



«Migration and Health»

FOR MIGRATION HEALTH ADVOCATES IN THE REPUBLIC OF MAURITIUS

Training Guide

A Focus
on Sexual and
Reproductive
Health
including the prevention of
HIV/AIDS/STI



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Over the past two years, Mauritius has experienced a steady growth of around 5 to 6% in the number of foreign workers legally residing in the country, which represents today around 9% of the number of employed persons in Mauritius¹. In addition, although the number of intra island movements especially from Rodrigues to Mauritius is still not sufficiently documented, it is clear today that the number of Rodriguans in Mauritius is significant and growing. In that context, IOM conducted a Study² in 2012 to collect information on the health and socio-economic conditions of Rodriguans living on the mainland of Mauritius and one of the main recommendation, which derived from the research was the importance to develop peer-led health communication, information and education programme on issues such as alcohol, sexual reproductive health, HIV, AIDS and sexually transmitted infections (STIs) and maternal and child health;

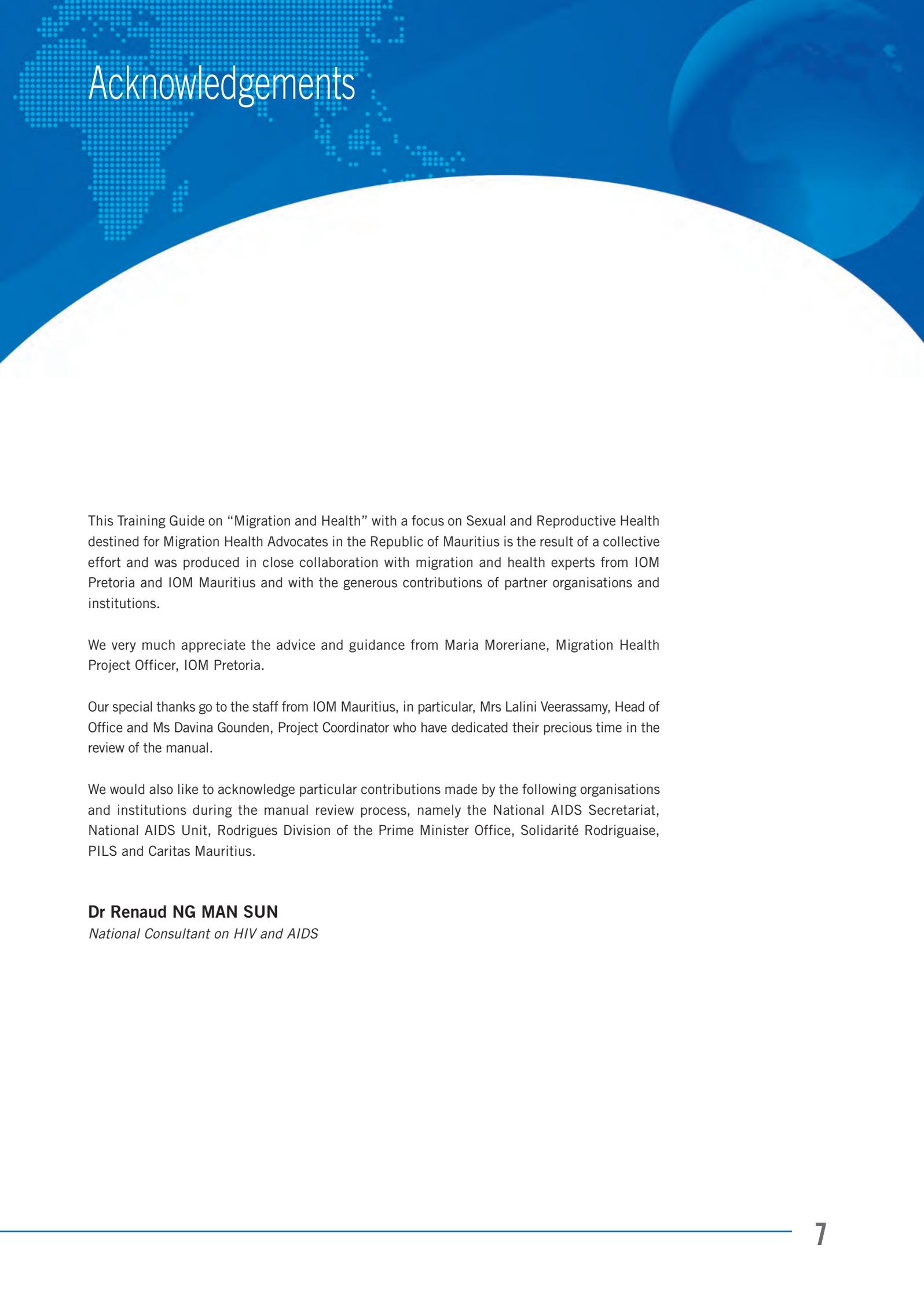
The health of migrants and health matters associated with migration are crucial public health challenges faced by governments and societies today. This notion formed the basis for the Resolution on the "health of migrants" which was endorsed by the Sixty-first WHA in May 2008. As a way to improve the management of migration health and reduce migrants' vulnerabilities to ill health, Health Promotion through information dissemination becomes crucial.

As a sequence to the Study and IOM's involvement in conducting post arrival briefings with migrant workers in Mauritius and with the support of PHAMESA³, this Training Guide on Migration and Health aims to respond effectively to the needs of migrants in Mauritius, including internal migrants through the establishment of trained Migration Health Advocates. It is therefore our hope that these members of NGOs and Health and Safety Officers within public and private institutions and companies will be bestowed with the necessary understanding of the relationship between migration and health, the knowledge of the distinctive challenges facing migratory populations and the capacity to design and deliver culturally-responsive health interventions focused on Sexual and Reproductive Health including the prevention of HIV/AIDS/STI to migrant workers and Rodriguans contributing to the socio and economic development of the Republic of Mauritius.

¹ The number of valid work permits delivered by the Ministry of Labour, Industrial Relations and Employment totalled 37,197 in May 2013 and valid occupation permits delivered by the Board of Investment totalled 13,533 in June 2013. 50,730. According to Central Statistics Office, the number of employed persons was 549 200 at the first quarter of 2013.

² An Assessment the Health and Socio-Economic Vulnerabilities of Rodriguans Residing in Mauritius, IOM, December 2012

³ Partnership on Health and Mobility in East and Southern Africa, funded by the Swedish International Development Cooperation Agency (Sida) and the Norwegian



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Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ATHENA	Network for advancing gender equity and human rights in the global response to HIV/AIDS
ART	Antiretroviral Therapy
CDC	US Centre of Disease Control and Prevention
CSW	Commercial Sex Worker
HIV	Human Immunodeficiency Virus
IBBS	Integrated Behavioural and Biological Survey
IDU	Injecting Drug Users
IOC	Indian Ocean Commission
IOM	International Organisation for Migration
IPPF	International Planned Parenthood Federation
MOH & QL	Ministry of Health and Quality of Life
MSM	Men having Sex with Men
MTCT	Mother To Child Transmission
NGO	Non-Governmental Organisation
NSF	National Strategic Framework
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PHAMESA	Partnership for Health And Mobility in East and Southern Africa
PILS	Prévention, Information, Lutte contre le Sida
PLHIV	People Living with HIV
PMTCT	Prevention of Mother To Child transmission
PWID	People Who inject Drugs
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
UCSF	University of California San Francisco
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNHCR	United Nation High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organisation

Glossary of terms or words

Abortion

The termination of a pregnancy resulting in the death of the foetus. It may be spontaneous or induced by surgical or chemical means. An **unsafe abortion** is the termination of an unwanted pregnancy by persons lacking the necessary skills, or in an environment lacking minimal medical standards, or both

Abuse

Improper, harmful or unlawful use of something. Abuse can be physical, sexual and/or emotional

Armed conflict

All cases of declared war or of any other armed conflict which may arise between two or more... [States], even if the state of war is not recognized by one of them (Art. 2, Geneva Conventions I-IV, 1949)

Asylum seekers

Persons seeking to be admitted into a country as refugees and awaiting decision on their application for refugee status under relevant international and national instruments. In case of a negative decision, they must leave the country and may be expelled, as may any alien in an irregular situation, unless permission to stay is provided on humanitarian or other related grounds. Source: IOM, 2011

Attitudes

Views, opinions, and feelings about something

Beliefs

Firm opinions normally based on religious and cultural principles

Class

A set of people grouped together by their level of wealth and/or the jobs they do in the economy

Coercion

To force to act or think in a certain way by use of violence, pressure, threats, or intimidation

Consensual

Involving the willing participation of both or all parties

Culture (cultural)

The beliefs, customs and practices of society or group within society (such as, youth culture) and the learned behaviour of a society

Discrimination

A failure to treat all persons equally where no objective and reasonable distinction can be found between those favoured and those not favoured. Discrimination is prohibited in respect of "race, sex, language or religion" (Art. 1(3), UN Charter, 1945) or "of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (Art. 2, Universal Declaration of Human Rights, 1948)

Displaced people (uprooted people)

People who flee their State or community due to fear or dangers for reasons other than those, which would make them a refugee. Displaced people are often forced to flee because of internal conflict or natural or man-made disasters

Documented migrants (also regular migrants)

Migrants who have the required documentation, which would allow them to enter and remain in a country legally

Economic migrant

A person leaving his or her habitual place of residence to settle outside his or her country of origin in order to improve his or her quality of life. It may equally be applied to persons leaving their country of origin for the purpose of employment

Ectopic pregnancy

A pregnancy that is outside the uterus. The fertilized egg settles and grows in any location other than the inner lining of the uterus. The large majority (95%) of ectopic pregnancies occur in the Fallopian tube. However, they can occur in other locations, such as the ovary, cervix, and abdominal cavity



Environmental vulnerability factors

IOM Migration and Health Working Definition: The term environmental vulnerability factors relates to the context within which an individual or a community lives and works that can increase vulnerability to ill health. Examples could include lack of access to health and social services, harmful cultural practices, gender inequalities, lack of recreational activities, poor living and working conditions

Endemic

Present in a community at all times but in relatively low frequency

Epidemic

The occurrence of more cases of a disease than would be expected in a community or region during a given time period. A sudden severe outbreak of a disease

Exploitation

The act of taking advantage of something or someone, in particular the act of taking unjust advantage of another for one's own benefit (e. g. sexual exploitation, forced labour, slavery etc.)

Family Planning

A program to regulate the number and spacing of children in a family through the practice of contraception or other methods of birth control

Gender

Refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (i. e. society's idea of what it means to be a man or woman). These attributions can change over time and from society to society

Gender-Based Violence

Gender-based violence both reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. It encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices. Any one of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances, results in death.

Source: UNFPA

Globalisation

In its literal sense globalisation is the process of making local or regional things or phenomena into global ones. It can also be described as a process by which the people of the world are unified into a single society and function together. This process is a combination of economic, technological, socio-cultural and political forces. Globalisation is often used to refer to economic globalisation, the integration of national economies into the international economy through trade, foreign direct investment, capital flows, migration, and the spread of technology

Health

A state of complete physical, social and mental wellbeing, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. Source: WHO

Healthy migration

A process of migration that ensures access to positive social determinants of health– including access to healthcare-throughout the migration cycle for both those that move and those that remain in the household of origin. IOM, 2010

Heterosexual

Emotional, physical and sexual attraction to people of the opposite sex

HIV prevalence

The percentage of alive individuals in a population who have HIV at a specific point in time

HIV incidence

The percentage of new individuals having been infected with HIV at a specific point in time

HIV-related stigma and discrimination

“...a ‘process of devaluation’ of people either living with or associated with HIV and AIDS...Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status.” It is important to note that even if a person feels stigma towards another, s/he can decide to not act in a way that is unfair or discriminatory

Host country or community

The country or community of destination. The country or community that has accepted or received migrants and mobile workers

Human Rights

Are universal legal guarantees protecting individuals and groups against actions that interfere with fundamental freedoms and human dignity. Some of the most important characteristics of human rights are that they are: guaranteed by international standards; legally protected; focus on the dignity of the human being; oblige states and state actors; cannot be waived or taken away; are interdependent and interrelated; and are universal

Individual risks factors

IOM Migration and Health Working Definition: Relates to behaviour and practices, which a person has control over. Source: UNAIDS 2008

Infertility

Infertility is the failure of a couple to conceive a pregnancy after trying to do so for at least one full year. In primary infertility, pregnancy has never occurred. In secondary infertility, one or both members of the couple have previously conceived, but are unable to conceive again after a full year of trying.

Internal and Cross-border (migrants and mobility)

Internal: movement of people from one area of a country. This movement may be temporary or permanent. Internal migrants move but remain within their country of origin. **Cross Border migrants** move across an international border

Masculinity

Social and/or physical qualities and attributes associated in a given time and place with being a man or being “manly”

Migration

The process of moving, either across an international border, or within a State. It encompasses any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people, and economic migrants. Source: IOM Glossary on Migration – International Migration Law (2004)

Migration and Health

IOM Migration and Health Working Definition: Delivery and promotion of comprehensive, preventive and curative health programmes which are beneficial, accessible, and equitable for migrants and mobile populations, contributing towards their physical, mental and social well-being, ultimately enabling them and host communities to achieve social and economic development

Migrant

At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where a decision to migrate is taken freely by the individual concerned for reasons of “personal convenience” and without the intervention of an external compelling factor. The term therefore applies to persons, and family members, moving to another country or region to better material or social conditions and they improve the prospect for themselves and their families. Source: IOM Glossary on Migration – International Migration Law (2004)

Migrant worker

A person, who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national

Miscarriage

Spontaneous abortion before 20 weeks

Mobile populations

People who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons. Source: UN Regional Taskforce on Mobile Populations and HIV Vulnerability, 2011

Mobile workers

Refers to a large category of persons who may cross borders or move within their own country on a usually frequent basis for a variety of work-related reasons, without changing place of habitual primary residence or home base. Mobile work involves a range of employment or work situations that require workers to travel in the course of their work. Mobile workers are usually in regular or constant transit, sometime (regular) circulatory patterns and often spanning two or more countries, away from their habitual or established place of residence for varying periods of time. Source: UNAIDS, 2011

Morning-after-pill

Emergency contraceptive pills that can be used five days after an unprotected sex to prevent pregnancy

Norms

Accepted forms and patterns of behaviour that are seen as 'normal' in a society or in a group within society

Patriarchy

A social system in which men are seen as being superior to women and in which men have more social, economic and political power than women

Pelvic Inflammatory Disease (PID)

Pelvic inflammatory disease (PID) refers to infection of the uterus, fallopian tubes and other reproductive organs that causes symptoms such as chronic lower abdominal pain. It is a serious complication of some sexually transmitted diseases and unsafe abortions.

Power

Possession of control, authority, or influence over others

Rape

Forcing a person to have any type of sex (vaginal, anal or oral) against their will

Refugee

A refugee is a person who "owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside their country of nationality and is unable to or, owing to such fear, is unwilling to avail themselves of the protection of that country" – Source: UNHCR Convention and Protocol relating to the status of refugees (1951)

Reproductive Health

Addresses the reproductive processes, functions and system at all stages of life. Reproductive health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so

Safer sex

Also known as 'protected sex', safer sex involves reducing risk, often by having sex using either a male or female condom or by exploring alternatives to penetrative intercourse

Sexual assault

Actual or threatened physical intrusion of a sexual nature by force or under unequal or coercive conditions

Sexual Harassment

Unwanted sexual advances or sexual attention

Sexual Relations (sex)

Any mutual genital stimulation, often, but not always, including sexual penetration. Sex also refers to the biological and physiological characteristics that define men and women

Sexual health

A state of physical, emotional, mental and social well-being in relation to one's sexuality

Sexual Network (sexual networking)

Is a social network that is defined by the sexual relationships within a set of individuals

Social Determinants of Health

The conditions, in which people are born, grow, live work and age, including the health system, that impacts upon health outcomes of the individual. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices

Source: Commission on the Social Determinants of Health, 2007

Social Exclusion

Has no agreed definition it can be used to describe group or individual exclusion from society by other groups or individuals, but it can also describe a choice made by individuals or groups to exclude themselves from the greater society

Socio-economic

Relating to, or involving a combination of social and economic factors

Spaces of Vulnerability

IOM Migration Health and Working Definition: Spaces of vulnerability are those areas where migrants and mobile populations live, work, pass-through or from which they originate. They may include the following; land border posts, ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-sending sites, detention centres, and emergency settlements

Status

The position or standing of a person in a society or group in relation to others For example, the social status of women in most societies is regarded as lower than that of men

Stillbirth

Intrauterine death of a foetus after the 20th week

Structural vulnerability factors

IOM Migration and Health Working Definition: Relates to the structural and social factors, such as the policy environment, poverty, population mobility, gender inequality and human rights violations that are not easily measured but that increase people's vulnerability to ill health

Undocumented migrants (also known as irregular migrants)

Someone who, owing to illegal or the expiry of his or her visa, lacks the legal status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorized to remain in the host country. Source: IOM Glossary on Migration – International Migration Law (2004)

Values

Accepted principles and standards of an individual or group

Violence

The use of force or power to harm and/or control someone

Vulnerable (vulnerability)

Conditions determined by physical, social, economic, and environmental factors or processes, which increase the susceptibility of an individual or community to the impact of something harmful. For instance HIV vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These may include (i) personal factors such as the lack of knowledge and skills required to protect oneself; (ii) factors pertaining to the quality and coverage of services, such as inaccessibility of services due to distance, cost and other factors; (iii) societal factors such as social and cultural norms practices, beliefs and laws that stigmatise and disempowers certain populations

The training of Migration Health Advocates through the development of a Training Guide pertaining to Sexual and Reproductive Health including HIV/ AIDS/STI derives from priority recommendation of the “Assessment the health and socio-economic vulnerabilities of Rodriguans residing in Mauritius” undertaken by the IOM Mission in Mauritius in 2012.

