although implementers have approached the migrant community that encompasses fishermen, these interventions have partially been in response to only being able to access fishermen inconsistently. Moreover, these interventions were initially intended to be HIV/AIDS related, but, by necessity, have extended beyond HIV/AIDS issues and touched on basic health. Through this contact, implementers have realized that other conditions also impinge upon these communities' well-being beyond health and HIV/AIDS, including the ability to secure basic rights. Most implementers, however, have just begun to touch upon these other issues.

Considering all of this, it seems that programming needs to extend beyond the current framework. A more appropriate framework for this type of programming may be to "reduce vulnerability" of mobile and migrant popula-

tions, where vulnerability consists of a set of conditions that restrict migrants' ability to access information, health, community, livelihood and rights. Although these issues have been touched upon under the current framework, it appears that implementers are still unclear on how to affect lasting changes in the broader environment. Perhaps a shift in programming is necessary. In this shift, the goal of HIV/AIDS reduction would be met through broad, long-term strategies aimed at affecting core issues that underlie migrant fishermen and related populations' vulnerability.

The current framework has been a necessary step in this process, and can act as a base for further development of these strategies. However, two main changes are necessary to promote greater coverage and sustainability. First, implementers need a more programmatic approach that goes beyond thinking in terms of individual project cycles. At this point, continuing to implement projects as though a single cycle of funding, or repetition of the same activities will result in sustained HIV/AIDS prevention among these populations is counter-productive. Implementers need to plan programmatically. In this way, projects can increase implementer's capacity, build on previous efforts, be responsive, and contribute to significant, lasting changes.

Secondly, project objectives and indicators need to be expressed more in terms of making systematic and structural changes, and move away from primarily quantitative indicators. In other words, an emphasis needs to be placed on developing and implementing systems that can be integrated into the work and social environments of migrant fishermen and related communities', focusing on three primary areas: influencing behavior, increasing access to health, and community development.

Graphically, this sort of programming scheme could be depicted as follows:

Figure 0 - Programming Schematic for Reducing Vulnerability of Migrant Fishermen and Related Communities to HIV/AIDS



This schematic can be elaborated as follows, starting at the base and moving up.

- The effectiveness of this programming relies on an organization's **capacity** in three primary areas:
 - **Research and assessment:** to identify conditions and underlying causes that contribute to vulnerability, to assess potential avenues and barriers for implementing strategies, and to inform monitoring and support advocacy;
 - **Technical capacity:** to support implementers' ability to plan and implement interventions more effectively, including the development of appropriate tools and materials, and the development of appropriate monitoring and evaluation;
 - **Coalition building:** to promote an enabling environment and support advocacy by working and negotiating with government, the PHO, business leaders and related NGOs and community-based organizations (CBO).
- The outputs and outcomes of these three capacity areas then act as a basis for informing and directing **advocacy** efforts. Advocacy should be used as a mechanism to promote changes in the political and social environment that enables implementation, improves rights of target beneficiaries, and fosters changes in the work environment and the health system.

- Intervention **strategies** focus on three areas: influencing behavior, increasing access to health, and community development. The goal of each of these strategies could lead to the development and implementation of appropriate systems in that field, such as integrating HIV/AIDS interventions into the workplace, developing a migrant community-health system, and establishing migrant community centers. Each of these systems would be comprised of component interventions including direct activities, most of which are being implemented to some degree currently. Careful consideration of the order that these strategies are pursued is necessary as well, with health interventions taking a central role.

- The changes made in these three strategic fields and in the political and social environment should lead to reducing the factors that contribute to vulnerability, and lead to the ultimate goal of reducing transmission of HIV/AIDS among migrant fishermen and their related communities. It could be argued that HIV/AIDS shouldn't even be the primary goal, and that 'quality of life' is more appropriate, as HIV/AIDS prevention, treatment and care is a component of a better life. Regardless of the way the **goal** is expressed, the success of this type of programming is dependent upon organizations' comprehension of how implementation contributes to this goal, and the willingness of donors' to support this type of programming.

Currently, multiple organizations are working on issues of HIV/AIDS, migration and mobility at numerous sites in both source and destination countries throughout Southeast Asia. Each implementing agency is at a different level of capacity, understanding of their sites, and development of their intervention strategies. Some organizations have begun strengthening their programming by drawing on relevant outside sources to share technical resources, information, and pursue advocacy through networks. The model presented above, although not comprehensive, could potentially assist implementers in further strengthening their programming by identifying elements necessary to their programming. The next section identifies organizational capacity issues within this

model that are necessary to support this type of programming.

