Health Without Borders
Improving health and reducing HIV/AIDS vulnerability among long-distance road transport workers through a multisectoral approach
# Table of Contents

- **Introduction**  
  page 1
- **Background**  
  page 4
  - Transport in GMS  
  page 5
  - Health dynamics in GMS  
  page 10
- **Health Without Borders Project**  
  page 17
- **Situational Analysis**  
  page 21
  - Lao PDR  
  page 27
  - Thailand  
  page 41
  - Viet Nam  
  page 57
- **Pilot Intervention**  
  page 69
- **Building Partnerships**  
  page 74
- **Regional Workshop 25-27 October 2006**  
  page 77
  - Issues and Recommendations  
  page 82-88
- **Phase Two**  
  page 89
Foreword

Long distance road transport workers are vulnerable to an array of health risks. Substance use, unprotected sex, unsafe roads, poor diets, long working hours and long absence from home are but some of the documented factors that lead to numerous communicable and non-communicable diseases and accidents. Importantly, the rapid spread of HIV across communities, countries and continents is a testimony to the linkages between mobile and migrant groups, such as road transport workers, and the growing epidemic.

The Greater Mekong Subregion (GMS) is illustrative of the aforementioned issues. By 2012, all GMS countries will be connected to one another, by a series of all-weather roads or “corridors.” Together with improvements in power and telecommunications, these roads will play a key role in promoting closer economic cooperation. However, enhanced subregional integration poses corresponding challenges to lifestyles and cultures, and serious health and environmental threats. The market-oriented vision for economic development of the GMS has not always been balanced by social and human development.

Truck drivers travelling across borders in the GMS are a good example of a social group that will face a negative health impact unless measures are taken to look beyond the economic benefits of South-East Asia’s developing highways to consider the health challenges as well. The seriousness of the problem is further attested to by the memorandum of understanding, signed in 2001, among Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam to jointly address the issue of population movement and HIV prevention, prior to developing national policies.

It is in this context that UNESCAP launched the ‘Health Without Borders’ project in 2005. As part of the project, UNESCAP together with partner organizations in Thailand, Lao PDR and Viet Nam, analyzed the transport and health issues along selected roads in the GMS. Additionally, a pilot intervention was initiated in Thailand to set up a model of health care and counselling for truck drivers that may be replicated in other parts of the region.

Apart from HIV/AIDS, the project examined other health concerns, many of which are of course related to HIV/AIDS – for example the use of alcohol, which is also a contributing factor to unprotected sex. The project was aimed at mobilizing relevant stakeholders, including the transport workers themselves, transport enterprises, relevant ministries and government agencies, as well as local and international NGOs to work more closely together to address the health concerns of long-distance road transport workers. Importantly, the project sought to advance a relevant policy framework whereby health concerns of a mobile and migrant population, such as long distance road transport workers are considered and addressed in terms of health promotion programmes within health systems development.

Given the partnerships developed in this project, it is now crucial to turn political commitment into action. Information, education and condom social marketing strategies need to be expanded to address the underlying causes not only of HIV infection, but also of other interrelated health concerns of long distance road transport workers. Health promotion interventions need to be developed to induce behaviour change, to reduce stigma and other factors that increase the vulnerability of transport workers, as well as to improve their access to preventive and curative health services, not just with regard to HIV/AIDS but all health related concerns.
Introduction

The Greater Mekong Subregion

The Mekong River, or “Mother of Rivers,” flows a distance of 4,800 kilometres from the Tibetan plateau into Southern China’s Yunnan Province, Myanmar, Lao PDR, Thailand, Cambodia, and Viet Nam.

These countries make up a developmental area referred to as the “Greater Mekong Subregion” (GMS). The subregion is vast, diverse and dynamic, covering 2.5 million square kilometres and home to more than 300 million people with a myriad of ethnicities and cultures.

Relative peace since the early nineties, following decades of armed conflicts, has fostered economic liberalization making the GMS countries more open to the outside world and among themselves. This has led to increasing inter-governmental cooperation in infrastructure development, and freer cross-border flows of labour, goods, and information.

The Asian Development Bank (ADB) estimates that in the last decade, GDP growth in the subregion averaged 6 per cent, notwithstanding the Asian financial crisis, the outbreak of SARS and avian flu and escalating oil prices.

Between 1992 and 2003, the combined exports of the subregion expanded by an average annual rate of 15 per cent. Intra-regional export growth was even more striking at 21 per cent per year, on average.¹

And foreign direct investment (FDI) increased, registering US$3.4 billion in 2003. As a result of rapid economic growth, the number of people earning less than US$1 a day has fallen by a dramatic 56 per cent.

The subregion’s development and infrastructure investment needs are estimated by the ADB at US$10 billion to US$15 billion over the next five to 10 years. A significant portion of the investment is expected to go into construction of new roads as well as to upgrade existing land transport linkages.

By 2012, all GMS countries are expected to be connected to each other, by a series of all-weather roads or “corridors.” Together with improvements in power and telecommunications, these roads will play a key role in promoting closer economic cooperation.

However, enhanced subregional integration, also poses corresponding challenges to existing lifestyles and cultures, and serious health and environmental threats. The market-oriented vision for economic development of the GMS has not always been balanced by social and human development.

As a general trend, development in the subregion is creating an unprecedented flow of people, capital and goods across borders, including trafficking in labour, prostitution, arms, drugs and other contraband.

These multiple flows are inevitably linked to the spread of serious infectious diseases, such as dengue fever and malaria as well as SARS, and more currently avian influenza. The combination of high mobility, intravenous drug use, and unsafe sex practices has further caused many parts of the subregion – Cambodia, Thailand and Yunnan – to become flash points of the HIV/AIDS pandemic.

**Health Without Borders**

Truck drivers travelling across borders in the GMS are a good example of a population that will face a negative health impact unless measures are taken to look beyond the economic benefits of South-East Asia’s developing highways to consider the health challenges as well.

One of the results of expanding economic ties and trade collaboration is the rapid increase in cross-border land transport in the GMS and the consequent rise in health risks for people involved in this economic sector.

A review of literature on the subject of mobility, the truck driving community and health in the GMS revealed several shortcomings in the research output so far. More specifically the problem with the understanding of the current situation is that it:

- Is based on incomplete and outdated evidence-base, leading to many misconceptions;
- Is limited in scope focusing largely on solutions centred around HIV/AIDS such as condom promotion, peer-counselling & health promotion through IEC material;
- Does not address underlying working conditions & occupational health and safety issues as determinants of vulnerability;
- Is short-term in outlook and fragmented in its analysis of the situation;
- Focuses mainly on country-level, not on cross-border dynamics;
- Fails to involve transport sector stakeholders in a meaningful way.
It is in this context that UNESCAP launched the ‘Health Without Borders’ project in 2005.

As part of the project, UNESCAP together with partner organizations in Lao PDR, Thailand and Viet Nam, carried out situational analyses of the transport and health issues along selected roads in the GMS. In addition a pilot intervention was initiated in Thailand to set up a model of health care and counselling for truck drivers that may be replicated in other parts of the region.

Apart from HIV/AIDS, the project examines other health concerns, many of which are of course related to HIV/AIDS – for example the use of alcohol, which is also a contributing factor for unprotected sex.

The project aims to improve the health of long-distance transport workers by strengthening understanding of the health concerns of the target group, implementing preventive and curative interventions and advancing a relevant policy framework.

**UNESCAP’s Role**

In the context of the wider UN reforms, UNESCAP has been evaluating its work and is in the process of re-focusing its activities. The ‘Health Without Borders’ project fits well into this approach:

- It is multisectoral in nature and relies on a partnership between two UNESCAP Divisions;
- It looks at mainstreaming of social development in a predominantly economic sector, namely transport;
- It focuses on research as well as policy recommendations.

**Outcome**

The project will provide directions on some answers on how best to address the cross-border health dynamics in the transport sector by informing stakeholders with up-to-date research.

The research and the pilot intervention will inform policy recommendations for key actors in and related to – both the health and transport sectors.

This report gives a detailed overview of the Health Without Borders project, its background, various components, recommendations and future plans.
The connection between transport and health is obvious at many levels - road accidents being the most common way in which moving vehicles cause injury or even death.

Some 75,000 persons were killed and more than 4.7 million were injured in road crashes in the ten countries, which make up the Association of Southeast Asian Nations (ASEAN) during 2003, with many victims severely disabled for the rest of their lives. Annual economic losses from road crashes were estimated to be around US$15 billion, or 2.2 per cent of the region’s total gross domestic product.¹

Pollution generated by poor quality of fuel used, high-density traffic and poor urban conditions is another well-known link.

However, there is inadequate attention to the health conditions of people who work in the transport sector, namely truck drivers, their assistants and other workers.

The traditional occupational health and safety problems of this group include muscular-skeletal and cardiovascular problems related to long working hours, ergonomically sub-optimal seats, unhealthy diets and lack of exercise.

Long periods of absence from home and adverse working conditions expose transport workers to risks of acquiring communicable diseases, particularly sexually transmitted infections (STIs) and HIV/AIDS.

¹ http://www.adb.org/Documents/News/2004/nr2004155.asp
Studies reveal that road transport workers are much more likely to visit sex workers. Furthermore, condom use among this group, although higher than in the general population, is still inadequate. HIV/AIDS among sex workers at truck stops and border crossings is high, ranging from over 20 to nearly 37 per cent in some GMS locations.²

Substance use (in particular alcohol and amphetamine-type stimulants) and undetected eye problems also contribute to road crashes and related injuries and deaths.

In the GMS, with continuous improvements in road infrastructure and increased transport facilitation, the number of trucks crossing GMS borders is likely to grow significantly. To address the constant threat to health faced by long-distance road transport workers a thorough analysis of both the transport and health sectors in the subregion is necessary.

I. Transport

Transport and Economic Growth

Transport is one sector of modern infrastructure that is essential in both developing and developed countries. The value added by transport and storage accounts for three to eight per cent of the GDP of countries in Asia and the Pacific, according to UNESCAP estimates.³ Employment in transport, storage and communications ranges between 2.5 and 11.5 per cent of total paid employment.

Demand for freight and passenger transport, particularly by road, has typically grown 1.5 to two times faster than GDP in most developing and transition countries. Public investment in transport typically accounts for 2.0 to 2.5 per cent of GDP and may rise as high as four per cent or more in countries modernizing or building new transport infrastructure. Logistics costs are typically more than 20 per cent of sales, of which transport costs alone can be as much as 13 per cent.⁴

Landlocked countries face logistics costs that are, on average, 50 per cent higher than those of countries with access to the sea. Consequently, many governments have assigned transport an important role to economic development and integration into the world economy.

Transport Infrastructure in GMS

A major structural impediment in the GMS is the absence of an integrated network of land transport links. As the region grows, improved national and regional transport networks will be needed to realize its full economic potential. Improvements in transport infrastructure will also more effectively promote the GMS as a land bridge, or a transit route for trade, between China and the rest of the ASEAN countries.

² http://www.fhi.org/NR/rdonlyres/enhu3qilbsfccih7h7/pbs6dak5cbsbqfa72xqwrwpbdxbxaetdwnkg3vak4r7 gankh5nbbasma5e/vietnambsssurvey.pdf

³ Poverty and Development Division, (2006). Enhancing regional cooperation in infrastructure development including that related to disaster management (UNESCAP, Bangkok)

⁴ ibid
To respond to this challenge, the GMS has adopted the economic corridor concept. This concept focuses on the construction, upgrading and rehabilitation of critical sections of roads along the East-West, North-South and Southern Economic Corridors.

The most advanced of these corridors, the East-West Economic Corridor or EWEC, is a 1,500 km road network connecting the Indian Ocean to the South China Sea. When completed in 2007, the EWEC will enable all weather travel between Da Nang Port in Viet Nam and the Mawlamyine Port in Myanmar, traversing Lao PDR and Thailand.

Already, the completed portions of the EWEC have significantly reduced travel time between major trading hubs, and cut the costs of doing business. For example, travel time from Aranyaprathet in Thailand to Phnom Penh in Cambodia and on to Ho Chi Minh City in Viet Nam has been cut in half to just 20 hours.

A pre-investment study shows that agro-industry, light manufacturing, trade, and tourism will receive a tremendous boost once the complete transport link is in place - transforming the corridor into a vibrant economic space.

**The Asian Highway project**

The Asian Highway project aims to enhance the efficiency and development of road transport infrastructure in Asia. The key objectives are to promote international and bilateral trade and tourism to encourage regional economic and social development.

The initiative is one component of the Asian Land Transport Infrastructure Development (ALTID) Project, first launched by UNESCAP in 1992. The Asian Highway network now comprises more than 141,000 kilometres of roads, passing through 32 member States. The Agreement has been signed by 28 countries and ratified by 13 countries enabling its entry into force on 4 July 2005.

The main obligations of the Contracting Parties within the Agreement are to:
- Adopt the Asian Highway network as a coordinated plan for the development of highway routes of international importance;
- Bring the network in conformity with the Asian Highway classification and design standards; and
- Place Asian Highway route signs along the network.

**Asian Highway in GMS**

The Asian Highway road network is classified into four types: Primary (four or more lanes, access controlled); Class I (four or more lanes); Class II (two lanes); and Class III (two lanes).
Status of the Asian Highway in GMS

<table>
<thead>
<tr>
<th>Country</th>
<th>Primary</th>
<th>Class I</th>
<th>Class II</th>
<th>Class III</th>
<th>Below</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>0</td>
<td>0</td>
<td>398</td>
<td>743</td>
<td>199</td>
<td>0</td>
<td>1340</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,335</td>
<td>40</td>
<td>3</td>
<td>2378</td>
</tr>
<tr>
<td>Thailand</td>
<td>182</td>
<td>2,572</td>
<td>1,226</td>
<td>1,128</td>
<td>0</td>
<td>4</td>
<td>5112</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>0</td>
<td>408</td>
<td>1915</td>
<td>104</td>
<td>251</td>
<td>0</td>
<td>2678</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>182</strong></td>
<td><strong>2,980</strong></td>
<td><strong>3,539</strong></td>
<td><strong>4,310</strong></td>
<td><strong>490</strong></td>
<td><strong>7</strong></td>
<td><strong>11,508</strong></td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td>1.58</td>
<td>25.90</td>
<td>30.75</td>
<td>37.45</td>
<td>4.26</td>
<td>0.06</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Asian Highway Routes in the Greater Mekong Subregion

Important international transport routes in the subregion

Several initiatives are underway to improve highway quality in the subregion. For example, Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam are cooperating on road building (and other areas) under the GMS initiative. In the area of transportation, the GMS project has been divided into three main corridors: North-South (comprising Kunming – Haiphong route and Kunming – Bangkok route); East-West (comprising the Mawlamyin – Da Nang route); and Southern (comprising the Bangkok – Quy Nhon route and the Bangkok – Vung Tau/Nam Can route).
In addition, the ASEAN Highway initiative has considerable complementarities with Asian Highway efforts. Other international financial institutions and bilateral donors are also assisting member countries in the GMS to improve transportation networks.

In addition to the designated Asian Highway routes there are also some short-distance routes under construction connecting border provinces:

- The road from Nan province in Thailand to Udomchai subdistrict in Laos.
- The construction of the bridge between Na-gra-seng village, A-hi subdistrict, Ta-li district, Lei province in Thailand and Kaen-tao village, Chai-ya-buli subdistrict in Laos.
- The construction of the third bridge across the Khong river (in Nakorn Panom).
- The development of the route between Chongsa-ngam (Sri-sa-ket province, Thailand) and Siam Reap in Cambodia.
- The road from Myawaddy to the foot of Ta-nao-sri mountain starting from the foot of the Thai – Myanmar Friendship bridge at Mae Sot district in Tak province, Thailand and continues towards the west bank of the river Moey through the town of Myawaddy to the foot of the Ta-nao-sri mountain.
- The bridge over the river Su-ngai Kolok at Bu-geh-tah village, Waeng district, Narathiwat province in Thailand. It connects Bu-geh-tah village, Waeng district, Narathiwat province to Bu-geh-bu-ngha of the Kelantan state of Malaysia
- The development of the route between Na-Ta-Wee, Pra-kob village, Malaysia’s border and Alor Star

**Current investment in the Asian Highway Network in GMS**

Considerable investment is being made in the Asian Highway network within GMS. It is estimated that countries in the subregion are currently investing over US $2.7 billion on rehabilitation and upgrading of the network.

This represents over 2,500 kilometres of highways plus several new bridges are also being constructed to improve network connectivity. Over 800 kilometres of Asian Highway in the subregion are being maintained or rehabilitated, with over 1,400 kilometres being upgraded.

<table>
<thead>
<tr>
<th>Country</th>
<th>Kms</th>
<th>US $ (mil)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>308</td>
<td>190</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>369</td>
<td>245</td>
</tr>
<tr>
<td>Thailand</td>
<td>1,273</td>
<td>373</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>572</td>
<td>1,961</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,522</td>
<td>2,769</td>
</tr>
</tbody>
</table>

Source: GMS Initiative, ADB

In absolute terms within the subregion Viet Nam is spending the most on the Asian Highway, with current investment levels at around US $1.96 billion, while Thailand is investing in the greatest number of kilometres (1,273 Kms).

---

5 This data represents investments as at 2004 that are backed by a financial commitment from either a Government or other source, including where construction will occur in future years. The scope and accuracy of this data is subject to verification and correction by member States.
### Current AH Investment Activities in GMS

<table>
<thead>
<tr>
<th>Country</th>
<th>Rehabilitation (Kms)</th>
<th>Upgrade &amp; New Construction (Kms)</th>
<th>Total (Kms)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>48</td>
<td>260</td>
<td>308</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>240</td>
<td>129</td>
<td>369</td>
</tr>
<tr>
<td>Thailand</td>
<td>810</td>
<td>463</td>
<td>1273</td>
</tr>
<tr>
<td>Viet Nam</td>
<td>0</td>
<td>572</td>
<td>572</td>
</tr>
<tr>
<td>Total</td>
<td>858</td>
<td>1424</td>
<td>2522</td>
</tr>
</tbody>
</table>

### Facilitation of international transport in the GMS

The hardware of infrastructure - roads, bridges, power plants, and telecommunications facilities - is of little use without the accompanying software, in the form of policies and regulations conducive to trade.

Under the auspices of the ADB, the Lao People’s Democratic Republic, Thailand and Viet Nam signed the Agreement on Facilitation of Cross-border Transport of Goods and People in the Greater Mekong Subregion (CBTA) in 1999, and subsequently Cambodia, China and Myanmar acceded to it. The Agreement entered into force in 2003 with ratification by all six GMS countries.

The milestone agreement deals with cross-border customs procedures, passage rights, vehicle and load specification, insurance provision, and transit and user fees. Full implementation of CBTA is expected in 2007, but work has already begun with the establishment of Single-Stop Customs Inspection system at selected border crossings.

The leaders of GMS countries have also endorsed the Strategic Framework for Action in Trade Facilitation and Investment. This framework will streamline and rationalize customs, immigration, and quarantine policies, rules, regulations and procedures among the six member countries, particularly along identified priority border crossings. It supports and complements the CBTA. Both agreements are expected to further facilitate the freer and more efficient movement of people, goods and services across borders in the GMS.
Selected agreements on transport facilitation between GMS member countries

- Agreement on Road Transport between the Governments of Viet Nam and the Lao People’s Democratic Republic (24 February 1992)
- Agreement on International Road Transport between the Governments of China and the Lao People’s Democratic Republic (3 December 1993)
- Agreement of 18 January 2000 between the Governments of Viet Nam and the Lao People’s Democratic Republic Amending and Supplementing Some Articles of the Agreement on Transiting Goods (23 April 1994)
- Agreement on Train Transport between the Governments of Thailand and the Lao People’s Democratic Republic (4 April 1997)
- Agreement on Road Transport between the Governments of Thailand and the Lao People’s Democratic Republic (5 March 1999) (to replace the 1978 Transit Agreement)
- Agreement on Road Transport between the Governments of Cambodia and the Lao People’s Democratic Republic (21 October 1999)
- Trilateral Agreement on Facilitation of Cross-border Transport of Goods and People between the Lao People’s Democratic Republic, Thailand and Viet Nam (26 November 1999)

II. Health

Occupational health and safety

It is widely recognized that people who drive for a living suffer more commonly from lower back problems. One of the main reasons for the increased incidence of back pain amongst truckers is the endless hours of sitting. However, there are other contributing factors: the constant exposure to low frequency vibration, the simple lack of activity, the poor diet while on the road, the strenuous work of pulling on chains and tarps, changing tires, doing field repairs, and jumping up and down from trailers and cabs – to name but a few.

A critical factor is that such strenuous activity often takes place after many hours of immobility without a warm-up. Spinal joints especially are designed to be flexible and mobile and inactivity is detrimental to the ligaments and muscles that act on them.

A study undertaken in 2000, has shown that the prevalence rates of working factors affecting health problems of truck drivers were significantly higher than those of clerical workers. The problems include irregular shift work, working environment, working posture, handling heavy materials, job stress due to overloading and long working time and limited time off. The prevalence rates for subjective symptoms (ringing in the ears, neck pain and low back pain) and present illnesses (hypertension, ulcers in the digestive tract, back injuries, whiplash injuries and haemorrhoids) among truck drivers were also found to be significantly higher than those of clerical workers.

