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**President's Foreword –**

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Tsunami disaster swept away not only lives, but also dreams, innocent smiles, and hopes. We have witnessed the most geographically widespread human disaster, taking more than 160,000 lives and unknown number missing. The waves struck the most populated rural areas, and that too in the poor countries. The incomes of the communities living around the shores of the Bay of Bengal and Indian Ocean are already below the poverty line, and such a calamity has left the population at the mercy of Nature. My heart goes out to our Asian colleagues who have suffered in this tragedy.

We fellow human beings are doing our bit, and one of the greatest relief operations in the human history was launched almost immediately, but the loss is too huge to compensate by any measures undertaken by all of us, individually and collectively.

The poor, weak and marginalised suffered the most, and their suffering will increase even more with the time. Along with the loss of lives, they have lost shelter and means of livelihood. There are innocent children, supposed to play joyfully and study, who have lost one or both parents, now will be growing without love, parental warmth and affection. Women and children who experienced the disaster and witnessed the giant waves taking their near and dear are in severe shock and it will take years to recover from this physical and psychological trauma.

The farmers and fisherman who stake out their life to have two square meal a day, have lost their fishing nets, boats and their small agriculture farms, and left with a large debt burden on their shoulders.

Our International Association of Agricultural Medicine and Rural Health has been working in these sectors and now we have to face even bigger challenges. The problem of potable drinking water, the diseases like Malaria, Diarrohea, Cholera and Malnutrition will be widespread in this region and we, along with our regional and national networks must gear up to work tirelessly so as to reduce the morbidity and mortality in the affected population.

I had initiated a Foundation called 'HOPE CHARITABLE TRUST' sometime ago and it will be working for the affected children. The HOPE CHARITABLE TRUST is based on a simple principle- to make the children socially responsible and economically productive. This will be done by making them 'Functionally literate', health consciousness through 'Health Literacy'. Vocational Skills Development (such as Electrician, Carpentry etc) and by inculcating Value Systems Education (such as integrity, honesty, loyalty etc). Now, HOPE will try to help these needy children and build a future with hope for them. I would like to initiate such project all over the world and I welcome all ideas, proposals and suggestions to make life worth living for the children.

# BLOOD PRESSURE CHARACTERISTICS OF THE IMMIGRANT POPULATION IN A RURAL HEALTH AREA IN TOLEDO (SPAIN)

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## Introduction

The foreign patient usually has a particular conception of the world and beliefs about health and disease (diversity). For this reason it could be necessary improving our knowledge and developing new skills in order that the relationship "patient-doctor" could be effective in both directions facilitating the access to the Health services .

This matter will be more and more important because of the continuous increase of of foreign patients in our consultations.

Nowadays they are 3.24 % of the whole Spanish population. For 2025, it would be 20 % of the total population.

Their origins are very diverse. The most important emigration areas are North of Africa, Sub-Saharan, Asia, South American, East Europe.

The hypertension is more frequent in black people , who also suffer more hypertensive complications, to a great extent due to their lower socioeconomic level and, in consequence, for their minor access to the necessary medical attention. It is probable that their higher prevalence of hypertension reflects as much genetic as environmental factors .

The association between hypertension and the stress factors -closely connected with low economic levels- is well known. In addition, the black person is more sensitive to the sodium intake.

It is also documented that the black people have major effect of left ventricle hypertrophy, brain vascular accident x and kidney terminal disease that the hypertense ones of white people .

Black people and also who come from Asia have frequently cough induced by angiotensin-converting enzyme (ACE) inhibitors. They respond well to

diuretics, calcium antagonists and  $\beta$ -blockers.

This differential response diminishes with the combinations of medicaments that include sufficient doses of diuretic. The angiodema due to the ACE inhibitors is between 2 and 4 times more frequent among the Afro American hypertenses .

The purpose of this study was to know the characteristics of the blood pressure (BP) in an immigrant population who live in Toledo Health Area.

## Method

This is a transversal and multicentric study. The selection and the recruitment were realized between December, 2002 and September, 2003.

Including criteria:

- Acceptance of taking part in the study
- Age  $\geq$  18 years old
- Residence in the Health Zones of Anover de Tajo, Fuensalida, La Puebla de Montalbán, Ocana, Sonseca o Villaluenga (Toledo Health Area)

Excluding criteria:

- Suffering some acute disease that could prevent their participation
- Not acceptance of taking part

The BP was always measured two times with an interval of five minutes between them and classified according the European Society of Hypertension and the European Society of Cardiology criteria (table 1).

We did a descriptive analysis with intervals of confidence (CI) and multivariate logistic regression.

## Results

Were included 266 immigrants, without diagnostic of high blood pressure (middle age :  $33.7 \pm 9.2$  years old , 52.6 % of them men and average time of residence in Spain of 3.8 years).

The countries of origin, from major to minor frequency, were Morocco, Ecuador, Mali, Romania, Pakistan, Ukraine (figure 1).

The average systolic blood pressure (SBP) was 117.5 and the diastolic blood pressure (DBP) 71.8. The SBP was higher in men ( $121.1 \pm 15.5$ ) than in women ( $113.3 \pm 17.1$ ), ( $t = 3.9$ ;  $p < 0.0001$ ).

The average systolic blood pressure (SBP) was 117.5 and the diastolic blood pressure (DBP) 71,8.

The SBP (121,1 +/- 15,5) than in women (113.3 +/- 17.1), (t = 3.9; p <0.0001).

A 45.5 % of the sample, of them had ideal BP. The 25.9 %, normal BP, a 13.9 normal high BP, and 14.7 % (CI 95 %; 10.5-18.9) high BP (figure 2).

A 51.9 % had overweight and 13.2 %, obesity. Sub-Saharan people had a 2.6 times higher probability of having high BP (table 2).

### Discussion

One of the possible limitations of our study was that the diagnosis of hypertension was not made. The purpose of the study was to know the characteristics of the BP in immigrant population of Primary Care. A 14.7 % presented high BP. Nevertheless our immigrant population is very young and goes a few years residing in Europe.

In spite of being very young and living in Europe few years, 14.7 % of our immigrant population had high BP

It is well-known that the individuals of black race in the USA have higher levels of hypertension. Cooper et al (1999), in his study of black people in seven populations of African origin, found that HTA's rates were: 7 % in the rural zones of Nigeria, 26 % in Jamaica and 33 % in the USA.

These rates were associated with major body mass index (BMI) and contribution of sodium, which suggested that the "overweight", together with the lack of exercise and the inadequate diet, explains from 40 % to 50 % of the increase of risk of hypertension that Afro-Americans present in comparison with the Nigerians.

Though the immigrants belong to a group of young age, we observe that a considerable percentage presents measurements of high BP, major in those of sub-Saharan origin.

We think that the measurement of the BP should always be done in Primary Care, in the initial medical evaluation of the immigrant.

**Table 1** Definitions and classification of blood pressure levels (mmHg)

Category	Systolic	Diastolic
Optimal	< 120	< 80
Normal	120-129	80-84
High normal	130-139	85-89
Grade 1 hypertension (mild)	140-159	90-99
Grade 2 hypertension (moderate)	160-179	100-109
Grade 3 hypertension (severe)	≥ 180	≥ 110
Isolated systolic hypertension	≥ 140	< 90

When a patient's systolic and diastolic blood pressures fall into different categories, the higher category should apply. Isolated systolic hypertension can also be graded (grades 1, 2, 3) according to systolic blood pressure values in the ranges indicated, provided diastolic values are <90.

2003 European Society of Hypertension-European Society of Cardiology guidelines for the management of arterial hypertension Guidelines Committee. Journal of Hypertension 2003; 21:1011-1053

Figure 1. The countries of origin

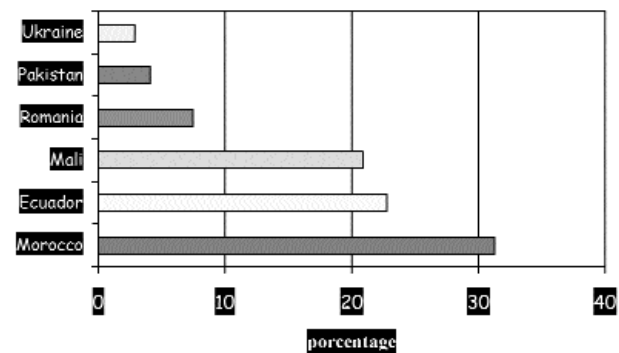


Figure 2. Blood pressure in immigrants qualified with the criteria of the European Society of Hypertension and The European Society of Cardiology

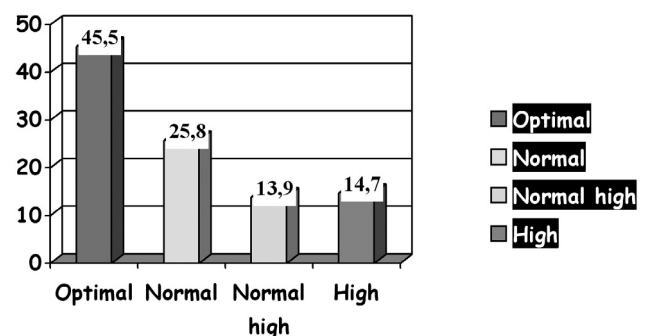


Table 2. Probability of presenting high Blood Pressure in immigrants

Variables	OR	CI	P
Sub-Saharan	2,6	1,17 - 5,9	0,01
Sex	1,18	0,8 - 1,8	NS
Age	1,01	0,9 - 1,05	NS
BMI	1,07	0,98 - 1,2	NS

OR: odds ratio, CI: confidential interval, P: signification,  
BMI: body mass index

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# Training and education in rural health: perspectives in Europe

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## Abstract

The aim of a sustainable development of rural areas can only be reached by combined long-term actions where local rural health experts play an important role. They have to be instructed in special training and education programmes dealing with the local environmental and health problems. The specific domains of learning the programmes should offer are presented.

Due to the complexity of the topics, a network of departments of high level educational institutions ( e.g. universities) specialized in these fields is to establish. Their expertise has to be offered to local rural health experts so that they get the chance to obtain the most advanced informations about environment and health protection. To solve the problem of communication, the use of advanced technologies such as e-learning is of special importance.

In contrast to their forward-looking importance, there are only some rural health teaching activities in Europe. The problem of funding seems to be a major obstacle to their implementation.

proposes: "... the creation of training and education programs dealing with the main local environmental and health problems and addressed to local technical staff."

Whereas in countries such as Australia, United States or Canada universities offer elaborative training concepts of educating rural health experts the development in this field is much more behind in Europe. So, in their perspectives for the IAAMRH European chapter, COLLOSIO et al. point to this deplorable state. Referring to the European situation, they argue: "Since a broad experience in this field of training and education in rural areas is not available yet, the realisation of pilot experiences such as short intensive courses seminars distance learning etc. is recommended." (COLLOSIO et al, 2004, p.16)

For planning and exercising training courses for rural health experts some fundamental considerations are necessary. The most important are:

- What are the educational objectives of rural health programmes?
- Which domains of learning have to be considered?
- Which institutions are responsible for teaching and how can they achieve it?

