

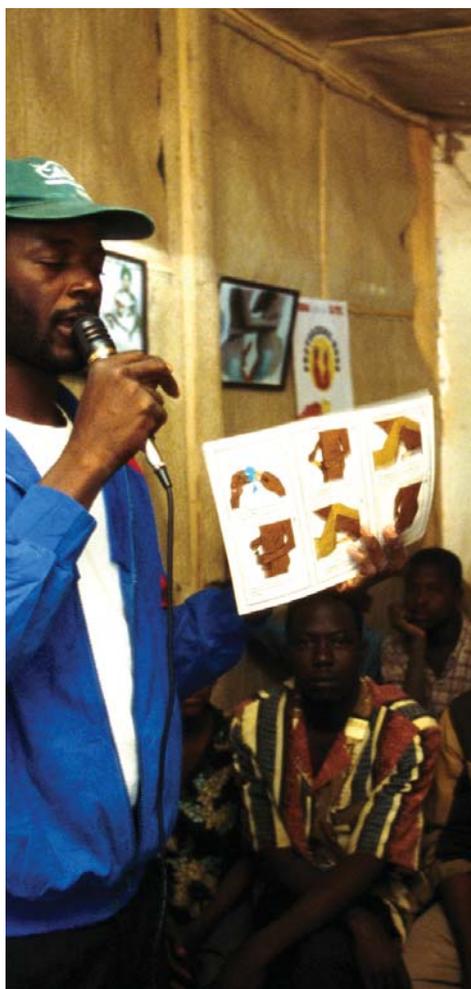


AIDS briefing paper:

Preventing the Spread of HIV/AIDS Among Mobile Populations

a regional programmatically approach

LifeLink West Africa



Malians on the move

"I began by doing manual labor on plantations in Côte d'Ivoire. Then I apprenticed as a driver. Today I'm a professional driver. I earn a living. I send money to my family in the village. Migration has changed my life. But I prefer to stay here in my country; I no longer want to return to Côte d'Ivoire."

"We like to dance in our bare feet..." – no condoms.

mobility in West Africa is characterized by internal and cross-border movement, with rural residents, youth in particular, attracted to urban areas and agro-industrial complexes as they search for employment and a better quality of life. "Sending zones" sit primarily in the drought-prone Sahel – a region of low HIV prevalence – while "receiving zones" about the Gulf of Guinea and feature comparatively higher HIV prevalence. Predictably, HIV is diffusing across the region from high prevalence to low prevalence areas. How? Alone on the road, physically separated from their regular sex partners, highly mobile people are at increased risk for HIV due to their vulnerability, livelihood insecurity and sexual contact with high-risk groups. Sedentary populations in the sending zone, often women awaiting their husband's return, may unknowingly adopt or be forced to adopt high-risk sexual behavior during their partners' absence –

"Bread and butter issues linked to day-to-day survival are more pressing for the majority of people, and being HIV positive is for some just another burden in an endless struggle for survival."

Ainsworth, Over et al, World Bank, 1998

and thus are exposed to sexually transmitted infections like HIV. Otherwise, populations living in low prevalence zones become exposed to HIV when their infected sexual partners return home. In light of the dynamics of mobility, HIV prevention in West Africa must be addressed aggressively, with an integrated program of interventions that treat the issue systemically (i.e., implemented in both sending and receiving zones), focusing on both those who travel and those who remain behind, addressing risk related not only to HIV/AIDS but to mobility itself. Welcome to CARE's LifeLink Program! ■

2001: HIV/AIDS Profile of West Africa

4.8 million people living with HIV/AIDS;

462,800 AIDS-related deaths in 2001;

2.7 million children orphaned since the epidemic's inception.

UNAIDS/West and Central Africa, Oct/Dec 2001

Mali's HIV seroprevalence rate is 2.03 percent, among the lowest in West Africa. Problematic in containing further spread of the disease is seasonal migration to Côte d'Ivoire, which has the region's highest HIV seroprevalence. Malians are the second largest group of foreign residents in Côte d'Ivoire, numbering more than 790,000. Not surprisingly, rural people in Mali refer to AIDS as "Ivorian malaria."

field research notes:

financial vulnerability among mobile malians

Through its LifeLink Program, CARE seeks to reduce risk related to mobility and HIV/AIDS. To better understand the dynamics of financial vulnerability, CARE invited a Fulbright Fellow, Matthew Reisman, to explore socioeconomic vulnerability among Malians living in Koro, a well-known sending zone in southeastern Mali, and in a receiving-zone community of Abidjan, Côte d'Ivoire's largest city.