---

6 Zasshi, Sangyo Eiseigaku (2000). Analyses of work-relatedness of health problems among truck drivers by questionnaire survey (Kochi Medical School, Department of Public Health, Japan)
Fatigue and sleep deprivation are also important safety issues for long-haul truck drivers. A 2003 study found significant positive correlations between fatigue experiences and driver and poor management systems of break taking and route scheduling. Numerous studies have documented that driver attention begins to lapse noticeably after about four hours at the wheel and declines very steeply after eight hours.

In addition, the constant stress of being responsible for the cargo, driving on bad roads, constant travel at high speeds, being away from home and family members and friends for long periods, working in the small and socially isolated conditions in their vehicles, often driving at night and the interaction with government officials at checkpoints, border points and roadblocks can have a negative impact on the mental health of a truck driver. In some cases, drivers may resort to high-risk behaviour as a coping strategy.

**Alcohol use and driving**

Alcohol is a depressant. Effects of moderate alcohol intake include dizziness and talkativeness; the immediate effects of a larger amount of alcohol include slurred speech, disturbed sleep, nausea, and vomiting. Alcohol, even at low doses, significantly impairs judgment and coordination. Long-term effects of consuming large quantities of alcohol, especially when combined with poor nutrition, can lead to permanent damage to vital organs such as the brain and liver.

The South-East Asian region has an estimated annual adult per capita consumption of around two litres. Countries comprising the South-East Asia Region of the World Health Organization, which had low levels of consumption of alcohol until recently, are steadily moving towards a higher level of alcohol use.

It has been known for a long time that alcohol consumption influences the functions of the brain. After drinking, the brain works inefficiently, taking longer to receive messages from the eye; processing information becomes more difficult and instructions to the muscles are delayed. Alcohol can slow down reaction time and also reduces ability to perform two or more tasks at the same time.

Alcohol reduces the ability to see distant objects and night vision can be reduced by 25 per cent. Blurred and double vision can also occur. Ability to perceive what is happening at the roadside is weakened. Loss of peripheral vision could be crucial. Alcohol may also create a sense of overconfidence, with the result that people are prepared to take greater risks. Under the influence of alcohol persons lose self-control and the way a vehicle is driven by a drunken person worsens with increased alcohol intoxication.

All available information hints towards the fact that there is a strong direct relationship between alcohol intoxication and traffic accidents. Moreover, an increase in alcohol consumption results in an increase in traffic accidents.

---


In addition, absence from work associated with harmful use of alcohol and alcohol dependence entails a substantial cost to employers and social security systems. There is ample evidence that people with alcohol dependence and problem drinkers have higher rates of sickness absence than other employees.\(^{11}\)

**Methamphetamine use and driving\(^{12}\)**

Methamphetamine is a variety of amphetamine-type stimulants (ATS), producing powerful effects on the central nervous system. Methamphetamine tablets are the predominant form of ATS in the GMS. Use of methamphetamine brings about: increased activity; a feeling of alertness; increased confidence; impairment of judgment and reduced inhibitions in some cases leading to outright recklessness; and, initially, heightened sexual urges. The effects of methamphetamine can last from four to 24 hours, depending on how it is ingested. The drug does not produce energy, but permits access to energy reserves in the body. Once those reserves are used up the body must replenish them.

Methamphetamine comes in many forms, including tablets, powder, and crystalline forms, and can be smoked, snorted, swallowed, or injected. The effect of a drug on a user depends on the characteristics of the drug, the route by which it was administered, its distribution, the metabolism of the user's body, and the way the drug is removed from the body.

It is generally acknowledged that long-term methamphetamine abuse produces very strong dependence. When higher doses are administered, tolerance develops, forcing the drug users to take ever-increasing doses to reach the same effect. This pattern of use can lead to impaired concentration and memory, chronic mental health effects, uncontrollable violent behaviour, severe emaciation, skin problems, and loose and/or broken teeth.

The evidence base concerning the impact of ATS on driving is ambiguous. It has been suggested that stimulants such as methamphetamine may increase some driving related skills, particularly in fatigued drivers and that they may play an indirect role in driver impairment with their major influence occurring in the 'come down' or withdrawal phase when stimulants have been eliminated from the body.\(^{13}\) The major symptom of this phase is fatigue, which has a significant detrimental effect on driving performance. Further, it seems reasonable to assume that a psychotic state emanating from gross methamphetamine-intoxication would be incompatible with satisfactory driving performance.\(^{14}\)

Another phenomenon is that the use of ATS can enhance the thrill of aggressive driving. In studies that have examined this phenomenon, participants described amphetamines as giving them increased energy, sharpened reflexes, and feelings of nervousness, aggression and confidence to the point of feeling invulnerable. While some associated these effects with an increased risk of having an accident, others were convinced that the use of methamphetamines improved their driving. However, evidence clearly shows that drugs

---

\(^{11}\) Global Status Report on Alcohol 2004 (Geneva, WHO).

\(^{12}\) Methamphetamine specific information was adapted from the UNODC Asia & Pacific Amphetamine Type Stimulant Information Centre (http://www.apaic.org/ATS_INFO/effectsofatsabuse.htm)

\(^{13}\) Henry-Edwards, Sue. (2004). Driving under the Influence of Illicit Drugs. (Australian National Expert Advisory Committee on Illicit Drugs)

\(^{14}\) Methamphetamine Action Plan (2003), Ministerial Action Group on Drugs, New Zealand (http://www.ndp.govt.nz/publications/methamphetamineactionplan.html)
can alter psychomotor functions, thereby affecting the capacity to respond appropriately to the environment.\(^{15}\)

A 2004 study showed that Australian drivers in whom stimulants were detected were 2.2 times more culpable for road accidents than drug free drivers. This increased to 8.8 times for stimulant positive truck drivers.

Even when an individual may never use drugs during working hours, the acute and chronic effects of psychoactive drugs are such that they can impair working efficiency, resulting in absenteeism, accidents or health care costs, all of which have effects on employers, colleagues as well as the user.\(^{16}\)

**HIV/AIDS among truck drivers**\(^{17}\)

**Truck drivers at risk**

Truckers have been the subjects of a great deal of attention as far as HIV is concerned. One reason is simply that there are so many of them: in India for example, it is estimated that two to five million people are long-distance truck drivers and helpers.\(^{18}\) Another reason for attention in relation to HIV is that truckers move between regions with different rates of HIV prevalence, and have multiple interactions with foreign and local populations as they travel.

Living and working conditions of truckers put them at risk of contracting and transmitting the virus. They are of an age to be sexually active; they are usually men, often living and working in a macho culture and separated from regular partners for extended periods of time; they are subject to stress; they usually carry significant sums of cash to meet their travel needs; they are attractive customers to the sex industry that tends to be active in so-called “hot spots” where trucks stop; and they often have inadequate access to health services, including to treatment for sexually transmitted infections.

Truckers stop at border crossings and checkpoints to unload merchandise, repair vehicles, and go through tax and examination procedures. Slow administrative procedures often cause delays and long stopovers that then provide opportunities for multiple sexual relationships. Linkages have been established between the length of time that drivers are away from home and the number of non-regular sex

---


16 ibid

17 Unless otherwise referenced, this section draws on: The Synergy Project : Putting on the brakes: Preventing HIV transmission along truck routes (Available at http://www.synergyaids.com/SynergyPublications/Synergypublications.htm)

partners. It is not only geographical factors such as a border crossings that may increase the truckers’ vulnerability to STIs/HIV but also poor road conditions or broken down bridges. These unexpected stopovers oblige drivers to spend one or more nights in given localities where local populations, including sex workers, often perceive them as good customers.

Truckers’ harsh work conditions – injuries, robbery, attacks, destruction of their vehicles, stress, malaria and respiratory infections clearly contribute to their low perception of the seriousness of HIV infection. In relation to the many other hazards they face they may consider that HIV is less immediate, or more of a danger to other people. Their immediate needs take precedence over the possible long-term consequences of unprotected sex.

The use of alcohol and methamphetamine can be linked to increased risk-taking in sex and an increased risk of HIV infection. A 1991 study from Thailand provides a good example of such linkages. The study showed that at the time, nearly all truck drivers who travelled domestic long distances used amphetamines. The truckers believed that consuming small amounts of alcohol helped to release the effect of the drug. In addition, to fully purge the drug, the truckers believed they had to either drink one-half glass of whiskey or have sexual intercourse. In many cases this was combined as truckers visited sex workers after having consumed whiskey. The study further showed that they felt that it was perfectly natural to sleep with sex workers and all drivers knew where to find them along the truck route. At the time, few truckers used condoms. One of the reasons for this was that the amphetamines and alcohol gave them “more confidence in themselves”.

A 1999 study in Thailand showed an increase in the desire for sex and actual intercourse of 54 per cent and 35 per cent respectively after taking methamphetamine. Methamphetamine has also been associated with rougher sex, which would also increase the risk of HIV transmission. The sense of feeling invulnerable commonly associated with the use of methamphetamines can increase sexual risk-taking which eventually increases HIV infection.

**Truck drivers: a bridge population**

In many developing countries, those living and working along truck routes were found to be among the early populations affected by the virus. Researchers following trends in the HIV epidemic, particularly of the developing world, noticed that the virus travelled from high- to low-prevalence areas along the same routes that trucks travelled. Changes in prevalence were also documented from urban to rural areas along truck routes. These trends existed in countries where HIV/AIDS was a serious problem, as well as in countries that had been relatively free of the disease.


21 Ibid

22 Yothin Sawaengdee and Pimonpan Isarabhakdi 1991. Ethnographic study of long-haul truck drivers for risk of HIV infection (Mahidol University Institute for Population and Social Research)


24 The Synergy Project (n.d.). Putting on the brakes: preventing HIV transmission along truck routes.
In some countries, people working with HIV prevention programme believed that truck drivers were playing a major role in transmitting HIV – that the drivers were, in fact, importing HIV infection as well as other STIs across borders and into rural communities, and to people who were previously uninfected. Thus, truck drivers were often seen as a bridge population, whereby HIV reaches the larger population, particularly people who are considered at low risk. For example, a trucker who had unprotected sex with a sex worker, then does the same with his monogamous wife, could act as a bridge for HIV infection.

In some countries, studies have shown that truck routes facilitate the importing of HIV infection from high-prevalence countries and regions to low-prevalence areas, as well as from populations who had been identified as practicing high-risk behaviour to the general population. The spread of HIV along truck routes is not just about the movement of large numbers of people from one place to another, it is more a reflection of a way of life along highways. People who live and work along truck routes are exposed to HIV and other STIs.

Commercial sex is only part of the sexual network that exists at truck stops and border crossings. In fact, it has been found that truckers are beginning to associate HIV/AIDS with sex workers, and this seems to be leading them to casual sex with people who they perceive as 'clean'. Moreover, both men and women who live and work at these settlements often have other regular sexual partners, in addition to their husbands and wives, and men sometimes have sex with other men. Some wives of truckers, who are left behind for months at a time, also have other sexual partners.

All of the people who engage in high-risk behaviour along truck routes are potentially at risk of contracting HIV. When they have multiple partners, who also have multiple partners, many people potentially contract HIV. It is important to dispel a widespread myth that truck routes as efficient transmission settings for HIV do not mean that truckers themselves necessarily have a higher rate of infection than other sectors of the population linked to truck routes, as the quote from Jeff Marck illustrates. “…long-distance truck drivers have nowhere been shown [to be] highly infected groups at the time they contributed most to the geographical spread of HIV. Even with two per cent or less [of a given trucker population] infected, they spread HIV to sex workers and other categories of women in their region’s furthest rural places. And those women, especially the sex workers, and in some cases wives, pass it on to the larger community.”

**Truck drivers and access to health services**

For truck drivers, many barriers exist for access to health services, including medical treatment and health-related services and products, such as condoms. Along many truck routes, health centres are either not available or they are not open at night where the truckers stop. Moreover, while drivers have the flexibility to leave their truck during stops, assistants often must stay with the truck. Hence, even if a health facility at a truck stop existed, assistants may not have the option of seeking treatment. In many cases, health

---

service facilities are also not conveniently located along the road. Truck drivers then would have the option of either leaving the truck unattended or otherwise navigating along streets that often do not accommodate a large truck.

Several studies report that truck drivers have difficulties with more formal medical facilities. Their mobility is a barrier to attending clinic appointments and regular follow-up visits. Driving schedules often do not allow for the driver to take the necessary time to seek proper medical treatment. In many cases, waiting rooms are full and truck drivers could spend up to a day waiting for a consultation. In cases where a driver requires treatment, the high level of mobility of drivers complicates proper follow up. This has an impact on adherence and compliance to any medications prescribed as well as a comprehensive diagnosis, which could involve laboratory tests and multiple visits. Furthermore, referral practices are unpractical as drivers are often registered at hospitals in their hometown.

The limited access to health services has a critical impact on the sexual health of drivers. Timely treatment of sexually transmitted infections (STIs) not only minimizes risk of contracting HIV, but also provides health workers an opportunity to interact with the client and promote condom use, thereby possibly preventing high-risk behaviour. Truckers generally do not seek treatment from qualified health workers – either for general illness or for STIs. On the occasions when truckers do seek treatment for STIs, they often do not return for follow-up (which is not surprising since they may be thousands of kilometres away on their appointment date).

Drivers from many developing countries felt that a stigma is attached to attending a STI clinic. Clinics that only provide treatment for STIs, and are advertised as such, are likely to be rejected. Many times, men who received treatment thought it was a negative experience. In many countries, truckers reported that doctors looked down on them and treated them as “irresponsible”. Feeling embarrassed also prevents truckers from telling their wives or other partners about their STI. Thus partners go untreated. Clinics have also found that truckers sometimes refuse to identify their partners for notification.

While treatment at established health centres is rare, some truckers do seek treatment and/or try to prevent STIs. Some go to traditional healers or non-trained health workers for STI treatment. Often these people are non-judgmental, and clients feel more comfortable visiting them. In some cases, they argue that the cost of treatment in formal health centres is higher than the costs of local practitioners. Self-medication is found to be common among truck drivers.
Health Without Borders: The Project

Introduction

When UNESCAP’s Health and Development Section of the Emerging Social Issues Division and the Transport Facilitation Section of the Transport and Tourism Division, embarked on the Health Without Borders project at the beginning of 2005, the objective was to find sustainable solutions to improve the health of truck drivers in the GMS. The inter-divisional collaboration was meant to address the health and transport dimensions of the problem equally.

A key activity of the project was to undertake a deeper analysis of working conditions and health behaviour along selected transport corridor(s) as a basis for planning better interventions. Based on this analysis, at least one health stop was to be piloted in partnership with existing health facilities for transport workers. The research findings, the lessons learned from the pilot interventions and policy recommendations to address the underlying concerns would then be disseminated to all stakeholders.

The project also aimed to mobilize stakeholders, including the transport workers themselves, transport enterprises, relevant ministries and government agencies, as well as local and international NGOs to work more closely to address the health concerns of long-distance road transport workers which have significant public health implications.

Mandate for the Project

By targeting a particularly vulnerable mobile population group (transport workers), the project built on UNESCAP’s work towards achieving the Millennium Development Goals (MDGs), in particular:

- Goal 6 - To combat HIV/AIDS, malaria and other diseases and;
- Target 7 - To have halted by 2015 and begun to reverse the spread of HIV/AIDS.

Two Commission resolutions, 57/1 and 59/1, mandate UNESCAP to address HIV/AIDS. Commission resolution 59/1 specifically requests the Executive Secretary to address causes of HIV/AIDS vulnerability related to mobility. Commission resolution 60/2 entitled: “Regional call for action to enhance capacity-building in public health” is also of relevance. UNESCAP expertise in HIV prevention and general health promotion, as well as related advocacy among policy makers, positions it well to address these issues.

UNESCAP has the expertise in promoting inter-governmental cooperation on the Asian Highway to improve road infrastructure in the region. UNESCAP is also providing technical assistance to GMS countries on international agreements governing the cross-border movement of people and goods.

Thus, UNESCAP’s multi-sectoral expertise in health and development, as well as in transport policy, facilitation and infrastructure development, was harnessed for project interventions.
**Strategy**

The project aims to improve the health of long-distance transport workers by strengthening understanding of the health concerns of the target group and by implementing preventive and curative interventions, towards advancing a policy framework.

A key project strategy is the building of national and subregional multi-stakeholder partnerships with a wide host of actors:

- Government agencies (responsible for road infrastructure, health centres, border crossings, small- and medium-enterprise development along highways, and community development).
- Private sector (companies for all forms of road transport of goods and people).
- Civil society (trucking and drivers’ associations/groups).
- Local communities and small local entrepreneurs at the identified locations that provide fuel for transport, and food and shelter for transport workers.
- International NGOs, which have projects that target transport workers in the GMS.
- ADB that funds and advises on the construction of the GMS highway infrastructure, as well as health-related activities in the region.
- ILO, WHO and UNAIDS.

Other key features of the project strategy are:

- Thorough situational analysis of the health, health concerns and health behaviour of long-distance road transport workers and the underlying social and economic determinants to ensure that tailor-made interventions address the needs of the target group.
- Establishment of health stop(s) where free check-ups, and health promotion material available in the relevant GMS languages (as feasible) could be offered.
- Health promotion on issues identified by transport workers (likely to include fatigue, substance use, eye sight problems, muscular skeletal problems, and nutrition related problems).
- Treatment of minor ailments, referral when needed and provision of STI treatment.
- HIV/AIDS and STI prevention interventions *in situ* and through the training of peer educators. HIV/AIDS voluntary counselling and testing, as appropriate and feasible.
- The long-distance transport workers are predominantly men. Their behaviour vis-à-vis the women they meet during their journeys directly impact on their health, as also that of the women. It is therefore planned that gender concerns be mainstreamed in all aspects of the project. Gender aspects will, *inter alia*, be included in the behavioural surveys to be conducted, the content of materials to be distributed and in the training of peer counsellors.
- Project coordination that would facilitate the sharing of good practices, and development of national and regional policy recommendations.

**Phase I**

Phase I of the project was designed with the following activities/outputs:

**Building of partnerships.** In all participating countries partnerships were forged with key players who would either be in a position to address the issues identified or to lobby those who can. For this reason the situational analyses were not contracted to individual
consultants but rather conducted by ministries of transport (Lao PDR and Viet Nam) with support from researchers and in close collaboration with UNESCAP.

**Situational Analyses** were conducted in Thailand, Lao PDR and Viet Nam to understand the underlying causes of ill health and risk behaviour as well as the key health issues and their magnitude. These issues vary from country to country and would consequently require different interventions. The Terms of Reference for the situational analyses require the National Counterpart Organisations (NCO) to conduct a final workshop to disseminate the findings and to develop policy recommendations. The NCOs share the responsibility for the distribution of the research report.

**A pilot intervention** was initiated at the border between Thailand and Lao PDR (Friendship Bridge, Nong Khai – Vientiane). The Planned Parenthood Association of Thailand (PPAT), a non-governmental organisation, is implementing the pilot in close collaboration with numerous stakeholders at the provincial level and some stakeholders at the national level. The pilot intervention involved, inter alia, setting up of a health stop (referral clinic), outreach work and peer education, a behaviour change communication strategy, working with the respective ministries and employers to highlight the issues at stake.

Various policy forums were organized, co-organized or actively participated in by UNESCAP to bring health in the transport sector on the agenda. Such meetings included:

- Meetings of the United Nations Task Force on Mobility and HIV vulnerability;
- A meeting organized by the ADB on Human Resource Development in the GMS;
- A meeting organized by ADBI on ‘Managing Regional Public Goods: Cross-Border Trade and Investment: Labour Migration and Public Health’;
- Several meetings bringing together the ‘multi-sector teams on HIV and Mobility’ of Cambodia, Lao PDR, Thailand and Viet Nam under the CSEARHAP Map-4 project;
- A national HIV/AIDS workshop, which was organized by the Ministry of Communication, Transport, Post and Construction, Lao PDR; ADB and UNESCAP participated.

**A final regional workshop** was held from 25-27 October 2006 bringing together all project stakeholders to discuss the project outcomes, the policy implications/recommendations and to fine tune activities for a second project phase.

**A policy advocacy document** and a comprehensive meeting report will be the outputs from the final workshop.
Project Summary

Project Title: Improving health & reducing HIV/AIDS vulnerability among long-distance road transport workers through a multi-sectoral approach in the GMS.
Project Goal: To improve the health of GMS long-distance road transport workers.
Participating Countries: Cambodia, Lao PDR, Thailand & Viet Nam (selected cross-border highways).
Target Group: Transport and health ministries of participating countries.
Beneficiaries: Long-distance road transport workers on GMS highways and their families, as well as communities along the highways.

Project partners

• National ministries (transport, health, labour)
• UN agencies, including ILO, UNAIDS, UNODC & WHO
• UN Regional Task Force on Mobility & HIV
• Multilateral institutions, including ADB, ASEAN, ACMECS
• INGOs & IOs, including CARE, FHI, PSI, World Vision & IOM
• National NGOs

Activities

• Situational analyses of health & socio-economic working conditions of road transport workers along selected corridors
• Building multi-sectoral partnerships with existing service providers, government departments, employers & employees, NGOs to strengthen provision of health services (promotional & curative)
• Policy advocacy informing the national transport sector & regional forums to mainstream health in the transport agenda

Key outputs

• National and regional partnerships & platforms on transport & health established for delivery of advocacy material & policy recommendations, as well as to act as catalysts for further action
• Policy recommendations for key actors in the transport sector formulated & delivered
• Pilot modality available to demonstrate feasibility & guide implementation of policy recommendations
• A second phase to scale up & expand project activities in the GMS
Situational Analyses

Introduction

A key activity taken up as part of the Health Without Borders project was situational analyses of health and transport issues conducted along selected Asian Highway corridors in the GMS. The countries chosen for this research were Lao PDR, Thailand and Viet Nam.