This study indeed presents many health challenges that low income Rodriguans, face in Mauritius, despite the free access of health services offered by the Government. For example, 21% of women reported the death of a child born alive and 23% of women in this same group reported a miscarriage or abortion or stillbirth in the 3 first months of pregnancy. On the issue of HIV and AIDS, the survey revealed a low level of knowledge (7% of men and 15% of women reported having never heard of HIV) and use of condoms. Almost half (48.5%) of the men reported having used illicit and intravenous drugs in the 12 past months. Women experience gender-based violence often linked with alcohol abuse.

Making use of the Training Guide

The Training Guide focuses on sexual and reproductive healthcare including HIV and AIDS and also addresses gender issues and human rights. It does not and cannot claim to cover all the different aspects of these themes. Its contents are essential thematic information required to promote health-seeking behaviours and behaviour change. It will serve as a support to a two-and-a-half-day training for Migration Health Advocates. The training approach will be a participatory and interactive one with some activities included in each module.

The Training Guide comprises five modules with key points to note at the end of each module and a number of educational tools with instructions. The contents will provide an informative and reference guidance that will assist Migration Health Advocates in their sensitisation programmes. Depending on the timing of these programmes, Migration Health Advocates will adapt the information contained in the different modules and make use of the educational tools.

Migration Health Advocates, be it members of NGO or Health and Safety Officers, after having been trained will be expected to sensitise Rodriguans and foreign migrant workers at the workplace or within the community.

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FOR MIGRATION HEALTH ADVOCATES IN THE REPUBLIC OF MAURITIUS

A Focus
on Sexual and
Reproductive
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Module 1

Module 1

General Aspects of Migration

Objectives:

This module will enable the Migration Health Advocate to:

1. understand the basics of migration and the four main stages of the migratory process;
2. understand migrants' health and rights;
3. have a baseline knowledge of the migration pattern in Mauritius

1.1. Basics on Migration and Migratory process

Migration may be defined as **the process of moving, either across an international border, or within a State**. It encompasses any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people, and economic migrants. Source: IOM Glossary on Migration – International Migration Law (2004)

The *International Organization for Migration's Standing Committee on Programmes and Finances* defines migration today as involving “a diverse group of people, including regular and irregular migrants, victims of trafficking, asylum seekers, refugees, displaced persons, returnees, migrant workers and internal migrants” (IOM, 2008:1).

We may distinguish two types of migration: firstly **internal migration**, which is a temporary or permanent relocation within one country and secondly **international migration** being the movement from one country to another for a short period of time or permanently. International migrants may be regular (documented) or irregular (undocumented) depending on the circumstances on arrival at destination.

Many migrants move for economic reasons, mainly in search of better livelihood opportunities for themselves and their families. Some are able to send money home for their families left behind. Others may face extreme poverty in their country of origin and migration is seen as the unique solution for survival. Other migrants are forced to leave their country as a result of political upheaval. They flee armed conflict or violations of human rights or similar situations and are recognized as refugees or asylum seekers.

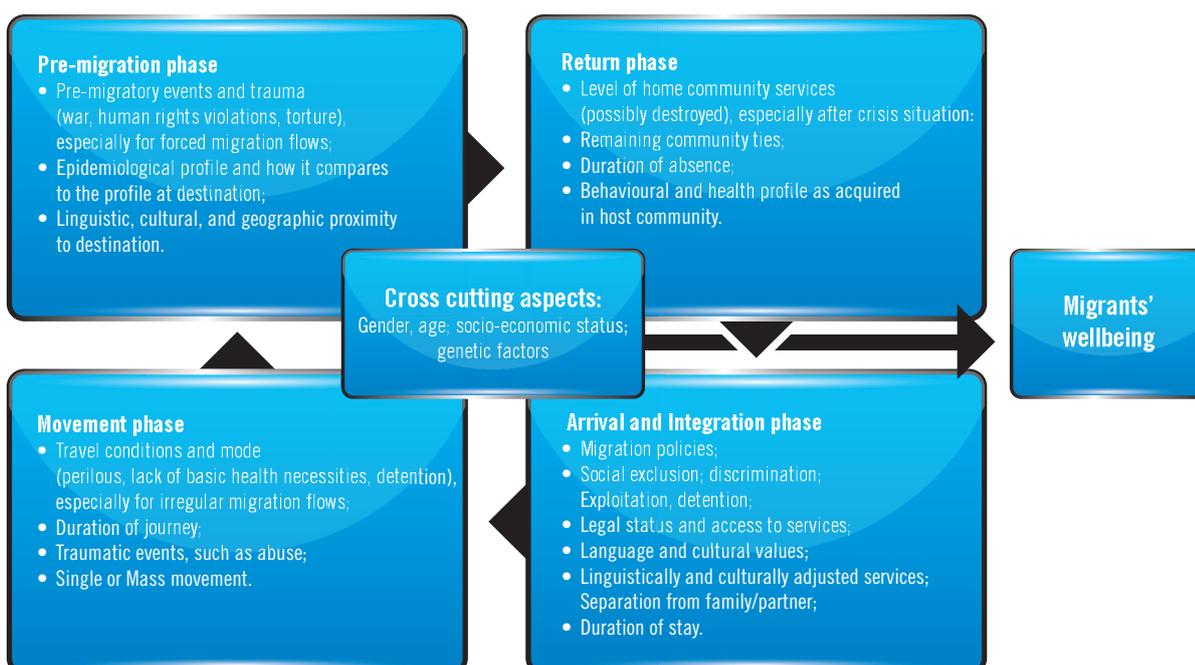


Fig 1: Migration Phases: Migration and Health: IOM's Programmes and Perspectives, 5-6 May 2008, SCPF/12

The migratory process includes four phases: **pre-departure, travel, destination or integration and in some cases return.** The pre-departure phase comprises the time before individuals leave from their place of origin. The travel phase (by sea, air or land) is the time spent to cover the distance from country of origin to destination. The destination or integration phase is when individuals settle either temporarily or long-term in their intended location. The return phase is when individuals go back to their place of origin, either temporarily or to resettle permanently.

1.2. Migrants' Health

Health is defined as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (World Health Organisation, 1948).

Migration is in itself a determinant of migrants' health. In fact, migrants moving through legal channels do not necessarily have negative health impacts. They may, however, have difficulty in accessing quality healthcare. They may be reluctant to seek medical assistance because of language and cultural challenges. For example, cultural norms may prevent women from accepting care from male practitioners. The management of sexual and reproductive health needs a complementary cultural competence in healthcare personnel.

On the other hand, subgroups of migrants such as trafficked persons, refugees and undocumented migrants are often confronted with major health risks. In general, migrants face many social inequalities and difficult experiences, which put their physical, mental and social wellbeing at risk. They are usually exposed to potential hazards and greater stress arising from displacement, integrating into the new country of destination and reintegrating the country of origin. In countries of destination or transit, migrants often suffer from poverty, exploitation, social exclusion, human rights' abuse, and denial of social benefits and accessible, quality healthcare, which have negative influences on their health.

Migrants' health should be considered throughout the different stages of migration. At the pre-departure phase, the health status of the migrant must be determined according to the local pattern of chronic diseases and epidemics as well as that of the destination country. The pre-departure stage is a beneficial time to conduct health promotion and offer information to potential migrants about essential health issues in the destination location. Separation from the family may be a traumatic event that may affect the psychological and physical health of the migrant especially during the travel. In addition, the migration journey itself can pose significant health risks, more particularly for undocumented migrants.

According to the IOM study "An assessment of the Health and Socio-Economic Vulnerabilities of Rodriguans in Mauritius", the area where the Rodriguan migrants first settle seems to be one of the major factors that determine how they will integrate into the Mauritian society. During the integration phase, risk behaviours among migrants either for communicable or non-communicable diseases appear to change when they are in new settings as cultural adaptation became more pronounced. Migrant women seem to be at greater risk of reproductive health problems and poor pregnancy outcomes, such as pregnancy complications, neonatal morbidity, and infant mortality. Among the low-income Rodriguan women, 21% reported the death of a child born alive and 23% reported a miscarriage or abortion or stillbirth.

During the return phase, migrants may experience the cumulative toll that migration exposures have taken on their physical and psychological wellbeing. Returning migrants may be seen as responsible for introducing new diseases or increasing the prevalence of infections among the local population. Some may be forced to return when their health conditions deteriorate. Many labour migrants, however, may return with reasonable remuneration and savings that help them afford a healthier lifestyle and better health care for themselves and their family.

Migration is not a new phenomenon, but it has changed significantly in number and nature with globalisation, including the ease of international transport and communication, the practicability of shifting capital, effects of climate change, and periodic political conflicts, including armed conflict.

Data from the United Nations Population Division show that increasingly **more women are migrating on their own**. A recent shift in migration patterns relates to an increase in the migration of single and partnered women who migrate without their families. Amongst the various factors influencing women to migrate are better financial prospects, escape of domestic constraints, lack of choice in homeland, family dissolution and in search of social achievement and fulfilment. Migrant women sending remittances to her family makes her as the main breadwinner. This may lead to a shift in gender roles and in power within the family.

Migration is a global phenomenon that influences the health of individuals and populations. Yet, there has not been commensurate development of coordinated policy approaches to address the health implications associated with modern migration.

Migration has often been associated with the spread of diseases, thus placing an additional burden upon the public-health systems of destination countries. This has become even more pronounced in the context of HIV, with destination countries increasingly concerned that cross-border migrants bring with them HIV. These perceptions lead to the denial of healthcare to non-citizens.

1.2.1 Social Determinants of Health

Effective health programmes should not only focus on ensuring access to healthcare but also on the key social determinants of health amongst communities.

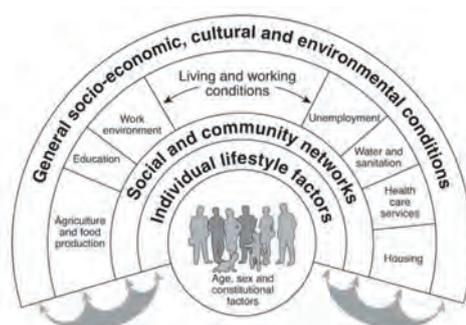


Fig 2: Social Determinants of Health (Dahlgren and Whitehead, 1991)

Social determinants of health are recognised as the conditions in which people are born, grow up, live, work and age (Commission on Social Determinants of Health, 2008). According to Dahlgren and Whitehead (Figure 2), there is a relationship between individuals, their environment and disease. Individuals are born with a set of fixed genes, which therefore cannot be modified. But socio-economic, cultural and environmental conditions in which they travel, live or work influencing their health can be modified for the better.

Personal behaviour and ways of living can promote or damage health, for example, choice to smoke or not, to use condom or not. Individuals are also affected by friendship patterns and the norms of their community. Social and community support as well as structural factors such as housing, working conditions, access to services and provision of essential facilities will determine their health status.

Unfavourable conditions of migration can have a greater impact of these factors. Language and cultural differences within the host community often lead to discrimination and social exclusion. Furthermore, low income for long hours of work, inappropriate housing and living conditions (lack of access to drinking water, good sanitation), unsafe working environment and lack of access to health services are some of the social determinants related to migrants' health.

In this context, the World Health Assembly (WHA, 2008) report on Health of Migrants has made clear that, with an increase in global mobility, the health of migrants must be considered as a key global public health concern, emphasising on the public health implications of migration as well as the unmet needs of vulnerable migrants. It also underlines the importance of intersectoral interventions at societal level to address the general socio-economic, political, cultural and environmental determinants of migrants' health.

The main public health goal is to **avoid disparities between the health status and the rights to access to preventive and curative health services of migrants and nationals**. As such, a population health approach is critical in order to align strategies and interventions aiming at improving the health outcomes of particularly vulnerable migrants.

It is a fact that migrant workers contribute to the productivity and development of both the countries of origin and destination and denying them healthcare can have a negative economic development impact. Consideration of migrants' health means recognition of their dignity and human rights and mitigates for the achievement of the **Millennium Development Goals (MDGs)**:

1. Eradicate extreme poverty and hunger;
2. Achieve universal primary education;
3. Promoting gender equality and empowering women;
4. Reducing child mortality rate;
5. Improving maternal health;
6. Combating HIV/AIDS, malaria and other diseases;
7. Ensure environmental sustainability;
8. Develop a global partnership for development.

1.3. Migrants' Rights to Health

All human beings are born free and equal in dignity and rights. Human rights are basic entitlements accorded to every human being, and include the right to life, freedom of movement and speech, security, dignity, health, education, shelter, employment, property, food,

Everyone is entitled to all the rights and freedom set forth in the *Universal Declaration of Human Rights* without discrimination on the basis of race, colour, sex, language, religion, class, political or other opinion, nation or social origin, property, birth or other status. Furthermore, no discrimination shall be made on the basis of political, jurisdictional or international status of the country or territory to which a person belongs.

Concerning the right to health, it is stipulated that it is the responsibility of governments to create a healthy environment for all. Such conditions range from ensuring availability of health services, healthy and safe working conditions, adequate housing and nutritious food. The right to health has been enshrined in international and regional human rights treaties as well as national constitutions all over the world.

Migrants' health and wellbeing should be considered in a Human Rights' perspective and are entitled to basic fundamental human rights. The right to health is more broadly formulated in the *International Covenant on Economic, Social and Cultural Rights*, Article 12, as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". The right to health is inter-linked with other civil and political rights, and economic, social and cultural rights. Migrants will fully enjoy their right to health if only all countries take appropriate measures through national laws to begin addressing issues related to migrants' rights.

The 61st WHA (A61.17), May 2008, recognised that health outcomes can be influenced by the multiple dimensions of migration, and noted that some groups of migrants, more specifically undocumented migrants, experience increased health risks. It therefore called upon Member States (includes Mauritius) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race.

As a Member State of SADC, Mauritius signed the SADC Protocol of Health (August 1999), which calls upon States Parties to co-operate in addressing health challenges through effective regional collaboration and mutual support for the purpose of achieving certain specific objectives, among which, to foster co-ordination and co-operation in the area of health with international organisations (such as IOM) and co-operating partners; to develop common strategies to meet the health needs of women, children and other vulnerable groups (including migrants).

Migrants should be free to make decisions on their health, free from discrimination and from non-consensual medical treatment. They should have the right to a system of health protection, the right to health-related decisions at community levels and the right to sexual and reproductive health.

Migrants are entitled to quality healthcare on the same level as nationals. Quality healthcare encompasses availability, accessibility and acceptability. Availability implies a sufficient number of health services and goods. Accessibility

should be granted in its four dimensions: geographical, non-discrimination, affordability and informative. Acceptability means that health facilities, services and goods should be culturally appropriate and respectful of medical ethics.

Several existing international human rights tools recognise the right to health. The *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (1990) (Article 28) explicitly identifies the right to health for migrants in regular and irregular status. It stipulates that migrant workers and members of their families have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the state concerned. Such emergency medical care shall not be refused to them regardless of any irregularity in their stay or employment.

The Convention further protects migrant workers in the workplace. Article 25 stipulates, “Migrant workers shall enjoy treatment not less favourable than that applies to nationals of the states of employment in respect of remuneration and other work conditions, terms of employment”. State parties shall take all appropriate measures to ensure that migrant workers are not deprived of any rights. However, this convention has been criticised, as it does not make provision for preventive medical treatment. **Mauritius is not signatory of this Convention.**

On the other hand, migrants have to assume their **responsibilities** concerning their health and that of the community or the country where they are living. It is the responsibility of migrants to:

- i) Take all precautions to prevent sickness;
- ii) Seek health advice or treatment in case of illness and adhere to the treatment;
- iii) Provide all information about their medical condition;
- iv) Take necessary precautions to prevent contaminating others.

The management of migrants’ health goes beyond the sole management of diseases among mobile populations. Consideration should be given to the fact that migrants’ health is closely linked with the broader social determinants of health and unequal distribution of health and social services. Consequently, multi-disciplinary and multi-sector partners should work together to avoid social exclusion and improve the health of all people including migrants.

diseases. There has been a marked decline and control in communicable diseases and maternal and child health issues, which is translated by an increasing longevity and low death rates with a change in its causes. In 2011, the life expectancy rate is 74 years, the infant mortality 12.6 per 1,000 livebirths and maternal death 34 per 100,000 livebirths. Actually, non-communicable diseases accounts for over 80% of the health burden. Diabetes, hypertension and its related complications form the main health profile of Mauritius. With respect to HIV and AIDS, the prevalence **is estimated at 0.97% with a concentrated epidemic profile** and its main driving factor being injecting drugs use.

1.4.2 Migration Pattern in Mauritius

Mauritius can be categorised as a sending and receiving country as regards migration. In most cases, lack of employment and economic opportunities at home constitute the main reason for the migration of skilled and unskilled workers. Data from the Ministry of Labour, Industrial Relations and Employment, Mauritius, shows, as at 31 May 2013, a number of **37,197 migrant workers** (25,562 males and 11,635 females) in Mauritius. They are mainly from India, Bangladesh, China, Sri Lanka and Madagascar. The majority of them are employed in the textile and construction sectors. According to press information, some female migrant workers are engaged in sex work in order to increase their earnings and remit back home. This activity puts them at risk as if not protected they may contract STI or HIV and even sometimes subject to violence by clients.

Under the **Occupation Permit Scheme** managed by the Board of Investment, several foreign nationals come to Mauritius as investors, professionals or self-employed. Others come to stay under the (i) Integrated Resort Scheme and (ii) Real Estate Development Scheme and the number of foreign students pursuing higher studies in Mauritius is also on the increase, with Mauritius positioning itself as an education hub in the sub-region.

