Community Responses to HIV/AIDS Along Transit Corridors & Areas of Intense Transport Operations in Eastern & Southern Africa

A Synthesis of Literature

(FINAL REPORT)

April 2004

Moving together to mitigate the impacts of HIV/AIDS in Africa: A partnership approach supported by DFID

Contents

Acronyms

AMREF	African Medical Research Foundation
ARV	Anti-retroviral
CBO	Community-based Organisation
COTU	Central Organisation of Trade Unions
CSIR	Council for Scientific & Industrial Research
CSWs	Commercial Sex Workers
DFID	Department for International Development (United Kingdom)
EAC	East African Community
ERB	Engineering Registration Board
GoT	Government of Tanzania
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
IFRTD	International Forum for Rural Transport & Development
ILO	International Labour Organisation
ITF	International Transport Worker's Federation
FKE	Federation of Kenya Employers
MoW	Ministry of Works
MTCT	Mother-to-Child-Transmission
NAC	National AIDS Council
NACC	National AIDS Control Council
NGO	Non-governmental Organisation
OIs	Opportunistic Infections
PEs	Peer Educators
PHE	Peer Health Education
PLWHA	People Living with HIV/AIDS
SADC	Southern African Development Community
SANAC	South African National AIDS Council
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SWAps	Sector Wide Approaches
TACAIDS	Tanzania AIDS Commission
TANROAD	Tanzania National Roads Agency
TB	Tuberculosis
UAC	Uganda AIDS Commission
URT	United Republic of Tanzania
VCT	Voluntary Counselling and Testing

Acknowledgements

This synthesis is a joint effort of many people and institutions who have contributed in various ways. The following deserve special mention: Harriet Iga of Transport Forum Group, Uganda; Mac Mashiri and Vasna Ramasar of the CSIR, South Africa; Rahab Mundara of ITDG, Kenya; Gasto Frumence of Transport Forum Group, Tanzania; Ken Odero of the Zimbabwe Forum for Rural Transport and Development and Peter Njenga, the IFRTD Coordinator for Eastern and Southern Africa. Their names, organisational affiliation, location and the case studies they drafted are listed below:

Uganda
Harriet Iga – Transport Forum Group, Kampala
Title: 'DESCRIPTION OF THE UGANDAN WORK ON HIV/AIDS AND TRANSPORT'

South Africa
Vasna Ramasar and Mac Mashiri – Council for Scientific and Industrial Research (CSIR), Pretoria
Title: 'A LITERATURE REVIEW OF HIV/AIDS AND THE TRANSPORT SECTOR IN SOUTH AFRICA: A FOCUS ON COMMUNITY RESPONSES'.

Kenya
Rahab Mundara – Intermediate Technology Development Group, Nairobi
Title: 'MITIGATING THE SPREAD OF HIV/AIDS WITHIN TRANSPORT ACTIVITIES: A SYNTHESIS OF LITERATURE IN KENYA'

Tanzania
Gasto Frumence – Tanzania Forum Group, Dar es Salaam, Tanzania
Title: 'MITIGATING THE SPREAD OF HIV/AIDS WITHIN TRANSPORT SECTOR ACTIVITIES: A SYNTHESIS OF LITERATURE'.

Zimbabwe
Kenneth K Odero – Zimbabwe Forum for Rural Transport and Development, Harare
Title: 'A SCOPING STUDY ON COMMUNITY RESPONSE TO HIV/AIDS ALONG TRANSIT CORRIDORS AND OTHER AREAS OF INTENSE TRANSPORT OPERATIONS'.

EXECUTIVE SUMMARY

The purpose of this synthesis is to report on comprehensive reviews of the extensive literature on HIV/AIDS, which identified key knowledge gaps for the transport sector in eastern and southern Africa. The five countries covered in this synthesis of the literature – Kenya, Uganda, Tanzania, South Africa and Zimbabwe – face severe and growing crises as a result of the HIV/AIDS pandemic. According to recent estimates, South Africa and Zimbabwe are ranked among African countries with the 'highest' adult HIV prevalence while Kenya, Uganda and Tanzania are in the 'very high' category (Jackson, 2002:11). HIV/AIDS has been declared a 'national disaster' by the respective governments.

Transport, particularly road transport, is a key sector of the economies of these eastern and southern African countries. Typically, 80 to – 90% of the region's passengers and freight is transported by road. Studies (for example, Medical Research Council of South Africa, 2000) show that mobility increases the vulnerability to HIV/AIDS of those who are mobile, their partners at home and sexual partners along transport corridors. Evidence from all the countries shows that on average, the seroprevalence among long-distance truck drivers is considerably higher than among other transport workers as well as the general population. It is thus reasonable to assume that communities living along transit corridors and areas of intense transport operations risk contracting HIV/AIDS due to their regular interaction with highly mobile individuals and groups.

A number of factors, perhaps not mutually exclusive, account for the spread of HIV/AIDS along transit corridors, areas of intense transport operations and surrounding rural areas. These include poverty, urbanisation, high-risk social behaviour, lack of access to knowledge and medical facilities, unemployment, migration, the social environment around truck stops, local cultures, and working conditions. In Tanzania, for example, truck stops attract mobile commercial sex workers (CSWs), petty traders, bar maids, etc., from surrounding areas. Commercial sex work and other economic activities become intricately interwoven, which in turn provides a potent environment for HIV transmission.

Given the dominance of road transport in eastern and southern Africa, the transport-community interface represents an important area for research on local responses to HIV/AIDS, since HIV transmission is not only confined to the transit corridors, but its impact necessarily spreads to the surrounding rural areas. This is explained by the fact that, on the one hand, residents along transport corridors and other areas of transport operations trade with rural traders, truckers and other passing traffic. On the other hand, truck drivers, their assistants, other transport operators as well as workers in the road construction and maintenance settlements, leave their families in

the villages and come back regularly to visit and sexually interact with them. Interaction between these individuals and groups forms the main axis of HIV/AIDS transmission.

Summary of Findings

The literature reviews summarised in this report explored the following key question: *How are communities (and their institutions) along transit corridors and other areas of intensive transport operations responding to the threat of HIV/AIDS?* While each country appears to have context-specific characteristics, the overall pattern seems to indicate the following:

- ❏ In general, fewer interventions are implemented by communities and their institutions than would be expected given the scale of the problem. For example, in Tanzania the review suggests that community institutions including faith-based groups, traditional authorities, burial societies, women's clubs, transport forums, school associations youth associations, etc. have been minimally involved in different HIV/AIDS interventions targeting communities living in transport corridors and other areas of transport operations.
- ❏ Development agencies are realising that the HIV/AIDS scourge is not solely a health problem needing medical solutions, but a developmental issue and socio-economic malady requiring economic and cultural remedial measures.
- ❏ Some communities are changing their traditions as a result of the threat of HIV/AIDS infection.
- ❏ In some communities, girls are more likely than boys to be pulled out of school when someone in the household is ill with HIV/AIDS. If unchecked, this practice could have a negative impact on girl-child school enrolment and indirectly on prospects for individual progress.
- ❏ HIV/AIDS activities should be integrated into other existing community primary health care programmes. Ideally, the most essential activities/services should be available as widely as possible at community level. These include voluntary HIV counselling and testing; psychosocial support for PLWHA and their families; palliative care and treatment for common opportunistic infections (Ols); pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS); nutritional care; STI care and family planning services; cotrimoxazole prophylaxis among HIV-infected people; and recognition and facilitation of community activities that mitigate the impact of HIV infection (including legal structures against stigma and discrimination).. However, due to resource constraints, lack of awareness, education and mobilisation, that often is not the case.
- ❏ Households are shifting labour and other resources from productive activities to provide support and care for people living with HIV/AIDS (PLWHA). As one study (Tabaijuka, 1997) shows, this has serious short and long-term consequences for rural livelihoods.
- ❏ Individuals and organised groups have been accepting responsibility for HIV/AIDS control and assuming specific tasks viewed as important.
- ❏ Members of different communities have been learning about HIV/AIDS (i.e. factors contributing to risks and methods of preventing infection).
- ❏ There is positive behaviour change (e.g. adopting use of safer sex methods) in some countries, both at transport nodes and more generally across the population.
- ❏ Some participation is occurring in intervention programmes (e.g. peer health education in Tanzania).

❑ Some programmes are initiating alternative income-earning activities. For example, along the Songea-Dar-Kibiti highway, Mbugua (2000) reports that over 600 women have enrolled in such groups, and have started small businesses such as hair salons, flour mills, dress-making and day care centres, taking themselves away from high-risk commercial sex work.

Studies conducted along major corridors, for example, Dar es Salaam – Lusaka (Tanzania/Zambia), Mombasa – Kisumu (Kenya), Beitbridge – Chirundu (Zimbabwe), and Maputo – Tete (Mozambique/South Africa) identify CSWs and truckers as some of the most vulnerable groups.

Key Knowledge Gaps

What are the key knowledge gaps for the transport sector?

