

## **The Health Risks of Migration:**

The Link between Health and Migration with Particular  
Consideration of Knowledge and Attitudes towards HIV/STIs  
and the Sexual Practices of Moldovan Migrants

Final report

**Elfriede Steffan, Consultant**

Samanta Sokolowski

**SPI Forschung gGmbH**

Kohlfurter Str.41-43

10999 Berlin, Germany

[spi@spi-research.de](mailto:spi@spi-research.de)

[www.spi-research.de](http://www.spi-research.de)

[www.bordnet.eu](http://www.bordnet.eu)

<b>1</b>	<b>Introduction .....</b>	<b>5</b>
<b>2</b>	<b>Methodology.....</b>	<b>7</b>
<b>3</b>	<b>Results .....</b>	<b>9</b>
3.1	Demographic data.....	9
3.1.1	Country of origin and ethnic group.....	9
3.1.2	Age .....	10
3.1.3	Education.....	11
3.1.4	Living and work situation/Children .....	11
3.1.5	Mobility.....	14
3.1.6	Summary of demographic results and mobility.....	20
<b>4</b>	<b>Health status and behaviour and experiences with the health services .....</b>	<b>21</b>
<b>5</b>	<b>HIV/AIDS and Sexual Practices.....</b>	<b>28</b>
5.1	Basic knowledge of HIV transmission ways.....	28
5.2	Wrong believes about HIV transmission routes (myths) .....	31
5.3	Knowledge of HIV protection .....	34
5.4	Received information about HIV/AIDS.....	36
5.4.1	Summary of HIV/AIDS knowledge.....	39
5.5	HIV Test .....	40
5.6	STI knowledge and diagnosis .....	44
5.7	Alcohol and drugs consumption.....	47
5.8	Sexual Behaviour and condom use .....	49
5.8.1	Sexual Behaviour.....	50
5.8.2	Condom use .....	55
<b>6</b>	<b>Conclusions and recommendations .....</b>	<b>61</b>
<b>7</b>	<b>Bibliography .....</b>	<b>64</b>
<b>8</b>	<b>Annex .....</b>	<b>65</b>

<b>Graph 1: To which ethnic group do you belong? (n=454)</b> .....	<b>10</b>
<b>Graph 2: Distribution of the respondents according to age and sex (men n=272, women n=182)</b> .....	<b>10</b>
<b>Graph 3: Education level, % (male n=267, female n=179)</b> .....	<b>11</b>
<b>Graph 4: Living situation (%), n=454</b> .....	<b>12</b>
<b>Graph 5: Employment situation (%), male n=272, female n=182</b> .....	<b>13</b>
<b>Graph 6: Travel destination according to sex, % (n=454) male n=272, female n=182</b> .....	<b>15</b>
<b>Graph 7: Frequency of travels to CIS/Non CIS countries in the last three years,</b> .....	<b>16</b>
<b>% (CIS n=277, Non CIS n=176)</b> .....	<b>16</b>
<b>Graph 8: Length of stay in CIS/Non CIS countries, % (CIS n=277, Non CIS n=176)</b> .....	<b>16</b>
<b>Graph 9: Type of visa for travelling abroad, % (n=488), multiple answers</b> .....	<b>17</b>
<b>Graph 10: Purpose of the travel, %, (n=454) multiple answers</b> .....	<b>18</b>
<b>Graph 11: Sector of activity abroad, % (n=450), multiple answers</b> .....	<b>18</b>
<b>Graph 12: If you have a problem abroad, to whom do you turn for help? %, (CIS n=392, Non CIS=236), multiple answers</b> .....	<b>20</b>
<b>Graph 13: Health insurance according to education degree, %, (school deg. n=145, voc. ed. n= 190, univ. deg. N= 99)</b> .....	<b>22</b>
<b>Graph 14: What do you do in the case of a health problem abroad? (% , multiple answers)</b> .....	<b>22</b>
<b>Graph 15: Most frequent health problems abroad (Answers Non CIS n=164, Answers CIS n=279), multiple answer</b> .....	<b>23</b>
<b>Graph 16: Use of the health system according to the possession of a health insurance, %, health insurance possession n=115, without health insurance n=291)</b> .....	<b>24</b>
<b>Graph 17: Difficulties with the health system in CIS (n=70) and Non CIS countries (n=38)</b> .....	<b>25</b>
<b>Graph 18: Sector of activity of the respondents that work/live under bad health conditions, %, (Non CIS n=34, CIS n=105), multiple answers</b> .....	<b>26</b>
<b>Graph 19: Complaints about work place/living conditions in CIS countries, % (work place n=76, living place n=59), multiple answers</b> .....	<b>26</b>
<b>Graph 20: “I am quite/fairly sure to know what HIV/AIDS is” according to age, % (n=440)</b> .....	<b>28</b>
<b>Graph 21: “How can HIV/AIDS be transmitted?”, %, (n=454)</b> .....	<b>29</b>
<b>Graph 22: Knowledge of HIV/AIDS among the respondents who stated to fairly/quite sure to know what HIV/AIDS is (n=380)</b> .....	<b>30</b>
<b>Graph 23: Knowledge level of HIV/AIDS transmission ways and myths of respondents in Moldova (n=427) and respondents in Russia (n=27)</b> .....	<b>30</b>
<b>Graph 24: You can get infected with HIV/AIDS by kissing/coming into contact with saliva according to the country in which the respondents were interviewed, % (In Moldova n=427, in Russia n=27)</b> .....	<b>32</b>
<b>Graph 25: Level of knowledge of protection ways, % (n=454)</b> .....	<b>35</b>
<b>Graph 26: Knowledge on protection ways according to education (n=235)</b> .....	<b>35</b>
<b>Graph 27: Ways of obtaining information on HIV/AIDS, % (Moldova n= 641, CIS country n= 169, Non CIS country n=104), multiple answers</b> .....	<b>37</b>
<b>Graph 28: What would be the best way to receive information on HIV/AIDS, % (n=454), multiple answers</b> .....	<b>38</b>
<b>Graph 29: Do you know if HIV/AIDS can be treated?, %, (In Moldova n=427, in Russia n=27)</b> .....	<b>39</b>
<b>Graph 30: Reason for required HIV Testing, % (n=144, multiple answers possible)</b> .....	<b>42</b>
<b>Graph 31: Reason for HIV Testing as a personal decision, % (n=137, multiple answers possible)</b> .....	<b>43</b>
<b>Graph 32: Which STI do you know?, % (n=454, multiple answers)</b> .....	<b>44</b>
<b>Graph 33: Knowledge of STIs of respondents in Russia (n=27) and in Moldova (n=427), %</b> .....	<b>45</b>