## 1.

### Introduction

The International Conference on rural health in the Mediterranean and Balkan Countries that was held at Bari (Italy) in 2002 closed up with the so-called Bari declaration. To improve rural health the declaration identified three main fields of interventions:

- Health of the General population
- Rural occupational health
- Environmental health

And the Bari declaration further pointed out that training and education of rural health experts in these fields of priority is a fundamental activity. It

## 2.

### Educational objectives of rural health programmes

Their general aim is promoting a sustainable health development for local population. Therefore, local rural health experts have to be created who deal with the main local environmental and health problems. They should be enabled to face, at any level, the different problems related to "rurality" and to act, in this way, as changing agents for health in their local surrounding. In this way, the access of the entire population to the basic elements of promotive, preventive and treatment services should be facilitated.

This general objective implies certain core competencies the rural health experts have to attain in the education. He/she has to become

Medical Expert for population-relevant diseases

Humanist with a sense of caring, sensitivity and concern for the problems of the people

Epidemiologist who is able to assess the health needs of the population by means of epidemiological methods

Expert in Risk Assessment by analysing the risk-factors for health in the rural environment and by setting priorities for actions

Health promoter for healthy life-styles in the community

Communicator who is able to listen to the people, to understand their needs and who can contribute to possible solutions

Collaborator who is aware of an interdisciplinary approach to health care and can integrate oneself efficiently in an interdisciplinary team

Learner with an orientation of life-long learning which keeps the expert up to date with the advances in health related knowledge and its application in responding to the health needs of people and communities. Appropriate learning-skills are to develop and to be applied during the whole professional life.

And, last but not least, *the rural expert is a person too!!* That means that he/she should be aware of the personal stress caused by the demands of the professional life. It is important to develop strategies for coping with these sources of stress.

This short description shows the variety of tasks of a rural health expert. He/she has to develop both - competencies as a 'generalist' and as a 'specialist' as well.

Education and training programmes have to face the complexity of this profile. By setting priorities they have to decide about the main topics of teaching.

That leads to the next questions concerning the contents of learning.

### 3.

#### Domains of learning

According to the Bari conference, there are three priorities for rural health action and training in Europe. They are closely linked to each other:

- Health of the General population
- Rural occupational health
- Environmental health

As rural health problems vary a lot among European countries, a specific country/area profile has to describe the local needs concerning these topics. It is the decisive basis not only for intervention but also for teaching by determining its focus.

For example, in Hungary, the country profile identifies the extension of life expectancy as an important issue (JAKAB, 2004). Due to this priority, health aspects of the general population (such as nutrition, tobacco/alcohol control, physical activities) have to be focussed by rural health experts. And they have to be preferably trained in identifying and reducing risk-factors and promoting healthy life-styles for the population. In another country, child labour, accident prevention or environmental pollution are on top of the agenda and therefore mainly to be dealt with in intervention planning and teaching.

To ensure a comprehensive learning process theoretical knowledge about general and local rural health issues and practical skills have to be learned. Both elements - knowledge and skills - are indispensable for meeting the above-mentioned rural health expert profile.

Related to knowledge about health of the general

population, Collosio et al. (2003) propose following main topics to be taught:

- Quality of life in rural areas
- Health delivery and health promotion
- Diet and nutrition
- Food safety assurance
- Food quality surveillance and monitoring
- Child food safety and nutrition
- Prevention of vector-borne disease
- Immunisation against vaccine preventable diseases

For occupational health they propose

- health prevention of agricultural workers - medical surveillance, information and training
- occupational health priorities in rural areas
- non-communicable resp. communicable diseases related to rural occupation

Teaching environmental health includes

- Environmental monitoring and risk assessment for different environmental targets ( e.g. sanitation, water supply )
- Pollution (air, water, soil)
- waste management
- other risks ( e.g. natural presence of asbestos)

Furthermore, a behavioural perspective should be added to the education. As the rural health expert is concerned with people and acts as changing agent, teaching should also aim at the

- improvement of the understanding of human behaviour by regarding cultural and psychosocial aspects of the rural population
- behavioural aspects of health promotion
- determinants for the change of health behav-

our in the rural population

Skills to be trained are

professional skills: such as

- decision-making skills
- data collection skills
- evidence-based risk assessment and risk management skills
- skills for strategic planning and intervention
- (inter-professional) communication skills

learning skills : they include the ability

- to ask the appropriate questions
- to set priorities
- to use various health information systems ( e.g. people, textbooks, internet etc.)
- to present information orally and in writing in a clear way

specific skills like

- first aid treatment
- training in emergency and trauma ( especially for rural GPs)

As rural health means multidisciplinary interaction the training should be addressed to different groups of health professionals. The target groups are

- medical doctors
- occupational health physicians
- rural practitioners
- technical staff
- nurses
- public health organisation personnel
- medical students (especially from rural areas)
- social workers

#### 4.

### **Organizational and institutional aspects of the teaching programmes**

It is clear that only an interdisciplinary approach of different scientific disciplines can meet the great demands on such a project. So, due to the complex-

ity of the topics, a network of high level educational institutions specialized in the different fields of the rural health issues is to establish. Preferable universities should be invited to offer their expertise to local rural health experts so that they can get the chance to obtain the most advanced informations. Further support seems necessary by Health associations and Ministries of Health.

With the opening of Europe and the internationalization of national universities according to the Bologna-process there are realistic chances to establish such a network. A good example for it is the "European Master degree-programme in risk assessment and risk analysis" organised by an academic consortium of Excellence consisting of several universities from the north and south of Europe (see: <http://www.unimi.it>).

An important characteristic for teaching must be its output instead of input orientation. The professional qualification of the participants for local rural health problems is its basis. For this purpose, studies must be offered in a modularized and consecutive way that opens different levels of teaching activities.

On a basic level, so-called micromodules can consist of short intensive courses (with a duration of three days to a week) which seem to be appropriate

- to face very specific problems
- in a well defined rural area and
- to train local staff specifically.

The teaching can also serve as refresher courses to update the rural health personnel.

So-called mesomodules consist of several different micromodules. This option enables the user to face more complex problems by covering a greater variety of topics. They should last about one month and should involve a staff of teachers from different fields of knowledge such as

- environmental health personnel
- staff of ministries and regulatory bodies
- rural practitioners and medical doctors
- occupational health physicals
- technicians.

A Master-Programme on rural health is a macro-module to be studied consecutively. It is the most

complex option. According to the European rules, it should last at least for one academic year with a total of 1500 teaching hours. By comprising micro- and mesomodules these activities should be equally subdivided in teaching training, practical training and individual learning. The target group to be addressed to are

- university researchers and teachers
- environmental protection and national prevention personnel
- rural physicians
- occupational health physicians

For the realization of the teaching activities, the use of e-learning is a precondition to overcome the problem of distance. Most of their parts ( such as the contact with tutors, written examinations or even the preparation of a thesis) can be carried out via web or via conference calls. There are some extend experiences with e-learning from abroad, especially from Australia. For example, a so-called e-mentor programme from James COOK-University shows that this approach can provide an efficient and effective low-cost model for linking rural health teachers in a non-rural location with their students in a remote area (GUPTA, GRANT, Mc KENZIE, 2003).

Here in Europe, we are just at the beginning of establishing rural health teaching programmes. The first steps in this direction have been done. For example, supported by EURIPA ( the European Rural and Isolated Practitioners Association) the Institute of Rural Health has successfully implemented an e-health and education programme in the UK ( see: <http://www.rural-health.ac.uk>). But until having a broad teaching network there are still many obstacles to overcome. A major problem is funding. So, creating a solid financial fundament for these programmes will be the challenge of the near future.

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# Health Impact Assessment and rural health

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## Introduction

After opening of the Suez Canal Ferdinand de Lesseps began construction of the Panama Canal in 1882. Unfortunately, diseases made disabled or killed most of his workforce causing enormous economic barrier on the construction, which resulted in bankruptcy of his company in 1889. Later on, due to increasing economic interests the US senate passed an act on construction of the Panama Canal in 1902. The major difference compared to attempt of Ferdinand de Lesseps was in assigning Dr. William Gorgas to assess health hazards and propose solutions before the construction began. Based on his recommendation changes in environment, preparation of workers, etc. was completed and the construction has begun in 1904, finished in 1914, the canal is still under operation<sup>1</sup>. This story success illustrates how important assessment of health impacts is in case of specific investment projects, but also on higher level of international work. Using a recent language, this is a *great case of Health impact assessment (HIA)!!!*

## What is HIA?

As the Gothenburg consensus paper states HIA is “any combination of procedures or methods by which a proposed policy or program may be judged as to the effects it may have on the health of a population”<sup>2</sup>.

There are different methodologies listed in literature, however experts agree on 6 major steps of methodology:

1. Screening – the purpose of screening is to determine the need to carry out an HIA. Screening filters out policies/programs/proj-

ects that do not need an HIA. Screening enables decision-makers to target time and resources for HIAs on policies. There are screening tools available to conduct screening, nonetheless usually specific screening tools are used to conduct screening, which might be produced either by proponents of policy, program or project, or by public health professionals, or by local authorities.

2. Scoping - the purpose of this step is to set the terms of reference for the HIA ensuring that HIA will be well designed and consistent with the values of HIA and clear roles and responsibilities and the methodology for the HIA process are clearly defined. A steering group responsible for HIA is assigned usually in this step and this group defines the main questions HIA is going to answer
3. Risk appraisal - the "heart" of the HIA. Assessment of impact is the major purpose of this step. Both positive and negative impacts on health of the population (or population subgroups) are assessed in this step. An analysis of the program/policy/plan/proposal, profiling of the affected population or population subgroups, collection and assessment of evidence, identification and characterization of potential health impacts are completed within this step of the HIA methodology. This step is usually based on epidemiological knowledge or risk assessment techniques. Social, economic, environmental risks are valued and assessed regarding future health impacts. Short, medium and long-term impacts are assessed not only compared to limit values, but also including balance of risks and benefits.
4. Information - this step is about reporting. HIA is done to add new knowledge to decision making, therefore it is extremely important to produce good quality report regarding their content and propose the best possible way of dissemination of findings.
5. Decision - the objective of HIA is to add to decision-making process. In this step of methodology the recommendations for decision makers are listed both regarding minimalisation of negative impacts and maximalization of positive ones.
6. Monitoring and evaluation - it is extremely

important to evaluate both the process of HIA and its outcomes to get information for future development of methodology. Out of set up of evaluation a monitoring plan is set up in this step to allow for long-term monitoring of real impacts once the assessed program, policy, plan or proposal is implemented.