Management and Organizational Capacity

Effective programming manifests from an organization's capacity level and management structure/style. Implementers' current level of effectiveness in this programming, overall, is inconsistent, pointing to capacity and management issues. The influence of donors, in the way they structure funding and push agendas, also cannot be denied. The following are areas where implementers could improve their capacity in this programming, and how donors could support them.

Technical Capacity

- **Personnel** - Organizations have had great difficulty in attracting and retaining experienced staff or those with necessary language skills to this challenging work. This points to a need to adjust recruitment strategies or provide a more enticing wage scale or both. Increased recruitment and utilization of migrant populations as implementers should also be considered.
- **Skills Building** - Field officers need to be provided with on-going technical support to bolster their implementing skills. Areas that should be emphasized include: principles and techniques of participatory learning and research, situational assessment and analysis skills, development and use of targeted IEC/BCC materials, and monitoring and evaluation of behavior change interventions.
- **Tools and Techniques** - The amount of outreach tools available for use with mobile and migrant populations in this sub-region needs bolstering. There is a need for increased development and sharing of outreach techniques and materials that can be used to target the specific populations currently being approached, such as fishermen, different types of sexworkers, housewives, and single women in seafood processing. Some sharing of materials and techniques has already begun, however this could be bolstered by

better coordination of the development of appropriate tools and techniques, accompanied by greater dissemination.

Monitoring and Evaluation

- **Monitoring Tools** - There is a need to develop a set of tools and techniques to monitor behavior change and estimate coverage for fishermen and other highly mobile populations that is easy for implementers to use and analyze.
- **Interlinked Monitoring** - A monitoring system needs to be developed that can be utilized not only at a single site, but can be replicated and linked with other sites to draw a current composite picture of fishermen and related populations' situation throughout Thailand, in order to track trends.
- **Stratification of Data** - Baselines need to distinguish sub-groups more specifically as a way of correlating specific behavioral changes to different groups. (e.g. Penis enhancement among certain ethnic groups of fishermen or on certain types of boats)

Advocacy Skills

- **Leadership and Negotiation** - Although many implementers participate in multi-sectoral coalitions, they need to be able to lead or negotiate with these coalitions in a way that supports advocacy efforts better.
- **Coordination** - Greater coordination among the various implementing agencies to show pragmatic solutions at the ground level could greatly support advocacy efforts.
- **Policy Analysis** - Greater understanding of migrant and related policies is necessary, accompanied by policy analysis, even if this is reliant on outside organizations.
- **Media** - Implementers need to become more media-savvy by developing media messages and campaigns that counter negative perceptions of migrant workers among the Thai public, and that address an international audience to promote broader support.

Project Funding and Structure

- **Objectives** - Project's objectives need to be framed beyond the context of HIV/AIDS. Although HIV/AIDS prevention may be the broader goal, HIV/AIDS interventions need to lead from other strategies that provide an immediate and lasting benefit to migrant populations, such as health or community. As part of this, objectives should be expressed in terms that include establishing systems. (e.g. Migrant Health System, HIV/AIDS interventions in the workplace...)
- **Sensitivity** - Donors need to be sensitive to the situation at migrant sites to ensure that objectives are not imposed that may conflict with other efforts. (e.g. Trafficking projects that could disrupt access to migrant laborers and sexworkers for HIV/AIDS prevention.)
- **Sufficient Time** - Community-development oriented strategies and structural changes require sufficient amounts of time. Funding periods need to be flexible and of long enough duration to accommodate development of these strategies, and allow them to adapt until they are viable.
- **Dedicating Staff** - This programming incorporates multiple objectives, and thus requires dedication of capable staff to specific objectives. Trying to make due by spreading staff over multiple objectives will not result in systematic changes. Implementers should anticipate personnel needs realistically, and present these needs to donors accordingly.
- **Budgeting for Personnel** - Budgets need to acknowledge and support the people working in this challenging field. Personnel budgets need to be able to attract and retain appropriate and skilled personnel, and funds should be included to provide on-going training and technical support.
- **Strategic Grants** - Providing different sized grants that focus on either broad or specific objectives is helpful. However, donors that give focused grants, such as for IEC development or women and children health, need to partially support the functioning of a site by providing a certain level of personnel and operating expenses.

Future Directions

As 'HIV/AIDS, Migration and Mobility' programming continues to evolve and expand, it is becoming necessary for implementers to move away from thinking at the single site level, and create linkages between related sites throughout the region. Currently, in Thailand, this programming is being scaled up through the support of the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM).