These situational analyses were planned to better understand the factors that affect the health of truck drivers. In the case of Thailand the results obtained from these studies were meant to inform the development of a pilot intervention to improve health promotion and health services for truck drivers.

In general the data generated provided the baseline for monitoring and evaluation. The research also constituted the foundation for the development of concrete policy recommendations for the health, transport and labour domains.

The criteria for selection of the transport corridors include:

1. National stakeholders are consulted, they are committed to the research along the selected corridor;
2. The research site must include at least one border crossing;
3. Specific health problems are known or are expected within the next few years;
4. The number of trucks using the road must be sufficient.

Research Outcomes

The research was conducted to achieve the following outcomes:

- To describe the health status of long-distance truck drivers and factors and behaviour related to their health;
- To evaluate the knowledge of HIV control and prevention, identify related risk factors and obstacles to condom use among long-distance truck drivers;
- To describe the available access to and utilisation of health services such as HIV blood testing, services for STI diagnosis and treatment by long distance truck drivers as also their health-seeking behaviour in general; and
- To propose suitable and effective health care methods for the long-distance truck drivers around the borders in the GMS.

Research Methodology for Situational Analyses

All three countries chosen for the situational analyses, as part of the Health Without Borders project, adopted a common research methodology. Any difference in implementation of the methodology was due to variations in local context and logistical difficulties encountered in the course of research.
Tools used for the situational analysis included structured questionnaires, in-depth interviews, focus group discussions, mapping and behavioural observation to collect information on the following key issues:

• Characteristics of long distance truck drivers and their assistants along the selected corridors, e.g. nature of transport, size of companies and demographic profile;
• Driving routes and health-related behaviour while working;
• Hotspots along the selected highways and behaviour related to those hotspots;
• Health-seeking behaviour of long distance truck drivers and their assistants, locations of and accessibility to health services provision;
• Socio-economic working and living conditions of long distance truck drivers and their assistants;
• Related policies that affect health as perceived by long distance truck drivers and their assistants.

The overall assessment involved:

1. A training and planning workshop.
2. Data collection in selected sites of the selected transportation routes.
3. Data verification, processing and analysis.
5. Dissemination of workshop outputs to key stakeholders.

Given below are the broad elements of the subjects, focus and methods of research adopted.

Quantitative study

The quantitative study was conducted among selected long-distance truck drivers because of their availability at defined sites along the highways earmarked for study. Drivers were interviewed using a standardised questionnaire to collect information that included the following:

• Driving behaviour.
• Income and spending habits.
• Use of alcohol, drugs and tobacco.
• Demography.
• Health-seeking and treatment behaviour.
• Sexual behaviour (multiple sex partners, unprotected sex, sex workers).
• Frequency of condom use, obstacles to condom use.
• Knowledge and utilisation of health services related to STIs.
• Knowledge of HIV.
• Knowledge and utilisation of HIV testing and counselling services.

Qualitative study

In-depth interviews and focus group discussions were carried out with drivers and other people that were able to provide detailed information of driver behaviour. Based on the
information provided by the authorities in different locations along the main highways, the mapping team identified sites and populations for data collection.

The selected data collection sites included:

- Truck stops, car parks, transport companies and gas stations.
- Restaurants and hotels.
- Health care centres and health services along the highways (hospitals, clinics, drugstores, counselling centres).
- Social services.
- Families of truck drivers.
- Entertainment establishments (bars, karaoke bars, massage parlours).
- Condom distributors.

In-depth interviews and focus group discussions aimed to identify the following factors:

**Individual factors**
- Economic, education, and social factors of the truck drivers.
- Conditions of living (sanitation, income).
- Challenges and needs (finance, law, environment, health care).
- Behaviour and attitudes toward drug use, types of drug used, and factors leading to drug use.
- Sexual behaviour (multiple sex partners, sex with sex workers, and high risk sex behaviour).
- Frequency of condom use, obstacles of condom use, correct condom use.
- Self-respect, knowledge and attitude towards health, health-seeking behaviour.
- Knowledge of HIV and STIs.
- Knowledge, access, and utilization of health services related to STIs and HIV testing and counselling services.

**Community factors**
- Knowledge and attitude of community concerning health issues.
- Discrimination against drivers.
- Availability, prices, and areas of sex work activities.

**Policy factors**
- Availability of the services, health education and communication campaigns on driver groups.
- Ability to access health services and social services during the trips and at home.
- Government policies concerning HIV, vulnerability factors and the risks of truck drivers.

**Research methods**

The situational analysis comprised of the following steps:

**Secondary research on land transport:**
- General information on country profile, national road transportation situation and existing policies;
- Type of companies operating along the surveyed roads, volume of trucks and estimated number of road transport workers using these roads;
• General condition of road infrastructure;
• The nature of risk behaviour pertaining to health along the selected roads, developing an appropriate definition of hotspots;
• Illnesses, relevant to the study, reported by health service providers along the selected roads;
• Health and accident insurance policies available to road transport workers.

**Data collection tools development**

The questionnaires, key questions and guidelines for group discussions and in-depth interviews, and observation information forms were developed. Questions were developed in collaboration with UNESCAP and were based on acknowledged indicators for the behaviours under observation.

**Pre-survey Mapping**

Researchers from the NCOs in each country conducted a pre-survey mapping along the corridor to identify areas for data collection. For this purpose, information was collected from the transport associations, owners of road transport companies, relevant land transport officials, such as provincial transport officers, highway police and verified with roadside stakeholders in the areas identified.

Sites were selected along the corridor where truck drivers regularly stopped for rest and/or to refresh themselves. Such sites included, gas stations, roadside restaurants, designated rest areas (i.e., parking lots) for drivers, and stretches of well-lit roads with a high density of restaurants often frequented by truck drivers.

**Training of interviewers and researchers**

The interviewers and researchers participated in training workshops, facilitated by a technical consultant. The objectives of the training were: to facilitate an increased understanding of the study’s objective and the study context; to familiarize the researchers and interviewers with the methodology and the data collection tools; to practice the use of the data collection tools and fine-tune interviewing techniques; and to plan the fieldwork through a participatory approach.

During the training background information was provided on the transport dynamics along the corridor, insurance coverage, access to health services, substance use, and STDs and HIV/AIDS. The training consisted of two components: classroom lectures and fieldwork to practice interview techniques.
Field data collection

Quantitative data collection

A questionnaire was developed for long distance truck drivers and their assistants that included comprehensive questions on the following data: demographic, occupational, health status, health seeking behaviours, and risk behaviours that impact on health.

Interviewers approached all truck drivers, stopping at the study site by approaching the vehicle. If the driver met the sample criteria and agreed to participate in the study, the interviewer took the driver to a place where no one could interrupt the interview, e.g. the back tables of a roadside restaurant. Trained interviewers interviewed the truck drivers by using a questionnaire.

Qualitative Data Collection

Focus group discussions (FGD) were organized with long-distance truck drivers along the selected highway routes. The average size of the groups was six to ten drivers. Six was the minimum required.

The team coordinator or supervisor would approach the truck drivers randomly to request their participation in the FGDs. In some cases, a trucking business owner was approached first to request permission to identify truck drivers among the employees.

The discussions took approximately one to two hours and were moderated by a qualitative researcher in accordance with guidelines prepared in advance.

In-depth interviews (IDI) were organized with key informants on the behaviour of truck drivers being studied. The key informants included owners of transport companies, health care providers, state officials, owners or employees of roadside restaurants, gas stations and entertainment/karaoke establishments. The interviews were conducted by a qualitative researcher in accordance with guidelines prepared in advance.

First-hand observation of the behaviour of truck drivers was also undertaken by researchers who travelled with truck drivers along sections of the selected transport corridors. Qualitative researchers conducted this activity in accordance with an observation sheet prepared in advance.

Quantitative Data Analysis

Qualitative data analysis consisted of a content analysis of the data collected from the focus group discussions, the in-depth interviews and the behavioural observation.

The results obtained from the content analysis were used to support and expand on the quantitative data collected and analyzed under the study.
Limitations of study

While care was taken to ensure that the research process produced results that are reliable, unavoidable factors limited access to certain kinds of information and sections of the target population.

One limitation was that previous studies, undertaken by other research teams within the same target populations, did so without clear explanation of objectives and the use of research results. This made it difficult sometimes to convince the target population to participate in the Health Without Borders study. Another difficulty was getting access to the appropriate respondents and sufficient number of groups for carrying out FGDs.

Another limitation was obtaining information from secondary sources. In Lao PDR for example the research team found it difficult to obtain needed information related to road transport along sections of the transport routes selected for study.

Unexpected developments during the course of the research have also affected its outcome. In Thailand for example during the study period the oil price, a variable cost for transport businesses, was raised significantly. To adjust for the increased operations costs, transport companies took the following temporary measures: the number of drivers was decreased, the distance travelled per driver was increased, transport along unprofitable routes was halted, and the allowance for drivers was decreased. This influenced the disposable income of drivers.
Situational Analysis - LAO PDR

1. National Profile

1.1 Geography

Laotian People’s Democratic Republic (Lao PDR) covers an area of 236,800 square kilometres, stretching a distance of approximately 1000 km north to south, and between 200 - 400 kilometres east to west. The most significant physical characteristic of Laos is its mountainous terrain. Only 10 per cent of the country is not mountainous, and this is for the most part along the flood plain of the Mekong River.

Lao PDR is land-locked, and thus has only limited access to ports, through the poor quality road networks to Viet Nam, and through links to Thailand across the Mekong River. The Lao PDR is the only country bordering all the other countries in the GMS. Its longest borders are a 2,000 kilometre eastern border with Viet Nam, and a 1,800 kilometre western border with Thailand. It has shorter western and northern borders with Myanmar and China, and a southern border with Cambodia.

The Lao PDR has a population of 5.6 million, of which 23 per cent is urban and 77 per cent rural. It is the least populous country in South-East Asia. Population density varies drastically throughout the country, with a much higher density prevailing in the Mekong River valley. For example, the population density of Vientiane is 177 people per square kilometre, while in Salavan and Sekong provinces, it is 30 and 11 people per kilometre respectively. The median average for all provinces is 24 people per square kilometre.
1.2 Economy

Lao PDR is classified by the United Nations as a ‘least developed country’ (LDC), one of four in South-East Asia. An LDC is defined by low levels of per capita income, low levels of human resource development and lack of economic diversification.

Only 27 per cent of the population aged 15 and over has completed more than a primary education and for females the proportion is only 22 per cent. Seventy-seven per cent of the labour force is in agriculture and 60 per cent of farms still produce mainly for subsistence, not for the market.

Lao PDR became a member of ASEAN in 1997. As a consequence, the country has become more open to the outside world. Infrastructure development, particularly road and dam construction, is a central component of the Government’s strategy for poverty reduction. Strong infrastructure is a prerequisite for further macroeconomic development and an essential factor in ensuring that the benefits of growth and development are shared equitably between urban and rural areas. Access to utilities, information and communications is gradually developing throughout the country.

However, there is still a very large disparity in access between urban and rural areas in terms of information, education, transportation and health care facilities. Although roads are being improved, the national economy is highly fragmented, with food in surplus areas unable to be moved to deficit areas. In certain instances, it is cheaper to buy imported goods than to buy from distant Lao suppliers. Some Lao suppliers sell successfully in local markets because transport costs of lower priced products from other provinces and imports are too high. And provinces still impose charges on movement of goods across their borders.

1.3 Transport

Government policy has identified road construction and transportation as a key area for national development. As a result, since Lao PDR became an ASEAN member, many national roads have been renovated and/or constructed, with support from many international donors. Route 13, the national North-South highway, is now almost completely paved from Luang Prabang in the north through Vientiane to Champasak, thus linking the three largest cities. Further bridges and roads are being upgraded to link Pakse in the south, and a good quality paved road is already in place between Pakse, Salavan, and Sekong. Geographical isolation, which has always been a characteristic of Lao PDR, is beginning to break down, affording both new potential and challenges for development.

Currently 53.1 per cent of national roads have been paved, while 21.7 per cent and 11 per cent of urban and special roads respectively are also paved. These figures indicate that both domestic and international goods transport and distribution are currently well facilitated.

After Lao PDR opened its economy to the world due to accelerated development the number of trucks and volume of transport increased spectacularly. Around the country, there are about 476,835 vehicles including 377,700 motorcycles/3 wheelers/tuktuks, 80,174 light cars/trucks and 18,961 heavy trucks of which 15,016 serve as cargo transporters. The larger the city, the larger the number of trucks that exist there. For instance, there are 7,035 cargo transport trucks in Vientiane, 1,541 in Savannakhet and 1,253 in Champassak.1

1 Statistics of vehicles around the country, Department of Transport, MCTPC, June 2006.
Information on cargo transportation from 1976 to 2005 reveals that the quantity of cargo transported has increased ten fold.\(^2\) However, statistics on the number of vehicles in the country shows that over a period of 30 years, the number of trucks has increased only about 3.5 times, thus revealing the increased burden on existing trucks. The number of vehicular accidents has also increased but lesser than the increase in number of trucks; about two to three fold.

### 1.4 Road Accidents

Road accidents registered a huge increase from 1997-2001, (3,407 – 4,157 cases respectively) due to increase in both new roads and motorcycles and vehicles after opening up of the country. The maximum number of road accidents was in 2003 with 9,788 cases, but this dramatically decreased in 2005 (762) due to interventions of many projects on road safety and the review of road transport rules and regulations. The majority of road accidents were reported to involve motorcycles and tuktuk riders, and very few with truck drivers.

### 1.5 Mobility and Migration

Lao PDR has ten border provinces with Thailand stretching for 1,835 kilometres. The Mekong River forms the border for much of this area. The first bridge to span the Mekong was built in 1994, at the Nongkhai-Vientiane border point. The most noticeable impact of this bridge was increased trading, bringing many traders and truckers to the area. The number of heavy vehicles in the area increased dramatically. Another area of expansion is Nongkhai itself with an influx of tourists – Thai, Lao, and foreigners). The second bridge was completed in Pakse, Champasak, where the Mekong does not form the border but flows into Lao PDR.

Another bridge is under construction at Mukdaharn-Savannakhet, as part of the East-West corridor to Thailand. These are the three major urban centres in Lao PDR, all on the Mekong, namely Vientiane with a population of 250,000; Savannakhet with 130,000, and Champasak with 109,000, all bordering northeast Thailand. A fourth bridge is planned for the other major crossing, bordering the north of Thailand, Chiang Khong in Chiang Rai, which borders Houayxai, Bokeo Province.

Currently, more than half of the population of Lao PDR lives in border districts due to the promise of enhanced income through trade and work opportunities in neighboring countries. A significant amount of the cross-border trade is conducted informally by individual traders, and this increase in income for traders has positive flow-on effects to the local domestic economy.

There are also at least 200,000 Lao workers in Thailand, 55 per cent of them women. These Lao workers send back as remittance an estimated US$100 million a year, which is equivalent to approximately five per cent of Gross Domestic Product (GDP).\(^3\)

\(^2\) Statistics on 30 years of products transportation, Department of Transport, MCTPC, June 2006.

\(^3\) The Lao National Human Development Report 2006, UNDP
1.6 Health

The quality and availability of the health care system in the Lao PDR are still relatively limited, particularly in rural areas. The maternal mortality rate - an important indicator of the availability and quality of health services - is 350 per 100,000 live births. Malaria and dengue fever are endemic. In the 2002-2003 household survey, 56 per cent of the population reported health problems that disrupted work. In the most remote rural areas, 63 per cent reported such problems.

Immunization coverage is now close to 100 per cent, but access to other preventive and curative services is still limited particularly in rural areas. 20 per cent of the rural population is more than 30 kilometres from a hospital, and 29 per cent is more than ten kilometres from the nearest health centre. And one fifth of the rural population that reported an illness disrupting work and needing treatment did not seek care because of distance and/or because the care was “too expensive”.

Most seriously is that in 2000, 40 per cent of children were still malnourished. Malnutrition of children not only reduces school enrolment and performance but it can also permanently reduce cognitive ability thus compromising the future human development of the next generation.

1.7 HIV/AIDS

Overall, Lao PDR remains a low prevalence country with an estimated 0.08 per cent HIV seroprevalence in the adult population. But there are several factors, which may either, mask a higher HIV prevalence, or may contribute to an accelerated spread of the epidemic. The second round of HIV surveillance targeted mainly sex workers(SW) and certain groups of their potential clients in six provinces.

STI remain high among SWs and clients. About one half or more of service women reported a potential STI symptom in the past 12 months. Even more telling, one fifth of SWs in Luang Namtha and Savannakhet reported a genital ulcer, sore, blister or wart in the past year – an indication that herpes may be quite prevalent in these areas.

Up to June 2006, the official cumulative number of people living with HIV was 2,003, of whom 1,201 were known to be living with AIDS. Six hundred and eighty-eight had already died. Fifty-nine per cent of reported HIV cases were male and 41 per cent female. Based on cumulative HIV case reports, more than 77 per cent of those infected were between the ages of 20 and 39 years. Of those whose mode of infection was known, 85 per cent had been acquired through heterosexual activity, 3.5 per cent through transmission from mother to child, 0.7 per cent through homosexual intercourse, 0.3 per cent through blood products and 0.2 per cent through intravenous drug use.

As a matter of fact, the number of officially registered AIDS related deaths is much higher than the estimated number of people dying of AIDS based on a 0.08 per cent prevalence. This would mean that either a group with a relatively high HIV prevalence was not captured in the second round of surveillance, and/or that the epidemic in the Lao PDR started much earlier than assumed. The latter would point to migrant labour working in Thailand, who may have brought HIV back to Laos in the early 90s.

Low levels of awareness, limited access to prevention and protection, including condoms, heightens the risk of rising prevalence of HIV/AIDS in the Lao PDR. Other factors such as the low socio-economic status of women, high levels of poverty and a widening generation gap compound the risk of the disease spreading. Increased population mobility, internal and external labour migration and changes in lifestyles and sexual behaviour are all important ingredients for an accelerated spread of the epidemic. Moreover, in recent years, the use of recreational drugs has rapidly expanded in Lao PDR. An alarming number of SWs are thought to be injecting drugs. International evidence shows that intravenous drug use (sharing of injecting equipment) may substantially accelerate the spread of the HIV epidemic. Alcohol also plays a significant role in the spread of HIV, particularly in relation to commercial sex and condom use. Under the influence of alcohol men are more likely to purchase sex and less likely to use condoms.

The second round on surveillance revealed also information on coverage and quality of prevention. Although between 2001 and 2004 the overall response to the epidemic improved considerably, the number of SWs, clients and labour migrants reached with interventions are still low, and none of the surveyed provinces achieved a full set of prevention services.

But not only prevention plays a role in the fight against HIV/AIDS; care and support services are also needed. In 2005, one site (Savannakhet) provided expanded care and support services, including antiretroviral therapy. Clearly an expansion of care and support services is needed to stabilize the epidemic.
2. The Study and its Outcomes

2.1 General Information

In this study, Road No. 9 and the AH 12 corridors were selected as locations for fieldwork.

Road No. 9 is a critical link in the East-West Economic Corridor being developed in the GMS. It is the only land route that traverses mainland South-East Asia on an east-west axis. The project was supported by ADB and the Government of Japan, and completed in mid-2006. The 1,500 kilometre road directly connects the port of Mawlamyine, Myanmar, to the Da Nang deep-sea port in Viet Nam, passing through Thailand and Lao PDR. The corridor will play a major role in integrating the GMS countries both physically and economically.

Asian Highway 12 (AH12) is currently being rehabilitated with support from the Government of Lao PDR and the ADB. This rehabilitation will complete the all-weather road link between Thailand, through Mekong Bridge 1, National Road No. 13 North, Road No. 3 and Boten in Yunnan Province of PRC. Given the good road network from Bangkok to Singapore and Boten to Beijing, the North-South Economic Corridor will reduce transport costs from the PRC capital to the tip of the Malay Peninsula; increase the efficiency of movement of people, vehicles, and goods; and expand investment and trade between the PRC and South-East Asia, and within South-East Asia itself.

Sample Size

150 respondents, all males, were involved in the study.

Age Group

The age of participants in the study ranged from 17 to 56 years old. As defined by most of previous research, long-distance transport workers (including the driver's helpers and assistants) are men aged 19 – 49 who drive vehicles over long distances, either domestically or across international borders within the subregion. However, this study had to take a wider age range due to the lack of target drivers for interviewing. The mean age of respondents in the study was 35, mean period of working as driver or assistant was 12 years (mode = 7) and 87.3 per cent of respondents reported their main occupation as drivers.

Marital Status

With regard to marital status, about 80 per cent of respondents were married, while 18 per cent were single and two per cent reported being divorced or widowers.

Education

Forty-one per cent of the respondents had completed tertiary education, 34 per cent finished secondary education, 20 per cent had completed only primary schooling, and about 4.7 per cent had certificates of training, diplomas or higher education.
The figures above suggest that, given their levels of literacy and educational qualifications, further education on health and preventing diseases within this mobile group will not be too difficult.