Mauritius has not ratified the 1951 Geneva Convention relating to the Status of Refugees and cases of **asylum seekers and refugees** are therefore very rare.

There is a growing trend of cross-border traders especially within the Indian Ocean Commission member States. Traders from Comoros and Madagascar come to Mauritius to sell their local handicraft products and with their earnings would buy essential materials or goods, unavailable in their country, for their home.

A special mention should be made regarding the issue of intra island migration - "internal" migration of inhabitants of Rodrigues island, an autonomous dependency of the Republic of Mauritius situated at 560 Km North East of Mauritius. The 2011 Census shows that 9,336 Rodriguans (4,311 males, 5,025 females) aged 16 years and over are living in mainland Mauritius. An assessment conducted by IOM Mauritius focusing on the socio-economic and health vulnerabilities also identified similar vulnerabilities between these "internal" migrants and cross-border foreign workers.

Furthermore and in addition to informal temporary and permanent emigration of Mauritians, the IOM Mission in Mauritius in collaboration with the Mauritian Government is facilitating **circular labour migration schemes** for Mauritians wishing to find employment overseas. Since 2008, the Mauritian Government has embarked on several circular migration programmes with Canada, Italy and France in order to widen the scope of opportunities for its nationals. Mauritians can take employment abroad for a specific period, as well as learn new skills and save part of their income, before returning to the country.

Module 1:

Key points to note:

1. There are various definition and types of migration: e.g., internal and international;
2. Phenomenon of Feminisation of migration is growing worldwide;
3. The different phases of migration process and conditions of migration can affect migrants' health at each stage – not migration itself;
4. The social determinants of health related to migration should not be overlooked;
5. There exist important language and cultural challenges for migrants to access health services;
6. Contributions to achievement of MDG;
7. The 61st WHA, 2008 calls for health promotion, disease prevention and care for migrants on the same basis as nationals;
8. Existence of several International Conventions that regulate migrants' health;
9. Mauritius is a sending and receiving country for migration and has also the particularity of having intra-island movements, which also constitutes migration;.

«Migration and Health»

FOR MIGRATION HEALTH ADVOCATES IN THE REPUBLIC OF MAURITIUS

A Focus
on Sexual and
Reproductive
Health
including the prevention of
HIV/AIDS/STI

Module 2

Sexual and Reproductive Healthcare

Objectives:

This module will enable the Migration Health Advocate to:

1. have an insight of sexual and reproductive healthcare services;
2. understand the benefits of family planning in terms of health and development;
3. understand the importance of maternal and child healthcare.

Introduction

This module covers three major areas of sexual and reproductive healthcare:

1. **The family planning services** offers one major solution to the problems of unwanted/unintended pregnancies. FP programmes help couples wishing to delay pregnancies, space births and achieve their desired family size.
2. **The maternal and child health services** including prenatal care, childbirth and postnatal care, and management of major abortion-related complications;
3. **Prevention, diagnosis and treatment of STI including HIV and AIDS.**

Linkages, policy, programmes, services and advocacy synergies between SRH and HIV are approaches that have the potential to increase universal access to both sexual and reproductive health as well as HIV prevention and care.

2.1 Family Planning

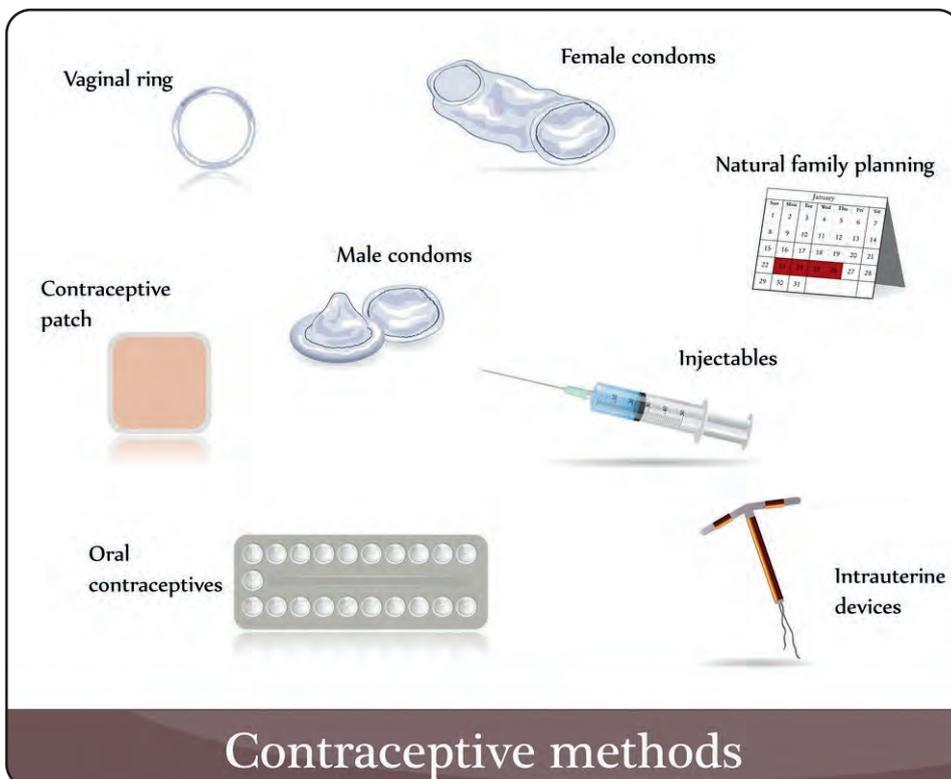


Fig 5: Some Family Planning Methods

Notwithstanding the progress accomplished in the several decades, millions of women and partners are not using family planning methods to help them space births and avoid early or unintended pregnancies. In many countries, girls are forced to marry at a very young age, become pregnant too early and cut short their education to take care of their young family.

Family Planning is key to slowing unsustainable population growth and the resulting negative impacts on the economy, environment and national as well as regional developments. In some countries, rapid population growth is putting pressure on the government to provide basic education and health services. The population issue is, in fact, one of gender. Many women lack the freedom to exercise choice when it comes to childbearing. In limited resources settings and remote locations, women are not allowed to go alone or have to walk long distances to get contraceptives and in some areas, these are simply not available.

Family Planning constitutes a basic right for women today and helps them to:

- Have a smaller, healthier and better educated family;
- Avoid many infant deaths by investing in each child's health of a smaller family; reduce infant mortality by preventing closely spaced and untimed pregnancies and births
- Reduce the economic burden of a large family and invest more on both boys and girls schooling, thus breaking the cycle of poverty;
- More time to have a better education for herself and consequently better employment opportunities and economic independence; Empowering themselves to enhance their education
- Face less risks of disabilities or death related to multiple pregnancies and childbirths or unsafe abortions;

At country level, low fertility rates facilitates economic growth through its association with better child health and schooling, reduced maternal mortality and morbidity, increased women's labour force participation and higher household earnings. In Africa, high fertility and population growth rates pose a bigger threat than HIV and AIDS to reducing poverty. Promotion of condom use and education programmes through family planning services help to prevent STI including HIV. Family Planning reduces the risk of unintended pregnancies among women living with HIV resulting in fewer infected babies and orphans. Male and female condoms provide dual protection against unintended pregnancies against STIs including HIV

The **concept of family planning was introduced in Mauritius in 1958**. Family planning services were centralised under the administration of the Maternal and Child Health Care Division of the Ministry of Health in 1972. As a result of the educational campaigns conducted by the Government and the family planning associations, the population of Mauritius has increasingly accepted contraception for spacing and limiting births. The prevalence rate of contraception in 2002 was over 75 % for mainland and 70% for Rodrigues. Over 160 points of family planning services integrated in the Primary Health Care Centres are available in Mauritius. As a result, the total fertility rate (children born/woman) is 1.42 compared to 4-7 in most of African countries.

2.2. Maternal and Child Health Care

In developing countries, hundreds of thousands of women die from complications of pregnancy or childbirth and many more suffer from related disabilities. Moreover, millions of babies are born dead or die before the age of one month (neonatal deaths) or before one year (infant death). The vast majority of maternal deaths occur in developing countries as a result of complications during and following pregnancy and childbirth. Most of the maternal, neonatal and infant deaths are due to the poor health and nutritional status of the mother coupled with lack of access to quality skilled care before, during and after child birth. They can thus be prevented with available and accessible quality maternal, neonatal and child health care interventions. In the Republic of Mauritius, maternal and child health services are integrated in all Primary Health Care centres as well as in the district and regional hospitals.

2.2.1 Antenatal Care (ANC)

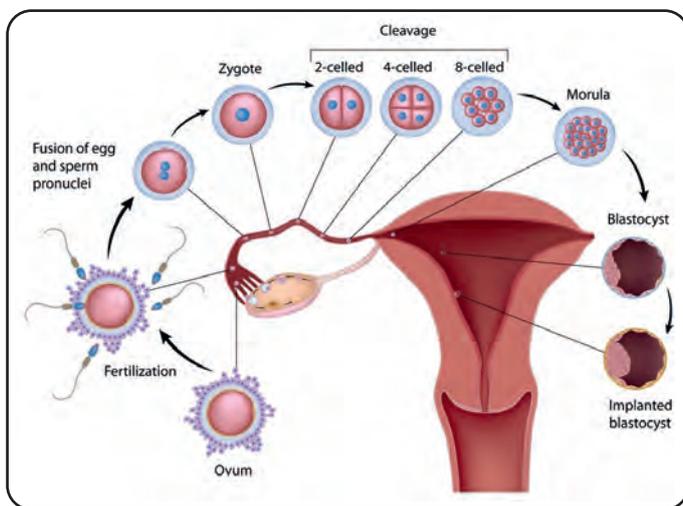


Fig 6: Human Fertilisation



Fig 7: Antenatal Care (monitoring foetal heart)

Antenatal or prenatal care refers to the regular medical and nursing care recommended during pregnancy. It is **best to start the ANC in the first trimester of pregnancy** to ensure that maternity health care takes account of all health needs and preferences and to attend regularly the subsequent appointments. Certain conditions require guidance/medical advice prior to conception. The ideal first ANC clinic is at a preconception clinic. In some cases where the woman suffers from illnesses such as diabetes, high blood pressure or cardiac diseases, it is preferable to see a doctor when planning to have a baby.

Antenatal care is important to monitor both the health of the mother and of the unborn baby. The clinical assessment of mother and foetus during pregnancy is to obtain the best possible outcomes for the mother and child. History and

examination are complemented by screening and assessment using a combination of methods, including biological, haematological and ultrasound. Efforts are made to maintain maternal, physical and mental well being, prevent preterm delivery, anticipate difficulties and complications at delivery and ensure birth of a live healthy infant and to assist the couple in parenting. Early monitoring and ongoing care during pregnancy is associated with more favourable birth outcomes. A series of blood and urine indicators, her weight and blood pressure are monitored. Blood tests can detect medical conditions that can affect the baby and where transmission to the baby can be prevented, for example, in the case of Rubella, Hepatitis B, Syphilis, HIV etc. Examination by a doctor or experienced mid-wife can assess the pelvis of the woman; monitor the heartbeats of the foetus, its size and position in the uterus. It is also a good time for the woman to talk to the service provider about habits such as taking alcohol or drugs or smoking that can pose a problem to the health of the baby. Taking medication for any medical purpose should be made known to the service provider. Complying with a good antenatal care prevents complications during childbirth and postpartum.

Antenatal care offers the pregnant woman the opportunity to receive a wide range of health promotion and preventive services such as counselling on a balanced diet, breastfeeding, STI/HIV/AIDS, PMTCT, prevention or treatment of anaemia, vitamin supplements and tetanus immunisation, preparation for postnatal period, infant feeding and subsequent contraception. General advice for nutrition and life style can be given during this period.

2.2.2 Childbirth

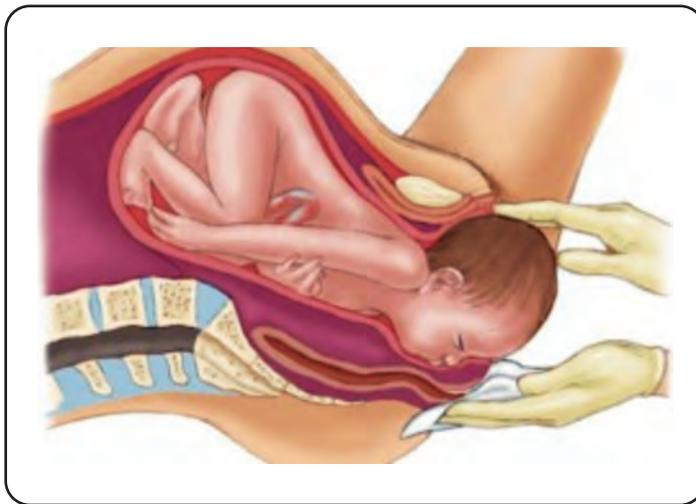


Fig 8: Normal childbirth (head presentation)

In poor countries, a woman has a 1 in 16 chance of dying in pregnancy or childbirth, compared to a 1 in 4,000 risk in a developing country. Many other women or their babies suffer from disabilities. Access to quality care during pregnancy, childbirth and the first month after delivery is key to saving these women's lives and those of their babies, and to preventing disabilities. Maternal mortality is highest in poorer developing countries. More than half of maternal deaths occur in Sub Saharan Africa and almost one-third in South Asia. Maternal mortality ratio in developing countries is 240 per 100,000 live births versus 16 per 100,000 live births in developed countries. This reflects the inequities in access to health services between countries, within countries between people with high and low income and between those residing in urban and rural areas.

Direct causes of maternal deaths are haemorrhage, infection, obstructed labour, hypertensive disorders in pregnancy, and complications of unsafe abortion. There are birth-related disabilities that affect many more women and go untreated like injuries to pelvic muscles, organs or the spinal cord. The risk of maternal mortality is highest for adolescent girls in developing countries. The leading cause of maternal death is complication in pregnancy and childbirth mainly: antepartum and post partum haemorrhage, sepsis, obstructed labour, hypertensive disorders, HIV and AIDS and unsafe abortion

Anaemia increases the risk for maternal and infant mortality, and developmental problems for babies. Nutritional deficiencies contribute to low birth weight and birth defects as well. The consequences of poor nutritional status (anaemia) and inadequate nutritional intake during pregnancy directly affects women's health status and has a negative impact on birth weight and early development. Low birth weight is a major determinant of mortality/morbidity.

HIV is becoming a major cause of maternal mortality in highly affected countries in Southern Africa. Mother-to-child transmission of HIV in low-resource settings, especially in those high HIV prevalence countries continues to be a

major problem. Early evidence shows that HIV may be a significant factor in maternal mortality in countries with high HIV prevalence. Common causes of HIV related maternal death include opportunistic infections such as pneumonia, TB, Malaria. Contributing factors include anaemia, puerperal/post abortion/ sepsis. New HIV infection through MTCT remains a challenge.

A majority of these deaths and disabilities are preventable, being mainly due to insufficient care during pregnancy and delivery. Most maternal deaths are avoidable as the health care solutions to prevent or manage are well known. About 15 per cent of pregnancies and childbirths need emergency obstetric care because of complications that are difficult to predict. All women need access to ANC in pregnancy, skilled care during childbirth, care and support post delivery. **All births should be attended by skilled health professionals whose timely management of complication can save lives.**

Evidence shows that girls' education improves their antenatal care, postnatal care and hence their childbirth survival rate. Educated girls, having higher self-esteem and more aware of their equal rights, are more likely to avoid HIV infection, gender-based violence and exploitation. To further improve maternal deaths, barriers that limit access to quality maternal health services must be identified and addressed at all levels of the health system.

While globally progress is made in terms of child mortality, a long way remains to be covered to achieve the MDG 4, which sets to reduce under-5 mortality by two-thirds by 2015. **In 2011, still around 7 million children died before reaching their fifth birthday.** The under-five mortality rate in developing regions was 57 deaths per 1,000 live births that is 8 times more the rate in developed regions. **Moreover, 23 countries in Sub-Saharan Africa are home to an under-five mortality rate above 100 deaths per 1,000 live births.**

Little progress has been achieved in limiting neonatal (new-born) deaths, which account for 43% of children under-five deaths and 60% of the infant under-one deaths. Maternal young age and ill health, multiple pregnancies, poor quality of antenatal and perinatal care are among the risk factors contributing to increased neonatal deaths. Resulting low birth weight and prematurity are the common causes of these deaths.

Improving the health and nutrition of mothers-to-be and providing quality reproductive health services are crucial to addressing many underlying causes of maternal and child mortality. Reducing inequities concerning maternal and child health care between developed and poor countries will certainly contribute towards the achievement of MDG 4.

2.2.3. Postpartum care (PPC)



Postpartum care needs great attention on the part of caregivers as well as of mothers and families. Proper postpartum care can prevent many maternal and neonatal deaths. **It includes adequate care and support towards the mother, newborn and infant in the postnatal period that covers six weeks after delivery.** During that period, the mother may encounter medical problems such as infections, haemorrhage, high blood pressure, formation of blood clots, opening of incisions, breast engorgement, and puerperal depression. They need medical as well as emotional support. Health providers should be apprised of any symptom of potential illnesses in view of referring the patient to the appropriate specialised care.

Fig 9: *Bonding with baby*

The newborn is given immediately or as soon as possible (case of caesarean section) to the mother to hold to provide skin-to-skin contact. A newborn can suffer from asphyxia or respiratory distress and need urgent treatment. Other conditions needing urgent attention are prematurity or low birth weight, congenital anomalies and neonatal sepsis. Premature or low birth weight babies are more prone to hypothermia, infections, and need more attention for their feeding. Hygienic precautions should be taken during childbirth, the room be kept warm and babies be kept next to their mothers. Jaundice is quite common in babies and usually subsides without treatment. But it can be dangerous and result in disabilities in preterm or low birth weight babies or in blood group incompatibility.