There are different levels where HIA shall be applied. As mentioned earlier in text programs, policies, plans and proposals could be assessed regarding their health impacts. As regarding time, HIA can be conducted prospectively, or retrospectively. It is of course better to do a prospective HIA to be effective on influencing of decision-making process and a prospective HIA allows better monitoring as well. Nevertheless, conduct of a retrospective HIA is useful as well; it brings experience and practice together with a chance to compare different scenarios with real impact. HIA could be applied on international, national, regional and local level. HIA of the common agricultural policy of the EU conducted by Swedish National Institute of public health could be one of the examples of HIA on international level<sup>3</sup>. Similar topic, agriculture and food policies of the Republic of Slovenia<sup>4</sup> are one of the best examples of national level HIA, however and interesting example could be presented by HIA of national budget of the Netherlands<sup>5</sup> which is completed annually. There are many good examples of HIAs conducted at regional level; among them integrated transport strategies or area renewal project could be find more frequently<sup>6</sup>. HIAs on local level dealt with very different topics ranging from community safety projects to waste management issue<sup>6</sup>.

Where does HIA come from? What are the values behind HIA?

The modern public health paradigm based on determinants of health claims that about 75-80 % of influence on health of population is out of hands of ministries of health and generally out of health sector. Steps and decisions taken in other then health sectors are influencing our

eating habits, physical activity, environment, transport, leisure time, recreation possibilities, social status and even availability of health care services is influenced frequently by some of these decisions (let's mention just traffic schemes). Consequently, there is an increasing interest to assess impact of policies, programs, plans and proposals on health earlier then implemented. Health impact assessment is long term part of environmental impact assessment but gives frequently only narrow, physical environment related results. Social determinants, lifestyle influences, interaction of determinants are left outside of environmental impact assessments frequently. Therefore a need for full scale, all determinants involved impact assessment arose in late 80's of XXth. Century. Health impact assessment is a logical product of this pressure and demand.

Democracy, solidarity, equity, respect for human rights, and participation become the major values of international and national health policies by introduction of Health for All policy of the World Health Organization. Health impact assessment shares these values and wants to add to transparency of decision-making processes. Social determinants, access to information, environment, access to health care are frequently different in rural compared to urban areas.

### **HIA and rural health**

As values behind HIA are as written above, rural health problems are integral part of HIA. There are several major points where rural health and HIA comes together. First of all, rural population shall be addressed separately in screening and risk assessment part of methodology due to differences in health determinants, in rural areas. At second, national strategies shall identify equally needs of urban and rural population and HIA might help to identify these needs. As third, HIA is a useful tool for development of local strategies both in health and non-health sectors. Certainly, HIA can contribute to estimates of future health impacts on local level both

in case on local policies and national policies. As fourth, HIA can and certainly on local level does increase participation on decision-making. Out of assessment functions, as fifths, HIA can contribute to development of local health monitoring, evaluation and planning activities, as well as to development of local health promotion plans and health service planning.

#### Conclusions

Funding agencies in case of revitalization plans and requests to different structural funds increasingly requires HIA. On level of rural health it can significantly contribute to both health promotion, disease prevention activities and to planning of health services.

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## COMMERICAL SEX AND HIV/AIDS: BEHAVIOURAL CHANGES AMONG FEMALE SEX WORKERS IN SMALL TOWNS IN INDIA – A CASE STUDY

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### Introduction

Commercial Sex, mainly followed by female, is culturally and legally discouraged in India, but remained as a major activity for obvious reasons of poverty, illiteracy and low status of women. Like many occupations, sex work has become an occupation, probably one of the 'oldest' profession' in the country because it meets an important social demand. A Commercial Sex Worker (CSW) is defined as - "*a person past puberty who receives money or goods in exchange for sexual services and consciously defines those activities as income generating*<sup>1</sup>."

Girl trafficking has been one of the multi-million and flourishing industries in the country. There are no official figures available to gauge the magnitude of the number of female engaged in sex trade. But, a modest estimate based on the well-known red light areas located in cities and big towns puts the figure at two million.

Before embarking into studying the problem of commercial sex, we must make our thinking explicit on the issue of "Sex Trade" to search for possible solutions. Are we against the institution of prostitution because we see it as a wedge against the sanctity of the family structure and societal norms, or do we feel that it is demeaning to the "wellness" & "human rights" of the person, or are we primarily concerned because of its role in spreading disease?<sup>10</sup>

### Commercial Sex and Public Health

There have been few times and places in which sex workers were free from persecution, stigma and violence. The ancient Romans decided to restrict brothels to special areas as a result of discussions, which were remarkably similar to those taking place today in many countries about how the sex industry might be appropriately located and controlled<sup>1</sup>.

women, was seen as an important public health issue throughout the 19th century. Concern about it declined in the 20th century, due to improved management of sexually transmitted disease (STD) and contraception and more liberal views about sexuality. However, HIV has refueled concern, and public health again dominates the way that most societies think about, and deal with, commercial sex.

### Commercial Sex and HIV/AIDS

HIV is the most recent issue in the long history of recurring moral and practical questions and conflicts raised around prostitution. When HIV/AIDS was first identified in the subcontinent 23 years ago, sex workers were immediately named as potential carriers of a fatal, sexually transmissible disease.

The available evidence also indicated that hetro-sexual promiscuity is the major determinant of transmission accounting over 86% of the infections in the country<sup>2</sup>. It was clear that sex worker, and possibly their clients, would be vulnerable both to HIV and to HIV-related discrimination. Responses developed at different rates across the country, ranging from repressive measures to effective community mobilization and public health programs. Then efforts were made to find out how many people living with HIV are selling sexual services. But these efforts were limited to Metropolitan areas and big cities. Mumbai has the country's largest brothel based sex industry, with over 15,000 female sex workers. It is estimated that in the region of 70% of the female sex workers in Mumbai and 47% of female sex workers in Pune are HIV-positive. A study in Surat found that HIV prevalence among female sex workers had increased from 17% in 1992 to 43% in 2000<sup>4</sup>. The overall HIV positivity rate among all Indian CSWs was 20%<sup>5</sup>.

Transmission of HIV within and from these groups drives the epidemic, but the infection is spreading to the general community. The epidemic is shifting toward women and young people, with about 25 percent of all HIV infections occurring in women<sup>3</sup>. By the end of March 2004, the country with an estimated over 4.5 million people are infected with HIV, making the second largest HIV-positive population

in the world, next only to South Africa<sup>13</sup>. The World Health Organization estimates that 330,000 new AIDS cases occur in India each year and predicts that by 2033, AIDS will account for 17 percent of all deaths in India and will be a factor in 40 percent of deaths from infectious disease<sup>3</sup>.

However, an estimated 68,809 AIDS cases were registered with the National AIDS Control Organization (NACO), of which 50,342 were male and 18,467 were female. Maharashtra state with an estimated 15,693 cases of AIDS ranked second in the country<sup>2</sup>.

As the HIV pandemic grew in the 1980s and early 1990s, international agencies, governments and non-governmental organizations (NGOs) increasingly recognized the need for health promotion and support services for female sex workers and, in some places for men and transgender people. Extending these services to clients has however been slower<sup>6</sup>.

Innovative programs by governments; communities and sex workers themselves now face the renewed challenge of making sex work safe. Current HIV/AIDS prevention strategies are limited to CSWs located in big cities, while this trade is equally spread to small towns affecting the villages across the country<sup>7</sup>.

#### **BEHAVIOURAL CHANGES IN CSWs IN SMALL TOWNS IN INDIA - A CASE STUDY**

Basic epidemiological information on CSWs and research in social and behavioural changes on commercial sex in small towns and villages likely to provide the most useful background for planning public health policies and services to combat the spread of HIV/AIDS and STIs. Surprisingly, there seem to be few attempts made so far by Public Health experts to assess the Knowledge, Attitudes and Practices (KAP) of CSWs in small towns, who are spreading the HIV/AIDS disease in majority of the rural areas.

It was against this background, Rural Medical College of Pravara Institute of Medical Sciences (Deemed University), Loni; Maharashtra, which has been working in rural areas and small towns for the

last 26 years, has taken the lead to carry out the present study with the following objectives.

#### **OBJECTIVES**

1. To find out the socio-economic attributes which indulge young girls and women into prostitution.
2. To study the demographic, living and working conditions of female CSWs in Shrirampur Town in Maharashtra.
3. To assess the Knowledge, Attitude and Practices regarding safe sex and prevention of HIV/AIDS among female CSWs active in Shrirampur Town in Maharashtra
4. To understand the association between socio-economic attributes and the knowledge, attitudes of CSWs towards HIV/AIDS.
5. To make recommendations for appropriate public health measures

#### **MATERIAL AND METHODS**

The present study was a population based, cross sectional, analytical, epidemiological design in the setting of a small town namely Shrirampur in Ahmednagar district of western Maharashtra. The town is connected to North and South Indian states by road and rail. The town is 300 Km away from Mumbai and 200 Km away from Pune - the two big cities of the State. It is one of the business centers, mainly wholesale Sugar market, of the state. It is a typical small town in Maharashtra. The educational hub of the state, Loni, where Pravara Institute of Medical Sciences (PIMS) with other sister institutions, is just 25 Kms away from the town. The total population of the town was around 75,000.

Keeping the expected parameter (proportion of CSWs with satisfactory knowledge) at 0.5 and with 0.1 as allowable margin of error on each side at an alpha error of 0.05 (two-tailed) (i.e., acceptable 95% confidence limit 0.4 - 0.6), the minimum sample size was worked to 100. The study however included 103 Commercial Sex Workers (CSWs) active in the Sex Trade at Ward No. 2 – known red light area of Shrirampur - a small town in Ahmednagar district of Maharashtra.

Employing a pre-tested structured interview schedule survey has been carried out in the month of June 2003.

The questionnaire included Personal details (age, education), Socio-economic variables (social acceptance, employment, income) High Risk behavior analysis, treatment seeking behavior etc., and Clients profile (why clients opted for sex with CSWs, uses of condoms and awareness level about HIV/AIDS & Drugs. The purpose of the study was explained and consent was taken from the participating CSWs. All the CSWs assured of full confidentiality of the data. After initial rapport building, the questions were asked by personal face-to-face method of interview. Categorical variables of socio-demographic characteristics like educational and knowledge, attitudes and practices were measured by contingency  $X^2$  analysis.

The final year undergraduate students of medicine (4 years of medical schooling) of Rural Medical College, Loni who were trained by the Faculty of Department of Community Medicine conducted the interviews. The faculty members supervised the conduct of the study. Interviewers were assisted by the local social/health workers belong to Bhausaheb Kute Memorial Foundation, Shrirampur.