### 2.2 Work Related Information

#### Nature of employment

As 51 per cent of drivers interviewed had their own truck, it is not surprising that their answer to a question on their ‘place of work’ mainly indicated individual or private locations. The study found that 90.7 per cent worked for privately owned companies, 7.3 per cent in joint venture companies and 2.0 per cent in government owned organisations.
Income

The average income of interviewed truck drivers and assistants is 1,500,000 Kip per month.

<table>
<thead>
<tr>
<th>Age of respondent</th>
<th>Range 17 – 56 years old</th>
<th>Mode 35 years old</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period of working as truck driver</td>
<td>0.5 – 40 years</td>
<td>7 years</td>
</tr>
<tr>
<td>Monthly income</td>
<td>200,000 – 48,000,000 Kip</td>
<td>1,500,000 Kip</td>
</tr>
<tr>
<td>Average number of days spent at home in one month</td>
<td>1 – 26 days</td>
<td>7 days (15 days in SVK)</td>
</tr>
</tbody>
</table>

The above table shows a big variation in the monthly incomes of long-distance road transport workers because the study included drivers working as employees of government and private companies, those driving hired trucks and also those who own the trucks they drive.

The study found that drivers who earn more than 1,500,000 LAK per month have more than one truck for transporting goods. Respondents whose monthly income is more than 15,000,000 LAK per month are mostly private transport company owners and have more than six trucks in possession. People who earn lower than 1,500,000 LAK are those who hire trucks or are employees of government transport associations (n = 3) and get paid a salary on a monthly basis, or work as truck drivers’ assistants.

Job Satisfaction

Questioned about job satisfaction, 82 per cent of respondents said they were satisfied with their current job (36.7 per cent very satisfactory, 45.3 per cent satisfactory), while 17.3 per cent said “they are so so”, and only one person (0.7 per cent) claimed to be “not satisfactory”. The respondents who felt very satisfied with their jobs are those whose monthly incomes are more than 2,500,000 LAK, and who have enough money for looking after their families, truck repairs, social support and recreation. The high percentage of job satisfaction was also revealed in focus group discussions with long distance road transport workers:

“I come to be truck driver because I love it. This job brings me to travel to many provinces in Laos and even to foreign countries. I think that this work can also make more money than many other jobs!”

Cargo carried

The cargo carried included a variety of products, from consumer goods, building materials, agricultural and forest products, to industrial raw material. Consumer goods were the most commonly transported cargo, accounting for 53.3 per cent of all goods carried. Industrial raw materials and agricultural products were the next most frequent transported cargo at 18.0 per cent and 14.7 per cent respectively.

---

Work and Travel

When asked: “On average, how many days per month do you stay home?” most drivers and/or assistants claimed that they could stay home only four to seven days per month. This number was seven to fifteen days or more in Savannakhet and four to seven days in Luang Namtha.

“Three years ago, I had at least six to seven trips per month to the Lao-Viet Nam border. But now, there are many trucks competing with each other to lower the transport prices, and the lowest one gets the job. At present, sometimes I have to wait for two weeks to load goods, I have to wait more than a month to have one trip; how can I raise money to support my family?”, complained a driver in a FGD conducted in the southern part of Lao PDR.

“We spend most of our lives here, in Nateuy checkpoint, waiting for loading goods back to Vientiane. Most of us stay home with families just about four to seven days, then travel and remain here for almost a month”, said another participant in a FGD in Luang Namtha.

While there was increased competition in the goods transportation business with Thai and Vietnamese trucks along road No. 9, on AH12 and along the Lao – China border, the trucking business of operators from Lao PDR were operating smoothly. However, drivers interviewed at Nateuy, Luang Namtha checkpoint were found to be staying away from home longer than those along road No. 9, waiting for loading and checking goods, thus giving opportunity for drivers and their assistants to look for entertainment of sorts, such as drinking and having sex with a casual partner and/or sex worker.

Duration of trips

Respondents said that most trips were two to ten days (59.6 per cent of drivers) in duration. However, drivers along road No. 9, which has a length of about 230 km, usually spent only one to three days per trip (72 per cent).

Most drivers reported temporarily stopping their trucks along the roads, at restaurants and inspection posts. They also said they often drove continuously for five hours, with about 10 hours the longest time of continuous travel. About one third reported that their driving to the destination point involved less than four hours.

Eighty-four per cent reported stopping along the road and sleeping in their trucks, while 12 per cent stopped their trucks and rested in hotels or guesthouses, and the remaining number reported stopping and resting at parking lots.

2.3 Health related information

Overall, truck drivers have good health status. The majority of truck drivers (78.6 per cent) considered themselves healthy (with 47.3 per cent healthy and 31.3 per cent very healthy). About 21 per cent said they are normal and only one person reported to be physically weak.

While driving, 74 per cent of drivers said they felt normal, 12 per cent felt fatigue and very few said they experienced back strap or shoulder pain. Six per cent reported having a good feeling while driving.
“Sometimes I have back or shoulder pain when I am home, but after driving for 10 to 15 minutes, it seems the pain disappears and I felt good and energetic”, said a driver.

When asked about signs and symptoms of pain and illness, 47.3 per cent of drivers claimed they never have pain or illness at all. Over 25 per cent of them felt back pain, 15.3 per cent had strap pain and 12 per cent felt shoulder pain, leg pain and other kinds of pain.

Almost half of drivers interviewed reported no pain or illness.

**Accidents**

Although the number of road accidents in Lao PDR were very high, only 12 per cent of truck drivers reported having had one traffic accident during their entire professional career. Causes reported were mainly due to collision with motorcycles (73 per cent). The other causes were bad quality of roads (23 per cent), soil erosion and overloading of goods in their trucks.

2.4. Risk Behaviour

When truck drivers travel over long distances, they experience exhaustion and sleepiness, which is one of the reasons for their stopping along the road to take rest. Drivers were asked about taking stimulants to keep them awake while driving, and the answers indicated that 78.7 per cent took energy drinks, 56.7 per cent reported having had coffee or tea, 8.7 per cent took alcoholic drinks, some reported smoking cigarettes, and almost 10 per cent reported using nothing apart from drinking water.

Only two drivers confessed to using drugs and both reported having used amphetamine. During the in-depth interviews most drivers reported that drinking alcohol or beer was common among long distance transport workers while waiting for loading goods and returning to their hometowns. Drivers in Luang Namtha reported considerably more daily consumption of alcohol than those in Savannakhet because they spend longer time away from home.

“As we have to spend most of our time away from home, we often look for something to kill time, and as you see, playing cards and drinking alcohol or beer are our common choices”, said a driver.

2.5 Sexual Behaviour

About 50 per cent of drivers reported having had sex when away from home and back from duty. Interviewed drivers said they regularly had sex with their wife (54 per cent). A second most common sex partner were SWs (21 per cent) and casual partners or girlfriends were reported to constitute only about 10 per cent.

Talking about sex is not common within the family or among friends. Sex education is also not part of the school curriculum in Lao PDR.
When asked questions related to sexual behaviour, many Lao people seem to be shy and as a result, approximately 20 per cent did not answer at all.

The table below shows the quantitative data based on interviews with 150 drivers who reported having sex with different partners in the last 12 months; most of the interviewed drivers had sex with their wives. The second most common partners were SWs followed by casual partners or girlfriends.

### Truck drivers reporting sexual intercourse in last 12 months

<table>
<thead>
<tr>
<th></th>
<th>AH12</th>
<th>Percentage</th>
<th>Road 9</th>
<th>Percentage</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wife</td>
<td>55</td>
<td>51.89</td>
<td>63</td>
<td>70.00</td>
<td>60.94</td>
</tr>
<tr>
<td>Casual partner</td>
<td>16</td>
<td>15.09</td>
<td>14</td>
<td>15.56</td>
<td>15.32</td>
</tr>
<tr>
<td>Sex worker</td>
<td>35</td>
<td>33.02</td>
<td>12</td>
<td>13.33</td>
<td>23.17</td>
</tr>
<tr>
<td>No Answer</td>
<td>0</td>
<td>0.00</td>
<td>1</td>
<td>1.11</td>
<td>0.55</td>
</tr>
</tbody>
</table>

The number of truck drivers reporting condom use during sex with partners

<table>
<thead>
<tr>
<th></th>
<th>AH12</th>
<th></th>
<th></th>
<th>Road 9</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>DNR</td>
<td>Yes</td>
<td>No</td>
<td>DNR</td>
<td>Yes</td>
</tr>
<tr>
<td>Wife</td>
<td>2</td>
<td>50</td>
<td>0</td>
<td>1</td>
<td>60</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Casual partner</td>
<td>4</td>
<td>8</td>
<td>0</td>
<td>9</td>
<td>6</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Sex worker</td>
<td>30</td>
<td>0</td>
<td>1</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>42</td>
</tr>
</tbody>
</table>

In the past 12 months, 99.3 per cent of drivers reported having had sex (only one person reported not having any sexual contact at all). The majority of drivers (79.3 per cent) reported having sex with their wives, ten per cent with casual partners or girlfriends, and 10.7 per cent with sex workers.

2.6 Condom Use

About 33 per cent of drivers reported using condom when having sex. Approximately 30 per cent of them said they “do not remember”.

The table below shows some differences in condom usage, by province:

<table>
<thead>
<tr>
<th></th>
<th>Condom use during travel, by province</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Luang Namtha (per cent)</td>
</tr>
<tr>
<td></td>
<td>Away from home</td>
</tr>
<tr>
<td>Yes</td>
<td>52.0</td>
</tr>
<tr>
<td>No</td>
<td>37.3</td>
</tr>
<tr>
<td>DNR</td>
<td>10.7</td>
</tr>
</tbody>
</table>

It is surprising that condom use amongst drivers along road No. 9 was relatively low. In contrast, percentage of those saying they “do not remember” was high (44 – 48 per cent).
When questioned about the number of times they had sexual intercourse in the last one month, drivers who had sex with their wife reported one to three times, those with casual partners or girlfriends zero to eighteen times, and those with SWs said one to ten times.

Condom use reported during sex with spouses was almost nil (2 per cent), while percentage of drivers who did not respond was quite high (24 per cent).

Fifty per cent of drivers reported using condom with casual partners or girlfriends. Condom use in Savannakhet was considerably higher than in Luang Namtha (60 per cent and 40 per cent respectively).

Reporting on last occasions of sex with SWs, 96.7 per cent of 18 respondents stated that they used condoms. Two drivers reported not using condoms because they did not think it was necessary (confident that their partner was ‘safe’). Another reason for not using condoms was the need they felt for preserving the ‘natural’ feeling of sexual intercourse.

Amongst drivers who reported using condoms, it has been found that this was often at the suggestion of SWs. Suggestion to use condoms by casual partner or girlfriend was very rare, as this would have been seen as questioning the ‘trust’ between them.

Regarding the frequency of condom use, the following chart explains the situation:
Percentage of condom use amongst interviewed drivers is relatively low (66 per cent) but matched with reports from the Second Generation Surveillance 2nd Round on HIV, STI and Behaviour.\(^7\)

### 2.7 Access to health-related information

Almost all drivers included in this survey (98.7 per cent) had heard about AIDS. Regarding mode of HIV transmission, 94.7 per cent said infection was transmitted through unsafe sexual intercourse i.e. without using condoms, 58 per cent said it could be transmitted through blood transfer, 14 per cent knew it could be transmitted from mother to child while giving birth. Some drivers mentioned other modes of transmission such as mouth-to-mouth kissing; sleeping together without sexual intercourse, sharing needles, but 3.3 per cent just said they “do not know”.

All respondents involved in the study said that SWs are the most-at-risk group because they are exposed to many sorts of clients, especially those who dislike use of condoms. From four observations of hot spots and several in-depth interviews with SWs, it has been found that truck drivers are less at risk because road distance is not so long from Savannakhet to Lao Bao, and drivers from another road corridor reported having no time to visit SWs due to preoccupation with unloading and reloading of goods at destinations.

Their sources of information were varied, but basically consisted of television, mobile teams, radio, newspapers, friends and posters. Sixty four per cent of drivers reported absorbing information from television, 50.3 per cent from mobile teams, 48.7 per cent from radio, 30.7 per cent from newspapers, and 13.3 per cent from friends. Only two drivers recalled nothing about their source of information on AIDS.

Talking about opinions on the best channel for HIV/AIDS/STI education, about 40 per cent suggested mobile teams, 26 per cent broadcasts on television, 12.7 per cent said the best channel was radio, 10.7 per cent said newspapers, 10.7 per cent preferred peer education, eight per cent suggested having posters, and 2.7 per cent mentioned stickers. Almost 13 per cent of drivers said they “do not know”.

Answering a question on protection from HIV/STI, 64 per cent of drivers said the best method was to use condoms when having sex with casual partners and/or SWs. About 25 per cent of interviewees mentioned being faithful to their wives, six per cent of drivers talked about being careful in choosing partners and not sharing unclean needles together. The remaining 15 per cent of drivers said nothing (no answer) and did not have anything to say (do not know).

Now, there are too many SWs, this business is mushrooming. If we can limit the expansion of this illegal business, HIV/AIDS/STI vulnerability of drivers, related people and SW themselves, will decrease considerably. (Customs official).

If everybody takes responsibility to protect each other, men stop dominating women about decision on condom use, HIV/STD infection will be under control. (SW in an IDI)

---

\(^7\) Center for HIV/AIDS/STI, Lao PDR (2005). Second Generation Surveillance 2nd Round on HIV, STI and Behaviour, p.9,
2.8 STIs and HIV

Just 90.7 per cent of drivers reported hearing about STIs. Of those who knew about STIs, 77.3 per cent knew of gonorrhea, 70 per cent knew of AIDS and 60 per cent knew of Chlamydia. Other STIs such as syphilis, candidiasis and herpes were unknown.

Percentage of drivers interviewed in Nateuy, Luang Namtha, who reported being aware of STIs is remarkably higher than drivers interviewed along road no. 9 in Savannakhet Province. 85.3 per cent of respondents in Nateuy, Luang Namtha were aware of gonorrhea 69.3 per cent of Chlamydia and 81 per cent of AIDS. Of those aware of STIs, 9.4 per cent experienced having symptom of discharge, 6.7 per cent had itching around the genital area, three per cent claimed pain during urination, and two drivers reported having had inguinal inflammation.

Only 15.3 per cent of drivers who have had STI symptoms reported going for a clinical examination. About 77 per cent of them recalled never going for examination, and 7.3 per cent said they did not remember. Of those who have sought examination, 60 per cent went to public hospitals, 32 per cent went to private clinics and eight per cent met general practitioners. Results of those who underwent examination indicated that 59.7 per cent were positive and 40.3 per cent negative.

Almost 44 per cent of drivers who tested positive were examined at the government hospital. An equal percentage of drivers (18.7 per cent) went to general practitioners and clinics; 12.5 per cent of them practiced self-medication and bought medicines at pharmacies, and 6.3 per cent reported using traditional medicines.

2.9 Health seeking behaviour

Drivers reported going to buy drugs from pharmacies (17 per cent). Thirteen per cent told that they went to government hospitals seeking medical diagnosis, treatment and advice. Six per cent of drivers reported using private clinics, and nine per cent said that they use other options for treating their illness such as self-medication, use traditional medicines or go to local health center.
SITUATIONAL ANALYSIS - THAILAND

1. National Profile

1.1 Geography

The Kingdom of Thailand is situated in South-East Asia above the equator and is part of the Indochina Peninsula.

Thailand, covering an area of approximately 514,000 square kilometres, is the third largest country among the ten Southeast Asian nations, ranking after Indonesia and Myanmar. Thailand’s borders cover a distance of about 8,031 kilometres, of which 5,326 kilometres are inland and 2,705 kilometres are coastlines.

1.2 Economy

Over half a century ago the Thai economy was mainly reliant on the agriculture sector. Local or village hand-made productions were the industrial merchandise.

In recent decades both urban and rural areas have evolved into a pattern of cash crop agriculture and industrial manufacturing for exports. Thailand’s economic system entered the era of systematic economic development following the advent, in the early sixties, of the five-year National Economic and Social Development Plans, an approach that put a greater emphasis on systematic economic planning.

As a result of economic development, Thailand’s annual economic growth rate, in the past three decades, was on average at 7.8 per cent. During the period of 1986-1990, the average economic growth rate was annually at 10.5 per cent. The figure was reduced to 8.3 per cent in the 1991-1995 period. Such growth has raised Thailand to the level of a lower middle-income country.

In 1996-1997, an economic crisis drastically hit Thailand’s economy as a result of which in 1997, the Thai economy had a negative growth rate of 1.7 per cent, and a greater decline to minus 10.8 per cent in 1998. Nonetheless, since 1999 Thai economic growth has been on the upswing again. ¹

¹ Source: National Economic and Social Development Board.
1.3 Transport

Thailand’s road transport network extends over 60,000 km of which 16,500 km are the main routes. This is one of the best road networks of South-East Asia. 90 per cent of goods transported in the country are carried on this road network.

About 30 per cent of these roads are in the country’s northeast region, 27 per cent in the north, 24 per cent in the central region, and 19 per cent in the south. Bangkok is in the central part of Thailand and is the main transportation hub of the country.

Thailand, due to its central location and high quality roads, is a key player in the Asian Highway project. New highways throughout the country will eventually become part of the East-West Economic Corridor (EWEC), which will link the South China Sea with the Bay of Bengal, and the North-South Corridor, which will link Singapore with Kunming.

1.4 Road Accidents

In 2004, Thailand ranked sixth in the world in terms of road fatalities with an average of 36 deaths a day. In that same year, the Ministry of Public Health estimated that road accidents were the third leading cause of death in Thailand2. In 2003, road accident statistics from the Office of Thai National Police showed that 91,623 accidents occurred, resulting in 13,209 deaths3.

1.5 Migration and Mobility

In recent decades Thailand’s booming economy has become a magnet for migrants from neighbouring countries. As the most developed country in the subregion, its per capita GDP is much higher than neighbours like Cambodia, the Lao PDR and Myanmar. Consequently, an estimated two million irregular migrant workers from Cambodia, the Lao PDR and Myanmar are now believed to be present in Thailand.

Many of these migrants are employed in Thailand’s fishery, agricultural, manufacturing, construction and service sectors.

The profile of these migrants varies widely. Some stay for extended periods in Thailand, particularly the estimated 1.2 million Burmese, who have few prospects in their home country. Others simply stay for seasonal work. Many Lao workers arrive in Thailand in time for the harvest in December and leave after a few months.

Thailand is also a major destination for trafficking in human beings, particularly women and children.

Due to its position as an economic hub in the GMS Thailand also has a high volume of temporary visitors such as truck drivers and transport workers ferrying cargo from neighbouring countries.

---

1.6 Health

Based on the overall national health account data derived from Thailand’s National Economic and Social Development Board (NESDB), the national health expenditure rose from 3.8 per cent of GDP in 1980 to 6.1 in 2000.

In terms of equity of health spending burden, data from 2000 showed the poor have a health expense burden 3.6 times higher than the rich, in terms of proportion of income spent.

During the bubble economy from 1993 - 1997, spending on medicine had sharply increased. The economic crisis of 1997 had a great impact on health expenditure due to a decline in household expenses on health.

In 2001, the Thai government introduced the Universal Health-Care system or ‘30 Baht’ gold card health scheme, to cover a wide range of ailments at very reasonable cost.

Sections of the Thai population are covered by other health insurance schemes such as Social Security that is for people in regular employment. In addition, health insurance coverage is provided under the Workers Compensation Act and Mandatory Car Insurance as stipulated by the scheme.

In case of illness, the 30 baht gold cardholders are entitled to medical treatment at the health service provider indicated on the gold card, i.e., in the locality where the individual is registered.

In case of accidents or sudden illness, gold cardholders are entitled to medical treatment at any government health-care provider and at private hospitals that have joined the scheme. In case of emergencies, treatment can be received at health-care providers different from the one specified on the gold card no more than twice a year.

For example, under the scheme the following services cost 30 Baht per service:

- Examination, diagnosis, treatment, and rehabilitation; including other alternative medical practices specified by National Health Security office
- Two cases of child delivery
- Food and basic room expenses for in-patients
- Tooth extraction, inlay, cleaning, plastic base denture, milk-tooth nerve treatment, artificial palate for children with a cleft lip and palate
- Drugs and medical supplies in accordance with the national basic drug list
1.7 HIV/AIDS


An early multi-sector response involving several key ministries, municipalities, NGOs, media, communities, private sector, and the police, focused largely on risk reduction in commercial sex, has enabled Thailand to achieve this turn-around in HIV infections.

Important factors in this success have been strong political commitment in the early 1990s and the formation of the National AIDS Prevention and Control Committee under the Office of the Prime Minister and the Prime Minister’s chairing of the NAPCC (National AIDS prevention and Control Committee) thus ensuring participation of all ministry supported by a comprehensive multi-ministerial plan by the NESDB.

Overall, three factors contributed to reducing sexual transmission of the HIV virus: reducing brothel visits, condom compliance, and improved STI control, thereby reducing risk of HIV infection.

2. The Study and its Outcomes

2.1 General Information

Research Site

For the situational analysis in Thailand it was decided to study long-distance truck drivers who use the Bangkok - Nakorn Ratchasima - Khon Kaen - Udon Thani – Nong Khai - Vientiane route, a road linking Thailand and Laos.


Sample Size

The sample size of truck drivers who participated in the study was 94.