In a study conducted in July and October-November 2001, 107 Malian men and women discussed their livelihoods as seasonal migrants, immigrants, commercial sex workers and cross-border traders. Individual questionnaires were administered in French and/or the local language and explored participants' mobility, education, wealth, income and financial risk-management practices.

an overview of findings

Despite recent political turmoil, Abidjan remains an important destination for Malians of all mobility categories. Secondary destinations include Ouagadougou and Bobo-Dioulasso in Burkina Faso, and plantation zones of southern Côte d'Ivoire.

Less than half of participants were lit-

erate in any language. Participants in Abidjan were more often literate than were participants in Koro. They were predominantly male and usually cross-border traders, rather than members of other mobility categories.

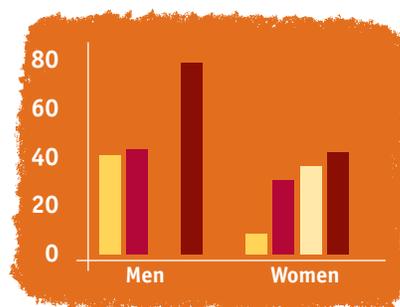
Among both men and women, the majority reported that their incomes had decreased in the past year compared to the previous year. Male participants possessed greater material wealth than female participants.

Men were more likely than women to report covering household expenditures without assistance from other persons, claimed greater numbers of dependents, and more often sent money and goods to persons in their countries of origin. However, 40 percent of women shouldered their households' food expenditures independently. The majority of women reported independently covering health care expenses, and three-quarters sent money or goods to people at home.

In sending remittances, almost all men and women used insecure means, either carrying money or sending it with acquaintances. Thus, participants exposed themselves to the risk of financial loss through theft or extortion -- both of which are frequent on the roads between Abidjan and Mali.

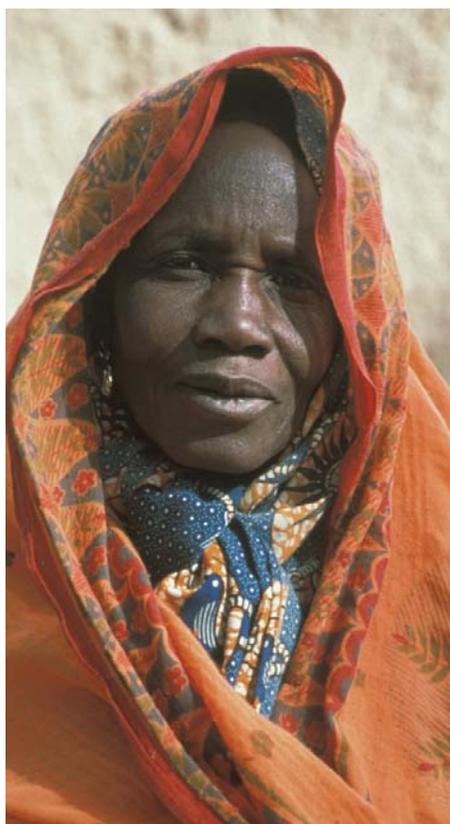
Chart 1: Literacy Among Study Participants by Mobility Category

percent literate

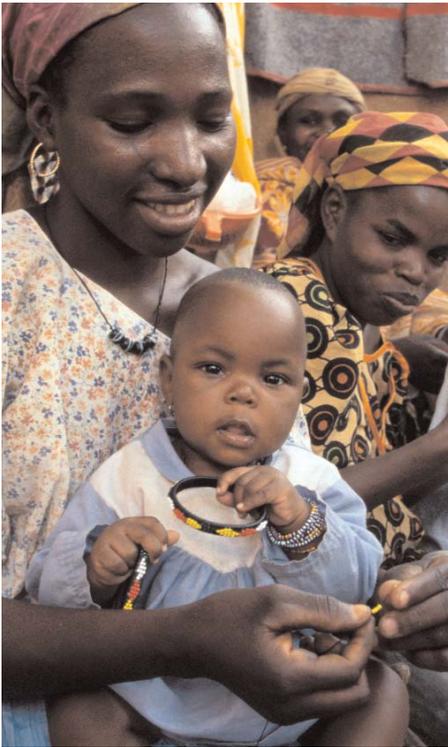


More than 60 percent of male participants and more than 80 percent of female participants regularly saved money. However, the vast majority kept their savings in their homes or with friends. Participants ran the risk of loss due to fire and theft.