## RESULTS & DISCUSSION

### a) Socio-Demographic characteristics of the CSWs

It was quite interesting to note that nearly 2/3<sup>rd</sup> of CSWs are Muslims, less than 1/4<sup>th</sup> are Hindus and about 6% are Christians (Table 1). Distribution of CSWs by religion was contrary to that of the national population distribution, wherein 82% Hindu and 14% Muslim and 2.5% Christians, 2% Sikhs and 2.5% Buddhists, Jains and Parsis <sup>8</sup>.

The higher rate of CSWs from Muslim community may be an indicative of their low socioeconomic status. Majority of the Muslim CSWs interviewed hailed from north Indian states including Uttar Pradesh and West Bengal. Quite a few sex workers interviewed belong to the neighbouring countries like Nepal and Bangladesh.

Table 1: Distribution of CSWs by Religion

Sr. No	Religion	No. of CSWs	Percent
1	Hindu	23	22.33
2	Muslim	63	61.16
3	Christian	6	5.82
4	Others	17	16.50
	Total	103	100.00

In the expected lines, 76 out of 103 i.e., 74 % of CSWs are in the prime age group of 21-30 years. It was shocking to know that about 8% CSWs interviewed were below 20 years of age, while about 2% were even below 15 years of age (Table 2). It was quite astonishing that nearly 48% of the CSWs reported that they started first sexual contact and multi sex practice at the age 16 years.

Table 2: Distribution of CSWs as per their Age

Sr. No	Age (in years)	No. of CSWs	Percent
1	Less than 15	2	1.8
2	16-20	7	6.2
3	21-25	40	38.83
4	26-30	36	34.95
5	31-35	14	13.59
6	36-40	4	3.88
	Total	103	100.00

Another important social indicator that reflects their present condition is their educational status. Majority of the CSWs was uneducated. Nearly 60% never attended to school, while 36% had only less than 7 years of schooling (Table 3).

Table 3: Distribution of CSWs by the educational status

Sr. No	Years of Schooling	No. of CSWs (n = 103)	Percent
1	No Schooling	61	59.22
2	1-4 years	14	13.59
3	5-7 years	24	23.30
4	8-10 years	04	3.88

Table 4: Distribution of CSWs by Main reason to enter into the profession

Sr. No	Causes	No. of CSWs (n = 103)	Percent
1	Poverty	44	42.77
2	Deserted by husband	25	22.27
3	Family Profession	23	22.23
4	Others (sold out)	11	10.68

In a country where unemployment is in such gigantic proportions, where does the compulsion of displacing millions of women who were already engaged in an income earning occupation, which supports themselves and extended families, come from? Women take up prostitution for the same reason as they may take up any other livelihood option available to them. Their stories are not fundamentally different from the labourer who pulls a rickshaw or the worker who works part time in a factory. Of course some of them get sold into the industry.

These sex workers ended up in the sex trade after going through many experiences in life including cheating by men who sexually exploited them in the pretest of a married life. Retrospectively, many CSWs felt that they have taken the profession as livelihood option often unwillingly, without understanding all the implications of being a prostitute fully.

On inquiring the reasons for opting to the profession, majority - 43% had alleged that they were pushed into sex trade due to poverty, nearly 1/4<sup>th</sup> confessed to the fact that their husbands deserting them and left them in debt. Interestingly, 22% got into the profession as a family occupation (Table 4).

The risk of getting STI or HIV/AIDS increases by the increase in span of Sex work. More than one-third - 37% of CSWs have been in the profession for about 4-6 years and about 24% for more than 7 years (Table 5).

Table 5: Distribution of CSWs by the Length of their Profession

Sr. No	Duration (in years)	No. of CSWs (n=103)	Percent
1	Less than 1	8	7.77
2	1-3	33	32.04
3	4-6	38	36.89
4	7-9	15	14.56
5	More than 9	9	8.74

The housing and sanitation conditions are abysmal, the localities are crowded, most sex workers are quite poor, and on top of it police harassment and violence from local thugs. Moreover, to add to the material condition of deprivation and distress, they have to take on stigmatization and marginalization - the social indignity of being 'sinful', being mothers of illegitimate children, being target of those children's frustrations and anger.

Hence majority of the sex workers are addicted to harmful habits. Over 50% of them are addicted to Pan with betel nut, 43% for tobacco chewing, 15% for smoking, 10% for alcohol, 5% for drugs (Table 6). Of course, 32% claimed that they are not addicted to any habits.

Table 6: Distribution of CSWs by their addictions (multiple response)

Sr. No	Addictions	No. of CSWs (n = 70)	Percent
1	Pan with betel nut	52	
2	Tobacco Chewing/ Gutka	44	
4	Cigarette/Bidi smoking	16	
5	Alcohol	8	
6	Drug Abuse	5	

The pace and risk of transmitting HIV infection is directly related to the partner exchange or number of clients each CSWs have per day. Promiscuous persons have a high rate of partner exchange, and they are thus at high risk of acquiring HIV infection. The nature of sex work by definition involves sex with many persons. The physical labour involved in providing sexual services to multiple clients in a working day is no less intense or rigorous than ploughing or working in a factory. It is definitely fun or frolic. A study of this aspect has given quite interesting information. Over 2/3<sup>rd</sup> of CSWs have 2-4 clients per day, while 30% of them have sex with more than 5 clients per day. About 35 CSWs i.e., 34% had permanent clients.

Table 7: Number of clients of CSWs per day

Sr. No	No. of Clients/ day	No. of CSWs (n = 103)	Percent
1	Less than 2	5	4.85
2	2-4	68	66.02
3	More than 5	30	29.13

Across all the socio-economic and age groups of CSWs interviewed there was general awareness of AIDS. The findings revealed that all the 103 CSWs had at least heard of either HIV, or AIDS or both. However there was a lacunae observed in the clarity about the causative agent of the infection. Only 3% knew that a virus called Human Immuno-deficiency Virus (HIV), which subsequently leads to the disease - "AIDS", causes the infection.

It was observed that all the CSWs interviewed knew that unprotected sexual intercourse is the key mode of transmission of HIV infection. However, the correct knowledge about the other modes of transmission like transfusion of blood having AIDS virus was satisfactory at 85%, improperly sterilized needles was low at only 46% (Table 8).

The knowledge about the incorrect modes of transmission is relatively high at 76% for Social contacts with infected person, low at 44% for both Mosquitoes and other insects, & Sharing clothes with HIV infected person (Table 8).

Table 8: Knowledge of CSWs about Modes of Transmission of HIV/AIDS

Mode of transmission of HIV/AIDS	No. of CSWs having correct knowledge (n = 103)	Percentage of CSWs having correct knowledge
Sexual intercourse	103	100
Social contacts with infected person	76	73.7
Improperly sterilized needles/syringes	47	45.63
Mosquitoes and other insects	45	43.68
Transfusion of blood having AIDS virus	88	85.43
Sharing clothes with HIV infected person	45	43.68

Less than 7% had correct knowledge about the "time of appearance" of signs and symptoms of HIV infection, while over 27% possess incorrect knowledge, and 66% had no knowledge at all. Majority i.e 65% had no knowledge about the "signs and symptoms" of the disease - "AIDS" (Table 9).

**Table 9: Knowledge of CSWs about Time of Appearance of signs & symptoms of AIDS**

Time of appearance of signs & symptoms of AIDS	No. of CSWs responded (n = 103)	Percentage
Immediately (within a week)	28	27.18
5-6 years later	7	6.79
Don't know	68	66.01

Of the 35% who had some knowledge, 57% attributed it to fever, 23% identified it with diarrhea, and 17% reflected it with weight loss (Table 10).

**Table 10: Knowledge of CSWs about Signs & Symptoms of AIDS**

Signs & symptoms of AIDS	No. of CSWs answered in affirmative (n = 35)	Percentage
Fever	20	57.14
Diarrhea	8	22.86
Weight Loss	6	17.14
All above	5	14.24
Others	5	14.24

Less than 5% had the knowledge about the treatment options available to the people living with HIV/AIDS (Table 11). There was no statistically significant difference observed ( $p > 0.05$ ) in the literate and illiterate CSWs with regard to the knowledge about treatment (Table 15). Over 2/3<sup>rd</sup> CSWs had the knowledge that even a single unprotected sexual intercourse can increase the risk of transmission of HIV infection. However, this knowledge is highly statistically significant ( $p < 0.01$ ) in the CSWs who were literate compared to illiterate (Table 15).

**Table 11: Knowledge about the treatment options for HIV/AIDS**

Available/Not available	No. of CSWs responded (n = 103)	Percentage
Available	5	4.85
Not available	98	95.75

Clearly there are at least two major issues involved in dealing with Commercial Sex. One very clear issue is that of the spread of sexually transmitted infections including HIV due to lack of awareness. Lack of basic education, poverty and among CSWs is the major problem in generating the awareness and changing their behaviours. Though all CSWs had knowledge that HIV transmitted through unprotected sex, their attitude towards single unprotected sex, HIV testing, HIV infected pregnant women, about insisting condom use in permanent clients is not satisfactory.

### c) Attitudes towards AIDS and the People living with AIDS

In India the social reactions to people with AIDS have been overwhelmingly negative. For example, in one study 36 % of people felt it would be better if infected people killed themselves, the same percentage believed that infected people deserved their fate. Also, 34% said they would not associate with people with AIDS, and one fifth stated that AIDS was a punishment from God (11).

It was interesting to observe in the present study that over 52 percent of CSWs had a positive and healthy attitude towards the people living with HIV/AIDS (PLWHs). Of which, 33% have not changed their behaviour even after knowing that their colleagues were HIV infected and 20% offered special care to them. However, the remaining 48% said that they would not associate with people with AIDS (Table 12). There is a need to change this stigma and discrimination towards PLWHs among CSWs.

**Table 12: Attitude towards People Living with HIV/AIDS**

Attitude of CSWs towards HIV infected person	No. of CSWs (n = 103)	Percentage
There was no change in their behaviour	34	33.01
Prefer Isolating the person	39	37.86
Prefer neglecting the person	10	9.71
Offer Special Care	20	19.42

However, a study of attitudes of CSWs towards the course of action to be taken by pregnant women infected by HIV has revealed that nearly 60% had advised for abortion, while 22% argued that the women should give birth to the child, the remaining were undecided (Table 13). It indicates that about 41% of the CSWs were unaware of the risk of mother to child transmission of HIV.

**Table 13: Attitude towards People Living with HIV/AIDS**

Attitude towards continuing the profession with HIV Status	No. of CSWs (n = 103)	Percentage
Prefer abortion	61	59.22
Prefer Giving birth to the child	22	21.36
Undecided	20	19.42

**Table 14: Attitude towards Continuing the Profession with HIV Status**

Attitude towards continuing the profession with HIV Status	No. of CSWs (n = 103)	Percentage
Prefer continuing the profession	44	42.72
Prefer giving up the profession	59	57.28

#### d) Practices towards HIV/AIDS

It is true that if all sex acts between sex workers and their clients were protected by properly using a condom, the chances of getting HIV infection both by sex worker initially, and the clients eventually,

would be very greatly reduced. However, there was ample evidence to suggest that for several reasons it was difficult to ensure that condoms were used every time and on all occasion. In the present study, 100 % CSWs who have multiple partners daily, reported that they insist on condoms with every customer, but only 66% had actually used a condom with the last customer. The reason is simple. If a sex worker is starving, either because she does not have enough customer or because most of her income goes towards maintaining a room or meeting the demands of madams, local power-brokers or the police, can she be really in a position to refuse a client who can not be persuaded to use condoms?