Age Group

The average age of the sample was 38 years. The age range of the sample was 31-40 years.
Marital status

Most of the truck drivers were married. Only 6.4 per cent of them stated that they were single.

Education

Most of the truck drivers only finished primary school (69.1 per cent). Those who continued their education after primary school were younger than 40 years.

Domicile

Most of the sample had their domicile in the northeast of Thailand (77.8 per cent). The second largest number were from the central region (13.8 per cent).

2.2 Work Related Information

Nature of employment

Most of the truck drivers participating in this study worked for a transport company (83 per cent). Only 10.6 per cent were owner-drivers.

<table>
<thead>
<tr>
<th>Status</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed drivers</td>
<td>83</td>
<td>88.3</td>
</tr>
<tr>
<td>Truck owners</td>
<td>10</td>
<td>10.6</td>
</tr>
<tr>
<td>Driver assistants</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Professional Experience

Most drivers, in the sample study, had worked in the trucking business for an average of 10 years. One third (27.7 per cent) of the truck drivers had been in this career for 20 years or more.

<table>
<thead>
<tr>
<th>Years in Profession</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 5 years</td>
<td>13</td>
<td>13.8</td>
</tr>
<tr>
<td>5-9 Years</td>
<td>22</td>
<td>23.4</td>
</tr>
<tr>
<td>10-14 Years</td>
<td>21</td>
<td>22.3</td>
</tr>
<tr>
<td>15-19 Years</td>
<td>12</td>
<td>12.8</td>
</tr>
<tr>
<td>20 Years or more</td>
<td>26</td>
<td>27.7</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Average working duration (Median) = 10 years

Income

For most drivers, their income consisted of their monthly salary and allowances or “extra” money they received from the employers. For owner-drivers, income consisted of the payment received upon delivery of cargo/load.
It was found that the monthly median income of the truck drivers was 12,000 Baht, which is higher than the national monthly median income (7,500 Baht per month in 2003). Most of the drivers (42.6 per cent) stated that their average monthly income was 7,501-15,000 Baht.

<table>
<thead>
<tr>
<th>Income</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>THB 7,500 per month or less</td>
<td>20</td>
<td>21.3</td>
</tr>
<tr>
<td>THB 7,501-15,000 per month</td>
<td>40</td>
<td>42.6</td>
</tr>
<tr>
<td>THB 15,001-22,500 per month</td>
<td>16</td>
<td>17.0</td>
</tr>
<tr>
<td>THB 22,501-30,000 per month</td>
<td>7</td>
<td>7.4</td>
</tr>
<tr>
<td>THB 30,001 per month or more</td>
<td>11</td>
<td>11.7</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Average salary per month (Median value) = THB 12,000 per month

Data collected from the focus group discussion revealed that some truck drivers also had two other types of additional income. The first type of extra income was received from the employer for overloading the truck, which is illegal, called a “loading allowance”.

As one driver stated:

“My per diem is not a lot. There’s loading allowance, though. I’ll get 800 Baht extra for overloading.”

The other type of extra income was earned by voluntarily making extra trips, in addition to those formally assigned by the employer. This type of income was called “diligence allowance”. It was generally offered only in large companies. As can be seen from the trucker’s quote below, if the trucker drives more than 5,000 km/month stipulated by the company, the employer will give him a diligence allowance of 5,000 – 8,000 a month depending on the extra distance he drives.

As one driver stated:

“There’s diligence allowance. If I make more than 5,000 kilometres a month, I’ll get 5 or 7 or 8 thousand more, as was the deal. Anyone can do that if he works hard enough.”

Driving behaviour

Most drivers had been in the trucking business for a long time. The average was 10 years. The main reason provided was the relatively high income compared to prospects in other careers, considering that their average educational level was only primary school.

Qualitative data collected showed that, the per diems make up a significant part of the monthly income. Therefore, monthly income varies depending on how many trips the driver makes or chooses to make.

Sleeping behaviour was found to be unhealthy. At least one third of the sample worked more than 15 nights a month. Moreover, it was found that only a small number of land
transport entrepreneurs have clear regulations regarding healthy sleep/rest practices. It was mainly left to the driver to determine how much time they took for sleeping/resting. Most drivers took only one to two hours of rest on each journey.

When they did take rest, they usually slept in the truck. It was found that one of the reasons why truck drivers slept for only short periods was that they were responsible for the cargo. Especially for an open top ten wheeler, the goods would only be covered with canvas, which made the cargo an easy target for theft. Consequently, the drivers would try to deliver the goods to the destination as fast as possible.

**Types of trucks**

In this study, most of the participants drove 18-wheel trucks, most of which were loaded with industrial products. Second most common were 10-wheel trucks followed by 6-wheel trucks, which were mostly loaded with agricultural products and industrial products, respectively.

**Cross border travel and overnight stays**

The truck drivers were asked whether they had travelled across borders and had spent a night outside the country in the past 12 months, which about half of the sample (43.6 per cent) had done. Moreover, almost all of those who had spent a night outside Thailand in the past 12 months (97.6 per cent) had done so in Lao PDR.

**Cross border travel and overnight stays in the last 12 months**

<table>
<thead>
<tr>
<th>Had driven across the border and had spent a night in other countries in the past 12 months</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41</td>
<td>43.6</td>
</tr>
<tr>
<td>No</td>
<td>53</td>
<td>56.4</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Countries where they spent the night in the past 12 months</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lao PDR</td>
<td>40</td>
<td>97.6</td>
</tr>
<tr>
<td>Cambodia</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**Stay away from home**

Truck drivers participating in this study made an average of seven trips per month. They were away from home for an average of 13 nights (approximately two weeks) per month.

**Stoppages**

After driving for an average of approximately four hours, truck drivers would take a break. The main reason for stopping was to cool down the engine.

Only half or less than half of the drivers cited their own wellbeing, going to a restroom, feeling hungry, feeling drowsy or feeling stiff, as a reason to take a break. Most drivers expressed concern about the impact on their job if they took too many breaks during a trip. In addition, there were very few owners who took consideration of the drivers’ parking needs. Only 3.2 per cent of the drivers worked for companies, which had regulated stop
times. Some employers remarked that their drivers could take a break after 300 kilometres or five hours of driving.

The most frequently mentioned stop places for truck drivers were gas stations (66 per cent)

<table>
<thead>
<tr>
<th>Places where truck drivers sleep during the trip</th>
</tr>
</thead>
<tbody>
<tr>
<td>Places to sleep during stopovers</td>
</tr>
<tr>
<td>In the truck</td>
</tr>
<tr>
<td>In a rental room</td>
</tr>
<tr>
<td>In a hotel</td>
</tr>
</tbody>
</table>

Accidents

Almost one third (28.7 per cent) of the truck drivers had been in an accident. A major cause was rear-ending.

Data obtained from a group discussion with truck drivers revealed that being stopped by police officers was another important reason for truck accidents. A hidden police roadblock would cause truckers to make a sudden turn and crash into other vehicles. Sometimes, the drivers were so afraid of being stopped by the police for overtaking that they would return to their lane without taking the time to check if it was clear.

As one employee of the Express Transportation Organization mentioned:

“At your big meetings, please raise this issue. Drowsy driving is not the main cause of road accidents. The main cause is the police, who are lurking behind the lamp posts and trees. If you can solve this problem, then the accidents will be reduced. As far as I’m concerned, the truck drivers drive responsibly.”

The fear of police roadblocks affected truck drivers so much that they were constantly stressed and worried about being stopped and fined. One reason for this is that fines would have to be paid out of their own pocket.
Job satisfaction

Approximately 98 per cent of drivers stated that they were satisfied with their career.

2.3 Health related information

Generally, most truck drivers found that they were fit enough to work the long hours required. Most truck drivers considered their health to be good to very good, both physically and mentally.

Trucker’s medical histories revealed that 54 per cent of the truckers had common illnesses and that they have visited a hospital or clinic in the past two years. This number showed that truck drivers do have health problems and they are not as healthy as they perceived themselves to be.

The most frequent ailments were of common colds and injuries.

<table>
<thead>
<tr>
<th>Common illnesses in the past 2 years</th>
<th>Numbers</th>
<th>Percentage (N=51)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu</td>
<td>12</td>
<td>23.5</td>
</tr>
<tr>
<td>Injuries and wounds</td>
<td>10</td>
<td>19.6</td>
</tr>
<tr>
<td>Stomach ache</td>
<td>5</td>
<td>9.8</td>
</tr>
<tr>
<td>Gastritis</td>
<td>4</td>
<td>7.8</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>3</td>
<td>5.9</td>
</tr>
<tr>
<td>Broken bones</td>
<td>3</td>
<td>5.9</td>
</tr>
<tr>
<td>Toothache</td>
<td>3</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Work-related illnesses

Most truck drivers experienced muscular pains from sitting behind the wheel for long periods. They did not consider this a chronic problem that affected their ability to work. When they had muscular aches, they would do simple stretching exercises.

However, the qualitative data revealed that some drivers suffered great pains in the legs and were not able to drive long distances. As a result, these drivers had to change jobs or drive short-distance routes only, which would affect their income.

Haemorrhoids were also common among truck drivers. To cure it, drivers who had haemorrhoids bought medicines recommended by their peers. Other illnesses identified included skin diseases, such as fungal infections and rashes caused by poor sanitation practices.

When asked about work-related health problems, 2.1 per cent of the truck drivers reported that they had never been ill, while 94.7 stated of them stated that they had felt stiffness (backache, shoulder ache), some of them had been injured from lifting heavy loads or repairing cars, others had eye problems and haemorrhoids.
Work related stress

Apart from work-related physical problems, truck drivers also reported mental health problems. Drivers attributed this to stress related to fear of being stopped by the police. When drivers are pulled over by police, they were usually fined for breaking some rule or other. Fines were paid out of the drivers’ own pocket. Ninety per cent of truck drivers surveyed claimed that police had stopped them.

Another source of concern was the trucker’s working conditions. It was found from the qualitative data that some employers did not give appropriate attention to truck maintenance. For instance, the employers did not have the tires changed even when they were worn out.

2.4 Risk Behaviour

In this study, it was found that truck drivers did not use amphetamines, heroin or marijuana anymore, unlike in the past. It appears that this is due to the change in government policy of more strictly pursuing and punishing those who used or possessed drugs. The truck drivers were, therefore, afraid to use drugs - even those who had used them in the past. Moreover, using illegal drugs affected their truck-driving career since owners of transport companies would fire drivers who used drugs.

The stimulating substances widely used among truck drivers at present were canned coffee and energy drinks. Most drivers used them every day. The reason why the drivers used these stimulating substances was to help them work for longer hours without being sleepy. As long as the truck drivers had to drive long hours, which were more than their bodies could stand, it was felt that these drinks would help them complete the assignments on time.

With regard to alcohol consumption, there were some truck drivers who drank alcohol while working. They primarily drank beer with low degrees of alcohol. This was because the police usually checked for alcohol levels. Most truck drivers had, therefore, stopped drinking or drank only in small amounts.

The drivers were asked about the frequency of substance use in the past three months. Most of the truck drivers drank energy drinks and tea/coffee everyday. There were some (approximately 12 per cent) claiming that they drank alcohol everyday or every week. The truck drivers did not use any other stimulating substances. Most truck drivers who used substances thought that drinking energy drinks, tea/coffee, or even alcohol would not hinder their ability to work.
Frequency of substance use by truck drivers in the past 3 months

<table>
<thead>
<tr>
<th>Frequency of use</th>
<th>Energy drink</th>
<th>Tea/Coffee</th>
<th>Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Number</td>
<td>Percentage</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>1-2 Times</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Every month</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Every week</td>
<td>20</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Everyday</td>
<td>55</td>
<td>60</td>
<td>6</td>
</tr>
<tr>
<td>Never use</td>
<td>15</td>
<td>11</td>
<td>75</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>94</td>
<td>94</td>
</tr>
</tbody>
</table>

The data obtained from group discussions with truck drivers indicated that drivers stopped using drugs due to the serious law enforcement measures of police officers and strict rules of company owners.

As some drivers stated:

“If the police just arrested you, it’s still OK. But this is far too complicated. They want to know the real source; where we bought it. At the end, we may be killed by the sellers.”

2.5 Sexual Behaviour

Most of the truck drivers (97 per cent) had engaged in sexual intercourse. Drivers who said they had never had sexual intercourse (three of them) were single and younger than 25 years old. The average age (median rate) of the first sexual intercourse of these drivers was 17 years. Eleven per cent of the drivers had their first sexual intercourse when they were under 15. The youngest age of first sexual experience cited was eight years (six drivers).

Age of truck drivers at first sexual intercourse

<table>
<thead>
<tr>
<th>Age range</th>
<th>Numbers</th>
<th>Per centage (N=91)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 15 years old</td>
<td>10</td>
<td>11.0</td>
</tr>
<tr>
<td>15-20 years old</td>
<td>66</td>
<td>72.5</td>
</tr>
<tr>
<td>21-25 years old</td>
<td>14</td>
<td>15.4</td>
</tr>
<tr>
<td>26 years old or older</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Average age when having first sexual intercourse (Median rate) 17.0

Remarks: Three drivers have never had sexual intercourse. Truck drivers were asked about the number of sexual partners they had in the past 12 months. Most of them claimed that they had only one while 15 per cent stated that they had more than one sexual partner.

Number of sexual partners in the past 12 months

<table>
<thead>
<tr>
<th>Numbers of partners</th>
<th>Numbers</th>
<th>Per centage (N=91)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of sexual partners in the past 12 months</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>1 sexual partner</td>
<td>73</td>
<td>80.2</td>
</tr>
<tr>
<td>More than 1 sexual partner</td>
<td>14</td>
<td>15.4</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Eighty-five per cent of the truck drivers who had a sexual partner in the past 12 months claimed they only had sex with their permanent partner. Two per cent of them had only had sex with a casual sex partner or SW. Thirteen of them had had sex with permanent partner and/or temporary partner and/or SW.

### Types of sexual partners in the past 12 months

<table>
<thead>
<tr>
<th>Types of sex partners of truck drivers in the past 12 months</th>
<th>Numbers</th>
<th>Per centage (N=87)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent partner</td>
<td>74</td>
<td>85.1</td>
</tr>
<tr>
<td>Temporary partner</td>
<td>-</td>
<td>0.0</td>
</tr>
<tr>
<td>FSW</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Permanent partner and casual sex partner</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>Permanent partner and FSW</td>
<td>7</td>
<td>8.1</td>
</tr>
<tr>
<td>Temporary partner and FSW</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Permanent partner and temporary partner and FSW</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>87</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

For truck drivers who had sex with SWs in the past 12 months, most of them (70 per cent) earned more than 9,500 baht a month and had spent a night in Lao PDR in the past 12 months. The data obtained from the group discussions with the truck drivers supported the quantitative data, which found that truck drivers who had sex with SWs were those who earned a lot and preferred to have sex with a foreign SW.

Some said that sex workers in other countries were clean since they’ve never had sex with foreigners.

However, the data obtained from the group discussion with the truck drivers showed that the numbers of drivers having sex with a SW appeared to be decreasing due to the driver’s difficult economic status. As one driver stated:

“There are still some, but not many. With this kind of economic situation, we could not spend money like we did in the past four to five years. Now, we have to plan when to use money. We have to save some. Our kids are still going to school. Like me, I have a two-year-old child. If I spent too much money, 500 Baht each time for a SW, I’d have nothing to eat. It costs 30 Baht a dish today.”

Places where the truck drivers have sex with a SW were often a temporary hut at the side of the highway. Sometimes the driver will accompany the SW on a motorbike to an alternate “hidden” venue.

The data obtained from the key informants at places where truck drivers usually used SW services revealed that most truck drivers did not patronise the places when their wives accompanied them. As one business owner stated:

“Mostly, married man get the job. They have more responsibility. In the past, those who were single would have assistants to accompany them on their trips. Some companies give their drivers assistants, but not ours. Our drivers take wives and children with them as their assistants because we pay not only the drivers but also their assistants. Therefore, they take their wives instead of others. Some companies don’t allow their drivers to do so, but we let them earn more income. This can help them though. When the husband drives fast, the wife can slow him down...”
2.6 Condom use

Most of truck drivers (85 per cent) stated that they did not use a condom when they had sex for the first time.

Almost 98 per cent of truck drivers who had sex with their permanent partners in the past 12 months stated they did not use condoms during their last encounter. Most of them believed it was not necessary to use condoms when having sex with permanent partners. Regarding the frequency of condom use when having sex with permanent partners, 94.1 per cent stated they had never used condoms with their permanent partners in the past 12 months.

Forty per cent of truck drivers who had sex with casual sex partners in the past 12 months did not use condoms during their last encounter. Most of them said it was not necessary to use condoms. There were only 40 per cent of truck drivers who had used condoms while having sex with casual sex partners in the past 12 months.

Thirty per cent of truck drivers who had sex with SWs in the past 12 months said that they did not consistently use condoms in their last sex with SW because condoms were not necessary or too expensive. Seventy per cent stated they always used condoms when having sex with SW.

<table>
<thead>
<tr>
<th>Use of condoms with sex partners in the past 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom use</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Use condom in the last sex</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Total</td>
</tr>
<tr>
<td>The frequency of condom use with last sex partners</td>
</tr>
<tr>
<td>Always use condoms</td>
</tr>
<tr>
<td>Often use condoms</td>
</tr>
<tr>
<td>Sometimes use condoms</td>
</tr>
<tr>
<td>Hardly use condoms</td>
</tr>
<tr>
<td>Never use condoms</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

The data obtained from group discussions with truck drivers showed that some drivers used two condoms at the same time, which could increase the risk of condom breakage. As one driver stated:

“Yes, I do use condoms. Not less than two to three condoms each time.”

The main reason why truck drivers used condoms when having sex with SWs was due to their fear of HIV/AIDS. Some stated that they would not use condoms if there were no HIV/AIDS.

It was found that the sources of condom the truck drivers used with their permanent or casual sex partners were different from those they used with SW.
They obtained condoms from convenience stores or public health centres to use with their permanent or casual sex partners. However, they did not need to find condoms themselves when having sex with SW, who would often provide the condoms on their own.

2.7 Access to health-related information

This study showed that most truck drivers received information on alcohol and the use of amphetamines, which related to their driving and job security. They had also received health information on hemorrhagic fever, HIV/AIDS and bird flu.

<table>
<thead>
<tr>
<th>Information</th>
<th>Number</th>
<th>Percentage (N=43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>17</td>
<td>39.5</td>
</tr>
<tr>
<td>Hemorrhagic fever</td>
<td>13</td>
<td>30.2</td>
</tr>
<tr>
<td>Use of condom</td>
<td>10</td>
<td>23.3</td>
</tr>
<tr>
<td>Bird flu</td>
<td>8</td>
<td>18.6</td>
</tr>
<tr>
<td>Exercising</td>
<td>8</td>
<td>18.6</td>
</tr>
</tbody>
</table>

Sources of information from which the truck drivers received information on health care and prevention of disease in the past six months were primarily television and radio. Other sources were hardly mentioned.

<table>
<thead>
<tr>
<th>Sources</th>
<th>Number</th>
<th>Percentage (N=43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Television</td>
<td>21</td>
<td>48.8</td>
</tr>
<tr>
<td>Radio</td>
<td>12</td>
<td>27.9</td>
</tr>
<tr>
<td>Lecturer/Expert</td>
<td>3</td>
<td>7.0</td>
</tr>
<tr>
<td>Newspaper</td>
<td>3</td>
<td>7.0</td>
</tr>
<tr>
<td>Public health volunteer</td>
<td>2</td>
<td>4.7</td>
</tr>
</tbody>
</table>

Note: Fifty-one truck drivers had not received any information on health care or prevention of disease in the past six months

Sources of information from which truck drivers have received information on drugs or road safety measures were billboards, television, radio, trainers, and policemen respectively.

The primary types of media to which the truck drivers had access were billboards and television. Truck drivers only made limited use of other media.

According to information from the qualitative data collection, the most effective media were billboards.

2.8 STIs and HIV

In this study, two drivers confessed to having STI during the past 12 months. However, 15 per cent of the drivers displayed high-risk sexual behaviour (i.e., multiple partners and/or sex with SWs in the past 12 months).

When asked to specify the symptoms of male’s STI, most truck drivers mentioned penile discharge (57.4 per cent), painful, burning sensation upon urination (28.7 per cent), penile abscesses (24.5 per cent), and other conditions.
When asked about penile discharge, which was a symptom of STIs mentioned by most drivers, only two drivers said that they had had this symptom in the past 12 months. One of them revealed that he did not seek treatment. The other resorted to self-medication.

Half the drivers (51 per cent) claimed they had been tested for HIV infection. All of them were tested voluntarily. Half of them tested for HIV infection (50 per cent) claimed they had received pre-test counselling and, almost half of them (45.9 per cent) had received post-test counselling. Most of the drivers tested for HIV infection claimed they received the results.

2.9 Health seeking behaviour

It was found when truck drivers feel sick, they mostly purchased the medicines themselves, as recommended by the drug sellers or their peers. Observations of the researchers who travelled with truck drivers revealed that most truck drivers buy medicines from gas station stores. These stores only sold common medicines such as painkillers and flu-relief drugs. The sales people were not pharmacists. Consequently, truckers diagnosed the illness themselves, a practice which had the potential to cause other health problems.

Some visited a hospital. They preferred private hospitals to government ones. There were a few truck drivers who had been to other places such as clinics or health centres.