The impact of HIV/AIDS on the transport sector has received very little attention relatively speaking compared to other sectors such as education, agriculture, health, etc. Within the transport sector, most of the research has been confined to truck drivers (truckers) and commercial sex workers. Very little work has been done on communities living along transit corridors. As a result, there appears to be little information on the interaction between communities and mobile populations.

This means that the interface between transport activities and communities living in areas where transport operations may inadvertently contribute to higher risks of exposure is a weak and/or missing link in formulating an effective response to HIV/AIDS by the transport sector.

As a consequence, the hypothesis linking (road) transport development with the spread of HIV/AIDS needs rigorous testing if it is to inform policy and action in strategic areas/issues such as poverty reduction.

There is a general consensus that the pandemic shows a higher degree of spatial concentration and that integrated, holistic and sector-wide approaches (SWAps) will need to be pursued in understanding and addressing the problem. However, there are lingering questions about the influence of mobility and associated vulnerability and/or susceptibility to risky behaviour. These are factors that need to be understood in seeking to mitigate the numerous causes of the pandemic. This calls for solutions that are developed on a multiplicity of fronts as HIV/AIDS affects all sectors in trade, regional cooperation, immigration, industry and transport.

Another line of enquiry could be to investigate the extent to which the link, if any, between transport activities and the spread of HIV/AIDS has affected the livelihood of rural communities given the rapid development of road infrastructure, which has increased mobility and enhanced social interaction between rural and urban dwellers. Similarly, to what extent have the communities living along the transport corridors and other areas of transport operations been involved in responding to the fight against HIV/AIDS in their localities? Finally, how can access of PLWHA to preventive treatments be increased?

Most programmes or interventions have depended on donor funding and thus their sustainability is not always guaranteed. This matter requires investigation to find out how sustainable HIV/AIDS interventions are, and if not, what measures could be taken to ensure they are sustainable. An interesting intervention from the transport sector would be to provide transport so that people can get around easily and cheaply. In rural areas bicycles and other (intermediate) transport devices could be

provided to improve the mobility of HIV/AIDS project staff. In most African countries with multiple rural transport problems, provision of transport is a useful intervention for PLWHA that could catalyse communities' response to the epidemic. But what kind of transport and how should it be programmed and managed? Here also, research is needed to determine appropriate modes in specific community contexts.

Health workers, social workers, PLWHA, religious organisations, welfare organisations, and community projects working on care are some of the institutions cited in the literature that could play a leading role providing palliative care. However, the configuration of these institutions and the specific role they could possibly play within the context of a comprehensive and integrated transport sector response to HIV/AIDS needs further analysis and institutional design.

While national HIV/AIDS policy frameworks exist in all countries studied, there is no information about what proportion of total AIDS funding is channelled to support community initiatives, and much less on communities living in areas of high transport operations. There is also little knowledge of what kind of resource constraints these communities face even though it is acknowledged that HIV/AIDS-related expenses cause serious leakage of individual and family incomes. These are real challenges that would have to be addressed in the context of the transport sector strategy and which therefore require further research.

What should a multi-sectoral response to HIV/AIDS look like?

Currently, most interventions are sector based. What role would the transport sector play in a sector-wide approach? Should different sectors integrate the transport component into their strategies towards the fight against HIV/AIDS? Should different sectors work together, sharing the load, complementing each other's skills, etc? What form of organisation should such a joint effort take? These are valid questions which require careful thought and analysis in order to provide a framework for a more coordinated approach than has hitherto been the case in dealing with the HIV/AIDS pandemic.

Developing an effective response to HIV/AIDS requires dealing with a host of problems such as securing sustainable funding sources, developing human resource capacity, infrastructure development, policy development and legislative reforms, re-engineering service delivery and partnerships, among others. Clearly each of these areas calls for a needs assessment and analysis to act as a platform for more detailed programming.

Finally, there are many models of home-based care such as hospital mobile outreaches, HIV/AIDS service organisation outreaches, community-linked programmes, church-based outreaches, community-based outreaches and networks of infected and affected people, to mention just a few. These and other community responses need closer examination in relation to the transport sector. The link between development and HIV/AIDS also has to be studied considering that good road networks allow more rural-to-urban movement, AIDS often being a passenger as well. A study probing these issues will indeed be helpful in eliciting the appropriate responses to HIV/AIDS in areas of intensive transport operations.

1. INTRODUCTION

This report is a synthesis of existing knowledge of HIV/AIDS in five eastern and southern African countries, Kenya, Tanzania, Uganda, Zimbabwe and South Africa. It summarises case studies carried out in these countries, which identify how communities and their institutions are responding to the threat of HIV/AIDS along transit corridors and other areas of intensive transport operations. In this report, 'community response' means all prevention, care and support initiatives taken primarily by communities living along transit corridors and other areas of intensive transport operations to reduce the impact of HIV/AIDS on the members of the (local) communities. Such initiatives may or may not have external assistance. In other words, a community response may be wholly owned and controlled by a community or it may have an element of partnership with external actors.

All the five case studies started from a common premise. Firstly, that missing from the transport sector strategy is the notion of the interface between the sector activities and the community living in areas where transport operations may inadvertently contribute to a higher risk of HIV exposure. Secondly, that communities living along and around areas of intense transport activities are an important line of defence against the spread of HIV/AIDS and should therefore be a legitimate focus of attention in transport sector HIV/AIDS strategies. Key community institutions include faith-based groups, traditional authorities, burial societies, women's clubs, transport forums, school associations, youth clubs, and local business associations.

A review of related literature was the main method of study used to identify how communities and their institutions are responding to the threat of HIV/AIDS. Extensive searches were conducted in libraries, of websites and list serves. The aim was to comprehensively review and synthesise the extensive literature on HIV/AIDS in a way that would make it possible to identify key knowledge gaps for the transport sector. Interviews and/or informal discussions that served to triangulate available documentary evidence were also conducted. The findings are discussed in the main text of the report.

The following section provides the background to the study by presenting the national contexts of HIV/AIDS in the five eastern and southern African countries. The findings are then presented in logical order starting with the nature and form of community responses to HIV/AIDS in Section 3. This is followed by a presentation of findings of the transport sector's response to HIV/AIDS. The section also identifies relevant HIV/AIDS initiatives and points of interface with the transport sector. Section 4 provides the conclusion. Based on the lessons from the case studies and main themes in the literature review, Section 5 unveils some areas for further research.

2. CONTEXTUAL REALITIES

The eastern and southern Africa region covered in this literature review has the highest HIV/AIDS prevalence in the world. According to recent statistical estimates as indicated in Table 1 below, Zimbabwe is ranked among countries with the 'highest' adult HIV prevalence while Kenya, Uganda and Tanzania are in the 'very high' category (Jackson, 2002:11). The epidemiology of the disease in all the five countries reviewed is almost similar: first detection in the early 1980s, then rapid spread mainly through heterogeneous sexual contact, and by the mid-1990s, an epidemic which reached crisis level.

Table 1: Country-Specific HIV/AIDS Estimates and Data (December 1999)

Country	Adults living with HIV/AIDS (15-49 yrs)	Women living with HIV/AIDS (15-49 yrs)	Children living with HIV/AIDS (0-14 yrs)	AIDS deaths 1999 (adults & children)	Population (thousands)
Kenya	2 000 000	1 100 000	78 000	180 000	29 507
South Africa	4 100 000	2 300 000	95 000	250 000	39 796
Tanzania	1 200 000	670 000	59 000	140 000	32 799
Uganda	770 000	420 000	53 000	110 000	21 109
Zimbabwe	1 400 000	800 000	56 000	160 000	11 509

Source: UNAIDS 2000 in Jackson 2002:12

Given the overall HIV/AIDS situation in these countries, fighting the disease is invariably considered as a national priority. In addition, as the response to HIV/AIDS at whatever level is likely to be a function of the prevailing historical, political, economic, social and demographic conditions, it would appear that a comparative analysis of the policy path and other trajectories in each country and their effect on combating the pandemic would make a significant contribution to our understanding of what works and why.

National HIV/AIDS policy frameworks exist in all five countries. The most visible aspect of these national AIDS policies are the national AIDS agencies: – the National AIDS Control Council (NACC) in Kenya, the Uganda AIDS Commission (UAC), the Tanzania AIDS Commission (TACAIDS), the National AIDS Council (NAC) in Zimbabwe, and the South African National AIDS Council (SANAC). The national AIDS policies and the institutions and processes that have been established under them are supposed to provide the framework for responding to HIV/AIDS in each country. However, as the dashed arrow in Figure 1 indicates, these national policies, institutions and processes reflect national priorities and plans and are weakly linked to local level needs and priorities[1]. Out of these have emerged sectoral responses to address the AIDS pandemic within the context of individual sectors (e.g. agriculture, education, health, etc.). Since sectoral responses tend to be uncoordinated, the result is often a mismatch between targets and outcome indicators. Also, lack of alignment between sectoral and community responses results in little impact in prevention and other areas.