The PHAMIT (Prevention of HIV/AIDS Among Migrant Workers in Thailand) Project

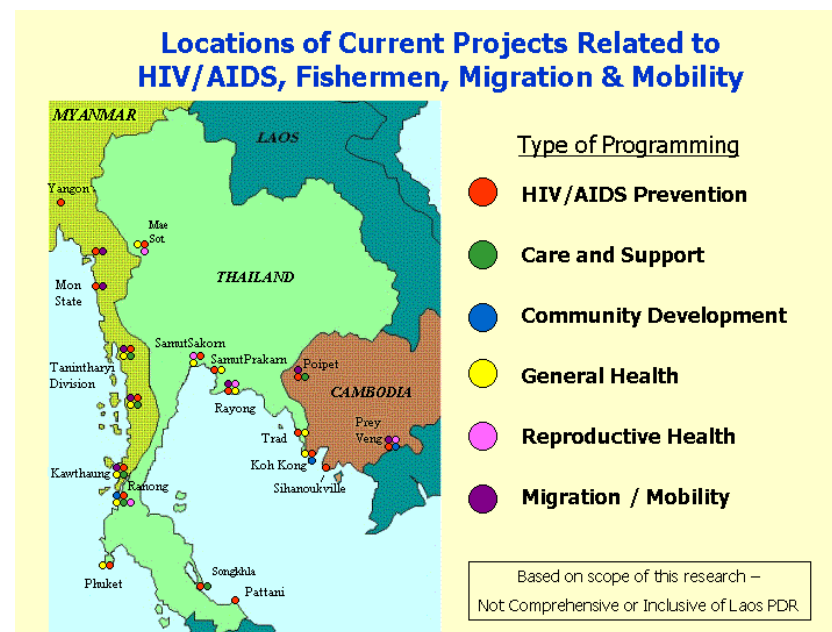
Raks Thai Foundation, the primary recipient, along with the partner organizations of WVFT, CAR, Stella Maris, MAP Foundation, Empower Chiang Mai, and the Ministry of Public Health, will increase the number of sites with HIV/AIDS programming for migrant workers and related populations. The project aims to cover all twenty of Thailand's coastal provinces and two provinces in the North (Chiang Mai and Tak). The objectives of the Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT) Project are to:

1. Increase condom use and reproductive health practices among migrant workers and related populations
2. Make health services more favorable to migrant workers and their families
3. Promote a supportive environment for migrants and their communities
4. Influence political factors at the national and international levels to support migrant workers' rights to health and treatment.

The PHAMIT Project will help to support linkages among the various implementers listed and their sites in Thailand. Yet, there is much to do outside of what the Global Fund can support. There are various programming areas extending beyond Thailand's borders that could increase the level of HIV/AIDS prevention and care, and enhance the well-being of the communities and populations affected by migration, mobility and

HIV/AIDS throughout the Greater Mekong Sub-Region. Source-destination linkages and border area projects, for example, have already shown some successes. Further support for the development of a source-destination model with the eventual inclusion of border areas and transit points could create corridors of safe mobility and result in actualizing linked HIV/AIDS programming in the sub-region.

Figure P - Locations of Current Projects Related to HIV/AIDS, Fishermen, and Migration & Mobility in Cambodia, Myanmar and Thailand



Ideas for Future Programming

This section identifies possible programming that could contribute to the further development of sub-regional programming on mobility and HIV/AIDS. Many of the activities listed here expand upon current activities, some which will be pursued under PHAMIT, or link related programming already in place. With adequate planning, coordination and support, a long-range vision could be pursued over time that progressively incorporates these elements into linked sub-regional programming.

Goal	<i>Integrate HIV/AIDS interventions into migrants' workplace</i>
Outcomes	<ul style="list-style-type: none"> HIV/AIDS interventions are integrated as part of the work environment, such as part of the docking or departing procedures for fishing boats, or during specific periods related to their occupation or migrant status, e.g. prior to shore leave, upon payday, during registration periods.
Activities	<ul style="list-style-type: none"> Interventions targeting boat and factory owners are given to promote greater cooperation and improve workers' health and rights. Language appropriate interventions are developed that can be integrated as part of docking or departing procedures (different interventions for different boat types), or given in the factory environment. Develop drop-in centers or "health corners" at piers and in seafood processing factories to post IEC and conduct outreach activities.
Research	<ul style="list-style-type: none"> Structure and functioning of the fishing industry (different types of boats/factories, crew/labor composition, docking patterns, docking and departing protocols, destination ports, etc.).
Advocacy	<ul style="list-style-type: none"> Ministerial levels (Health, Fisheries, Maritime, Industry) to incorporate health standards into labor policies and procedures. Relevant owners, Fisheries Associations, Port Authorities, and maritime offices provide greater access to information on boats' docking schedules, provide access to fishing boats and seafood processing factories, and dedicate locations for activities and IEC materials.