<table>
<thead>
<tr>
<th>Places drivers visit when they have work-related illnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of health service</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Self-medication</td>
</tr>
<tr>
<td>Private hospital</td>
</tr>
<tr>
<td>Government hospital</td>
</tr>
<tr>
<td>Clinic</td>
</tr>
<tr>
<td>Health centre</td>
</tr>
</tbody>
</table>

Eighty-six per cent of truck drivers had bought medicines to treat their illnesses during the past two years.

Five-four per cent of those, who had bought medicines for themselves, were advised by the pharmacists. A smaller number diagnosed the illness on their own.

Truck drivers also reported that they knew which medicines and which brand to buy from advertisements.

2.10 Health insurance

Every truck driver was covered by at least one kind of health insurance. Half of the drivers stated that they felt that they had benefited from services provided by health insurance. However, most drivers did not visit health care centres unless they were very ill, therefore utilization of health insurance remained low.

Truck drivers felt visits to a health care centre was very time consuming. In addition, to use the health insurance in non-emergency situations, drivers would have to go to specified hospitals, which is inconvenient for them since they were always travelling.
Most drivers preferred visits to health care centres under the 30-baht universal health scheme rather than those covered by social insurance. To use social insurance, drivers had to pay in advance before being reimbursed. To use universal health insurance, they had to pay only 30 baht in emergency cases. Moreover, government health care centres covered by the 30-baht universal health scheme could be found throughout the country.

**Health insurance used by truck drivers**

<table>
<thead>
<tr>
<th>Types of health insurance</th>
<th>Numbers</th>
<th>Percentage (N=94)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government’s 30-baht health insurance</td>
<td>60</td>
<td>63.8</td>
</tr>
<tr>
<td>Social insurance</td>
<td>62</td>
<td>66.0</td>
</tr>
<tr>
<td>Health insurance with private company</td>
<td>7</td>
<td>7.5</td>
</tr>
<tr>
<td>Health insurance with government or state enterprise</td>
<td>2</td>
<td>2.1</td>
</tr>
</tbody>
</table>
1. National Profile

1.1 Geography

Viet Nam occupies a territory of 330,000 square kilometres and extends over 2,000 kilometres from north to south. The geographical terrain ranges from coastal plains and river deltas to foothills and mountains. The population exceeds 82 million with 26 per cent in urban areas and coastal plains, which are densely populated. Life expectancy is 67 years for males and 71 years for females.

1.2 Economy

In 1986, the Government approved broad economic reforms that dramatically improved the business climate and Viet Nam became one of the fastest-growing economies in the world. In 2005, the GDP grew over eight per cent, as it has been doing since the mid-90s. The rate of poverty has been reduced from more than 70 per cent of the population in the mid-1980s to 37 per cent in 1998. A 2002 study showed that in Viet Nam poor households living in rural communes with paved roads had a 67 per cent higher probability of escaping poverty than those in communes without paved roads¹.

Foreign trade and investment have improved significantly and the market-oriented economic model has resulted in improved quality of life for many Vietnamese. The 2005 per capita income of US$ 638 rose significantly from the 1994 figure of US$ 220. Vietnamese society is undergoing a major transition, as market economic mechanisms are further developed to stimulate economic productivity, but with attempts to keep the social and political structure of the country in place.

1.3 Transport

As a result of rapid economic development, the Vietnamese Government mobilised considerable resources from its own budget, and from donors, to build transportation corridors, new and renovated roads, and more efficient border crossings. The country currently has 210,900 kilometres of road of which national-level roads comprise 16,100 kilometres, provincial roads 21,400 kilometres, urban roads 8,300 kilometres, district roads 46,500 kilometres and communal roads 118,600 kilometres. According to the Viet Nam Road Administration, close to 50,000 kilometres (or 22 per cent) of Viet Nam’s roads are paved. There are 8,300 bridges. National transportation data state that in 2005 there were a total of 601,529 vehicles in the country of which 225,658 were trucks.

Road infrastructure is still at a preliminary level but investment on roads and infrastructure continues to increase from both overseas development assistance and the national budget. The Ministry of Transport reported that about 6,000 kilometres of new roads and highways will be built in Viet Nam by 2025 and that approximately 260 kilometres of expressways designed for high-speed travel will be built each year until 2025, at a total estimated cost of US$23 billion.

1.4 Road Accidents

Traffic accidents and trauma have become the leading cause of death in this rapidly changing country and road accidents have been increasing at an alarming rate in recent years.

Viet Nam’s record on road safety has deteriorated over the last 10 years rather than improved and according to the FIA Foundation, Viet Nam has an official fatality rate of around 8.3 persons per 10,000 registered vehicles, an injury rate of 10.7 persons per 10,000 vehicles and an accident rate of 12 cases per 10,000 registered vehicles. In OECD countries the average is one to two fatalities per 10,000 registered vehicles and only China has a worse record than Viet Nam with 25 to 30 fatalities per 10,000 vehicles.

From 1990 to 2002, road accidents increased as much as 30 per cent and fatalities and injuries between ten and 45 per cent a year depending on the region. Accidents in Viet Nam occur for many reasons, including speeding (a factor in more than 30 per cent of all accidents) and illegal or inappropriate overtaking (which is the cause of approximately 20 per cent of accidents). Almost 50 per cent of accidents occur on large, national roads, which have often been renovated and re-paved. In 2005, there were 14,711 accidents, 11,184 deaths and 12,013 injuries.

1.5 Migration and mobility

The construction of new roads facilitates movement, and mobility and migration have increased considerably. In major cities, such as Hanoi and Ho Chi Minh City, migrants comprise approximately 30 per cent of the total population. Thousands of truck drivers working for various transportation companies account for a large portion of mobile populations playing an important role in the country’s transportation and trade.

---

Rapid economic growth has resulted in societal changes with wider gaps between the rich and poor, and increasing internal migration to urban areas. It has also resulted in the construction and renovation of roads throughout the country, and dramatic increases in trade and mobility. Economic pressures have allowed more women to consider sex work as a viable economic option, and drug use as a coping mechanism has increased dramatically nationwide. Between increased sex work and intravenous drug use, and changing societal norms, risk and vulnerability to HIV and STIs is increasing considerably.

**1.6 Health**

Due to central-level investments in primary health care, Viet Nam has relatively high levels of health status for a lesser-developed country. The population growth rate is 2.2 per cent, the infant mortality rate is 30-60 per 1,000 live births, and the maternal mortality rate is 170 per 100,000 live births. The immunization rate for tuberculosis, diphtheria, tetanus, polio, and measles is high with all provinces reporting over 90 per cent coverage.

Malnutrition remains a public health concern, but is being addressed with improved nutrition programmes in remote, rural areas. Reproductive health related infections and unwanted pregnancies have increased dramatically among Vietnamese youth and premarital sex is becoming increasingly common.

The budget is the main challenge to maintaining the quality of public-health services for Viet Nam. The total public health expenditures stands at 5.2 per cent of GDP. Annual public health spending is about US$6 per capita, which is only one-half of World Bank’s recommendation to finance an essential package of health services. The ratio of public health spending for curative services to that for preventive intervention is high at 5.2:1 in 1997, much higher than the 2:1 ratio recommended by the World Bank. The poor quality of hospitals and health care centers, the lack of a universal health care insurance system, and overcrowding of facilities, has led to the majority of Vietnamese self-medicating at pharmacies as their primary first-level health care treatment.

**1.7 HIV/AIDS**

The spread of HIV in Viet Nam is widely attributed to increased economic growth resulting from the country’s transition to a market economy over the past 15 years. Expanded business development, rapid urbanisation, and a thriving tourist industry have given rise to structural and social adjustment problems, including widespread unemployment, widening income gaps, increasing rural-urban migration, the disruption of rural family life, and the rise in drug use and sex work.

While Viet Nam is still at the early phases of an HIV epidemic with low HIV prevalence among the general public, the rate is increasing and has grown from 0.20 per cent in 1994 to over 0.30 in less than ten years. In Viet Nam, people with HIV are largely intravenous drug users (IDUs) who share syringes. In 1996, nine per cent of IDUs had HIV, but by 2005 that figure was over 35 per cent.

According to UNAIDS-supported models estimating prevalence and projecting the direction of the epidemic, sexual transmission is increasing. According to the MOH, as of

---

3 WHO, Regional Office for the Western Pacific [http://www.wpro.who.int/countries/vtm/healthsituation.htm](http://www.wpro.who.int/countries/vtm/healthsituation.htm)
31 December 2005, there were 102,316 reported people with HIV. The estimated number of people living with HIV more than doubled between 2000 and 2006, from approximately 122,000 to 280,000. UNAIDS estimated at the end of 2005, 0.54 per cent of Vietnamese between 15 - 49 years had HIV, making it a concentrated epidemic amongst IDUs and SWs, relating to specific risk behaviour.

2. The Study and its Outcomes

2.1 General Information

The research was conducted along three primary cross-border routes of the GMS.

AH14: The 450-kilometer northern corridor runs from Haiphong, through Hanoi and Lao Cai, Viet Nam to Kunming, China. The portion of the route from Haiphong to Hanoi is National Highway 5, which has received upgrades over the past seven to eight years resulting in good road conditions. Along this section of the road, there are many accident rescue stations and resting areas for drivers.
**AH16:** The central corridor, also known as “The East–West Corridor,” connects three countries – Viet Nam, Lao PDR, and Thailand, with expectations to extend into Myanmar. Upgrades on this 260-kilometer route have occurred over the past four to five years and the road condition is good. It is considered an essential corridor for transportation, tourism, and trade in the region. The route runs though some of Viet Nam’s less developed provinces and directly links them with the border trade zone, the new industrial zone and airport of Chu Lai just south of Danang, as well as Lao and Thailand.

**AH1** – The southern corridor runs from Vung Tau, Viet Nam through Ho Chi Minh City and Moc Bai to Phnom Penh, Cambodia. This route is being further extended to reach Bangkok’s trading centre and sea port. This corridor crosses Ba Ria, Vung Tau, Dong Nai, Ho Chi Minh City, and Tay Ninh provinces – all of which are in lowland areas. This corridor has been considerably renovated over the past three years and private health clinics, district health stations, and provincial hospitals are located along the route. As the corridor is only 190 kilometres, drivers generally do not stop for rest along the route.

**Sample Size:** The study surveyed 191 drivers with 74 of the respondents in in-depth interviews and 35 in focus group discussions.

**Age Group:** The age of drivers ranged from 21 to 58 with the greatest proportion (40.3 per cent) being in the age group 31 to 40. Almost 30 per cent of drivers were 20 to 30 years old.

**Education:** Over half finished high school, 42 per cent finished middle school, and two stopped studying at primary school. None had been to college, university, or vocational school.

**Marital Status**

Most of the drivers were married (84 per cent) and 30 were single and one was divorced. Similarly, 93 per cent of the drivers lived with their family, with the rest living alone, or with their friends or their employers (2.1 per cent).

**2.2 Work Related Information**

**Nature of Employment**

Seventy-eight per cent of the trucks belonged to enterprises. The drivers owned 14 per cent of the trucks and 8.4 per cent were rented.

**Income**

The survey revealed that the average income of long distance truck drivers was 2,188,000 Vietnamese Dong (VND) (approximately US$ 140) per month. The proportion of drivers with an income less than three million VND per month was almost 80 per cent, with the highest amount being 15 million VND and the lowest being one million VND. There were only two cases where drivers earned more than nine million VND per month. The three highest-paid drivers (over six million VND/month) were working in private or non-state-owned companies.
None of the truck drivers reported having other sources of income. When asked whether their salary was adequate to raise a family, 15 per cent said that it was not enough and the rest felt their income was at least adequate for their family.

I am not able to save any money. My salary is just enough for my wife and my three children. (Driver)

I am married so I must earn enough money for my family. I spend about 30 per cent on myself. It is okay now with my income. (Driver)

When asked about what they did with the money they earned, 87 per cent of them reported they give most of it to their family, 11.5 per cent kept most of it to spend and only 0.5 per cent used most of it to invest in business. There was only one who spends half and gives his family the rest.

Professional Experience

The proportion of drivers who had been working as drivers for over five years made up 68 per cent and 16 per cent had worked three to five years. Several drivers reported having worked for over 20 years: none reported working less than a year.

Job Satisfaction

Despite many respondents feeling that long distance truck driving was a very difficult job, 90 per cent reported being satisfied with their current job. Ten per cent reported not being pleased with their job.

There are many reasons driving is hard work, such as driving overnight. We are often tired of staying up overnight and not getting enough to eat. In general, food and drink are not good enough to keep fit. (Driver)
Duration of Trips

Drivers estimated that most trips were of three to seven days duration (55 per cent of drivers). Drivers reported they often drove continuously for six hours, with 12 hours as the longest time. Half the respondents reported trips that involved continuous driving of less than five hours.

Stoppages

Most drivers reported regular fatigue while driving, and 53 per cent were affected in their driving. The long hours of driving resulted in drivers stopping for rest. Eighty per cent reported stopping along the roadside and 20 per cent at small roadside restaurants. Ten per cent reported having more than one driver and being able to change drivers along the way. Besides stopping for rest, drivers stopped to fill up at petrol stations and at border check points.

Stay away from home

When asked about the number of nights they spent away from their home during the past month, 30 drivers did not respond or remember. Of the remaining 161 drivers, almost 50 per cent reported being away from home between one to ten nights, almost 40 per cent reported 11-20 nights and 18 per cent reported 21-30 nights.

I spend over 20 nights outside each month. Sometimes we go away on business for the whole month depending on the goods carried. (Driver)

Almost 35 per cent of the drivers reported staying overnight across the border. Of this number, several reported that they crossed regularly. One driver spent 80 per cent of the time sleeping on the other side of the border.

2.3 Health related information

The majority (64 per cent) of truck drivers considered themselves healthy, and only three per cent considered themselves physically weak. Thirty per cent of drivers reported having never been to the doctor for a medical exam. Over 70 per cent of drivers felt they were able to stay in good physical shape.

Most health complaints reported by drivers are largely related to the nature of driving with 50 per cent reporting backaches, and approximately 20 per cent reporting neck and muscle pains. Ten per cent of drivers reported stomach aches and exhaustion. Related to mental health, drivers are generally mentally healthy with only one per cent considering suicide. Eight per cent of drivers reported feeling too depressed or bored to drive or do anything. Almost 20 per cent reported sleeplessness as a problem.

The most common ailments were pain in the wrists (51.6 per cent), stomach ache (21.1 per cent), shoulder and neck pain (13.2 per cent), exhaustion (10.7 per cent), and migraines (17.3 per cent). A few truck drivers had respiratory problems, kidney and urinary infections, high blood pressure or chronic bronchitis.
Drivers reported seeking medical advice and doctors’ diagnosis for a variety of complaints including bone pain (particularly the wrist) and arthritis (52 per cent), stomach aches (21 per cent), shoulder pain (13 per cent), and exhaustion (10 per cent). Other diagnoses included respiratory infections, vision problems, high cholesterol, and high blood pressure.

**Work related stress**

Approximately 24 per cent of drivers reported being regularly stopped by traffic police and 45 per cent being stopped occasionally. Fifteen per cent reported occasionally or rarely being stopped and 15 per cent reported never being stopped. Many drivers expressed the difficulties in following the requirements of the trucking company, making money, and being stopped by the police.

*According to the law, we cannot exceed the load limit of 12 tons per truck. If we carry only 12 tons to Hanoi, however, we do not make enough money to pay for fuel; we have to overload. When we are overloaded we either get stopped by the police or drive at night to avoid being fined.* (Driver)

**Accidents**

Almost 20 per cent of drivers reported having had one traffic accident. Six per cent have had more than one accident (seven drivers reported two accidents and four had had three). Causes reported were largely (40 per cent) due to other people on the road, bad quality roads (30 per cent), and bad quality trucks and exhaustion each accounting for 15 per cent of accidents. In-depth interviews indicated that drivers falling asleep and speeding are also factors that lead to accidents.

**2.4 Risk Behaviour**

Seventy-two per cent of drivers reported smoking tobacco and 45 per cent drink caffeine drinks such a Red Bull, coffee and tea, when driving. Almost 40 per cent reported drinking alcohol while driving. No one reported using drugs while driving and seven per cent reported using nothing.

**Drug and Alcohol Use**

Only two drivers reported ever using drugs and both reported having used opium. During the in-depth interviews, most drivers thought that drug use was not common among long-distance truck drivers as their companies could fire them and they lacked adequate disposable income to purchase drugs.

Alcohol use was considerably more common with 30 per cent of drivers reporting daily consumption of alcohol and 30 per cent reporting drinking at least once a week. Drivers in the north and central sites reported considerably more daily alcohol consumption than drivers in the south. Drivers who reported drinking daily or frequently were four times more likely to have sex with SWs than drivers who reported not drinking or drinking infrequently. Truck drivers away from home for longer periods of time report more alcohol consumption.

During discussions drivers stated that some drivers keep alcohol in the cab of the truck. Focus-group discussions with local authorities, and communities, in the north and south
indicate that heroin and diazepam are available and that drivers who do use drugs, smoke so that they are not identified as drug users by injection scars on their skin. Several drivers stated that drug-using drivers inject drugs because they do not have time to smoke, indicating that some drivers are intravenous drug users.

**Smoking**

Sixty-four per cent of the 191 interviewees smoked daily. (28 per cent reported being non-smokers.)

Amongst the daily smokers, approximately 50 per cent reported smoking 10 to 20 cigarettes a day and 20 per cent reported smoking over 20. Just over 25 per cent reported six to ten per day and four per cent reported smoking under five cigarettes daily.

**2.5 Sexual behaviour**

Ninety per cent of the drivers reported they had their first sexual experience when they were still below 25 years of age. Twenty per cent reported being under the age of 20 and 70 per cent reported being between 20 and 25.

Approximately half of the drivers reported their first sexual partner was their girlfriend and 40 per cent said it was their wife. Three per cent said their first partner was a casual girlfriend and the same number said their first partner was a SW.

In the twelve months prior to the survey, 80 per cent of drivers reported having sex with their wives. Fifteen per cent reported sex with girlfriends, 30 per cent with causal girlfriends, and 40 per cent with SWs. Similarly, in the previous month 90 per cent of drivers reported having had sex with their wives or steady girlfriend, 30 per cent with casual girlfriends and close to 40 per cent with SWs. In the month before the research, 69 per cent of drivers reported having one partner and 29 per cent reported having two sexual partners. Four drivers reported having three partners and one driver reported having five.

Interviewed drivers most regularly had sex with their wife or regular girlfriend with just over 90 per cent reporting having had sex in the previous month. During the previous month, those who had sex with SWs made up 38 per cent; and almost 30 per cent had sex with casual girlfriends. Close to five per cent reported not having sex in the previous month. None of them reported ever having had sex with other men.

*The nature of our job is to travel here and there. We have to spend most of nights away from home, so we sometimes look for small fun. Moreover, when drunk, it is easy to follow your friend to have sex.* (Driver)

The research shows a link between fatigue and exhaustion and multiple sex partners. Over 33 per cent of truck drivers who felt fatigue during long distance driving report having multiple sex partners. The percentage of drivers who reported fatigue and multiple sex partners is two times higher than drivers not reporting fatigue. This sexual behaviour may be a result of drivers finding places to rest such as guesthouses, small restaurants, and cafes. Focus group discussions indicate that drivers visit sex workers in mid-afternoon when they can rest and drink. Similarly, both drivers and the communities that drivers stop in say that drivers tend to have two, three or many regular girlfriends.
2.6 Condom Use

Sixty per cent of drivers reported condom use with wives and regular girlfriends. Approximately 20 per cent reported rarely using them and 20 per cent reported frequently using condoms. The main reason for not wearing condoms with their wife or steady girlfriend was because it was not felt to be necessary (45 per cent). Over 30 per cent used other methods to avoid pregnancy, 26 per cent trusted their wife or girlfriend, and 6 per cent wanted to have a baby. Just over five per cent did not use condoms because they do not like them.

Condom use amongst casual girlfriends was higher with 65 per cent reporting occasional or frequent use.

During previous sex with a casual girlfriend, 68 per cent of the 31 respondents stated they did not use a condom. One-third of the drivers reported not using a condom because they were using another method of contraception and one-third said condoms were not necessary. Approximately 40 per cent said that condoms were not available and nine per cent said they did not know where to buy them. Almost 20 per cent said they did not like them and five per cent said their partner did not like them.

Seventeen per cent of the 64 drivers who visited SWs in the past month also reported not using a condom. Almost 72 per cent reported frequent condom use and 10 per cent reported using condoms occasionally. Of truck drivers visiting SWs and who are absent from home over seven days at a time, almost 70 per cent of them report not using, or only sometimes using, a condom.

2.7 Access to health-related information

Just over 97 per cent of the interviewees reported hearing about STIs. Of the 186 drivers who knew of STIs, all drivers knew of HIV, half knew of gonorrhoea and 40 per cent knew of syphilis. Chlamydia and candidiasis were almost unknown with only one driver reporting hearing of them. Only two per cent of drivers knew of herpes. 10 per cent of drivers knew STIs in men may have symptoms such as discharge, pain and swelling. Almost 95 per cent of drivers knew nothing of STIs and symptoms that affect women.
All of the drivers who were interviewed in the survey knew about HIV. Their sources of information were varied, but primarily consisted of television, radio, newspapers, and magazines. Ninety-five per cent of drivers reported accessing information from TV, 90 per cent from radio, and 75 per cent from newspapers and magazines. Other primary sources of information included posters and leaflets, loudspeakers, and friends and relatives. Ten per cent of drivers reported obtaining HIV information from health staff. Only one to four per cent of drivers reported accessing HIV information from workplaces, population outreach workers, public meetings, or the internet.