---

[1] This is most evident in the case of South Africa where 'civil society sectors' such as traditional healers, PLWHA, women, disabled people, etc. are loosely linked to the relevant national and provincial structures to manage HIV/AIDS.
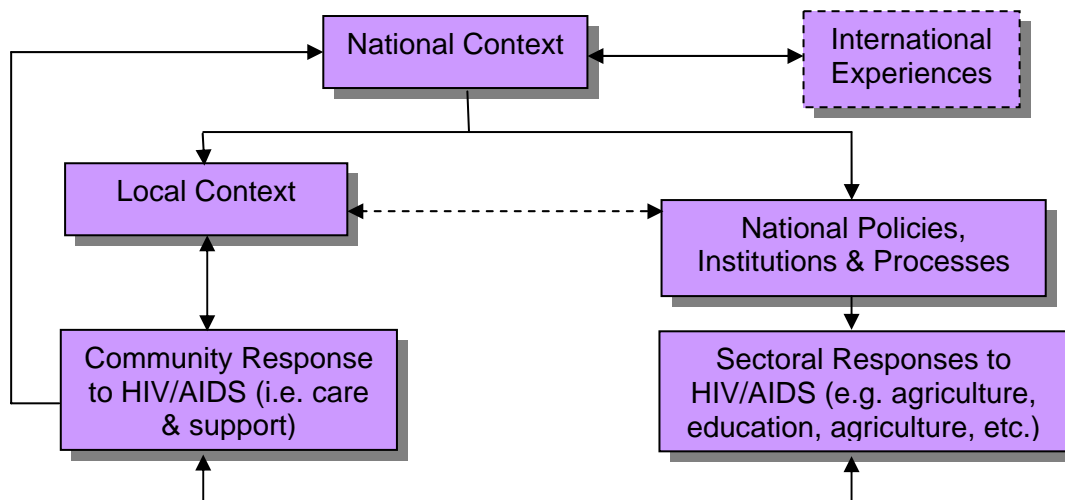
Figure 1: Illustration of the HIV/AIDS Prevalence-Response Linkages

Increasingly, nations are recognising that HIV/AIDS and other communicable diseases such as tuberculosis and malaria are multi-dimensional problems with potentially devastating impacts on livelihoods. Uganda is one such country where its relative success in the fight against HIV/AIDS is said to be partly due to the use of a multi-sectoral approach. In the case of Tanzania, formulation of a National Multi-sectoral Strategic Framework on HIV/AIDS (2003 – 2007) is seen as the linchpin to addressing the problems inherent in a sectoral approach. The Kenyan case study also explicitly acknowledges the need to adopt a multi-sectoral approach.

The issue of how to effectively integrate HIV/AIDS in the transport sector in order to ensure a balance between national and local level priorities is still an issue even in the context of a multisectoral approach. As already hypothesised and confirmed by the literature, the general thrust of the transport sector strategy revolves around the operators/drivers of transport services and their support staff; people who work on construction and maintenance sites; travellers; and generally professionals engaged in management of the transport sector. Currently missing from the transport sector strategy is the notion of the interface between transport sector activities and the communities living in areas where transport operations may inadvertently contribute to higher risks of exposure.

While there is no theoretical necessity for the above relationship, its empirical probability cannot be ignored. As the remainder of this report shows, the case for pursuing this line of inquiry is compelling, both in terms of the likely policy and value-added programming. There is increasing agreement on the need for multi-sectoral approaches with regard to controlling the spread of HIV/AIDS and mitigating its impacts. However, this raises a number of questions: how should such an approach evolve? Under what conditions would sustainability be assured? It is recognised, for example, that the development of efficient and affordable transport may inadvertently increase the rate of spread of HIV/AIDS: How can this dilemma be resolved, given the diverse transport contexts in these and other countries coupled with the challenges of HIV/AIDS? These and other questions require much reflection and analysis.

3. COMMUNITY RESPONSES TO HIV/AIDS

The impact the pandemic is having on communities is most evident in the broader context of HIV/AIDS outlined here. . HIV/AIDS reduces productivity, capacities and opportunities, and makes significant demands on resources and eventually causes premature death. Invariably, it is the quality of lives, livelihood opportunities and incomes of people living with HIV/AIDS that are ultimately affected. Ironically, HIV/AIDS research has largely neglected the social embeddedness of the pandemic. Besides, preoccupation with the search for better strategies to combat the epidemic has proceeded without a clear theoretical framework of existing community-based 'approaches' and 'programmes'. As a result, there is little understanding of the resultant institutional responses (Sibanda, 2004).

A key finding from the reviews is that fewer interventions are implemented by communities and their institutions than might be expected given the scale of the problem. It is conceivable that HIV/AIDS creates a demand for certain kinds of responses from communities: Care and support are the pillars of a community's response to HIV/AIDS. The supply of these responses by the community depends on the willingness and capability of its fundamental institutions to provide these services. The capability depends in part on the cost of providing care and support. The cost depends in part on existing knowledge about the design and operation of care and support. The stock of knowledge, in turn, depends on past experiences as well as a previously existing set of institutions and the nature and degree of research on institutions.

In the event that existing arrangements cannot provide care and support, as the literature seems to suggest, this becomes the basis for institutional change. In addition to the effects of the stock of knowledge, the cost of supplying new institutions depends on the prices of the factors used in institutional design. Implementation costs will also affect the supply. Willingness to provide new institutional arrangements also depends greatly on the private benefits and costs of providing the change that accrue to the agents who are in a position to provide change. Thus, the fundamental institutions of society and the initial distribution of power will have a significant impact on the kind of institutional arrangements that are supplied.

3.1 Interventions and their Impacts

The literature cites three goals for responding to HIV/AIDS: firstly, to reduce HIV-related mortality and morbidity, secondly, to improve the quality of life for PLWHA, and thirdly, to improve the chances of survival of PLWHA. Different but complementary activities can be undertaken in responding to HIV/AIDS. As Table 2 below indicates, the various activities can be categorised according to need, complexity and cost. The most basic or essential activities include HIV testing of transfusion blood, the promotion of universal precautions and health policy activities such as the regulation of care provision and drugs supply. These should be taken everywhere. However, the literature suggests that because of resource and other constraints, they often are not.

Table 2: Care & Support Activities by Need, Complexity & Cost

Essential Activities	**HIV voluntary counselling & testing** **Psychosocial support for PLWHA & their families** **Palliative care & treatment for common OIs: pneumonia, oral thrush, vaginal candidiasis & pulmonary TB (DOTS)** **Nutritional care** **STI care & family planning services** **Cotrimoxazole prophylaxis among HIV-infected people** **Recognition & facilitation of community activities that mitigate the impact of HIV infection (including legal structures against stigma & discrimination)**
Care & support activities of intermediate complexity and/or cost	*ALL THE ABOVE PLUS* **Active case finding (& treatment) for TB, including smear negative & disseminated care & support activities of intermediate complexity and/or cost TB among HIV-infected people** **Preventive therapy for TB among HIV-infected people** **Systemic antifungals for systemic mycosis (such as cryptococcosis)** **Treatment of HIV-associated malignancies: Kaposi's sarcoma, lymphoma & cervical cancer** **Treatment of extensive herpes** **Prevention of mother-to-child transmission of HIV** **Post exposure prophylaxis of occupational exposure to HIV and for rape** **Funding of community efforts that reduce the impact of HIV infection**
Care & support activities of high complexity and/or cost	*ALL THE ABOVE PLUS* **Triple antiretroviral therapy** **Diagnosis & treatment of opportunistic infections that are difficult to diagnose and/or expensive to treat, such as atypical mycobacterial infections, cytomegalovirus infection, multi-resistant TB, toxoplasmosis, etc.** **Advanced treatment of HIV-related malignancies** **Specific public services that reduce the economic & social impacts of HIV infection**

Source: UNAIDS & WHO, 2000

3.1.1 Testing and Counselling

Testing and counselling are reported in nearly all case studies. Uganda is carrying out a number of programmes to address the issues related to the reduction of exposure to, the prevalence of, and the magnitude and transmission of HIV/AIDS. These include mobilisation and provision of voluntary counselling and testing services in the major towns, among other interventions. Counselling services are provided under the Peer Health Education (PHE) model used in Tanzania. South

Africa's Transport Sector HIV/AIDS Strategic Plan recommends promotion of voluntary testing as one of the activities under the prevention objective.

In order to be effective, the implementation of voluntary counseling and testing (VCT) services requires many key elements, including community awareness, education and mobilisation to ensure that those wishing to be tested understand what the test process is and where testing may be undertaken, and to ensure that those who are tested and found infected are not discriminated against. In Kenya, the NACC has published national guidelines on testing and counseling. When dealing with HIV testing in South Africa, , confidentiality and disclosure are codified under the country's labour laws and regulations.

