MOBILITY MIGRATION AND HIV VULNERABILITY OF POPULATIONS ALONG THE PORTS OF THE RED SEA AND GULF OF ADEN

Situation and Response Analysis
Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden

Situation and Response Analysis
This report provides a comprehensive update on the regional initiative addressing Mobility, Migration, and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden.

The initiative is implemented through the collaborative efforts of the UNAIDS Regional Support Team for the Middle East and North Africa; UNDP’s HIV/AIDS Regional Programme in the Arab States (HARPAS); the Inter-Governmental Authority on Development (IGAD); and the International Organization for Migration (IOM).

This initiative is based on commitments made in several high-level meetings involving the countries of the Horn of Africa, where Djibouti has played a prominent role. Advocacy efforts that have been undertaken over the last decade, culminated in September 2010, in the “Djibouti Declaration of Commitment and Call for Action,” which called for universal access to HIV services for mobile people, migrants and other marginalized groups residing in, or passing through, the ports of the Red Sea and the Gulf of Aden.

To support continued momentum under the regional initiative, we decided to produce a report providing a comprehensive and updated picture on the situation. The report focuses on the latest evidence, achievements, and also includes experiences from regions outside of the Red Sea and Gulf of Aden as they provide important lessons for programme directions.

The complex layers of vulnerability experienced by such cross-border mobile populations require highly-targeted responses, especially in these resource-scarce times that we witness in the development field.

We hope that partners concerned with this specific target population will find in the conclusions of this report, which are informed by evidence from across Africa, and the recommendations it makes, insightful cues that can guide and support their continued and future programming.

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Abreviations

AIDS Acquired Immune Deficiency Syndrome
ART Antiretroviral Therapy
ATGWU Amalgamated Transporters and Genderal Workers’ Union
BCC Behavioural Change Communication
BSS Behavioural Surveillance Survey
ECOWAS Economic Community of West African States
FSW Female Sex Workers
GBV Gender-based Violence
GNI Gross National Income
HCT HIV Counselling and Testing
HDI Human Development Index
HIV Human Immunodeficiency Virus
IEC Information Education Communication
IDP Internally Displaced People
IDU Intravenous Drug Users
IGAD Intergovernmental Authority on Development
IOM International Organization for Migration
IRAPP IGAD Regional HIV/AIDS Partnership Programme
MENA Middle East and North Africa
MDG Millennium Development Goal
MSM Men who have sex with men
NGO Non-governmental Organization
PEP Post-exposure Prophylaxis
PFO Project Facilitation Office
PMTCT Prevention of Mother-to-Child Transmission
PPP Public-private partnership
ROADS Regional Outreach Addressing AIDS through Development Strategies
STI Sexually Transmitted Infection
TB Tuberculosis
UNAIDS Joint United Nations Programme on HIV/AIDS
UNDP United Nations Development Programme
UNGASS United Nations General Assembly Special Session on HIV/AIDS
UNHCR United Nations High Commissioner for Refugees
UNOCHA United Nations Office for the Coordination of Humanitarian Affairs
VCT Voluntary Counselling and Testing
WHO World Health Organization
The relationship between HIV and mobility is widely recognized. While mobility and migration are not risk factors for HIV by themselves, the often harsh, unsafe and isolated conditions surrounding the mobility process can give rise to behaviours strongly associated with increased vulnerability to HIV, while also posing barriers to access to HIV prevention, treatment and care. Recent research has explored these dynamics in the Red Sea ports and adjacent transport corridors and found that cross-border mobile populations interact in spaces shaped by high HIV vulnerability throughout the Horn of Africa and Arab Peninsula. This reality has the potential to drive the propagation of the epidemic in the region, and undermine efforts made towards universal access and the achievement of the Millennium Development Goals.

In 2004, the Joint United Nations Programme on HIV/AIDS, Regional Support Team for the Middle East and North Africa (UNAIDS RST MENA) initiated discussions on the risks and vulnerabilities linked to HIV in the context of cross-border migration and mobility in the Horn of Africa. Since then, UNAIDS has worked closely with its counterparts at the International Organization for Migration (IOM) and the United Nations Development Programme (UNDP) to advance the issue through a series of high level conferences involving stakeholders from around the region. This work has been carried out in partnership with the Intergovernmental Authority on Development (IGAD), which has worked to address challenges related to HIV among cross-border mobile populations through its Regional HIV/AIDS Partnership Programme (IRAPP) since 2007.

In 2008, these discussions led UNAIDS and the Republic of Djibouti to suggest the development of another regional initiative that would establish a response at the level of the Red Sea Ports, which function as important crossroads for migration. The present initiative, entitled Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden, is based on the commitments laid out in the 2010 Dubai Consensus, which called for accelerated action towards universal access in MENA and the 2010 Conference in Djibouti on ports, mobility, migration and HIV vulnerability, and compliments the work being carried out by IRAPP in the Horn of Africa. It’s overall objective is to contribute to universal access for the mobile people, migrants and other marginalized groups residing in or passing through the ports of the Red Sea and the Gulf of Aden.

The current report builds directly on the 2010 UNAIDS report, Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and the Gulf of Aden:
Synthesis, desk review and exploratory studies report, to provide a literature review and updated situational analysis of the HIV vulnerability factors experienced by key populations in Djibouti, Egypt, Eritrea, Ethiopia, Somalia, Sudan and Yemen\(^1\), to present a response analysis for activities completed under this initiative in 2011, and to consider lessons from programming experiences outside of the region. A large body of materials produced by UNAIDS, IOM, UNDP and IGAD, were collected and analysed towards these goals, including program reports, strategic documents, presentations, regional studies, national mappings, rapid assessments and field consultations carried out in high traffic locations in these countries. The results were presented at the 2011 Qatar Symposium on the Family, the Millennium Development Goals and AIDS in the Middle East Region, held in Doha, Qatar 1-2 November 2011. The following provides a summary of the report’s key findings, conclusions and recommendations.

Two hundred and fourteen million people lived outside of their countries of origin in 2010: 19 million in Africa and 26.6 million in the Middle East, one of the fastest growing migrant regions in the world.\(^2\) The Red Sea and Gulf of Aden region, which includes Djibouti, Egypt, Eritrea, Ethiopia, Jordan, Saudi Arabia, Somalia, Sudan and Yemen, includes those migrating for economic, livelihood and lifestyle reasons, and those migrating to escape conflict and natural disaster. In every case, mobility is on the rise, with growing numbers of people moving across borders throughout the Horn of Africa or across the Red Sea and Gulf of Aden to the Arab Peninsula.

At the same time, more than 1.2 million people are living with HIV in the countries bordering the Red Sea and Gulf of Aden.\(^3\) National HIV prevalence is wide ranging in these countries, from less than 0.1 percent of adults in Egypt to 2.5 percent of adults in Djibouti.\(^4\) In all countries, key populations at higher risk – sex workers, people who inject drugs and men who have sex with men - are heavily impacted by the epidemic. HIV prevalence is as high as 20 percent among female sex workers in Djibouti’s capital city.\(^5\) The bridging populations, including truck drivers, military personnel, sailors, migrant labourers and other clients of sex workers, also experience relatively higher HIV prevalence than the general population.

The growing literature on HIV risk factors in the Red Sea and Gulf of Aden demonstrates that it is often the conditions surrounding the mobility process, especially the spaces of vulnerability, which lend to social contexts in which mobile men and women are vulnerable to engaging in behaviours that pose high risk of HIV transmission. According to IOM’s definition, spaces of vulnerability are those areas where migrants and mobile populations live, work, pass-through or from which they originate. They may include the following: land border posts, ports, truck stops or hotspots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant sending sites, detention centres and emergency

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1. While research is planned for Saudi Arabia and Jordan, it had not yet been conducted at the time of the writing of this report.


3. Note that this calculation does not include the number of people living with HIV/AIDS in Saudi Arabia and Yemen due to lack of data.


5. UNAIDS, 186.
settlements. Transactional sex is openly or covertly available in these spaces and gender-based violence and sexual abuse are extremely common. Women and children are particularly vulnerable to HIV infection in these settings.

These spaces of vulnerability, or “hotspots” are frequented by large numbers of mobile people throughout the Red Sea and Gulf of Aden region, including female sex workers, truck drivers and their assistants, seafarers, uniformed service men, pastoralists and irregular migrants. Mobile men are often young, sexually active, and spend long periods of time away from their families and regular partners. These groups self-report engaging in multiple concurrent sexual partnerships with casual or regular partners, including sex workers. The female sex workers interviewed report that truck drivers are their most common clients, followed by uniformed service men, nomads, and other mobile men. In nearly every context, respondents reported low or irregular condom use and demonstrate limited HIV knowledge and risk perception. This combination of factors, including the high HIV prevalence observed among female sex workers in many places, indicates that HIV vulnerability is extremely high in these settings.

Gender-based violence and sexual abuse are also common in high traffic settings, as well as in refugee/IDP camps and other contexts shaped by conflict or crisis. Migrant women, women affected by humanitarian crisis and female sex workers who experience marginalization, disempowerment and poverty will be extremely vulnerable to gender-based violence, sexual abuse, and offers of money, food or shelter in exchange for sex. Uniformed service men in particular have been strongly associated with the perpetuation of sexual violence during conflict and violence against women is common in refugee camps and other humanitarian settings. Pastoralist women are required by custom to engage in harmful traditional practices, including female genital mutilation, wife sharing and wife inheritance, which increase risk of exposure to HIV. Forced or coerced sex in any setting places women in greater danger of HIV infection.

The mobility process is isolating and cross-border mobile populations generally lack access to information, health services and other forms of social support in and around hotspot areas. At the same time, few services or programs target the unique needs and situations of mobile people. In general, the range of health facilities that exist along the major transport corridors and in stopover towns is narrow and facilities tend to be understaffed, overstretched and lacking in crucial resources. In addition to limited or nonexistent HIV testing and prevention services, STI and HIV medication stocks are often in short supply and staff training on HIV, STI and gender is limited. Minimal outreach is conducted to encourage high-risk groups to access services that do exist and some facilities report that it is difficult to reach people on the move.

Essentially, mobile populations in the region of the Red Sea and Gulf of Aden experi-
ence three levels of vulnerability: individual, social/economic and programmatic. Individual vulnerability refers to the loneliness and isolation that mobile people experience as result of long-distance separation from family and partners, disconnection from social norms and traditions, and differences in language and culture. These factors can lead individuals to engage in behaviours associated with high risk for HIV. Social and economic vulnerability is associated with extreme poverty, either as a cause or consequence of movement, lack of legal status and rights in transit and/or destination countries, stigma and discrimination, and prevalent gender inequality, which makes women vulnerable to violence and abuse. Finally, programmatic vulnerability refers to the limited access to health, information and other support services that mobile people experience.

IRAPP has spent the last few years working to redress these gaps in health care access for mobile populations in 7 IGAD countries in the Horn of Africa: Djibouti, Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda. The Program reflects the common objective of the National AIDS authorities of IGAD Member States and development partners to work in a mutually supportive way to address sub-regional cross-border mobile populations in the context of the HIV epidemic. More specifically, the Program aims to (1) improve access to HIV prevention, care, treatment and mitigation programs for cross border and mobile populations, refugees, IDPs, returnees and surrounding host communities in selected sites in the IGAD Member States; and (2) to enable the scaling up of the approach and the sustainability of the provision of holistic HIV services to these populations, by strengthening IGAD and establishing a common approach to support these populations in the IGAD Member States.

Over the past few years, IRAPP has worked to facilitate the provision of coordinated HIV services for mobile populations on either side of borders through the harmonization of protocols and the facilitation of inter-country collaboration between ministries of health and key HIV service providers in the IGAD countries. IRAPP has also worked to scale up HIV and STI prevention outreach and strengthen the capacity of health facilities to provide comprehensive treatment and care at cross-border points. Since project inception in 2009, more than 20,000 people have been reached through community based prevention programming, 185,000 people have received HIV counselling and testing in project sites, and the number of people receiving ART has increased from 379 in 2009 to 2134 in 2011. Training has been provided to 8786 people, including health care providers, peer educators, youth, people with HIV, sex workers and community leaders, and new associations of people with HIV have been established to support community outreach.7

IRAPP documented important progress in selected project sites in four Red Sea countries in 2011. In Djibouti, training and equipment have been provided to communities and health facilities in two hotspots and a network of associations has been assembled to
reach truck drivers, sex workers and mobile youth. In Ethiopia, accomplishments include the delivery of comprehensive HIV care at the Ethiopia-Sudan border, the provision of training to health and community workers, and the implementation of an advocacy campaign. In Somalia, completed activities include the rehabilitation of health centres, training and deployment of health care providers and the establishment of Voluntary Counselling and Testing (VCT) centres. And at the Port of Sudan, a new health facility has been built and developed to serve the community in and around the hotspot.

Despite this progress, IRAPP notes that provision of ART, PMTCT and comprehensive HIV care is still limited and member states must take immediate action to upgrade all health facility sites and ensure that these services are being provided. Referral services should be strengthened to ensure efficient links to health facilities at hotspot areas for vulnerable populations. Outreach to people with HIV and other community leaders must also be supported and associations established. IRAPP also recommends that capacity building activities and trainings held at the regional level are better coordinated and shared with implementing partners at the local level and that coordination between service providers must be improved. Finally, programming directed at preventing and controlling gender-based violence remains inadequate and must be strengthened.

Experiences from African transport corridors and port areas outside of the Red Sea and Gulf of Aden provide important lessons for programme directions. First, interventions for mobile people must account for the unique needs and situations that these people experience and involve targeted solutions that reach the most isolated and vulnerable. For example, experiences from IOM’s Friendly Project on the Kampala-Juba Transport Corridor, which runs between Uganda and Sudan, have demonstrated that truck drivers are more widely reached with HCT if this service is available at night. The Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project at the Port of Dar Es Salaam in Tanzania has found that attractive “safe” spaces that draw port workers away from bars at times when they are most vulnerable and help them stay connected with their families are essential.

Second, partnerships with local actors and institutions that involve work within existing frameworks will support the development of interventions that reach wider audiences. Experiences from a project based on the Abidjan-Lagos Transport Corridor, which runs between Cote d’Ivoire and Nigeria, have shown that effective partnerships with the public sector, private sector and civil society, including transport sector organizations, are critical success factors. Based on the success of the Cornelder Port Project at the Port of Mozambique, IOM recommends the use of HIV and health campaigns based on public private partnerships to use existing workforce and company capacities to reach workers with key prevention messages.
Based on these lessons and the status of the current situation and response in the port areas and adjacent transport corridors of Red Sea and Gulf of Aden, it is clear that existing interventions must be strengthened. Highly targeted responses must be designed to address the complex layers of vulnerability experienced by cross-border mobile populations. Specific evidence generated by current and ongoing research should directly inform these responses, and additional research should be conducted in countries for which evidence is lacking. Existing prevention campaigns should be expanded and tailored to meet the specific needs of these populations and ART, PMTCT and comprehensive HIV care services must be established in hotspots throughout the Red Sea and Gulf of Aden region. Additional partnerships with the private sector, labour organizations and civil society should be developed at the local level.

The following recommendations are advanced:

**Planning**

1) Support the integration of specific evidence on HIV vulnerability factors among cross-border mobile populations in the Red Sea and Gulf of Aden into national and regional level strategic planning.

2) Develop strategies for implementing targeted responses at the level of the Red Sea ports that account for the dimensions of individual, social and economic vulnerability and marginalization that mobile populations face.

3) Mainstream issues related to gender inequality and gender-based violence into regional and national strategies addressing the HIV vulnerability of cross-border mobile populations.

4) Develop mechanisms and set specific goals for scaling up ART, PMTCT and comprehensive HIV care at hotspot health facilities in target countries.

**Programming**

5) Design outreach campaigns for mobilizing HCT provision and condom distribution based on existing information on the movements, schedules, and spaces occupied by mobile people to widen and fine-tune the scope of these efforts.

6) Develop and implement interventions for providing appropriate and attractive alternatives to the bars, khat houses and lodges that mobile people frequent and providing resources for maintaining contact with loved ones and accessing services.
7) Continue to strengthen and harmonize referral services between health facilities at hotspots and health facilities providing comprehensive HIV care to improve access of mobile people to HIV treatment, care and support.

**Partnerships**

8) Continue to promote and strengthen collaboration and coordination between regional organizations, national actors, health providers and implementing partners to facilitate timely and harmonized implementation.

9) Work to build bridges to existing institutions and frameworks to support the sustainable scale up of HIV interventions for mobile people.

10) Develop new partnerships with the private sector and civil society to facilitate the provision of crucial HIV information, services and resources.

**Research**

11) Initiate data collection on HIV prevalence among the key populations addressed in this report in order to support the development of well-informed strategic directions at the regional, national and local levels.

12) Develop research on those countries not currently targeted by IRAPP activities – Egypt, Eritrea, Jordan, Saudi Arabia and Yemen – to facilitate the development of organized responses in these places.

13) Prioritize research into the changing dynamics of population movement in the region, including the expansion of transport corridors and increases in commercial traffic, and the impact that these changes will have on the HIV vulnerability of mobile people.
Introduction
The relationship between the HIV epidemic and migration was officially recognized by the United Nations during the General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001. Article 86 of the 2011 UNGASS Political Declaration commits: “to address, according to national legislation, the vulnerabilities of HIV experienced by migrant and mobile populations and support their access to HIV prevention, treatment, care and support.”

In 2004, the Joint United Nations Programme on HIV/AIDS, Regional Support Team for the Middle East and North Africa (UNAIDS RST MENA) initiated discussions on the risks and vulnerabilities linked to HIV in the context of trans-border migration and mobility in the Horn of Africa. Since then, UNAIDS has worked closely with its counterparts at the International Organization for Migration (IOM) and the United Nations Development Programme (UNDP) to advance the issue through a series of high level conferences involving national stakeholders from around the region. This work has been carried out in coordination with the Intergovernmental Authority on Development (IGAD), a regional development organization that brings together 7 countries from the Horn of Africa: Djibouti, Ethiopia, Kenya, Somalia, South Sudan, Sudan and Uganda. In 2007, IGAD began implementing its Regional HIV/AIDS Partnership Program (IRAPP) to address challenges related to HIV among cross-border and mobile populations in these countries, and together, IGAD, UNAIDS, IOM and UNDP have continued to work together closely on these issues.

In 2008, the Republic of Djibouti and the UNAIDS RST MENA suggested the development of another regional initiative complementing IRAPP that would develop a response at the level of the Red Sea Ports, which function as important crossroads for migration throughout the Horn of Africa and the Arab Peninsula. High-level meetings were held in 2008 and 2010 to advance this initiative, and resulted in a series of declarations of commitment among stakeholders. The present initiative, entitled Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden, is based on the commitments laid out in those meetings, and compliments the work carried out by IRAPP. The 2010 UNAIDS report of the same title provided an overview of existing evidence on HIV vulnerability in mobile contexts in the region.

In the last year new research has been conducted and a number of project activities have been advanced in selected sites. The current report aims to build directly on the previous report to present an updated situation and response analysis on HIV in the
context of mobility and migration in the Red Sea and Gulf of Aden to support continued momentum under the regional initiative. The report was presented at the 2011 Qatar Symposium on the Family, the Millennium Development goals and AIDS in the Middle East Region: linkages, challenges and opportunities, held in Doha, Qatar, 1-2 November 2011. The recommendations will be integrated into the symposium’s final report.

Background

Two hundred and fourteen million people lived outside of their countries of origin in 2010: 19 million in Africa and 26.6 million in the Middle East, one of the fastest growing migrant regions in the world.9 The Red Sea and Gulf of Aden region, which includes Djibouti, Egypt, Eritrea, Ethiopia, Jordan, Saudi Arabia, Somalia, Sudan and Yemen, includes countries of origin, transit and destination for large numbers of people. These include those migrating for economic and livelihood reasons and those migrating to escape conflict and natural disaster. In every case, mobility is on the rise, with growing numbers of people moving across borders throughout the Horn of Africa or across the Red Sea and Gulf of Aden to the Arab Peninsula.