Goal	<i>Develop and formalize migrant community health systems</i>
Outcomes	<ul style="list-style-type: none"> A formalized and sustainable system to provide health services to migrant communities is established that falls under the auspices of the PHO and incorporates migrants in the provision of services.
Activities	<ul style="list-style-type: none"> Develop materials for public health stations that assist in overcoming language barriers, and train health personnel in their use. Develop referral systems that include volunteers, multi-media IEC, and hotlines in the language of migrants. Formalize and expand referral and health-volunteer networks to include specialised services, such as care and support for PLHA, follow-up on special treatments such as DOTS or ARVs, and the ability to administer all types of contraception. Establish community-health centers for migrants at locations favorable to migrants.
Research	<ul style="list-style-type: none"> Health needs of migrant communities and service preferences. Social and monetary benefits of a migrant health system.
Advocacy	<ul style="list-style-type: none"> Promote use of funds generated from migrant registration to directly fund migrant health systems. Promote support for migrant health systems and health centers through coalitions of health agencies and providers. Develop health insurance schemes to include dependents and family. Establish a registration category for migrants working in the health system or with NGOs, including foreign doctors, as appropriate.

Goal	<i>Develop and support migrant communities at destination sites</i>
Outcomes	<ul style="list-style-type: none"> Community networks, groups and activities that promote community and improve well-being are strengthened.
Activities	<ul style="list-style-type: none"> Establish multi-service centers located within migrant communities that act as a hub for communications and information, counseling and (possibly) financial services, cultural and social/recreational activities, or even childcare and schooling. Promote and support social groups such as sports teams, clean-up crews, or housewife groups; support cultural activities such as festivals, life-cycle events (birth, wedding, funeral) and practice of religion.
Research	<ul style="list-style-type: none"> Identify existing community leaders and support systems in migrant communities, such as spiritual leaders, respected counselors or benefactors, informal leaders and traditional healers, or social groups.
Advocacy	<ul style="list-style-type: none"> Improve sanitation in migrant communities, by upgrading septic systems, and ensuring trash removal and protection from hazardous substances. Promote understanding of legal rights, policies and laws with provision of access to legal counsel or other support. Secure understanding with authorities about rights of migrants to meet in groups and communicate amongst themselves.

Goal	Improve migrants' rights at local, national and regional levels
Outcomes	<ul style="list-style-type: none"> Local, national and regional level government entities acknowledge and enforce migrants' rights.
Activities	<ul style="list-style-type: none"> Form coalitions of Public Health Offices, local governments and business leaders to support proposals on labor and health policies for migrants. Engage in proactive dialogue with national level lawmakers to guide development of registration policies, international MOUs and migrant registration systems. Develop media campaigns targeting the Thai and international public to diminish stigma of migrants and draw attention to their plight.
Research	<ul style="list-style-type: none"> Coordinate research among sites and develop reports for use as an advocacy tool on health conditions and rights violations. Pursue substantive policy analysis to support policy recommendations.
Advocacy	<ul style="list-style-type: none"> Develop reports from coordinated activities, monitoring and research at site levels to demonstrate to national level authorities the feasibility and benefits of proposed changes (e.g. migrant health systems). Publicize public-interest stories related to rights that are expressed under international conventions, including issues of children's rights to citizenship and education.

Goal	Develop source-destination linkages that reduce vulnerability
Outcomes	<ul style="list-style-type: none"> Greater linkages are developed between source and destination sites to share information and resources, coordinate activities, and develop systems for safer migration.
Activities	<ul style="list-style-type: none"> Implementers at source and destination sites jointly develop interventions and materials to promote safer migration and mobility, and promote health. Develop appropriate communication systems between source and destination communities that are linked to and supported by other interventions, such as investment or recruitment schemes, and possibly including circulated newsletters or employment listings. Cross-visits to compare and share situational information between sites. Develop specialized pre-departure/returning campaigns coordinated at both source and destination locations that follow seasonal trends in migration, and provide counseling, mass media and entertainment events.
Research	<ul style="list-style-type: none"> Coordinate research to assess relationship between sites, and the impact of migration and HIV/AIDS.
Advocacy	<ul style="list-style-type: none"> Formalize recruitment systems between destination, source and transit sites Coordinate necessary documentation between sites such as vaccination schedules for children, or follow-up medical treatment of diseases.