Approximately 35 per cent of drivers reported knowing someone with HIV and 15 per cent reported having a close friend die of AIDS. Four per cent had a family member who died of AIDS.

Of all the interviewed drivers, 83 per cent stated that wearing condoms could protect people from HIV infection. Seventeen per cent reported that condoms were not protective or they did not know if they were protective. Seventy per cent of drivers believed that having only one sexual partner (who does not have HIV) would prevent HIV transmission. Ninety-three per cent reported that sharing syringes could transmit HIV. Almost 90 per cent of drivers stated sharing a meal with a person with HIV does not transmit HIV and 77 per cent reported that mosquitoes were not a risk (13 per cent thought mosquitoes were a risk and 10 per cent did not know).

Eighty per cent of the truck drivers knew that mothers could transmit HIV to their child but when asked how that transmission could be prevented, most (70 per cent) did not know how to prevent that transmission.

### 2.8 STIs and HIV

Among the 191 drivers in the study, 30 per cent were tested for HIV and almost 85 per cent of the tests had been conducted within the previous two years. Of the 136 who had not had an HIV test, 75 per cent believed they did not have HIV. Twenty per cent never thought about getting a test, and three per cent did not know what was a HIV test. Of those who had an HIV test, half got it done voluntarily and half were required to by their company or as part of their medical exam. (A law passed in 2006 will make mandatory testing for HIV illegal.) Over 75 per cent of drivers who had a test reported that there had been no pre-test or post-test counselling but 87 per cent were informed the results.

### 2.9 Health seeking behaviour

Almost 30 per cent of drivers reported that in the previous 12 months they had been to a government hospital, four per cent reported going to private hospitals, and 66 per cent reported not going to a hospital or doctor at all. In focus-group discussions, many drivers were not able to name health centres or hospitals they had used or knew, indicating that branding and publicity of health services has not adequately reached mobile populations.

> Private hospitals are better if you do not have much free time. You can go to them anytime you have a health problem. State hospitals require a lot of time, as you always have to wait for long time. (Driver)

Fifty-four per cent of truck drivers had bought medicines at pharmacies to treat illnesses such as headache, backache, flu, cough and stomach ache. Medicines commonly purchased
when self-medicating included antibiotics, analgesics, and antipyretics, which were bought based on advice from pharmacists or based on the last prescription. Half of the drivers reported self-medicating when sick. Some drivers said it was too difficult to find a health centre along trucking routes. Even when they were so seriously ill, only 60 per cent of them went to government hospitals. Many bought medicines at pharmacies and self-medicated. They explained that the government hospitals were far and treatment would affect their travelling and income.

In order to take good care of long distance drivers, we must have health care branches situated in districts on their routes. (Driver)

2.10 Health insurance

Fifty per cent of the drivers reported having no health insurance. Thirty per cent reported having insurance through their company, and 20 per cent reported obtaining insurance on their own.

Drivers belonging to state-owned companies were ten times more likely to have health insurance than drivers who owned or rented a truck.

Among drivers who had health insurance, 63 per cent of them had used the insurance for medical treatment. Of these, 55 per cent felt satisfied with the insurance coverage and 35 per cent felt it was an average or unsatisfactory service. Difficulties using the insurance programme included residency or geographic location when using insurance. For example, drivers mentioned the following:

            Hospital staff told me that since I was from Quang Tri and not from Saigon or Hanoi, I needed to go back to Quang Tri to be able to use my health insurance. It is clear that health insurance should be more flexible. (Driver)

In focus-group discussions, drivers felt that the health care with insurance was inadequate and only provided periodic medical exams measuring weight and height. Drivers felt that when they used their insurance card they received less quality services and were treated poorly. Focus-group discussion indicated that many drivers treat themselves through pharmacies rather than use their insurance at hospitals.
Pilot Intervention

Introduction

It is afternoon time in Nong Khai, the northeastern Thai town bordering Lao PDR. As vehicles, large and small, speed past on the Bangkok-Nong Khai highway, there is much laughter and jovial bantering among a dozen truck drivers who have gathered together at a roadside place for a fun event.

No, this is not another drunken karaoke session that is underway. Instead the cause of all the excitement is a wittily presented training session on the basics of sexually transmitted diseases, HIV/AIDS and the importance of safe sex practices.

The activity is part of a pilot intervention initiative launched by the Planned Parenthood Association of Thailand (PPAT) under UNESCAP’s ‘Health Without Borders’ project, which seeks to address various health related issues among long distance truck drivers.

“Truck drivers are one of the most difficult target groups to address on health related issues because of the nature of their work and the constant mobility involved. Yet we are taking up the challenge precisely because this work is important for both truck drivers as well as society at large” says Montri Pekanan, Deputy Director of PPAT.

Specifically, the pilot intervention, being implemented at the Nong Khai – Vientiane international border crossing consists of:

- Setting up one health stop for truck drivers;
- Training peer-educators
- Developing a behaviour change communication strategy

Implementing Agency

The intervention is being managed by PPAT, which has been chosen as a UNESCAP partner for this purpose.

The PPAT is a pioneer in family planning in Thailand and a private, non-profit and non-political organization. It has been operating in Thailand for over three decades and aims to educate and serve the entire community for a better quality of life and to promote the right to reproductive health information and services.

Expected Outcomes

The locally managed health stop is expected to provide a variety of health-related services, including those pertaining to traditional occupational health and safety concerns, abuse of substances like methamphetamines and alcohol, HIV and STI prevention and to encourage health promotion behaviour.
Some of the expected outcomes from the pilot intervention are:

1. Setting up a health stop for truck drivers in partnership with local authorities in Thailand. These include the officials from the provincial health office, the provincial transport authority, labour office, cross-border authorities, the private sector, local NGOs, communities and small local entrepreneurs as well as authorities in Vientiane, Lao PDR.
2. Developing appropriate Behaviour Change Communication material.
3. Training peer educators on HIV/AIDS prevention and general health promotion, including on the use of the health stop(s).
4. Developing in close consultation with UNESCAP a monitoring and evaluation framework and organize an evaluation workshop at the end of the project bringing together all stakeholders.

**Issues Identified**

The various issues being addressed through the pilot intervention were identified through a comprehensive situational analysis and subsequent consultations. Among the recommendations emerging from the situational analysis were:

- STI/HIV prevention programmes should specifically address truck drivers (including cross-border issues).
- Occupational health and safety issues of truck drivers, including road accidents need to be addressed.
- Health services need to be accessible, including through the use of health insurance like the ‘30-Baht’ scheme.
- The government should review laws, policies and regulations and actual practice that may negatively impact the health of long-distance drivers.

Based on the qualitative and quantitative research on the health conditions, risk behaviours, health-seeking behaviours of long distance truck drivers and the underlying socio-economic and working conditions, the following recommendations were made towards the design and implementation of a pilot intervention:

**A) General health problems of long-distance truck drivers**

Health education and medical treatment programmes need to be organized to address health problems arising from the nature of work of long distance truck drivers. A vital part of such a programme would be establishing increased self-assessment capacity among drivers as well as increased attention to the health of truck drivers by employers. Regular health check-ups should be institutionalized and regularized in the road transport sector.

While the law provides for driving regulations including working hours and rest times, the government should constantly review these laws and regulations and in particular their implementation and monitoring. Drivers must get adequate rest before taking a new trip or continuing a trip. This is one way in reducing accidents that may not only affect
the driver but also other road users. At the same time such regulations should not affect the salaries of the drivers.

The setting up of appropriate rest facilities, fully equipped to provide for the basic needs of the driver such as food, toilets and washrooms, rest areas, and health care services would also assist in making journeys safer and healthier. The facility should further provide basic security measures to ensure that truck drivers can rest and be assured that their cargo is safe.

It is further recommended that organizations, such as state run transportation departments, the highway police and other agencies, which are key stakeholders in law enforcement and random roadblocks along roads, place the issue of driver stress due to police controls at the top of their agenda.

A system for full or partial reimbursement by the employer for fines/bribes paid by truck drivers to law enforcement officials along the road should also be explored. The nature of reimbursement could be determined by the nature of the violation (those related to car maintenance or overloading may be beyond the direct responsibility of the driver) and the probability that the violation indeed occurred.

B) Prevention of sexually transmitted diseases

It is recommended that STI/HIV prevention programmes be implemented focusing on safer sex behaviours between the truck drivers and the marital, casual and commercial partners. These programmes should include behaviour change communications, including targeting the spouses of drivers and other sexual partners, and making condoms readily available to both drivers and potential partners. To minimize the impact of truck drivers as a potential bridge population, it is critical that interventions to promote safer sex behaviour and the prevention of STI/HIV should cover all stakeholders in the sexual networks of drivers.

While there is a range of existing media and information programmes on HIV/AIDS for the Thai population, few of these media address HIV and mobility or are tailored to truck drivers. In addition, the messages do not address certain misconceptions that result in higher risk, e.g., that some populations are less likely to have HIV/AIDS than others.

Information and condoms can be distributed at truck stops and particularly at locations where the truckers may have to stay overnight. Some of these locations were identified during the pre-survey of the study.

The study shows the linkages between risky sexual behaviours, travel to the Thai-Lao PDR border area and the perception that Lao women are less likely to have contracted HIV infection. Therefore, HIV and STI specific programmes implemented along the corridor should focus on the cross-border nature of the long-distance driver behaviour. Hotspots and potential sites for interventions are in Nong Khai and just across the border where the Thai trucks are allowed to enter for unloading cargo.
The key agencies for implementing this set of recommendations are the Ministry of Public Health, the Ministry of Transport and the Ministry of Labour, in collaboration with government officials concerned with border proceedings, i.e., customs officials.

C) Access to health services

It is recommended that the Ministry of Public Health and the Ministry of Labour set up health services that are more accessible for the truckers. It seems most appropriate that the truck drivers can utilize existing health centres by utilizing their health insurance scheme anywhere along the route.

In addition, special attention would have to be given to the needs of truck drivers such as no or only minor deviation from their route, fast-track services and service providers that understand the specific health concerns of the truckers. Given the relatively minor health problems of truckers and short consultation times expected, this should be possible without burdening health care providers or inconveniencing other patients. Health care providers should also be involved in targeted health promotion.

D) Safety during Work

By law the employer or owner of the vehicle is responsible for ensuring that the drivers have proper driving licenses and that they are capable of driving the vehicle. Therefore interventions should also be directed towards the employers or truck owners to ensure that they can live up to these responsibilities.

It is recommended that the truckers and employers are familiarized with the regulations related to land transport and traffic laws. This should lead to more positive driving behaviour that will build more confidence among the truck drivers, and thereby also reduce stress. The practice of regular vehicle maintenance should also be promoted.

It should be noted that for any campaign aimed at improving driving behaviour to be successful, it would by necessity need to focus on all road users.

E) Programme design and implementation

First of all, all recommendations should be integrated into a comprehensive health programme for long distance drivers to include the many interrelated aspects of health promotion and treatment rather than only one aspect, such as HIV/AIDS. This may be more attractive to the drivers and the employers who will see the potential benefits in participating in the programme. Such an approach may provide soft entry points for addressing other health conditions with a greater public health dimension.

Secondly, all interventions should be developed through a multisectoral response including the Ministry of Public Health, the Ministry of Labour, the Ministry of Transportation and the transport employers and the truck drivers themselves. Efforts should be made to build a platform for pro-active truck driver participation in decision-making in lieu of formal
truck driver associations. In addition, to enable client-tailored messages and information it is suggested that experienced non-governmental organizations be used to explore effective methods of communications.

These agencies may choose to work with experienced NGOs for the message development and delivery. It is further suggested that international and regional organizations should collaborate with organizations at the national level to scale up interventions and to ensure that prevention programmes reach the main land transport routes leading to cross-border destinations.

Thirdly, health education and promotion programmes need to be developed to improve the health and health-seeking behaviour of truck drivers. Such programmes should include self-assessments to spot early symptoms; understanding of causes and should provide options for preventing such conditions. The messages should include advice on physical exercise and non-risk-behaviour stress relief techniques.

Although further investigation is needed on the specific health messages and media appropriate for the truckers, the study shows that one form of message delivery could be in the form of audiotapes or CDs. This format is compatible with the nature of work of the truckers and can be listened to while driving or resting. Information in attractive presentations could be made available at key parking areas. It is important that the messages must be tailored to the needs and preferences of the truckers. Dissemination at appropriate locations, such as border crossings, would allow services to reach truck drivers employed by companies as well as owner-drivers.

Designing the information messages on STI and HIV should be tailored to the nature of the truck drivers whether it is the occupational nature, the subculture in the industry or the use of information. NGOs working with other mobile populations found that cartoon books and videos that are based on the lives of the targeted population group were much more effective than general messages.

Finally, driving behaviour has to be changed within the sector allowing drivers the necessary time to practice healthy behaviour while on route. Additionally, curative and promotional health interventions should be targeted at places where drivers make longer stops, such as border crossings. As such stops also provide the most opportunity for high-risk sexual behaviour, BCC programmes including STI and HIV prevention should also take place at these sites combined with other strategic locations along the corridors.
Building Partnerships

A key strategy of the Health Without Borders project is the building of national and sub-regional multi-stakeholder partnerships with a wide host of actors:

- Government agencies responsible for road infrastructure, health centres, border crossings, small and medium-enterprise development along highways, and community development;
- Private sector companies for all forms of road transport of goods and people;
- CSOs such as trucking and drivers’ associations/groups;
- Local communities and small local entrepreneurs at the identified locations that provide fuel for transport, and food and shelter for transport workers;
- International NGOs, in particular, International Organisation for Migration (IOM), CARE International, Family Health International (FHI), World Vision, PPAT, and Population Services International, which have projects that target transport workers in the GMS;
- ADB that funds and advises on the construction of the GMS highway infrastructure, as well as health-related activities in the region.
- United Nations agencies such as the International Labour Organisation, World Health Organisation and UNAIDS.

Throughout the implementation of the project a conscious effort has been made to forge partnerships among government, the private sector, and civil society, and the mobile populations themselves to mobilize social and financial capital to deliver more adequate health promotion and curative services for truck drivers. Various activities undertaken as part of the project too have targeted the national transport sector and regional forums to mainstream health in the transport agenda.

This strategy is clearly evident in the choice of national counterpart organizations to carry out the situational analysis in the three GMS countries selected as part of the project. Instead of commissioning individual contractors to provide the analysis a conscious effort was made to bring in relevant ministries and state agencies as well as reputed NGOs as partners to assist in providing health services, health personnel, build sustainability and facilitate policy dialogue.

The following section describes the National Counterpart Organizations (NCOs).

**Thailand**

**Raks Thai Foundation**, formerly known as CARE Thailand, a non-profit organization mandated to strengthen the capacity of poor and disadvantaged communities, to analyze root causes of problems, determine suitable solutions and actively participate in the development process was commissioned by UNESCAP to undertake the situational analysis.

Qualitative and quantitative data were collected concerning risks and behaviours of truck drivers that might affect their own health and people they meet en route. To conduct this study, the Raks Thai foundation collaborated with Office of the Population Technical Assistance team (OPTA), an organization providing quality social research for more than 15 years.
The pilot intervention at Nong Khai on the Bangkok-Nong Khai-Vientiane highway is being managed by PPAT, which has been chosen as a UNESCAP partner for this purpose.

The PPAT is a pioneer in family planning in Thailand and a private, non-profit and non-political organization. It has been operating in Thailand for over three decades and aims to educate and serve the entire community for a better quality of life and to promote the right to reproductive health information and services.

**Lao PDR**

In Lao PDR, UNESCAP chose the Urban Research Institute (URI), Ministry of Communication, Transport, Post and Construction, as the NCO.

URI is a technical organization, whose role is to assist the ministry in terms of research and technology for urban planning, and in other fields as assigned. It is involved in formulating project documents, research activities, setting technical standards, monitoring environmental facilities and evaluating economic, social and environmental aspects of development projects.

**Viet Nam**

The Department of Social Evils Prevention (DSEP), Ministry of Labour, Invalids and Social Affairs (MOLISA), Government of Viet Nam coordinated and provided guidance to the situational analysis undertaken in Viet Nam. This included identifying, in collaboration with UNESCAP, an appropriate organization in Viet Nam to undertake the situational analysis. UNESCAP subsequently entered into a separate agreement with the identified organization to undertake the substantive research activities under coordination of DSEP/MOLISA. In addition, DSEP/MOLISA organized the orientation and final workshops for the situational analysis, and ensured the participation of key national stakeholders in both the situational analysis and the workshops.

DSEP/MOLISA plays a key role as the foremost public sector manager of Viet Nam's response to new and emerging social issues. DSEP/MOLISA has taken the lead in developing a coordinated and multi-sectoral response to HIV/AIDS, sexual risk behaviour and substance use in collaboration with a wide range of government and UN agencies, and NGOs, including through international cooperation. DSEP/MOLISA is the primary NCO for the coordination of international support to programming on social issues in Viet Nam.

As a result of this collaboration with DSEP/MOLISA in Viet Nam, UNESCAP identified the Ministry of Transport and International Organization for Migration (IOM) as partners to carry out the situational analysis.

**Ministry of Transport (MOT)**

The Ministry of Transport's primary responsibility is to manage the transportation on roadways, railways and waterways across the country; to manage public transportation; and to be a resource to the national government on issues related to transport. The MOT also has a HIV/AIDS and Social Evils Prevention committee, the vice chairman of which is also the director of MOT's health department. Key activities of this committee are
information campaigns using billboards and leaflets, and training courses for workers of companies and units under MOT on the prevention of HIV.

The MOT also has its own health department, which receives direction from the Ministry of Health. This department has many responsibilities: organizing health care and protection for workers in the transport sector; developing long-term occupational health care projects; and developing standards and norms for health and working conditions for vehicle drivers to name a few.

*International Organization for Migration (IOM)*

Founded in 1951, the International Organization for Migration is the leading intergovernmental organization in the field of migration and works closely with governmental, intergovernmental and non-governmental partners.

IOM works to help ensure the orderly and humane management of migration, to promote international cooperation on migration issues, to assist in the search for practical solutions to migration problems and to provide humanitarian assistance to migrants in need, including refugees and internally displaced people.

IOM first began operations in Viet Nam in 1987 and continues to operate under a Memorandum of Understanding with Viet Nam’s Ministry of Foreign Affairs, signed in 1991.

*Lessons Learned*

Building partnerships is difficult and time-consuming but crucial.

During the course of project implementation, following repeated communication between Ministries of Health, Ministries of Transport (to some extent Ministries of Labour) and other agencies, cooperation between other government and NGOs has significantly improved. Trust has developed. In particular the non-health stakeholders have a much deeper understanding of the issues at hand and the possible approaches to address them.

By the end of the project good partnerships/networks were established in Lao PDR, Thailand and Viet Nam on which a second phase of the project could easily be built.

Some progress has been made with regard to national policy change. In particular in Lao PDR and Viet Nam the Ministries of Transport have taken up the issues at hand. However capacities need to be built in this regard and mechanisms for policy development and implementation supported. On the regional level not much progress was made in terms of meaningful policy dialogue / policy change.
The Health Without Borders Regional Workshop

Bangkok, 25-27 October 2006

I. ORGANIZATION OF THE WORKSHOP

A. Background

The UNESCAP “Health without Borders” regional workshop was held at the United Nations Conference Centre on 25-27 October 2006. The Health and Development Section (HDS), Emerging Social Issues Division (ESID) and the Transport Facilitation Section (TFS), Transport and Tourism Division (TTD) of UNESCAP organized the workshop. The Royal Government of the Netherlands provided funding for the workshop.

The workshop was organized under the UNESCAP project “Health without Borders: Improving health and reducing HIV/AIDS vulnerability among long-distance road transport workers through a multi-sectoral approach.” The project aimed to improve the health of long-distance road transport workers traveling along GMS road transport corridors selected under the project.

B. Objectives

The workshop aimed to:

• Share the outcomes of the “Health without Borders” project among the project partners.
• Present the project outcomes to a wider range of stakeholders.
• Arrive at concrete policy recommendations regarding the health issues of truck drivers in the GMS and beyond.
• Develop concrete ‘next steps’ for phase II of the project.
• Bring all the elements of the project together – resulting in the final project report.

II. OPENING OF THE WORKSHOP

In their opening statements, both Ms. Thelma Kay, Director, Emerging Social Issues Division and Ms. Geetha Karandawala, OIC, Transport and Tourism Division of UNESCAP stressed that Health Without Borders was possible only if a multi-sectoral approach was adopted to tackle HIV/AIDS and other communicable diseases.

“It is good to see that such a broad range of stakeholders has responded to our invitation, truly reflecting the multi-sectoral approach of the ‘Health without Borders’ project. Participants represent the Ministries of Transport of all four project countries, Ministries of Health and National AIDS Programmes, as well as other government entities. The private sector, national and international NGOs, as well as many international organizations are also present here today,” said Ms Thelma Kay welcoming the workshop participants.
III. SUBSTANTIVE WORKSHOP SESSION OUTCOMES

A. Welcome and introduction to the objectives of the Workshop

Mr. Bernhard Barth, Associate Social Affairs Officer, Health and Development Section of the Emerging Social Issues Division presented an overview of the “Health without Borders” project and elaborated on the workshop programme.