Infant mortality (death of a baby before reaching his/her first birthday) has multiple causes. However, no specific cause (after thorough investigation) can be attributed to the Sudden Infant Death Syndrome (SIDS) or more commonly known as Cot Death. Nevertheless, several risk factors, such as mother smoking during pregnancy, inappropriate bed and bedding or sleep positions of the baby, can lead to SIDS and its risk can thus be reduced.



Fig 10: *Breast feeding*

Breastfeeding must be established as soon as the baby can start suckling (half to one hour after delivery) and maintained as long as possible. Breast milk provides optimal nutrition for infants, protects them against infections and allergies and promotes mother-infant bonding. In the case of HIV positive mothers, special advices are given depending on the socio-economic and environmental situation of the families.

During the postpartum period, women need counselling on contraception. If the mother exclusively breastfeeds the baby she can, at least for the first six weeks, rely on the contraceptive effect of lactation amenorrhoea (LAM). After the six weeks, she needs to seek advice from the family planning service provider for an appropriate contraceptive method.

Subsequent postnatal visits for the mother and the baby are also crucial to the future wellbeing of both. Consequently, mothers should be made aware of the timing of these visits. These visits will enable the caregiver to watch for potential signs of any postpartum illness, to follow the development of the baby (weight and height), to provide necessary immunisation for the baby as per vaccine schedule

In some cultures, gender and power issues determine much of what happens to a woman and her newborn in the postpartum, particularly with regard to the resumption of sexual activity. In fact, mothers and their newborns have a special status regarding rights to protection, rights to attention to their physiological, psychosocial and environmental needs.

2.2.4 Complications of Abortion

A miscarriage is the spontaneous loss of a foetus before **20th week of pregnancy**. Spontaneous abortion (miscarriage) or unprovoked interruption of pregnancy affects 10-15% of all known or suspected pregnancies. Though complications are quite rare, it often requires treatment at hospital. It is less fatal than induced unsafe abortion.

Induced abortion is the oldest, and probably still the most widely used method of fertility control (Royston and Armstrong, 1989). **Every year about 42 millions of women with unintended pregnancies choose abortion and nearly one half of these procedures are unsafe (Population Reference Bureau, 2011: WHO estimates)**. Many reasons are put forward: i) many women do not have access to modern contraceptives ii) they do not use contraception correctly iii) violence against women lead to unwanted pregnancies iv) women are forced to abort v) too young or too poor to raise a child.

Complications of unsafe abortions result in a high rate of mortality and morbidity for women in developing countries. Unsafe abortions account for a significant number of maternal deaths. **Every year 47,000 women die due to unsafe abortions (Population Reference Bureau, 2011: WHO estimates)**. It is one among the three leading causes of maternal mortality. In fact, a woman in a developing country faces a risk of death 250 times higher if she has to seek the services of an untrained, unskilled abortionist than if she has access to a skilled provider and hygienic conditions. Immediate physical consequences of unsafe abortions can be haemorrhage, perforation of pelvic organs and infections.

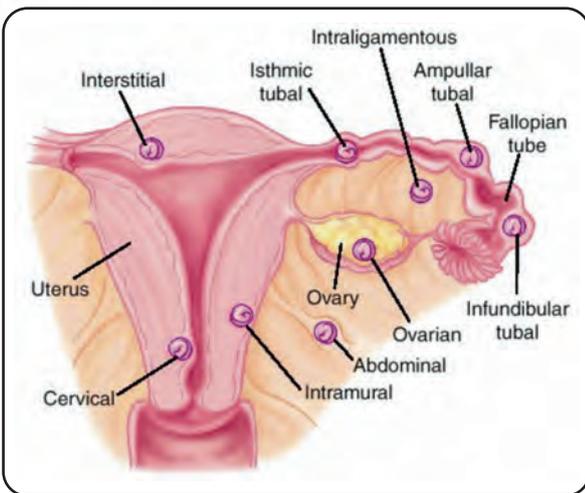


Fig 11: Sites of Ectopic Pregnancies

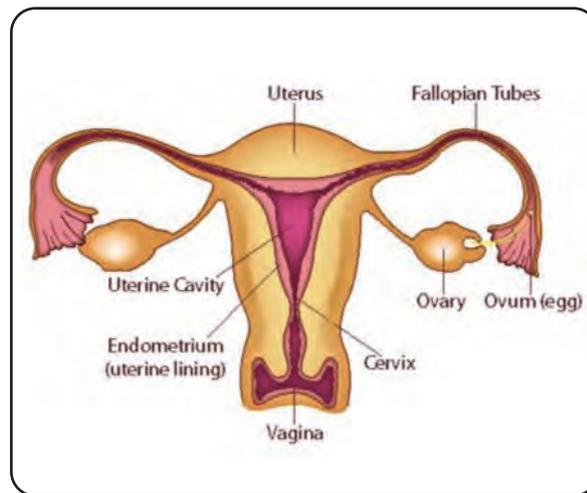


Fig 12: Causes of Infertility

Late complications include pelvic inflammatory disease with constant low abdominal pain, infertility, ectopic pregnancy, and labour difficulties in subsequent pregnancies,

Emergency contraception such as the “morning-after pill” taken up to 72 hours after intercourse can have an abortive action. Complications include nausea, vomiting or persistent bleeding. The “abortion pill” (RU 486) can be used only during 7 to 9 weeks of pregnancy. The abortion pill’s complications: severe abdominal pain, nausea, diarrhea, vomiting, low heart and blood pressure, and prolonged and heavy bleeding.

Abortion leaves also painful emotional and psychological consequences. Women who have experienced it are urged into denial and process feelings such as guilt, shame, anger, and anxiety with disturbed sleep. They may show signs of “post-abortion blues” or even long-term depression with suicidal tendency. Some may have recourse to alcohol or psychotropic drugs abuse. A host of negative emotional side effects often follow an abortion procedure. It is commonly known as Post Abortive Syndrome which includes symptoms such as social and relation breakdown, sexual dysfunction, loss of self esteem, guilt and remorse, nightmares, post traumatic stress disorder, drug or alcohol abuse, depression or suicide. Adolescents can become more reclusive and have antisocial behaviours.

Deep analysis of the reasons and causes of abortions shows that gender inequality, cultural norms and poverty for the most vulnerable women leave them no choice. Either they accept risk death or disability from an unsafe abortion on an undesired forced pregnancy, or face social exclusion from the family and extreme poverty. Women and adolescent girls should have the right to make their own decisions about their sexual and reproductive health and well being, and be able to choose whether, when and how many children to have.

Activity 1: Role Play – Counselling on Family Planning Methods

Activity 2: Role Play – Counselling on Maternal and Child Health

Module 2:

Key points to note:

1. SRH comprises three major areas, namely Family Planning, Maternal and Child Health, STI/HIV/AIDS;
2. The basic right of women to be able to plan her family, thus avoiding abortions;
3. The impact of Family Planning on the family, community and nation;
4. The importance of Antenatal Care, Assisted Childbirth and Postnatal Care on the well health of both mothers and babies;
5. Abortions, particularly unsafe ones, can have disastrous consequences and long-term physical and psychological aftereffects;
6. Contraception, pregnancy and childbearing raise specific issues for women migrants.

Module 3

An Overview of HIV Infection and AIDS in Mauritius

Objectives:

This module will enable the Migration Health Advocate to:

- i) understand the “concentrated” nature of the HIV epidemic in Mauritius;
- ii) realise the driving factors of the Mauritian HIV epidemic that can make it become “generalised”;
- iii) identify the key affected populations;
- iv) be aware of the key interventions of the national response.

Module 3: An Overview of HIV Infection and AIDS in Mauritius

3.1 Epidemiological Situation

Globally, as at end of 2011, **34 millions people are living with HIV an AIDS**, of whom only half know their status while **1.7 millions people died of AIDS** and 2.5 new infections occurred. Worldwide, an estimated 0.8% of adults aged 15-49 years are living with HIV, although the burden of the epidemic is not the same for all countries. The pandemic affects most severely Sub-Saharan Africa with nearly 5% of adults HIV positive and being home of 69% of the people living with HIV globally. After sub-Saharan Africa, the regions most heavily affected are the Caribbean and Eastern Europe and Central Asia, where 1.0% of adults were living with HIV in 2011.

In Mauritius, the first AIDS case was notified in 1987. In the eighties and nighties, only a few cases of HIV positive, mainly imported, were registered. As from the year 2000, HIV and AIDS registered cases doubled each year to reach a peak of 921 in 2005.

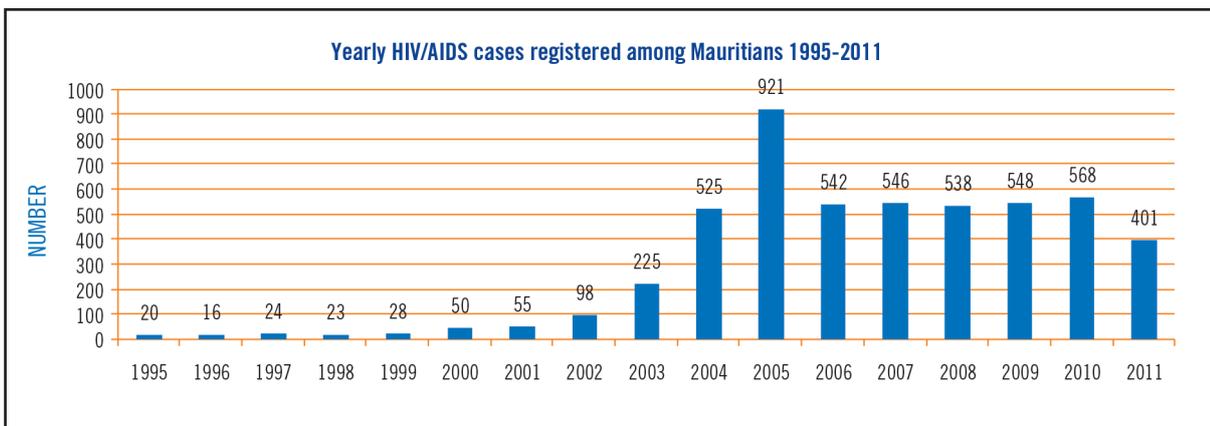


Fig 13: Trend of new HIV registered cases in Mauritius (1995 – 2011)

Source: National AIDS Secretariat, Mauritius

From there, the annual HIV incidence seemed to stabilise with an average of 545 cases annually till 2012 when a drop to 320 cases was observed. The monthly reported cases also dropped from an average of 50 cases in the past 5 years to 27 cases in 2012.

As at December 2012, in the Republic of Mauritius, 5,508 cases of HIV and AIDS had been detected cumulatively, out of which 1,133 (20.6%), are females. The total number of known deaths registered among PLWHA is 623. Data for Rodrigues indicate 55 known HIV cases, among which 24 are women. Heterosexual transmission accounts for 65% (36 cases) while 30% (17 cases) are among injecting drug users and 16% (9 cases) are among pregnant women. One woman has transmitted HIV to her baby.

Module 3: An Overview of HIV Infection and AIDS in Mauritius *Continued*

On the overall HIV and AIDS cases, as at the end December 2012, it is noted that **72.7% of transmission was due to transmission through injecting drug use**. In 2000, only 2% of the new infected cases were among PWID and it gradually increased to 92% in 2005 (7% in 2001, 14% in 2002, 66% in 2003, 87% in 2004). Following the introduction of Harm Reduction measures in 2006, transmission among the PWID steadily decreased from 86% in 2006 to reach 47.2% in 2012 as shown in Figure 14.

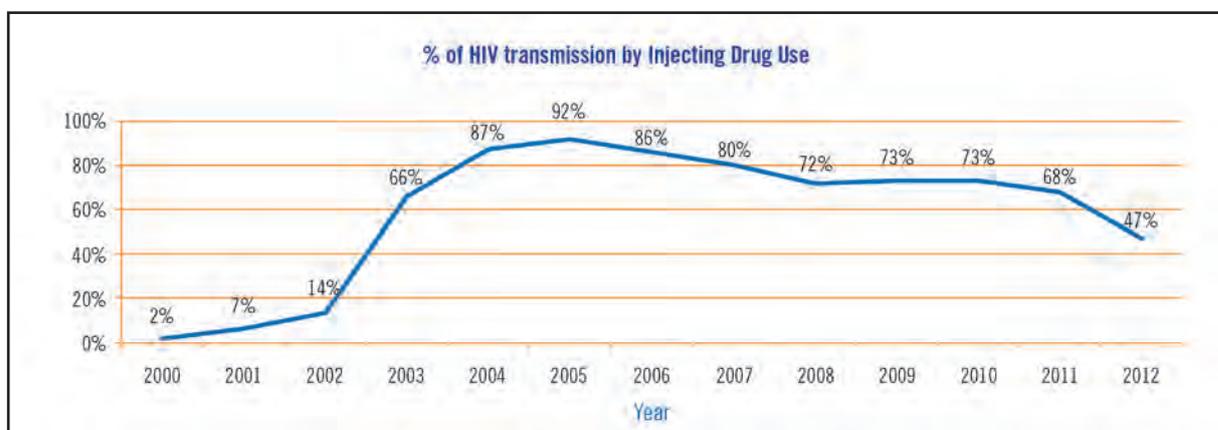


Fig 14: Percentage of transmission through Injecting Drug use (2000-2012)

Source AIDS Unit Register, MOH & QL

Prevalence figures for HIV in Mauritius is estimated at 0.97% (Confidence Intervals 0.6%-1.96%) amounting to an average of 8,000 PLHIV. Monthly statistics Report reveals that the mean transmission percentage of HIV infection since 1987 has remained constant with an average of 73% among PWID and 19% among heterosexual.

This situation characterises the epidemic as a “concentrated” one, with HIV prevalence estimates above 5% among KAP while it remains low at 0.4% in the pregnant women population.

The following data from the National AIDS Secretariat, Mauritius show the prevalence in the different groups:

IDU: The IBBS PWID 2011 estimated the HIV prevalence to be at 51.6 % among a population of 10,000 PWID, with a geographical concentration around Port-Louis.

CSW: The IBBS on CSW in 2010 gave an estimated HIV prevalence of 28.9 % among a population calculated to be 1,500. The study highlighted the fact that 40% of the CSW also inject drugs.

MSM: According to the IBBS done among MSM in 2010, the HIV prevalence is 8.1%.

Prison Inmates: During 2011, there was a turn-over of 4979 prison inmates, among whom the prevalence of HIV was 19.9%. This high prevalence was due to the fact that many inmates were incarcerated for drug-related offences.

Seafarers: In 2008, a regional survey conducted by the IOC for the ACP countries of the IOC showed a higher HIV prevalence among Mauritian sailors of 6.9%.

ANC Surveillance Data.

HIV prevalence among ANC attendees closely reflects the HIV prevalence in the general adult population. For this reason, ANC HIV sentinel surveillance provides important data on the status of the epidemic over time, especially in the Republic of Mauritius as 95% of pregnant women are tested for HIV.

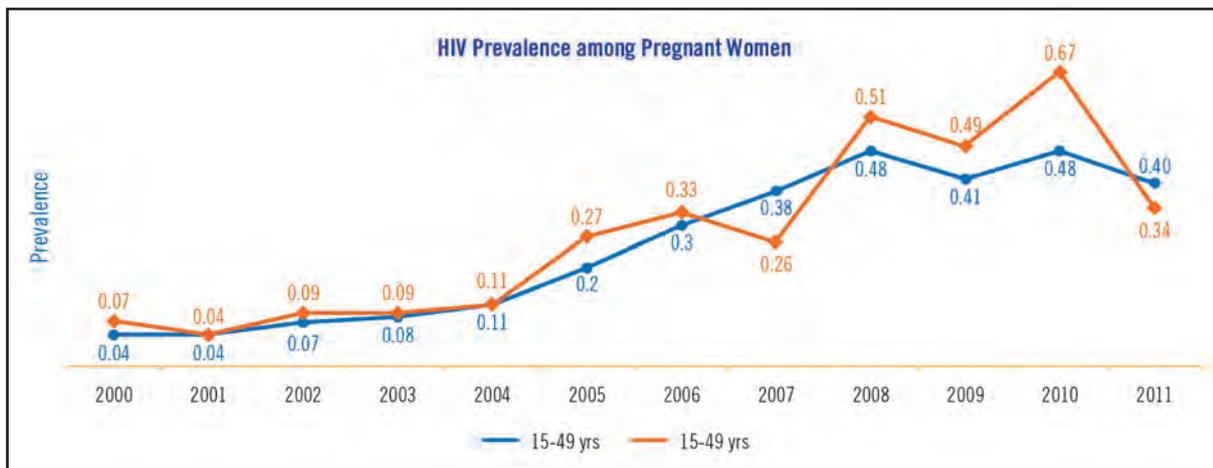


Fig 15: Antenatal (ANC) Prevalence (15-49 yrs)

Source: ANC register, MOH & QL

The HIV prevalence rate among pregnant women aged 15-49% remains in the range of 0.4%-0.05% since 2009. The same data can be used as a proxy to determine the prevalence rate of HIV among youth aged 15- 24 years old and the figures show an improvement with 0.34% in 2011 as compared to 0.67 in 2010.