Insecurity and economic difficulties experienced in 2000–2001 prompted many Abidjan-based Malians, particularly men, to consider returning to Mali. Yet migration is viewed as essential to securing livelihoods; study participants concluded that in Mali, there was no viable way to meet their families' basic needs. ■



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at home in niger: fear, stress and stigma

“Our partners can’t hold still. As soon as they leave for Côte d’Ivoire, they are sexually promiscuous...”

“A woman whose husband has died while in Côte d’Ivoire, or after a trip to Côte d’Ivoire, is likely to spend the rest of her life without ever remarrying.”

Experts estimate Niger’s national HIV seroprevalence rate to be 5.9 percent. The majority of AIDS cases are recorded in Tahoua Region – Niger’s principal migrant-producing zone that has established satellite communities in Abidjan.

CARE’s program of HIV/AIDS interventions in Tahoua has evolved over time, from health education and condom distribution through the 1990s to public debate and local action to confront the realities of today’s epidemic. ■

Beyond the 5 percent threshold:

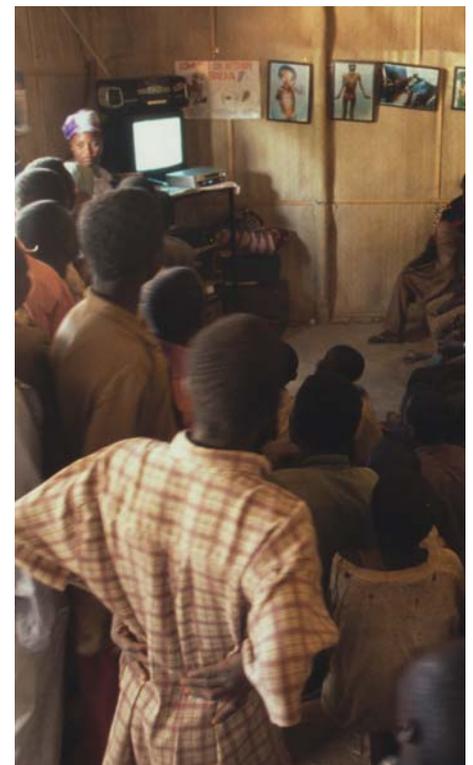
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|-------------------------|----------------------|
| Côte d’Ivoire : 10.76 % | Liberia : 8.2 % |
| Burkina Faso : 7.17 % | Sierra Leone : 6.0 % |
| Nigeria : 5.06 % | Niger* : 5.9 % |

UNAIDS/West and Central Africa, Oct/Dec 2001 * Estimate, 1999

migrant communities face tough new issues:

In the not-too-recent past, HIV/AIDS was not publicly discussed in mixed company in villages such as Zongon Naroua, Kachefewa and Bagga. Today, these communities are reeling from the effects of HIV/AIDS – imported, as it were, along with soap and plasticware, from the coast. Women raise their concerns about infidelity and the risk of infection in front of men, and young people – eyes downcast – ask frank questions in front of their elders. Although most will not say that they know someone with AIDS, they’ve heard of a case of AIDS in the “village down the road.”

