Towards Borderless Strategies Against HIV/AIDS

South East Asia
HIV and Development Programme
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FOREWORD

Paradoxically, although the HIV/AIDS epidemic has long been recognised as a global epidemic, policy and programme responses have to a large extent been conceived of and implemented within the framework of national borders.

Even if the virus knows no borders, action within national borders benefits from many advantages, which have been clearly shown in a previous paper on the use of mapping assessments in national policies and programmes. However, action within national borders has its limitations and a response which attempts to deal with HIV within its catchment areas set by population movements and mobility systems, requires action beyond the national level. Part I of this paper explores how a number of South East Asian countries became aware of this issue and are organising their responses, a high point of this process being represented by the November 2001 Declaration on HIV/AIDS by the ASEAN Heads of State at their summit.

Once such awareness and understanding takes place, the key is the operationalization of policies and programmes beyond national borders in responding to mobility; this is discussed in the second part of this paper. This second part shows how programmes have to expand their activities from interventions on migrants to more complex and holistic interventions on mobility systems. It is shown that this process can take place over several phases as experience is acquired.

It is also demonstrated that such an approach naturally leads to linking sectoral interventions, which have often been considered in isolation, to mobility interventions under a general framework for HIV/AIDS and Development. It is thus that in the presence of HIV/AIDS epidemics, development strategies need to be revisited by giving human factors considerably more importance than generally happens.

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BACKGROUND AND OBJECTIVES

1. Looking back at migration, mobility and HIV/AIDS

In the late 1980’s and early 1990’s, efforts were made (e.g. by GPA/WHO\(^3\)) to convince the world that HIV/AIDS was a global epidemic rather than a disease limited to certain geographical areas such as Africa; trades like that of sex workers or truck drivers; and characteristics of people (e.g. MSM\(^4\)). One must remember that at that time many countries denied that the AIDS epidemic could spread to them. For example, the former Soviet Union, large parts of Asia and the Middle East considered that although they could have individual cases, especially of foreigners or nationals having travelled abroad, these would not reach epidemic levels. With the benefit of retrospective wisdom, it seems paradoxical that the responses to a global epidemic should have been boxed into national programmes and boundaries, largely ignoring population movements, except for a few categories such as truck drivers, seafarers, foreign residents or students, but not tourists. Besides efforts aiming at care and treatment of infected people, prevention focused on testing, safer sex, safe blood and injecting equipment.

The spread of HIV was perceived as the virus moved through sexual networks, but there was a tendency to overlook how the virus spread over space moving from network to network or inside a network spread over space. Of course, even in a global epidemic, national responses are essential. However, the influence of national borders is so strong on programme and policy thinking that first attempts at stopping the international spread of HIV often aimed at keeping out of a given country any traveller potentially infected with HIV/AIDS. Even at the international level and after a number of discussions, migration, rather than mobility, appeared on the agenda of the Inter-Agency Advisory Group (IAAG) to UNAIDS only for the first time in 1997. Although this was done after extending the IAAG mandate to include development issues, it was centred on migrants’ risks of infections or on their role as vectors, thus overlooking background development factors and how these development factors could be modified as part of primary prevention.

It should then come as no surprise that at the end of 1998, a number of Heads of national programmes on HIV/AIDS in South East Asia noted that there was little awareness of mobility issues in relation to the HIV epidemics of their countries\(^5\). This lack of awareness was true not only of the national AIDS programmes and the health sector, but also of other sectors directly concerned with mobility such as the transport or construction sectors whether they be public or private.

There was already concern about truck drivers, but they were perceived as a high risk group just like drug users or sex workers and programme responses were organised accordingly. This had programme implications: intense information, education and communication (IEC) activities were carried out at rest stops, in bars and at places where truck drivers congregated. Interventions to reduce idle time at borders, loading and unloading places or in modes of

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\(^3\) GPA/WHO : Global Programme on AIDS of WHO, the precursor of UNAIDS.

\(^4\) MSM = Men who have sex with men.

\(^5\) Based on interviews by Lee-Nah Hsu of Heads of national AIDS programmes of GMS countries.
payment of salaries either in lump sum to the individual truck drivers and their assistants
directly or split salary payments to the drivers and their families were not previously explored
because they did not come under the health perspective or the direct purview of AIDS
programmes. Had such measures been conceived, they would have belonged to the
Ministry of Transport or that of Construction who did not consider that they have a role in
HIV prevention. It is thus quite understandable why population movements, not to mention
mobility systems were not perceived as being crucial for fuelling the spread of HIV or for
shaping policies, strategies and programmes at the time.

2. The progress made

Less than three years after national Heads of AIDS programmes acknowledged the lack of
awareness of the role of population movements, on 5 November 2001, in Brunei Darussalam,
the ASEAN Heads of State adopted a declaration on HIV/AIDS which, among others,
stressed the importance of joint regional action to “reduce the vulnerability of mobile
populations” and to “promote innovative intersectoral collaboration to effectively reduce
socio-economic vulnerability and impact, expand prevention strategies and provide care,
treatment and support”.

A previous paper on the impacts of mapping assessments described how building a
knowledge base together with national capacity had shaped and expanded national
programmes on HIV/AIDS in some countries of the region. However, such national changes
did not happen in a regional vacuum; a complex synergy took place over the three years
between national efforts, ASEAN mechanisms and support from the United Nations system
and in particular directly through the UNDP South East Asia HIV and Development project.
The UN Regional Task Force on Mobile Populations and HIV Vulnerability also played a
role.

3. Objectives of the paper

The objectives of this paper are to highlight in the first part some of the changes at the
regional level which took place and their significance. Although the regional level serves
multiple roles and functions, this paper focuses on two major ones: first, regional events
provide snap shots at a given moment of the consensus existing on an issue and can thus
serve as indicators of awareness and knowledge of it; second, regional events serve as
facilitators of joint inter-country action. This latter dimension of the regional contribution
against HIV is programmatically important as the virus ignores borders: regional responses to
HIV are required in the face of a borderless epidemic riding on some of the socio-economic
forces driving the integration of the region. In this context, the term borders can be

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6 For the purpose of this paper, the term « region » covers the ASEAN countries as well as Guangxi and Yunnan,
the South Western Provinces of China bordering ASEAN countries.
7 Excerpt of Paragraph 22 of the Declaration. See Annex I (c) for the full text.
8 The Impacts of Mapping Assessments on Population Movement and HIV Vulnerability in South East Asia.
http://www.hiv-development.org/publications/mapping.asp
9 In particular the ASEAN Task Force on AIDS (ATFOA) of the ASEAN Secretariat.
10 See for example, Early Warning Rapid Response System: HIV vulnerability caused by mobility related to
From AIDS Epidemics to an AIDS Pandemic: is an HIV/AIDS hub building in South-East Asia? August 2000,
UNDP South East Asia HIV and Development Project.
understood in the usual geographical sense as well as between sectors, e.g. between health and development sectors such as transport, construction and agriculture.

In order to show the importance of the regional level in responding to HIV/AIDS, there is no need to carry out a comprehensive or exhaustive analysis of regional activities; it is enough to illustrate the evolution in the understanding at the inter-governmental level of some issues involving mobility and multi-sector strategies in the field of HIV/AIDS.

In the second part, the paper takes further steps concerning issues of mobility and multi-sector strategies in order to promote discussions on bringing these issues together for policy formulation and developing programmatic responses.

PART I

SOME MILESTONES IN REGIONAL AWARENESS OF POPULATION MOVEMENTS AND MOBILITY

Three events are selected to serve as milestones in the regional awareness and response to mobility and HIV/AIDS. The first one serves as a benchmark and the other two show respectively the more technical dimension of policy progress in the area of mobility and HIV/AIDS and the highest level of political endorsement of mobility, situating it in the general framework of efforts against HIV/AIDS.

1. The Chiang Rai Recommendation

The ASEAN Workshop on Population Movement and HIV Vulnerability was held in Chiang Rai, Thailand from 10-12 November 1999 and was organised by the UNDP South East Asia HIV and Development project in collaboration with the Ministry of Public Health of Thailand, WHO Regional Office of South East Asia, Family Health International and SEAMEO-GTZ-CHASPPAR. The originality of the workshop could be found in the fact that it brought together a mix of heads or representatives of HIV/AIDS programmes and those dealing with population movement, such as the Ministry of Public Works and Transport; Department of Immigration, Ministry of Interior; Planning and Monitoring Division, Commission on Population; Department of Employment, Ministry of Labour and Social Welfare; and Department of Criminal Police, Ministry of Public Security; UN system experts, academics, NGOs, private companies hiring migrant workers, as well as the ASEAN Secretariat. This mix provided a variety of perspectives on the issue of population movement. The workshop went beyond the concept of population movement which was often understood as having essentially an international dimension and introduced the concepts of mobility and mobility systems. These latter concepts link internal to international movements and to inter-relations with sending, transit and receiving communities.