3.2 Overview of the Mauritian Response

3.2.1 National Strategic Framework (NSF)

The current National Strategic Framework for HIV and AIDS (NSF) 2013 – 2016 defines how the Government of Mauritius and all sectors of society at all levels will respond to HIV and AIDS. In fact, this NSF has been developed through consultations with all stakeholders. Mauritius has identified national priorities and articulated national targets (results) that all stakeholders will collectively contribute to according to the “Three Ones Principle” and the “Getting to Zero strategy”. Having taken cognizance of the main drivers of the HIV infection in Mauritius, the NSF focuses on the achievement of the following results:

1. Reduced HIV transmission
2. Reduced morbidity and mortality of PLHIV
3. Reduced stigma and discrimination related to HIV

Specific prevention interventions aiming at migrant workers, and mobile populations such as seafarers are integrated in the strategies related to key-affected populations.

3.2.2 Three Ones Principle:

- 3.2.2.1 One agreed HIV and AIDS Action Framework that forms the basis for coordinating the work of all partners
- 3.2.2.2 One national AIDS coordinating authority with a broad based multi-sector mandate
- 3.2.2.3 One agreed M&E framework for overall national monitoring and evaluation

3.2.3 Getting to Zero Strategy (UNAIDS 2011-2015)

- 3.2.3.1 Zero new infections
- 3.2.3.2 Zero AIDS-related deaths
- 3.2.3.3 Zero stigma and discrimination



Module 3:

Key points to note:

1. The low HIV prevalence in Mauritius but increasing gradually as from 2000;
2. The actual “concentrated” nature of the HIV epidemic in Mauritius;
3. The expected outcomes of the NSF 2013-2016 based on the UNAIDS Zero Strategy.

Module 4

Basic concepts on HIV and AIDS

Objectives:

This module will enable the participants to:

- i) understand the difference between HIV and AIDS;
- ii) understand the natural progression of HIV infection;
- iii) master the modes of transmission and non transmission of HIV;
- iv) explain the risk reduction strategies;
- v) have a good knowledge of voluntary counselling and testing;
- vi) have general notions on common sexually transmitted infections;
- vii) understand the stigma and discrimination related to HIV and AIDS;
- viii) discuss the holistic approach of treatment, care and support to PLHIV.
- ix) clear misconceptions and misunderstandings through the games.

Module 4: Basic concepts on HIV and AIDS

4.1 Definitions

HIV stands for Human Immunodeficiency Virus.

This virus is responsible for the condition known as AIDS. **When a person is infected, the virus enters the body and then replicates primarily in the white blood cells, namely the T CD4 positive cells, more specifically in the immune cells and destroys or impairs their function.** Infection with HIV results in the progressive deterioration of the immune system, leading to 'immune deficiency'. Our immune system is essential to protect us from developing infections and cancers.

Heat, water, detergents, soap or “Javel” can easily destroy HIV. Salivary enzymes and stomach acidity also damage HIV.

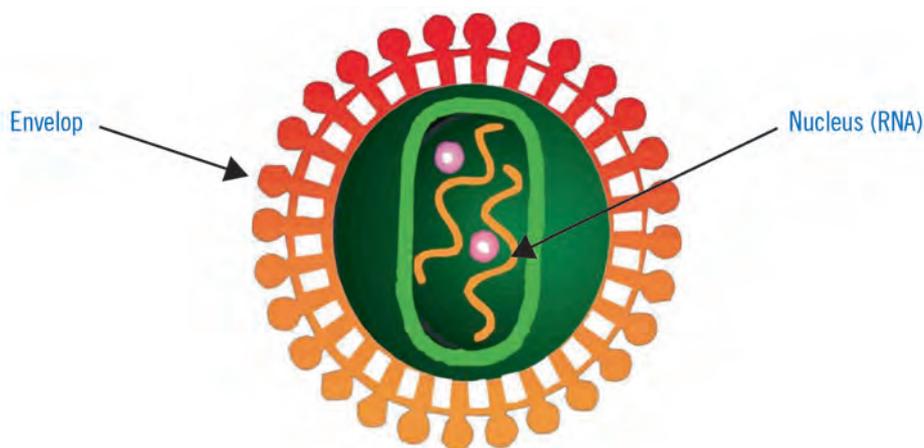


Fig 16: HIV Structure

There are two major types of HIV:

1. **HIV1** is most common in Sub-Saharan Africa and around the world. HIV1 is sub-divided into groups M, N O and P. The group M predominates in the pandemic and is divided into subtypes A – J.
2. **HIV2** is mostly found in West Central Africa, parts of India and Europe.

Both cause the same pattern of disease but HIV2 causes a slower progression disease than HIV1. HIV 2 viruses are less virulent and transmissible than HIV 1 M group.

AIDS stands for acquired immunodeficiency syndrome.

As HIV replicates in an infected person, it either damages or kills specific immune cells, weakening the immune system and leaving the person vulnerable to rare diseases known as opportunistic infections and illnesses. There are more than 20 opportunistic infections, which are signs of a declining immune system. Most of the opportunistic infections occur when the CD4 cell count is below 200 cell/mm³ of blood, that is during AIDS stage. Opportunistic conditions are considered as AIDS defining conditions (irrespective of CD4 cell count). Only when someone with HIV begins to experience one or more of these conditions or loses a significant amount of immune cells are they diagnosed with AIDS.

Module 4: Basic concepts on HIV and AIDS *Continued*

In some people, AIDS develops soon after infection with HIV. Some people rapidly progress to AIDS while other may take 8 to 10 years. A few remains without any signs or symptoms for a longer period. Early detection and treatment plays an important role in slowing the progression to AIDS and helps many people with HIV lead relatively normal lives.

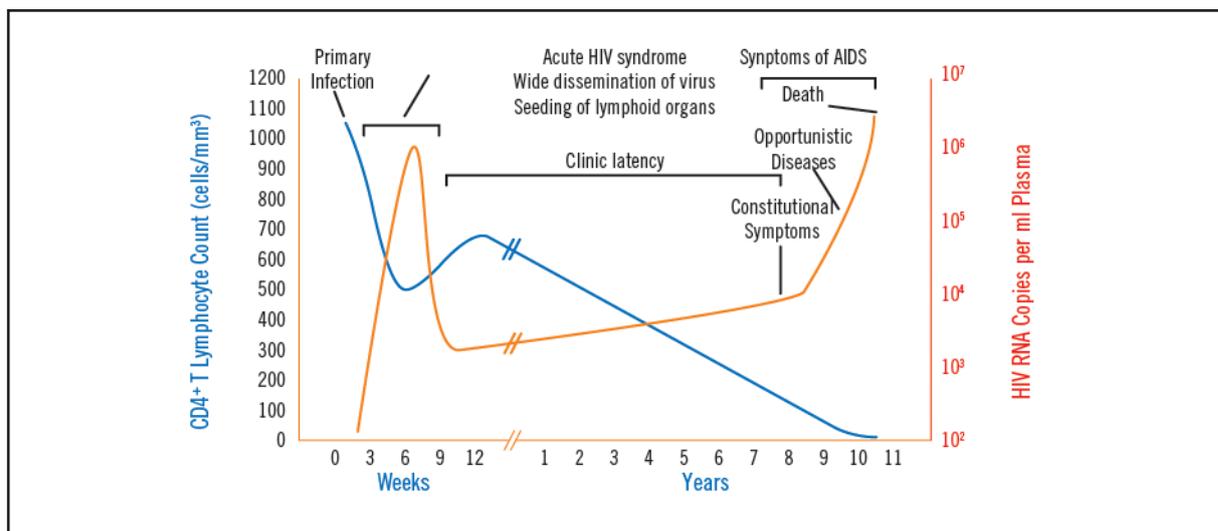


Fig 17: Natural progression of HIV infection

Source: WHO HIV/AIDS Classification System

HIV sero-status

Sero-status refers to the term 'seroconversion' which is defined as the production of antibodies in response to an antigen. Sero-status can be either seropositive or seronegative; meaning either an individual tests positive when the antibodies are found in its blood or negative when not found. Sero-status most often refers to HIV status and whether or not an individual is HIV+ or HIV-.

It is important for each and everyone to know his/her sero-status as an early effective treatment turns a formerly fatal infection into a chronic manageable disease and prevents to some extent its transmission.

Window period

HIV window period is a period of time after a person is infected during which they won't test positive for HIV. It can be from 9 days to 3-6 months, depending on the person's immune response and on the HIV-test that is used. During that time, a person can test HIV negative even though he is already HIV infected. One can still contract HIV from someone who is in the window period. The risk of HIV infection is high during the window period.

CD4 cells

CD4 cells are white blood cells- T helper cells which play an important role in the **human body's immune system**. During a contamination, they usually send the signal to other immune cells – killer cells - that will eliminate the intruder (virus, bacteria...). If CD4 cells become depleted, like in HIV infection, the body becomes vulnerable to

opportunistic diseases that it would otherwise have been able to fight against

The normal range of CD4 is 800 – 1200 cells/mm³. In Mauritius, PLHIV are put on HAART when CD4 count is below or equal to 350 cells/mm³ of blood. AIDS stage is reached when CD4 is below 200 cells/mm³ of blood. The efficacy of treatment is monitored through CD4 cell count and viral load.

Viral Load

Viral load is the measurement of the amount of active HIV in the blood of a PLHIV. The higher the value of the viral load, the more rapid the disease progresses to AIDS. HAART aims at reaching an undetectable level of active HIV. that is below 50 copies /ml of blood

Other Sexually Transmitted Infections (STI)

Sexually transmitted infections are mostly spread from one infected person to another through unprotected sexual intercourse. They are caused by more than 30 different sexually transmissible bacteria, viruses and parasites. The most common STI are **Syphilis, Gonorrhoea, Chlamydial infection, Trichomoniasis, Genital Herpes, Genital Warts and Hepatitis B infections**. The presence of untreated STI in a person can increase his/her risk up to 10 times of contracting or transmitting HIV.

The most common symptoms that must lead a person to seek medical advice are: genital ulcer, urethral or vaginal discharge, genital warts or pimples, lower abdominal pain. The majority of the common STI are treatable and in the absence of treatment, severe complications may be encountered. Timely treatment and partner notification are key to the prevention of the spread of STI. More details on STI can be found in the DVD attached to this manual.

Like HIV, syphilis, can also be transmitted from mother to child during pregnancy childbirth, and through blood products and tissue transplant. In pregnancy, untreated early syphilis is responsible for 1 in 4 stillbirths and 14% of neonatal deaths.

STI often exist without symptoms, particularly in women. But they can lead to chronic diseases, pregnancy complications, infertility, cervical cancer and death. Sexually transmitted infections are important causes of Fallopian tube damage that lead to infertility in women Post-infection damage of the Fallopian tubes is responsible for 30% to 40% of female infertility cases. **Between 10% and 40% of women with untreated chlamydial infections develop symptomatic pelvic inflammatory disease.**

One of the most deadly sexually transmitted infections is the human papilloma virus (HPV). **Virtually all cervical cancer cases are linked to genital infection with HPV.** The new vaccine that prevents the infection could reduce these cervical cancer-related deaths. It is recommended for girls and young women aged 9 to 26 years (US CDC).

The partner notification process, which is an integral part of STI care, informs sexual partners of patients about their exposure to infections so that they can undergo screening and treatment. Partner notification can prevent reinfection and reduce the wider spread of infections.

Early diagnosis and quality treatment of STI are crucial to prevent complications, which can have a severe impact of sexual and reproductive life more particularly of women.

4.2 Modes of transmission and non-transmission of HIV

HIV does not discriminate. It is not who you are but what you do that determines whether you are at risk of becoming infected with HIV.

4.2.1 HIV transmission

HIV can only be transmitted if a sufficient quantity of viruses enters the body of a person. This is the reason why it can be transmitted only through certain body fluids namely blood, sexual secretions - semen, vaginal, and breast milk. The virus can be transmitted only if these HIV-infected fluids enter the body of another person. This type of direct entry can occur (1) through the linings of the vagina, rectum, mouth, and the opening at the tip of the penis; (2) through intravenous injection with a syringe; or (3) through a break in the skin, such as a cut or sore.

Usually, HIV is transmitted through:

i) Unprotected sexual intercourse (either vaginal or anal) with someone who has HIV.

Anal penetration is particularly a higher risk especially for the receptive partner as the rectum has a thin lining and can tear easily during the act. Unprotected oral sex with someone who has HIV does carry a minimal risk of HIV contamination. A few cases of HIV transmission are attributed to oral sex in specific circumstances.

ii) Sharing needles, syringes, or injection equipment with someone who has HIV.

HIV can survive in used syringes for a month or more. That's the reason why it is recommended that people who inject drugs should never reuse or share syringes or drug preparation equipment. This includes needles or syringes used to inject both legal and illicit drugs as well as other types of needles, such as those used for body piercing and tattoos.

iii) Mother-to-child transmission during pregnancy, childbirth, or breast-feeding.

Any woman who is pregnant or considering pregnancy should be tested for HIV. Those who test positive can follow a treatment to prevent HIV transmission to the newborn. They are counselled either not to breast-feed or to exclusively breast-feed. Mixed milk feeding should be avoided.

4.2.2 Non transmission of HIV

Systematic screening the blood supply for HIV in Mauritius has virtually eliminated the risk of infection through blood transfusions. And because of strict medical universal precautions, one cannot get HIV from giving blood at a blood bank or other established blood collection centre. In Mauritius health settings, single usage disposable use syringes and needles are utilised for any injection making HIV transmission through this route impossible.

There have been no documented cases of HIV transmission through other body fluids such as sweat, tears, vomit, and urine. Mosquitoes, fleas, and other insects do not transmit HIV.

Scientists and medical authorities agree that HIV does not survive long outside the body. HIV is unable to reproduce outside its living host, unlike many bacteria or fungi, which may do so under suitable conditions. Therefore, it does not spread or maintain infectiousness outside its host. Up to now, no one has been identified as infected with HIV due to contact with an environmental surface.

4.3 Prevention: Risks reduction (sexual, MTCT, injecting drug use)

4.3.1 Safer sex

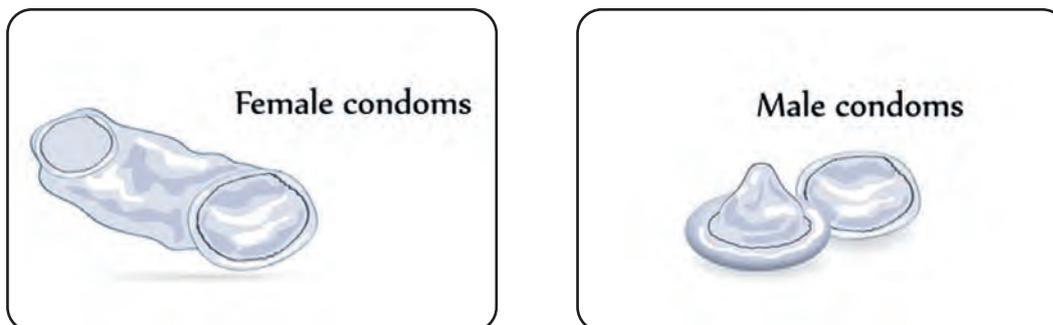


Fig 18: Female and Male Condoms

Apart from being abstinent or faithful to one partner, practising safer sex which include the following prevents HIV transmission:

- i) Limit the number of concurrent sexual partners
- ii) Proper and consistent use of condoms protects up to 99% from HIV infection. Use of only water-based lubricants as oil or petroleum-based lubricants damage latex condoms
- iii) A dental latex dam is recommended for oral sex
- iv) Limit the use of alcohol or drugs as these impair judgement

Practicing safer sex will also help a person to avoid other sexually transmitted infections (STI), which can increase his/her risk of acquiring and transmitting HIV. HIV-positive individuals who are infected with another STI are more likely to transmit the virus through unprotected sexual relationship. HIV-negative individuals who are infected with another STI are up to five times more likely to contract HIV through sexual contact with an HIV-positive person.

Microbicides are substances that can potentially kill HIV or other microorganisms in the vagina. However, at present, they are still under development and are yet to be shown to be effective against HIV or other STI. Microbicides are important to women because in instances where use of condoms is problematic, they may offer an effective alternative since they can be used with or without the consent or knowledge of their partner.

4.3.2 Harm Reduction related to Injection of Drugs

Injecting drug users (IDU) should not share syringes or other injection equipment with others.

In Mauritius, the Government is providing free access to:

- i) Methadone Substitution Therapy: IDU shift from injecting drugs to oral ones. Evidence shows a decrease in new infections among IDU
- ii) Needle Exchange Programme: IDU can get new sterile syringes and needles

Concerning tattoo, it should be practiced by a qualified personnel using disposable equipment or sterilised reusable one.

4.3.3 Prevention of Mother To Child HIV Transmission

It is imperative that all pregnant women have an HIV test done and if the test is positive, they should follow and adhere to a special treatment protocol that reduces the risk of HIV transmission to the baby. PMTCT is a sort of Post-Exposure Prophylaxis as the baby is exposed to the mother's HIV. The treatment to mother and baby aims at preventing transmission to the baby. Treatment (HAART) is initiated in early pregnancy to achieve an undetectable viral load, which will reduce risks of HIV transmission to the baby. Prophylactic ARV is provided for one month to the baby. In Mauritius, the above HAART is given to HIV positive pregnant women and artificial milk provided free of user cost for two years.

4.3.4 Post-Exposure Prophylaxis

Post-Exposure Prophylaxis (PEP) for HIV refers to a set of medical interventions aimed at preventing infection in a person who may have been exposed to the HIV infection.

It comprises first aid care, counselling and risk assessment, HIV testing following informed consent. Depending on the risk assessment, a short course (28 days) of antiretroviral drugs is given, with follow-up and support. Research studies suggest that, if the medication is initiated quickly after possible HIV exposure it prevents HIV infection.

As a rule, PEP should be started as soon as possible (within 2 hours) and no later than 72 hours. It should be for 28 days without interruption.