Throughout the world, population mobility has long been linked to the spread of infectious disease. Though migration itself does not harm health, the conditions surrounding the migration process may directly lead to increased health vulnerability.10 Mobile populations commonly face harsh and unsafe living and transit conditions including poor sanitation, lack of access to basic needs, and violence.11 At the same time, migrants often lack legal status and rights, which limits their access to health and other social services. While migration and mobility are not risk factors for HIV by themselves, the context of mobility can encourage behaviours strongly associated with high vulnerability to HIV and can pose barriers to access to HIV prevention, awareness and treatment services.12 In MENA, the vulnerability of mobile populations stems from poverty, separation from family and regular sexual partners, differences in language and culture that lead to isolation, separation from native socio-cultural background, lack of community support, lack of access to health and social services, lack of official legal status in transit and destination countries, and a sense of anonymity.13

Though the HIV epidemiological context is varied among the Red Sea and Gulf of Aden countries, higher HIV prevalence is concentrated within key populations at higher risk throughout the region and these populations come into close contact with mobile populations living or travelling in vulnerable circumstances in port areas and migration corridors. This trend has the potential to drive the propagation of the epidemic, undermine efforts made towards the achievement of universal access to antiretroviral therapy, and pose a barrier to the achievement of the Millennium Development Goals. It is therefore essential that appropriate and targeted responses take careful account of the complex layers of vulnerability facing cross-border mobile populations.
The Initiative and its Objectives

The present initiative, *Mobility, Migration and HIV Vulnerability of populations along the Red Sea and the Gulf of Aden* was developed in response to the presence of a large population of mobile people in that region, and the lack of a sufficient HIV response to their unique conditions and vulnerabilities. The initiative builds directly on the statements advanced in the 2010 Dubai Consensus, which called for accelerated action towards universal access in MENA, as well as the commitments laid out in the 2010 Conference in Djibouti on ports, mobility, migration and HIV vulnerability.

This work also directly supports the commitments laid out in the 2011 UNGASS Political Declaration on HIV/AIDS and the Millennium Development Goals (MDG), in particular MDG 6: Combat HIV, AIDS, malaria and other diseases, Target A: To have halted and begun to reverse the spread of HIV by 2015. The initiative is also in accordance with the UNAIDS Outcome Framework 2009-2011. UNAIDS will continue to recommend implementation of comprehensive National Responses to AIDS, in particular for accelerated prevention efforts to halt the epidemic. Based on this framework, UNAIDS will focus its activities on achieving results in ten priority areas that will directly contribute to achieving Universal Access targets and will simultaneously help achieve results linked to the MDGs.

Objective

The overall objective of the initiative is to contribute to Universal Access for the mobile people, migrants and other marginalized groups residing in or passing through the ports of the Red Sea and the Gulf of Aden.

Specific Objectives

1. Strengthen advocacy and leadership over mobility and HIV issues at national and regional levels
2. Integrate interventions on mobility and HIV in national strategic plans and ensuring regular sharing of strategic information for improved planning
3. Enhance ability of civil society and the partnership with the private sector on national and regional levels
4. Develop a common communication strategy, putting emphasis on human rights so as to create a favourable environment when targeting these mobile populations.

Methodology

The current report builds directly on the 2010 report to document the social determinants of HIV vulnerability of cross-border populations in the region. The aim is to provide a literature review and updated situational analysis of the HIV vulnerability factors experienced by key populations, to present a response analysis for activities completed under
this initiative in 2011, and to consider lessons from programming experiences outside of the region. A large body of materials produced by UNAIDS, IOM, UNDP and IGAD, were collected and analysed towards these goals, including program reports, strategic documents, presentations, regional studies, national mappings, rapid assessments and field consultations carried out in Djibouti, Egypt, Eritrea, Ethiopia, Somalia, Sudan and Yemen. 

Key Concepts
This analysis is guided by the spaces of vulnerability approach advanced by IOM. This approach is based on an understanding that health vulnerability stems not only from individual factors, but also a range of environmental factors specific to the unique conditions of a location, including the relationship dynamics among mobile and sedentary populations. These factors must be taken into consideration when addressing migration health concerns and interventions must consider and target both migrant and mobile populations and the communities with which they interact, including families in migrant-sending communities. Spaces of vulnerability are those areas where migrants and mobile populations live, work, and pass-through or from which they originate, where various services, including transactional sex, are negotiated and exchanged. These may include the following: land border posts, ports, truck stops or hotspots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-sending sites, detention centres, and emergency settlements.

These spaces of vulnerability are occupied by key populations at higher risk, bridging populations and other populations characterized by social and behavioural vulnerability. The key populations at higher risk are those groups that experience the highest risk for HIV infection in the region and include sex workers, people who inject drugs, and men who have sex with men. These populations are in contact with the bridging populations, defined as the populations that bridge HIV infections from the key populations at higher risk to the general population. UNAIDS identifies these bridging populations as: truck drivers, taxi drivers, military personnel, fishermen, sailors, migrant labourers and the sexual partners of the key populations at higher risk. Finally, other groups characterized by social and behavioural vulnerability, including women, refugees, and other mobile populations, will be taken into consideration.

Structure of the Report
The first section of the report presents a literature review that provides an overview of the regional context, including mobility patterns, HIV epidemiology and HIV vulnerability in contexts of high mobility. The second section provides a synthesis of recent data collected by IGAD and IOM on HIV vulnerability among mobile populations, including female sex workers, truck drivers and their assistants, seafarers, nomads and pastoralists,
uniformed service people, refugees and internally displaced people, and women, in Djibouti, Egypt, Eritrea, Ethiopia, Somalia, Sudan and Yemen. The third section describes the response to HIV and mobility in the Red Sea and Gulf of Aden countries, with particular focus on activities completed in 2011. The fourth section reviews experiences and considers lessons learned from other parts of Africa. Conclusions and recommendations for moving forward are presented at the end.
Literature Review

HIV and Mobility in the Red Sea and Gulf of Aden
Mobility and Migration: Regional Overview

The geographic region of the Red Sea and the Gulf of Aden, which is comprised of the countries that share borders with those bodies of water, accounts for nearly 285 million people. The region’s geopolitical location has made it one of the most important transport corridors in the world: the Red Sea and the Gulf of Aden not only serve as bridges between the Horn of Africa and the Arab Peninsula, but also function as a global crossroads between Europe, the Middle East, Africa and Asia.

With the advent and increasing spread of globalization, the number of migrants in the region has increased significantly in recent years. Seventy-four thousand people crossed the Red Sea from the Horn of Africa to Yemen in 2009 – 50 percent more than undertook the same journey in 2008. Planned expansions at the Port of Djibouti – an important link between maritime traffic in the Red Sea and the Gulf of Aden – are expected to nearly double truck traffic there. While migration in the region has traditionally been a male phenomenon, the number of migrant women is steadily increasing. With the increase in both overland and maritime traffic, port areas along the Red Sea are emerging as important commercial hubs for mobile people and surrounding communities.

Population mobility in the Red Sea and Gulf of Aden is motivated by a number of factors. Endemic poverty, low economic development and high unemployment in countries of origin lead large numbers of people to emigrate in search of work and economic opportunity in countries where there is a high demand for migrant labour. The region is home to some of the least developed countries in the world. Djibouti, Ethiopia, Somalia and Yemen ranked in the bottom 25 percent of countries on the UN Human Development Index (HDI) in 2010. Eritrea and Ethiopia have levels of gross domestic income (GNI) per capita that are among the lowest in the world.

At the same time, increases in trans-border exchange and transportation of commercial goods also give rise to population mobility throughout the region. The expansion of transport corridors to meet growing demand has dramatically increased traffic everywhere in the Horn of Africa. For example, the termination of the war between Eritrea and Ethiopia in 2000 initiated growth of infrastructure and services that has led to an

17. Calculated using country population data provided by the Human Development Index: http://hdr.undp.org/en/countries/
18. Mork, 8.
19. IOM, 208.
20. Mork, 8.
22. Ibid.
increase in demand for supplies and rapid increase in traffic along the Djibouti-Addis Ababa transport corridor.\textsuperscript{23} In Sudan, the main transport corridor between Port Sudan and Khartoum has been extended to accommodate expansions of industrial trade in recent years.\textsuperscript{24} This expansion has brought with it significant changes along the corridor, including greater population diversity.\textsuperscript{25}

\begin{table}
\centering
\caption{Table 1. Population and Selected Human Development Indicators for Countries bordering the Red Sea and Gulf of Aden, 2010.}
\begin{tabular}{|l|c|c|c|c|}
\hline
Country & Population & Life Expectancy at Birth (years) & GNI per Capita (2008 PPP US$) & Human Development Index Value \\
\hline
Djibouti & 879,000 & 56.1 & 2471.4 & 147 \\
Egypt & 84,474,400 & 70.5 & 5,889.2 & 101 \\
Eritrea & 5,224,000 & 60.4 & 643.4 & n/a \\
Ethiopia & 84,975,600 & 56.1 & 992.0 & 157 \\
Jordan & 6,330,200 & 73.4 & 5,300.0 & 95 \\
Saudi Arabia & 26,246,000 & 73.3 & 24,726.0 & 55 \\
Somalia & 9,358,600 & 50.4 & n/a & n/a \\
Sudan & 43,192,400 & 58.9 & 2,051.1 & 154 \\
Yemen & 24,255,900 & 63.9 & 2386.6 & 133 \\
\hline
\end{tabular}
\end{table}

Source: Human Development Index, hdr.undp.org/en/countries

Human and demographic factors contributing to high levels of population mobility around the Red Sea and Gulf of Aden ports include cross-border family reunification and pastoralist lifestyles that carry entire communities across borders in search of grazing land and water sources.\textsuperscript{26} Often these nomads are marginalized and excluded by local sedentary people in power, who refuse access to fertile land and other resources, reinforcing the socioeconomic vulnerability of pastoralist communities. Rural exodus is also an important dynamic throughout the region as rural populations struggle to subsist on diminishing agricultural livelihoods. In Sudan, desertification and soil erosion have made agriculture an increasingly difficult livelihood to sustain and has led to rapid population growth in suburban districts where high numbers of people live in very poor conditions.\textsuperscript{27}

Conflict and natural disaster, as well as persecution, ethnic tension, human rights abuse and other forms of violence, have led to the forced displacement of millions. While Africans constitute only 12 percent of the global population, an estimated 28 percent
of the world’s refugees and just under 50 percent of its 20 million internally displaced people are found on the continent. Both Sudan and Somalia have experienced protracted civil wars that have resulted in the destruction of crucial infrastructure and the displacement of millions. Recurring natural disasters in the region, including drought, flood and famine are also major causes of population movement. In Somalia, twenty years of conflict and waves of drought including the 2011 crisis have uprooted a quarter of the country’s population. In the first half of 2011, more than 83,000 Somalis fled to Kenya and 54,000 to Ethiopia. By mid-2011, an additional 2,600 Somalis had crossed the border to Djibouti.

In contexts characterized by poverty and instability, the countries of the Red Sea and Gulf of Aden struggle to support large mobile populations with decent living conditions and health care, both of which are completely inaccessible to mobile people in some places. For example, in Somaliland, the health care system is characterized by a dearth of medical staff, limited capacity to supply medication, and a large and increasing need for health care among the population. A 2007 report by the United Nations Office for the Coordination of Humanitarian Affairs (UN-OCHA) revealed that this situation has been made worse by the arrival of close to 40,000 internally displaced people fleeing violence in the centre and the south of Somalia and who then found themselves placed in highly precarious sanitary conditions. Throughout the region, the health of mobile populations, as well as their access to health services, has become more and more unpredictable. In this context, we move to consider the HIV epidemic in the region and the complex dynamics between HIV and mobility.

**HIV Epidemiology**

More than 1.2 million people are living with HIV in the countries bordering the Red Sea and the Gulf of Aden. National HIV prevalence is wide ranging in the region, from less than 0.1 percent of adults in Egypt to 2.5 percent of adults in Djibouti. Low HIV prevalence is observed in a number of countries, including Egypt, Jordan, Saudi Arabia and Yemen. Generalized epidemics are observed in some parts of Somalia and Sudan. Despite this variation, in all countries, key populations at higher risk – sex workers, people who inject drugs and men who have sex with men - are heavily impacted by the epidemic. HIV prevalence is as high as 20 percent among female sex workers in Djibouti’s capital city. The bridging populations, including truck drivers, military personnel, sailors, migrant labourers and the clients of sex workers, also experience relatively higher HIV prevalence than the general population. In the Horn of Africa countries, women shoulder a large share of the HIV burden.

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29. Mork, 12.
30. Lahlou, 1.
31. See UNHCR: http://www.unhcr.org/pages/4e1f14b06.html
32. Ibid.
33. Ibid.
34. UNAIDS, IOM, IGAD, Mobility, Migration and HIV Vulnerability of populations along the ports of the Red Sea and the Gulf of Aden: Synthesis, desk review and exploratory studies report (2010), 21-22.
35. Note that this calculation does not include the number of people living with HIV/AIDS in Jordan, Saudi Arabia and Yemen due to lack of data.
37. UNAIDS, 186.
Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden

HIV and Mobility

A growing literature on HIV risk factors in the Horn of Africa and MENA has demonstrated the relationship between mobility and the spread of HIV. While migration and mobility are not risk factors for HIV by themselves, the context of mobility can encourage some individuals to engage in HIV risk behaviours while also posing barriers to access to HIV prevention, awareness and treatment services. 39 Mobile populations of all kinds are often exposed to unique pressures and situations, being separated from their families, disconnected from their social norms and traditions, and often facing cultural and linguistic marginalization in both host and transit communities. 40 Poverty, displacement,
conflict or discrimination can lead mobile individuals to HIV high-risk behaviours. Studies on mobile groups, including truck drivers, traders, military personnel and seafarers, have identified migration as a factor related to HIV vulnerability, and in many countries, regions reporting significant seasonal mobility also have higher rates of HIV. Women, children and especially young girls are particularly vulnerable to HIV infection during processes of migration.

It is often the conditions surrounding the mobility process, especially the spaces of vulnerability, which increase risk of HIV transmission and generally aggravate the marginalization of mobile people. Spaces of vulnerability are the areas where goods and services such as fuel, lodging, vehicle repair, loading/unloading, immigrations or customs clearance, meals, entertainment and drugs, are offered to people who live or work near highways or ports. Transactional sex is openly or covertly available in these spaces. Due to the economic instability usually associated with mobility, mobile populations often face food shortages, physical and psychological insecurity and abuse, extreme poverty, poor hygiene, lack of education and other hardships in these contexts. Women and children are often the most vulnerable — in some cases, women and girls are forced to submit to sexual abuse and have little choice but to involuntarily trade sex for economic survival.

Though there is little epidemiological data corroborating high HIV prevalence among mobile groups in the Red Sea and Gulf of Aden, recent evidence suggests that mobile populations in the region are highly prone to a range of vulnerabilities. UNAIDS reports that socioeconomic factors including poverty and unemployment, socio-cultural factors including illiteracy, gender and sexual violence, and institutional factors including the availability, accessibility and performance of health and education systems, all increase vulnerability to HIV in the context of international and national mobility in the Red Sea. Road transport corridors and international maritime transport routes throughout the region lend to social contexts in which men and women are particularly vulnerable to engaging in behaviours that pose high risk of HIV transmission.

For example, a mapping of cross-border mobile populations in Somalia found that although HIV prevalence is significantly lower than in neighbouring countries, Somalia’s close socioeconomic links and high population flows between itself and its neighbours increase the vulnerability of Somali populations to HIV risk. A UNAIDS report on Yemen found that key populations at higher risk, including sex workers, intravenous drug users and men who have sex with men, face even higher risks in contexts of high mobility, which are often also characterized by low levels of education, lack of HIV-related information, unemployment, gender inequality and lack of access to health services. In many countries, poverty and gender inequality exacerbate vulnerabilities associated with mobility and migration in hotspot areas and lead to higher risk for HIV among marginalized populations.
Despite these stark realities, and the numerical importance of mobile populations in the region, these groups are not adequately addressed by national AIDS programmes, according to mapping assessments carried out in 7 IGAD countries in 2005 and 2006. Mobile populations often live in peripheral areas that are underserved by health services even for permanent residents, which deprives them and local people of crucial prevention, care, treatment and support services. Mobile populations are often missed out by the national health promotion activities and interventions, due to their mobility, which makes them an “invisible” population group.49 While the refugee challenges in the Horn of Africa have been dramatically exacerbated as a result of the fragile political situation throughout the region, refugees often fall outside of national AIDS programmes and surveillance. In general, the marginalization and alienation that mobile populations experience for political, linguistic and/or geographic reasons, mean that they lack access to community and public sector services including health care, and are rarely addressed in national AIDS programmes.50

49. IRAPP, IRAPP M&E Implementation Manual, 6.
50. The World Bank, 1.
Three:
Situational Analysis

Key Populations
The evidence presented in the following section comes from a series of rapid assessments and mapping exercises carried out by IGAD and IOM over the last 5 years to monitor the HIV situations among cross-border populations in the Horn of Africa. These studies used literature reviews and field consultations involving key informant interviews, focus group discussions, population and vehicle censuses, and surveys of local health, entertainment and lodging facilities, gathering information about mobile populations, including population size, mobility, health, vulnerabilities, knowledge, and access to services. [See annex for a summary of the specific objectives, methods, findings and recommendations associated with each individual study.] Though each study worked with a unique set of populations and questions, taken together we are provided with useful new insights into the vulnerability to HIV experienced by a range of population groups, including sex workers, transport workers, migrant workers, uniformed service men, refugees, internally displaced people, nomads, pastoralists and women.

The evidence shows that diverse cross-border mobile populations throughout the region interact with each other in contexts shaped by vulnerability – either related to the nature of their work or their own individual, socioeconomic and legal circumstances. Female sex workers, a key population at higher risk, have high risk sexual contact with bridging populations, including truckers and uniformed service men, in the stopover towns or border crossing points known as “hotspots” throughout the region, where mobile populations pass through and gather in large numbers. Women, children and other marginalized groups also experience abuse and violence in these and other mobile contexts, which increase their relative vulnerability. The following data synthesis is organized by population group, beginning with female sex workers, and continuing with truck drivers, seafarers, nomads, uniformed service men, refugees and internally displaced people, and women.

### Female Sex Workers

Sex work is a near universal phenomenon. In MENA, economic pressures and acute poverty, family disruption or dysfunction and political conflict are repeatedly cited as the most immediate factors leading women to engage in sex work. As is the case everywhere in the world, female sex workers share a disproportionate burden of the HIV epidemic in the countries surrounding the Red Sea and Gulf of Aden, where sex

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51. Mork, 23.
52. UNAIDS, WHO and the World Bank, 45.
work is often illegal and highly stigmatized. HIV prevalence is consistently higher among female sex workers than the general population, reaching relatively high proportions in some countries. Female sex workers in Djibouti have the highest rate of HIV in the region among countries for which there is data at 20.3 percent, by far the highest figure recorded in MENA. High HIV prevalence is also found among female sex workers in Eritrea and Somalia at 7.8 and 5.5 percent respectively. Evidence from IGAD also indicates that levels of STI among female sex workers throughout the region are high compared with the general population.

Evidence indicates high concentrations of female sex workers in and around hotspot locations along transport corridors and in port settings throughout the Red Sea and Gulf of Aden. For example, a study conducted in hotspots in the Afar Region of Ethiopia found that the region has the highest concentration of female sex workers due to the heavy traffic on the main highway and the large population of migrants in the area. Similarly, in Galafi, a hotspot on the Ethiopian-Djiboutian border, sex work is rampant and fuelled by high levels of migration. Both studies also found large numbers of migrant women in hotspots who were in transit to other destinations, either in search of economic opportunity or due to forced repatriation. Women in both cases reported turning to sex work during their journeys to afford their transport fees. This population is also observed to be highly mobile, which makes them extremely difficult to reach with information and services. For example, in Djibouti, two-thirds of female sex workers travel and a third of those who travel do so with truckers. In Sudan, a third of female sex workers surveyed said that they travel and that the women they work with do as well.