AIDS is, however, a real-enough threat that communities are taking it seriously. Now as brides await their fiancés’ imminent return from Abidjan, fathers in Kachefewa openly discuss the need to test the betrothed for HIV. Traditional leaders in Badaguichéri insist that, once a month, sex workers get tested for STIs at the local clinic. Widowers rethink remarriage, and young men complain bitterly about lack of access to condoms. Potentially destabilizing, these are painful but necessary debates. To a village, community leaders have reiterated their commitment to sustain the dialogue and to act. Their one request: moral support.



forced displacement: Commercial sex workers (CSWs) fleeing Shariah law in Nigeria recently took refuge in Nigerien villages just across the border. In addition to psychological stress associated with displacement, these women were vulnerable to scorn, harassment from authorities, and abusive treatment by clients. In an effort to reduce transmission of HIV and other sexually transmitted infections, CARE has launched a peer-education scheme to reinforce knowledge and practice of safe sex. Through the project, condoms have been more readily available to CSWs and their clients. Yet financial necessity often compromises a CSW’s resolve to insist upon condom use. CARE has been working to develop micro-finance activities for women in this situation, to reduce their vulnerability – to give them real options when it comes time to enforce the **no condom, no sex** rule! ■

in the receiving zone: participatory and rights-based

The Story of Monsieur

Bigboss: *Plentysville is long on vice and short on sympathy. M. Bigboss owns a tenement where he lodges newcomers who stumble into his neighborhood: shoeshine boys, houseboys, maids, migrants and drifters alike. He takes them all in, extracting room rent without fail at the end of each month – either in cash or in kind. Ever entrepreneurial, M. Bigboss has reserved a special block of rooms at the back of his porn theater for women who wander into his lair. M. Bigboss is a frequent, non-paying guest ...*

In Abidjan, CARE is experimenting with interactive theater to communicate with youth about sexually transmitted infections (STIs), HIV/AIDS, rights and responsibilities. Bigboss refuses to use a condom with a woman who is newly arrived in his tenement building. The ensuing discussion focuses on reinforcing information on safe sex but also explores power relations and the need to respect the rights of an individual to sexual health. Further, the group begins discussing the community's role in ensuring that rights are valued and respected. ■

LifeLink, next phase

CARE is securing additional funds to expand its LifeLink program to new countries in West Africa and to add a new transport sector. The next phase, which begins in July 2002, will include program activity in Senegal and Burkina Faso and focus on the regional railway network. CARE also is seeking funds to implement LifeLink programming across Ghana, Togo and Benin in the Gulf of Guinea region, and will explore programming options addressing internal migration and HIV/AIDS in Mali.

Project BAOBAB: Abidjan, a city of more than 3 million residents, remains the principal transiting and receiving zone in West Africa. The Ivorian Ministry for the Fight against AIDS estimates that 15 out of every 100 people residing in Abidjan are HIV-positive, compared to 11 out of 100 nationwide. Characterized by crowded, unhygienic conditions and deep poverty, Abidjan's quartiers populaires are fertile grounds for the diffusion of HIV. Here, CARE is collaborating with municipal authorities, traditional leaders and youth associations to develop community-tailored action plans to fight the AIDS epidemic. In the intervention zones, youth support groups trained by CARE are preparing participatory community assessments – mapping resources and “hot spots” in their neighborhood, defining primary and secondary causes of high-risk sexual behavior among peers, identifying rights abuses, gaps in service delivery – and subsequently prioritizing steps for local action. As part of our intervention, CARE will assist community health centers to create youth-and-migrant-friendly services, upgrade STI diagnosis and treatment and make referrals to accredited centers for voluntary counseling and testing. Other agencies are strengthening care and support programs in the same areas.

As LifeLink's “receiving zone” component, Project BAOBAB targets areas that are densely populated with migrants and other mobile people, such as Bromakoté, a location particularly favored by immigrants from Niger's Tahoua Region. CARE's strategy is inclusive, however: All residents are project clients, regardless of ethnicity or mobility profile. ■

CARE International is one of the world's largest private humanitarian organizations, committed to helping families in poor communities achieve lasting victories over poverty. A confederation of 12 separate member organizations, CARE International reaches tens of millions of people each year in more than 60 countries in Africa, Asia, Europe and Latin America. Together, CARE International members not only collaborate on poverty-fighting projects, they also work together on advocacy, communications, fund-raising and building relationships with governments and other organizations. CARE International is coordinated by a secretariat in Brussels.

CARE's key strengths for responding to the HIV/AIDS crisis are its geographic coverage, multi-sectoral expertise, and experience in strengthening the capacity of community-based organizations. Our experience in HIV/AIDS programming started in 1987 and has shown that effective responses can be mounted at the community, national and international levels. Beginning with one HIV/AIDS project in 1987, CARE's portfolio now includes more than 50 projects with HIV/AIDS components. ■

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