Some sex workers may not even be in a position to try negotiating safer sex with clients, so-called "permanent client", as they may be too emotionally controlled. 18 CSWs, of the 35 who reported to have permanent clients confirmed this inability. The literacy status has not significantly helped the CSWs to negotiate for safe sex ( $p > 0.05$ ) using condoms with permanent clients (Table 15). This may be due to traditional norms, which exempt men from responsibility for the consequences of sex and sexuality, and to the fact that clients are generally less, visible than sex workers for motivating and promoting safe sex practices.

Nearly 11% of CSWs had chosen sterilization as a permanent method of contraception. Over 30% said, in spite of their HIV positive status they are ready to donate the blood.

Majority i.e., 76% of CSWs had reported that they are undergoing HIV test periodically. Of which, 60% are undergoing the test every month, 20% are quarterly, and the remaining 20% occasionally. The literacy status of the CSWs has played a highly statistically significant role ( $p < 0.01$ ) on the practice of the periodical HIV testing (Table 15)

**Table 15: Association of Knowledge, Attitudes and Practices (KAP) towards HIV/AIDS with Educational Status of CSWs**

	Literate		Illiterate		X2 Test
	Yes	No	Yes	No	
Knowledge about HIV transmission by single unprotected sexual contact	41	1	26	35	$P < 0.01$
Knowledge about treatment of HIV	3	58	2	40	$P > 0.05$
Practice about using condom with regular customers	9	5	9	12	$P > 0.05$
Practice towards HIV testing	39	3	36	25	$P < 0.01$

## CONCLUSION

It may be pertinent to mention that the area of study has been subjected to some AIDS educational activities by social and non-governmental organizations as well as semi government organizations during the past 2-3 years. Apparently, this could be one of the major reasons of satisfactory levels of knowledge and changes in behavioural patterns towards HIV/AIDS. It is good to see that investments in the conventional strategies for prevention have already started taking place. Of course, there is a great scope to improve in all aspects of the issue in the study population. Responses to the HIV epidemic should focus on dealing not only with the causes of the epidemic but making the sex work safe.

Although some individuals and organizations believe that commercial sex is wrong and should be abolished, many sexual contacts in almost all societies are paid for, regardless of attempts to eliminate the sex industry. Punishing sex workers clearly fails to end the sex industry. Academic researchers have offered many explanations for why people decide to sell sex. Perhaps the best one is simply that it is to meet demand. It is reasonable to assume that while demand exists it will always be met, regardless of economic and social conditions.

There is no single, universal model for emancipation, empowerment and comprehensive service for

the CSWs. Several combinations of services and policies like legalizing prostitution; rehabilitation of sex workers should be explored.

The goal of sex work related STD/HIV prevention should be to reduce the health risks associated with sex work. HIV/AIDS control and prevention efforts must recognize that ad hoc promotion of condom use or similar such programs will not be effective. While promoting the use of condoms, in order to change the sexual behaviour of sex workers it was not enough to enlighten them about the risk of unprotected sex but to improve their communication and negotiation skills<sup>16</sup>. Major source of information for CSWs were TV and Social Workers operating in the region. So these two sources have to be effectively utilized to increase the knowledge and changing their behaviours and imparting negotiating skills.

More extensive developmental work aimed at betterment of living and working conditions of CSWs, which include access to adequate sanitation and security, and the right to reject unsafe practices, to rest, and to be free from violence is required for effective HIV/AIDS prevention<sup>14</sup>. Comprehensive care and support systems, which include voluntary HIV counseling and testing, should be created so that CSWs can know their HIV status and deal effectively with it. Psychological support should be provided to help people cope with the implications of having a life-threatening disease<sup>15</sup>.

Ultimately the whole Society needs to be educated and helped to find solutions to tackle the problems of social stigma, human dignity and human rights of those engaged in selling the sex. It is not necessary or even likely that all the ills of so called "sex work" will be solved by one magic bullet. It requires social support to help HIV-positive CSWs, their children cope with the economic and social consequences of sickness and death due to AIDS should be developed. There is little doubt that the sex industry will continue, and that some people will demand sexual services. The effort must be to minimize the deleterious effect.

## Growing problem of Migration and Health: Trafficking in Persons and Its Impact on the Health of Rural Regions

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### Summary:

This paper provides a theoretical understanding of trafficking and the issues around the trade of persons, as a human rights violation, a migration dilemma and particularly as a risk to public health safety of sending, transit and destination countries alike and the health of the trafficked person her/him self. Trafficking should be looked at as both a global crisis and in the context of central, eastern and south-eastern Europe, as a regional problem. Special attention should also be given to the effects of trafficking on rural populations in countries of origin. While trafficking in persons is carried out for a number of purposes, such as for prostitution, for cheap domestic and agricultural labour, for slave labour, for organ harvesting, for street crime and begging, and while this paper touches upon all end results of trafficking, its predominant focus is on trafficking of women and children into the global sex industry.

### Brief History of Trafficking:

The trafficking of human beings, one of the most deplorable of phenomenon in society is sadly an age-old trade, which has just been accelerated and increased in our globalized world. Early records show that during Middle Ages and the Renaissance, "thousands of women and, children from East Prussia, the Czech lands, Poland, Lithuania, Estonia and Latvia were sold in the slave markets" of Europe and purchased by buyers from Italy and France and later from the Middle East. This trade route into Western Europe ceased with the expansion of the Ottoman Empire into Constantinople, but the trade continued, with the new focus on West Africa as a source of slave labour.

In the early twentieth century in Europe, human rights campaigners in Europe were the first people to publicize the horrors of trafficking in human beings, and demand an urgent answer. At that time the focus

of work was primarily on British women, who were forced into prostitution on the continent of Europe, whereby the term "white slavery" was coined. With the increasing continuation of this practice, the International Agreement for the Suppression of the White Slave Traffic, was drafted in 1902, as the first piece of universal legislation attempting to combat this growing trend. Subsequent political efforts, including the US Mann Act of 1910, the 1949 UN Convention for the Suppression of Trafficking of Persons and the Exploitation of the Prostitution of Others, the US Trafficking Victims Protection Act of 2000 and its amendments, The EU Council Framework Decision of July 2002 on Combating Trafficking in Human Beings, and most importantly, the UN Protocol to Prevent Suppress and Punish Trafficking in Persons, Especially Women and Children, amongst other significant steps in the last 20 years, have unfortunately been unable to counter or quell this trade in persons, in particular, of women and children.

### Magnitude and Routes of Trafficking:

The exact numbers of those trafficked in what the UN Secretary-General Kofi Annan has called "a worldwide plague" are hard to corroborate. Elizabeth Kelly, in a study on trafficking in Europe, on referring to the lack of agreement on how to estimate global and regional trafficking, talks about "guesstimates" and notes that despite repeated calls from international bodies, most countries still do not have mechanisms in place to monitor or collect data on trafficking. The US State Department in 2002 estimated that 700,000 to 4 million people were, "bought, sold, transported and held in slavery-like conditions for sex and labo(u)r exploitation", and in the 2004 report places the figures around that 600,000 to 800,000 women and children trafficked internationally annually. The Swedish NGO Kvinna Till Kvinna estimates that of the annual international flow, 500,000 women are transported each year into Western Europe. A recent European Commission publication puts the numbers of women and children being trafficked into the European Union each year at 120,000 mainly through the Balkans and an IOM figures suggest that 10,000 women, the majority of which are from Moldova,

Romania and Ukraine, are working in the sex trade in Bosnia Herzegovina alone. None of these figures include internal trafficking, which is defined as, "essentially trapping persons from mainly rural areas and small towns for sexual exploitation in major cities and in border areas of high commercial transit" , within a state's boundaries, and is an issue barely dealt with by governments. What is certain is that trafficking in the 21st Century has taken on global proportions and provides a transnational challenge on a variety of fronts. This "contemporary form of slavery" is not only a criminal activity and a serious human rights abuse, but also a matter of state security and central to the discourse of global economic empowerment and social justice.

Trafficking today is considered by those involved in running trafficking rings, as a high-profit, low-risk trade, yielding returns on par with the arms and drug trade. National laws and law enforcement agencies have been unable to keep up with traffickers who with near impunity have extended their webs, increasing the scope of this appalling exploitation to include, forced prostitution, forced labour, domestic servitude, begging, harvesting of organs and illegal adoption/baby delivery services. The majority of persons trafficked are women and girls who are trafficked to fuel the sex-industry world-wide, usually from economically and politically unstable to stable countries, from developing to industrialized nations, from rural to urban centres and from developing regions to adjacent developed regions.

Within this region of central, eastern and southeastern Europe, as with the global trend, human trafficking takes place on three different levels :

- (1) Sending countries or 'Countries of Origin': For this region, primary source countries include Albania, Bulgaria, Moldova, Romania and the Ukraine.
- (2) Transit countries/regions: Traffickers transfer women and children through these countries on the way to Western Europe. Some traditional transit countries are Bosnia, the Province of Kosovo and Albania. Women and children are at equal risk of exploitation in transit as they are on arriving at their destination.

- (3) Destination countries/regions: These are often highly industrialized or highly developing countries and regions, like Western Europe and the US. Many Balkan states, like the Province of Kosovo and Bosnia, became destinations of trafficking with the large influx of foreign armed services. In other cases, regions undergoing development (like central Europe), may become more destinations than transit points.

- (4) In all the above, the lines dividing the categories are not clear cut, and often countries operate on two-three levels. Hungary for example, is less of a sending country than before, still a transit country, and increasingly a destination country. In certain sending countries, like Moldova, the trafficking of women is almost reaching epidemic levels, as increased economic strife severely restricts the opportunities available to Moldavians.