Due to their high concentrations along transport corridors and in port areas, female sex workers throughout the region report interacting with a common set of highly mobile clients, including transport workers, uniformed service men, port workers, nomads, government employees, private sector workers, and other locals. In sites in Ethiopia, Djibouti and Sudan, truck drivers and their assistants were the most common clients among female sex workers interviewed. Samples of female sex workers reported that 78.3 percent, 61.5 percent and 34 percent of their clients were truck drivers along the Djibouti-Addis Ababa, Djibouti-Galafi, and the Port Sudan-Khartoum transport corridors respectively. Uniformed service men and port workers were frequently the second and third most common clients of female sex workers across the region. Frequent sexual interaction with these highly mobile clients, who are reported to engage in high-risk sexual activity with multiple partners (as will be discussed at length later in this section), increases the likelihood that the sex workers will become exposed to HIV. In turn, high HIV prevalence among female sex workers in this region suggests that sexual interaction with bridging populations may increase HIV prevalence within these populations, who will be more likely to expose the general population when they return home.
To compound these issues, the female sex workers interviewed in hotspots throughout the region overwhelmingly reported low levels of condom use with their clients despite engaging in a high number of sexual acts with multiple partners. In some cases, respondents acknowledged that they were aware of the benefits of using condoms but still reported frequently engaging in unprotected sex. This was the case among respondents near the Port of Djibouti, who reported that condoms were inaccessible so they did not always use them. According to that study there are no private health clinics near the hotspots and 60 percent of female sex workers reported not knowing where to access health care. The same study found that unprotected sex was one of the primary modes of HIV transmission among female sex workers. However, access to condoms is varied among the different sites studied. In Sudan, 86 percent of female sex workers interviewed say condoms are available at the nearest facility and nearly all female sex workers know where to go for HIV counselling and testing. Still, only 43 percent reported using condoms and 31 percent reported never using them. Seventy-five percent of female sex workers in this study reported that their clients have refused to use condoms in the past but 74 percent say that they will refuse sex when clients refuse to use condoms.

In the same study in Sudan, female sex workers indicate that it is not easy to negotiate condom use with clients. In many cases, using a condom will reduce the payment they receive, and in other cases, a sex worker may lose a client for insisting on condom use especially when another sex worker is willing to have unprotected sex for a similar price. Awareness of these two possibilities often makes it difficult to turn clients away for refusing to use condoms. An analysis of the epidemic in IGAD countries found that financial incentives, preference for unprotected sex with “trusted” partners and violence are common reasons for inconsistent condom use among female sex workers. For example along the Addis Ababa-Matamma transport corridor in Ethiopia, female sex workers reported being more likely to practice unprotected sex when their male clients refuse to use condoms, even knowing the risk of HIV, but feeling constrained due to their lack of an alternative livelihood source. Sex workers in Sudan report that it is difficult to negotiate condom use with regular or “trusted” partners, and they are less likely to wear a condom with these clients despite no knowledge of the client’s HIV status. In other settings, hotspot conditions and facilities, including bars, lodges and khat houses can create circumstances in which sex must be negotiated quickly in uncomfortable situations. In the Afar Region of Ethiopia, the combination of khat use and the lack of private environments often leads to quickly negotiated sex in backyards or other uncomfortable or public conditions where condom use is more difficult. In any case, the combination of low condom use with high volume of sexual partners among a high HIV prevalence population is a troubling indicator for increased spread of the virus.

Violence is also a common barrier to negotiating condom use for female sex workers, as well as a key factor contributing to HIV vulnerability in this group. Forty-three percent
of female sex workers interviewed in a Sudanese hotspot said that they had experienced violence from clients.69 The majority of female sex workers interviewed for a study in Djibouti had also experienced violence from clients. Most commonly this involved beating, forced sex, or refusal to pay.70 Another study in Djibouti found that the illegality of sex work creates an environment conducive to violence, which is perpetrated most commonly by uniformed service men. In that study nearly 70 percent of female sex workers had experienced violence.71 In the Afar region of Ethiopia, female sex workers are often forced to practice unsafe sex for reasons related to prevalent gender inequality within the culture. Women interviewed in a 2008 mapping study in Somalia reported frequent ill treatment from clients but report feeling powerless to resist or take action against perpetrators due to their disenfranchised and stigmatized position in society. According to that study, there is widespread acceptance among sex workers that they can be threatened or violated with impunity by attackers.73 Gender-based violence will be discussed at greater length later in the section.

Finally, because of the illegal or semi-legal status of sex work in most contexts, the high levels of stigma associated with sex work and high levels of poverty, female sex workers are generally a highly marginalized and excluded group. UNAIDS reports that the illegal or semi-legal status of sex work can dramatically increase the HIV vulnerability of sex workers for a number of reasons, including that their ability to negotiate condom use is often undermined by their lack of social and legal status; that their access to health care is limited especially when operating in illegal environments; that they are highly vulnerable to sexual violence without official recourse; and that there is a general lack of protective legislation and policy to shield them from stigma and discrimination.74 In Yemen, attempts to scale up programming for sex workers are made difficult by the fact that implementers and service providers are reluctant to work with such a stigmatized group. At the same time, female sex workers can be hard to identify and reach, because in most settings, a large proportion of these women are working informally and outside of known hotspots. Moreover sex workers are often migrants and sometimes mobile, meaning that some of the challenges related to HIV prevention programming with migrant and mobile groups may also apply to them.75 In many cases, these issues will be compounded by poverty, which not only leads women to take up sex work in times of dire economic need, but also complicates their ability to negotiate condom use and access health services. A study in Djibouti found that while sex workers in Djibouti town, especially those operating from bars, always have access to HIV, AIDS and STI prevention (information, promotion and distribution of condoms) and health care activities, this is not the case for sex workers in the working class quarters of Djibouti town and the districts of the interior, especially those located in border areas and along the main roads.76

These factors – lack of legal status, stigma and discrimination and poverty – combined with other common issues, including language barriers, illiteracy, fear of violence and

70. Kassa, 60.
71. M.A. Mohamed, 42-43.
72. IGAD, Rapid Assessment for Gender and HIV&AIDS: Transmission in Hotspots (Hayou and Galafi), Afar; Regional State, Ethiopia, 34.
74. UNAIDS, IOM and IGAD, 36-37.
75. See Gharama et al.
disempowerment, make female sex workers extremely hard to reach with information and services.\textsuperscript{77} This was clear based on the results of studies carried out in the Port of Suez, where female sex workers lacked knowledge of HIV and STI, had low risk perception, serious misconceptions about modes of transmission, and low condom use;\textsuperscript{78} and in Ethiopia, where their low levels of knowledge about HIV/STI was combined with high number of sexual partnerships and inconsistent condom use.\textsuperscript{79} This was especially true where sex workers were particularly marginalized. For example, in Djibouti, where prostitution is illegal but tolerated and practiced under tough and unhealthy conditions, a study found a general lack of information among female sex workers and their clients.\textsuperscript{80} However, in other locations, female sex workers were well informed about HIV but continued to engage in high-risk behaviours. This was the case in Sudan, where results showed that female sex workers have strong knowledge of modes of transmission and of their own high level of risk, in part due to workshops that are provided to them.\textsuperscript{81} Yet that same study found that despite this, most FSW say they continue to have sex while experiencing STI symptoms.\textsuperscript{82}

### Truck Drivers and their Assistants

Transport workers, including truck drivers and seafarers, lead extremely mobile lives and the number of truck drivers passing through transport corridors throughout the region appears to be increasing with recent expansions of a number of main highways. It is well documented in other parts of Africa that long distance truck drivers are a key force in the spread of the HIV epidemic, and that women living near truck stops face high HIV vulnerability. Studies conducted in East Africa in the 1990s show high HIV prevalence among long distance truck drivers and their assistants,\textsuperscript{83} as well as higher HIV prevalence at truck stops along major highway corridors than are found among the general population.\textsuperscript{84} However, this study is nearly 20 years old and thus lacks validity for understanding current epidemiological trends. New research must be undertaken to establish contemporary epidemiological data on this bridging population. At the same time, sparse evidence exists on these dynamics within the countries of the Red Sea and Gulf of Aden specifically. However, the research reviewed in this report does show a high burden of STI among truck drivers in the region, as well as evidence that truck drivers face high vulnerability to HIV.

Many aspects of transport workers’ demographic profile and working conditions in the Red Sea and Gulf of Aden contribute to the likelihood that they will engage in risky sex with multiple partners. Truck drivers are highly mobile, often young, sexually active men, who spend long periods of time on the road away from their families and partners. The transport corridors, stopovers and crossing points that they frequent on their journeys are characterized by high levels of sexual activity, attracting large numbers of sex workers and other mobile populations living in temporary accommodations away from their respective homes.
families. The loneliness that truckers experience as a result of being far from home, the proliferation of alcohol and khat at hotspots, and their need for entertainment and companionship leads them to engage in casual sex, transactional sex, or regular sexual relationships in one or more of these stopover towns along the major highways. In general, transport workers may feel less bound by social restrictions on their sexual behaviour while working far from home. A study in Yemen found that truck drivers travelling long distances and spending long hours away from their homes and their partners commonly engage in high risk behaviours on the road. Research conducted around the Port of Suez found that this behaviour is repeated in multiple stopping points along transport routes and that truckers who are living with HIV are likely to carry infection to a number of different hotspots.

The comingling of female sex workers and truck drivers, two mobile, sexually active, high-risk populations, explains high prevalence of HIV and STI rates in truck drivers. The combination of these two populations creates an environment where individuals are engaging in sexual acts with concurrent multiple partners, thereby increasing the likelihood of contracting HIV and other STIs. Studies also found that unprotected sex was common among truck drivers in the region. In the Port of Suez, truck drivers frequently engaged in unprotected sex during high-risk sexual activities with high-risk sexual partners. A study in Djibouti found that while 49.2 percent of truckers reported always using condoms, 45.8 percent reported never using condoms. Along the Addis Ababa Matamma transport corridor, of 120 truckers interviewed, 65 percent self-reported having paid for sex at some point and only 58 percent reported always using condoms. This sexual behaviour has the potential to bridge HIV infection from high-risk groups to the general population when these truck drivers return home to their regular partners.

The consumption of khat and alcohol is strongly associated with high-risk sexual behaviour, and a number of studies cited evidence of high levels of khat and alcohol consumption and sexual activities among truckers in the region. For example, in Djibouti, parking sites constitute places of interaction between mobile populations and local populations, including youth who have dropped out of school, young girls, khat and alcohol vendors, small traders and nomads from neighbouring camps. Unlike other populations, drivers and traders have the money to spend to reduce fatigue, stress and boredom by taking khat, drinking alcohol and having sex with multiple women. According to a survey of road users by Save the Children, HIV vulnerability among truck drivers is high during these journeys: 55 percent of road users report consuming alcohol, 40 percent report consuming khat, and nearly 35 percent report having unprotected sex with several occasional partners.

Another important vulnerability factor is the low level of HIV knowledge observed among truck drivers in some areas. Studies from Djibouti, Ethiopia and Egypt report low HIV/STI knowledge and serious misconceptions about HIV transmission methods.
among the truck drivers interviewed. In the Port of Suez, truckers have low HIV/STI risk perception, low HIV/STI knowledge, serious misconceptions regarding the modes of transmission/prevention and a general lack of knowledge regarding using condoms as an HIV prevention tool. Some variation is evident however. Decent levels of HIV knowledge was reported among truckers in the Port of Djibouti-Galafi transport corridor. In part these variations in knowledge levels may relate to access to education and HIV services. Unfortunately we know little about the extent of trucker access to these resources in the region, other than research in Sudan in which truckers reported that health services were not available along a main corridor between Hamra and Gedaref. More research is needed in this area.

Seafarers

There are 1,227,000 seafarers worldwide, and with a number of busy port cities along the Red Sea and Gulf of Aden, the region is heavily traversed by shipping vessels and their crew. A literature review conducted by IOM found evidence from around the world of high rates of HIV infection, low levels of HIV knowledge and high probability of high risk behaviour among seafarers in different settings around the world. Although most of those examples came from outside of Africa and the Middle East, a 2009 study explored prevalence and risk factors for HIV-1 infection among sailors in Ethiopia and found that HIV-1 prevalence was 9.6 percent within that group. Only 14 percent of the studied population reported condom use, though even that use was irregular. Research on seafarers and HIV prevalence and vulnerability in the other countries surrounding the Red Sea and Gulf of Aden is limited. The following provides a synthesis of available information, with particular focus on the study conducted on the Port of Suez.

That study found that while crew members have limited opportunity to mix with the population in Suez, a third of crew members reported engaging in sex with women while visiting other sea ports, particularly those who travel along the Red Sea and to the Far East. Certain seaports in the region were mentioned by participants as having risk zones conducive to engaging in transactional sex and narcotic use, including El Sawaken and Kasla in Sudan, and Asab and Maso in Eritrea. Both that study and a study carried out in the Port of Djibouti found low condom use among seafarers, a key indicator of HIV vulnerability. In Djibouti, the primary modes of HIV transmission among seafarers include through infected needles and unprotected sex.

Seafarers are also powerfully impacted by stigma and discrimination in maritime settings. The study in the Port of Suez found that HIV and STI tests are compulsory for crewmembers every three years. If found to be positive, they are fired immediately. Yet ship medical services do not provide HIV/STI counselling or treatment on board,

97. IOM, Rapid Assessment: Vulnerability to HIV among Key Population Groups in Hotspot Areas in the Port of Suez, 23.
98. M.A. Mohamed, 34.
100. IOM, Global Partnership on HIV and Mobile Workers in the Maritime Sector; Literature Review and Lessons Learned: HIV Prevention and Seafarers [International Organization for Migration, 2009], 3.
103. IOM, Rapid Assessment: Vulnerability to HIV among Key Population Groups in Hotspot Areas in the Port of Suez.
104. See M.A. Mohamed; and IOM, Rapid Assessment: Vulnerability to HIV among Key Population Groups in Hotspot Areas in the Port of Suez.
in general, the high mobility of seafarers makes them difficult to reach with care and information. Low levels of schooling among this population decrease the effectiveness of school-based programs. Reaching seafarers with services and information becomes even harder when they are undocumented migrants. The study in Suez found that seafarers lack essential basic knowledge related to modes of transmission and means of protection. They held a number of misconceptions, including that non-penetrative sex is safe, that condoms should only be used with female sex workers, and that AIDS is a disease only affecting men who have sex with men.

**Nomads and Pastoralists**

There are more than 20 million pastoralists in the Horn of Africa. Sudan and Somalia are home to the largest populations with 7 million each; Ethiopia follows with 4 million. In Somalia, where 40 percent of the population is nomadic, pastoralism is one of the only viable livelihood options in the northern and central parts of the country. In Djibouti, where nomads are forced to move continuously in order to find water and pastures to sustain themselves and their livestock, they account for nearly 26 percent of the total population and 52 percent of the country’s rural population. The majority of pastoralists are poor and vulnerable to hazards such as drought, armed conflict and encroachment on their lands, while also facing economic, social and political marginalization. The degree to which pastoralists are marginalized, combined with their high numbers and cultural propensity to high mobility, suggests that they are powerfully affected by the HIV epidemic, especially in those countries experiencing generalized epidemics.

However, virtually no data exists on HIV prevalence among pastoralist populations in the countries surrounding the Red Sea and Gulf of Aden. And often prevalence is assumed to be low due to low HIV prevalence among rural populations, and assumed low contact between pastoralists and other populations. Pastoralists are also extremely difficult to reach with information and are difficult to monitor using standard surveillance systems. In response to the lack of information on pastoralists and their general condition of isolation, IGAD member states have prioritized this group in national and trans-border health and development efforts. IGAD proposes that pastoralists face high vulnerability to HIV due to high-risk behaviours, high levels of gender-based violence, low literacy rates, high-risk cultural practices and poor access to services and information. The studies reviewed for this report that addressed pastoralist populations confirm many of these vulnerabilities.

Pastoralists are by definition mobile. Traditionally, this mobility is carried out when entire households move to secure grazing and water for livestock. Today pastoralist mobility is also often carried out by young men over long distances to market products or pur-

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105. IOM, Rapid Assessment: Vulnerability to HIV among Key Population Groups in Hotspot Areas in the Port of Suez.
107. IOM, Rapid Assessment: Vulnerability to HIV among Key Population Groups in Hotspot Areas in the Port of Suez, 19.
108. A widely used definition of pastoralism comes from Swift 1988: “pastoral production systems are those in which 50 percent of gross household revenue (i.e. the total value of marketed production plus the estimated value of subsistence activities).” IGAD expands on this by adding to the pastoralist ethnic groups who no longer rely solely on livestock production for their livelihoods but who follow the pastoralist culture and way of life.
110. Abdi Borle, 3.
111. Ali Kamil, 16.
112. See Mork; and UNAIDS, IOM, IGAD.
Pastoralists also encounter a range of social, economic and cultural vulnerabilities to HIV that can be closely tied to this group’s high level of mobility. A study on pastoralism, gender, HIV, and AIDS in IGAD countries, found that poverty and disempowerment, which are strongly associated with the increasing erosion of agricultural livelihoods, contribute directly to pastoralist vulnerability to HIV. Pastoralist communities increasingly face destitution and disease and a number of issues have created high risk livelihood situations that may translate into high risk coping behaviour, including: diminishing livestock numbers and assets, increased competition for scarce resources in dry land areas, recurring livelihood shocks due to conflict, poor access to markets, natural disaster and economic crisis. These challenges can lead to more frequent and less traditional forms of mobility, like labour migration, which has been shown so far in this discussion to be strongly associated with high vulnerability for HIV. Extreme poverty on its own can be an important HIV vulnerability factor, especially when it is accompanied by poor sanitary conditions and high rates of other diseases.

At the same time, a number of pastoralist cultural practices increase vulnerability to HIV and are carried with them when entire households move to secure grazing and water for livestock. A study on gender in the Afar Region of Ethiopia refers to these socio-cultural risk factors as Harmful Traditional Practices, which include all practices done deliberately by men on the body or psyche of other human beings for no therapeutic purpose, but rather for cultural or socio-conventional motives and which have harmful consequences on the health and rights of the victims. Among pastoralist communities, these include wife sharing, wife inheritance, the use of unsterilized childbirth instruments, female genital mutilation, male circumcision, and body tattooing and piercing. Women, girls and the marginalized are disproportionately impacted by these practices, all of which are accompanied by a high risk of HIV transmission.

115. See Kassa.
119. IGAD, Rapid Assessment for Gender and HIV&AIDS: Transmission in Hotspots (Hayou and Galafi), Afar; Regional State, Ethiopia, 44.
120. While male circumcision is associated with decreased risk of HIV transmission, Okundi indicates that male circumcision performed by “traditional medics” is associated with increased risk of HIV transmission.
Another source of HIV vulnerability among pastoralists is their extremely limited access to education and information, coupled with low literacy rates. Studies from around the region found that knowledge about HIV is low among rural populations in general and pastoralist populations in particular. A study on pastoralism and HIV in IGAD countries found that this group lacks knowledge about HIV prevention transmission, lacks awareness of the services available to them, and have not been targeted for messaging or outreach campaigns. A study on gender in the Afar region found that the mobility of pastoralists makes them unreachable with information. At the same time, distributing leaflets or pamphlets in predominately non-literate Afar society is futile and the native pastoralist communities remain unaddressed despite these outreaches. In general knowledge of HIV, especially in rural areas, is either inadequate or full of misconception. For example, the study found that most Afar believe that condoms contain HIV and thus avoid using them. The study points out that on the other hand, the Afar have an excellent traditional information dissemination system which could have been used successfully had it not been for the development actors’ tendency to apply a one size fits all approach to programming. In a clan-based social organization, any intervention can be successful when it is accepted and channelled through clan and religious leaders.

Studies also found that nomad populations generally lack access to health care and services. An assessment conducted on the Afar Region of Ethiopia found that pastoralists are often excluded from health services both for prevention and treatment and lack of access to health services renders them vulnerable to HIV infection as well as to the harm of opportunistic infections. That study found that pastoralists self report that lack of access to health services and mobility were main factors in increasing their vulnerability to health risks. Nearly all pastoralist respondents did not know where to access HCT, ART, psychosocial counselling, support for people with HIV, condom promotion and STI services. Another study found that health centres serving nomads were situated in villages far from nomad camps, which limited their access to services. This was also the case according to the rapid assessment on gender in Djibouti, which found that nomads are often in remote areas and as a result lack access to health services, making them vulnerable and vectors of disease. In Djibouti, the health centres available to nomads are generally dysfunctional, with shortages of medication, lack of motivation among staff, limited services and lack of reproductive health services. The health centres are also often far from the nomads’ camps, so that the long distance required to reach services considerably reduces accessibility of the nomad population to health services.