**Graph 34: Alcohol consumption in Moldova and abroad, % (Moldova n= 353, CIS country n= 280, Non CIS country n= 191) ..... 48**

**Graph 35: Frequency and quantity of alcohol consumption in Moldova, % (n=335)..... 49**

**Graph 36: The number of sexual partners in total over the last three years, % (n=454)..... 50**

**Graph 37: Comparison of number of sexual relationships between respondents interviewed in Moldova and in Russia, % (In Moldova n=400, in Russia n=26)..... 51**

**Graph 38: Number of sexual partners in the last three years concerning the countries of destination, % (n= 425)..... 52**

**Graph 39: Do you know if your partner has had any of the following?, %, more than one option possible. Moldova n= 308, CIS country n=137, Non CIS country n=54..... 53**

**Graph 40: Condom use during sexual intercourse with regular and Non regular partners, % (n=454)..... 55**

**Graph 41: Condom use according to the number of sexual partners, % (n=131)..... 56**

**Graph 42: How do you act when your partner does not want to use condoms? %, (n=258)..... 58**

**Graph 43: Reasons for not using condoms, %, (n=49) ..... 59**

# 1 Introduction

In 2005, an estimated 270,000 people were newly infected with HIV in Eastern Europe and Central Asia, bringing the number of people living with HIV in the region to 1.6 million, an almost twenty-fold increase in less than ten years.

In the same year, approximately 62,000 people died of AIDS-related illnesses in the region, almost double the number of two years before. Another worrying trend is the number of young people infected: approximately 75 percent of new infections over the last five years have been in people younger than 30 years of age – a significantly higher percentage than in Western Europe where the rate is 33 percent.

The AIDS epidemics in this region continue to grow and in some countries are showing signs of crossing over from high-risk groups to the general population. Increasing rates of sexual transmission of HIV – an early warning sign that epidemics are becoming generalised – have been recorded in Belarus, Kazakhstan, the Republic of Moldova and Ukraine.

The biggest epidemics in the region are in the Russian Federation and Ukraine, where the vast majority of new infections are in young people and the epidemics continue to be driven by high rates of injecting drug use, though rates of sexually transmitted infection are on the rise.

While the growth rates of the HIV epidemics in Eastern Europe and Central Asia are rapid, the numbers are still in their early stages. The risk to the region if prevention, treatment and care are not greatly scaled up is enormous. At the same time, there is now a critical opportunity to halt and reverse the spread of HIV in these countries. Funding to combat HIV is beginning to increase in the domestic health budgets of a number of countries in the region – and quite notably in a few. In addition, Global Fund grants are financing a wide range of prevention and treatment interventions, including harm reduction services and education targeting young people and other high-risk populations.<sup>1</sup>

In the frame of HIV transmission patterns, also the mobility of the population plays a significant role. A high percentage of the population of central- and east European countries goes

---

<sup>1</sup> UNAIDS, 2005

abroad for shorter or longer time periods to earn their livings outside of their home countries because of high unemployment rates and economically and socially unstable living conditions. This affects almost 40 % of the working population of Moldova<sup>2</sup> This behaviour is a solution to improve poor living conditions individually and to stabilize family systems in the home countries through to remittances of a part of the earnings abroad.