As an essential care and support activity, institutionalising testing and counseling remains an issue for a number of reasons. Going by the evidence, the effectiveness of testing and counseling among truckers, for example, is still very limited. VCT services are mostly available in urban centres, putting in doubt their accessibility by larger sections of populations resident in rural areas. While testing and counseling are integral to HIV/AIDS initiatives in and by the transport sector, their impact, especially on the community, is yet to be seen. Part of the challenge is to scale up the various initiatives being carried out at both national and regional level (e.g. the project on HIV/AIDS Prevention in the Transport Sector of Southern Africa launched in 2002). Unfortunately, although the International Transport Worker's Federation (ITF) acknowledges that other organisations, such as community-based AIDS groups, advocacy groups, national and international NGOs and other international organisations, have expertise in specific fields, and unions are encouraged to work closely with them, the evidence of such collaboration is scant.

3.1.2 Psychosocial Support

The needs of people living with HIV/AIDS go beyond clinical care and treatment. PLWHA's needs also include, for the most part, social support to alleviate the socio-economic impact of HIV (e.g. food, shelter and school fees), psychological support to cope with the implications of having a life-threatening condition, PLWHA's right to protection in employment, to confidentiality, to medical care and access to new treatments, counselling, emotional support , protection against discrimination and stigma, social support for their orphans left behind after the patients die, etc. (UNAIDS & WHO, 2000).

Psychosocial support should thus be part of the care package at all levels, since at its most basic level it requires the establishment and support of peer-support groups for those found positive and those affected by HIV/AIDS. Many examples of such services – which act as a focus for education, training, and provision of material, basic economic, spiritual and psychosocial support – currently exist in the five eastern and southern African countries.

In Tanzania the PHE model has been used effectively. As used in Tanzania, the concept of peer education implies that people with common experiences, interests and lifestyles are more effective teachers within that group than outsiders. Since Peer Educators (PEs) share the concerns, values and norms of the client group, they are credible, trusted and have access to the group. PEs are selected within the group and as such they are able to continuously reinforce messages in culturally appropriate ways, times and places (Laukamm-Josten, et al., 2000; Mbugua, 2000; & Mwizarubi, et al., 1997).

In Kenya there are a number of organisations providing psychosocial support. These include the National Aids Control Council, the Association of People with Aids in Kenya and Grace Centre International amongst others. PHE is also seen as a strategy that could be used in the transport industry. Currently, government and trade unions are considering using truck drivers as PEs.

In South Africa education and training are considered as important activities in prevention. In the Tateni Home Care Service project, for example, about 2 100 family members and volunteers have been taught capacity-building skills to enable them to care for and support someone in the home over a three-year period. The project has been a model and many organisations are now following it to provide home care and support.

3.1.3 Promotion, Supply and Use of Condoms

The pattern of condom use is varied across the region: A study was carried out by the Medical Research Council of South Africa to determine HIV prevalence and risk behaviour in a sample of truck drivers visiting commercial sex workers at truck stops. From this study, 29% reported never using condoms with sex workers, whereas 13% had used condoms with their wives. In Uganda, condom use among truckers, for example, doubled in 1986. However, defective condoms and lack of consistency in their use are still a challenge. Behavioural traits such as alcoholism and preference for higher monetary gain are some of the reasons for not using condoms during intercourse.

The promotion and supply of condoms is one of the strategies widely used in the region. In Kenya, "promotion and marketing of condoms by mobilising community towards self-financing for HIV/AIDS activities" is part of the implementation strategy of the national AIDS policy agenda. In Tanzania the African Medical Research Foundation (AMREF) has used "promotion and marketing of condoms" by mobilising the community towards self-financing for HIV/AIDS prevention activities in the truck stops along the Dar es Salaam – Zambia highway. In the AMREF intervention, condom sales outlets were strategically set up along the transport corridor at major truck stops. PEs also distributed and sold condoms (social marketing) to fellow peers educators and surrounding community members. Condoms were also distributed along the highways and at road construction sites as well as in guesthouse rooms, streets, dispensaries and pharmacies.

Part of the care for PLWHA involves the promotion of safe sex and condom use. Contacts with health services should be used to encourage preventive behaviour and to promote safe sex and condom use. Several freight companies in Zimbabwe have programmes on workers' education and condom distribution, amongst other support schemes. Condoms have been made freely available and distributed in places where people can have easy access to them, after hours and close to where they live, for example, in public toilets, minibus taxis and other public transport areas, hostels, and truck stops.

3.1.4 Treatment of Sexually Transmitted Infections

The link between sexually transmitted infections (STIs) and HIV has long been established. According to UNAIDS' *Technical Update on Opportunistic Infections*,[i] worldwide, the main burden of disease in PLWHA arises from a limited number of common infections, namely tuberculosis (TB), pneumonia, diarrhoea, and candida infection of the mouth and throat. Diagnosis and treatment of STIs are important not

only to prevent HIV, but also to prevent complications from STIs. Treatment of STIs and TB has to be an integral part of the response to AIDS since people with these diseases are more vulnerable.

As the Tanzanian case illustrates, treatment services have focused on those living at and around truck stops, targeting the female partners of truck drivers. In this programme, local health care providers offered treatment to women two days per week outside the normal working hours of the health facility or simply dispensed drugs. STI services were also integrated into the regular activities of the health facilities. Women consulted clinicians during the normal clinic hours together with other patients.

In Kenya, human rights activists have argued that the government should provide free treatment for sexually transmitted diseases (STDs), which according to studies done can reduce the prevalence of HIV/AIDS by 40%. UNAIDS cautions that prevention should be the main objective of HIV/AIDS programmes. The transport fraternity, which includes employers (under the Federation of Kenya Employers, FKE), the Central Organisation of Trade Unions (COTU), NACC and other development partners, is collaborating to set up integrated service centres at stop-overs, refueling points and rest places along transport routes. The centre services will include treatment of STI, VCT and dissemination of information.

In South Africa, the Roadside Health and Information Unit project is a product of the National Bargaining Council for the Road Freight industry. It is managed by the Learning Clinic (Pty) Ltd. Its main objective is to reduce transmission of HIV/AIDS by long-distance truck drivers and commercial sex workers. The project has three levels of intervention, namely the treatment of STDs for truck drivers, treatment of STDs for commercial sex workers and condom distribution for both truck drivers and commercial sex workers.

In spite of the efforts made so far in various countries, the reality is that treatment and care are not yet reaching the vast majority of people in need. Clearly, the challenge remains one of finding ways of dramatically increasing the access of PLWHA to preventive treatments. In tandem with the global agenda for anti-retroviral (ARV) treatment, increasing access to comprehensive HIV care and support, including anti-retroviral medicines and treatment for HIV-related opportunistic infections, is a high priority in Zimbabwe. Constrained for resources, however, the government is currently providing very limited ARV therapy to a fraction of those requiring treatment.

As in most other high-prevalence countries in the region, in Zimbabwe programmes on prevention of mother-to-child transmission (MTCT) are currently being scaled up. However, these programmes face many generic challenges, including weakness of antenatal care infrastructures and services, lack of awareness of HIV transmission and personal HIV infection in many pregnant women, reluctance to engage in VCT for HIV, relatively weak compliance in taking ARVs, and dilemmas in maintaining infant feeding options. The importance of each of these problems in the transport sector needs careful study.

3.1.5 Nutritional Care

Nutritional care is essential for HIV-positive people in order to ensure that they receive an appropriate diet for the symptoms they are experiencing. Good nutrition, coupled with the systematic use of anti-retrovirals, postpones the onset of AIDS. Yet

the literature has very little to say about nutritional care, perhaps because it falls outside the purview of public intervention and is squarely in the 'private good' domain. Given the link between poverty and AIDS, and the fact that the problem of HIV/AIDS cuts across all sectors, people's access to a healthy diet should be included in any diagnosis-prognosis of the pandemic.

Community-owned and managed gardens are a viable model of a project that could be developed and replicated in rural and urban environments where vegetable gardens are already a common feature. Such projects could be beneficial not just in terms of producing a variety of fresh fruits and vegetables, which are obviously necessary for the enhanced nutritional needs required by HIV sufferers, but for a marketable surplus that would generate income so desperately needed by people infected and affected by HIV/AIDS.

3.2 The Transport Sector and HIV/AIDS

The literature shows that the effects of HIV/AIDS permeate all sectors. Sectoral impacts, though variable, can be severe. Some of the sectors at greatest risk of high infection levels are those with highly mobile workforces. In all the countries covered in this review, the seroprevalence among long-distance truck drivers is considerably higher than among other transport workers as well as the general population.

The realisation that the transport sector can make a significant contribution to the fight against HIV/AIDS by improving prevention and care, reducing people's vulnerability to HIV/AIDS and alleviating the epidemic's devastating social and economic impact is only now emerging. In Tanzania, for example, where initiatives in the transport sector are most visible, an HIV prevention programme at the truck stops along the Dar es Salaam – Zambia highway proved to be consistently effective in positive behaviour change, particularly among long-distance truck drivers, their assistants and CSWs at various truck stops.

Uganda is carrying out a number of programmes aimed at reducing the exposure, prevalence, magnitude and transmission of HIV/AIDS. These include sensitisation of drivers and commercial sex workers at truck stops and border points to AIDS prevention and condom use, community sensitisation and awareness through radio messages on local FM stations that broadcast in local languages, and mobilisation and provision of voluntary counseling and testing services in the major towns.