11 Countries represented were: Brunei Darussalam, Cambodia, China (not a member of ASEAN), Indonesia, Lao PDR, Malaysia, Philippines, Singapore, Thailand and Viet Nam, see ASEAN Workshop on Population Movement and HIV Vulnerability, June 2000, ISBN: 974-876378-1, http://www.hiv-development.org/publications/ASEAN_workshop.asp.
The mobility and mobility system concepts, however, go beyond internal and international movements as these concepts set the movements in catchment areas of potential migrants (just like a river basin catches all the water in the area it covers) and identify the forces behind the movements. Furthermore, the introduction of a systems approach facilitated the linking of mobility factors to issues of development rather than limiting discussions to migrants which constitute but one component of a much vaster mobility system. Of course, one could not expect all the aspects to be covered in depth, but the door was opened to the wider development dimension\(^\text{12}\), although much of the discussions at the time of the Chiang Rai consultation centred on a broad range of issues relating to migrants, their vulnerabilities, the degree of risk of their behaviours and the difficulties of programmes in reaching out to them.

The Chiang Rai consultation adopted a recommendation, hereafter called the “Chiang Rai Recommendation”:

> **ASEAN governments adopt a common policy recommending the integration of HIV prevention programmes as a precondition for construction and infrastructure development contracts bidding and approval**.

The contrast between this very focussed and specialized recommendation and the range of discussions held at the meeting is striking! The explanation can be found in the fact that for most participants, the issues discussed were very new and therefore they needed more time to think these issues over before being able, as a group, to comfortably formulate and adopt recommendations on population movement or mobility. As often happens in such cases, specific participants have an interest in a specific issue which then emerges as a recommendation, whereas with subjects participants are familiar with, meeting organisers usually face the opposite problem of reducing the number of recommendations.

The landmark Chiang Rai Recommendation is important as it is the first one of its kind in South East Asia and was endorsed by many countries and civil society: the recommendation corresponded to a concern and commitment which explains why, to the difference of many other recommendations, this one was followed up and implemented. If one looks at the recommendation more closely, one can note that the need for a regional response is recognised: “adopt a common policy”. The recommendation also stresses the need to link HIV programmes to a development sector which employs large numbers of migrants: implicitly this sets the base for programme interventions in a system, i.e. a mobility system. It identifies a very concrete way in which a particular sector – the construction sector – can participate in HIV prevention. The recommendation stresses that the inter-relations between HIV programmes and development interventions are most useful in preventing HIV infection.

The Chiang Rai Recommendation is furthermore important in the following aspects:

i) It indicates that at the end of 1999, issues of mobility were not at all self-evident and that the region was just beginning to grapple with them.

ii) It shows that all the actors from government programmes, the UN system, and (I) NGOs were becoming concerned and willing to develop activities in the area of mobility.

\(^\text{12}\) For example, the consultation led to conceiving, discussing and developing a few months later the model of Early Warning and Rapid Response System (EWRRS).
For these reasons, this recommendation marks the beginning of a flurry of activities in conceptual development; in mapping the situation; in involving sectors, e.g. land transport in Laos PDR; etc.\textsuperscript{13} This recommendation can serve as a benchmark indicating the first steps at the regional level for interventions in mobility and HIV issues.

Furthermore, as mentioned earlier, the Chiang Rai Recommendation, after identifying the construction sector, was actually implemented. With legal assistance provided by the Department for International Development (DFID) of the United Kingdom, a model contract clause was developed and endorsed at the United Nations Regional Task Force on Mobile Population and HIV Vulnerability\textsuperscript{14} meeting of 30\textsuperscript{th} August 2001 \textsuperscript{15} (see Annex II).

Finally, the Chiang Rai Recommendation was endorsed by the 7\textsuperscript{th} ASEAN Task Force on AIDS (ATFOA) meeting in Brunei from 16th to 18th November 1999. This endorsement gave the recommendation its full official force – before this endorsement, it was just the result of a technical workshop. The ATFOA meeting, although held very shortly after the Chiang Rai meeting, did “digest” its discussions: it linked together population mobility, poverty, illicit drug use and the gap in economic growth between neighbouring countries. Mobility was clearly integrated into a development framework. The role of such a framework was further emphasized by recognising the role of direct as well as of indirect factors in the rapid spread of HIV/AIDS in the region. The ground was thus readied to elaborate on development based strategies.

2. The Memorandum of Understanding (MOU)

The text of the MOU is provided in Annex I (b). It is the direct outcome of the Chiang Rai consultation, of both the substantive developments spearheaded by UNDP South East Asia HIV and Development project (UNDP-SEAHIV) as well as its support to national AIDS programmes in the area of mobility. Although the commitment and action of national AIDS programmes was necessary to reach the MOU result, it also needed to be complemented by a constellation of factors and cooperation among key players. Activities were developed along several tracks simultaneously, but in a coordinated manner as follows:

(1) one track focusing on mapping of the situations,
(2) one conceptual and substantive track which provided assistance to national policy and programme development in uncharted areas,
(3) the national programme tracks in a number of countries, and
(4) the regional track with the United Nations Regional Task Force on Mobile Population and HIV Vulnerability which regroups countries, UN system, donors, NGOs and the ASEAN secretariat.


\textsuperscript{14} NB. There are two task forces mentioned in this paper: this present United Nations Regional Task Force specialised on mobility and HIV/AIDS involving UN, governments, INGOs, intergovernmental entities; research institutions and donors; and the ASEAN taskforce which covers all aspects of HIV/AIDS and it is an inter-governmental Task Force known as ATFOA.

All these four tracks were necessary to bring the countries to sign the MOU at the ministerial level. The commitment of the key players and institutions is indicated by the brevity of time in which such a complex process took place, i.e. in less than two years.

In the process of the signing of the MOU, a remarkable occurrence happened. The original intention was that the Provincial Health Bureaux of the two Chinese provinces of Guangxi and Yunnan would sign as these two provinces had been participating with other countries of the Greater Mekong Sub-region (GMS) in activities on mobility of the UNDP South East Asia HIV and Development Project. However, the central authorities in Beijing decided that it would be the Minister of Health at the national level, rather than the two provincial Health Bureaux who would sign, therefore on behalf of the whole country.

This turn of events is especially important if one considers that this signature is made at the time of China joining the World Trade Organization (WTO): China already has a very large rural-urban movement of people which is expected to increase as the impact of the WTO rules are felt in rural areas. Mobility can be expected to become an even more significant factor than at present in future socio-economic developments of China. Its inter-relations with the spread of HIV/AIDS could represent a serious potential threat. Furthermore, by going beyond the two provinces: Guangxi and Yunnan, bordering the Greater Mekong Subregion (GMS), there is an implicit recognition that the land transport integration and development which are presently taking place will have effects beyond these two provinces. For example, trade and passengers by road can link Kunming (Yunnan) not only to Bangkok or Ho Chi Minh City, but also to Guang Dong, Shanghai, Beijing, Mongolia and beyond.

Following the first round of signatures by Cambodia, Lao PDR, Thailand, Viet Nam and China, Myanmar decided to add its signature to the MOU. This is important because the movements of people between Myanmar and its Eastern and Northern neighbours are significant: the participation of Myanmar thus completes the zone covered by the major catchment area for the mobility systems in that part of the world (see Figure 1.) and provides a greater base for programme effectiveness. The present joint cross border activities can now be systematically expanded.

Besides the geographical coverage, the MOU shows that the Ministries of Health, through signing for the governments, recognize the relevance of mobility, beyond the issue of migrants, for the spread of HIV/AIDS. It also means an acknowledgement of development factors and processes in the spread of HIV/AIDS and the need to address factors of vulnerability. This represents a major step in developing joint programmes with complementary health and development strategies.

As mentioned in the introduction, the objective in this paper is not to carry out an exhaustive analysis of agreements such as the MOU, but to highlight some of its key aspects in relation to mobility and development.

Four points are singled out on the MOU:

A. Access to information and services

Greater access to information and services for mobile populations is to be facilitated. One needs to remember the diversity of languages, dialects, and ethnic groups involved in mobility in the South East Asia region. Co-operation in translation or in checking cultural
From Chiang Rai Recommendations to Memorandum of Understanding & Joint Action Programme

A process facilitated by UNDP-SEAHIV

### 10th-12th November 1999 Chiang Rai Consultation
UNDP-SEAHIV, WHO, Thailand MoH, FHI, SEAMEO-GTZ-CHASPPAR, ATFOA

- Chiang Rai Recommendation
- clustering of countries for joint responses to mobility and HIV vulnerability: BIMPS and GMS clusters

### GMS cluster
Cambodia, Southern China, Lao PDR, Myanmar, Thailand, Viet Nam

### BIMPS cluster
Brunei, Indonesia, Malaysia, Philippines, Singapore

### Hanoi consultation, April 2000
Viet Nam as cluster coordinator
UNDP-SEAHIV, UNAIDS-SEAPICT, Viet Nam, Myanmar, Cambodia, Yunnan-China

- Draft MOU and Joint Action Framework (JAF)

### Genting Highlands, Malaysia consultation September 2000
Malaysia as cluster coordinator
UNDP-SEAHIV, Canadian Human Rights Foundation, UNAIDS-SEAPICT, CARAM, UNDP-S/SW Asia, IOM