Mr Barth said the objective of the regional workshop was to share the outcomes of the Health Without Borders research among project partners and develop policy recommendations regarding health issues of truck drivers in the GMS and beyond.

The opening session of the workshop had two presentations reviewing the situational analysis from Lao PDR and Viet Nam.

B. Presentation of situational analysis, Lao PDR

Ms. Saykham Thammanosouth, Director, Cooperation and Training Division, Urban Research Institute, Ministry of Communication Transport Post and Construction gave details of the situational analysis from Lao PDR.

Based on the findings from the Lao PDR situational analysis, the following recommendations were made for future planning and implementation

- Health facilities and services should be established at places where truck drivers work or take rest.
- Easily accessible, inexpensive or free HIV/STI medical examination, counseling and treatment should be available to drivers and their assistants.
- Health education material on HIV/AIDS/STI, and specifically on behaviour change for drivers to adopt healthy behaviour related to common health problems should be developed and adequately distributed.
- Inter-personal communication (through mobile teams and peer education) targeting drivers' risk behaviour and the importance of condom use to protect themselves and their families should be established and conducted at major truck stops, guesthouses, and restaurants where truck drivers gather.
- The expansion of the 100% Condom Use Program nationwide, with special emphasis on truck drivers, to make condoms accessible at all times, at all stops is necessary.
- A national health services network for the transport sector should be established to meet specific health care needs of long-distance truck drivers. Such a network should include regular health checks, health education, counseling, and a system to maintain the health records of driver's. Pharmacies and private clinics should also be included in the network.
- Along with a national health services network, there should be an establishment of a “Mobile Health Insurance Policy” that is convenient for long-distance truck drivers and other mobile groups, enabling them to easily access health care services along the roads.
- The sex industry should be controlled, limited, and sex workers should be regularly checked for STIs and receive appropriate treatment, with follow up and systematic recording of data.
- The transport sector, policy makers, health sector, transport companies and police
should be involved together in planning for reducing stress of truck drivers, and other related issues affecting drivers’ health. HIV/AIDS/STI activities targeting truck drivers, already included in the National Strategic and Action Plan, 2006-2010, should be at least selectively implemented.

In the discussion that followed, it was suggested that the reasons for the low use of condoms while having sex with spouses and also casual partners, as revealed by the situational analysis from Lao PDR, should be explored further.

Another important point was made regarding data presented from the Lao study that showed a significant percentage of truck drivers practice self-medication when they have STIs. It was suggested that pharmacies that cater to such truck drivers should be equipped to provide more comprehensive counseling and other services to deal with STIs.

There were some doubts raised about the small number of truck drivers who reported use of amphetamines and other stimulants while working as per the Lao PDR situational analysis. Some participants pointed out that the actual numbers, based on anecdotal evidence, could be much higher and further studies were required on this issue.

C. Presentation of situational analysis, Viet Nam

Dr Pham Hai Yen of the Health Department, Ministry of Transport, Viet Nam presented the situational analysis from Viet Nam.

Based on the findings and conclusions from this study, the following are recommended for future activities and research with truck drivers:

- Mobility-specific public-health communications should be developed based on accurate research and proven behaviour change methodologies for drivers to adapt healthy behaviour related to sexual partnerships, alcohol and tobacco use, and on their return to wives and families.
- Mobility-related health information and services should be geographically appropriate and mobile-friendly to reach drivers where they stop and work.
- BCC using inter-personal communications (peers and outreach workers) targeting drivers on risk behaviour, and the campaigns emphasising the importance of condoms and the need for carrying them in their trucks at all times, should be conducted at major truck stops, and hotels, and restaurants where drivers stop.
- Inexpensive, or free, STI and HIV medical exams and counseling should be readily available for drivers, along with associated treatment options.
- Information campaigns should target drivers and companies explaining the new HIV law banning mandatory HIV testing.
- Information campaigns should target alcohol consumption and driving, and management policy related to alcohol.
- A comprehensive safe driving BCC programme should be initiated with drivers to better protect them against drunk driving, unprotected sex, and speeding.
- Specific condom use information should be emphasised for sex with casual and regular partners.
- Information should use media channels such as radio and cassettes that drivers listen to regularly.
- The transport sector and policy makers, companies, and police should be involved together in planning and objective setting to reduce pressures on drivers, such as the
need for speeding, overloading vehicles, and the risk of being stopped by police during day-time driving.

- A national-health service network for the transport sector should be established to meet the specific health care needs of long-distance truck drivers. Such a network should establish a health-record management system, and include regular health checks and counseling for long-distance truck drivers. Related to a national-health service network, there should be the creation of a “mobile insurance” policy that is convenient for long-distance truck drivers (and other mobile populations), enabling them to visit health providers along their transport routes. Mobile population and migrant friendly services must be introduced and trained.

- Pharmacies and private doctors need to be included in health-care and health-seeking strategies. Including pharmacies and private services into provincial training is essential to the comprehensive approach of provincial health care.

- Low-cost, or free condoms should be made readily available and accessible at gas stations, parking lots, hotels and guesthouses, restaurants, and places drivers gather along transport corridors.

- Advocacy should be conducted amongst policy makers and insurance companies to increase the proportion of insured drivers, especially those not employed by state-owned companies.

- Further studies on long-distance truck drivers, such as their working environment, occupational health, HIV, and the health-care system should be conducted.

- Truck drivers rely on private pharmacists and doctors and do not necessarily have accurate diagnostic and treatment information. Health care information would be useful.

There was concern raised by participants over the high proportion of truck drivers who reported consuming alcohol on a daily basis and who also smoked. It was suggested that special attention be paid to these factors that affected not only high-risk behaviour but also the overall health of the drivers.

In the presentation from Viet Nam there was also significant evidence that transactional sex is a big issue when drivers cross borders, for e.g., drivers from Viet Nam going over the Chinese border or Thai drivers to Lao PDR. However, participants from Lao PDR involved said their enquiries about sexual behaviour of Thai drivers in Lao PDR showed very few cases of visits to local sex workers.

The Viet Nam presentation also pointed to the role of working conditions of truck drivers affecting their levels of stress, alcohol consumption and consequent high-risk behaviour. The fear of being stopped by police officials for over loading their trucks, for example, forces many truck drivers to drive at night leading to loss of sleep, accidents and additional worries.

Another participant referred to the large gaps in incomes within the community of drivers and the implications in terms of their risk behaviour. From the data presented it was felt that while truck drivers with higher incomes were more likely to visit sex workers often but those with lower income were more likely not to use condoms while visiting sex workers.

An important issue raised was the need to build the capacity of local people to monitor the situation in their areas, instead of sending outsiders to do research.
Mr. Vincent Valentine, Economic Affairs Officer at UNESCAP’s Transport and Tourism Division gave a historical overview of the development of the Asian Highway and pointed to its benefits for trade and poverty alleviation in the region. While road networks increased the numbers of truck drivers traveling across borders he said that efficient management at border crossings and cargo loading and unloading points could reduce the time drivers have for indulging in high risk behaviour.

Ms. Hoang Thi To Linh, IOM, Viet Nam explained that health and social problems are complex and require integrated, multi-disciplinary approaches and experience. These problems are often addressed more effectively by bringing together the technical and managerial expertise of several organisations to reach desired results.

It was pointed out by several participants that multi-sectoral / multi-stakeholder partnerships are very important. Non-health Ministries in particular need to realize that their role is not to replicate the work of the Ministry of Health but to actually reduce the vulnerability of their stakeholders.

In his presentation on the pilot intervention underway at Nong Khai Mr Montri Pekanan, Deputy Director, PPAT said that IEC material produced for Thai truck drivers should be easy to understand. He supported the idea of campaigning against drinking alcohol as a way of cutting down road accidents and other health related problems among road transport workers.

Ms. Lisa Studdert, Health Specialist with the ADB said there were five critical elements of HIV prevention programs for mobile population groups. These were:

- A task group is formed and active;
- Local capacity to implement;
- The local situation and needs of mobile groups are understood;
- Local community is taking visible steps towards becoming HIV resilient;
- Mobile people have received support for behaviour change.

Some participants requested more research on the perspectives of sex workers on the problems. More studies on the working and socio-economic conditions of truck drivers were recommended.

**D. Presentations based on Thematic Working Groups**

On the second day of the regional workshop participants broke up into four thematic working groups to identify the issues involved and recommend possible solutions. The four themes were working conditions, collaborating across borders, transport and health.
1. Theme: Working Conditions

1.1. Key Issue: Working hours

Discussion: The typical working hours of long distance truck drivers is too long. There is nobody to monitor whether they get adequate rest at regular intervals while working. Very often they do not get enough sleep, a factor that affects their health and increases the risk of being involved in road accidents.

Harassment by traffic police also seems to be a common reason for added stress to the lives of truck drivers. Arbitrary interpretation of traffic laws and plain corruption among police officials result in truck drivers being hauled up and asked to pay fines of different kinds, most often from their own pockets.

Additionally, if the truck drivers have family problems, the stress level increases.

Such stress results in truck drivers resorting to smoking and consumption of alcohol and relaxation in sex services. Lack of access to health facilities or counseling increases their vulnerability to ill health in different ways.

Recommendations:

• Employers implement proper working hours for truck drivers;
• Trucks should stop for rest every two or three hours;
• Employers should regularly track the movement and activities of drivers while at work through the use of mobile phones and other means.

1.2 Key Issue: Cross Border Mobility

Discussion: When truck drivers cross international borders and go to another country their normal behaviour changes. They are more experimental, more curious about local women and more willing to take risks of various kinds. Being in an unfamiliar place also means they have difficulties in accessing condoms on their own.

Recommendations:

• Improve access of truck drivers to condoms;
• Distribution of condoms required at places before reaching border immigration point.

1.3 Key Issue: Absence from home

Discussion: Staying away from home for long periods on work also changes the normal behaviour of truck drivers. They seek companionship and the services of sex workers as a result of which there is an increased risk of unsafe sex.

Recommendation:

• Improve access to condoms
1.4 Key Issue: Hotspots

Discussion: There is a mushrooming of entertainment places along highways in the GMS. This has resulted in easy and low cost access to sex services. Access to alcohol has also increased, which apart from fuelling high-risk behaviour is also harmful to the health of truck drivers.

Recommendations:

- More prevention activity at hotspots;
- Target owners and sex workers too as part of awareness campaigns;
- Ensure availability of condoms;
- More emphasis on cutting down consumption of alcohol.

1.5 Key Issue: Monetary Incentives

Discussion: Long distance truck drivers often receive lump sum payment for their trips as an incentive to drive faster and return quickly in order to increase their chances of making more money. Business clients who receive cargo also tip drivers to deliver quickly. This encourages them to drive at high speeds and without taking regular rest thus affecting their health and increasing chances of road accidents.

More money often correlates with higher risk sexual behaviour on the part of truck drivers. However, the money is also not large enough for them to invest meaningfully in education or health and improving the lives of their family.

In some countries, like Viet Nam, there are strict limits to the cargo load, which is decided on the basis of road types that the truck travels on. But truck owners, in order to make money, often overload the trucks, which then becomes a cause for traffic police to harass drivers and make them pay fines. All this increases the stress levels of drivers.

Recommendations:

- Change monetary incentives to stop fast driving
- Educate business clients about not insisting on speedy deliveries of cargo
- Study loading limits for safety and also business viability of truck companies
- Improve quality of roads so that trucks can carry higher loads of cargo without compromising safety concerns.

1.6 Key Issue: Health Service

Discussion: Truck drivers, in countries like Lao PDR, do not have access to good quality health facilities. This along with other factors results in truck drivers resorting to self-medication or taking medicines on the advice of pharmacists who are often not aware of HIV issues.

Recommendations:

- Improve access to health facilities;
- Equip pharmacies to counsel drivers on HIV and STIs;
- Improve quality and reach of public health services.
1.7 Key Issue: Company Practice

Discussion: Few truck companies have HIV awareness programmes for their employees. There is often no information available at the workplace about HIV or STIs.

Recommendations:

• Owners or managers of truck companies can help mobilize truck drivers for awareness and prevention programs;
• They can also provide space for meetings and workshops on HIV and other health-related issues.

1.8 Key Issue: Public image of truck drivers

Discussion: Truck drivers have a higher status in society as compared to many other professions of comparable income and skill level. Operating large vehicles often reflects a macho self-image among truck drivers of themselves. This puts pressure on them to reassert their ‘manly’ behaviour and gives them a sense of domination and power.

Recommendations:

• Find ways of channeling their high self-esteem into positive and constructive activities;
• Help truck drivers serve as role models of responsible behaviour for other sections of society.

2.0 Theme: Collaborating Across Borders

2.1 Key Issue: Health across borders

Discussion: Many truck drivers are not covered by health insurance policies, and even if they are, such cover does not usually extend across national borders. In several of the GMS countries vehicle insurance is compulsory but not for the truck drivers or their assistants.

While in another country truck drivers also find it difficult to access health services due to complicated procedures and language barriers.

The health services provided at immigration check points currently are just a formality which are not utilized for prevention or curative purposes. There is also a lack of cooperation between health authorities of neighbouring countries and under-utilization of disease surveillance networks.

Recommendations:

• There should be compulsory health insurance, valid both within and across countries, for truck drivers;
• Provide curative and preventive health services at border immigration posts for all drivers;
• Produce and distribute health promotion material in different languages.
2.2 Key Issue: Regional forums on transportation

Discussion: There is very limited discussion in regional transport forums on health issues.

Recommendations:

- Regional organizations such as ASEAN, GMS, ADB, ACMEC and UNESCAP should take up health issues at meetings and workshops on transport they organize.
- Such forums can also take up issues such as reducing the waiting time for truck drivers at border checkpoints during trans-shipment.

2.3 Key Issue: Increase in risk behaviour at border checkpoints

Discussion: Often truck drivers are attracted to sex services in border areas as a way to ‘kill time’ and overcome boredom while waiting for clearance of cargo at the check points.

Recommendations:

- Comprehensive truck stops should be set up at borders to attend to the various needs of the truck drivers;
- Waiting areas at border checkpoints can provide health care, low risk entertainment, restaurants, accommodation, showers and vehicle maintenance services;
- Provide health services for local communities in border areas;
- Target BCC strategy required for truck drivers, addressing their cross border behaviour. Such communication material should be produced in multiple languages.

2.4 Key Issue: Monitoring, social impact assessment and follow up of regional developments

Discussion: The implications of increasing movement of trucks across borders needs to be addressed. The responsibility for monitoring developments in cross border transportation and their impact on health is yet to be clearly assigned to any agency or organization.

Recommendations:

- Establish mechanisms for monitoring the changes in transport and making data available for programming;
- Establish multi-sectoral committees and mechanisms with clear responsibilities for:
  - Social/health impact assessment;
  - Programme response;
  - Monitoring and evaluation.
3.0 Theme: Transport Group

3.1 Key Issue: Integration of health concerns into transport services and policy

Discussion: There is a need for regular education on HIV/AIDS prevention for truck drivers. They also need access to a proper health care system, preferably a kind of one stop service at rest areas along the road. There is also a need to simplify procedures at border checkpoints to reduce waiting time for truck drivers.

Recommendations:

- HIV/AIDS prevention methods should be integrated into driver training programs;
- Raise awareness of existing drivers on HIV/AIDS prevention;
- Mobile health care system for truck drivers;
- Establish one stop service at rest areas along the transport corridors;
- Implement single stop and single window inspection at the border check points.

4.0 Theme: Health

4.1 Key Issue: Low awareness of health issues among truck drivers

Discussion: There is poor access to information and channels of information on health issues for truck drivers.

Recommendations:

- BCC should be undertaken through mass media like radio, community radio, newspapers;
- Public health training and information should be provided for sex workers.

4.2 Key Issue: Poor health seeking behaviour

Discussion: Truck drivers face numerous occupational risks in the form of accidents, fatigue, police harassment, stress, poor road conditions, and inadequate nutrition. This has an impact on their behaviour resulting in alcohol consumption, unprotected sex and frequent use of sex workers and drugs.

All this combined with low-income levels prevents them from seeking health services on a regular basis. There are also psychosocial issues that arise due to long absence from home and family.

Recommendations:

- Ministry of Transport along with transport companies should ensure regular driving schedules for truck drivers;
- Two drivers to take turns on same job;
- Low cost, accessible, appropriate resting places for truck drivers should be made available;
• Improve driving conditions – chair quality, air-conditioning;
• Medical exams, first aid and public health training should be required for issuance of driving license;
• Provide first aid kits (including condoms) to truck drivers.

4.3 Key Issue: Inadequate health infrastructure

Discussion: Truck drivers have poor access to health services often due to lack of adequate health infrastructure in many GMS countries. Several countries also do not have proper policies addressing health issues of mobile populations, like for instance lack of insurance coverage for truck drivers.

Recommendations:

• Make condoms readily available and free;
• Make low cost, regular medical check ups readily available and accessible (along roads, at border areas) for families/partners of drivers;
• Capacity building on public-health and HIV prevention for transport company owners;
• Medical mobile units and health should provide outreach services to truck drivers;
• Cross-border mobile health units specifically for mobile and migrant populations;
• Better cooperation and planning required between transport, health and police;
• Establish national surveillance systems (for HIV surveillance and reporting, behavioural surveillance) for migrant and mobile populations.

IV. CLOSING OF THE WORKSHOP

In her closing remarks Ms Thelma Kay, Chief, Emerging Social Issues Division said that the concept of health without borders is only possible if a multi-sectoral, multi-ministerial approach is adopted, which includes a clear response to public health concerns of mobile populations, including HIV/AIDS and other communicable diseases.

“You have outlined several recommendations from concrete health promotion interventions at specific places to necessary policies and programmes that must be put in place and implemented efficiently and effectively at local, national and regional levels”, she said thanking the participants for ‘crossing borders’ to make the workshop a success.
Key Recommendations

- Employers should implement proper working hours for truck drivers.
- Monetary incentives for truck drivers should be changed to discourage fast driving.
- Help truck drivers serve as role models of responsible behaviour for other sections of society.
- HIV/AIDS prevention methods should be integrated into driver training programmes.
- Set up national health surveillance systems for migrant and mobile populations.
- Improve quality and reach of public health services for transport workers.
- Improve access of truck drivers to condoms.
- Help transport workers cut down consumption of alcohol.
- Public health training and information should be provided to sex workers.
- There should be compulsory health insurance, valid both within and across countries, for truck drivers.
- Produce and distribute health promotion material in different languages.
- Waiting areas at border checkpoints can provide health care, low risk entertainment, restaurants, accommodation, showers and vehicle maintenance services.
- Implement single stop and single window inspection and clearance facilities for transporters at the border checkpoints.
Health Without Borders: Phase II

Introduction

Phase I of the Health Without Borders project focused on forging partnerships, conducting situational analyses to provide the evidence and implementation of one pilot intervention to test the modalities of “health stops” and how to reach the target group. Phase II of the project will be shaped by the policy recommendations that have come out of the final regional workshop.

One suggestion is that Phase II could possibly consist of pilot interventions in Lao PDR and Viet Nam and the extension of the pilot in Thailand to support policy formulation in these countries and in the region. However, more importantly a regional policy framework would need to be set up as part of Phase II. This would be a sustainable project outcome and would be entirely in line with UNESCAP's drive towards normative work.

Additional pilot interventions and the cooperation on the policy level have been discussed with ADB. These would be fine-tuned in additional consultations with the ADB.

Recommendations from the Regional Workshop

Some of the suggestions made by workshop delegates for designing and implementing Phase II of the Health Without Borders project in the GMS region were:

- More collaboration and research is required to understand the impact of activities along the East-West transport corridor, linking Thailand to Viet Nam on health of long distance truck driver.
- There is a need to set up health services in each of the project countries specifically aimed at migrants (both temporary and long term).
- Efforts are required to overcome language barriers while dealing with populations coming from across the border.
- There is a need to consolidate all elements of collaboration along the corridor that already exists.
- More work required through existing channels between three GMS countries selected as part of the project. This includes sectors other than just truck drivers.
- There is need for a working mechanism to bring transport and health ministries, truck companies, NGOs together on the East-West corridor issue to make it entirely safe.

Pilot Intervention in Thailand: Future Options

Thai participants at the regional workshop met together to discuss the future of the pilot intervention in Nong Khai undertaken by the PPAT. Following are some of the recommendations from the discussions.
Main Recommendations

- Scale Up Nong Khai pilot intervention program to address similar issues at other border crossings in Thailand.
- Improve National HIV policy on migrant and mobile populations.

Further Research

- Socio-Economic condition of truck driver families.
- Alternate professional career for truck drivers.
- Hopes, ambitions and expectations of truck driver families.
- Overall health problems of truck drivers.

Activities

- Advocacy to improve policy on migrant and mobile populations.
- Documentation of pilot intervention experience.
- Link intervention with Thailand’s National AIDS Bureau.
- Extend network to include more stakeholders.
- Disseminate information on truck driver health issues through media.
- Work with peer group.
- Set up truck driver friendly Health Stop Services.
- Promote overall healthcare for truck drivers.

Key Stakeholders

- Provincial governor.
- Provincial health officials.
- Provincial public relation officials.
- Immigration Police.
- Truck company owners.
- Hot spot owners.
- Peer leaders among truck drivers.