### Uniformed Service People

The Horn of Africa is prone to conflict and hosts a large number of uniformed service people, refugees and internally displaced people, all of whom face high levels of vul-
Situational Analysis

nerability to HIV. Though evidence is sparse, available information does indicate that uniformed service people experience higher HIV prevalence than the general population. For example, the war between Ethiopia and Eritrea led to a prolonged mobilization and deployment of troops along the border on both sides and HIV infection rates of Ethiopian soldiers were estimated at 15 percent at the front line, 12 percent behind the front, and 7 percent for soldiers living closer to their families and spouses away from military camps. A mapping study conducted in Ethiopia found that military personnel have two to five times higher rates of STI than civilians; a difference which can skyrocket to 50 times or higher during wartimes. High rates of HIV are also observed in communities located near military bases.

Additional evidence confirms that the front lines are particularly high-risk environments for the armed forces for a number of reasons. A mapping exercise conducted in Ethiopia reported that military personnel are often in environments characterized by “masculine values,” in which high stress, boredom, alcohol use and high rates of sexual activity create high vulnerability contexts. Soldiers who are accustomed to risk taking in their work lives are likely to take risks in their sex lives as well. Military camps also often attract the sex industry, bringing together two high-risk groups. Research conducted in Somalia found that soldiers are both vehicles and victims of HIV infection.

A Djibouti-based study also found that away from the front lines, uniformed men stationed at border posts are still particularly vulnerable to HIV and STI, due to their isolation and distance from the family, young age, propensity for multiple sexual relationships, consumption of khat and alcohol and limited access to information and condoms. Uniformed men interviewed in Djibouti indicated that khat, alcohol and sex were the only leisure activities that enabled them to “survive” while in service. Those activities bring uniformed service men into constant contact with all categories of the population, including sex workers and other mobile groups. While data on HIV prevalence was not collected, this study found that 40 percent of the sample admitted having symptoms of STI, confirming the general vulnerability of this group to HIV.

Research also showed that sexual violence perpetrated by uniformed service men is a key factor in the spread of HIV in the region. During conflict, soldiers, militiamen and other armed groups perpetrate sexual violence while roaming and as a result, their mobility during conflict can spread HIV if their HIV prevalence is already high. According to a study on HIV, AIDS and gender in IGAD countries, during conflict and displacement, women and children, especially girls, are disproportionately vulnerable to HIV risk. Rape is often used as a weapon of war and sexual violence and exploitation are common in refugee setting. Soldiers may exist in social contexts where violence, especially sexual violence, is seen as a social ritual that transcends the normal restraints of law and morality. At the same time, women and children struggling to meet basic needs during times of conflict may be compelled or forced to exchange sex for money.
food and protection from soldiers. Children who are alone are especially vulnerable to sexual and physical violence and exploitation during conflict.

Evidence from Djibouti and Somalia demonstrates that knowledge and risk awareness are generally low among uniformed service men. While soldiers had heard of HIV and considered the disease serious, they had little knowledge of prevention and transmission, poor risk perception and reported risky behaviour in their sexual relationships, including multiple partners and no condom use. Information, sensitization and access to condoms were irregular within this group. The Somalia mapping also found that HIV and STI prevention activities for uniformed men and for local populations near military camps are lacking, which serves to maintain and increase HIV vulnerability among these groups. A Djibouti study found that while the military and police health services provide care for TB, Malaria, STI and HIV, this health care is not available in border areas, thus depriving the uniformed men who are the most vulnerable of this benefit.

Refugees and Internally Displaced People

Chronic humanitarian crises and conflict in the Horn of Africa has generated a high volume of refugees and internally displaced people in the region. The countries bordering the Red Sea and Gulf of Aden are the source of nearly 1.5 million refugees, more than half of which – 770,000 – originate in Somalia. In 2011 alone, fighting in Somalia has displaced more than 220,000 people and led 70,000 to migrate across borders. Sudan, Eritrea and Ethiopia are also countries of origin for large numbers of refugees at 387,000, 222,000, and 69,000 respectively. At the same time, the countries around the Red Sea and Gulf of Aden are host to nearly 650,000 refugees. However, there is limited research documenting HIV prevalence among refugees and their surrounding host communities. Studies in Sudan have yielded varied results for HIV prevalence among refugees: 1.57 percent, 1 percent, 4 percent, 1 percent, 0.26 percent, and 0.27 percent – all but one near or below the national adult HIV prevalence documented by UNAIDS for 2001 (1.1%) and 2009 (0.4%).

A larger body of evidence demonstrates that refugees face high levels of vulnerability to HIV. Though less attention was paid to refugees as compared with other vulnerable groups in the research reviewed in this report, nearly all studies found refugee and internally displaced people to experience high levels of vulnerability to HIV for a number of reasons. Much like other mobile populations, Refugees are uprooted from their homes, communities, relationships and existing social structures. As community and family cohesion deteriorate, norms regulating social and sexual behaviour are weakened and psychological stress can lead to the deterioration of coping mechanisms. This context can give rise to new and risky sexual behaviours that carry with them high risk for HIV. For example, a mapping conducted in Ethiopia found that refugees were a key client for sex workers in a number of high transit hotspot areas.
At the same time, precarious conditions in refugee camps – often characterized by poor sanitation, overcrowding, abuse and violence – can increase the propagation of risk and the deterioration of health. Faced with extreme poverty and hunger, women and children may be forced into harmful coping strategies, including trading sex for basic needs. Refugees and IDPs, particularly women and children, are also extremely vulnerable to sexual abuse and violence in these settings, including forced high-risk sexual contact and rape. A mapping exercise of Somalia’s cross-border mobile populations found that HIV spreads fastest during emergency situations when conditions such as poverty, powerlessness, social instability and violence against women are most extreme.\textsuperscript{145} A rapid assessment conducted in the Wad Sharifey refugee camp in Sudan found that gender-based violence including female genital mutilation, domestic violence, as well as forced and early marriage, are widespread in the camps.\textsuperscript{146}

Complex emergencies can also increase vulnerability to HIV by reducing access to HIV prevention services and breaking down health infrastructure. In some host countries, whether or not infrastructure is damaged, HIV prevention information is not made available to refugee populations.\textsuperscript{147} In many cases, it is either difficult or impossible to access condoms during situations of crisis. The rapid assessment on Sudanese refugee camps and hotspots found that lack of access to HIV services and information is a main risk factor for HIV infection there. These dynamics increase the likelihood of HIV transmission and pose challenges to the management of the epidemic.\textsuperscript{148} A key concern is that

\begin{table}
\centering
\textbf{Table 3. Number of Refugees and IDPs Residing and Originating in Countries Bordering the Red Sea and Gulf of Aden, 2011}

<table>
<thead>
<tr>
<th>Country</th>
<th>Refugees Residing in Country</th>
<th>Refugees Originating in Country</th>
<th>Internally Displaced Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Djibouti</td>
<td>15,104</td>
<td>566</td>
<td>0</td>
</tr>
<tr>
<td>Egypt</td>
<td>95,056</td>
<td>6,913</td>
<td>0</td>
</tr>
<tr>
<td>Eritrea</td>
<td>4,809</td>
<td>222,460</td>
<td>0</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>154,295</td>
<td>68,848</td>
<td>0</td>
</tr>
<tr>
<td>Jordan</td>
<td>450,915</td>
<td>2,254</td>
<td>0</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>582</td>
<td>667</td>
<td>0</td>
</tr>
<tr>
<td>Somalia</td>
<td>1,937</td>
<td>770,154</td>
<td>1,463,780</td>
</tr>
<tr>
<td>Sudan</td>
<td>178,308</td>
<td>387,288</td>
<td>1,624,100</td>
</tr>
<tr>
<td>Yemen</td>
<td>190,092</td>
<td>2,076</td>
<td>220,994</td>
</tr>
</tbody>
</table>

Source: The United Nations High Commissioner on Refugees: www.unhcr.org

\textsuperscript{145} Abdi Borle, 6.
\textsuperscript{146} Omer Haroun, Rapid Assessment for Gender and HIV/AIDS Transmission in IRAPP Project Sites: Sudan Country Report. (Intergovernmental Authority on Development Regional HIV/AIDS Partnership Programme, 2010), 91.
\textsuperscript{147} UNAIDS, WHO and the World Bank, 137.
\textsuperscript{148} See Haroun
refugees hosted by high HIV prevalence countries will become infected while abroad and will contribute to spreading the virus when they return to their countries of origin.

A number of the issues addressed here are illuminated in the example of Djibouti, where the refugee situation was thoroughly documented in a recent IGAD mapping. Since its independence in 1977, Djibouti has been confronted with a massive influx of refugees brought by conflict and social and political strife in neighbouring countries. At the time of the mapping there were two remaining refugee camps in Djibouti hosting almost 100,000 people. While there is a health centre offering preventing health care in each refugee camp, these centres do not offer voluntary testing services and no HIV or STI prevalence study has been conducted. Despite this lack of data on prevalence, the study showed a number of important vulnerability factors among refugees at the camps, many specifically related to women, who experience abuse, forced sex at the hands of soldiers, and resort to sex work in the face of extreme poverty. The use of condoms is minimal and khat consumption is widespread, especially among women. There is a marked lack of HIV and STI prevention and health care services for local populations and a general lack of knowledge of HIV prevention and transmission methods.149

Women

Research into HIV and mobility has prioritized consideration of gender as a key issue. Across the Horn of Africa, women have shouldered a disproportionate part of the AIDS burden. Today, women are more likely than men to be infected, and more likely to be the ones responsible for caring for people living with HIV.150 Women are close to 60 percent of those infected with HIV in Sub-Saharan Africa and among those between 15 and 24 years of age, 75 percent are female.151 In MENA, though men continue to experience a higher share of HIV infections, prevalence among women appears to be increasing, from 43.5 percent of adults infected in 2001 to 47.7 percent in 2009.152

Issues related to women and gender inequality have been raised throughout this section. Female sex workers are marginalized by gender inequality and vulnerable to gender-based violence in their relationships with clients and their position in host countries where their work is illegal and stigmatized. Mobile women in vulnerable economic positions and social settings are forced into unprotected sex and experience abuse and violence from soldiers and other mobile men, including pastoralists. Because HIV is more likely to be transmitted from HIV positive men to women during forced or unwanted sex, women who are the victims of these abuses are extremely vulnerable to HIV infection.

A number of the studies reviewed took a closer look at these phenomenon and gender inequality at hotspots in general. A risk assessment on gender, HIV, and AIDS in the Afar region of Ethiopia found that culturally rooted gender inequality among pastoralists

relegates women to subordinate social and economic positions in society in which they face increased vulnerability. Cultural norms require that women are submissive to their husbands and other male members of their households, that they are married off to their first cousin and therefore lack choice in who they marry, and that they can’t request that their partner is tested for HIV/STI before having intercourse. Women are also subject to multiple marriages and are denied the right to own or inherit property. Gender inequality in the Afar Region hinders the ability of female sex workers to negotiate condom use. Gender-based violence is also common in the Afar community. Despite the existence of protective laws, women are often ashamed to speak up against violence, a problem related to the patriarchal tradition and culture. All of these factors contribute to vulnerability to HIV.

In contexts characterized by high mobility, women migrants, often in search of employment, may cope with poverty by involuntarily trading sex for economic survival. Often women have limited opportunities for employment and are forced to work in informal jobs that lack administrative security and health benefits. Women in these positions are frequently sexually exploited by local or migrant populations. At the same time, these women are often marginalized and or alienated for political, linguistic and/or geographic reasons, putting them at a disadvantage in terms of accessibility to community and public sector services, including health information, care and support.

Gender-based violence is a key issue in considering vulnerability to HIV in the Red Sea and Gulf of Aden. A rapid assessment in Sudan found that gender-based violence is widespread in refugee camps, including female genital mutilation, domestic violence, and forced and early marriage. Although study respondents had a low level of knowledge about gender-based violence, they identified a few common practices, including the denial of girls’ rights to education, physical violence against children and rape as key problems. Another study found that physical and sexual violence are also present in the Gellabat area of Sudan, where there is a wide mix of cross-border populations, including uniformed service, seasonal workers, trade men, and truck drivers. A rapid assessment of Afar found that women and female sex workers face gender-based violence including rape, forced unprotected sex, offers of money for unprotected sex, capitalizing on women’s economic vulnerability, psychological abuse and forced drinking and drug use.

Conclusion

The evidence presented in this section clearly indicates that mobile populations in the Red Sea and Gulf of Aden countries experience high levels of vulnerability to HIV. This vulnerability can be characterized as relating to three distinct levels: Individual vulnerability was observed in nearly all populations that experienced long-distance separation
from families and partners and alienation from social norms and values governing sexual behaviour. Economic and Social vulnerability was also extremely common, and manifested in the spaces of vulnerability that mobile and migrant populations occupy, the extreme poverty that many of these groups experience either as a driver or consequence of their travel, the lack of legal status they face in transit or destination countries, the stigma and discrimination associated with work, lifestyle or immigrant status, and prevalent gender inequality which renders women particularly vulnerable in mobile contexts. Finally, programme access vulnerability was evident among most groups as well, who experienced limited access to health, information and other support services.

However, there were also important gaps in the evidence that must be addressed in future research. Primary among these is data on HIV prevalence levels among mobile population groups at the national level, but also in and around hotspot areas. While strong data exists on HIV prevalence among sex workers, this data is lacking for truck drivers and their assistants, seafarers, nomads and pastoralists, uniformed service men, refugees and internally displaced people in most countries in the Red Sea and Gulf of Aden. In general, the assessments and mappings reviewed for this report focused more heavily on sex workers and truck drivers than on the other groups addressed. There is also a strong need for more information on the Middle East countries, Egypt, Jordan, Saudi Arabia and Yemen.
Four:
Response Analysis
The evidence reviewed in this report indicates that despite marked vulnerability among cross-border mobile populations in the Red Sea and Gulf of Aden, these groups lack access to HIV and other health services and few services or programs target their unique needs and situations. In general, the range of health facilities that exist along the major transport corridors and in stopover towns is narrow and facilities tend to be understaffed, overstretched and lacking in crucial resources. In addition to limited or nonexistent HIV testing and prevention services, STI and HIV medication stocks are often in short supply and staff training on HIV, STI and gender is limited. Minimal outreach is conducted to encourage high-risk groups to access services that do exist and some facilities report that it is difficult to reach people on the move. On the national level, IGAD has found that mobile populations are not adequately addressed by national programs despite their numerical importance and high HIV vulnerability. As a result, these populations are often missed by national health promotion activities and interventions.

IRAPP has spent the last few years working to redress these gaps in health care access for mobile populations in the Horn of Africa, specifically in Djibouti, Ethiopia, Kenya, Somalia, Sudan, South Sudan and Uganda. The Program reflects the common objective of the National AIDS authorities of IGAD Member States and development partners to work in a mutually supportive way to address sub-regional cross-border mobile populations in the context of the HIV epidemic. The Program contributes to the reduction of HIV infections and to the mitigation of the socioeconomic impact of the epidemic in the IGAD region through improving regional collaboration and implementing interventions that add value to the efforts of each individual country. The Program has also established a referral system between treatment sites in IGAD Member States so as to provide service continuity to the targeted population, based on harmonized treatment protocols/guidelines for HIV, AIDS and STI. The Program objectives are:

1. To improve access to HIV prevention, care, treatment and mitigation programs for cross-border and mobile populations, refugees, IDPs, returnees and surrounding host communities in selected sites in the IGAD Member States; and
2. To enable the scaling up of the approach and the sustainability of the provision of holistic HIV services to these populations, by strengthening IGAD and establishing a common approach to support these populations in the IGAD Member States.

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161. For more general information on health care access and availability, see K.A.R.A. Mohamed, Kassa, Dare and Report on the Cross Border Mapping Exercise.
162. IRAPP, M&E Implementation Manual.
163. Ibid.
164. Ibid.
The four-year project is structured by three components:165
1. Support to refugees, IDPs, returnees, surrounding host communities and cross-border and mobile populations
2. Cross-border collaboration on the health sector response to HIV and
3. Project management, coordination, capacity building and monitoring and evaluation (M&E)

To date, IRAPP has documented a number of important achievements towards realizing these objectives in selected project sites. Since project inception, IRAPP has: supported the development of harmonized HIV protocols and standardized referral charts to facilitate coordinated work in either side of borders; facilitated inter-country collaboration through cross-border meetings aimed at this harmonization of services, capacity development, and knowledge sharing; and worked to strengthen health facilities providing services at cross-border points. Specifically, the Red Sea countries supported by IRAPP – Djibouti, Ethiopia, Somalia and Sudan – have conducted national protocol workshops and developed standardized materials and training modules on the implementation of new protocols and tools. These countries have also held cross-border meetings and developed operational guidelines to support inter-country collaboration. Finally, health facilities have been renovated and health care providers trained in at least 5 hotspots.166

The following provides an overview of regional activities completed through the third quarter of 2011, followed by a review of 2011 country-level progress.

Progress Report through August 2011: Regional Overview

HIV prevention is the most important and effective strategy for reducing and controlling the spread of HIV and other STIs among the cross-border mobile populations, refugees and IDPs, host and surrounding communities at IRAPP supported sites. IRAPP has promoted a number of prevention approaches at these hotspots, including Information Education Communication (IEC), Behavioural Change Communication (BCC), condom distribution, STI treatment, HIV counselling and testing, and PMTCT. Specifically, by the third quarter of 2011, 41 community-based programs were working on IEC/BCC; more than 20,000 people have been reached through community based programming, particularly sex workers, long distance truck drivers, cross-border mobile populations, refugees and IDPs; 287 people with HIV have enrolled in home-based care; 8 schools have integrated HIV into their curricula; nearly 20,000 HIV-related books, brochures and leaflets have been distributed to the target population; more than 6,000 HIV posters sending messages related to prevention, care and treatment have been hung at hotspots; 5 billboards have been erected at hotspots; and many sites have started using radio as a means to reach the vast majority of target groups. In the third quarter of 2011, nearly 400,000 male condoms were distributed, bringing the total number of condoms distributed since the onset of the project to nearly 3.7 million.167

165. Ibid.
STIs are the most common cause of illness in all IGAD Member States among young people, and are therefore considered a major public health problem in the region. A number of studies suggest that the presence of an untreated STI increases the likelihood of HIV transmission during unprotected sexual intercourse. **Prompt and appropriate STI prevention, control and treatment** are considered essential approaches to preventing the spread of HIV. To date, all IRAPP Member States have provided training to health care providers on the syndromic approach to STI treatment and the harmonization of STI protocols has supported coordination on treatment choices among health care providers across borders. In the third quarter of 2011, more than 3000 STI patients were treated according to the syndromic approach to treatment, which increased the cumulative uptake of STI treatment to nearly 38,000. This achievement more than doubles the project target.

At the beginning of the project, few sites were providing voluntary and provider initiated HIV counselling and testing. Today, **HIV counselling and testing** is available at all IRAPP sites. Forty-seven health facilities are providing HCT and some sites are also providing outreach counselling and testing services. In the third quarter of 2011 alone, more than 60,000 people were tested for HIV, including pregnant women. The cumulative total since the project inception stands at more than 185,000 people counselled and tested. The number of IRAPP **PMTCT** sites has increased from 11 in 2009 to 16 in 2010 to 28 in the third quarter of 2011. The scaling up of PMTCT programming has resulted in an increase in the number of pregnant women who have completed their course of ARVD prophylaxis from 204 in 2009 to 293 by the third quarter of 2011. The total number of pregnant women who have received ARVD prophylaxis for PMTCT now stands at more than 1000. Despite this progress, the numbers of PMTCT sites remain limited.

**Gender-based violence** is prevalent in refugee and internally displaced populations camps, as well as in mobile hotspots. IRAPP has prioritized increasing gender-based violence awareness among key populations to help reduce the number of abuses. During 2011, only 54 percent of survivors of reported cases of gender-based violence received medical care. Of the reported cases, 15.7 percent were raped and 80 percent of those victims received prompt and appropriate Post-Exposure Prophylaxis (PEP) by trained ART medical personnel. IRAPP has found that with such high levels of gender-based violence in refugee and IDP camps, programming directed at preventing and controlling gender-based violence must be strengthened.