4.3.5 Male circumcision

Male circumcision has been proven to be a complementary mean of HIV prevention. In fact, three randomised controlled trials in 2005, 2006 (Kisumu, Kenya; Rakai, Uganda; South Africa Orange Farm) showed that male circumcision performed by well-trained medical professionals was safe and **reduced** the risk of acquiring HIV infection by approximately **60%**.

The efficacy of male circumcision in reducing female to male transmission of HIV has been proven beyond reasonable doubt. But male circumcision of a positive male partner does not reduce the risk of HIV transmission to the female partner.

It is worth noting that male circumcision does not provide complete protection against HIV infection. Circumcised men can still become infected with the virus and, if HIV-positive, can infect their sexual partners. Promoting and providing safe male circumcision does not replace other interventions to prevent heterosexual transmission of HIV but provides an additional strategy.

4.3.6 HIV Vaccine

Progress towards the development of an HIV vaccine is slow but it took 47 years to have a polio vaccine and 42 years for the measles one. The best vaccine developed so far was tested in a 2009 trial in Thailand, which prevented about 30% of infections. While those results were encouraging, the vaccine clearly wasn't effective enough for widespread use.

4.4 Voluntary Counselling and Testing

HIV testing must be voluntary and free from coercion. Patients must not be tested without their knowledge.

4.4.1 Some related definitions:

Screening: Performing an HIV test for all persons in a defined population.

Opt-out screening/ Provider initiated testing and counselling: Performing HIV screening after notifying the patient that 1) the test will be performed and 2) the patient may elect to decline or defer testing.

Diagnostic testing: Performing an HIV test for persons with clinical signs or symptoms consistent with HIV infection.

Targeted testing: Performing an HIV test for groups of persons at higher risk.

Informed consent: A process of communication between patient and provider through which an informed patient can choose whether to undergo HIV testing or decline to do so.

HIV counselling: An interactive process service provider/client of assessing risk, recognizing specific behaviours that increase the risk for acquiring or transmitting HIV, and developing a plan to take specific steps to reduce risks. It can be a one-to-one or group counselling.

4.4.2 Types of HIV tests

There are a number of tests that are used to find out whether a person is infected with HIV. Usually there are two types of HIV test – Conventional (ELISA – HIV anti body test) and rapid test which are the simplest ones. Other more specialised ones are (p24 antigen test and PCR test). Western blot is the confirmatory test performed in laboratory.

Once a person has been diagnosed HIV positive other tests are carried out to follow the progression of the infection (CD4 count and viral load).

Either a blood sample (taken from the arm or finger) or an oral fluid sample (ORA QUICK) will be taken, depending on the type of test used at the site. The test is always strictly confidential and only goes ahead if the person agrees to it. Depending on the test used, it can take anything from minutes (rapid test), to days and weeks, for the results.

An HIV antibody test looks for HIV fighting proteins called **antibodies** in blood, saliva or urine. If antibodies to HIV are detected, it means a person has been infected with HIV. There are only two exceptions to this rule:

1. Babies born to HIV infected mothers retain their mother's antibodies for up to 18 months, which means they may test positive on an HIV antibody test, even if they are actually HIV negative.
2. Some people who have taken part in HIV vaccine trials may have HIV antibodies even if they are not infected with the virus.

4.4.3 Justifications of HIV screening

HIV screening is justified for many reasons:

1. HIV infection is a serious health disorder that can be diagnosed before symptoms develop;
2. HIV can be detected by reliable, inexpensive, and non invasive screening tests;
3. Infected patients have years of life to gain if treatment is initiated early, before symptoms develop;
4. ART reduces the risks of HIV transmission by an infected person compliant with his/her treatment; and
5. Maternal transmission of HIV to the baby can be prevented

4.5 Stigma and discrimination

Worldwide, fighting stigma and discrimination related to HIV infection is a challenge. HIV-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS.

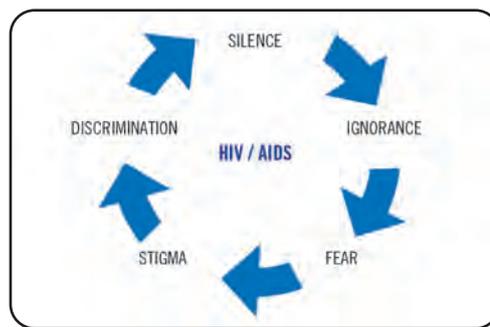


Fig 19: *Stigma and Discrimination Cycle*

Fear of contagion coupled with negative, value-based assumptions about people who are infected leads to high levels of stigma surrounding HIV and AIDS. HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatised in many societies. Moreover, PLHIV also have a tendency to self stigmatise.

Stigma may vary depending on the dominant transmission routes in the country or region. In Sub-Saharan Africa, for example, heterosexual sex is the main route of infection, which means that HIV-related stigma in this region is mainly focused on promiscuity and sex work. In Western countries where injecting drug use and sex between men have been the most common sources of infection, it is these behaviours that are highly stigmatised.

The consequences of stigma and discrimination are manifold for the PLHIV:

- They are shunned by family, peers and the wider community;
- They get poor treatment in healthcare and education settings;
- Their rights are eroded;
- They suffer psychological damage.

And the end-result is that stigma has a negative effect on the success of HIV testing and treatment, and hence on the global prevention programme. Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly. PLHIV may be turned away from healthcare services and employment, or refused entry to a foreign country. In some cases, they may be forced to quit home by their families and rejected by their friends and colleagues. The stigma attached to HIV and AIDS can extend to the next generation, placing an emotional burden on those left behind.

Denial goes hand in hand with discrimination, with many people continuing to deny that HIV exists in their communities. Today, HIV and AIDS threaten the welfare and wellbeing of people throughout the world. At the end of the 2011, 34 million people were living with HIV and 1.7 million had died from an AIDS-related illness that year. Combating stigma and discrimination against people who are affected by HIV and AIDS is vital to preventing and controlling the global epidemic.

UN Secretary-General Ban Ki Moon states: “Stigma remains the single most important barrier to public action... Stigma is the chief reason why the AIDS epidemic continues to devastate societies around the world.” (The Washington Times, August 2008).

HIV-related stigma is not static. It changes over time as infection levels, knowledge of the disease and treatment availability vary.

Stigma and discrimination will continue to exist so long as societies as a whole have a poor understanding of HIV and AIDS as well as the pain and suffering caused by negative attitudes and discriminatory practices. Stigma and discrimination can be overcome through a social change of attitudes. This can only be reached by continuous information and education at community and national levels. But a certain amount can be achieved through the legal process. In some countries people living with HIV lack knowledge of their rights in society. In this case, education is needed so they are able to challenge the discrimination, stigma and denial that they encounter. Institutional mechanisms can enforce the rights of people with HIV and provide powerful means of mitigating the worst effects of discrimination and stigma. Enlightened laws and sound policies are key elements to fight stigma and discrimination.

A more enabling environment needs to be created to increase the visibility of PLHIV as a 'normal' part of any society. Availability of quality treatment can make this task easier as it offers PLHIV the opportunity to live a fulfilling and long life with HIV. People are more willing to be tested for HIV, to disclose their status, and to seek care if necessary.

In total, the task is to confront the fear-based messages and biased social attitudes, in order to reduce the discrimination and stigma of PLHIV.

4.6 Treatment, care and support

In the early 1980s when the AIDS epidemic began, people living with HIV were not likely to live more than a few years. However, with the development of safe and highly active drugs, PLHIV now live longer and healthier.

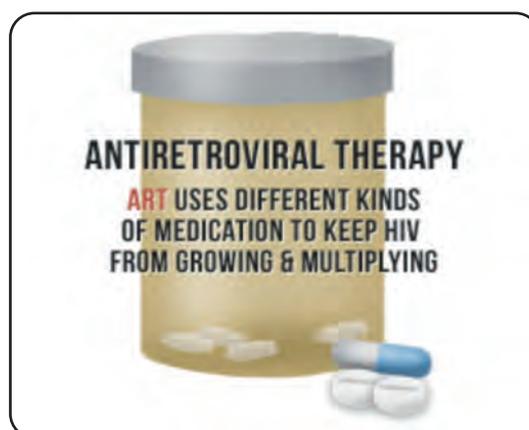


Fig 20: Antiretroviral Therapy

Source: AIDS.gov (Overview of HIV treatment)

Currently available drugs do not cure HIV infection but they do prevent its progression and hence complications leading to death. They can stop the virus replicating in the body and the damage done to the immune system, but they cannot eliminate HIV from the body. Once initiated, PLHIV need to take antiretroviral drugs lifelong.

WHO recommendations for HIV treatment state that three different ARV drugs need to be taken at all times. The reason is that HIV is a very clever virus that quickly adapts to whatever ARV drugs are being taken as it changes itself through mutations and can develop resistance to these ARVs. However, taking at least 3 ARVs at the same time makes it harder for the virus to adapt and become resistant. The combination of three drugs also targets the different steps the virus undergoes when replicating. Taking the ARVs everyday at the right time and in the right way keeps the right levels (dosage) of the medications in the body. Thus the virus is less likely to develop resistance to these ARVs. But missing the medication can give the HIV a chance to become resistant to the ARV medicine. If wrongly taken through missing or not respecting the time and dosage, resistance can be developed.

ARV drugs can produce side effects such as nausea and vomiting and headache. Usually most side effects are not serious and improve once the patient gets adapted to these drugs. However as with all drugs, sometimes unpleasant or dangerous side effects can appear. Long term side effects of ARV drugs such as changes in body shape and redistribution of body fats are caused by certain specific ARVs. This can be upsetting for the patient. Usually changing the ARV medication will lead to improvement in the patients well being.

There is no cure for HIV. However, with good and continued adherence to treatment, the progression of HIV in the body can be slowed down and almost halted. Increasingly, people living with HIV are kept well healthy and productive for long periods, even in low-income countries.

Treatment has improved survival rates and quality of life of PLHIV dramatically, especially since the introduction of highly active antiretroviral therapy (HAART) in 1996. With HAART, HIV infection has been transformed into a chronic and manageable disease for a well-treated PLHIV and drastically minimising risks of transmission. However, more efforts should be directed towards effecting earlier diagnosis to benefit fully from HAART.

Despite this remarkable improvement in HIV medical treatment, a positive HIV test result often leads the one concerned to overwhelming emotions ranging from anger to denial and despair. It is thus important that PLHIV receive appropriate care and support services to improve their quality of life. Care and support begin once a person's HIV infection has been diagnosed and extends throughout life.

Treatment and care should provide a comprehensive range of services using a multi-disciplinary approach. This includes prevention of transmission, addressing medical, psychosocial, nutritional, human rights and legal needs of PLHIV with protection against discrimination and violence. Efforts also should be directed towards facilitating PLHIV access and adherence to treatment services in view of reducing HIV-related morbidity and mortality and new HIV infections.

Steady advances are being made in the research of new ARV drugs that offer new mechanisms of action, improvement in potency, activity and, safety, dosage convenience and increased tolerability. Vaccine candidates are being tested on volunteers but up to now not a single vaccine tried has been discovered to give a positive protective response.

Since there is actually no cure to HIV infection, prevention remains far better than the cure to come. **“Test (early) and treat”** strategy is also part of prevention.

Activity 3: True/False Game - See Annex 1

Activity 4: Risk Perception Game - See Annex 2

Module 4:

Key points to note:

1. The correct definitions of common terms used in HIV prevention and follow-up of PLHIV;
2. The modes of transmission and non-transmission of HIV;
3. The documented means of prevention and research in that field;
4. HIV testing: its confidentiality, types of tests, its importance for early diagnosis and treatment;
5. Ignorance and fear fuel stigma and discrimination, which are obstacles to proper prevention and care;
6. HIV infection has become a chronic disease with highly active Antiretroviral treatment: PLHIV can live longer and healthier

«Migration and Health»

FOR MIGRATION HEALTH ADVOCATES IN THE REPUBLIC OF MAURITIUS

A Focus
on Sexual and
Reproductive
Health
including the prevention of
HIV/AIDS/STI

Module 5

Migration and HIV and AIDS

Objectives:

This module will enable the participants to:

- i) reinforce their understanding on the linkages between migration and HIV and AIDS;
- ii) discuss gender issues related to Migration, HIV and AIDS;
- iii) reinforce their skills in promoting risk-reduction behaviours.

5.1 Migration and HIV and AIDS

HIV infection remains one of the world's most significant public health challenges, particularly in low- and middle-income countries. The relationship between migration and HIV and AIDS is complex as up to now, it is not very clear just how and to what extent migration affects the spread of HIV. A proper understanding of the economic, behavioural, sexual and gender factors associated with migration is key to understand the vulnerability of migrants and mobile populations to HIV infection.

Evidence seems to suggest that they and their families as well as communities with whom they interact on a daily basis are particularly at risk.

5.1.1. Spaces of vulnerability to HIV

The places where migrants live, work or transit can be high-risk “spaces of HIV vulnerability”. Migrant and mobile populations are bound to interact with local communities at such places as land border posts, ports, construction sites and the surroundings where they live. Poverty and lack of job opportunities in the communities surrounding such places or looking for more money also induces many individuals (both migrants and locals) to engage in transactional and commercial sex with those who have resources or disposable incomes. Evidence from the regional survey among seafarers shows the interaction between the seafarers and sex workers in the ports and also in nightclubs. In Mauritius, media information also reports transactional sex by female migrant workers in the surroundings of entertainment places such as casinos, nightclubs and hotel/restaurants.

To understand the spaces of HIV vulnerability, it is important to understand the ways in which migrants and mobile populations interact with local communities, in an environment conducive to multiple concurrent partnerships or higher-risk sex.

Migrants are less restricted by home and community norms, which can create a sudden feeling of anonymity and freedom, which may lead to high-risk sexual behaviour. The sexual networks link migrant workers, their partners at home, along their journey and at their destination. These relationships stretch across regions, often connecting low prevalence and high prevalence countries, different levels of sexual and HIV education, and one space of vulnerability to another.

Migrants are globally seen as HIV carriers. However, evidence usually suggests the opposite, implying that migrants are more vulnerable than local populations. Migration is not in itself a risk factor to HIV. But the unsafe conditions under which people migrate, live and work tend to make migrants vulnerable or put them at risk. Another reason is that sensitisation of mobile or migrant workers on HIV and AIDS is scarce - generally, limited information is provided to migrant workers through all migration cycle from community level to destination country. Moreover, the number of trainers well informed about both issue HIV and AIDS and migration at the same time is limited.

Workers who are engaged in circular migration for longer periods away from home with relatively high salaries have a higher HIV infection risk. For example, seafarers are a group of mobile workers known to exhibit risky sexual behaviour.

They tend to be younger males who leave their families for extended periods of time, have relatively well paid employment visiting distant locations and are more likely to turn to commercial sex workers. A regional study (“Étude socio-comportementale au VIH/sida parmi les marins dans les pays membres de la Commission de l’Océan Indien, COI) among this group (Comoros, Madagascar, Mauritius, Seychelles, 2008) under the aegis of the IOC showed an HIV prevalence of 6.9% in the Mauritian arm of the study, though other risk factors such as injecting drugs prevail in the studied group. Sex workers are also identified as at-risk communities, many of whom are known to migrate domestically or regionally within the countries of the IOC in search of opportunities. Sex workers are often some of the most marginalised members of society, thus heightening their vulnerability to HIV.

HIV vulnerability is indirectly linked to poverty or hardship. Persons providing sexual services to the mobile populations are often driven by poverty and lack of opportunity. Unprotected sex is sometimes associated with commercial sex and may become a key source of HIV and STI transmission.

Apart from the regional study conducted by IOC among seafarers in 2008, specific data are lacking on the sexual behaviour and risk factors of migrant groups in the sub-region. In Mauritius, some press articles mentioned about the sex work of female migrant workers. Given this, more research is needed to determine levels of risk and factors that drive decision-making of mobility and sexual behaviour in this region.

Separated from families, communities and social support systems, migrants and mobile populations are more likely to be exploited and victimised, or engage in risk behaviour that can result in HIV infection. Gender norms favouring multiple sexual partners are often found among migrant men, exacerbating HIV vulnerability. Unsafe migration can be caused by lack of protection afforded to migrant workers during the course of the migratory cycle. Consequently, migrant workers are often subjected to multiple violations that occur in the context of the recruitment procedures, precarious employment abroad as well as upon return to their countries of origin. Exploitation, discrimination and abuse, denial of healthcare combined with low awareness of HIV and AIDS among migrant workers put them under increased risk of becoming infected.

Women are increasingly migrating independently to work more often as informal traders or domestic workers rather than as spousal or family dependents. These low-skill labour opportunities subject women to poor working conditions, including abuse or harassment from supervisors or employers. Some have been forced to engage in transactional sex in exchange for better conditions of work and accommodation.

5.1.2 Migration, Gender and HIV and AIDS

Gender refers to the socially constructed roles and responsibilities, behaviours, activities, and attributes that a given society considers appropriate for men and women. The distinct roles and behaviours of men and women in a given culture, dictated by that culture's gender norms and values, give rise to gender **differences** which do not necessarily imply inequity. Gender norms and values also give rise to gender **inequalities**, which are differences between men and women that systematically empower one group to the detriment of the other.

Both gender differences and gender inequalities **can give rise to inequities between men and women in health status and access to health care**. For example:

- A woman cannot receive needed health care because norms in her community prevent her from travelling alone to a clinic;
- A teenage boy dies in an accident because of trying to live up to his peers' expectations that young men should be "bold" risk-takers;
- A married woman contracts HIV because societal standards encourage her husband's promiscuity while simultaneously preventing her from insisting on safer sex.