A new initiative in Kenya targeting urban commuter taxis (Matatu) is exploring the roles they could play in the fight against HIV/AIDS. Instead of focusing on role models, such as footballers, musicians and athletes, the messages on the taxis could focus on the dangers of HIV/AIDS. The project hopes that the Matatu owners and operators will allow their vehicles to be painted with educational HIV/AIDS material and slogans promoting morality, which is pivotal in keeping the disease at bay.

The International Labour Organisation launched a project on HIV/AIDS prevention in the transport sector of southern Africa in Zimbabwe 2002 to try and reduce the incidence of infection among transport workers in the sub-sectors of road, air and rail transport. As an organised entity the transport sector, at national, regional and international level, has gone some way towards addressing the issue of HIV/AIDS among its employees. This is partly because HIV/AIDS has hitherto been seen as being exclusively a workplace-related issue. Thus, while the South African National Transport Sector Strategy developed by the National HIV/AIDS Transport

Coordinating Committee provides guidelines on action within and for the transport sector, it does not recognise the need for community-based interventions. The plan is not supported by a transport policy either, which should ideally set out goals, objectives and principles for HIV/AIDS management in the transport sector.

4. CONCLUSION

The response to HIV/AIDS by the transport sector has thus far been exclusively to target transport operators and workers. There is an implied assumption in this that the benefits of such interventions will trickle down to communities living along transport corridors and other areas of intense transport operations. There are a number of fallacies in this assumption, though. It is, for instance, erroneous to treat only one of the partners in a multiple sexual relationship. In the treatment and control of STIs, it is not uncommon for suffers to be asked to bring their partners in for treatment. Why should the same not apply to HIV/AIDS? It is interesting, and several studies repeatedly confirm this, that education campaigns, condom distribution and other HIV/AIDS interventions are not always a panacea for changing sexual behaviour. Such interventions are designed with the transport sector operators only in mind. This is because truck drivers, who are mobile and spend long periods away from their spouses, are regarded as likely to engage in sex. But this completely ignores the other side of the reality, which is that communities which are poor and isolated probably have an even stronger incentive to engage in HIV/AIDS-threatening activities both for monetary reward and for status.

Finally, feedback effects from community members (e.g. CSWs) to truck drivers and other transport workers are completely ignored. The impact of these feedback effects is little understood and they need to be studied and appropriate measures taken if they are found to be significant. As the Kenyan case suggests, "the management of HIV/AIDS, as a strategy, must be in place in order to assist infected workers to live longer, quality lives and be able to make their contribution in the workplace and family. The strategy should include the administration of ARVs and educating infected workers on the value of *using a clean and affordable balanced diet and natural herbs*". As a minimum, this would require community-level initiatives to ensure the supply of an affordable balanced diet and natural herbs.

5. SUGGESTIONS FOR FURTHER RESEARCH

5.1 Knowledge Gaps

The literature review has identified two key knowledge gaps for the transport sector. The first is that the interface between transport activities and communities living along transit corridors which face greater risk of exposure to HIV/AIDS infection is a weak and/or missing link in formulating an effective response to HIV/AIDS by the transport sector. Second, the specific roles that various community-based institutions could play within the context of a comprehensive and integrated transport sector response to HIV/AIDS have hardly been articulated.

From this it follows that community responses to HIV/AIDS should be examined in the context of the transport sector's contribution to an integrated, holistic and sector-

wide approach to the problem of HIV/AIDS. As a start, the greater involvement of people affected by HIV/AIDS as a vehicle for generating psychosocial support in communities should be considered in the design of comprehensive care and support programmes. This would obviously need a more detailed examination of the different AIDS support groups and networks that exist or should exist.

For those living far from care and treatment facilities, or without the means to obtain transport to medical and psychosocial support services, provision of care in the home and community-based care is critical. Such provision requires community-level organisation, training and support to ensure that services are being appropriately implemented and used. Nursing care and support of nursing activities in home-based care and elsewhere must be encouraged. The role that the transport sector might play in this process needs further investigation to determine the critical components in the lives of people affected by or living with HIV/AIDS.

5.2 Outline of a Research Agenda

Besides examining community responses to HIV/AIDS in the context of the transport sector's contribution to an integrated, holistic and sector-wide approach to the pandemic, the next phase of the project will seek, firstly, to trace the trajectory of the CSW from the transport node/truck-stop to her rural community. The project team will seek to understand the level of contact and interaction between the CSW and her rural community (before infection): how sexually active she is in her community; what contributions she makes to that community via her household (e.g. she could be the sole bread winner; responsible for sending children to school; looking after her parents; member of a church group, etc.).

Secondly, the project team will also seek to understand and unravel issues concerning the post-infection period – she is unlikely to remain active in her trade, and she is likely to be forced into early retirement, most likely in the village. What are the implications of this with regard to the following?

- ❑ How she is perceived in her own family.
- ❑ Her changing role in the household (as she can no longer be the provider).
- ❑ Community responses to what has happened to the CSW.
- ❑ Community institutional mechanisms to cope with this (local politicians, community-based organisations, e.g. societies (stokvel in South Africa), traditional leadership, faith-based groups, transport forums, etc. do not seem to have come together to think creatively about responding meaningfully to this socio-economic malady, partly because of the stigma associated with it and partly because of the stealth, rapidity and "in-your-face" way the pandemic has unravelled – wiping out households, including community leaders, who might be expected to take a lead in the generation of innovative ways to cope with the disease at a community-wide level).
- ❑ Universal access (at the individual, family, community and eventually administrative levels) to both traditional and modern medical help and the role that transport currently plays and could creatively play is a key building block of the prevention-care continuum (this is where innovative transport solutions could be generated, for example, auditing and reviewing the transport function of the district with a view to aligning it with creative local solutions as imperatives for the effective delivery of prevention or mitigation measures, for instance, bicycle/motorbike ambulances, brokerage systems, mobile services,

affordability issues, etc. Home-based care solutions, for example, could be facilitated by community health workers on bicycles or motorbikes, etc.).
- ❑ In the event that the CSW's infection eventually leads to death, the project team will seek to understand how the community deals with the orphans in terms of social support, access to socio-economic opportunities, etc. and what role the sector is playing and could play.

Thirdly, the project team will seek to investigate any positive and proactive roles the CSW could play in enlightening the community, given that she is the subject of concerted educational campaigns at the node (where the government and the private sector target truckers and CSWs). She could indeed be the harbinger of prevention promotional work for the community. In the South African and Tanzanian case studies, CSWs were employed by research organisations to get an in-depth understanding of their clients' (truck drivers) motivations when they engage in casual sex as well as their HIV/AIDS status. This information gathering technique of relatively sensitive information worked well indeed. However, whether her message will be taken seriously by her community depends on how she is perceived by that community.

A related issue would be to unravel how the CSW could gain access to community members to disseminate the information. The project team will seek to investigate the use of intermediate means of transport such as bicycles and motorcycles, and the use, for example, of schools as conduits for information dissemination – also churches, sports arenas, market places, traditional centres of authority such as headman and chiefs, and so on. A community social marketing approach such as this could include:

- ❑ Creative ways of community mobilisation
- ❑ Mutually reinforcing ways of building capacity and training
- ❑ Sensitisation/orientation meetings/workshops for stakeholders, etc.

These issues need probing and investigation.

Finally, while sex is biological, the role of gender is socially assigned. Gender dynamics also need to be explored at the household and community level. As they relate to this project, gender dynamics are understood as the different roles, expectations, identities, needs, opportunities and obstacles that society assigns to women and men based on sex (see Mashiri & Mahapa, 2002). Addressing gender roles and power dynamics between women and men, and how they impact on sexual relations and decision-making is central to effective HIV/AIDS prevention. How can the CSW's family and many others become the front line and bulwark of an effective response?

What are the practical implications of our work? Ultimately, we seek to strengthen and "ground-truth" our action research by designing a demonstration project that will put into place interventions to alleviate the situation created inadvertently by truckers (and of course CSWs) at the node. These interventions would seek to strengthen the coping mechanisms of communities by buttressing their institutions on the one hand, and improving access to medical help on the other. The obvious challenge is to determine what institutions need to be in place for communities, and indeed for local authorities, to be engaged in the prevention-care continuum. How do we promote partnerships between these community-based organisations and officialdom such as departments of health, transport, local government, education, etc. as well as the

private sector to inculcate the point that HIV/AIDS responds well to being addressed as a cross-cutting, multi-sectoral phenomenon?

To address these and other related questions, the project team will seek to develop guidelines/toolbox, based on various scenarios, complete with a monitoring and evaluation facility, for strengthening community institutions and improving access to better cope with the ever-devastating pandemic. Clearly, this is not a task that can be achieved without the involvement of other players. Thus the project team intends to use a partnership approach by collaborating with relevant stakeholders, including national HIV/AIDS control agencies (e.g. ministries of health and national AIDS control councils or committees), transport-related organisations (e.g. the Uganda Transport Cooperative Union, the International Transport Union), research institutes (e.g. the African Medical Research Foundation and national universities), regional economic communities (i.e. SADC and EAC), the civil society sector (business, labour, NGOs, CBOs, traditional leaders, etc.), amongst others. This list is only preliminary at this stage and is likely to grow longer as more local groups and institutions (some of which were identified as part of the first phase of the project), are invited to be party to the second phase.