IRAPP is recommending that **comprehensive HIV services** be provided to all hard to reach populations, including cross-border mobile populations, IDPs, refugees, and host and surrounding communities at hotspots. IRAPP is certain that the introduction of **ART** and the provision of quality health services at hotspots will greatly reduce AIDS-

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168. Ibid, 17.
169. Ibid, 18.
170. Ibid, 19.
related morbidity and mortality. The number of people receiving HIV care has increased from 59 in 2009 to 8767 at the end of the third quarter of 2011. IRAPP is also advancing the provision of home-based care. Since introducing this component in 2010, a total of 1485 people with HIV have received home-based services. The number of people accessing ART has drastically increased since 2009 when there were only 379 people receiving ART at IRAP sites. As of the end of the third quarter of 2011, the number of people receiving ART has increased to 2134. However, the number of people receiving ART at the end of 2010 was 2666, which indicates that the program lost a total of 532 patients. According to IRAPP, reasons for this may include patient transfer to other health facilities, patients who stopped taking their medications, patients who died, or problems related to patient monitoring systems. This issue must be investigated further.172

Despite limited resources and the complexity of comprehensive care and support programs, IRAPP has made efforts to support the provision of economic and psychosocial support to both people with HIV and orphaned and vulnerable children. In general, people with HIV are in need of ART, rehabilitative support and income generation activities. Support for orphaned and vulnerable children, involving shelter, food, education, psychosocial support and medical and legal protection, requires strong attention as well. Support provided to both of these populations should also consider the family or communities affected by this care. In 2011, through the third quarter, financial and material support was provided to 1963 people living with HIV and orphaned and vulnerable children, increasing the total number of people reached with these services to 2831 since the project onset in 2009.173

IRAPP has also prioritized the involvement of people with HIV in the process of scaling up HIV prevention, care, treatment and support among cross-border mobile populations, host and surrounding communities. The engagement of associations of people with HIV with reducing stigma and discrimination is already high, so IRAPP recommends that implementing partners work with these associations to intensify all HIV interventions to support behaviour change, knowledge generation, and improved access to prevention, care and treatment services. IRAPP has supported the establishment of associations of people with HIV, beginning with 3 in 2009, increasing to 16 in 2010, and reaching 28 associations of people with HIV by the third quarter of 2011. However, this progress is only 80 percent of the target originally set. There is a need for implementing partners to intensify this community component and continue establishing these associations.174

A major pillar of IRAPP has been strengthening human capacity – both in the health sector response and at the community level – to provide HIV prevention, care, treatment and support programs. A number of trainings have been provided at regional, national and site levels by IGAD, IRAPP, the Project Facilitation Office (PFO), Member
States, UNAIDS and UNHCR since the onset of the project. Since 2009, a total of 2020 health care providers, 1793 peer educators, 646 youth, and 4327 people with HIV, sex workers and community and political leaders have been trained.175

2011 Country-level Achievements

**Djibouti**

At the beginning of the project, 1 hotspot, Galafi/Yoboki, and one refugee camp, Ali Abde refugee camp were selected as target sites. In 2011, three additional sites were identified for project activities: Obock, PK12 and Dora. During 2011, Djibouti conducted a number of important activities at the PK12 hotspot. A network of three associations was created to facilitate outreach to mobile and resident populations, including truck drivers, sex workers and local youth. Training was provided to health care providers as well as 85 peer educators, including 41 youth, 20 women leaders, 15 religious leaders, eight community actors, five truckers and four sex workers. These trainings were facilitated in three different languages – Amharic, Somali and Afar. Equipment was also provided to the PK12 health centre. Finally, an agreement was made with the Ministry of Health to support capacity building and quality improvement at the health centre. However, IRAPP notes that despite this progress at the PK12 site, the pace of service provision in all sites is not encouraging. IRAPP reports that the Djibouti National AIDS Commission is expected to urgently resume health sector and community based programming at Galafi/Yoboki and send progress reports, and to conduct rapid assessment and initiate services at Obock, PK12 and Dora.176

**Ethiopia**

IRAPP has identified three hotspots in Ethiopia – Haweli, Metemma and Togochale – and one refugee camp known as Awberre. Six HIV counselling and testing sites, 6 STI sites, 3 PMTCT sites and 3 ART sites have been established in these locations. Metemma City, which borders Galabad, Sudan, is the only one of these sites that provides the comprehensive HIV care package. In 2011, a number of activities were carried out in Metemma, including the delivery of comprehensive HIV prevention, care, treatment and support at the hotspot. Training has been provided to both health workers and community based workers, an advocacy campaign was conducted in the city, an assessment was conducted to build the information centre and a cross-border meeting was held with the Galabad side. Finally, with the facilitation of IRAPP, a 2011 action plan was developed in collaboration with key stakeholders. IRAPP recommends that next steps in Ethiopia include equipping the Haweli and Togochale sites with comprehensive HIV services.177

**Somalia**

Somalia has eight hotspots and one IDP/returnees camp supported by IRAPP. The num-

175. Ibid, 23.
177. Ibid, 5.
ber of sites with functioning HCT and STI services increased in Somalia from 5 in 2009 to 10 in 2010. Specific actions undertaken in 2011 took place in the Berbera and Bossaso hotspots. Berbera is the Northern port town on the Gulf of Aden and serves as a primary port to Somaliland, serving all shipping interests of the region and acting as a commercial hub. Integrated Behavioural Surveillance Surveys (IBSS) have shown that Berbera town has gone beyond the generalized epidemic threshold of 1 percent in the general population. Bossaso is a commercial capital of the Puntland state of Somalia and functions as a key exit point for the entire Horn of Africa with an estimated population of 400,000. Bossaso reportedly harbours sea piracy and this has been attracting a number of sex workers due to the vast amounts of money in circulation. In response to these dynamics, UNAIDS and Somaliland National AIDS Commission in collaboration with IRAPP have conducted a hotspot mapping rapid assessment that looked into various demographic, socioeconomic issues, behaviour and health facilities in both Bossaso and Berbera ports. Additional interventions carried out since the beginning of 2011 include the rehabilitation of the health centres, deployment of health care providers, training of health care providers, establishment of VCT centres and procurement of basic laboratory reagents. Next steps identified by IRAPP include the initiation of comprehensive HIV services in all sites in Somalia, and the submission of reports for 2011.178

Sudan

Sudan has two functional sites, Galabad and Wad Sharifey, which provide HCT and STI treatment; ART and PMTCT are only provided at the UNHCR refugee camp. In 2011, IRAPP has worked in collaboration with SNAP at the Port of Sudan and the main transport corridor between Metemma and Galabad (Sudan – Ethiopia) to launch and establish a new health facility near two local hotspots – a market and a customs truck check point – to support the provision of HIV prevention education to target groups. Based on the results of an assessment of the context, population and health services available in the area, a comprehensive plan was prepared in full collaboration with the local AIDS programme and implementing partners that outlined the health and community services needed in the area. A piece of land near the market was selected for the site of the new health facility and is now officially owned by the Ministry of Health, which will be responsible for providing services to the target populations. Two “containers” were purchased for use as the health facility clinics and offices, and are currently in place on location and under renovation. Basic furniture and equipment have also been purchased for the health facility. By June 2011, 15 health providers had been trained in HCT, PMTCT and syndromic STI management, 153 clients had been counselled and tested and know their results, 25 clients had received STI services, and 2881 condoms had been distributed. Finally, an agreement has been signed with an NGO to implement community-based activities for mobile populations. However, IRAPP notes that comprehensive HIV services, including ART and PMTCT are not yet being provided and must be initiated.179

178. Ibid, 4-5.
179. Ibid, 3-4.
Conclusion

As a result of IRAPP’s work, HIV counselling and testing services are available in most hotspots and clients have access to these services. Most sites also have PMTCT services with the exception of Somalia and one site in Ethiopia, STI services are being provided in most IRAPP supported hotspots and more than half of the targeted VCT sites have been established. This shows that there is infrastructure in place that can be used to scale up services to cross-border and mobile populations. However, IRAPP notes that more work must be done to ensure the existence of HIV interventions at cross-border points and to ensure the provision of ART and PMTCT services at all health facilities. Referral services should be strengthened to ensure efficient links to health facilities at hotspot areas for vulnerable populations. Infrastructure that is already in place for service delivery must be used in scaling up service coverage. At the same time, capacity building activities and trainings held at the regional level are not always coordinated and shared with implementing partners at the local level. IRAPP recommends that these activities be better relayed to service providers at hotspots and that coordination between service providers within and between countries be improved. Finally, target countries must send in progress reports, follow through with additional research and conduct scheduled initiation of services.180

180 Ibid.
Lessons Learned from Beyond the Red Sea Region
Sub-Saharan Africa has the highest regional adult HIV prevalence in the world, estimated at 5.0 percent. The region is also home to a number of cross-border transport corridors and sea ports which experience heavy traffic and high HIV prevalence. In recent years, programming on the issue of HIV vulnerability in the context of mobility and migration has advanced in some parts of the region. The following examples provide useful insights, best practices, and lessons learned from beyond the Red Sea Region that will contribute to a better understanding of how interventions might be developed in the Red Sea and Gulf of Aden.

Kampala-Juba Transport Route, Uganda and Sudan

The progression of peace processes and the relative improved security in Northern Uganda and South Sudan has resulted in an opening up of the Kampala-Juba transport route, with significant increases in traffic there in recent years. Traffic along this route is due to demands for goods in South Sudan, the transportation of goods from Kampala to Juba, and northern migratory movement of individuals seeking employment opportunities. A 2008 IOM mapping and situational analysis raised a number of key issues related to HIV risk behaviour along this route. Truckers are extremely mobile, transactional sex is at high levels, and condom use is below that needed to curb the transmission of HIV and STIs. There are very high levels of STI self reported by truck drivers and later confirmed by a review of health facility data. Health facilities along the route tend to be small, private dispensaries and drug shops.

In this context, IOM’s mission in Uganda collaborated with the Amalgamated Transporters and Genderal Workers’ Union (ATGWU) and UNAIDS to support three private health clinics at HIV hotspots along the highway between May 2010 and August 2010 in an effort to avert the escalating spread of HIV among key populations at higher risk. The aim of the Friendly Project was to assess effective modes of HIV service delivery to these populations through three components (1) achieving universal access to HCT; (2) increasing condom use; and (3) reducing numbers of concurrent sexual partners among hotspot communities. Each clinic received a regular and sufficient supply of free condoms and free HIV testing kits, and was supported to conduct mass mobilization campaigns to encourage these populations, including female sex workers, traders and

183. Alan Ferguson, Kelsi Kriitmaa and Greg Irving, HIV Hot-Spot Mapping and Situational Analysis Along the Kampala-Juba Transport Route (Kampala: International Organization for Migration, 2008).
truckers, to utilize the available HIV services. The first phase of the project was launched in May 2010 targeting the hotspots of Kigumba, Mweyale and Karuma in Kiryandongo.\textsuperscript{184}

The project has enjoyed a number of key achievements, including community mobilization for project uptake, the identification and training of 30 community volunteers as peer educators, and the identification, branding and capacity development of three partner private clinics. IEC materials, including 100 t-shirts and 200 stickers have been distributed, 30 condom pick up points have been established, and 12 HCT mass campaigns were conducted. Under component 1: universal HCT, more than 2000 people were tested for HIV. Under component 2: increase condom use, more than 60,000 condoms have been distributed. And under component 3: reduce the number of sexual partners, more than 3000 people have been reached with HIV prevention messages on an interpersonal basis over three months. IOM’s intervention has contributed to a 10 percent increase in demonstrated awareness of facilities at which to acquire condoms among the target populations, a 17 percent increase in the number of target people accessing free condoms, and a 32 percent increase in the number of target people getting tested for HIV. According to IOM, these increases are not only strong signals of change, but evidence that behavioural patterns and practices of the key populations at higher risk can be changed for the better through targeted programming.\textsuperscript{185}

Five major recommendations have emerged from the pilot project.\textsuperscript{186}

1. It is essential that the frequency of mass mobilization campaigns be increased as they are clearly contributing to the rise in the number of key populations at higher risk that are being tested.

2. Moonlight HCT services should be provided to ensure that truckers are reached. Camps should be established at HIV hotspots, remaining intact for several days at a time and through the night, to make certain that truckers are reached and tested.

3. An effective referral service for key populations at higher risk who test positive for HIV through mass mobilization campaigns and moonlight HCT services should be established so that these people can access services such as ART or PEP as soon as possible.

4. Condom distribution must be strengthened. There is a 17 percent increase in the number of key people at higher risk who have received free condoms since IOM’s April 2010 baseline study was carried out, but this still only represents approximately one in five people. Noting that the cost of condoms is constantly indicated by target populations as being a barrier to frequent usage, there is a clear need to increase the supply of free condoms to private health clinics and other high demand outlets such as drug shops and bars, guesthouses and hotels.

\textsuperscript{184} IOM, HIV Service Delivery Along Transport Routes: Kampala-Juba Highway, Migration Health Programme Project Report (Kampala: International Organization for Migration, 2010).

\textsuperscript{185} Ibid.

\textsuperscript{186} Ibid.
5. A scalable HIV awareness programme should be implemented to address existing myths and misconceptions, mobilize uptake of HIV services and foster the adoption of safer sex practices.

Abidjan-Lagos Transport Corridor, Cote d’Ivoire and Nigeria

The Abidjan-Lagos transport corridor is the major east-west transport corridor in West Africa, connecting the capital cities of five countries: Cote d’Ivoire, Ghana, Togo, Benin and Nigeria. The ECOWAS policy of free movement of nationals of member countries, which include all five countries along the corridor, contributes to increased travel along the Abidjan-Lagos transport corridor. Travel takes place over short and long distances and for social and commercial reasons. With increased trade taking place between the countries along the corridor, commercial drivers have become increasingly common on the highways. While travel along the corridor is recognized as an essential requirement for the socioeconomic development of the region, it also offers opportunities for faster transmission of HIV and other infections. Sex workers, commercial vehicle drivers, migrants and local populations who live along the corridor are vulnerable groups that may be adversely affected by the absence of HIV prevention, care and support services.187

In this context, the Abidjan-Lagos transport corridor project objective is to increase access to HIV prevention, basic treatment and support and care services for underserved vulnerable groups along the corridor. Particular attention is given to transport sector workers, the migrant population, sex workers, and local populations living along the corridor, especially at the border towns. The project is expected to contribute to reducing the spread of HIV and to mitigating the adverse social and economic impact of HIV through three components: (1) HIV prevention services for the targeted population; (2) HIV and AIDS treatment, care and support services for the targeted population; and (3) project coordination, capacity building and project development.188

Component (1) supports the implementation of an integrated HIV/IEC/BCC policy along the transport corridor, as well as the social marketing of condoms in the 8 geographic border communities, with the participation of the public sector, the private sector and civil society organizations. Component (2) supports the strengthening of public and private health care facilities to provide VCT and STI treatment, the provision of grants to civil society organizations to undertake community-based initiatives in HIV care and support, and the disposal of medical waste related to the project. The project is also supporting access to ARVs in coordination with national AIDS programmes. Finally, component (3) supports the development of HIV inter-country coordination mechanisms and partnerships among governments and other project stakeholders, capacity building


188. Ibid.
among the implementing partners, and the implementation of transport sector policies favourable to arresting the erosion of social capital, including for the smooth movement of commercial traffic along the corridor.\textsuperscript{189}

\textbf{The project has yielded a number of important lessons:}\textsuperscript{190}

1. Working within the framework of existing institutions is best but it may be necessary to create new institutions to cater to the regional dimensions.

2. Effective involvement of the transport sector cannot be taken for granted. Selecting the appropriate public and private sector transport organizations and identifying champions for the design and implementation of programs at an early stage are always likely to be critical success factors.

3. Experience has confirmed that national programs are not generally geared up to address the problems in the cross-border areas that the corridor project was designed to address.

4. Substantial benefit can be derived from the expertise and experience of the private sector in mounting successful programs. Commercially oriented approaches, such as branding services and products within a specific corridor, may be effective in overcoming obstacles to cross-border HIV programs.

5. Language and cultural differences between member countries are significant factors to be addressed.

6. Getting the balance right in the priority given to prevention, treatment and care is a dynamic exercise.

7. Consensus building has to be given priority in dealing with the wide range of potential external partners.

\textbf{Port of Dar Es Salaam, Tanzania}

The Regional Outreach Addressing AIDS through Development Strategies (ROADS II Project) has expanded to 36 sites in 10 countries in East and Central Africa, and Zambia. The ROADS vision is to reach key populations at higher risk, foster community driven programming, and to address root causes of vulnerability. ROADS is active in the port of Dar Es Salaam, where HIV prevalence in the Temeke district is 10 percent. The port sees more than 2,300 port workers per day, many of whom are away from home for extended periods. There are high levels of sexual interaction between port workers, including seafarers and transport workers, and vulnerable community members. Key drivers of HIV infection around the port include: multiple and concurrent partnerships, transactional sexual relationships, idleness among youth, cross-generational sex, and alcohol and drug use. There is high stigma at the community and family levels, resulting
in low disclosure of HIV status by many people with HIV. Despite port authority workplace programmes, there are low levels of condom use and women lack condom negotiation skills.\textsuperscript{191}

As a part of the ROADS project, “SafeTStop” Recreation and HIV Resource and Wellness Centres have been established along the main transport corridors and a centre is currently being established at the port of Dar Es Salaam. The centre will offer an alcohol-free setting as an alternative to bars and lodges, satellite TV, pool and other games, and internet access to help transport workers stay connected with their families. The centre will also offer HIV education, condom distribution, HCT, STI diagnosis and treatment, alcohol counselling and men’s discussion, in addition to referral to facility and community based outlets, including private sector pharmacies. Joint prevention care and support programming will also be offered.\textsuperscript{192}

As of the 2009 Regional Workshop on HIV Responses among Seafarers and Port-Based Communities in Southern Africa in Durban, the ROADS Project at Dar Es Salaam had been functioning for 6 months and had experienced a number of key achievements. Thirty five thousand people had been reached with relevant HIV prevention messages and 3,000 people had been provided with HIV counselling, testing and results through collaboration with the Temeke district Ministry of Health. HIV-positive clients were referred to community and facility based services including ART. All programming had been carried out in close collaboration with Port Authorities through dialogue meetings, regular updates and a community partnership pact.\textsuperscript{193}

The ROADS Project has produced the following recommendations:\textsuperscript{194}

- It is essential that attractive “safe” spaces to draw port workers away from bars at times when they are most vulnerable be established.
- Workers who are far from home must be helped to stay connected with their families.
- It’s recommended not to focus on one target audience in isolation but to reach transient workers and other vulnerable audiences together.
- Port authorities and local ministries of health should be involved in the planning process from the beginning to ensure that project services complement those that already exist.

Port of Beira, Mozambique

Beira is the second largest port in Mozambique and handles over 1.5 million tonnes of cargo per year. Located in Sofala Province, the centre of the country, where the Pungue River meets the Indian Ocean, the port and city of Beira serve as a primary transportation point for export items coming from Zimbabwe, Malawi and Zambia. The Sena Rail-
way line links the coalfields of Moatize in Tete Province, a convenient transport stop near Zambia and Malawi, directly to the port. All three of the ports of Mozambique, Beira, Maputo and Nacala are considered “spaces of vulnerability” by IOM both for migrants and for the populations who work and live around the ports.195

The majority of port-users work for private companies, including at the port of Beira, which has been under the management of Cornelder of Mozambique, a privately owned Dutch port management company, since 1999. In a 2010 assessment of health vulnerabilities among migrant and non-migrant workers in Mozambique’s ports, IOM found that Cornelder’s Health Port Project demonstrated a viable public-private partnership (PPP) model. Healthy Port began as an informal discussion group among Cornelder employees and grew into a funded project addressing HIV in the port of Beira through HIV training and testing and involves port workers from 26 companies. The project staff and volunteers directly target four social groups: (1) workers’ wives, (2) workers’ sons, (3) workers’ daughter, and (4) transporters and those that serve the transport sector, including sex workers and bar owners. By 2009, over 5,000 port users and port-user family members were tested for HIV, 14,000 hours of training has been provided and 116 young men were circumcised by the local hospital.196

Based on this experience, IOM recommends the continuation and increase of PPP HIV and health campaigns in the port areas to use the workforce and their company capacities to reach their workers. The Cornelder Health Port Project is considered a best practice.