But the migration and the work abroad often takes place under legally and socially severe circumstances. Numerous categories of migrants are exposed to increased risk-taking due to the unique pressures, constraints and living environments specific to their status and situation. Many are residing in totally alien cultural environments, away from their spouses, families and regular partners, which affects their sexual behaviour, namely through a feeling of anonymity and freedom from social norms prevalent in their community. In some settings, living and recreational environments for migrants and mobile workers are almost exclusively male, which sometimes leads to development of commercial sex services and pressures to use them<sup>3</sup>. Understanding of migrant behaviour/practices, their motivations, psychological state and reasoning is essential for the designing of effective preventive interventions and bringing about behavioural change among the at-risk groups.<sup>4</sup>

Furthermore, recommendations of the National Scientific and Practical Centre for Preventive Medicine AIDS Centre for 2005 stipulate that there is an acute need to determine and analyse the risk factors and ways of infection in a behaviour research, especially in relation to the conditions abroad<sup>5</sup>. Also the prevention/intervention actions for vulnerable population groups are stated as an objective in the *National Programme to Prevent and Combat HIV/AIDS 2006-2010 of Moldova*<sup>6</sup>. In addition, discussions with local officials have confirmed the deficiency of information on health dangers and service outlets for medical assistance in the main countries of destination for migrants from Moldova. This inadequacy is exacerbated through an alarming lack of knowledge of health systems/services available to returning migrants at home, thus marginalizing both outgoing and returning groups.

Hence, an intervention has been designed to conduct an assessment, focusing on the following critical and inter-linked areas:

---

<sup>2</sup> IOM, 2006

<sup>3</sup> UNAIDS Best Practice Collection, 2001

<sup>4</sup> UNAIDS, 2005

<sup>5</sup> UNAIDS, 2005 (2)

<sup>6</sup> UNAIDS, 2006

- (1) HIV/AIDS knowledge, attitudes and practices among Moldovan migrants
- (2) Main conditions and factors contributing to vulnerability to HIV/STI and sexual risk behaviour of migrants in the main states of destination

## 2 Methodology

The research was planned as a cross-sectional study with qualitative and quantitative components. The qualitative phase was characterized by focus groups discussions and in-depth interviews. Trained staff organized and conducted five focus groups in December 2006, with a total of 39 participants in Chisinau, Cahul and Balti. Five focus groups were conducted, with a total of 39 participants and 16 detailed interviews. The data was collected based on an interview guideline following the following structure: subjective understanding of risks and anxiety, general knowledge of HIV/AIDS, protection methods and possibilities, HIV test, prevention and information activities, medical services and risk behaviour abroad.<sup>7</sup>

### **Target group**

Moldovans, who have been abroad in the last 3 years for at least 1 month

### **Research field**

Republic of Moldova, sample representative of the Moldovan migrant population

### **Sampling**

The sampling of the group will take place according to the following criteria:

### **Target Group**

- a. Age 16-60
- b. Sex 50%-50% male-female
- c. Educational level – all
- d. Diversity – two target groups based on destination countries– CIS and non-CIS countries

### **Sample Recruitment**

Sample size will be 400 persons

The survey is based on quantitative research method and carried out through an face-to-face questionnaire. The data collection took place between December 25 and January 15, and it was carried out by CBS-AXA Consultancy. The questionnaire contained 60 questions (mostly closed single- and multiple-choice), divided in four thematic parts: 1) general part (socio-demographic data, living and working situation – 8 items), 2) crossing-border and interna-

---

<sup>7</sup> For focus group report, contact IOM Moldova

tional mobility patterns – 8 items; 3) Health status and behaviour – 8 items); 4) HIV/AIDS/STIs and sexual practices (knowledge, subjective risk perception, level of HIV/STIs risk exposure, preventive measures and risk reduction strategies)– 41 items. The data analysis proceeded with SPSS and presents mostly descriptive and inferential statistical analysis.

The target group for the quantitative questionnaire were Moldovans who were abroad in the last 3 years for at least one month. The age of the group ranges from 16 years old to 60. The sex distribution was planned to be 50%/50%, however, the actual distribution is 60% men and 40% women. The sample size is 454 respondents. 427 of these respondents were interviewed in Moldova and 27 were interviewed in Moscow, Russia through the NGO “Speranza”.

Researches show that especially vulnerable topics are more easily discussed in a migration setting. Therefore this small group of interviewees serves throughout the survey as a comparison of the answering behaviour of Moldovans interviewed in Moldova and Moldovans interviewed abroad, in a migration setting.