BIBLIOGRAPHY

AIDS Captions, *Family Health International*, Volume 3, No. 2, July 1996.
AIDS in Africa at http://.aidsandafrica.com/aids.html accessed on 15 January 2004.
1. Highly mobile populations drive the spread of HIV/AIDS in Kenya. Rose Lukalo.
2. Mass media & the AIDS pandemic in Kenya, 1997-98: a moral panic perspective. Lewis Odhiambo, School of Journalism, University of Nairobi.
Annual Review, Planning & Technical Meeting, Nairobi, 25-26 October 1994.
Arndt, Channing & Jeffrey D. Lewis. The macro implications of the HIV/AIDS Epidemic: A preliminary assessment. *South African Journal of Economics*, (Forthcoming).
Barnett T & Whiteside A. (2002). AIDS in the twenty-first century: Disease & globalisation. Palgrave Macmillan. Hampshire. United Kingdom. 416pp.
Barton, T.G. (1991). Sexuality & health in sub-Saharan Africa. AMREF. X 673pp.
Bloom, D. E. et. al. (2002). HIV/AIDS & the private sector – A literature review. Harvard School of Public Health, 665 Huntington Avenue, Boston.
Bollinger, L. et al. (1999). The economic impact of AIDS in Tanzania. The Futures Group International & Research Triangle Institute. The Centre for Development & Population Activities (CEDPA). Tanzania.
Cuddington, John T. (1993). Modelling the macroeconomic effects of AIDS with an application to Tanzania. *World Bank Economic Review*, Vol. 7, no. 2, pp.173-89.
Department of Health (DOH) (2000). HIV/AIDS/STD Strategic Plan for South Africa 2000-2005. Government of South Africa. Pretoria. 33pp.
Department of Health (DOH) (2003). National HIV & syphilis antenatal sero-prevalence survey in South Africa: 2002. Government of South Africa. Pretoria. 21pp.
Desmond, C., Michael, K. & Gow J. (2000). The hidden battle: HIV/AIDS in the family & community. Health Economics & HIV/AIDS Research Division (HEARD), University of Natal, Durban, 21pp.
Donahue, J.K. Kabucho & S. Osinde (2001). HIV/AIDS: Responding to a silent crisis among micro finance clients in Kenya & Uganda. Nairobi, Kenya;

commissioned by Micro Save-Africa, a joint initiative of the CGAP, DFID & UNDP.

Dorrington R, Bourne D, Bradshaw D et al. (2001). The impact of HIV/AIDS on adult mortality in South Africa. MRC Technical Report, September 2001.

Eaton, L. et al. (2003). Unsafe sexual behaviour in South African youth. *Social Science & Medicine*, 2003, 56, 149–165.

Equity Project. (2001). Bambisanani: Community orientation to HIV/AIDS prevention, care & support. Collaboration between CADRE & PPASA, Eastern Cape. 69pp.

Family Health International, (2003). Final report for the AIDSCAP programme in Tanzania: Background & country context. This report was accessed on 17 January 2004 at http://www.HIVAIDS/publications/achieve/aidscapreports/finalreportAIDSCAP Tanzania/Fnl_Rprt_AIDSCAP_Tanzania_Back_context.htm

Forsythe, S., (1992). An assessment of the economic impact of AIDS in Kenya. AIDSTECH.Chapel Hill, NC: Family Health International.

Groots International (2002). Press release: Jeffrey Sachs, Special Advisor to Secretary General Koffi Annan pledges to assist AFRUS AIDS in accessing resources to advance African grassroots women's groups work on the ground. Johannesburg, South Africa. 29 August 2002.

Grosskurth, H., et. al. (1995). Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: Randomised controlled trial.

Gathere W. Loice, (2000). The impact of peer education on the behaviour of female sex workers in two different areas in Nairobi. Masters thesis in Public Health.

Hancock, J., et. al. (1996). The macroeconomic impact of HIV/AIDS: AIDS in Kenya. Forsythe S, Rau B (ed.). Arlington Virginia, USA: Family Health International.

Haomr-Knipe M. and R. Recter (1996). Crossing borders: Migration, ethnicity & AIDS, London: Taylor & Francis.

Haour-Knipe, M., Leshabari, M & Lwihula, G. (1992).Interventions For Workers Away From their Families. In: *Preventing HIV in Developing Countries: Biomedical & Behavioural Approaches, edited by Gibney, et al, New York 1999.*

Hatendi, F.L.S. (2001). Assessment of the level of implementation of the Zimbabwe National HIV/AIDS policy & accessibility of the National Aids Trust Fund by civil society. Executive summary report for the Zimbabwe National Association of Non-Governmental Organisations (NANGO) & Zimbabwe AIDS Network (ZAN), September. Acc. on Mar. 17, 04 from the Comm. Initiative URL: www.comminit.com/st2001/sld-3398.html.

HIV prevention among commercial sex workers in Kenya. Aids Infothek, the magazine of AIDS information – Switzerland, 12th Year 2000. Special issue supported by the Federal Office of Public Health, Switzerland. HIV in Africa.

HIV/AIDS – A global emergency: A multi-sectoral response for the Commonwealth Conference in Melbourne, Australia, 4 October 2001.

HIV/AIDS prevention & care in resource-constraint settings, Family Health International, 2001.

Iga, H.K. Community response to HIV/AIDS along transport corridors. *Uganda Country Report*, March 2004.

ILO (2003). HIV/AIDS Policy for the Transport Sector of Zimbabwe. Prepared by the Project Advisory Committee of Zimbabwe, ILO Project on HIV/AIDS Prevention in the Transport Sector of Southern Africa.

ILO/EAMAT (1995) The impact of HIV/AIDS on the productive labour force in Tanzania. Eastern Africa Multidisciplinary Advisory Team Working Paper No. 3, Addis Ababa. Quoted in: *Lori Bollinger, et al., (1999). The economic Impact of AIDS in Tanzania. The Futures Group International and Research Triangle*

Institute. The Centre for Development and Population Activities (CEDPA). Tanzania.

International Transport Federation. (2004). Transport Workers & HIV/AIDS In: *The Journal of the International Transport Workers Federation.* Issue No. 11, April 2003. Available at: [http://www.itf.org.uk/TI/11/English/index.htm]. Accessed on: 16 April 2004.

Isabela Mbugua. Keeping on Truckin' – but Playing it Safe. Daily Nation Newspaper - Special report. Available at http://www.nationaudio.com/news/Daily Nation/15072000/Features/Num18.html (accessed on 17 December 2003)

ITF (2004). ITF campaign against HIV/AIDS, *ITF Information Sheet*, London: ITF. Accessed at: www.itf.org.uk/general/section_brochures/english/index.html

Jackson, H. (2002). AIDS Africa: Continent in Crisis, Harare: SAfAIDS

Kahindo, M. et al. (1997). Multi centre study on factors determining the differential spread of HIV in African towns: Kisumu site.

Kamau, J. Muthoni (1996). Sexual behaviour in relation to awareness of HIV/AIDS among secondary school girls in Nairobi. Thesis UON main library.

KANCO, (2001). Information package on HIV/AIDS policy Development & Advocacy. KANCO Resource centre: KANCO.

Kenya N.F.G. (2004). A scoping study on community responses to HIV/AIDS along the transport corridors, & areas of transport operations: Mitigating the spread of HIV/AIDS within transport activities: A synthesis of literature in Kenya. Draft Report, DFID KAR PROJECT R8155.

Kitts, J. & Roberts, J. H. (1996). The health gap. IDRC.

Lwihula, G. K. (1998). Coping with the AIDS pandemic: The experience of peasant communities of Kagera region, Tanzania. Paper presented at the Technology Development Needs of African Smallholder Agriculture, Harare, Zimbabwe, & quoted in: *Lori Bollinger et al. (1999). The economic impact of AIDS in Tanzania. The Futures Group International and Research Triangle Institute. The Centre for Development and Population Activities (CEDPA). Tanzania.*

Lwihula, G. K. (2001). Supporting the strengthening of prevention & case management of STI/HIV among vulnerable populations in eastern & southern Africa: A consultancy report (November 2001-February 2002). Harare, Zimbabwe.

Marcus, T. (1997). Interpreting the risks of AIDS: A case study of long-distance truck drivers. *Development in Southern Africa,* Volume 14, Number 3, October.

Marcus, T. (2000). Exposure & experience confounded by structural constraints: Assessing the impact of accidents, predation & AIDS on long-distance truck drivers. SHSS Sociology. University of Natal, Pietermartizburg, Prepared for UNIARC. 37pp.

Martin, P. and Widgern, J. (2002). International Migration: Facing the challenge. *Population Bulletin*, March.