Walvis Bay, Namibia

Walvis Bay is Namibia’s only deep-water port and is the focus point of a large commercial fishing industry, which attracts job seekers from other parts of Namibia as well as other southern African countries. In addition to being the hub of the commercial fishing sector, Walvis Bay is a key node on the two major highways – the Trans-Caprivi Highway, and the Trans-Kalahri Highway that link Namibia directly with Angola, Zambia, Botswana and South Africa. Indirectly these highways link the town of Walvis Bay with destinations well beyond its immediate neighbouring states.197

IOM’s research into the dynamics of HIV risk behaviour among fisherman, truck drivers and sex workers in Walvis Bay revealed a nexus of vulnerability factors among these populations. Foreign fishermen’s vulnerability to HIV stems from lack of HIV knowledge and education, frequent unprotected sex, high-risk sexual activities and short-term relationships with sex workers, frequent abuse of alcohol, and language barriers. Although the various types of sex workers experience different sources of vulnerability, most are negatively impacted by poverty, marginalizing cultural and gender practices, exposure


196. Ibid.

197. IOM, Regional Workshop on HIV Responses among Seafarers and Port-Based Communities in Southern Africa 4-6 November 2009 Durban, South Africa.
to violence, stigma and victimization, alcohol and drug abuse, language barriers, frequent exposure to unprotected sex and high risk sexual practices and frequent contact with high risk, highly mobile clients. Finally, truck driver vulnerability stems from their constant mobility and instability, frequent sexual activity with sex workers, frequent unprotected sex, lack of education or unwillingness to internalize HIV education, and frequent alcohol abuse.\textsuperscript{198}

IOM’s response to this situation was to develop a model that outlines components of an HIV prevention and care project among mobile workers. The model incorporates a number of components, including (1) workplace policies to create a conducive work environment; (2) building life skills (e.g. financial literacy); (3) peer education and referral to primary health care; (4) gender interventions addressing discriminatory gender dynamics and prejudices through the training of male role models; (5) sustainability, in terms of institutional capacity and building local partners; (6) facilitating access to health care and services including VCT, ARVs and condoms; (7) recreational activities – addressing the issue of loneliness and boredom and other contextual factors that impact HIV vulnerability; and (8) integrated and locally tailored social change communication programmes, which link all components.\textsuperscript{199}

At the time of the regional workshop where these experiences were presented, the IOM HIV interventions in Walvis Bay were working with local implementing partners to target local and foreign seafarers, particularly in the fishing sector and working with five fishing companies to target seafarers through a pilot intervention. IOM is also working with the Namibian Maritime Fisheries Institute to mainstream HIV within seafarers’ vocational training and producing advocacy and training material.\textsuperscript{200}

**Busia and Malaba, Uganda**

Following post-election violence in December 2007 and January 2008, more than 6,000 Kenyans fled to Uganda to seek refuge. In Busia and Malaba, Uganda, ROADS community “clusters” – associations of like-minded community based organizations reaching specific populations – mobilized themselves to assist the refugees. Acting on their own initiative, they have provided food and clothes and have extended HIV services. Until being moved to refugee camps in Mulanda, Uganda, about 30 kilometers from the Kenyan border, approximately 3,000 people were being sheltered at Busia Integrated Primary School at St. Stephens Church in Malaba. There, peer facilitators with the youth cluster conducted sessions with Kenyans from across the border, gave magnet theatre performances at St. Stephens, and linked Kenyans to services provided by an outreach clinic set up by a Malaba health centre. The Malaba low-income women cluster distributed condoms to Kenyans at St. Stephens and opened its offices to refugees so they can access HIV information and be linked with community services. In Busia,
the Red Cross, which leads the youth cluster, has been coordinating the emergency response. Through the clusters, Red Cross mobilized community assistance including refugee registration and material support (food, soap, etc). The clusters conducted HIV-related outreach and mobilization at Busia Integrated Primary School. Though the cluster model was developed through ROADS to expand community-based HIV programming, clusters are finding the model useful in organizing community responses to other issues, including emergencies, environment and governance.201

Conclusion

These examples provide a number of important lessons. First, it is clear that working within existing frameworks facilitates more effective and sustainable implementation of HIV interventions for mobile people. Second, interventions should be designed with strong reference to available information on the unique needs and situations that distinct mobile groups experience, so that those interventions are better equipped to provide the information, services and care that those groups require. Third, partnerships with local actors, institutions and businesses are essential to supporting the development of interventions that are capable of reaching wide audiences and that are more sustainable over the long-term. Based on these lessons and the status of the current situation and response in the port areas and adjacent transport corridors of Red Sea and Gulf of Aden, it is clear that existing interventions must be strengthened. Highly targeted responses must be designed to address the complex layers of vulnerability experienced by cross-border mobile populations. These responses should be directly informed by the specific evidence generated by current and ongoing research, and additional research should be conducted in countries for which evidence is lacking. Additional partnerships with the private sector, labour organizations and civil society should be developed at the local level to facilitate continued and expanded work within existing frameworks and institutions.

Conclusion
The information presented in this report provides a developing picture of the HIV vulnerability factors that cross-border mobile populations face in the Red Sea and the Gulf of Aden, and the steps currently being taken to address this situation in the region and beyond it. Essentially, the same factors that drive population movement in the region, including poverty, unemployment and displacement, also give rise to high-risk sexual activity. The loneliness and isolation that transport workers, young pastoralist men and uniformed services feel during long distance separations from their families and communities can lead many of these men to engage in high risk sexual activity with multiple partners. Mobile women, including female sex workers, who are faced with poverty, disempowerment, and gender inequality, may cope with risky behaviour and are vulnerable to gender-based violence. These dynamics play out in spaces shaped by vulnerability, where the combination of high HIV prevalence and high HIV vulnerability indicate that there is a strong likelihood that the epidemic will spread quickly in these zones.

To compound matters, mobile people passing through or around the hotspots in the Red Sea and Gulf of Aden lack access to crucial health services, including HIV prevention, care, treatment and support. This gap is due both to isolation and marginalization and to limited service availability in remote areas, even for local resident populations. Recent work has begun to address these gaps in the region, through the scaling up of existing HIV services at targeted hotspots and the promotion of coordination and collaboration among national actors and across country borders. Programming from outside the region demonstrates that targeted interventions should be built to serve the unique needs and situations of distinct mobile groups using existing frameworks and infrastructure and involving collaboration and partnership across sectors.

The following specific conclusions are presented:

**Situational Analysis**

*Cross-border mobile populations in the Red Sea and Gulf of Aden experience multiple levels of vulnerability to HIV, including individual, social/economic and programmatic.* Individual vulnerability refers to the loneliness and isolation that mobile people experience as result of long-distance separation from family and partners, dis-
connection from social norms and traditions, and differences in language and culture. These factors can lead individuals to engage in behaviours associated with high risk for HIV. Social and economic vulnerability is associated with extreme poverty, either as a cause or consequence of movement, lack of legal status and rights in transit and/or destination countries, stigma and discrimination, and prevalent gender inequality, which makes women vulnerable to violence and abuse. Finally, programmatic vulnerability, refers to the limited access to health, information and other support services that mobile people experience.

These populations interact with each other in “spaces of vulnerability” or hotspots along the transport corridors, at border crossings and in port areas that are characterized by high-risk sexual activity. Spaces of vulnerability are the areas where goods and services such as fuel, lodging, vehicle repair, loading/unloading, immigrations or customs clearance, meals, alcohol, drugs and entertainment, are offered to people who live or work near highways or ports. These “hotspots” are frequented by large numbers of mobile people throughout the Red Sea and Gulf of Aden region, including female sex workers, truck drivers and their assistants, seafarers, uniformed service men, pastoralists and refugees. These groups self-report engaging in multiple concurrent sexual partnerships with casual or regular partners, including sex workers. The female sex workers interviewed report that truck drivers are their most common clients, followed by uniformed service men, other mobile men, and in some places, nomads. In every country, respondents reported low or irregular condom use and demonstrate limited HIV knowledge and risk perception. This combination of factors, including the high HIV prevalence observed among female sex workers in many places, indicates that HIV vulnerability is extremely high in these settings.

Traffic is increasing along many of the most important transport corridors and around key port areas in the region, which means larger numbers of mobile people will be passing through these hotspots. Expansions in transport corridors to accommodate growing demand for trans-border shipping and exchange of commercial goods has led to significant increases in traffic in a number of hotspots around the Red Sea and Gulf of Aden. For example, planned expansions at the Port of Djibouti are expected to nearly double traffic there and traffic is also increasing between the Horn of Africa and the Arab Peninsula − 50 percent more people crossed the Red Sea from Africa to Yemen in 2009 than in 2008. These increases in the number of transport workers and seafarers frequenting hotspots around the region may mean an expansion of the sex work industry in these areas and increased potential for the spread of the epidemic in and around hotspots.

Gender-based violence and sexual abuse are extremely common in mobile contexts in the Red Sea and Gulf of Aden, especially contexts shaped by conflict or crisis. Migrant women, women affected by humanitarian crisis and female sex workers who ex-
perceive marginalization, disempowerment and poverty will be extremely vulnerable to gender-based violence, sexual abuse, and offers of money, food or shelter in exchange for sex. Uniformed service men in particular have been strongly associated with the perpetuation of sexual violence during conflict and violence against women is common in refugee camps and other humanitarian settings. Pastoralist women are required by custom to engage in harmful traditional practices, including female genital mutilation, wife sharing and wife inheritance, that increase risk of exposure to HIV. Forced or coerced sex in any setting places women in greater danger of HIV infection.

Response Analysis

Research indicates that mobile populations in the Red Sea and Gulf of Aden are not adequately reached by existing health services and programming in the region. The mobility process is isolating and cross-border mobile populations in hotspots generally lack access to information, health services and other forms of social support. At the same time, few services or programs target the unique needs and situations of mobile people. In general, the range of health facilities that exist along the major transport corridors and in stopover towns is narrow and facilities tend to be understaffed, overstretched and lacking in crucial resources. In addition to limited or nonexistent HIV testing and prevention services, STI and HIV medication stocks are often in short supply and staff training on HIV, STI and gender is limited. Minimal outreach is conducted to encourage high-risk groups to access services that do exist and some facilities report that it is difficult to reach people on the move.

IRAPP has begun to implement a response to HIV vulnerability of mobile populations in IGAD countries and has made strong progress on strengthening of health facilities, supporting inter-country collaboration, and harmonizing protocols at project sites. Over the past few years, IRAPP has worked to facilitate the provision of coordinated HIV services for mobile populations on either side of borders through the harmonization of protocols and the facilitation of inter-country collaboration between ministries of health and key HIV service providers in the IGAD countries. IRAPP has also worked to scale up HIV and STI prevention outreach and strengthen the capacity of health facilities to provide comprehensive treatment and care at cross-border points. Since project inception in 2009, more than 20,000 people have been reached through community based prevention programming, the number of people receiving ART has increased from 379 in 2009 to 2134 in 2011, training has been provided to 8786 people, including health care providers, peer educators, youth, people with HIV, sex workers and community leaders, and new associations of people with HIV have been established to support community outreach.

IRAPP also documented important progress in selected project sites in four Red Sea

countries in 2011. In Djibouti, training and equipment have been provided to communities and health facilities in two hotspots and a network of associations has been assembled to reach truck drivers, sex workers and mobile youth. In Ethiopia, accomplishments include the delivery of comprehensive HIV care at the Ethiopia-Sudan border, the provision of training to health and community workers, and the implementation of an advocacy campaign. In Somalia, completed activities include the rehabilitation of health centres, training and deployment of health care providers and the establishment of Voluntary Counselling and Testing (VCT) centres. And at the Port of Sudan, a new health facility has been built and developed to serve the community in and around the hotspot.

Despite progress in scaling up HIV services in hotspots around the region, IRAPP has found that health facilities in these areas still lack the capacity to provide HIV treatment on site, including ART and PMTCT. Among the services provided by health facilities at cross-border points, the most common is HIV counselling and testing, followed by STI treatment and treatment of opportunistic infections. However, few health facilities have the capacity to provide HIV treatment services and as a result, ART and PMTCT are not available in most hotspots. Capacity building activities related to HIV treatment provision must be prioritized at the regional level and transmitted to implementing partners to redress these gaps.

IRAPP reports that collaboration among health facilities, with civil society, and among regional, national and implementing actors must be improved. Specifically, referral services should be strengthened to ensure efficient links to health facilities at hotspot areas for vulnerable populations. Outreach to people with HIV and other community leaders must also be supported and associations established. IRAPP also notes that capacity building activities and trainings held at the regional level must be better coordinated and shared with implementing partners at the local level and that coordination between service providers must be improved.

Lessons Learned from beyond the Red Sea Region

It is clear from experiences across Africa, as well as in the Red Sea and Gulf of Aden countries, that working within existing institutions and frameworks facilitates more sustainable implementation of HIV interventions for mobile populations. In its experiences scaling up HIV interventions at hotspots throughout the Horn of Africa, IRAPP has found that more effective work can be done through renovating and revitalizing existing service delivery infrastructure in order to scale up service coverage. Examples from other regions in Africa corroborate this finding. The Abidjan-Lagos Transport Corridor Project found that working within the framework of existing institutions is best, though it may be necessary to create new institutions to cater to regional dynamics.
IOM’s work in Walvis Bay emphasizes sustainability through building the capacity of local partners. Finally, the ROADS Project at the Port of Dar Es Salaam recommends supporting synergy with existing programming by involving local authorities and ministries of health in the planning process from the beginning to ensure that ROADS project services compliment what already exists.

Interventions that consider the unique needs and situations of distinct mobile groups are better equipped to provide the information, services and care that those groups require. A number of important lessons have emerged from IOM’s Friendly Project along the Kampala Juba Transport route regarding the importance of targeting the unique needs and situations of distinct mobile populations. For example, after 6 months the project found that HCT services must be available at night, when truckers are likely to pass through and be available for testing. The project has also recommended that condom distributions target important spaces of vulnerability, including drug shops and bars, guesthouses and hotels. The ROADS Project at the Port of Dar Es Salaam found that it’s essential to create attractive “safe spaces” to draw port workers away from bars at times when they are most vulnerable and support those who are far from home to stay connected with their families. In a similar spirit, IOM’s work in Walvis Bay has found that recreational activities that address issues of loneliness and boredom and other contextual factors that impact HIV vulnerability are essential.

Partnerships with local actors, institutions and businesses support the development of interventions that reach wider audiences and are more sustainable over the long-term. In the Port of Mozambique, employees of the Cornelder company, which manages the Port of Beira, began an informal discussion group on health and HIV in 2005 that has since grown into a funded project addressing HIV in the port area through HIV training and testing and involves port workers from 26 companies. This experience reflects a best practice in the use of public-private partnerships to disseminate key HIV prevention messages. The Abidjan-Lagos transport corridor project has found that substantial benefit can be derived from the expertise of the private sector in mounting successful programs. Commercially oriented approaches such as branding services and products within a specific corridor may be effective in overcoming obstacles to cross-border HIV programs. The project also demonstrated that effective involvement of the transport sector during the early stages of program implementation is a critical success factor.

Research Gaps

There is a marked lack of data on HIV prevalence among mobile groups in the Red Sea and Gulf of Aden countries more broadly, and in and around hotspots more specifically. While some data exists on HIV prevalence among sex workers in the Red
Sea and Gulf of Aden countries, very little information is available on HIV prevalence among the other mobile groups discussed in this report, including truck drivers, seafarers, pastoralists, uniformed services and refugees. This information is essential to the formation of a more complete picture on the level and types of responses that would best address the situation.

It is also clear that less information is available on the HIV vulnerability of cross-border populations in those countries not currently targeted by IRAPP activities – Egypt, Eritrea, Jordan, Saudi Arabia and Yemen. One study each was reviewed for Egypt, Eritrea and Yemen and no studies related to Jordan and Saudi Arabia were reviewed for this report. At the same time, IRAPP activities are currently not being supported in any of these countries. It is essential that additional research is developed on these countries and new data is generated on Jordan and Saudi Arabia in order to facilitate the development of organized responses in these places.

The lack of information on HIV vulnerability among cross-border mobile populations in the Arab Peninsula countries makes it difficult to characterize regional dynamics. Though a study on Yemen was reviewed and integrated into this report, that was the only country for which the available research was still incomplete. Though a rapid assessment is planned for Saudi Arabia, that study had not been carried out by the time of the writing of this report. Because there is a general lack of data on the HIV epidemic in these countries, it is essential that further research be carried out when possible.
Based on the results of this study, the following list of recommendations is advanced:

**Planning**

1. Support the integration of specific evidence on HIV vulnerability factors among cross-border mobile populations in the Red Sea and Gulf of Aden into national and regional level strategic planning.

2. Develop specific strategies for implementing targeted responses at the level of the Red Sea ports that account for the dimensions of individual, social and economic vulnerability and marginalization that mobile populations face.

3. Mainstream issues related to gender inequality and gender-based violence in regional and national strategies addressing the HIV vulnerability of cross-border mobile populations.

4. Develop mechanisms and set specific goals for scaling up ART, PMTCT and comprehensive HIV care at hotspot health facilities in target countries.

**Programming**

5. Design outreach campaigns for mobilizing HCT provision and condom distribution based on existing information on the movements, schedules, and spaces occupied by mobile people to widen and fine-tune the scope of these efforts.

6. Develop and implement interventions for providing appropriate and attractive alternatives to the bars, khat houses and lodges that mobile people frequent and providing resources for maintaining contact with loved ones and accessing services.

7. Continue to strengthen and harmonize referral services between health facilities at hotspots and health facilities providing comprehensive HIV care to improve access of mobile people to HIV treatment, care and support.
Partnership

8. Continue to promote and strengthen collaboration and coordination between regional organizations, national actors, health providers and implementing partners to facilitate timely and harmonized implementation.

9. Work to build bridges to existing institutions and frameworks to support the sustainable scale up of HIV interventions for mobile people.

10. Develop new partnerships with the private sector and civil society to facilitate the provision of crucial HIV information, services and resources.

Research

11. Initiate data collection on HIV prevalence among the key populations addressed in this report, especially truck drivers and their assistants, seafarers, uniformed services, pastoralists, and refugees, in order to support the development of well-informed strategic directions at the regional, national and local levels.

12. Develop research on those countries not currently targeted by IRAPP activities – Egypt, Eritrea, Jordan, Saudi Arabia and Yemen – to facilitate the development of organized responses in these places.

13. Prioritize research into the changing dynamics of population movement in the region, including the expansion of transport corridors and increases in commercial traffic, and the impact that these changes will have on the HIV vulnerability of mobile people.
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### Title
HIV Assessment Port of Djibouti Galafi Transport Corridor

### Objective
The objective of the assessment is to capture information on basic knowledge, risk behaviour, health seeking behaviour, and access to targeted comprehensive prevention programming in the IGAD region of risk and vulnerable populations.

### Methodology
The assessment includes the following components: mapping using geographic information systems, focus group discussions with female sex workers, port workers and truckers, key informant interviews, survey of bars, tea shops, chichi and resting rooms, truck census, investigation into the health-seeking behaviour of truckers, dock workers and female sex workers, and health facilities inventory.