- Including GMS + BIMPS & South Asian countries
- Outlining a generic manual on pre-departure, post-arrival and returnee re-integration

### During 2001, development of
- a) Regional strategy for mobility & HIV vulnerability reduction Jointly with GMS countries, CIDA, ADB, WVI, MBC, UNDP-SEAHIV, UN Regional Task Force on Mobile Population and HIV Vulnerability, UNAIDS-SEAPICT &
- b) Model contractual clause to support the Chiang Rai Recommendation with support from DFID

### MOU signing 5th September 2001
Phnom Penh, Cambodia as GMS cluster coordinator

- Signed by Thailand, Cambodia, Lao PDR & Viet Nam
- Late September signed by China
- In December 2001 signed by Myanmar

### Phnom Penh Consultation 18-19 February 2002
UNDP-SEAHIV

- Converting JAF to Joint Action Programme

### BIMPS cluster consultation Manila, Philippines 15-17 April 2002
Malaysia remains cluster coordinator with Philippines as co-coordinator
UNDP-SEAHIV, Philippines Government, UNDP-Philippines, CHASPPAR as secretariat, & ATFOA

- a) draft MOU
- b) developed Joint Action Programme
appropriateness of information is essential and can be organized at a fraction of the cost by bringing together national programmes tackling such issues. Just as important, migrants are either normally excluded or feel excluded from the services available in the receiving countries. This is ineffective from an epidemiological and a human rights perspective. Opening systematic access to services is a crucial development.

**Figure 1. Map of population movement into and out of the GMS region**

![Map of population movement into and out of the GMS region](http://www.hiv-development.org/publications/sea_publications_papers.asp)

**B. Decentralized local level collaborations**

One of the more original aspects of the MOU is the encouragement given to local authorities, (I)NGOs and civil society to collaborate with their counterparts in neighbouring countries. Until now, a number of cross border activities have been negotiated, but, involving, each time, central authorities can be cumbersome. This clause provides a considerable degree of flexibility and the possibility to adjust to local situations. One should recognise the considerable number of border crossings between the countries and that such decentralisation and encouragement are necessary if activities are going to reach a scale commensurate with the number of crossings. Flexibility is also important because the situation can change rapidly.

at any given crossing point and local level collaborations should enable rapid responses from programmes. This kind of capacity of adaptation and comprehensiveness should also be facilitated by encouraging authorities to work together with (I)NGOs and civil society, and harnessing together the comparative advantages of each. This is certainly the best way to ensure a comprehensive approach ranging from prevention to care. It should be noted that without being specified, this local approach corresponds to an implementation of local governance\textsuperscript{17}. One should be able to expect the emergence in the forthcoming years of more effective programmes and activities.

\textbf{C. Shifting the focus from high risk mobile groups to a programme approach for sending, transit to receiving communities}

The MOU takes a major step forward by going beyond the concept of high risk groups of mobile people (e.g. fisher folks, construction workers) to endorse a programme approach covering \textit{sending, transit and receiving communities}. As will be discussed in Part II, this will facilitate the implementation of programmes intervening within a mobility system and reduce some of the causes of vulnerability. This is important because from an epidemic perspective, one does not need to deal with all causes, but only with those most amenable to interventions in order to reduce sufficiently their role in the system so there is no threshold or multiplier effect for HIV to spread through the mobility system. This could lead to very innovative ways of setting up responses\textsuperscript{18}. When one combines this with the flexibility given to local levels, one can hope for very creative and innovative developments. Ministries, of course, need to encourage this.

\textbf{D. The Chiang Rai Recommendation}

The Chiang Rai Recommendation previously discussed in this paper and already endorsed by ATFOA is re-endorsed by the MOU. This should be understood in the context of the activities carried out since the ATFOA endorsement with the preparation of the model contractual clause: this gives teeth to the recommendation as there now exists a tool for its effective implementation (see Annex II).

One can thus but be impressed by the progress made in a remarkably short period of time between the Chiang Rai recommendation and the signing of the MOU. This could not have happened without the effective team work of a number of key actors in the countries and at the regional level.

\textbf{3. The 7th ASEAN Summit Declaration}

It is interesting to note that the MOU brings together all the countries concerned by systems of mobility primarily based on land transport. There is a logic to the grouping of the countries. In the Brunei, Indonesia, Malaysia, Philippines and Singapore cluster (BIMPS)


countries of South East Asia, population movements and mobility are also very significant\(^\text{19}\), but are somewhat different as they take place from and between mostly island states. However, as shown in Figure 1, a number of migration flows link these BIMPS cluster countries to those GMS countries covered by the MOU. It is necessary for the entire ASEAN countries to consider the MOU. This was done and later reflected at the 7\(^{th}\) ASEAN Summit Declaration on HIV/AIDS on 5th November, 2001 in Brunei Darussalam (see Annex I (c) for the full text). With this political Declaration, nearly the entire South East Asian region is covered. From the perspective of mobility, this is rational as it encompasses the major flows of populations in the region.

The ASEAN Summit Declaration is a crucial step forward because it not only sends out a strong signal that HIV/AIDS is recognised as a major issue at the highest levels of state, but gives legitimacy to both multi-sector and multi-level strategies to combat HIV/AIDS. Such multi-sector, multi-level strategies fulfil an important requirement in intervening in mobility because certain aspects can only be dealt with at the sub-national level, others at the regional level, and in each case by involving relevant sectors. By definition, the Heads of State bring together all the sectors of government and public policy: this greatly facilitates co-operation with AIDS programmes and between sectors.

The Declaration covers HIV/AIDS in general and only the parts useful for the issue of mobility are presented here. Among many important aspects, the Declaration stresses under its section on leadership, the role of leading and guiding HIV/AIDS activities into (paragraph 16) “the mainstream of national development planning, including poverty eradication strategies and sectoral development plans” and (paragraph 18) “intensify and strengthen multi-sectoral collaboration involving all development ministries and mobilising for full and active participation, a wide range of non governmental organisations, the business sector, media, community based organisations, religious leaders, etc”.

Within the broad multi-sector framework, the Declaration identifies in its paragraph 22 issues of mobility as requiring joint regional actions: “to reduce the vulnerability of mobile populations to HIV infection and provide access to information, care and treatment; adopt and promote innovative inter-sectoral collaboration to effectively reduce socio-economic vulnerability and impact, expand prevention strategies and provide care, treatment and support”.

As has been shown in “The Impacts of Mapping Assessment”\(^\text{20}\), mobility has begun to be identified as an area for national and sub-national intervention. Following the mapping exercise, the MOU recognised and promoted joint cross border activities and the Declaration endorses joint regional action. Because mobility is not only a multi-sector, but also a multi-level issue, the multi-sectoral aspect needed to be specifically identified and legitimised in order to build systematic multi-dimensional and holistic interventions.

In the Declaration, the Heads of State adopted the ASEAN Work Programme on HIV/AIDS. This means the Declaration is already being translated into operational terms in the area of mobility. In fact, this translation has been tailored to sub-regions and has been further spelt out in a Joint Action Programme for Mobility and HIV, 2002-2004 (JAP). The Joint action covers also activities between the GMS countries of ASEAN and the Yunnan and Guangxi provinces of China (see Annex III). The Joint actions are built around the goals of empowerment of communities, reducing vulnerabilities relating to mobility through development strategies and building collaborative regional responses in these areas.

It should be stressed that in less than three years, the region went from a quasi total lack of awareness of mobility as an HIV/AIDS issue to the building of a knowledge base on population movements and mobility in relation to HIV which is effectively being used as a base for policies and programmes at both national and regional levels. The contrast between the Chiang Rai recommendation and the MOU and ASEAN Declaration is striking. The stage is now set, the question which remains to be answered is what action will be taken over the next few years and with what impact.

The approach developed in the South East Asia region appears to be quite unique. Why did it emerge in South East Asia and not in Africa, South Asia or Latin America? Is it suited only for the South East Asian situation and circumstances or can it be fruitfully adapted or replicated by other regions? These are but some of the questions which could be explored between South East Asia and other geographic regions in the form of South-South co-operation.
TOWARDS THE OPERATIONALIZATION OF MOBILITY RELATED RESPONSES

Once the groundwork has been carried out for multi-sector and multi-dimension interventions, it is useful to discuss in particular two immediate concerns for the translation of policies into programme activities such as those endorsed in the Joint Action Programme. Such interventions require both going beyond activities for migrants to interventions on mobility systems as well as linking mobility and sector interventions.

1. From interventions on migrants to mobility system responses

When thinking and strategies are mainly shaped through focusing on safer sex, it is not self-evident to develop interventions on mobility systems which fall outside of the models or conceptual frameworks being utilized. The common frameworks lead to strategies targeting high risk groups, e.g. sex workers or injecting drug users. However, within these approaches, one category does emerge as being vulnerable and of high risk and that is the one of migrants. This emerging awareness results in setting up activities in receiving communities (see Figure 2, Phase I) to inform migrants on HIV/AIDS and encourage prevention through condom use. Unfortunately this kind of activity is often of limited effectiveness because the migrants are difficult to reach operationally as they can disperse or go underground, especially if they are undocumented or belong to linguistic and cultural groups different from those of the receiving communities.