Historically migrants or mobile populations have mostly been men in search of better livelihood opportunities while their wives are left behind. Very often, they experience poor conditions of work and accommodation, discrimination and marginalisation on the part of the host community. **Coupled with boredom and loneliness, these working conditions and discriminating environment can lead to dangerous "masculinity" behaviours such as multiple concurrent sex partners, excessive alcohol or even illicit drugs.** In fact, women are migrating more frequently and are also faced with these harsh conditions that can force them to exchange sex for better pay or accommodation. Both men and women migrants are potentially at risk of contracting HIV infection or any other sexually transmitted infection.

In general, **women bear a higher burden of the HIV pandemic.** Women are estimated to represent 50% of PLHIV worldwide and 69% in Sub-Saharan Africa. Estimates also show a higher prevalence rate for young women aged 15-24 years as compared to young men of the same age group. Women and especially girls are particularly vulnerable due to biological, social and economic reasons. They are on the forefront to shoulder the burden of providing care to their sick relatives and of replacing the breadwinner in case this one is sick.

With all other risk factors controlled, it is easier for a woman to contract HIV when having sex with a man than vice versa. The reason is that a woman has a larger surface of the genital organ exposed to a larger quantity of infectious fluid during sexual intercourse than a man. Forced sex increases the risk as a result of tears or abrasions of her genitals. The presence of STI very often unnoticed by a woman also increases the risk of contracting HIV.

In certain countries, where patriarchal norms prevail, early marriages of young girls to older men are common. This can be a source of increased risk to having HIV or other STI especially if the man had previously more unprotected sexual exposure. Likewise, for many women, being married means a high risk of HIV infection. Social norms permitting men to have premarital and extramarital sexual relationships and forbidding women to negotiate safer sex with their intimate partners put women at risk. For these women "be faithful" is unfortunately no protection.

Low level of education and being economically dependent on husbands are also factors of HIV infection as they impede access to information and healthcare. Limited income-earning opportunities due to low level of education and often abandoned by their husband, many women are forced into commercial sex. In Mauritius, the literacy rate in 2011 among males and females aged 12 years and above is respectively 92.3% and 87.3%.

Pregnancy and childbearing raise specific issues for women HIV positive. In most developing countries, a high risk of infant death is associated with maternal HIV infection. Certain cultural norms prevent women to go alone for antenatal or postnatal care, which is essential particularly in the case of HIV positive women.

As noted in Module 3, breastfeeding may transmit HIV to a baby born to a HIV positive mother. But it is a fact that breastmilk contains the mother's antibodies, which protects the baby from deadly diseases such as gastroenteritis. It is thus advisable for HIV mothers to exclusively breastfeed their baby rather than using mixed feeding. In Mauritius,

free artificial milk is provided for two years to HIV positive mothers. In some communities, women may be seen as HIV positive by the fact that they are not breastfeeding their baby.

Stigma associated with HIV infection is a barrier to men and women accessing health services. Women are even more affected by the stigma and discrimination. Notwithstanding many monogamous housewives are HIV positive, it is widely believed that HIV infection is linked with sexual promiscuity or drug abuse. Moreover, while men can decide independently to go for an HIV testing, many women need to discuss with their partners before. The use of condoms is gender-related. In general, men are the ones who would decide when to use or not to use male condoms. Female condoms that can partially give an answer to women's independence on the use of condoms are unfortunately too expensive for many women to be able to use them. Notwithstanding free of access to health services as in Mauritius, many HIV patients are seen in hospitals only in the final stage of AIDS because of the stigma.

5.1.2.1 Gender-based Violence

Gender-based violence (GBV) is defined as: Any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life (Source: UN Declaration on the Elimination of Violence against Women, 1993). It reflects gender inequities between men and women. It is more frequent than one would think. Around the world, one in three women has been beaten, coerced into sex, or abused in some way or another. GBV compromises far and foremost the dignity and health of its victims. It can take any form of human rights violations from domestic violence, sexual assault and harassment, sexual abuse of children, rape, trafficking of women and girls to harmful traditional practices such as female genitals mutilation. Such abuses leave definitely deep psychological scars and irreversible damage to the reproductive and sexual health of the victims and may even lead to death or suicide.

GBV is an important driving factor of HIV transmission. Poor respect of the human rights of women and girls are key factors in the HIV pandemic. Some women cannot even negotiate safer sex with their intimate partner as this may end up in a violent response. The fear of violence prevents many women from accessing HIV information, and from getting tested and seeking treatment, even when they strongly suspect they have been infected. Forced sex or rape may lead to HIV contamination as the resulting wounds to the female genitals increase the risk of transmission. GBV may both be the cause and consequence of HIV infection. The disclosure of one's HIV status can have many serious consequences particularly for a woman, which may lead to rejection by husband, parents, friends and community, denial of human rights such as rights to employment, health... This has been the case of a Mauritian woman living with HIV who having disclosed her status on the World AIDS Day was thrown out of her home by her parents and from the village by the community.

Labour migration exposes both men and women to HIV risk as long periods away from spouses or partners may lead to extended sexual networks. Living in precarious conditions, they are prey to drug dealers, sexual aggression or may be forced into sex work. But as gender inequalities and discrimination are exacerbated in the workplace because people take their gender identities to work, women are more at risk. They are often victims of sexual harassment and abuse at the workplace. For example, domestic workers, mostly women, are frequently at risk from sexual coercion from employers or other household members, and isolated from support and information networks. In this context, the ILO Code of Practice on HIV and AIDS and the World of Work (2001) includes the principle of gender equality, stressing that successful prevention and impact mitigation will depend on "more equal gender relations and the empowerment of women".



Ending gender-based violence will mean changing cultural concepts about masculinity, and that process must actively engage men, whether they are policy makers, parents, spouses or young boys. In other words, girls, women as well as boys and men should unite their actions to end violence against women and girls.

Activity 4: Wild Fire Game

Module 5:

Key points to note:

1. Migrants are not HIV carriers but are vulnerable due to their conditions of living and working;
2. Migrants interact with communities at high-risk “spaces of vulnerability” (places where they transit, live and work);
3. Gender inequality (low level of education, economically dependent...) coupled with their biological weakness leads to an enhanced vulnerability of women;
4. Sexual networks involve many people both in the country of origin and host country;
5. Gender-based violence as an important driving factor of HIV

Evaluation: Participants will be given a short topic on which each one will make a brief presentation in front of the facilitators and peers.

TRUE/FALSE GAME

Objective: To get Migration Health Advocates to discuss on misconceptions pertaining to HIV infection

Instructions

1. Present the pack of cards to each participant and ask each one to pick up a card on which is written a statement on issues pertaining to HIV infection
2. Ask each participant to read the statement for the audience
3. Ask him/her to say according to him/her whether the statement is true or false
4. Ask the participant to justify his/her choice
5. Ask the others their comments, if any
6. The facilitator will each time give his/her views



**AIDS can be cured
if proper treatment is taken regularly**

HIV infection is easily contracted

**HIV can be passed
through infected blood**

**Living in an island surrounded
by sea protects you from being
infected with HIV**

**AIDS is a disease known as Acquired
Immunodeficiency Syndrome**

HIV is the virus that causes AIDS

**Anyone, anywhere can be infected
with HIV**

Kissing spreads HIV



A seropositive mother can transmit HIV to her baby

Shaking hands with a PLHIV can infect you

HIV is mainly sexually transmitted

Sharing needles for injecting drugs spreads HIV

Swimming in a pool can infect a person with HIV

Viruses can cause disease in humans

Mosquitoes transmit HIV for sure

AIDS is caused by a virus that weakens the immune system

You can be infected and yet do not know

AIDS patients get rare diseases that healthy people do not get

PLHIV can transmit HIV by coughing on someone

Many doctors and nurses are infected with HIV at work



Paper seat covers must be used in public toilets to prevent the spread of HIV

Drinking in the same glass as a PLHIV can infect you with HIV

You must wear disposable gloves to shake hands with a PLHIV

HIV is very hard to kill outside the human body

Sitting beside a PLHIV in the bus can infect you with HIV

You have AIDS when you are infected with HIV

You can tell that someone is living with HIV just by looking at him/her

A person in the window period cannot infect other persons

Migrants are usually HIV carriers

Migrants are usually more at risk of contracting HIV

An HIV woman should not bear a child

It is ok if the woman I am in relationship with does not want to have sex



It is ok for a man to pressure his partner when she does not want to have sex

Women who wear short skirts are to blame if they get raped

If I do a favour to a woman, then I am entitled to have sex with her

Only women can be raped

A woman cannot be raped by her husband

It is mostly strangers who rape women or girls

Sex is more enjoyable when the partner also wants to have it

TRUE

DON'T KNOW

FALSE

GAME GUIDE

1. HIV infection can be cured if proper treatment is taken regularly.

ANSWER: This is a FALSE statement. There are currently methods of treatment for PLHIV to live longer and healthier, but there is NO cure.

2. HIV infection is easily contracted.

ANSWER: This is a FALSE statement. HIV is found primarily in the blood, semen or vaginal fluid of an infected person. Sharing of these fluids is the only known way to get HIV and potentially develop AIDS.

3. HIV can be passed through infected blood.

ANSWER: This statement is TRUE. HIV can be passed through blood-to-blood contact.

4. If you live in a small island surrounded by the sea, you really do not have to worry about being infected with HIV.

ANSWER: This is a FALSE statement. HIV infected individuals can be found all over the world. Behaviours determine your risk factor; not where you live.

5. AIDS is the disease known as acquired immunodeficiency syndrome.

ANSWER: This is a TRUE statement.

6. HIV is the virus that causes AIDS.

ANSWER: This is a TRUE statement.

7. Anyone, anywhere, can be infected with HIV if they come into contact with the virus.

ANSWER: This is a TRUE statement. Coming into contact with the virus is the only known way to become infected.

8. Kissing spreads HIV.

ANSWER: This is a false statement. Casual kissing does not spread HIV.

9. An infected mother can pass HIV to her unborn baby.

ANSWER: This is a TRUE statement. HIV is known to pass from an infected mother to her unborn child. However, if an HIV positive mother is in treatment, the risk of transmitting HIV to an unborn baby is almost zero.



10. You cannot get infected with HIV by shaking hands with an infected person.

ANSWER: This statement is TRUE. You do not get HIV infection from casual contact.

11. HIV is mainly sexually transmitted.

ANSWER: This is a TRUE statement. The majority of HIV infections in the world are the result of unprotected sex.

12. Sharing contaminated needles with someone infected with HIV can spread HIV.

ANSWER: This is a TRUE statement. Sharing needles and syringes with someone infected with HIV is a known method of transmission.

13. Some viruses cause disease in humans.

ANSWER: This is a TRUE statement. HIV is just one of many viruses known to cause disease in humans; Viruses can cause disease in many living things, including plants and animals.

14. A person can be infected with HIV while swimming in a pool because the virus could still be in the water.

ANSWER: This statement is FALSE. HIV is a fragile virus that does not live outside the human body for long.

15. Mosquitoes can transmit HIV.

ANSWER: This statement is FALSE. There is no evidence that HIV can be transmitted by a mosquito bite.

16. AIDS is caused by a virus that weakens the immune system.

ANSWER: This is a TRUE statement. HIV attacks specific cells of the immune system, weakening it to the point that it can no longer fight off disease.

17. You can be infected with HIV and not know you are infected.

ANSWER: This is a TRUE statement. Individuals infected with HIV frequently have no symptoms for months, even years after infection.

18. AIDS patients often get rare diseases that healthy people do not get.

ANSWER: This is a TRUE statement. The weakened immune system can no longer fight off diseases that healthy people can easily handle.

19. If an AIDS patient coughs on you, you could get infected with HIV.

ANSWER: This statement is FALSE. HIV is not transmitted through droplets.

20. Many doctors and nurses have been infected with the AIDS virus at work.

ANSWER: This statement is FALSE. Although it is true that some health care professionals have been infected, it is rare. They understand the modes of transmission and protect themselves and their patients against any transfer of the virus.

21. Public toilets have paper seat covers used to prevent the spread of HIV.

ANSWER: This statement is FALSE. Toilet seats do not transmit HIV.

22. You cannot get infected with HIV by drinking water in the same glass as a PLHIV

ANSWER: This statement is TRUE. HIV is not transmitted from drinking after an infected person.

23. You can safely shake hands with an AIDS patient only if you wear disposable gloves.

ANSWER: This statement is FALSE. HIV is not transmitted through casual contact, so the gloves are not needed.

24. HIV is very hard to kill when it is outside the body.

ANSWER: This statement is FALSE. HIV is very fragile outside the human body.

25. You might get infected with HIV if you sit next to an infected person in the bus.

ANSWER: This is a FALSE statement. HIV is not passed through casual contact.

26. If you are infected with HIV, you have AIDS.

ANSWER: This statement is FALSE. It takes years to develop the symptoms of AIDS. Infection does not imply manifestation of the disease.

27. You can tell that someone is living with HIV just by looking at him/her

ANSWER: False statement as only a blood test result can tell whether one is infected or not

28. A person in the window period cannot infect other persons

ANSWER: False statement. The person's blood test may be negative but still is infectious.

29. Migrants are HIV carriers

ANSWER: False statement. It is not who you are but what you do that determines whether you can be infected with HIV or not.



30. Migrants are more at risk of contracting HIV

ANSWER: It can be a true statement taken into consideration that their vulnerability result from their loneliness, boredom and conditions of employment and lodging as well as the stigmatising and discriminating environment of the host community.

31. An HIV positive woman should not bear a child

ANSWER: False. Childbearing is the human right of all women. HIV positive pregnant women can be treated to prevent MTCT.

RISK PERCEPTION GAME

Objective: To get Migration Health Advocates to ponder over situations that may be risky to HIV transmission

Instructions

1. Present the pack of cards to each participant and ask each one to pick up a card on which is written a statement describing a particular situation
2. Ask each participant to read the statement for the audience
3. Ask him/her to state, according to him/her, the level of risk of the situation described on the card
4. Ask the participant to justify his/her choice
5. Ask the others their comments, if any
6. The facilitator will each time give his/her views



Giving a hug to a PLHIV

Sexual relation without condom with a stranger

A circumcised man having sexual relation with a HIV positive woman

Sexual relation with a person having a STI

A woman having sexual relation with a circumcised HIV positive man

Shaking hands with a PLHIV

Drinking in the same glass as a PLHIV

Sleeping beside a PLHIV



Sharing used needles

HIV positive mother breastfeeding her baby

Using public toilets

Swimming in public pools

Kissing

A member of the family who is HIV positive cuts himself

Sharing toothbrush

Insects' bite

Masturbation

Tattooing

Being transfused with blood

Donating blood



Sexual relation with your wife or husband

Anal sex without condom

Oral sex

Multiple concurrent sex partners

I use condom consistently

I do not know my status and I do not use condoms

Having unprotected sex with CSW

Unprotected sexual relation with an HIV positive person on ARV treatment

Woman having unprotected sex relations with her husband IDU

Needle prick

Working with a migrant worker in the same room

No Risk



Low Risk

Medium Risk

High Risk

Don't Know

GAME GUIDE

Statement	Risk	Remarks
1 Giving a hug to a PLHIV	No risk	No infectious body fluid enters your body through hugs
2 Sex without condom with a stranger	High risk	You don't know his/her status and you are not protected
3 A circumcised man having sexual relation with an HIV positive woman	Medium to high risk	Male circumcision does not provide complete protection against HIV infection (only 55% – 60%)
4 Woman having sexual relation with a circumcised HIV positive man	High risk	Male circumcision does not protect women from being infected and protects only partially men
5 Sexual relation with a person with a STI	High risk	The presence of a STI increases the transmissibility of HIV
6 Shaking hands with a PLHIV	No risk	A normal skin a perfect barrier to microorganisms. There is no transfer of infectious body fluid.
7 Drinking in the same glass as a PLHIV	No risk	Saliva contains too little HIV to effectively transmit it.
8 Sleeping beside a PLHIV	No risk	No transfer of infectious body fluid
9 Sharing used needles	High risk	HIV may survive for several days in syringes after HIV-infected blood has been drawn up into the syringe and then flushed out.
10 HIV positive mother breastfeeding her baby	Medium risk	HIV can be transmitted through breast milk. The risk is increased if there are cracks or inflammation in the nipple or the baby has mouth inflammation/infection.
11 Using public toilets	No risk	No transfer of infectious body fluid
12 Swimming in public pools	No risk	No transfer of body fluid. HIV cannot survive in the chlorinated pool water.
13 Kissing	No risk	Saliva enzymes kill HIV
14 A member of the family who is HIV positive cuts himself	No risk	IF universal precautions are observed when you have to deal with the cut.
15 Sharing toothbrush	No risk	Toothbrush is normally not shared but if it is, then it is well cleaned before use. HIV will not survive
16 Insects' bite	No risk	HIV does not survive in insects.
17 Masturbation	No risk	No transfer of infectious body fluid
18 Tattooing	No risk	Provided the needles used are disposables or properly sterilised
19 Receiving a blood transfusion	No risk	In Mauritius, all blood donors and donations are screened for HIV, syphilis and hepatitis B & C.
20 Donating blood	No risk	All universal precautions are taken to prevent the donor from being contaminated
21 Sexual relation with your wife/husband	No risk High risk	No risk if both partners have been tested and are faithful. High risk if not.
22 Anal sex without condom	High risk	The anal mucous membrane allows HIV to penetrate easily in the bloodstream. Anal tears facilitate contamination.