### Key Findings
- The common health problems for both truckers/dock workers and female sex workers are fever and infectious diseases, followed by UTI/STI;
- The study revealed complaints about the lack of health services and a lack of attention to the specific needs of truckers and female sex workers;
- Both female sex workers and dock workers/truckers engage in a significant amount of risky behaviour and condom use is low;
- Most dock workers/truckers and female sex workers waited at least 2 days while experiencing STI symptoms before seeking help;
- Nearly 40 percent of dock workers/truckers and 50 percent of female sex workers continue to have sex while experiencing STI symptoms;

### Table 7: Summary of HIV Assessment Port of Djibouti Galafi Transport Corridor

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<td>Methodology</td>
<td>The assessment includes the following components: mapping using geographic information systems, focus group discussions with female sex workers, port workers and truckers, key informant interviews, survey of bars, tea shops, chichi and resting rooms, truck census, investigation into the health-seeking behaviour of truckers, dock workers and female sex workers, and health facilities inventory.</td>
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</tbody>
</table>
| Key Findings | - The common health problems for both truckers/dock workers and female sex workers are fever and infectious diseases, followed by UTI/STI;  
  - The study revealed complaints about the lack of health services and a lack of attention to the specific needs of truckers and female sex workers;  
  - Both female sex workers and dock workers/truckers engage in a significant amount of risky behaviour and condom use is low;  
  - Most dock workers/truckers and female sex workers waited at least 2 days while experiencing STI symptoms before seeking help;  
  - Nearly 40 percent of dock workers/truckers and 50 percent of female sex workers continue to have sex while experiencing STI symptoms; |
The current health facilities along the corridor are limited to few and are not designed to cope with the huge traffic that is expected to double in the near future; no specific services targeting truck drivers and female sex workers are available and these groups have to share the limited health services with the general population; the large majority of female sex workers do not know where to go for health services; staff training and STI management is satisfactory and first line treatment is available. However, lack of comprehensive VCT is an immediate problem; respondents demonstrated strong knowledge of HIV, despite their risk behaviour.

**Recommendations**

There is a need to put in place a package of targeted interventions for the truckers/dock workers and female sex workers. The package should include:

- Increase the HIV prevention activities in health services offered along the corridor, including targeting VCT;
- Prioritize the community surrounding the hotspots in targeting prevention interventions to reduce HIV by raising awareness;
- Develop suitable information, education and communications materials for truckers/dock workers and female sex workers. IEC material can be developed in local languages and distributed through the private businesses along the corridor, especially chichi, shops, restaurants and resting rooms. A mobile health team targeting truckers/dock workers and female sex workers should be established and mobilized;
- Promote social marketing of condoms, taking into consideration the religious and traditional views towards condoms;
- Develop a regional program that addresses the cross-border mobility of truck drivers and female sex workers;
- Mainstream HIV in all IGAD programs and build IGAD capacity to support member countries in mainstreaming HIV in their economic, social and political programs.

**Reference**

## Table 8: Summary of Final Report on HIV/AIDS/STI/TB/Malaria Mapping [Djibouti]

<table>
<thead>
<tr>
<th>Title</th>
<th>Final Report on HIV/AIDS/STI/TB Malaria Mapping [Djibouti]</th>
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<tbody>
<tr>
<td>Objective</td>
<td>The aim of this study is to assist in the establishment of a monitoring system for the trans-boundary prevalence of HIV, AIDS, TB, Malaria and other health problems, the trans-boundary movement of people and vehicles and obtain other information regarding the spread of HIV, AIDS, TB and Malaria.</td>
</tr>
<tr>
<td>Methodology</td>
<td>The methodology used for this study was based on several methods for the data and information collection, thus making it possible to raise through triangulation, the level of interpretation and validation of the results of the study. It will involve literature review, field visits, qualitative study, and mapping through the geographical information system.</td>
</tr>
</tbody>
</table>
| Key Findings | • Although the vulnerability factors of mobile populations to HIV/STI/TB/Malaria are many and varied, they can be summarized as follows:  
  - Poverty, which forces them not only to move frequently, but also forces some to indulge in sexual activities in order to earn a living  
  - Little knowledge about the means of transmission and prevention of HIV/STI/TB/Malaria  
  - Considerable interaction with local populations  
  - Risky sexual factors;  
• Lack of reliable data, low capacities of health facilities in areas frequented by mobile populations and the non-existence of specific studies made it difficult to assess the degree to which the mobile populations are hit by these diseases;  
• Despite the large number of programs providing health care to the mobile populations and the high level of vulnerability of these populations, health care remains very little;  
• There are no policies or strategies specific to mobile populations;  
• HIV/AIDS/STI activities, including sensitization and condom use promotion are sporadically organized in an irregular manner; |

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*Annexes*
• Local populations who maintain close relations with mobile populations are also excluded from HIV/STI/TB/Malaria prevention and health care activities.

Recommendations

1. Establish a regional coordination framework of the actors involved, including representatives of the civil society;
2. Establish a regional system for understanding, monitoring and evaluation of vulnerability factors and interventions;
3. Establish measures for the prevention of the spread of HIV/STI/Malaria for mobile populations;
4. Support the provision of health care for people infected with HIV/STI/TB/Malaria and improvement of its quality;
5. Reduce the socioeconomic impact of HIV/STI.

Reference


Table 9: Summary of Rapid Assessment for Gender and HIV/AIDS Transmission in IRAPP Project Sites: Djibouti, Ethiopia, Kenya, Sudan and Uganda [Djibouti]

<table>
<thead>
<tr>
<th>Title</th>
<th>Rapid Assessment for Gender and HIV/AIDS Transmission in IRAPP Project Sites: Djibouti, Ethiopia, Kenya, Sudan and Uganda [Djibouti]</th>
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</thead>
<tbody>
<tr>
<td>Methodology</td>
<td>This assessment employed literature review, policy review, key informant interviews, focus group discussion and a survey of facilities.</td>
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<tr>
<td>Key Findings</td>
<td>• The Afar Region experiences marked gender inequality; • Young people spend time using khat and alcohol; • Population has been sensitized to HIV but lacks prevention tools; • Risk-taking attitudes are still very present; • Unemployment is a serious problem; • HIV prevalence is 1.7 percent among pregnant women and 1.2 percent in all districts;</td>
</tr>
</tbody>
</table>
• The flow of people on both sides of the border is a vector of increase in HIV prevalence;
• Pastoralism is a common lifestyle in this region;
• Pastoralists lack access to health facilities;
• This population is a huge market for prostitution;
• Sexual violence is common among mobile populations;
• Gender-based violence is hard to evaluate but women report experiencing abuse;
• Gender inequality poses barriers to women reporting gender based violence;
• Harmful traditional practices, including female genital mutilation, are reported;
• In general, access to health care and HIV services is limited.

1. Improving living conditions is one of the main recommendations:
   • Set up income generating activities for men and women in the locality;
   • Organize women group in an recognized association;
   • Establish vocational training for those who have no business;
   • Improving access to water and electricity;
2. Revitalizing current AIDS programmes at national level (NAC and NPA) and locally (NGO);
3. Improving access to free condoms continuously;
4. Strengthen peer education with adequate HIV messages;
5. Improving coordination between all stakeholders;
6. Implement quickly PMTCT locally and involve men in the intervention as a bridge to VCT acceptance;
7. Achieve continuity of action on both sides of the borders;
8. Conduct a training on gender and HIV for HIV focal points in UN agencies and NGOs working in refugee camps and hotspot;
9. Harmonize monitoring and evaluation activities and disseminate widely the results;
10. Trained police on gender and HIV issues;
11. Programs that are focused on empowering women should build into their aims an objective of eliminating all forms of discrimination and violence against women:
   • Life skills training and support for youth in schools;
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<tr>
<td>• Community conversations involvement with religious and community leaders; • Income-generating activities for women and men; • Develop training materials on gender issues, including those circumstances that lead women to engage in transactional sex.</td>
<td></td>
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</table>
Title
Rapid Assessment: Vulnerability to HIV Among Key Population Groups in Hotspot Areas in the Port of Suez

Methodology
The following methods were used by the consultant in undertaking the rapid assessment: an orientation briefing, desk review, field visit, in-depth interviews, and focus group discussions.

Key Findings
- The rapid assessment revealed that, in port of Suez there isn’t a whole lot of risk behaviour going on, as would be expected in economic zone with high population mobility;
- No specific zone inside or around the port of Suez could be safely nominated as “HIV hot-spot”. Other sea ports in Suez need to be assessed for HIV vulnerability among migrants, mobile and native populations;
- Most of the crossing ships don’t stop in the port of Suez, except in emergency. They only wait few hours to cross with the convoy;
- For their crew members to enter the city of Suez a “shore leave pass” is needed, the procedures of which are too long;
- All crew members of ships, with fixed trip lines from Suez to different ports on the Red Sea are Egyptians, which means that we need to look also at different seaports;
- Transactional sex and drugs are offered in and around the ports of El-Sawaken Kasla in Sudan, Assab and Masuaa in Eritria);
- Tests for HIV, HBV, HCV, syphilis and gonorrhoea are compulsory for crew members every 3 years, as a requisition for his “annual physical examination certificate”. If positive, the officer will be fired;
- Crew members are lacking the basic needed STIs/ HIV related knowledge and preventive skills;

Table 10: Summary of Rapid Assessment: Vulnerability to HIV Among Key Population Groups in Hotspot Areas in the Port of Suez

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  - Tests for HIV, HBV, HCV, syphilis and gonorrhoea are compulsory for crew members every 3 years, as a requisition for his “annual physical examination certificate”. If positive, the officer will be fired;  
  - Crew members are lacking the basic needed STIs/ HIV related knowledge and preventive skills; |
There are serious misconceptions regarding modes of transmission and prevention among crew members, truckers and female sex workers;
They have no access to reliable source of information regarding STIs and HIV;
Truck drivers vulnerability stem from their frequently engagement in unprotected sex and high risk sexual activities with high risk sexual partners;
Given the mobility of truck drivers, infection picked up along any of the main transport routes could be carried all the way to cause new infection;
In transactional sex, unprotected sex is dominating and almost all female sex worker’s clients are Egyptians;
In Suez, drug (mainly hypnotic tablets and hashish) is common practice, but injection drug use is rare.

Recommendations

• Further assessment of HIV vulnerability among migrants, mobile and native populations in other ports in Suez is needed;
• Owner/ management of ships need to be sensitized to the importance of creating an environment conductive to workers/ seamen learning their HIV sero-status and staying healthy;
• Given the time spend on-board, HIV/ STIs education would have to be given to crewmembers whilst they are at sea;
• Ships should have health volunteers/ peer educators to provide counselling and awareness rising on issues of HIV. They should be trained and sensitized, with guidance and support from the ship’s medical officer;
• For truck drivers, corridor- wide campaigns are needed that promote: knowledge of sero-status, reducing number of partners and consistent condom use;
• Further in depth qualitative exploration among female sex workers in form of BBS is recommended;
• VCT service needs to be introduced, which should offer anonymous unlinked service to migrant, mobile and native population in Suez;
• It could be of benefit to establish a link between the ship medical officers and the NAP focal point in Suez;
• STIs/ HIV should be included in the in-service training programme for crewmembers;
• Production of pocket size guidelines for crewmembers on “seamen health affairs”, including STIs/ HIV might be of help;
• Availing reliable source of information for crew members within the premises of the seaport on issues related to STIs/ HIV modes of transmission and prevention is needed.

Recommendations for NAP Egypt:

• HIV intervention programs should focus more on vulnerable populations, whether mobile, migrant or native;
• Programmes need to be designed to address each category of MARPs. It should be based on skills development and behaviour changes, with neither stigma nor discrimination;
• The civil society role in STIs/ HIV prevention needs to be enhanced and strengthened, especially those NGOs working with the seamen and the port labour force in Suez;
• Interested NGOs should be encouraged to mainstream STIs/ HIV prevention in their agenda, in which trans-border migrant, mobile and native population should be targeted with special emphasis to MARPs;
• Networking among interested NGOs in Suez could potenti ate their role and avoid duplication;
• Partnership, coordination and liaison between the civil society and NAP focal point in Suez have the potential to enhance the civil society role, in the light of the national strategy and policy;
• A capacity building programme for HCPs/ SCPs including the ships medical officers is needed to strengthen their knowledge and skills, to enable them to intervene effectively among vulnerable population, whether trans-border or mobile;
• It could be of benefit to establish a link between the ship medical officers and the NAP focal point in Suez;
• Establishment of anonymous unlinked registry for STIs cases at the dermato-veneriology clinic in the general hospital is strongly recommended. It could be used as a surrogated marker for the prevalence of health risky behaviours and HIV infection;
• Counselling service needs to be introduced as essential com ponent in STIs clinic. It should avail its service for migrant, mobile and native population in Suez;
<table>
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<th>IOM. Rapid Assessment: Vulnerability to HIV among Key Population Groups in Hot-spot Areas in the Port of Suez. 2010.</th>
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- The umbrella of service should include the sexual partner(s) of STIs client, by encouraging the client to bring the partner;
- VCT service is needed, to encourage the target population to ask for HIV test;
- Availing VCT service for crewmembers within the premises of the port, which offers anonymous unlinked service, is strongly recommended.
Cross-border Mobile Populations Mapping [Eritrea]

**Objective**

To develop an integrated means of effectively monitoring trans-border HIV prevalence levels, other health factors, vehicle and people, traffic, trade and other data relevant to HIV/AIDS transmission of mobile population that will be used to:

- Help design inclusive programs to combat HIV and strengthen the M&E of HIV programs in mobile population in the IGAD member states;
- Understand the social, economic and immigration patterns within mobile population as it relates to HIV;
- Identify gaps in coverage of HIV interventions for the target group and;
- Make recommendations that will be used to develop policies and interventions for mobile populations in order to reduce their vulnerability to HIV.

**Methodology**

The HIV mapping exercise and inventory of cross-border mobile population is an exploratory/descriptive type of study. It had involved multiple data collection and information gathering methods. Desk review, quantitative and qualitative surveys and geographical information system were used for data collection and information gathering.

**Key Findings**

- Though national HIV/STD policies do address some mobile populations, including sex workers, military personnel and tourists, the policies do not target cross-border mobile populations;
- Other ministries involved in the multisectoral response to HIV.

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**Table 11: Summary of Cross-border Mobile Populations Mapping [Eritrea]**

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<td>• Though national HIV/STD policies do address some mobile populations, including sex workers, military personnel and tourists, the policies do not target cross-border mobile populations;</td>
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</table>
have not addressed cross-border mobile populations in their policies;
- National and international NGOs, faith-based organizations and associations of people with HIV are important partners in the multisectoral response to HIV and potential partners for work with cross-border mobile populations.

The overall objective of the assessment is to investigate the gender dimensions of HIV/AIDS (including sexual and reproductive health issues) among the refugees, internally displaced people, returnees, surrounding host communities and cross-border mobile populations targeted by IRAPP with regard to possible transmission routes of HIV, impacts of HIV on men and women, and opportunities and constraints to prevention, care and treatment (including opportunistic infections).

The study employed qualitative research methods with different data collection techniques, including literature and archival documents review, focus group discussions, key and general informants individual and small group interviews, and observation.

- The major causes of vulnerability and risk factors include lower socio-economic and cultural position of women, lack of access to information, especially among the native population, presence of huge number of migrant workers owing to the presence of large-scale farms, construction projects and mining sites, military garrisons, and various conditions that compel inconsistent use or non-use of condoms;
- There are few health facilities both for treatment and care services even when compared to the situation in other remote regions. Those that exist lack the necessary attention and support by local health authorities, including supervision and medical supplies;
- The relevant regional government bodies suffer from acute...
shortage of skilled manpower and there is a glaring discrepancy between its plans on paper and empirical implementation of the same;
- There is a general mismatch between legislations / policies / strategies and implementation at the national level;
- Interventions are operational, piecemeal, short-lived and uncoordinated;
- The prevention methods and approaches currently in use by the few actors operating in the region are not specifically tailored to fit the objective economic and socio-cultural realities of the area;
- While recent national level reports indicate reductions in high-risk sexual behaviour and HIV infection rates in some urban and rural populations, the claim needs to be substantiated by focused and comprehensive studies;
- Condom use is inconsistent and therefore contributes little to the prevention of the population of Afar/Galafi from infection by the pandemic;
- Women are the most vulnerable segment of society primarily due to culturally deep rooted gender inequality and the subordinate social and economic position of women;
- Gender inequality incapacitates women, including female sex workers, to negotiate condom use, renders them victims of violence including rape, subjects them to multiple marriages, and denies them the right to own and inherit property;
- The changing face of transactional sex work manifested in the proliferation of khat chewing houses as the important centres of transactional sex, the non-existence of hotel rooms for settle sex, dictated by the hot climactic condition of the hotspots that compel people to do sex in circumstances inconvenient or condom use.

Reference
HIV/AIDS Assessment in Dicheoto-Haweli, Logia and Awash Arba, Main Transport Corridors along Djibouti to Addis Ababa Root

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<thead>
<tr>
<th>Title</th>
<th>HIV/AIDS Assessment in Dicheoto-Haweli, Logia and Awash Arba, Main Transport Corridors along Djibouti to Addis Ababa Root</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>The general objective of this study is to assess the situation of HIV among populations of Dicheoto – Haweli, Logia and Awash Arba, main transport corridors on Djibouti to Addis Ababa root.</td>
</tr>
<tr>
<td>Methodology</td>
<td>Data was collected by trained interviewers using standardized questionnaire which was developed by IGAD technical working groups. The questionnaire was translated to Amharic language. The data collection tools that were used include: desk review, key informant interviews, health facilities survey, bar and lodgings survey, focus group discussions, truck census, and geographical information survey mapping.</td>
</tr>
</tbody>
</table>
| Key Findings                                                         | • The highways were carrying relatively high volumes of traffic;  
• Transactional sex is already at high levels and condom use is below that needed to curb the transmission of HIV/STIs;  
• Furthermore, there were very high levels of STIs self reported by truck drivers and FSWs, again it was later confirmed by review of health facility data;  
• Health facilities along the route tend to be small;  
• STI drugs were available in most private health facilities, but unavailable in most public health facilities;  
• Few staff has been trained in STI syndromic management;  
• Mobility of truckers and female sex workers was high. |
| Recommendations                                                      | 1. “FSW-friendly” and “trucker-friendly” integrated health services: Access to targeted integrated services is required, with special emphasis on location, operating hours, and preferences of sex workers and truckers on the service package. Activities should include:  
• Training of providers on national guidelines for diagnosis and treatment of STIs;  
• Expansion of VCT;  
• Provider-initiated counselling and testing (PICT); |
2. Peer education: Peer groups of female sex workers can be organized within each truck stop, with emphasis on recruitment and retention strategies, including limiting time of membership. Activities should include:
   • Condom negotiation and usage;
   • Health-seeking behaviour, especially VCT, early STI diagnosis, and proper STI treatment;
   • Referral and linkages to available services;
   • Sensitization and avoidance of gender-based violence.

3. Development of targeted behavioural change communication toolkits for implementing partners on transport corridors:
   • Targeted towards specific risk-behaviours, under national BCC frameworks;
   • Focus on consistent condom usage with casual and regular partners, treatment seeking behaviour and completion of STI regimen, accessing VCT;
   • Involvement of national BCC working group and implementing partners in development and dissemination;
   • Demand creation strategy for VCT and STI services;
   • Mobility of populations necessitates strengthened coordination at local, national, bilateral, regional, and inter-regional levels.

Reference

Table 14: Summary of Report on the Cross Border Mapping Exercise [Ethiopia]

<table>
<thead>
<tr>
<th>Title</th>
<th>Report on the Cross Border Mapping Exercise [Ethiopia]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>Strengthen collaboration in the area of health services and HIV prevention and control and harmonize monitoring and evaluation of HIV prevention, care, treatment and support activities across borders.</td>
</tr>
<tr>
<td>Methodology</td>
<td>This assessment included three components: desk review of available literature, interviews at central and field levels with implementers and community members, and mapping of services at border crossing areas. A generic set of data collection tools developed by IGAD were adapted for the Ethiopian context in consultation with an experienced investigator.</td>
</tr>
</tbody>
</table>
| Key Findings | • There is scanty literature relevant to cross border populations and HIV/TB/Malaria in Ethiopia;  
  • Though the degree of knowledge varies, there is appreciation of HIV/STI/TB/Malaria as serious health issues;  
  • Officials and members of local communities do not perceive HIV interventions to be adequate;  
  • Little has been done to address the health needs of cross-border population;  
  • A key barrier to access to health services at or around border crossing points is the lack of a clear policy on “fee for service;”  
  • VCT services are not available in some of the concentration areas, especially on the Ethio-Somali border; |
| Recommendations | Several levels of harmonization of health services are recommended:  
  1. At the policy level  
     • Harmonize definitions of mobile populations across borders;  
     • Agree on mechanisms to facilitate cross-border referral of cases, especially AIDS and TB;  
     • Establish a mechanism to monitor implementation of cross-border activities especially regular consultations between |
2. At the technical guidance level
   • Harmonize case definitions;
   • Harmonize treatment regimens;
   • Establish mechanisms for regular interaction between clinicians (attempted by Ethiopian and Djiboutian clinicians).