Figure 2. Migrant based interventions focusing on communities separately
The idea then naturally emerges that programme interventions in receiving communities of migrants should be complemented by activities at points of transit because migrants are generally channelled through a limited number of transit points such as border crossings. These transit points appear as very convenient locations to introduce information, education and communication (IEC) activities at bus stops and connections between the various modes of transport (Figure 2, Phase II). Transit places often develop into hot spots as the migrants have to stay while waiting for a connection to continue their journey. As the migrants can be disoriented and scared, they can significantly modify their usual behaviour. Such transit points exist both inside countries for internal migrants, but also for international population movements. Transit communities become bustling hubs of trade and services of all kinds, including sex and drugs. Such places are easy to identify for HIV/AIDS programmes and activities designed to target migrants. The MOU presented in Part I of this report encourages joint cross border activities between neighbouring provinces and districts of the countries in the region.

As one thing leads to another, AIDS authorities become aware that migrants passing through transit points start from somewhere else and that migrants also include returning migrants on the way back to their communities of origin. It thus makes sense to expand activities to sending communities (Figure 2, Phase III). Interventions can inform the sending communities of the vulnerabilities of migrants (or of potential future migrants) and educate them in prevention. Not all communities in a country at a given time are sending communities. Sending communities have certain characteristics (high levels of poverty, remoteness or, on the contrary, are located near a road) and can be identified for programme intervention.

As not all inhabitants of these communities will migrate, activities need to be designed both for potential migrants and for those who will not migrate, but will be affected by the departure or return of a migrant. Sending communities can be located in the country of the national programme, but also in a neighbouring one which then requires international collaboration between the AIDS programmes. In this case also, the MOU recognises the linkages between the sending and the receiving communities and provides the basis for collaboration to cover migration systems. The term migration system is used here because places of origin, transit and arrival are linked and form a system through the movements of migrants. Until now, programme emphasis has been placed on migrants themselves and IEC activities for them: migrants are made aware of risks and taught to reduce them.

A number of programmes are reaching Phase IV described in Figure 3. In this phase, the migration system is dealt with as an integrated system, at least in one of its directions, i.e. from the sending through to the receiving community. The return component of the system, in particular, at points of transit (returning migrants often carry money and are thus in a different situation compared to that when they were on their way out) and when back in their community of origin remains yet to be developed. This particular component of the system is important because it is the sex network of the migrants which can influence the spread of HIV.

Up to this point the discussion has covered interventions in the systems formed by population movements between sending and receiving areas. It has also become clear that as long as one is focusing on migrants themselves, activities take on mostly the form of IEC. There are several limitations with working only with migrants, which of course should not be interpreted as meaning one shouldn’t! In particular, such an approach results in the following scenarios which further disadvantage the migrants:
i) Migrants are perceived as high risk groups rather than as vulnerable groups and, therefore, as with sex workers, there is a danger of blaming them for being a vector of HIV, thus constituting a cause of the HIV epidemic.

ii) Interventions reactive to migration flows are considered as a given. The result is that one tends to stress activities aimed at reducing possible high risk behaviours of the migrants themselves thus ignoring other dimensions of the mobility system of which the migrants are a part.

Figure 3. Migration system-based interventions linking the communities in a system

There are, however, other possible interventions which can be added to those already directed at migrants. Programmes can intervene on the forces which make people move. As noted, not all inhabitants of a community move, the poorest in particular. Nor do people move in significant numbers from all communities. There are communities which are particularly disadvantaged and for which emigration is a solution as it releases the pressure on the community as well as opens possible opportunities for the migrant and the family through remittances. Furthermore, inside a given community, not all families are equally poor or disadvantaged and some families are more vulnerable than others. Such vulnerabilities can be caused by problems of land tenure, by insufficient access to water resources or forest products which might be captured or monopolized by the powerful groups inside or outside of the community. Individual characteristics of families are also important; for example, disabilities due to an accident or an illness of one of the important family workers, etc. Such background factors which create vulnerabilities and are often solved by out-migration of a family member, are factors related to development issues (see Figure 4, Phase V). These factors are thus open to interventions of a more systemic nature in development. For example, improving land tenure legislation or its customary application; rights to water; facilitating access to markets; or ensuring that rural credit is available to the poor.
As shown in Figure 4, Phase VI, at least two types of development interventions are possible:
(1) interventions to modify negative factors, e.g. improving land tenure or protecting rights of widows; and
(2) interventions to reduce vulnerabilities, such as providing education for children including skills for securing employment.
In this latter case, one is no longer addressing issues limited to migrants, but to the mobility system in which migrants are the most visible component. It is clear that these measures are not unique to reducing HIV/AIDS vulnerabilities. They are normal development activities but chosen because of their potential impact on the HIV epidemic.

When an AIDS programme becomes ready to move from interventions on an individual migrant to interventions in a mobility system, it entails a different mode of operation. Besides the IEC type of activities, it has to work with development actors such as the Ministry of Agriculture or of Transport. Such collaborations aim at identifying the policies and programmes sectoral ministries are conducting or planning to carry out. These policies and programmes may need to be modified or coordinated to achieve the desired results in reducing community and migrant vulnerabilities to HIV as well as the specific Ministry’s purely sectoral objectives in areas such as rice output, yield increase or transport of goods and people.

2. Linking sector and mobility interventions in a general framework for HIV/AIDS responses

A general framework has been presented in Early Warning Rapid Response System\(^2\) and is reproduced in Annex IV (a). This general framework was elaborated in order to situate an HIV development based paradigm in relation to a health based one as well as to show their complementarities. The development based paradigm is centred on background factors of vulnerability to HIV infection whereas the health one focuses on immediate risks of infection.

\(^2\) See Footnote 8.
Several other points need to be highlighted here. The health approach focuses on individuals and groups (e.g. truck drivers, MSM, sex workers) and their individual *risks* of infection. Operationally, it is cost effective to centre efforts on so called high risk groups. However, this approach has limitations when prevalence levels are high in the general population. The development based approach focuses on macro-level issues and on *vulnerabilities* which can result in individuals and groups adopting higher risk behaviour than otherwise which in turn can result in HIV infection. It will centre its efforts, for example, on reducing the vulnerability of a farm system based on a single crop such as rice which leads not only to farm-households being vulnerable to the crop failure, but also to the existence of a slack season in which part of the rural population migrates to cities to earn additional income.

The agricultural policy response to reduce vulnerability could encourage the production of other cash crops, e.g. palm sugar, fruits and thus facilitate their adoption and marketing by farmers. Such crops could occupy all the members of the farm-household during the slack season. For example, both men and women have a number of tasks in order to collect the sap from the fruit of the sugar palm tree, the fire wood for its heating and processing, etc. When the income thus generated by this extra crop is sufficient, out-migration of a family member is less necessary. One should be aware that seasonal migration can also be a legitimate and valid economic solution to improve the farm-household income. However, for seasonal migration to take place under favourable conditions for the migrant and the sending communities, a development approach would be concerned with teaching the would-be migrants marketable skills. This would enable them to be less open to exploitation because they could more easily find employment as well as earn higher income in the receiving town. A simple model, also derived from the Early Warning one is presented in Annex IV (b) and discussed in another paper. This framework focuses on linking a sector to mobility. For this example, we use the agriculture sector and HIV/AIDS in a development paradigm.

What is important to keep in mind when preparing policies and programmes are the distinctions between development based strategies focusing on *vulnerabilities* and their complementarities to health ones focusing on *risks*. Their complementarity resides in the fact that factors open to development interventions or induced by them, create the conditions which impact on risk taking behaviours or situations. It is also important to note that these factors which serve as background for risk taking behaviours are anterior to them. This is why monitoring of the vulnerability factors is important for *early warning* that a situation is changing with potential negative consequences for HIV.

Until now, health based approaches have received the most attention and funding support, but they have shown in many cases that, alone, they are not sufficient to keep the spread of the HIV epidemic in check. Complementing the health sector based approach with development based strategies dealing with background factors could create positive synergies in increasing the effectiveness of policies and programmes.

What is needed now, is to fit the various pieces together. The dovetailing of health and development has been shown (refer to Annex IV (a)), but inside the development paradigm one has to link a development sector to mobility. This is not difficult as the original EWRRS

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model was conceived in a modular manner which can be assembled in various ways, like pieces of a LEGO®. Essentially the first column of the figure in Annex IV (a) has been replaced by the first two columns of the figure in Annex IV (b) when adapting to each of the development sectors.

Changes in the situation of a given sector generally have an impact on mobility. For example, the building of a road facilitates migration. As shown in the previous section on mobility systems, one eventually needs to intervene on the factors impacting mobility systems. Such interventions are not direct HIV/AIDS interventions per se, but development interventions designed to impact factors leading to migration and risk taking. Naturally one cannot expect a development sector to identify by itself such factors and the mechanisms through which they can operate. This requires the assistance of the AIDS programme. Once the factors are identified and the type of intervention is conceived and prepared, actual intervention is to be carried out by the sector rather than by the AIDS programme on the basis of their comparative advantages. Therefore, the dovetailing of sectors to mobility is necessary in order to set up many strategies of the same type.