Statement	Risk	Remarks
23 Oral sex	Medium risk	The risk is increased with the presence of mouth lesions or ulcers.
24 Multiple concurrent sex partners	High risk	Risk of having sex with someone HIV positive is multiplied
25 I use condom consistently	No risk	Condoms when used properly and consistently do protect against HIV infection.
26 I do not know my status and I do not use condoms	High risk	Knowing one's status can prevent to infect others (wife or husband). Not using condom puts yourself and others at risk.
27 Unprotected sex with CSW	High risk	CSW have multiple clients who do or do not use condoms. CSW may have several STI without her being aware.
28 Unprotected sex with an HIV positive person on ARV treatment	Medium risk	PLHIV on ARV treatment with undetectable viral load are much less contaminant.
29 Woman having unprotected sex with her husband IDU	High risk	The risk of IDU getting infected with HIV is high especially when they share needles with their peers.
30 Needle prick	Low to medium risk	See N° 9 remarks. The risk of infection in the absence of an early treatment is 0.3%. PEP decreases the risk.
31 Working with a migrant worker in the same room	No risk	Being a migrant worker does not necessarily means he/she is HIV positive. Where is the risk if you do not come in contact with his body fluids that transmit HIV?

WILDFIRE GAME

Objective:

To enable participants to :

1. understand how quickly HIV can spread among social networks ;
2. experience various feelings and emotions related to testing and PLHIV.

Materials:

Pieces of paper on which is written positive result or negative result
One envelop to hold each piece of paper

Procedure:

- Ask participants to form a large circle.
- Explain that participants will play a game on how HIV is transmitted. The sex act will be symbolised by shaking hands with someone.
- Tell participants to close their eyes. Explain that trainer will go round the circle behind the participants and will tap the shoulder of 1 person (2 if group is large) in the group. The action of tapping someone symbolises transmission of HIV. The trainer asks if anyone can guess who was tapped by looking at the face of that person.
- Tell participants that whoever was tapped is HIV +. Whenever he/she shakes someone's hand (sexual act), he/she will scratch the palm of that person from now on. If your palm is scratched by someone, you must scratch the palm of everyone you shake hands with after that. Clarify directions if necessary.
- Tell participants to shake hands with at least three persons. Begin the game and allow 2 minutes for the game to continue.
- Re-assemble the participants and ask them, "How many of you had your palms scratched? " Ask those who were scratched to stand on the left side of the room; those not scratched on the right side of the room. Ask the not scratched how they feel about their status and how they feel about the others. Then ask the scratched group the same question
- Ask participants to guess who was originally tapped by the facilitator. Now tell them that there was only 1 (2 if large group) person who was initially "scratched" but within a short time a large number of people had their palms scratched. You may disclose who was initially tapped. Include in the discussion that you cannot tell by looking at a person if someone is positive or negative. Only a HIV test can tell you the status of a person.

- Ask the scratched group:
 - Do you want to get an HIV test? Why?
 - Do you want to see a counselor? Why?
 - Who does not want to be tested? Why?

- Now have each person in the scratched group, take an envelope only if they want to get an HIV test. Each person may read his/her result. Ask:
 - How they feel after finding out their HIV status?
 - How they feel about their friends who were either + or -?
 - Those who wanted testing and were HIV+, what they will do next? Who will they tell or not tell? Spouse or partner, family, friends, employer, supervisor, etc.? If they decide to reveal their status to someone else, what are possible ramifications they might face, for example, the risk of being divorced if he/she decides to tell his/her spouse.
 - Would they continue having sex with his/her partner?

- Now have the whole group return to their seats and ask:
 - What were you thinking when you were asked to shake hands with others?
 - What were your feelings when you were scratched?
 - What did you do after being scratched?
 - How do you feel now after knowing the significance of the game?

- Conclude this game by asking participants what issues were addressed in this game.
 - Transmission
 - Testing
 - Impact on loved ones
 - Emotions and feelings.

ICE BREAKERS AND ENERGISERS

Ice Breaker 1: Interview introductions

Purpose: To get to know one another better

Instructions:

1. Divide the participants into pairs.
2. Ask them to take three minutes to interview each other.
3. On top of the name and place of residence, each interviewer has to find 3 interesting/funny facts about their partner.
4. Ask everyone to present the 3 facts about their partner to the rest of the group.

Ice Breaker 2: Name that person

Purpose: To get to know one another better

Instructions:

1. Divide participants into two teams.
2. Give each person a blank piece of card.
3. Ask them to write five little known facts about themselves on their card. For example, I have a pet iguana, I was born in Iceland, my favourite food is spinach, my grandmother is called Doris and my favourite colour is vermilion.
4. Collect the cards into two team piles.
5. Draw one card from the opposing team pile.
6. Each team tries to name the person in as few clues as possible. Five points if they get it on the first clue, then 4, 3, 2, 1, 0.
7. The team with the most points wins.

Ice Breaker 3: People Bingo

Purpose: To get to know one another better

Instructions:

1. Make a 5 by 3 grid on a piece of card and duplicate for everyone in your group.
2. Supply pens or pencils.
3. Each box contains one of the statements below.
4. Encourage the group to mix, talk to everyone to try and complete their card.
5. If one of the items listed on the bingo card relates to the person they are talking with, have them sign their name in that box.
6. End the activity after 10 minutes
7. Review some of the interesting facts the group has discovered about each other.

Statements:

1. Has brown eyes
2. Has eaten farata this morning
3. Plays football
4. Is wearing blue
5. Knows what a ninja is
6. Plays a musical instrument
7. Has 2 or more pets
8. Has visited two or more foreign countries
9. Hates “poisson sounouk”
10. Has 2 or more siblings
11. Name begins with an 'R'
12. Loves Chinese food
13. Loves to listen to Beethoven
14. Loves to watch football matches
15. Likes to get up early
16. Someone who's favourite TV show is “The VOICE”
17. Someone over 6ft tall
18. Weighs 75 kg
19. Snores at night
20. Is married

Ice Breaker 4: Picture this

Purpose: To encourage participants to give his/her comments in front of an audience

Instructions:

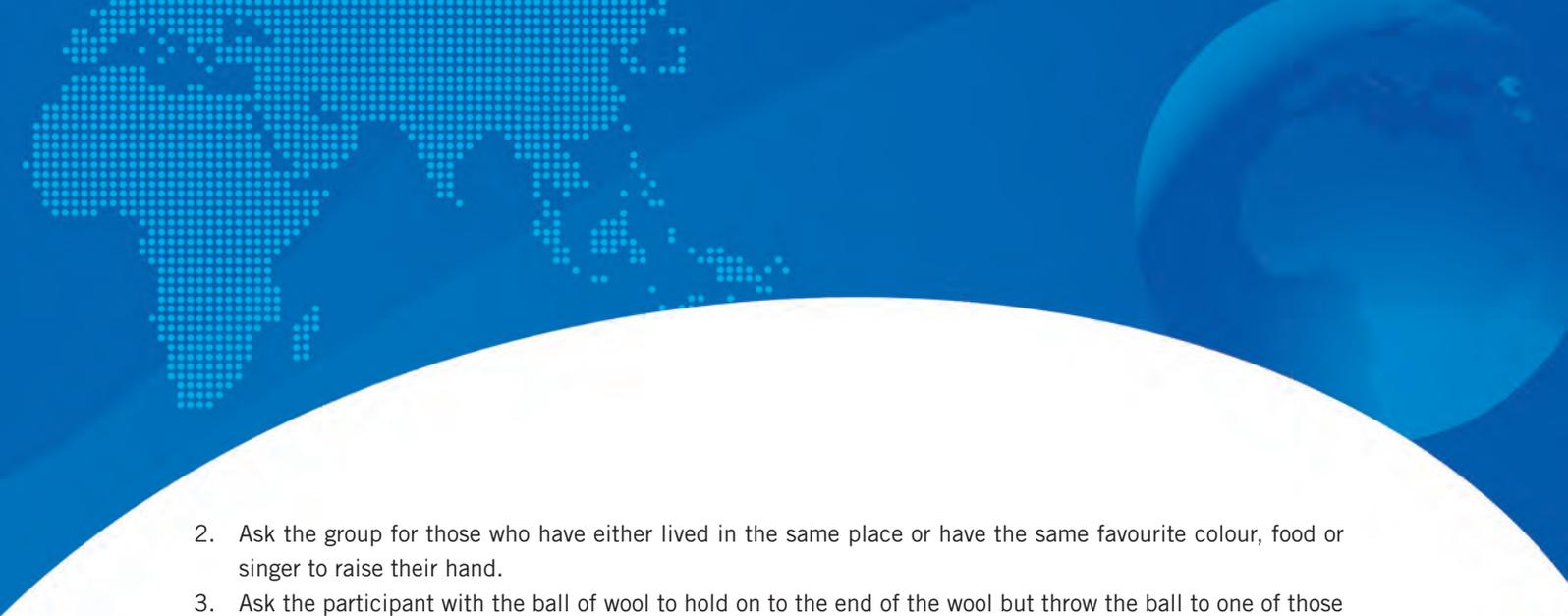
1. Select at random a few participants
2. Display some posters/postcards on the table
3. Ask the selected participants to chose a poster/postcard that speaks to them in some way
4. Ask each participant to voice out why the chosen poster speaks to him/her.

Ice Breaker 5: The Social Spider Web

Purpose: To get people moving and create a sense of cohesion at the beginning of the workshop. To get an idea of the places where people in the room have lived.

Instructions:

1. Ask participants to stand in a circle. Give a random participant the ball of wool. Ask the participants to introduce him/herself, by stating his/her name and naming one or two places s/he has lived before living here and either their favourite colour, food or singer.

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2. Ask the group for those who have either lived in the same place or have the same favourite colour, food or singer to raise their hand.
 3. Ask the participant with the ball of wool to hold on to the end of the wool but throw the ball to one of those participants with which they have something in common.
 4. Complete the circle this way.
 5. Once the spider web has been completed, point out the interconnectedness that exists amongst the group. Explain that in the past, countries were able to operate as single entities, but now they are tied together in a complicated web (globalisation). This same web is the reason we are all here together in the same room

Energiser 1: Going Blank

Purpose: To get people up, move around and have some fun

Instructions:

1. Ask the group to brainstorm three categories of anything at all – foods, fruits, cities, political leaders, flowers, birds, etc.
2. Ask for a volunteer to start out being “it.”
3. Ask the group to form a circle with the person who is “it” standing in the centre.
4. Explain that whoever is “it” points to anyone in the circle and names one of the three categories.
5. The person picked must name something within that category (for example, a type of fruit) within three seconds.
6. If the person fails to respond in time or responds incorrectly, that person becomes “it.”
7. The person who is “it” must move quickly around the circle to try and catch people off guard.

Energiser 2: I write my name

Purpose: To get people up, move around and have some fun

Instructions:

1. Ask participants to stand up.
2. Then put an imaginary pen in the hand they normally write with.
3. Instruct them to write their first name in the air with the imaginary pen.
4. Then ask them to put the imaginary pen in their other hand and write their first name in the air.
5. Repeat, asking them to put the imaginary pen in their mouth and write their first name in the air.
6. Finally, ask the learners to put the imaginary pen in their belly button (navel) and write their first name in the air.

This usually surfaces lots of laughter and everyone is energised!

Energiser 3: My Mama says

Purpose: This energizer gets the group up and moving around and deals with the importance of following instructions and knowing whose example to follow.

Instructions:

1. Ask participants to stand up.
2. Explain that you will be the leader.
3. Tell participants that the goal of this exercise is to follow the directions of the leader.
4. Every time the leader says, "My mama says to do something," they should do it.
5. Say that what makes this exercise challenging is that they shouldn't do anything unless it is preceded by the phrase, "My mama says..."
6. Give an example. "If I said, 'My mama says pat your head,' you would pat your head. Go ahead now and pat your head until I give the next direction. Now, 'My mama says clap your hands.' " Wait for learners to clap their hands. Then say, "Stick out your tongue. "
7. Point out that because mama didn't say to stick out your tongue, no one should be doing it.
8. Participants who stuck out their tongues would be out of the game and have to sit down.
9. The last person standing is the winner.
10. Encourage the group to clap for the winner

Energiser 4: Three things in three minutes

Purpose: To practice listening and agreement skills.

Instructions:

1. Ask for two volunteers for this activity and have them come to the front of the room. Have the volunteers decide who will leave the room and who will stay to receive instructions.
2. Ask volunteer one to leave the room.
3. Ask the group to decide on three things for volunteer one to do upon returning (for example, sneeze, roar like a lion, take a nap).
4. Volunteer two will have three minutes to get volunteer one to do all three things. However, volunteer two cannot directly say what to do. He or she has to hint, imply and suggest. For example, to get them to sneeze, volunteer two might say, "You look like you have a cold. "
5. Volunteer two will have to continue with hints until volunteer one successfully performs the intended action.
6. When volunteer one gets it right, the group should applaud.
7. Volunteer two will then quickly move on to the next action.
8. After explaining the activity and having the group pick the three actions, call volunteer one back into the room and explain that the group has come up with three things they want him or her to act out.
9. Volunteer two will allude to them, but not say them directly.
10. Suggest that the best way to accomplish this task is to act rather than to think.
11. Allow three minutes for the exercise.

Training Programme of Migration Health Advocates

Facilitators: Ms Davina GOUNDEN, Project Coordinator, IOM Office, Mauritius
Dr Renaud NG MAN SUN, National Consultant HIV and AIDS

Day I

9h00 - 9h15	Opening of the training session by IOM Mauritius (15 min)
9h15 - 9h25	Ice Breaker 1: Interview Introductions (10 min)
9h25 - 9h30	Presentation of the proceedings and objectives of the training programme and Answering to queries of participants (5 min)

Module 1: General Aspects of Migration

9h30 – 9h40	Activity 1: The Social Spider Web (20 min)
9h40 – 9h55	Brainstorming session (15 min) To oral test the knowledge of participants on: <ol style="list-style-type: none"> 1. The migration phases? Internal v/s Foreign 2. The potential problems to be encountered at each stage and eventual preventive measures? 3. Migrants' Health and Rights
9h55 – 10h40	Presentations (45 min) : <ol style="list-style-type: none"> 1. Migratory process (10 min) 2. Migrants' Health (15 min) 3. Migrants' Rights to Health (15 min) 4. Overview of migration pattern in Mauritius (5 min)
10h40 – 10h50	Discussion (10 min)
10h50 – 11h15	Tea Break

Module 2: Sexual and Reproductive Healthcare

11h15 – 11h25	Energiser 1: I write my name (10 min)
11h25 – 11h40	Brainstorming session (15 min) To oral test the understanding of the participants of: <ol style="list-style-type: none"> 1. Sexual Health and Reproductive Health? 2. The main areas of Sexual and Reproductive Healthcare?
11h40 – 12h55	Presentations (75 min) : <ol style="list-style-type: none"> 1. Family Planning: its importance and related gender issues (15 min) 2. Antenatal Care (15 min) 3. Childbirth (15) 4. Postpartum Care (15 min) 5. Complications of Abortions (15 min)
12h55 – 13h05	Discussion (10)
13h05 – 14h30	Lunch



Module 3: An Overview of HIV infection and AIDS in Mauritius

14h30 – 14h40	Energiser 2: Going Blank (10 min)
14h40 – 14h55	Brainstorming session (15 min)
	To oral test the knowledge of participants and discuss on: <ol style="list-style-type: none"> 1. Low level, Concentrated and Generalised Epidemics? 2. The driving factors of HIV epidemic in the world and in Mauritius? 3. The strategic pertinent preventive policies?
14h55 – 15h20	Presentations (25min) : <ol style="list-style-type: none"> 1. Epidemiological Situation (15 min) 2. Mauritian Response: overview (10)
15h20 – 15h35	Discussion (15 min)
15h35 – 16h00	Tea Break
16h00	End Day 1

Day 2

Module 4: Basic Concepts on HIV and AIDS

9h00 – 9h15	Ice Breaker 2: Picture This (15 min)
9h15 – 9h35	Brainstorming session (20 min)
	To oral test the knowledge of participants on: <ol style="list-style-type: none"> 1. STI 2. The meaning of HIV, AIDS, Serostatus etc. 3. Transmission and non transmission of HIV 4. Prevention methods 5. Stigma and discrimination 6. Treatment, care and support
9h35 – 10h40	Presentations (1h05 min) : <ol style="list-style-type: none"> 1. Definitions of commonly used terms and STI (30 min) 2. Modes of transmission and non transmission of HIV (15 min) 3. Prevention means (20 min)
10h40 – 11h00	Tea Break
11h00 – 11h30	Activity 2: True/False Game
11h30 – 12h15	Presentations cont. (45 min) <ol style="list-style-type: none"> 4. Voluntary Counselling and Testing (15 min) 5. Stigma and Discrimination (15 min) 6. Treatment, Care and Support (15 min)
12h15 – 12h30	Discussion (15 min)
12h30 – 14h00	Lunch
14h00 – 14h30	Activity 3: Risk Perception Game (30 min)

Module 5: Migration and HIV and AIDS

14h30 – 14h45	Brainstorming session (15 min)
	To oral test participants' knowledge on: <ol style="list-style-type: none">1. Vulnerabilities of migrants to HIV infection2. Migration, gender and HIV infection3. Gender-based violence
14h45 – 15h15	Activity 3: Wild Fire Game (30 min)
15h15 – 15h55	Presentations (40 min) <ol style="list-style-type: none">1. Spaces of vulnerabilities to HIV (15 min)2. Migration, Gender and HIV and AIDS (15 min)3. Gender based violence (10 min)
15h55 – 16h05	Discussion (10 min)
16h05 – 16h20	Tea Break
16h20	End of Day 2

Day 3: Evaluation of Participants and handing of Certificates

9h00 – 12h00 including tea/ coffee	Each participant will be given a small topic from the training programme to present in front of the facilitators and other participants. They will be evaluated on their technical and communication skills.
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