Mashiri, M & Mahapa, S. (2002). Social exclusion & rural transport: A road improvement project. In: *Balancing the Load: Women, gender & transport (ed) Priyanthi Fernando & Gina Porter.* Zed Books Ltd., London. pp15-24.

Mbugua, I. (2000). Keeping on Trucking – but Playing it Safe. *Daily Nation* Newspaper - Special report. Available at: http://www.nationaudio.com/news/Daily Nation/15072000/Features/Num18.html

McDonald, D. A. & Crush, J. (Eds). Destinations unknown: Perspectives on the brain drain in southern Africa. Africa Institute of Southern Africa, Pretoria.

McKay, V., Sarakinsky, M., Morr, H., Sekgobela, E., Mokotong, E., Mokotong, T., & Sham, B. (2001). Evaluation of the Roadside Health Information Units in Harrismith & Beaufort West: Evaluation commissioned by the EU/GTZ

supported project: HIV/AIDS prevention in the Road Transport Sector in Southern Africa. University of South Africa. Pretoria, South Africa.

Meadover, M. A. et al. (1996). Coping with AIDS: The economic impact of adult mortality from AIDS & other causes on households in Kagera, Tanzania, quoted in: *Lori Bollinger et al. (1999). The economic Impact of AIDS in Tanzania. The Futures Group International and Research Triangle Institute. The Centre for Development and Population Activities (CEDPA). Tanzania.*

Measure, D. H. S. South African (1998) Demographic & Health Survey. HIV/AIDS Indicators Database. Available at http://www.measuredhs.com/hivdata/surveys/start.cfm

Media & HIV/AIDS in eastern & southern Africa: a resource book (2000)

Medical Research Council. (2000). The role of truck drivers in the spread of HIV/AIDS, Press Release. South Africa. Medical Research Council.

Ministry of Health. (1997). Kajiado HIV sentinel surveillance. Kajiado STD/AIDS Control Programme. Nairobi, Kenya.

Ministry of Health. (1997). Sessional paper no. 4 of 1997 on AIDS in Kenya. Nairobi

Ministry of Health. (1999). Strategic plan for the Kenya national HIV/AIDS & STDs control programme for 1999–2004. Nairobi: Kenya National AIDS & STDs Control Programme.

Ministry of Health. (2001). National guidelines on home-based care for HIV/AIDS. Nairobi.

Ministry of Planning. (1993). HIV/AIDS & development, Chapter 12. In: *National development plan 1994–1996. Nairobi.*

Ministry of Works. (2003). Sectoral response & situation analysis of HIV/AIDS. Nairobi.

Morley, D. Maasai warriors & their sexual partners. Lancel 337. March, 1991 p. 667.

Mungai, G. (2002). VCT in HIV infection: Evaluation of individual risk perception in Nairobi. Masters thesis in Public Health.

Mwizarubi, B. et al. Working in high-transmission areas: Truck Routes. In: Ng'weshemi, J., et al. (Eds.). (1997). HIV Prevention & AIDS Care in Africa: A district-level approach. Royal Tropical Institute, The Netherlands.

National AIDS and STD Control Programme (2000). AIDS case reporting system & sentinel surveillance system. Nairobi: NASCOP. Unpublished reports.

National AIDS and STDs Control Programme. AIDS in Kenya. Background projections, impact & interventions. 3rd ed. Okemo, T.M., Mutemi, R., Baltazar, G. (Ed.)

National AIDS Control Council (2000). National HIV/AIDS strategic plan, 2000 - 2005. Nairobi.

National AIDS Control Council & Ministry of Health AIDS Control Unit (2001). National guidelines for voluntary testing & counselling. Nairobi

National condom policy & strategy 2001-2005 (2001). Ministry of Health in collaboration with the NACC.

National HIV/AIDS Transport Co-ordinating Committee (NHTCC). (2001). Transport Sector HIV/AIDS Strategic AIDS Plan. Pretoria. South Africa. 43pp

National Research Council (US) panel on data & research priorities for arresting AIDS in sub-Saharan Africa. Mitigating AIDS in sub Saharan Africa. Preventing & mitigating AIDS in sub Saharan Africa: research & data priorities for the social & behavioral sciences. Barney Cohen & James Trussell, (Eds): Panel on Data & Research priorities for arresting AIDS in sub-Saharan Africa, Committee on Population, Commission on Behavioural & Social Sciences & Education, 1996. p. 240 - 244.

New Year's Message by the President, 31st December 1999. Dar es Salaam, quoted in The United Republic of Tanzania, Prime Minister's Office, (2003). National

Multi-Sectoral Strategic Framework on HIV/AIDS-2003 – 2007, Dar es Salaam, Tanzania.

Nyamuryekung'e, Dr K. and Hamelmann, Dr C. (1996). "STD Survey in seven truck stops along - the Dar es Salaam – Songea Highway in Tanzania", report of AMREF- Tanzania.

Nyamuryekung'e, K. et al. Risk factors for HIV infection among truck drivers & their sexual partners in Tanzania: Data from cross-sectional studies in 1991 & 1993.

Nyamuryekung'e, K., Laukamm-Josten, U. et al. STD services for women at truck stops in Tanzania: evaluation of acceptable approaches. *East African Medical Journal* vol. 74 no. 6, 1997.

Oxfam International, (2002). Report on HIV/AIDS programmes in Tanzania. http://www.Oxfam.org/eng/story_tanz_aids.htm , December 2003.

O'Connor, P et a.l (1992). Ethnographic study of the truck stop Environment in Tanzania. Dar es Salaam, Tanzania.

Personal Communication with Grace Mwangwa, a member of the Technical AIDS Committee of the Ministry of Works. 17 January 2004.

Personal communication with Mr. Abdullah Faraji, an official with the African Medical and Research Foundation (AMREF). January 2004, at AMREF's office, Dar es Salaam, Tanzania.

Personal communication with Mr Deo K. Ng'wanansabi, Sales Manager of PSI, Tanzania branch. January 2004.

Policy Project. (2002). National & Sector HIV/AIDS policies in the member states of the Southern African Development Community. Prepared for the SADC/HSU. 57pp.

Ramjee, G. & Gouws, E. (2003). Prevalence of HIV among truck drivers visiting sex workers in KwaZulu-Natal, South Africa. HIV Prevention & Vaccine Research Division, Medical Research Council of South Africa. Paper in preparation.

UNDP. Reduction of HIV vulnerability within the Land Transport Sector: Towards a public policy framework for addressing HIV/AIDS in the transport sector. Bangkok, 22-23 November 1999.

Report: Defining the way forward for HIV/AIDS initiatives in the road transport sector in Southern Africa. Harare, 19-20 June 2002.

Republic of South Africa. (2000). Code of Good Practice: Key Aspects of HIV/AIDS & Employment. Department of Labour, Government of South Africa. Government Printers. Pretoria. 12pp

Republic of South Africa. (2000). HIV/AIDS/STD Strategic Plan for South Africa 2000-2005. Department of Health, Government of South Africa. Government Printers. Pretoria. 33pp

Republic of Zimbabwe. (1999). National HIV/AIDS Policy (2000-2004). Harare. Government Printers.

Republic of Zimbabwe. (1999). National HIV/AIDS Strategic Framework (2000-2004). Harare. Government Printers.

Ritter, T. T. (2000). Commercial sex workers & truck drivers: Background for a core transmitter intervention. At: www.ugangadish.org/core.doc. Accessed on December 2003.

SAfAIDS. (2000b). Sex Workers. Fact Sheet No. 6 (December). Harare.

SAfAIDS. (2000a). HIV & AIDS Surveillance. Fact Sheet No. 1 (December). Harare.

Sentumbwe, S. (2001). Knowledge & sexual behavioral patterns related to HIV/AIDS among commercial sex workers in Kampala. *Gender Issues Research Report*, Series 15, Osserea.

Sibanda, M. (2004). Community-based orphan care in urban Zimbabwe: Theory, practice & emerging issues. Position paper presented on 31 May 2004 during

the Masters Class seminar, Department of Rural & Urban Planning, University of Zimbabwe.

South African Institute of International Affairs (SAIIA). (2003). Southern African Scenarios 2015: Renaissance, Asymmetry or Decline and Decay? South African Institute of International Affairs. Johannesburg. South Africa. 126pp.

Synergy Project. Putting on the Brakes: Preventing HIV Transmission along Truck Routes. Available at Http://www.synergyaids.com (accessed on 17 December 2003).

Tadd, T. & James, J. S. (1994). (ATN) Nutrition & AIDS. Interview with Kristin Weaver, Bay Area Nutrition Counseling Center and Clinic (BANC), at San Francisco General Hospital. *AIDS Treatment News*, Issue No. 204 (August 5).

Tadd, T. and James, J. S. (1994). (ATN) Nutrition & AIDS: Interview with Kristin Weaver (Part 2). *AIDS Treatment News*, Issue No. 205 (August 19).

Tanzania Aids Commission. Report on HIV/AIDS in Tanzania. Available at http://www.tanzania.go.tz/hiv_aids.html (accessed on 19/12/2004).