In the present case illustrated with the agriculture sector, Annex IV (b) introduces in the larger development ellipse, agriculture interventions which impact on two different levels:

1. the farm system, e.g. the rice and sugar palm system, and
2. the farm-household system.

This kind of intervention should have an objective to improve agriculture production (the main concern of the Ministry of Agriculture) and should be carried out in such a way that they also result in rural development - an often neglected dimension of the mandate of Ministries of Agriculture, reducing the vulnerability or, in other words, increasing the resilience, of the farming systems and farm-households. In turn, this type of intervention has an impact on the volume and, just as important, on the conditions under which migration takes place. It makes all the difference if a young farm girl has enough skills to find a job in a factory as compared to if, because of a crop failure, the family is forced to sell her to traffickers, prematurely terminating her basic schooling.

Furthermore, it should be noted in Annex IV (a) that the diamond in the third column "Modifying migration and mobility systems" symbolises any one of the phases of migration or mobility system already discussed and represented in Figures 2, 3 and 4 (Part II, Section 1). This means that depending on the stage reached or the priority given in a programme, Phase II or IV, for example, can be inserted in its stead. This is possible because of the modular nature of the framework.

In such a framework, a new challenge for AIDS programmes is to learn to work together with development sectors to identify common areas of concern and develop both human and physical capital. Isn’t that, in final analysis, what development is all about?!
CONCLUSIONS

The reader might be tempted to think the discussion in Part II on mobility systems and linking sectors to mobility systems has drifted far away from the first part of the paper reviewing some important milestones in regional policy responses to HIV/AIDS. However, if one adopts a holistic perspective, one becomes aware of the fact that the economic development and integration taking place in the region can, if not properly managed, set the stage for a major HIV epidemic\(^\text{24}\) which could imperil the economic development achieved without even mentioning human suffering. It is heartening to note that decision-makers in national AIDS programmes, in health and other sectoral Ministries and in (I)NGOs are increasingly aware of the threat building up and are laying the foundations at the regional level which complement the national efforts to prevent or diffuse the threat from occurring.

Of course, conceiving and, especially, implementing holistic strategies inside and between countries represents a challenge. Are there simpler effective alternatives? Unfortunately, the history of development of the past decades is full of examples of failures due to the understandable desire to achieve quick results through technical fixes and various shortcuts. These have often been justified by stressing urgency, even emergency. However, in retrospect, these quick fixes have actually taken longer and been less successful than more holistic and longer term development strategies based on capital formation and human development. HIV/AIDS is no exception.

\(^{24}\) Refer to Footnote 8.
ANNEX I  MILESTONES

(a) The Chiang Rai Recommendation, 12 November 1999

ASEAN governments adopt a common policy recommending the integration of HIV prevention programmes as a precondition for construction and infrastructure development contracts bidding and approval

(b) The Memorandum of Understanding (MOU), 5th September 2001
Between
The Kingdom of Cambodia
The People’s Republic of China
The Lao People’s Democratic Republic
The Kingdom of Thailand
The Socialist Republic of Viet Nam
The Union of Myanmar

Preamble

The UNDP-organized ASEAN workshop on Population Movement and HIV Vulnerability was held in Chiang Rai from 10th to the 12th of November 1999. The 7th ASEAN Task Force on AIDS (ATFOA) meeting held in Brunei from 16-18th November 1999 agreed that HIV/AIDS policy and programme should integrate mobile workers as recommended by the Chiang Rai workshop since the population mobility, poverty, illicit drug use and the gap in economic growth among neighboring countries are factors contributing directly or indirectly to the rapid spread of HIV/AIDS in the region.

I. Background

In order to have a more specific response for each of the sub-regions in ASEAN, the 7th ATFOA meeting agreed that Viet Nam would be the coordinator for the group comprised of The Lao People’s Democratic Republic and The Socialist Republic of Viet Nam. Later at the Hanoi ATFOA Greater Mekong Subregional cluster country Joint Action Programme development workshop, 24-26 April 2000, The Kingdom of Cambodia, The People’s of Republic of China, and The Union of Myanmar were added to this cluster. The Kingdom of Thailand, in addition to its bilateral collaboration with Cambodia, continues to serve as the overall mobility theme coordinator for the ATFOA.

The 7th ATFOA requested the cluster coordinators to submit a project brief to the Chairman of ATFOA.

The parties to this Memorandum of Understanding have already concluded a number of agreements containing commitments for collaborative effort in reducing HIV vulnerability among mobile population.

II. Further Efforts

It was agreed at the Hanoi meeting, April 2000 that the governments facilitate and support further collaboration in the implementation between and among these countries the Greater Mekong Subregional Joint Action Programme on reducing HIV vulnerability among mobile populations.

In particular, it is recommended:
That the Parties to this Memorandum of Understanding agree to facilitate access and reduce obstacles to information and services for mobile populations;

That governments, where appropriate, will support and facilitate the International and National non-governmental Organizations ((I)NGOs), civil society and local authorities to collaborate with the (I) NGOs and local authorities of neighboring countries who are signatory to the Memorandum of Understanding;

That behavioural change communication, sexually transmitted infections services including counseling and condom promotion be provided to mobile populations including fisher folks, entertainment facility workers, factory workers, transport operators and construction workers from sending, transit and receiving communities;

That the Chiang Rai recommendation endorsed by the Brunei 7th ATFOA be implemented: “That ASEAN governments adopt a common policy recommending the integration of HIV prevention programmes as a precondition for construction and infrastructure development contracts bidding and approval”.

III. Extension of Memorandum of Understanding

The term of this Memorandum of Understanding is for a period of two-years starting from the date of signatures. With the mutual consent of all parties, this Memorandum of Understanding may be extended to cover other types of collaboration to reduce HIV vulnerability for mobile population in South East Asia on terms and conditions to be agreed upon. Other Governments in the region may be invited to become parties to the present Memorandum of Understanding on the said terms and conditions. Any such changes will be reflected in mutually agreed written revisions to this Memorandum of Understanding.

This Memorandum of Understanding may be revoked by mutual agreement in writing if in the judgment of the Parties, any reasonable circumstance arises which interferes with or threatens to interfere with the successful accomplishment of its purpose.

In witness whereof, the Governments sign the present Memorandum of Understanding on the dates appearing opposite their respective signatures.

The Kingdom of Cambodia

Date: ______________________________

The People’s Republic of China

Date: ______________________________

The Lao People’s Democratic Republic

Date: ______________________________

The Kingdom of Thailand

Date: ______________________________

The Socialist Republic of Viet Nam

Date: ______________________________

The Union of Myanmar

Date: ______________________________
We the Heads of State and Government of the Association of South East Asian Nations (hereinafter referred to as ASEAN):

Recalling that the ASEAN Vision 2020, adopted by the 2nd ASEAN Informal Summit held in Kuala Lumpur in December 1997, envisioned ASEAN as a concert of South East Asian nations, outward looking, living in peace, stability and prosperity, bonded together in partnership in dynamic development and in a community of caring societies;

Recalling the UN Declaration of Commitment on HIV/AIDS adopted at the 26th Special Session of the General Assembly in June 2001 that secured a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat HIV/AIDS in a comprehensive manner;

Deeply concerned that the HIV/AIDS pandemic is a threat to human security and a formidable challenge to the right to life and dignity that affects all levels of society without distinction of age, gender or race and which undermines social and economic development;

Recognising that at least 1.6 million people are living with HIV/AIDS in the ASEAN region, and that the number is increasing rapidly through risk behaviors exacerbated by economic, social, political, financial and legal obstacles as well as harmful attitudes and customary practices which also hamper awareness, education, prevention, care, support and treatment efforts, particularly to vulnerable groups;

Reiterating the call of the Hanoi Declaration adopted by the Sixth ASEAN Summit in December 1998 that we shall make sure our people are assured of adequate medical care and access to essential medicines and that cooperation shall be stepped up in the control and prevention of communicable diseases, including HIV/AIDS;

Noting the Joint Declaration for a Socially Cohesive and Caring ASEAN adopted at the 33rd ASEAN Ministerial Meeting held in Bangkok in July 2000, to strengthen people-centered policies that will promote a positive environment for the disadvantaged, including those who are in ill health;

Committed to realizing a drug-free ASEAN, as called for by the Joint Declaration for a Drug-Free ASEAN adopted by the 33rd ASEAN Ministerial Meeting held in July 2000 and the Bangkok Political Declaration in pursuit of a Drug-Free ASEAN 2015 adopted by the International Congress “In Pursuit of a Drug Free ASEAN” held in October 2000;

Encouraged by the notable progress of the ASEAN Task Force on AIDS in responding to the call by the Fourth ASEAN Summit held in Singapore in February 1992, to implement regional activities on health and HIV/AIDS aimed at curbing and monitoring the spread of HIV by exchanging information on HIV/AIDS, particularly in the formulation and implementation of joint policies and programs against the deadly disease;