3. At the administrative level
   • Simplify procedures for free treatment;
   • Simplify procedures for accessing VCT;
   • Ensure that all lodging facilities have bed nets.

Reference

Table 15: Summary of Rapid Assessment for Gender and HIV&AIDS Transmission in Hotspots (Hayou and Galafi), Afar Regional State, Ethiopia

<table>
<thead>
<tr>
<th>Title</th>
<th>Rapid Assessment for Gender and HIV&amp;AIDS Transmission in Hotspots (Hayou and Galafi), Afar Regional State, Ethiopia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>The overall objective of the assessment is to investigate the gender dimensions of HIV &amp; AIDS (including sexual and reproductive health issues) among the refugees, internally displaced people, returnees, surrounding host communities and cross-border mobile populations targeted by IRAPP with regard to possible transmission routes of HIV, impacts of HIV on men and women, and opportunities and constraints to prevention, care and treatment (including opportunistic infections).</td>
</tr>
<tr>
<td>Methodology</td>
<td>The study employed qualitative research method with different data collection techniques. The specific techniques included review of literature and archival documents, focus group discussions, key and general informants individual and small group interviews, and observation.</td>
</tr>
<tr>
<td>Key Findings</td>
<td>• There are indicates that the HIV prevalence rate in the Afar Region is alarmingly high;</td>
</tr>
</tbody>
</table>
• HIV prevention and control efforts being carried out in the region stand nowhere near what the situation calls for;
• Relevant government bodies suffer from an acute shortage of skilled manpower;
• Existing interventions are piecemeal, short-lived and uncoordinated;
• While recent national level reports indicate reductions in high risk sexual behavior and HIV infection rates in some populations, the claim needs to be substantiated by focused and comprehensive study;
• Condom use is inconsistent;
• Women are the most vulnerable segment of society due to deeply rooted gender inequality and the subordinate social and economic position of women;
• The changing face of sex work is manifested in the proliferation of khat chewing houses, lack of hotel rooms, and hot climatic conditions that discourage condom use;
• The harsh climatic conditions are also assumed to be a major impediment to NGO interventions;
• There is a lack of access to information among the native population;
• There is a large presence of migrant workers in the hotspot.

**Recommendations**

1. Develop strategic information;
2. Focus on empowerment;
3. Promote awareness and behaviour change communication;
4. Focus on female-controlled prevention methods;
5. Adapt good practices;
6. Assist the HIV prevention effort among the armed forces;
7. Focus on capacity building;
8. Facilitate partnership and networking;
9. Encourage the participation of young women and girls, especially women infected or affected by HIV, in program design and implementation;
10. Improve IRAPP visibility.

**Reference**

IGAD. Rapid Assessment for Gender and HIV&AIDS: Transmission in Hotspots (Hayou and Galafi), Afar; Regional State, Ethiopia. Intergovernmental Authority on Development Regional HIV&AIDS Partnership Program, 2010.
Title: Somalia HIV/AIDS Mapping Exercise and Inventory of Cross-Border Mobile Populations.

Objective: The main objective of the study was to create a means to monitor trans-border prevalence levels, other health factors, vehicles and people traffic, trade and other data relevant to HIV transmission of cross-border mobile populations in Somalia.

Methodology: Methodology involved multiple data collection and information gathering tools, including desk review, qualitative methodologies including key informant interviews and mapping, and quantitative methodologies including structured and non-structured questionnaires with stakeholders.

Key Findings:
- The cross-border areas which are active for informal trade transit goods and sponsorship migrations are Wajale, Rig-omane and Doblei;
- Wajale border area has a higher number of people who cross the border compared to Doblei and Rig-omane;
- Daily average number of vehicles crossing the borders was high in Wajale, Rig-omane and Doblei;
- The khat chewing and selling places were very high in Wajale, Buhoodle North West Zone, Doblei and Belet Hawo Central South compared to Rig-omane and Galdagob North East of Somalia;
- North West and North East have HIV prevalence higher than the Central South and national prevalence;
- Concentrated HIV epidemics are sustained in groups with high risk behaviours such as merchants, refugees and IDPs.

Recommendations:
- Conduct HIV sero prevalence for the cross-border mobile populations;

Table 16: Summary of Somalia HIV/AIDS Mapping Exercise and Inventory of Cross-Border Mobile Populations

<table>
<thead>
<tr>
<th>Title</th>
<th>Somalia HIV/AIDS Mapping Exercise and Inventory of Cross Border Mobile Populations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>The main objective of the study was to create a means to monitor trans-border prevalence levels, other health factors, vehicles and people traffic, trade and other data relevant to HIV transmission of cross-border mobile populations in Somalia.</td>
</tr>
<tr>
<td>Methodology</td>
<td>Methodology involved multiple data collection and information gathering tools, including desk review, qualitative methodologies including key informant interviews and mapping, and quantitative methodologies including structured and non-structured questionnaires with stakeholders.</td>
</tr>
<tr>
<td>Key Findings</td>
<td>The cross-border areas which are active for informal trade transit goods and sponsorship migrations are Wajale, Rig-omane and Doblei; Wajale border area has a higher number of people who cross the border compared to Doblei and Rig-omane; Daily average number of vehicles crossing the borders was high in Wajale, Rig-omane and Doblei; The khat chewing and selling places were very high in Wajale, Buhoodle North West Zone, Doblei and Belet Hawo Central South compared to Rig-omane and Galdagob North East of Somalia; North West and North East have HIV prevalence higher than the Central South and national prevalence; Concentrated HIV epidemics are sustained in groups with high risk behaviours such as merchants, refugees and IDPs.</td>
</tr>
<tr>
<td>Recommendations</td>
<td>Conduct HIV sero prevalence for the cross-border mobile populations;</td>
</tr>
</tbody>
</table>
• Conduct Behavioural Surveillance Survey (BSS) to provide valuable data about HIV related knowledge, attitude and behaviours for the cross-border mobile populations;
• Implement HIV control programmes – prevention and control interventions for the cross border sites for the urgent implementation of integrated Prevention, Treatment Care and Support Action Plan to reduce the incidence of HIV infection;
• Implement TB/STI treatment programmes for the cross-border sites: the TB centres must used as dual treatment approach for both tuberculosis and HIV using the DOTS strategy and ART.

Reference

Table 17: Summary of Somalia HIV Hotspot Mapping: Exploring HIV Vulnerability among Populations at Increased Risk

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Objective</td>
<td>Overall, the study aimed to explore HIV vulnerability among populations at increased risk, particularly in relation to transactional sex; and to establish an evidence base as a pre-surveillance assessment to identify populations, develop appropriate behavioural questionnaires, and design sampling frames for development of larger scale research, including HIV and STI surveillance and surveys among populations at increased HIV risk.</td>
</tr>
<tr>
<td>Methodology</td>
<td>Using purposive sampling, 350 individuals were interviewed. Ninety-eight key informants participated in the initial information gathering and consultation exercise. The remaining 252 individuals completed in-depth semi-structured interviews in 11 sites.</td>
</tr>
<tr>
<td>Key Findings</td>
<td>• Most sex workers and sex clients reported inconsistent or no condom use with multiple, concurrent sexual partners, with sex workers reporting significant difficulty negotiating condom use with clients;</td>
</tr>
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</table>
### Recommendations

<table>
<thead>
<tr>
<th>Recommendations</th>
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</thead>
<tbody>
<tr>
<td>1. Structural Level</td>
</tr>
<tr>
<td>• It is essential to go beyond approaches that focus solely on individual behaviours, and HIV prevention efforts must take into account the contexts in which HIV risk takes place in order to be effective.</td>
</tr>
<tr>
<td>2. Interventions and Services</td>
</tr>
<tr>
<td>• Develop integrated prevention, treatment, and care specifically engaging and targeting populations at increased risk, particularly those who are mobile;</td>
</tr>
<tr>
<td>• Ensure that female sex workers have access to comprehensive HIV services delivered through a package that emphasizes sexual and reproductive health and rights;</td>
</tr>
<tr>
<td>• Harmonize and coordinate comprehensive programming across international borders;</td>
</tr>
<tr>
<td>• Strategically plan and mobilize resources to address the HIV vulnerability of populations at increased risk.</td>
</tr>
<tr>
<td>3. Research</td>
</tr>
<tr>
<td>• Increase focus of research to sampling key populations at higher risk, for example sex workers and clients including truck drivers, uniformed services and other mobile populations;</td>
</tr>
<tr>
<td>• Develop and conduct HIV integrated Biological and Behavioural Surveillance (IBBS) surveys among populations at increased risk, including sex workers and clients.</td>
</tr>
</tbody>
</table>

### Reference

To investigate the gender dimensions of HIV (including sexual and reproductive health issues) among the refugees, surrounding host communities and cross-border mobile populations targeted by IRAPP with regard to possible transmission routes of HIV, impacts of HIV on men and women, and opportunities and constraints to prevention, care and treatment (including opportunistic infections).

The assessment is a descriptive, exploratory, cross-sectional study, utilizing both quantitative and qualitative methods. Data collection tools included a standardized administered questionnaire, key informant and in-depth interviews, and focus group discussion.

- People in both sites are obviously at risk for contracting HIV infection. The main risk factors include:
  - Accessibility to HIV services and information;
  - Mobility;
  - Trafficking;
  - Poverty;
- Forms of gender-based violence are widespread in the sites, including female genital mutilation, domestic violence, and forced and early marriage. Some of these practices are not perceived by respondents as gender-based violence, but part of their norms, values and religious obligations;
- Level of knowledge about gender-based violence among the study population was found to be low;
<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive health services available in Wad Sharifey include HIV counselling and testing, PMTCT/antenatal clinics;</td>
</tr>
<tr>
<td>In the Galabat hot spot, the study found low uptake of VCT services and lack of registration records;</td>
</tr>
<tr>
<td>There is a high prevalence of STI among populations;</td>
</tr>
<tr>
<td>At the capital level there are gender mainstreaming policies/practices and programming and hence they adopt measures to enhance women’s accessibility to information, and skills in general and not necessarily linked to HIV;</td>
</tr>
<tr>
<td>Sudan has a national strategy for women’s empowerment rather than a gender policy;</td>
</tr>
<tr>
<td>There is limited understanding of gender and no consensus about the importance of gender issues in policy and programming;</td>
</tr>
<tr>
<td>Gaps in HIV service provision include comprehensive programming addressing the socioeconomic and cultural dimensions about HIV.</td>
</tr>
</tbody>
</table>

Based on the results of this rapid assessment; the recommendations deal with various areas that might be addressed to ensure reduced risk and vulnerabilities for the targeted groups in addition to special considerations for the gender dimensions to HIV, to address these issues IGAD/IRRAP and UNHCR should:

- Enhance a process of drafting a national gender policy for Sudan with strategic directions and mechanisms of implementation;
- Enhance introduction of gender specific approaches to the HIV strategic plan with a view to keeping it at the current low levels;
- Support the harmonization of policies, curriculums and guidelines across border to ensure continuity of care for the mobile communities;
- Measures to enhance the capacity of HIV service providers is needed especially in the areas of analysing the gender dimension of the HIV and addressing the specific vulnerability of women to get HIV;
- Comprehensive and multi-sectoral approach to address Gender and HIV;
- IRRAP need to strengthen the reproductive health and HIV prevention/ care/treatment activities with precise attention to
Galabat hotspot site;
• Strengthen Sexually Transmitted Infections prevention, partner(s) notification in both study sites;
• Building capacities of local authorities, civil society and implementing bodies in gender capacity building and gender mainstreaming policy and program is important and are enhancing women and men capacity to reduce their vulnerability to HIV infection;
• Enhancing capacity and sensitization of national and local authority on gender issues;
• Furthermore, Gender and HIV should be seen in a broader perspective than only from a health care provider point of view. Therefore, IGAD/IRRAP/UNHCR should strongly advocate for the education of girls / women and support literacy classes.

Reference

Table 19: Summary of HIV Rapid Assessment in Main Transport Corridors in IGAD Region with Desk Review on HIV, Transport and Ports [Sudan]

<table>
<thead>
<tr>
<th>Title</th>
<th>HIV Rapid Assessment in Main Transport Corridors in IGAD Region with Desk Review on HIV, Transport and Ports [Sudan].</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methodology</td>
<td>Rapid qualitative and quantitative assessment in a selection of hotspots identified jointly by the National AIDS Commissions and stakeholders. The following data collection methods were employed: desk review, key informant interviews, health facilities survey, bar and lodgings survey, focus group discussions, truck census, and geographic information system mapping.</td>
</tr>
<tr>
<td>Key Findings</td>
<td>• The female sex workers in Galabat and Gedaref are young in age, have been in their profession for short duration, some</td>
</tr>
</tbody>
</table>
of them have fixed rates and negotiate their price with their clients, others accept low rates, and some have non-transac-
tional sex acts;
• The majority of female sex worker clients are uniform service and truck drivers. Both groups are vulnerable and have fam-
ilies and therefore act as bridging populations from the key populations at higher risk to the rest of the population;
• There is a presence of sexual and physical violence in Gala-
bat, an area that has a mixture of uniform service, seasonal workers, trade men, truck drivers and people crossing borders into other countries;
• There is a mix between moderate level of knowledge about HIV and ways of protection, as well as multiple partners and low levels of condom use;
• Female sex workers tend to use condoms with new clients but not with regular clients;
• In Gery and Al Jaily there is a low presence of female sex workers;
• IEC coverage is good and has reached most of the partici-
pants but has not generated positive behaviour yet.
• STI infection is prevalent and ill persons seek health opinions but adherence to treatment is poor;
• Female sex workers with STI continue to have sex without tak-
ing strong measures to protect their partners.

Recommendations

1. Programming:
   • Awareness raising: active continuous awareness raising ac-
tivities should be developed to expand on the limited exist-
ing activities. These programs should use relevant radio channels, which are listened to by the truck drivers. Multiple relevant languages should be used to ensure to cover the diverse nationalities and ethnicities that are working along the transport corridor. Special harmonized awareness mes-
sages should be transmitted through various means throughout the transport with focus to the hotspot areas;
   • Condom availability: condoms should be availed at the stops and in abundance at the hotspots. This should be hand in hand to the awareness activities;
   • A special attention should be paid to the Cross-border pro-
gram activities to be strengthened, as many people behave
differently when they cross to different countries. This means all prevention activities should be continuous in neighbouring counties;

- Hotspot surrounding communities: Most people running business in hotspots are from or living in adjacent communities, therefore special HIV awareness programs targeting hotspots surrounding communities should be developed and intensified;
- To involve CBOs and NGOs to expand the coverage and to address all target population;
- Private business: All stakeholders with special focus to private business should have a role to play, such as the transport companies, private clinics and pharmacies as well as the service business of concern;
- Accessible STI clinics should be focused on, this will result in easy entry points for HIV testing and counselling it will diminish the added risk for HIV transmission cause by STI.
- HIV interventions: all HIV intervention should be scaled up. New HIV counselling and testing sites, PMTCT, stigma reduction activities and formation of associations for PLWHA, should be increased in number and operationalized and supported by the relevant authorities;
- Health care providers: as they play a crucial role to increase the uptake and to contributed to behaviour change; health care providers working along the transport corridor and in the hotspots should be exposed the social aspect of the truck drivers, female sex workers and to be equipped with best ways to deal with from social aspect as well as medical aspect.

2. Hotspot management:
- The management of the Rest houses in the hotspots for the truck drivers should be improved by providing the relevant entertainment methods and the companies running the business should contribute to providing the best way to ensure less risky behaviour for their staff;
- Alternative income generating activities social programs to address FSW communities and to get to the roots and the background of the social factors putting ladies in such a vulnerable situation. Such a program should be supported
by income generating activities to encourage and enable women to manage a stable and regular social life.

2. Transport corridors:
   • Truck drivers union should be more involved in the health issues of their staff with regard to lifelong threats, such as HIV;
   • Entertaining radio program mixed with HIV and important information such as alcohol, drugs and substance abuse should be broadcasted;
   • Work regulation should be scrutinized for both transport workers as alcohol and substance abuse should have aggressive penalties and there should be means for monitoring. And for the companies and the owners to improve the working conditions.

Mohamed, Khalid Abd Rahman Abdelsalam. HIV Rapid Assessment in Main Transport Corridors in IGAD Region with Desk Review on HIV, Transport and Ports [Sudan]. IGAD Regional HIV/AIDS Partnership Programme.

<table>
<thead>
<tr>
<th>Title</th>
<th>IGAD/World Bank Cross Border Mobile Population Mapping Exercise: Sudan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>This study is part of a regional assignment conducted in all IGAD members states to develop a basic knowledge necessary for the development of an integrated means to effectively monitor transborder HIV prevalence levels, other health factors, vehicle and people traffic, trade and other data relevant to HIV transmission.</td>
</tr>
<tr>
<td>Methodology</td>
<td>The methodology used in this mapping survey involves multiple data collection and information gathering methods to enrich the interpretation and validation of findings through triangulation.</td>
</tr>
</tbody>
</table>
This includes desk review, in addition to gathering both qualitative and quantitative data.

<table>
<thead>
<tr>
<th>Key Findings</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Key health services such as diagnosis and treatment for TB, Malaria and STIs are not available at many border points and when they exist they are of poor quality;</td>
<td>• Upgrade the health facilities in all active border points;</td>
</tr>
<tr>
<td>• Medical and health personnel are usually junior cadre and health facilities are also so deficient in terms of quality of buildings, equipments and supplies;</td>
<td>• Build the capacity of local NGOs and communities at border points;</td>
</tr>
<tr>
<td>• There is a huge gap in information in regards to cross-border mobile population, such as behavioural data, for example, HIV related knowledge, prevalence rates for HIV, STIs, Malaria and TB;</td>
<td>• Establish Mobile VCT services;</td>
</tr>
<tr>
<td>• NGOs and government programmes usually based in towns close to border points and rely mainly on some outreach activities to serve the border points host communities and cross-border mobile population.</td>
<td>• Expand Key Health Services;</td>
</tr>
<tr>
<td></td>
<td>• Undertake baseline behavioural study for cross-border and border points’ population;</td>
</tr>
<tr>
<td></td>
<td>• Establish sentinel sites for Surveillances in all active border points;</td>
</tr>
<tr>
<td></td>
<td>• Integrate refugee issues into national health and HIV programmes;</td>
</tr>
<tr>
<td></td>
<td>• Combine funding streams;</td>
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<td></td>
<td>• Implement sub regional initiatives.</td>
</tr>
</tbody>
</table>

The assessment report was implemented using qualitative analysis. Thirty-eight structured face-to-face interviews were conducted with the following target groups: truckers, fishermen, dock workers, migrants and sex workers.

- Despite growth in awareness of HIV risk factors, real knowledge of HIV remains superficial, especially among young people and key populations at higher risk;
- The structure of the mobility process and living conditions of mobile people lead to increased exposure to STI and HIV infection;
- Marginalized groups, especially illegal immigrants, sex workers, people who are addicted to psychoactive substances and men who have sex with men, continue to engage in high risk practices.

1. Know your epidemic in young terms, meaning
   - Disaggregate data, including figures from program monitoring and evaluation, by sex, age and other appropriate equity parameters, in order to identify who is at risk, whether they are being reached equitably, and whether programs are working for those most in need;
   - Build the capacity of program managers, policy-makers and health care providers to understand and address the links between gender inequalities and HIV;
   - Ensure that national health sector HIV policies and programs explicitly integrate gender and allocate financial
and human resources to promote gender-responsive strategies;
• Support prevention by promoting equality between women and men in sexual decision-making and building women’s skills to negotiate safer sex including through use of female and male condoms.

2. Family planning, counselling and contraception among young men and young women
• Support the provision of information and assistance regarding family planning and reproduction to young people, including those with HIV.

3. The development of training for adolescents and young people
• Provide training to young people based on life skills.

Reference
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www.iigad.int