Tanzania Care. AIDS in Tanzania, accessed at http://www.tanzaniacare.org/htmls/AIDS_tanzania.html, December 2003.

Tanzania Road Agency (TANROAD). Workshop's report on HIV/AIDS and Gender Awareness for TANROADS Staff.

Tibaijuka, A. K. (1997). AIDS & economic welfare in peasant agriculture: case studies from Kagabiro village, Kagera region, Tanzania. Quoted in Lori Bollinger, et al., 1999. The economic Impact of AIDS in Tanzania. The Futures Group Internationaland the Research Triangle Institute. The Centre for Development and Population Activities (CEDPA). Tanzania

Tibaijuka, A. K. (1997). AIDS & economic welfare in peasant agriculture: Case studies from Kagabiro Village, Kagera Region, Tanzania. Quoted in: *Lori Bollinger et al. (1999). The economic impact of AIDS in Tanzania. The Futures Group International & Research Triangle Institute. The Centre for Development & Population Activities (CEDPA). Tanzania.*

Laukamm-Josten, U. et al. Preventing HIV infection through peer education & condom promotion among truck drivers & their sexual partners in Tanzania, 1990-1993. In: AIDS CARE (2000), Vol. 12, No. 1.

UNAIDS (1998). The Public Health Approach to STD Control, UNAIDS Technical Update, Geneva: UNAIDS.

UNAIDS (1999). A review of households & community responses to the HIV/AIDS epidemic in the rural areas of Sub-Saharan Africa (June). Geneva: UNAIDS.

UNAIDS (1999). Sex & youth: Contextual factors affecting risk for HIV/AIDS. Geneva: UNAIDS.

UNAIDS (1999). Comfort & hope: Six case studies on mobilizing family & community care for & by people with HIV/AIDS. UNAIDS Best Practices Collection (June). Geneva: UNAIDS.

UNAIDS (2000). Migrant population & HIV/AIDS. The development & implementation of programmes: Theory, methodology & practice (June). Geneva: UNAIDS.

UNAIDS (2001). Population mobility & AIDS (February). Geneva: UNAIDS.

UNAIDS (2003). Access to HIV treatment & care. Fact sheet (September), Geneva: UNAIDS.

UNAIDS (2003). AIDS epidemic update (December). Accessed from www.unaids.org

UNAIDS & WHO (2000). Key elements in HIV/AIDS care & support. Geneva: UNAIDS/WHO.

UNAIDS (1998). HIV/AIDS & the workplace: Forging innovative business responses. UNAIDS Technical Update. Joint United Nations Programme on HIV/AIDS. Geneva. 9pp.

UNAIDS (1999). A review of household & community responses to the HIV/AIDS epidemic in the rural areas of sub-Saharan Africa. United Nations Joint Programme for HIV/AIDS Best Practice Collection.

UNAIDS (1999). Summary Booklet of Best Practices. Issue 1. Joint United Nations Programme on HIV/AIDS. Geneva. 221pp

UNICEF. UNICEF Global Database: Antenatal Care. Available at http://www.childinfo.org/eddb/antenatal/database1.htm

United Nations Population Division. World population prospects: The 2002 revision. Available at http://esa.un.org/unpp/

United Republic of Tanzania (2003). National Multi-Sectoral Strategic Framework on HIV/AIDS - 2003 – 2007. Dar es Salaam: Prime Minister's Office.

United Republic of Tanzania (URT), Ministry of Health. National Multi-Sectoral Policy Guidelines on HIV/AIDS/STIs. Tanzania Mainland.

United Republic of Tanzania (URT), Ministry of Works. Tanzania National Road Agency (TANROADS). Songwe – Tunduma Road Rehabilitation Project: Workplace intervention of HIV/AIDS/STIs. 2003.

United Republic of Tanzania (URT), Prime Minister's Office. (2003). National Multi-Sectoral Strategic Framework on HIV/AIDS. 2003 – 2007. Dar es Salaam, Tanzania.

White, Joanna (2002). Facing the challenge: Experiences in mitigating the impacts of HIV/AIDS in Sub-Saharan Africa. London: Natural Resources Institute.

Whiteside, A. & Sunter, C. (2000). AIDS: The challenge for South Africa. Human & Rousseau Tafelberg. Cape Town, South Africa.

WHO (1994). Management of Sexually Transmitted Diseases, Geneva: WHO.

WHO (1996). TB/HIV: A Clinical Manual (WHO/TB/96.200), Geneva: WHO.

WHO (1997). Treatment of Tuberculosis: Guidelines for National Programmes, 2nd Ed. (WHO/TB/97.220), Geneva: WHO.

WHO & UNAIDS (1997). Sexually transmitted diseases: Policies & principles for prevention & care, Geneva: WHO/UNAIDS.

WHO & UNAIDS (1998). Guidance modules on antiretroviral treatment. Geneva: WHO/UNAIDS.

WHO & UNAIDS (1999). Guidelines for sexually transmitted infections surveillance. Geneva: WHO/UNAIDS.

WHO & UNAIDS (2000). Safe & Effective use of antiretroviral in resource-constrained settings. Geneva: WHO/UNAIDS.

WHO & UNAIDS (2000). Consultation on STD interventions for preventing HIV: What is the evidence? Geneva: WHO/UNAIDS.

WHO/AFRO (2001). HIV surveillance report for Africa, 2000. November 2001. Available at http://www.afro.who.int/aids/surveillance/resources/hiv_surveillance_report_2000.pdf

WHO/AFRO (2003). HIV/AIDS Epidemiological Surveillance Update for the WHO African Region 2002. Available at: http://hivinsite.ucsf.edu/global.

WHO/AFRO. Database on HIV surveillance.

World Bank (1997). Confronting AIDS: Public priorities in a global pandemic, New York: Oxford University Press.

World Bank (2004). HIV/AIDS in the Transport Sector. PowerPoint presentation available at http://www.worldbank.org . Accessed on: 15 April 2004.

www.afronets.org. African Networks for Health Research & Development. Established in 1997 to facilitate exchange of information among different networks active in health research for development in Anglophone Africa & to facilitate collaboration in the fields of capacity building, planning & research.

www.aidsandafrica.com, a site that gives comprehensive & up-to-date information on AIDS in Africa. The site gets news stories on AIDS on Africa mostly from newspapers.

www.aidsmap.com. The site has information on treatments of HIV, information on the disease, global issues about AIDS and the international HIV/AIDS alliance, online publications, etc.

www.allafrica.com, www.rnw.nl (Radio Netherlands site), www.irinnews.org. News sites like these occasionally carry very informative information on HIV/AIDS.

www.doh.gov.za. The Department of Health, South Africa. The site has reports, policy documents, facts, statistics & other such information on HIV/AIDS in South Africa.

www.equinetafrica.org. The Network on Equity in Health in Southern Africa. This is a network of research, civic society & health sector organisations. It is based in Milton Park, Harare.

www.fda.gov The Department of Health and Human Services, United States of America. The site belongs to the US Food and Drug Administration & contains information on drugs that are used to treat complications of HIV/AIDS. By 2002 FDA had approved 40 drugs.

www.fhi.org. The Family Health International website. The FHI carried out a detailed research project at Beitbridge, Messina & Zimbabwe & the Zambian side of the Chirundu border.

www.fleetwatch.co.za. Fleetwatch is a transport magazine which gives significant attention to HIV/AIDS issues in the transport sector. The magazine was the best transport magazine in South Africa from 1994 to 1999.

www.frtd.gn.apc.org. The International Forum for Rural Transport and Development. The site has vital information on the transport industry.

www.health.gov/nhic. The site of the US Government National Health Information Centre.

www.kztransport.gov.za. The KwaZulu-Natal Department of Transport's home page. The site also gives attention to HIV/AIDS-related issues.

www.policyproject.com. This Policy Project site seeks to improve reproductive health through policy changes. Policy Project works with host country governments and civil society. The site is funded by USAID.

www.rhap.org.za. The Regional HIV/AIDS Programme, Southern Africa. It was launched by USAID in mid-2000 to target high-HIV-transmission areas at cross-border sites & to implement appropriate interventions.

www.safaids.org.zw. A regional HIV/AIDS resource centre. Their mission is to disseminate and communicate relevant, adequate & quality HIV/AIDS information, to promote effective ethical responses to AIDS in Southern Africa, influence policies & improve individuals' & institutions' ability to cope with & manage the pandemic.

www.transport.gov.za. The Department of Transport's site, South Africa. The site has a section that looks at HIV/AIDS issues.

www.unaids.org. This United Nations site advocates global action on HIV/AIDS. UNAIDS leads, strengthens & supports an expanded response to the pandemic.

www.undp.org. The United Nations Development Programme site. It looks at issues like poverty & development.

www.worldbank.org The World Bank site. Sites like this & the European Union site have helpful information about HIV/AIDS.

NOTES

i Available at: www.unaids.org/html/pub/Publications/IRC-pub04/WHOUNAIDSCARE_en_doc.htm#P263_22217#P263_22217. Accessed in April 2004