Realising that prevention is the mainstay of the response to HIV infection and that there are opportunities for the ASEAN region to prevent the wide-scale spread of HIV/AIDS
by learning from the experiences of some ASEAN Member Countries, which have invested in prevention programs that have reduced HIV prevalence or maintained a low prevalence;

[11] Acknowledging that prevention, treatment, care and support for those infected and affected by HIV/AIDS are mutually reinforcing elements that must be integrated in a comprehensive approach to combat the epidemic;

[12] Stressing that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS, and that youth are especially vulnerable to the spread of the pandemic and account for over fifty percent of new infections;

[13] Affirming that a multi-sectoral response has resulted in a number of effective actions for HIV prevention, treatment, care and support and minimization of the impact of HIV/AIDS;

[14] Aware that resources commensurate with the extent of the problem have to be allocated for prevention, treatment, care and support;

[15] Emphasising that the epidemic can be prevented, halted and reversed with strong leadership, political commitment, multi-sectoral collaboration and partnerships at the national and regional levels;

Hereby declare to:

LEADERSHIP

[16] Lead and guide the national responses to the HIV/AIDS epidemic as a national priority to prevent the spread of HIV infection and reduce the impact of the epidemic by integrating HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of national development planning, including poverty eradication strategies and sectoral development plans;

[17] Promote the creation of a positive environment in confronting stigma, silence and denial; elimination of discrimination; addressing the prevention, treatment, care and support needs of those in vulnerable groups and people at risk, particularly young people and women; and strengthening the capacity of the health, education and legal systems;

[18] Intensify and strengthen multi-sectoral collaboration involving all development ministries and mobilising for full and active participation a wide range of non governmental organisations, the business sector, media, community based organisations, religious leaders, families, citizens as well as people infected and affected by HIV/AIDS in the planning, implementation and evaluation of national responses to HIV/AIDS including efforts to promote mutual self help;

[19] Intensify inter-ministerial collaboration at the national and international levels to implement HIV/AIDS programmes;
Support strongly the mobilization of technical, financial and human resources to adequately advocate for and implement national and regional programs and policies to combat HIV/AIDS, including efforts to promote mutual self-help.

REGIONAL ACTIVITIES IN SUPPORT OF NATIONAL PROGRAMMES

Continue collaboration in regional activities that support national programs particularly in the area of education and life skills training for youths; effective prevention of sexual transmission of HIV; monitoring HIV, STDs and risk behaviors; treatment, care and support for people living with and affected by HIV; prevention of mother to child transmission; creating a positive environment for prevention, treatment, care and support; HIV prevention and care for drug users and strengthening regional coordination among agencies working with youths;

JOINT REGIONAL ACTIONS

Strengthen regional mechanisms and INCREASE and OPTIMISE the utilisation of resources to support joint regional actions to increase access to affordable drugs and testing re-agents; reduce the vulnerability of mobile populations to HIV infection and provide access to information, care and treatment; adopt and promote innovative inter-sectoral collaboration to effectively reduce socioeconomic vulnerability and impact, expand prevention strategies and provide care, treatment and support;

Monitor and evaluate the activities at all levels and systematically conduct periodic reviews and information sharing with the full and active participation of non-governmental organisations, community-based organisations, people living with HIV/AIDS, vulnerable groups and caregivers;

INTERNATIONAL COLLABORATION

Urge ASEAN Dialogue Partners, the UN system organisations, donor agencies and other international organisations to support greater action and coordination, including their full participation in the development and implementation of the actions contained in this Declaration, and also to support the establishment of the Global HIV/AIDS and health fund to ensure that countries in the region would have equal opportunity to access the fund;

ASEAN WORK PROGRAMME ON HIV/AIDS

Adopt the ASEAN Work Programme on HIV/AIDS and work together towards accomplishing the regional activities in support of national programs and joint regional actions.

Adopted on this Fifth Day of November 2001 in Bandar Seri Begawan, Brunei Darussalam.
The ASEAN response on Mobility and HIV Vulnerability at the Policy Level
Social Development Unit, ASEAN Secretariat

Background

In 10-12 November, 1999, Thailand’s Ministry of Health, jointly with UNDP South East Asia HIV and Development Project (UNDP-SEAHIV), WHO Southeast Asia Regional Office, Family Health International and SEAMEO-GTZ-CHASPPAR, organized the ASEAN Workshop on Population Movement and HIV Vulnerability in Chiang Rai. Since then, the collaboration between ASEAN Task Force on AIDS (ATFOA) and UNDP-SEAHIV has strengthened through various collaborations including the Regional Summit on Pre-departure, Post-arrival and Reintegration Programme for Migrant Workers in Genting Highlands, Malaysia, 11 to 13 September 2000, to the UN Regional Task Force on Mobile Population and HIV Vulnerability, 2000-2001.

The 7th ATFOA Meeting held in November 1999, endorsed the outcomes and recommendations of the Chiang Rai consultation and appointed Malaysia as the coordinator for Brunei Darussalam, Indonesia, Malaysia, Philippines and Singapore, known as BIMPS cluster, on pre-departure, post-arrival and returnee reintegration for migrant workers; Thailand to coordinate Thailand and Cambodia, on sea-farers; and Viet Nam to coordinate Laos, Viet Nam and Myanmar on mobile populations. In April 2000, with the support of UNDP-SEAHIV, Viet Nam hosted the consultation among GMS countries (Cambodia, Myanmar, Viet Nam and Yunnan, China) and drafted a Memorandum of Understanding. Later, at the 2nd ASEAN Inter-Country Consultation Workshop to prepare for ASEAN Heads of State Summit of 2001, Cambodia was assigned to coordinate the GMS cluster countries on “Patterns and Effects of Population Movement Which Contribute to the Spread of HIV” that included Thailand and Cambodia. Indonesia expressed an interest in joining.

The signing of the MOU between Cambodia, Lao PDR, Myanmar, Thailand, Viet Nam and China took place on 5 September 2001 in Phnom Penh, organized by UNDP-SEAHIV, where a joint action framework was agreed to. The collaboration between ASEAN and UNDP-SEAHIV was further solidified at Joint Action Programme Consultation in March 2002 in Phnom Penh to operationalize the joint action framework into a programme on mobility among GMS cluster countries and China. It was agreed that a project coordinating committee (PCC) comprising the MOU signatories will be formed and will report to ATFOA and the UN Regional Taskforce on Mobility and HIV Vulnerability Reduction, 2002-2004.

The ASEAN Summit, 5th November 2001

At the 7th ASEAN Summit in Brunei Darussalam, leaders of the ten-member nations affirmed their support for a regional cooperation in response to HIV/AIDS. The ASEAN Heads of Government adopted the 7th ASEAN Summit Declaration on HIV/AIDS and a four-year ASEAN Work Programme on HIV/AIDS (2002-2005) and affirmed their commitment to work together in combating HIV/AIDS transmission in ASEAN countries. In the Declaration, leaders committed their countries to “strengthen regional mechanisms and increase and optimise the utilization of resources to support joint regional actions to reduce the vulnerability of mobile populations to HIV infection and provide access to information, care and treatment; adopt and promote innovative inter-sectoral collaboration to effectively reduce socio-economic vulnerability and impact, expand prevention strategies and provide care, treatment and support.”

Looking Forward

Similarly at the BIMPS cluster consultation on migrant workers HIV vulnerability reduction, organized by UNDP-SEAHIV and SEAMEO-CHASPPAR, 15-17 April 2002 in Manila, the Philippines, Brunei Darussalam, Indonesia, Malaysia, Philippines and Singapore agreed to submit a draft MOU of collaboration among the BIMPS Countries on the Reduction of HIV Vulnerability to their respective authorities for approval. The participants also recommended that a National Committee on Mobile Population be established in all Members Countries to supervise and monitor the work on mobile population. They further agreed to consolidate the BIMPS Joint Action Programme with that of the GMS region and develop linkages between the two clusters through the Programme Coordination Committee of ATFOA and UN Regional Task Force on mobility and HIV vulnerability reduction.
ANNEX II   MODEL CONTRACT CLAUSE

CONTRACT FOR THE PROVISION OF AN HIV AWARENESS PROGRAMME TO THE CONTRACTOR'S EMPLOYEES AND OTHERS

[UNAIDS/ other distributing organisation] has provided this model contract free of charge to the executing parties. It is the responsibility of the parties to ensure the model contract is appropriate to their needs and to amend the model contract as they see fit and to seek independent legal advice as necessary. [UNAIDS/ other distributing organisation] accepts no liability for any loss howsoever arising in relation to the use of this model contract.

THIS CONTRACT is made on the [   ] day of [   ] 20[   ]

BETWEEN:
(1) […………………………….] ("the Contractor"); and
(2) […………………………….] ("the Approved Service Provider").