### **The Business of Trafficking:**

Unfortunately, within the debate on trafficking, both on an abstract and practical level, the argument of sex work versus prostitution continues to obfuscate the matter and prompts the question of what constitutes "choice", pitting regulationists against abolitionists, and ultimately deflecting the spotlight away from the trafficker and the crime. Hynes and Raymond note that, "distinctions between 'forced' and 'consensual' prostitution promote the view of prostitution as the individual act of an individual woman and conceal the role of an enormous global industry that propels women and children into prostitution." In fact, when scrutinizing the mechanisms of trafficking, we see that it is a well run industry, with networks that allow sexual exploitation to move easily and quickly across local and national borders, in the same manner as goods are transported across the world. These 'pipelines' of exploitation and de-centralized structures of transport, allow the traffickers a flexibility and adaptability that make counter-trafficking measures often seem behind the times as traffickers re-route and change their modus operandi to avert being shut down. An example of the quick shift in behavioural patterns of traffickers is the departure from the use of local bars as a traditional space where trafficked women are held and their services bought. As judicial forces in the region have started to crack down on such bars, trafficked

women have been moved to private apartments by their traffickers and their services are now offered through this private (and thus harder to enter), more hidden space than the public bars. More use is also being made of the internet (as a 'cyber-mall') as a space of exploitation. In the same way, as certain border controls have been tightened and others loosened, the traffickers have redirected their networks to take advantage of changes.

While trafficking stands at the axis of crime and migration, the subject of the trafficked person, central to this process, makes this an issue of more than just a transnational crime or a security issue (though the issue has been, like other migration issues, heavily securitized post September 11th.) The increase we see in trafficking is a manifestation of enhanced international transport systems (visible and invisible), global communications, North-South economic disparities, and gender inequality and is further intensified by capitalist policies and ideology. The issue of demand for sex workers/prostitutes is the one aspect of trafficking that is the least investigated and is forgotten within the debate. Within this context of supply and demand, inherent within a capitalist structure, the trafficked person (primarily women and increasingly children) become objects of trade and literally consumer goods - to be consumed by the insatiable buyer - through massage parlours, strip shows, internet sites, and pornography.

Research on trafficking shows that child prostitution is a significant global problem, with numbers of around 1 million children a year being trafficked globally into the flesh trade, and with an estimated 10 million children already enslaved as prostitutes. While certain regions like Asia have extensive child trafficking rings, especially across the Nepal-India border, it is only recently that the numbers of children being trafficked into the EU is on the increase. These unaccompanied minors primarily come from eastern Europe (49%), with the next significant majority from Africa (29%). 70% of these minors are female and most are destined for the sex industry to fuel the growing demand for young people, who are considered to be less likely to carry HIV or other STDs.

There are also indications of the alarming possibility of children being trafficked for organ harvesting from and into the Balkans, as well as for illegal adoptions. This growing trend of trafficked children for harvesting of organs is but a sordid extension of the objectification of the human body and of persons, and of the idea of demand being met by supply, by those who can pay, for those who cannot.

### **Public and Individual Health Care:**

Health care matters around trafficking can roughly be divided into two overlapping arenas of health assistance for the individual (trafficked person) and public health policies for the general public of a country, region etc.. Health assistance for victims of trafficking must encompass more than physical care and include mental, emotional care, reproductive health and psychosocial support, while public health policies must also look beyond the safety and physical well-being of the population and strive for sustainable structures, mechanisms and human resources for the long term prevention and control of this phenomenon.

Regardless of the end purposes of trafficking, whether it is for labour, sexual or any other form of exploitation, victims of trafficking are exposed to a range of health-related problems. Alison Phinney, in her article entitled, "Trafficking of Women and Children for Sexual Exploitation in the Americas", writes that:

Clandestine migration often requires sub-optimal means of transportation, putting the victims at risk for starvation, drowning, suffocation and exposure to the elements."

Furthermore, in-humane practices of servitude experienced by trafficked persons, especially women and children during captivity, such as physical violence, sexual exploitation, psychological abuse, poor living conditions and exposure to a wide range of diseases intensify the horrors and long lasting physical, reproductive and mental health consequences of trafficking. Between the control exerted on their minds, liberties and bodies, the trafficked person sees very little in the way of health care, while being exposed to a great many health dangers. The London School of Hygiene and Tropical Medicine, in a

recent report, entitled, "The Health Risks and Consequences of Trafficking in Women and Adolescents: Findings from a European Study", write that the relationship between public health and violence (physical and psychological abuse) against women is increasingly being recognized as inter-linked issues. "In the case of trafficking in women, however" the study points out, "health has not been a central theme of research."

"Providing appropriate health promotion and care services for trafficked persons is not only a humanitarian obligation, but also a public health concern for countries of origin, transit and destination alike" . Even when victims of trafficking are assisted, the ability of NGOs and shelters to offer comprehensive health assistance is restricted, due to lack of awareness, funds, and infrastructure. Since the general population is also exposed to the high health risks associated with trafficking, states need to commit themselves to disease prevention, education and control in this area. The anxiety over public health is not limited to just the spreading of sexually transmitted infections (STIs) and 'common' infectious diseases, but also the (re)-emerging problems of TB, HIV/AIDS and of Hepatitis B and C. One of the consequences of the demolished public health system in the majority of countries of origin, is that health assistance is at a minimum, with even less afforded to stigmatized victims of trafficking. For many women in this region in particular, those from rural areas or marginalized communities (such as the Roma), very little is provided in terms of basic health information, sexual health education and/or health care. The study done by the London School of Hygiene and Tropical Medicine, shows that few trafficked women have any access to information or services in transit or destination countries, and in fact, "sexual education, including knowledge and use of modern forms of contraception and awareness of STIs still remains limited." One result of this breakdown of health systems is that on a public health level, vaccine preventable diseases are spread to transit and destination countries where physicians who have not been confronted with these pathologies before, must provide appropriate and adequate care, within constrained circumstances and in effect, must act as the first line of security against such risks.

To achieve significant advances in the field of health assistance to trafficked persons and public health, the IOM training manual on the mental health aspects of trafficking in human beings, suggests that governments must harmonize their public health policies including service provision, availability of specially trained practitioners, and data and information sharing, so as to ensure the welfare of the society and of the victims of trafficking. One proposal put forward is the creation of a regional, European, and eventually global, counter-trafficking health database, which would consolidate all the data on individual victims of trafficking and allow smoother research and data collection on various scales. The aim of such a database would be to track an individual's (private) health and care experience from country of transit/destination to country of origin (from rescues to reintegration) and simultaneously provide data of the "bigger" picture of public health issues and policy.

#### **Individual Health Profile of Trafficked Persons:**

In this region of central, eastern and southeastern Europe, the main source countries for trafficked women are Albania, Bulgaria, Moldova and Romania and Ukraine. Studies show that victims of trafficking undergo severe physical, emotional and mental harm at the hands of their traffickers, their clients (in the sex industry) and sometimes by the very state apparatus set up to help them. While physical violence is the most common and obvious form of control used on trafficked persons, transcribing the body with ownership, the more insidious form of psychological control is just as damaging. Physical forms of risk and abuse range from murder, to torture, to gang rape, to sexual humiliation, with health consequences such as death, acute chronic physical disabilities, malnutrition, starvation, fatigue, HIV/AIDS, STIs, damage to the vaginal tract, unwanted pregnancies and abortions and cervical cancer and infertility. Psychological and psychosocial abuse such as intimidation and threats, lies, emotional blackmail, forced isolation, coercive use of alcohol and drugs, restrictions on movement, activities and communication, denial of privacy etc., result in victims of trafficking exhibiting such men-

tal health consequences as suicidal thoughts, anxiety, chronic insomnia, memory loss, dissociation, loss of trust, substance dependency, violent outbursts, somatic complaints, feelings of isolation and loss of self-worth.

Research on trafficked women assisted in this region show that the above risks and symptoms are unfortunately common in their experiences of trafficking. Women trafficked into the Province of Kosovo for example, were usually bought and sold three to six times during their journey to Kosovo alone. The IOM survey on assisted women in Kosovo shelters shows that, "many of them (the women) were sexually abused or exploited already in the transit countries", with 76.4% being physically abused, 58.4% being sexually abused by their traffickers and traffickers friends (this is not counting clients), and almost 50% being allowed freedom of movement only when escorted and nearly 40% totally denied any freedom of movement. 35% of women interviewed were denied any access to medical care, with starvation/malnutrition and lack of communication with each other etc., being part of the common experience.

Rape as a tool of coercion is also widespread. The London School of Hygiene and Tropical Medicine report observes that "it is common for perpetrators to use rape as a tactic to wear down a woman's defences to the point where they 'agree' to sex work". The study also notes that not surprisingly the most common health problems reported by victims of trafficking were gynaecological complications, and even when trafficked women are aware of the benefits of condoms, their use is usually at the "discretion of the owner, pimp or client." In many cases trafficked women in the sex industry are denied use of condoms or made to pay for condoms (thus increasing their debt). Recent research on Moldovan trafficked women (who make up 52% of persons trafficked into Kosovo) show that 99% of those interviewed suffered from vaginitis, 91% from womb erosion and inflammation, 62% from cervix erosion, 30% from Chlamydia and 12% from Syphilis. These statistics are mirrored in the victims of trafficking from the Ukraine and elsewhere in the region.

Among other symptoms of trafficking, these women also suffer from post-traumatic stress disorder, depression and dissociation. Mental health is often the most overlooked sphere of care when working with trafficked women. But, issues of trust, anxiety, and feelings of suicide, amongst other mental health problems play a key role in the reintegration process. The IOM training manual on mental health care assistance notes that, "mental health consequences of trafficking should not be considered in isolation... physical problems may cause negative psychological reactions, which in turn result in additional physical, family or work problems." A trafficked woman is often caught between cultures - either away from home, or returning after a traumatizing experience - and finds herself confused by language, cultural differences and a sense of lost time. The effects of the process on the trafficked person's mental health are more subtle and demand greater sensitivity in treatment. A high percentage of trafficked persons use acts of self-injury as a way to deal with emotional stress and painful memories.

A common result of trafficking is an increase in substance abuse. According to the July 2004 IOM report on trafficking in the Balkans:

Longer stays in the country of destination can have several outcomes on victims...Psychologists working with these victims report that they suffer severe personality changes and have great difficulty in responding to treatment. IOM and NGOs have already assisted several victims addicted to drugs or alcohol...Drugs are usually first forced on them by the traffickers as a long-term investment to guarantee dependency and submissiveness, whereas alcohol is part of the victims' work.

In fact, many women are coerced into consuming alcohol, especially the women working in bars, who often have to purchase drinks so as to keep the clients company. One respondent in the London School of Hygiene and Tropical Medicine study reported that because of her good relationship with the bartender, she managed to get her drink filled with juice instead of alcohol. In other situations, trafficked women felt that it was the clients who put pressure on them to drink, hoping that when the women got drunk it would be easier to control them/demand certain services and as a way of believing that the women were of 'ill repute' and thus

unworthy of help or sympathy.

Another issue central to rehabilitation is the idea of schedules and relationship building. In both their personal schedules and lives, during the trafficked period, victims of trafficking have been controlled and subjugated to distortions of relationships (with the client, with each other, with the trafficker) and a lack of trust in people is common. Also common is the need to depend on another person (usually the bar owner or trafficker) to set their schedules, provide them with instructions and commands - especially for persons who were trafficked for a number of years - any sense of autonomy or individualism may be buried. In this context, victims of sexual trafficking, often find that they have become more nocturnal in their behaviour and that their internal clocks do not necessarily function on a 9 to 5 schedule as prescribed by society at large. Such manipulations of schedules and relationships must be respected by health care workers and a framework of what is considered 'normal' cannot be enforced on victims as a means of rehabilitation.