Goal	Promote safer mobility along corridors of mobility
Outcomes	<ul style="list-style-type: none"> Link source-destination programming to include transit points, primarily border areas, by developing appropriate programming related to the character of each site as concerns migration and mobility, HIV/AIDS prevention, care and support.
Activities	<ul style="list-style-type: none"> Develop referral and care and support systems using informal networks that include source, destination and transit points, to send PLHA either to their homes, or to locations of their choice where care and support is available. Create interventions at transit sites that increase access to information, in order to diminish the risks inherent in mobility that can lead to trafficking.
Research	<ul style="list-style-type: none"> Assess linkages and relationships among various source, transit and destination sites to identify patterns and characteristics of migration. Assess the character, dynamics and needs of transit sites as relates to HIV/AIDS, migration and mobility.
Advocacy	<ul style="list-style-type: none"> Coordinate governments, health offices and NGOs on both sides of the borders to facilitate transport of PLHA, and promote safer migration and mobility.

Goal	Mitigate the effects of migration on source communities
Outcomes	<ul style="list-style-type: none"> Source and vulnerable communities receive proactive and responsive support to diminish the impact of migration and HIV/AIDS.
Activities	<ul style="list-style-type: none"> Develop and support appropriate schemes for individual families to invest remittance from migrants. Develop schemes that promote community investment into schools, health facilities, etc. at source and vulnerable communities. Strengthen subsistence activities for labor-depleted communities, such as personal gardens, rice-banks, or labor-sharing projects. Train volunteer networks in general health, OI and home-based care, to assist families and communities affected by AIDS.
Research	<ul style="list-style-type: none"> Assess the impacts of migration on communities as relates to livelihood, health and well-being. Create a set of indicators to identify vulnerable communities and communities affected by migration for implementers to use in planning.
Advocacy	<ul style="list-style-type: none"> Support cottage industry income-generation, or micro-loan schemes that are accessible to all families in source and vulnerable communities. Promote campaigns to reduce stigma among returnees and PLHA, supported by proper VCT.

APPENDIX 1

List of Organizations Visited & Interviewed

The key researcher went with an assistant to the following locations, and interviewed the organizations listed:

THAILAND

South

- Ranong (World Vision Foundation of Thailand, Public Health Office - AIDS Division, Dept. of Labor and Social Welfare)
- Songkla (Stella Maris, Fisheries Association, Dept. of Employment Services)
- Phuket (Stella Maris, Public Health Office - AIDS Division, Hospital, Employment Services Office, Fisheries Association)
- Pattani (RTF Seafarers Project, Public Health Office, Fisheries Association)

Central

- Mahachai (CARE/RTF Seafarers Project and Reproductive Health Project, Mahachai Hospital)
- Samut Prakarn (CARE/RTF Seafarers Project)

East

- Rayong (PATH and CAR / PROMDAN, Municipal Health Center, Rayong Hospital, CAMILIAN)
- Trad (CARE/RTF Seafarers Project, District Public Health, Khlong Yai Hospital)

CAMBODIA

Phnom Penh (Capital City)

- National Government agencies related to AIDS (NCHADS, NAA)
- Headquarter offices of various International NGOs working on AIDS (CARE Cambodia, World Vision Cambodia, CARAM, PSI)

Prey Veng (Source Community)

- PROMDAN / CWPD and PATH
- Provincial AIDS Office

Sihanoukville (Main fishing port in Cambodia)

- Local NGOs (KWCD and RHAC)
- Provincial AIDS Office

MYANMAR

Yangon (Capital City)

- International NGOs and UN agencies working on AIDS and or fishermen (UNFPA, UNICEF/UNAIDS, PSI, World Vision Myanmar, CARE Myanmar)
- CARE Myanmar fishermen project in Yangon area

Mon State (Source Community)

- CARE Myanmar

APPENDIX 2

Contact Information for Implementing NGOs

THAILAND

Organization

Raks Thai Foundation

Contact person

Promboon Panitchpakdi
Brahm Press

Title / Position

Executive Director
Interventions Advisor

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185-187 Phaholyothin Soi 11, Samsennai,
Phayathai Bangkok 10400