WHEREAS:
A. the Contractor has established or intends to establish a construction site in [location] ("the Site") in connection with a contract between the [Employer/Client] and the Contractor ("the Construction Contract");

B. the establishment of construction sites is associated with the increased risk of the transfer of the HIV virus between and among construction workers and the local community;

C. the Contractor has undertaken in the Construction Contract to take certain measures to raise awareness amongst the construction workers at the Site and the local community of the risk of infection with the HIV virus; and

D. the Approved Service Provider has agreed to provide certain HIV awareness-raising activities and services.

IT IS HEREBY AGREED as follows:

1. In this Contract:

"Approved Service Provider" means the organisation named above, provided it has been approved by the National HIV/AIDS Authority for the country in which the Site is located;

"Contractor's Employees" means all workers under the control of the Contractor or any of its sub-contractors (other than the Approved Service Provider) who are at times on the Site in connection with the Construction Contract;
"HIV Awareness Programme" means an HIV awareness programme as provided in the project documentation or in accordance with UNAIDS guidelines available on its website www.hiv-development.org or on request;

"Local Community" means the communities local to the Site which are most likely to have contact with the Contractor’s Employees and, in particular, sex workers in those communities;

“National HIV/AIDS Authority” means the authority in the country where the Site is located designated by the relevant national government to have responsibility for preventing and/or combating HIV/AIDS; and


2. The Approved Service Provider will begin providing the HIV Awareness Programme in accordance with the project documentation or UN guidelines to the Contractor's Employees and the Local Community as soon as possible after signing this Contract but, in any case, within 2 weeks after the Contractor's Employees arrive at the Site.

3. The Contractor will give the Approved Service Provider all reasonable access to the Site for the purpose of providing the HIV Awareness Programme.

4. The Contractor must make sure the Contractor's Employees are available to attend the HIV Awareness Programme at the times reasonably arranged by the Approved Service Provider (in consultation with the Contractor).

5. The Contractor must do nothing to dissuade the Contractor’s Employees from attending the HIV Awareness Programme.

6. In exchange for the provision of the HIV Awareness Programme, the Contractor will pay the Approved Service Provider (exclusive of VAT or any equivalent tax) [fixed fee] [currency] for the initial phase and [fixed fee] [currency] for each follow-up phase of the HIV Awareness Programme.

7. When the Approved Service Provider completes the provision of a phase of the HIV Awareness Programme, it will promptly give the Contractor an invoice. The Contractor will pay the Approved Service Provider the amount invoiced no later than 30 days after receiving the invoice.

8. This Contract and all matters arising from or connected with it shall be governed by the law of and subject to the jurisdiction of the courts of the country in which the Site is located [or, if more than one Site, the Site where the Approved Service Provider predominantly provided the HIV Awareness Programme].

IN WITNESS WHEREOF the Contractor and the Approved Service Provider have entered into this Contract as of the day and year first above written:
HIV Clause for Inclusion in all Contracts

1.1 For the purpose of this Clause:

“an Approved Service Provider” means a person or entity approved by the National HIV/AIDS Authority to provide the HIV Awareness Programme;

“the Contractor’s Employees” means, without prejudice to any other definition contained in the Contract, all workers who are under the Contractor’s control and on the Site in connection with the Contract, including any workers who are under the control of any person or entity to whom the Contractor has sub-contracted any of its obligations under the Contract other than those responsibilities set out in this Clause;

“the HIV Awareness Programme” means an HIV awareness programme [as set out in the Project documentation/in compliance with the HIV Awareness Programme curriculum and guidelines published by UNAIDS and available on its website www.hiv-development.org or on request];

“the Local Community” means the communities local to the Site most likely to have contact with the Contractor’s Employees and, in particular, sex workers in those communities;

“National AIDS Authority” shall mean the authority in the country where the Site is located designated by the relevant national government to have responsibility for preventing and/or combating HIV/AIDS;

“UNAIDS” shall mean [the agency of the United Nations of that name or the United Nations Regional Task Force on mobile population and HIV vulnerability].

1.2 It shall be a Condition of the Contract that the Contractor:

- sub-contracts with an Approved Service Provider to provide an HIV Awareness Programme to the Contractor’s Employees and the Local Community as soon as practicable after the Contractor’s Employees arrive at the Site but in any case within two weeks after the Contractor’s Employees arrive at the Site;

- gives any representative of the Approved Service Provider, the Employer and the National HIV/AIDS Authority all reasonable access to the Site in connection with the HIV Awareness Programme;
1.2.3 if the National Aids Authority has not provided the names of available Approved Service Providers within two weeks after being asked the contractor may select its own service provider after consultations with the appropriate UNAIDS office;

1.2.4 instructs the Contractor’s Employees to attend the HIV Awareness Programme in the course of their employment and during their normal working hours or any period of overtime provided for in the relevant employment contracts and uses all reasonable endeavours to ensure this instruction is followed;

1.2.5 provides suitable space for delivery of the HIV Awareness Programme and does nothing to dissuade the Contractor’s Employees from attending the HIV Awareness Programme;

1.2.6 as soon as practicable, notifies the National HIV/AIDS Authority of its sub-contract with an Approved Service Provider to facilitate the National HIV/AIDS Authority’s audit of Approved Service Providers; and

1.2.7 gives all reasonable co-operation to the National HIV/AIDS Authority if it exercises its right to audit the provision by the Approved Service Provider of the HIV Awareness Programme.

1.3 The Contractor shall be entitled to be reimbursed by the Employer for any payments made under a sub-contract made for the purpose of Clause [1.2.1] in accordance with the relevant provisions in the Contract.

1.4 Where the Contract does not provide for reimbursement of named costs, the amount paid by the Contractor to the Approved Service Provider shall be added to any lump sum to be paid by the Employer to the Contractor under the Contract and, before such lump sum is paid, the Contractor shall provide to the Employer evidence of:

1.4.1 payment of the amount claimed to the Approved Service Provider; and

1.4.2 provision of the HIV Awareness Programme (e.g. a certificate issued by the Approved Service Provider).

1.5 Where a clinic is provided on behalf of the Contractor on Site, the Contractor shall ensure that such clinic provides to the Contractor’s Employees, on request and without charge:

1.5.1 counseling and advice on AIDS in compliance with UNAIDS guidelines; and

1.5.2 condoms that comply with either the current ISO standard or WHO/UNAIDS Specification and Guidelines for Condoms 1998 or any more recent equivalent publication to a maximum of [number] per member of the Contractor's Employees per year on a [weekly/monthly] basis.

1.6 Where the Contractor sub-contracts any of its obligations under the Contract, it shall require any sub-contractor to comply with sub-clauses [1.2.2 to 1.2.6] of the Contract as if it were the Contractor.
ANNEX III  JOINT ACTION PROGRAMME FOR MOBILITY AND HIV VULNERABILITY REDUCTION  2002-2005

a) Greater Mekong Sub-region Joint Action Programme

*Joint Action between the GMS countries of ASEAN, and Yunnan and Guangxi Provinces of the People’s Republic of China*

The Joint Action Programme outlines how the countries of the GMS will achieve objectives of the ASEAN Work Programme on HIV/AIDS II, 2001-2004. These objectives are:

a. to build resilient and empowered communities by improving their choices in reducing HIV/AIDS vulnerability caused by development related mobility;
b. to enhance national responses to reduce HIV/AIDS vulnerability by improving systems of governance on development-related mobility; and
c. to build collaborative regional responses to reduce HIV/AIDS vulnerability from development-related mobility while developing methods to build community, national and regional HIV/AIDS resilience and document these methods as a knowledge base for dissemination.

**Development strategies**

- Establish mechanisms and capacity for early warning and rapid response systems, including advocacy, research and surveillance, that identify and disseminate information about the development factors that affect mobility-related HIV vulnerability.

- Enhance community resilience by preparing communities to understand, anticipate and adjust to development factors that contribute to HIV vulnerability resulting from mobility. Special attention should be given to specific geographical areas which are regional epicentres.

- Identify and utilize links between areas, sectors, institutions, communities, families and individuals involved in migration systems to reduce HIV vulnerability. For example, building links between mobile and stable communities, or building partnerships between the agriculture and transport sectors.

**Enabling policies**

- Disseminate and advocate for the adoption and implementation of the MOU at various levels and among relevant sectors.

- Advocate, promote and facilitate multi-sectoral cooperation, both at the intra and inter-country level, relevant to HIV and mobility issues.

- Raise awareness and support among policy makers for supportive policies relating to HIV vulnerability reduction for mobile populations.
Prevention and care activities

- Collaborate to develop and implement HIV prevention and care programmes within communities at source, transit, destination and cross-border locations.

- Identify methods and support for the scaling up of successful prevention and care activities.