### **Budapest Declaration on Public Health and Trafficking in Human Beings:**

"Until recently, much of the support in the fight against trafficking has focused on information exchange, police and legal cooperation, and return and reintegration assistance." In the last year, a number of protocols and declarations have been signed and published in an attempt to call international attention to the "serious health concerns related to trafficking." As part of this endeavour to improve public health policy and assistance for trafficked persons in the region, a conference on Public Health & Trafficking in Human Beings in Central, Eastern and Southeast Europe, was held in March, 2003, in Budapest. The Conference adopted the 'Budapest Declaration', which noted that "more attention and resources should be dedicated to the health and public health concerns related to trafficking," and added that "victims of trafficking must be given access to comprehensive, sustained, gender, age and culturally appropriate health care which focuses on achieving overall physical, mental, and social well-being." The significance of this breakthrough event is underlined well by the fact, that UN

Secretary General Kofi Annan in his report and speech on trafficking in 2004 has quoted this declaration.

The Budapest Declaration also affirms that trafficking in human beings is a violation of human rights and voices its concern that victims of trafficking in central, eastern and southeast Europe have been and continue to be exposed to a range of health-related problems, including, but not limited to, physical and psychological abuse and trauma, sexually-transmitted and other infectious and non-infectious diseases and complications, including HIV/AIDS and tuberculosis. The Declaration recognizes that some countries in the region are currently experiencing epidemic levels in the incidence of HIV and tuberculosis, particularly drug-resistant tuberculosis and is convinced that there is a need to address the health and public health aspects of trafficking in human beings. The participants, from all over the region, agreed and committed themselves to the following:

- Despite much effort and progress in combating trafficking in human beings both regionally and globally, more attention and resources should be dedicated to the health and public health concerns related to trafficking;

- Victims of trafficking must be given access to comprehensive, sustained, gender, age and culturally appropriate health care which focuses on achieving overall physical, mental, and social well-being;

- Minimum standards should be established for the health care that is offered to trafficked victims; and

- Different stages of intervention call for different priorities in terms of the health care that is offered to victims.

Health Service Delivery and the Minimum Standards of Mental Health Care Assistance:

Providing health care to trafficked women, either in a trafficked setting or once they have been assisted, poses a number of challenges. Some of the most pressing issues observed by researchers are the

multi-dimensional service needs of trafficked women, cultural and gender sensitivity, and the issue of gaining trust.

In response to the Budapest Declaration, an IOM appointed expert team composed of health care professionals, IGO and NGO counter-trafficking personnel and academics working on mental health and trafficking issues developed a set of minimum standards of health care assistance focusing on mental health provisions (the "Minimum Standards"). These Minimum Standards, which are structural-operational in nature, and act as baseline requirements to meet acceptable standards of mental health care, are divided into eight major clusters:

- Environmental Standards
- Staffing and Team Composition
- Staff Training and Development
- Job Assignments
- Management
- Programme Activities
- Record Keeping and Reporting
- Ethical Standards of Conduct

Each cluster takes into account the length of time of stay/assistance provided (that is, short, mid and long-term care) and presents functional suggestions for care shelters and rehabilitation and reintegration centres working with trafficked persons.

One of the common stated problems in health care delivery to trafficked persons is the difficulty of language and culture. In this respect, the Minimum Standards propose that interpreter is an essential component of the extended team of a shelter/centre. Several providers worry about, "misinterpretation of women's behaviour because care-givers may view women through an ethno- and socio- centric lens". In this context, the Minimum Standards strongly suggest a strengthening of cultural awareness amongst medical and non-medical staff and an increase in awareness and sensitivity to mental health issues and mental health symptoms in general. Certain other items to note are the suggestion for greater access to and presence of more female medical professionals, especially with regard to mental health care (such as psychologists, psychiatrists etc) and a priority on environment and space for victims of trafficking to adjust to their surroundings and status. The Minimum Standards also propose essential

guidelines for the record keeping process and offer suggestions on the ethics of conduct and reporting confidential information, etc.

The multi- dimensional needs of a trafficked person require a multifaceted health approach, whereby trust is vital to the relationship between the health care giver and the victim. Many of the health care risks and the anxieties suffered by trafficked persons act as barriers that keep the victim from reaching out for help. The Minimum Standards hope to at least provide the concrete groundwork for effective and sustainable mental health care assistance to trafficked persons.

### **Effects on Rural Areas:**

Counter-trafficking experience and research in the region is beginning to yield factual information on the linkages between social class and the profile of trafficked victims. Those trafficked persons who come from the lower social classes of their respective countries are more easily exposed to certain diseases related to poverty and poor living conditions, pre or post their time trafficked. "Recent epidemiological data suggest that tuberculosis (TB), which is regarded world-wide as a re-emerging infectious disease, has reached epidemic levels in the countries of the former Soviet Union and Romania. (Unfortunately no relevant epidemiological data are available from BiH, Province of Kosovo and FYR of Macedonia.)" Internal and international trafficking victims often originate from rural areas and small towns. On repatriation and rehabilitation these persons, are usually returned to their village or town hopefully with a set of skills or loans provided for by through counter-trafficking initiatives. Repatriation and 'rehabilitation' can themselves be problematic in both conceptual and practical terms and in return to rural areas, the traumatic effects of trafficking are played out to a greater degree on the victim and his/her social space. In this region, as economies and societies continue to change, the turmoil and chaos produced by such rapid transformations to eco-social structures is felt acutely in the health field. Changes in health policies and cuts to health care tend to be more severe for rural areas, often isolating rural communities from the mainstream and each

other. One outcome of returning trafficked persons to rural areas is that the assistance necessary for the complete reintegration of the victim is sometimes hard to continue or even find. In addition to the lack of public funds for health care, in some villages and rural regions, a resurgence of TB, Hepatitis B and C and an increase of HIV/AIDS and STIs have created a significant public health risk.

A report on trafficking in Bangladesh (where trafficking follows the international pattern of migration from poorer/rural to richer/urban areas) and its effects on rural communities notes that:

Disintegration of the rural communities and the grim reality of the poor and the marginal people, mainly women and children, is the primary cause of trafficking.

In a catch-22 situation, trafficking itself adds to the collapse of rural societies, with the young often being lured away and if returned, returning traumatized and possibly to further abuse. Into the bargain of returning to a small community after possibly having been trafficked to a big city, women in particular, are often stigmatized for their trafficked past.

One of the growing trends in this region is the trafficking and growing vulnerability of children of trafficked victims who have been housed in orphanages or with relatives and friends upon their mother's departure. In villages and small towns this exposure to traffickers leads to a second generation of trafficked persons. The IOM report on trafficking in the Balkans, notes that in some cases in Albania, especially in rural areas, parents have stopped sending their daughters to school for fear of kidnapping and trafficking. The education of girls is a challenge in Albania without the added restriction of parent's worries and, especially in rural districts, lack of education makes girls and young women more vulnerable to trafficking.

The increase in internal trafficking, whose victims are later trafficked internationally, predominantly targets women and children in rural areas because of the lack of education and lack of awareness around trafficking and its dangers. Internal trafficking in certain countries in this region, like Albania, has grown exponentially, with very young girls trafficked from rural to urban areas and to popular

trafficking routes along border zones to gain 'experience' before being sent abroad. This growth of trafficking women and children from rural areas can also be seen in Moldova, where in 2002 only 36.93% of victims came from the rural parts of Moldova, whereas in 2003, this proportion increased to 52.25%. While there are no statistics as yet, the concern over 'second-generation' trafficking seems well placed as according to an IOM psychologist in Moldova, an increasing number of assisted victims, somewhere in the region of 30%, were raised and targeted in state institutions (called Internats).

### **Conclusion and Public Health Policy Suggestions:**

In the political arena of trafficking itself, more attention needs to be paid to internal trafficking and the rise of young girls being trafficked within from rural to urban or highly commercial border zones before they are trafficked abroad. Hynes and Raymond write that "there has been a recent trend to separate international sex trafficking from domestic sex trafficking and prostitution." A principal factor in fostering of international trafficking is the operation of already existing licensed and illegal spaces for prostitution.

The debate on trafficking, especially in an internal context, seems to have focused on whether the women and girls are engaged in prostitution or sex work (one being illegal, the other licensed/legal and with different degrees of choice built into each notion). Instead of just accepting the "unexamined premise" that women may need prostitution to survive economically (that this is the oldest trade and thus should survive/continue), more work should be done into providing other income generating options of survival to women in need. A women's body should not be the only wealth or commodity she can trade on to survive.

It is also important that public health responses and epidemiological models of such communicable diseases as AIDS etc to become socialized, politicized and gender-based. A more holistic proposal to the risk of AIDS and prostitution would not only to advocate for the health and safety of women within

the sex industry, but also attempt to dismantle the industry or reduce the number of women coerced into the sex industry. Another public health initiative would be to look at trafficking and the health issues around trafficking (indeed around migration) as more than just a specific state or region's problems. Instead, a universal or global perspective needs to be taken to effectively counter the spread of STIs, HIV, TB and vaccine preventable diseases. Trans-border transfer of health data and trans-border (continuous) case management are vital in migration health and especially in health care of trafficked persons. Health care assistance is not uniform from state to state and there are several gaps in the system in particular with relation to trafficked persons. The proposed trafficking health database would ensure that care is uniform and maintained even when victims of trafficking are moved from destination and transit countries to their source countries. In this regard, a standardized data collection and registration system is a minimum requirement for international cooperation.

In conclusion not only must the agenda for public health care policy for trafficked persons (and migrants), by the very nature of the processes, be global in character but to be most effective, must place the health of the trafficked person (and migrant) at the centre of the debate. A comprehensive strategy towards health care - considering the rural health aspects of the phenomenon as well - would ensure that the individual and the public overlap and that the well-being of each individual (regardless of gender or race or nationality) is protected so that the well-being of a society is also protected.