E-mail

info@raksthai.org
promboon@samart.co.th
brahm@raksthai.org

Telephone/Fax

T: 66 2 279 5306
F: 66 2 271 4467

Organization

World Vision Foundation of Thailand

Contact person

Kobchai Tanpaitoonditi

Title / Position

Relations Officer

Address

582/18-22 Soi Ekamai
Sukhumvit 63 Wattana District Bangkok 10110,
Thailand

E-mail

kobchai_tanpairoonditi@wvi.org

Telephone/Fax

T: 66 2 381 8863 5
F: 66 2 711 4100 2

Organization

PATH

Contact person

Tussnai Kantayaporn

Title / Position

Program Officer

Address

37/1 Ruamprasong Building 3rd Floor, Soi
Petchburi 15 Petchburi Road Bangkok 10400,
Thailand

E-mail

tkantaya@path.org

Telephone/Fax

T: 66 2 653 7563, 66 2 653 7564, 66 2 653 7565
F: 66 2 653 7568

Organization

CAR (Center for AIDS Rights)

Contact person

Supatra Nacapew

Title / Position

Director

Address

PROMDAN Project
17 Nawattree Road Paknam A. Muang Rayong
21000, Thailand

E-mail

carbkk@loxinfo.co.th

Telephone/Fax

T: 66 38 618011

PHAMIT Partner Organizations - (In Addition to above Organizations)

Organization

MAP Foundation

Contact person

Jackie Pollock
Sansoen Duangdee

Title / Position

HIV/AIDS Programme Director

Address

Chiangmai University, P.O. Box 7
Chiang Mai 50202, Thailand

E-mail

mapnet@cm.ksc.co.th

Telephone/Fax

T: 66 53 811 202

Organization

Ban Sooksan / Seafarers' Center - Stella Maris

Contact person

Sitthichai

Title / Position

National Director

Address

4/17 Rat-uthit Road Tumbol Bo-yang Aumphur
Muang Songkla 90000, Thailand

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Telephone/Fax

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F: 02-635-0334

Organization

Empower

Contact person

Pornphit Phitplaen (Chaing Mai)

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badgirls@empowerfoundation.org

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T: 66-2-526-8311
F: 66-2-526-3294

CAMBODIA

Organization

PATH Cambodia

Contact person

Hou Samith

Title / Position

Project Officer

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PATH Cambodia
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Sangkat

Khan Daun Penh, Cambodia

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shou@path.org

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T: 855 23 215 005
F: 855 23 720 170

Organization

Cambodia Women for Peace & Development

Contact person

Chou Bun Eng

Title / Position

Project Coordinator/ Executive Director

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#23, street 47 Sras Chak Phnom Daun Penh
Phnom Penh, Cambodia

E-mail

cwpc@bigpond.com.kh

Telephone/Fax

T: 855 23 724 274
M: 855 12 872 639
F: 855 23 360 192

Organization

CARE Cambodia

Contact person

Sok Pun

Title / Position

HIV/AIDS Programme Manager

Address

House 52 Street 352 Phnom Penh, Cambodia

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carehiv.aids@bigpond.com.kh

Telephone/Fax

T: 855 23 215267
855 23 215269
F: 855 23 426233
M: 855 72 914 129

Organization

Khmer HIV/AIDS NGO Alliance (KHANA)

Contact person

Contact Organization for local NGOs

Address

#25 Street 71, Boeung Keng Kang I, Chamcar
Morn

Phnom Penh, Cambodia

E-mail

khanapt@bigpond.com.kh

Telephone/Fax

T: 855 23 211 505
F: 855 23 214 049

MYANMAR

Organization

World Vision Myanmar

Contact person

Dr Shwe Win

Title / Position

Project Manager Seafarer Care & Support

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16 Shin Saw Pu Road Ahlone Township Yangon,
Myanmar

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wvm@mptmail.net.mm

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T: 95 1 525 191
95 1 706 225
95 1 510 148
F: 95 1 527 502

Organization

CARE Myanmar

Contact person

Dr Sid Naing

Dr Soe Kyaw

Title / Position

Health Program Coordinator

Deputy Project Manager

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98-A, Ka Ba Aye Pagoda Road Bahan Township
Yangon Myanmar 11201

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caremya@mptmail.net.mm

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95 1 544 805
95 1 544 289
F: 95 1 549 338

Organization

PSI - Population Services International

Contact person

Dr. Ko Ko Kyaing

Title / Position

Project Officer

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