- Support and advocate for pilot testing, and disseminate regionally the results of, innovative prevention and care activities.
### b) BIMPS Joint Action Programme

**Joint Action Programme Framework**

<table>
<thead>
<tr>
<th>AREAS</th>
<th>OUTCOMES</th>
<th>STRATEGIES</th>
<th>ACTIVITIES</th>
<th>LEAD/ FOCAL PERSON/ ENTITY</th>
<th>TIME FRAME</th>
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<tbody>
<tr>
<td>Policies</td>
<td>1. All BIMPS countries Implementing pre-employment and pre-departure programmes for all departing nationals (e.g. migrant workers, diplomats, military, etc.) complimentary to and in harmony with post arrival programs</td>
<td>1. Consultation and consensus building/ meetings with relevant institutions (e.g. Ministry of Foreign Affairs, Human Resource, Defense, Labor, Health, GOs and NGOs, etc.)</td>
<td>1. Convene ad-hoc national committee</td>
<td>ATFOA Focal person</td>
<td>May-September 2002</td>
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<td></td>
<td></td>
<td>2. Advocacy for approval by appropriate government institutions utilizing platforms such as BIMPS, ATFOA, ASEAN, etc.</td>
<td>2. Conduct national consultation/ consensus building meeting with relevant agencies</td>
<td>National Coordinating Committee on Mobility and HIV</td>
<td></td>
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<td></td>
<td></td>
<td>3. Monitoring of policy implementation</td>
<td>3. Draft TOR of National Coordinating Committee on Mobility and HIV Vulnerability Reduction</td>
<td></td>
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<td></td>
<td></td>
<td>4. Joint accreditation of testing centers by sending and receiving countries</td>
<td>4. Gather information/list of government, non-government agencies, working in relation to the migrant/mobile population and submit to UNDP for a regional profile</td>
<td>PCC</td>
<td>September 2002</td>
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<tr>
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<td>5. Joint development of testing protocols</td>
<td>5. Submit progress report to ATFOA</td>
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<td></td>
<td>6. Consultation among BIMPS countries</td>
<td>6. Convene a National Coordinating Committee on Mobility and HIV Vulnerability Reduction (multi-sectoral; receiving countries may include representatives of sending countries and vice-versa)</td>
<td></td>
<td>October 2002-October 2003</td>
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<td></td>
<td></td>
<td></td>
<td>7. Draft, policies, technical papers re: issues related to mobile population (e.g. medical regulations, testing, etc.)</td>
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</table>
by sending and receiving countries

5. All HIV testing in both sending and receiving countries should be accompanied by pre and post test counseling

6. A standard protocol agreed upon by both sending and receiving countries on issues of deportation/repatriation of undocumented and HIV+ migrant workers is utilized (should include disclosure of reason/s for deportation)

8. Advocate and lobby for approval of the policies, MOU

9. Coordinate and monitor the implementation of the policies at national and regional levels (upon approval of the policies/MOU)

10. Conduct regular coordinating meetings at BIMPS/ATFOA and specific ASEAN Ministerial meetings (Labor, Health, Foreign Affairs), to include period Review/assessment of policies

11. Work out commonly agreed upon procedures with regards to on site testing
   - pre & post test counseling
   - disclosure (info exchange)

12. Identify counterpart entities where regular exchange of info regarding HIV testing is undertaken

13. Build capacity of welfare officers to undertake pre-integration counseling

14. Documentation of existing practices with regards to repatriation of HIV+ returnees

15. Development of standard protocol

16. Pilot testing of standard protocol

17. Review and revision of protocol based on results of pilot test

Continuing
<table>
<thead>
<tr>
<th>Services</th>
<th>1. Pre-employment and pre-departure programs include preventive education, economic planning (remittances), rules and regulations of receiving countries and other relevant topics</th>
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<tbody>
<tr>
<td></td>
<td>2. Migrant workers have access to health facilities and other services in host/receiving countries</td>
</tr>
<tr>
<td></td>
<td>3. HIV+ returnees are provided with services that address treatment, care and support needs</td>
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<tr>
<td></td>
<td>4. Economic reintegration is part of services available to migrant workers</td>
</tr>
<tr>
<td></td>
<td>5. Referral system for psychosocial/ emotional and other kinds of support are available for migrant workers</td>
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</table>

<table>
<thead>
<tr>
<th>Development and production of IEC materials by a multi-sectoral group including PLWHAs</th>
<th>1. Collect and review existing relevant IEC materials nationally and regionally</th>
</tr>
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<tbody>
<tr>
<td>Identification of appropriate implementing agencies who can deliver pre-employment and pre-departure programmes</td>
<td>2. Develop and produce appropriate IEC materials for pre-departure, post-arrival and reintegration programmes (post ATFOA 2002)</td>
</tr>
<tr>
<td>Information dissemination through the use of different channels of communication</td>
<td>3. Pilot the implementation of IEC materials</td>
</tr>
<tr>
<td>Advocacy</td>
<td>4. Develop information kits for departing workers on receiving countries (post ATFOA 2002)</td>
</tr>
<tr>
<td>Monitoring implementation of programmes</td>
<td>5. The multi-sectoral committee to identify the relevant partners/ agencies nationally for implementation</td>
</tr>
<tr>
<td>Involvement of families, communities and PLWHAs</td>
<td>6. Training of trainers on the necessary competencies on pre-departure and post-arrival programmes in sending and receiving countries</td>
</tr>
<tr>
<td>Community organizing</td>
<td>7. Conduct seminar/ workshops on pre-departure, post-arrival and reintegration programmes for employers/ recruiting agencies (June-Aug 2003)</td>
</tr>
<tr>
<td>School-based approach</td>
<td>8. Encourage use of alternative therapy (e.g. traditional, herbal, etc.)</td>
</tr>
<tr>
<td>Linkages with institutions re; Pension plans and sickness benefits</td>
<td>9. Capacity building of health professionals providing services to HIV/AIDS cases especially in local levels</td>
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<td>10. Integration of HIV/AIDS in the school curriculum</td>
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<tr>
<td>Information Exchange</td>
<td>1. Sending countries regularly updated by receiving countries on policies, rules and regulations and other issues related to migrant workers (e.g. testing centers, etc.)&lt;br&gt;2. Complete and transparent regional data relevant to migrant workers available to all BIMPS countries</td>
</tr>
</tbody>
</table>
ANNEX IV  FRAMEWORKS
a) Sector and mobility interventions in a general framework for HIV/AIDS responses
Developed by: Jacques du Guerny and Lee-Nah Hsu, May 2000
b) Framework for agriculture and HIV/AIDS

*The model: sequence of points of intervention*

<table>
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<tr>
<th>Development Framework</th>
<th>Health Framework</th>
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<tr>
<td>1. Factors or events</td>
<td>2. Impact on</td>
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<td>3. Impacts on</td>
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<td>vulnerabilities</td>
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<td>of systems</td>
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<tr>
<td>Agricultural</td>
<td>4. Impact on</td>
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<tr>
<td>Policies and</td>
<td>vulnerabilities</td>
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<td>Programmes,</td>
<td>of individuals</td>
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<tr>
<td>Natural events</td>
<td>5. Impacts on</td>
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<td>(drought, flood)</td>
<td>risk behaviour</td>
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<td>Socio-economic,</td>
<td>6. Responses</td>
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<td>Political, etc. 1.</td>
<td>7. Level of</td>
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<td>response</td>
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<tr>
<td>Farming System Farm-</td>
<td>Increases Risk</td>
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<td>Household System</td>
<td>Or</td>
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<td>Decreases Risk</td>
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<td>(no infection)</td>
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<td></td>
<td>Care Mitigation</td>
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<td></td>
<td>Individual</td>
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<td>Family Community</td>
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## Publications

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| January 2000 | Cambodia HIV Vulnerability Mapping: Highway One and Five*  
http://www.hiv-development.org/publications/cambodia_mapping.asp | 974-680167-8 |
| February 2000 | Population Mobility and HIV Vulnerability in South East Asia: An Assessment and Analysis*  
Author: Ronald Skeldon  
http://www.hiv-development.org/publications/sea_publications_papers.asp  
Language: English, Vietnamese, Lao | 974-858351-1 |
| March 2000 | Governance and HIV/AIDS*  
Author: Lee-Nah Hsu  
Language: English, Burmese, Chinese, Khmer, Lao, Thai, Vietnamese | 974-680171-6 |
| March 2000 | HIV Vulnerability and Population Mobility in the Northern Provinces of the Lao People’s Democratic Republic*  
Author: James R. Chamberlain  
Language: English, Lao | 974-859138-7 |
| April 2000 | Population Mobility in Asia: Implications for HIV/AIDS Action Programme*  
http://www.hiv-development.org/publications/mobility_action_programmes.asp | 974-858353-8 |
| April 2000 | Population Movement, Development and HIV/AIDS: Looking Towards the Future*  
Authors: Lee-Nah Hsu and Jacques du Guerny  
http://www.hiv-development.org/publications/mobility_action_programmes.asp | From pps. 1-7 of publication:  
ISBN: 974-858353-8 |
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<td>April 2002</td>
<td>The Potential Costs and Benefits of Responding to the Mobility Aspect of the HIV Epidemic in South East Asia: A conceptual framework</td>
<td></td>
<td></td>
<td>974-680-206-2</td>
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*Please note that publications indicated as * are no longer available as hard copies, however, they can be downloaded from our web site: www.hiv-development.org.*
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UNDP South East Asia HIV and Development Programme, United Nations Building, Rajdamnern Nok Ave, Bangkok 10200, Thailand

Development is the process of enlarging peoples' choices to live long and healthy lives, to have access to knowledge, and to have access to income and assets: to enjoy a decent standard of living.