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IOM, *Mental Health Aspects of Trafficking in Human Beings: Training Manual*, 34

This is in reference to Colin Powell's statement in the summer of 2003, where he said that that, "what we (sic) are dealing with is "modern day slavery and slave trading" from which the US State Department website often refers to human trafficking as a contemporary form of slavery. See Laura J. Lederer, Deputy Senior Advisor, Office to Monitor and Combat Trafficking in Persons Remarks at White House Conference on Missing, Exploited, and Runaway Children, "Trafficking in Persons: A Modern-Day Form of Slavery". Washington, DC

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**Report of the Executive Bureau Meeting of the  
*International Association of Agricultural Medicine and Rural Health*  
Belgrade, May 27th, 2004.**

**Participants of the meeting**

**President:**

Ashok Patil

**Secretary General:**

Istvan Szilard

**Vice Presidents:**

Claudio Colosio

Shosui Matsushima

**EC members:**

Petar Bulat

Ivan Ciznar

Kanae Hamano

Hans-Joachim Hannich

Kazumi Ichikawa

Miodrag Milosevic

Shengli Niu (*ILO Invitee*)

Agnes Simek

**Special invitees:**

John Wynn-Jones

*President of EURIPA*

Shusuke Natsukawa

*Director of Saku Central Hospital, Japan*

Sandor Balogh

*Director General of the National Institute of  
Primary Health Care, Hungary (NIPHC)*

Andras Eros

*NIPHC*

Ferenc Hajnal

*NIPHC*

Renata Papp

*NIPHC*

**Secretariat Officer:**

Gergely Pongracz

**The President's report**

The president welcomed all the members and others who were present at the meeting.

The President informed the members about the sad demise of our Past President, Dr. Tenyi Jenő last year in autumn. All members remembered his contribution to the cause of Rural Health and his positive and compassionate approach to all the problems. The Bureau members observed two minutes silence in his memory.

Members were also informed about the relocation of the Secretariat. According to the President, the secretariat is situated at the Hungarian National Institute of Primary Health Care in Budapest. The Memorandum of Understanding is signed, both by the President and Sandor Balogh, Director General, NIPH, Hungary on behalf of the Ministry of Health, Govt. of Hungary. The validity of this agreement starting with 1st of January 2004 is for three years, until the next IAAMRH general assembly and elections.

The president greeted John Wynn-Jones and gave a short introduction about him and his organization (WONCA/EURIPA). He also announced his will to cooperate in a pilot project regarding occupational health issues, and that further arrangements were about to be made for the common goal the two organizations should be working on together.

**The Secretary General's report**

The Secretary General (SG) began his report by reviewing the expectations of the last Board Meeting held in Thailand, 2003 that were the following:

Re-location and re-establishment of the Secretariat  
Structural and financial stabilization of the Secretariat

Re-vitalization of the European Chapter

Updating of the members' list

Membership fees update - opening of a new bank account – transfer of all the financial means to this new bank account

Re-start the publication of the Association's Journal

Finalize the place of the coming 2006 World Conference

The SG continued his presentation by pointing out the tasks achieved within the short time since the Secretariat has been available again, which were the following:

Memorandum of Understanding between the Hungarian National Institute of Primary Health Care (NIPHC) and IAAMRH signed in March 2004

A working group to work out a short and medium term proposal for the revitalization of the European Chapter, formed at the Budapest meeting of the European Chapter on 20th March 2004. Members: Claudio Colosio, Hans-Joachim Hannich, Sandor Balogh

New Issue of the Journal of IAAMRH published for the Belgrade conference.

Opportunity for the board to make the decision on the site of the 2006 World Conference.

As for the tasks not achieved, the Secretary General highlighted the problems with the Polish side, namely their disability in transferring the necessary documents and bank papers.

### **Sandor Balogh's financial report about the newly established Secretariat of the Association**

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The Director General of the Hungarian National Institute of Primary Health Care made a brief presentation about the re-establishment of the secretariat of IAAMRH. His speech included information about the levels of financial support that - with the generous support of the Hungarian Ministry of Health, Family and Social Affairs - the NIPHC provided the secretariat with.

#### **Technical level:**

Infrastructure (pc, internet, telephone/fax, other office supplies)

Staff (secretariat officer ?full time employee)

#### **Communicational level:**

New e-mail account

The publishing of the Journal of IAAMRH (Typographical preparation of the journal, all press expenditures, Delivery)

#### **Conference level:**

Support for the participation of the Secretariat staff and others at regional and international conferences, meetings and workshops.

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## INFORMATION ABOUT COMING EVENTS

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### **Claudio Colosio - Information about the forthcoming 16th International Congress of IAAMRH in Cremona in 2006.**

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Before Dr. Colosio's presentation, The President reviewed the possibilities for the venue of the coming conference. Recommendations had been made before the meeting by Carla Patterson and Hans-Joachim Hannich, but for various reasons they both have withdrawn their offers before the meeting.

Following Dr. Colosio's introduction of Cremona, this small rural town is strong in occupational health services. The facilities offered are reasonable and the town is quite easy to approach, and therefore members agreed to have the conference there, in Cremona, Italy.

Another agreement was made about setting up a working group for the preparation of the conference. Members are: Ashok Patil, Claudio Colosio, Istvan Szilard, and Agnes Símek

Present Members also agreed to have Claudio Colosio as Conference President. He will be responsible for arranging the core group in Italy.

Technical support will be provided by the Secretariat in Budapest.

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### **Kazumi Ichikawa's oral presentation about the coming 10th Asian Conference of Agricultural Medicine and Rural Health in Kinugawa, Tochigi Pref., Japan.**

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**Main Theme of the congress:** Specialization and Unification in Asian Rural Medicine

**Venue:** Kinugawa, Tochigi Pref., Japan

**Date:** 23-26 November 2005

**Congress President:** Isao Kawamura, M.D.  
Director, Shimotsuga General Hospital  
(First Vice President, Asian Chapter, IAAMRH)

**Topics:** New and reviving infections - SARS, Bird flu,  
Food and diseases  
Rural areas and lifestyle induced diseases  
Rural Areas and preventive activities  
Prospects of Asian Rural Medicine  
Pesticide poisoning and farm machinery accidents

**Provisional schedule:**

23rd November: Executive Board Meeting, Congress President's invitational dinner  
24th November: Scientific session, Welcome reception  
25th November: Scientific session, all participant's gathering  
26th November: Field Study (AM)

**Abstract deadline:** 31st August 2005

**Registration fees:**

	By 30th September	By After 1st October30th
Full fee	USD 250	USD 350
Accompanying and student	USD 150	USD 250

**Congress Secretariat:**

**5-32 Fujimi-cho, Tochigi City, 328-8505, Japan**  
**Phone: +81-282-22-2551, Fax: +81-282-24-1631**  
**E-mail: mmc@db3.so-net.ne.jp**

### **Introducing WONCA/EURIPA by president of Euripa, John Wynn-Jones**

Dr. John Wynn-Jones made a short introduction of WONCA, world organization of family doctors and EURIPA, the European section of WONCA. Within his contribution he highlighted the common goals the two organizations (IAAMRH, EURIPA) have, and suggested to organize a joint meeting of boards.

The president and members agreed in this, and made an oral request towards Dr. Wynn-Jones to proceed with the required official correspondence, which would be followed by further, exact arrangements.

### **Trans-Nation Study on Hypertension - Agnes Simek and Ashok Patil**

Within this presentation Dr. Simek introduced "**A comparative study on metabolic, social, biophysical, life style and genetic factors in hypertension in Hungarian and Indian populations in urban and rural setups**" that was done by *International Association of Agricultural Medicine and Rural Health and the Hungarian Scientific Association of Rural Health*.

The prospective study will analyze the biophysical, social - nutritional customs and the genetically standards differences, and also the consequences and the utilization in both countries.

The aims of the study are of description, definition and prevention. Cooperation, connection and comparison are highlighted as specific objectives.

The exact areas of the study will be a big city in Maharashtra - Ahmednagar, and villages round Pravara University, Loni on the Indian side, and a big city in Hungary - Pecs, and villages all round Hungary on the Hungarian side.

The criteria in the involved population will be:

- Ill - healthy
- Big city - village
- India - Hungary
- Comparison - control

Participants throughout the study will consist of 5/5 urban/rural family physicians both in Hungary and in India, along with 20/20 patients and 20/20 healthy persons from urban and rural areas. That's 10 Hungarian, 10 Indian doctors dealing with 20 patients suffering in hypertonia and another 20 healthy persons for control, which is 200 ill And 200 healthy samples altogether in each country.

The results are expected to show differences in metabolism, genetically differences and the importance of life-style changes/ food consumption, food composition, and moving/

Possible obstacles are mainly caused by the great distance between the two countries that cause not only problems in communication, but big cultural and health care & research background structural differences.

It is crucial to mention that the financial background for this study is not yet provided. Dr. Ágnes Simek counseled to have the genetic background edited out in the first term, because its observation is very expensive and no positive effect is expected.

According to the agenda of the study, there will be a 3 months period for the preparation, six months for the process and another three months for evaluation. This one-year would be followed by another 12 month of utilization.

The program is both vertically - other parameters - and horizontally - other countries - available to be improved.

### **Claudio Colosio - A Plan of Action for the European Chapter**

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*"To be a forum for professionals, scientists and workers to advocate for rural communities who in many countries do not have strong organizational structures to voice their grievances and influence policy makers and planners."*

These were the opening words of Dr. Colosio's presentation followed by the opening point of his presentation: "How to address this general issue for Europe?" and "How to take into account the changes that are in course in Europe?"

First, he referred to the Bari Declaration, in which the main field of intervention has been identified:

- Health of the General Population
- Rural Occupational Health
- Environmental Health

These areas of intervention will be addressed through specific programmes, developed on the base of the definition of: **Rural Health Country Profiles ( RHCP)**

In the following, the mainstream of the presentation consisted of the aspects of RHCP:

- What is a RHCP?
- How to build a RHCP?
- Why "country profiles"?
- Example of profile
- Indicators for a RHCP

Dr. Colosio also made a comparison between EU Mediterranean and non-EU countries by listing the examples of priority established through an occupational health profile.

As closing words, Dr. Colosio pointed out the IAAMRH perspectives and the goal for the next triennium: **increasing the number of active members and updating mailing list.**

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Next, the board discussed the issue of the inclusion of the past outstanding members of the Bureau in the current Bureau of the IAAMRH. This was important for continuity and also for utilizing the rich experience of these members. It was resolved that the Bureau would nominate such members, to be confirmed by the General Assembly and such honorary members would be called as 'Members of Honor'. It was further decided to make necessary amendment if the Memorandum of the IAAMRH and get it approved by the General Assembly. It was also resolved that Dr. Wakatsuki, Japan and Dr. Knabe, Germany be invited to the Bureau as Members of Honor. All members present agreed in having the retiring Presidents and Secretary Generals automatically as 'Members of Honor' of the Board.

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There has also been an agreement in posthumous awarding Late Immediate Past President, Jenő Tényi with IAAMRH Honorary Medal.

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On the proposal of the President the Board has elected unanimously Dr. Sandor Balogh for Treasurer of the Association.

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As the last bullet of the agenda, Board members made a prompt agreement regarding the election of the *Editorial Board of the Journal of IAAMRH*. There was a clear understanding of having the Presidium and the Presidents of Commissions as the editorial board, with one additional member, Dr. Shengli Niu.

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The meeting ended with thanks to the Chair.