To get more open and realistic answers on the often tabooed questions on e.g. HIV/AIDS/STI, homosexuality, prostitution, drug consumption, it was initially agreed to reassure the clients confidentially using the snowball technique, recruiting peers as “survey mediators” for the sample recruitment and to do the interviews outside the homes of the interviewees. This was suggested to avoid that relatives who might not be familiar with the activities of the respondents abroad could represent potential obstacles for the interviewees to be able to obtain open and truthful answers.<sup>8</sup> This procedure is based on international standards, as “the snowball sampling develops trust as referrals are made by acquaintances or peers than other more formal methods of identification” (Atkinson et al, 2001)

However, taking into account the narrow time frame of the survey<sup>9</sup> and the feasibility of this research method in Moldova, it was unfortunately not possible to implement the snowball method in the recommended manner in practice.

The questioning of the respondents took place in the home of the interviewees and face-to-face by interviewers and not by peers as survey mediators. Even though the questioning was

---

<sup>8</sup> See explanations and agreement on methods in TOR

<sup>9</sup> The respondents had to be interviewed in the very narrow time frame of the Christmas holidays

done in a separate room where only the respondent and the interviewer were present, this cannot be described as an ideal confidential frame for the interview.

Due to these methodical changes some of the answers of the respondents are probably influenced by social desirability, other questions were not answered by many interviewees. Unfortunately the biases of the answers through the not always confidential setting of the interview are not identifiable in the aftermath. However, some answers show hints on the answering behaviour. In these cases, the attention of the reader will be drawn to this.

Despite the questioning method, enough plausible and also international comparative data is available to allow a new insight in the knowledge of HIV/AIDS and STIs, attitudes and sexual behaviour of the cross border mobile population of Moldova.

### **3 Results**

The analysis of the data was carried out with the help of descriptive and inferential statistical methods<sup>10</sup> using SPSS. In order to profile the different groups and situations, apart from the usual independent variables age, sex and education, we have included the variables place of residence (city/ rural area), migration destination (CIS/Non CIS) and country in which the interview took place (Moldova/ Russia) to be able to make comparisons. In the further analysis, these categories will not be explicitly named if they don't have an influence on the analysed variable.

#### **3.1 Demographic data**

##### **3.1.1 Country of origin and ethnic group**

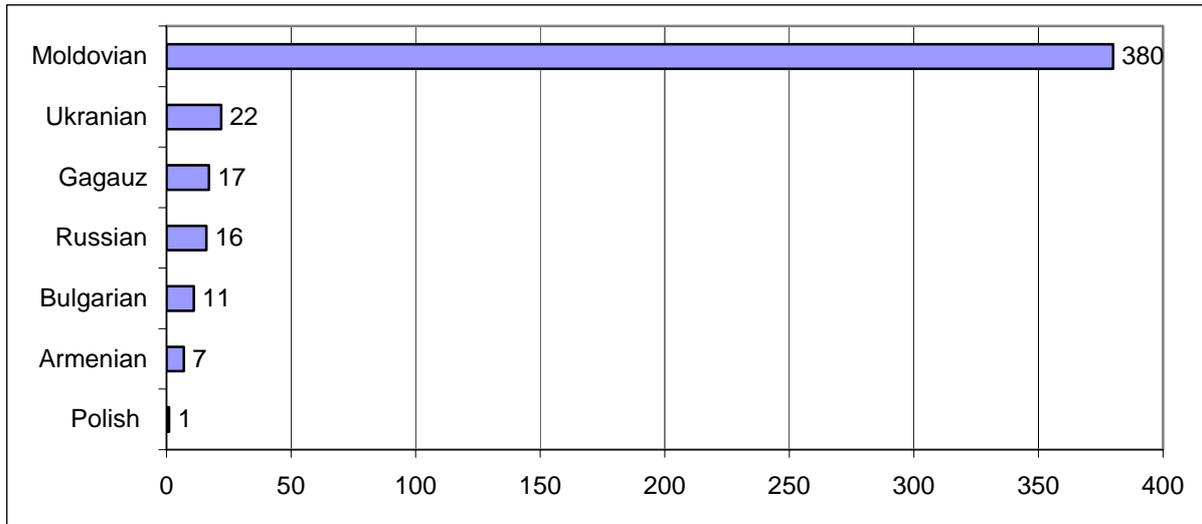
The sample consists of 454 Moldavian citizens with migration experiences, being 59,9% male and 40,1% female. Most of the respondents were reached in different Moldavian regions (94,1%, 427), a smaller group was interviewed while being abroad in Russia (5,9%, 27

The vast majority of the respondents were born in Moldova (94,7%, 430), followed by 16 (3,5%) persons that were born in the Ukraine. Asked about the ethnic affiliation, the majority stated to be Moldavian (83,7%, 380), followed by Ukrainians (4,8%, 22), as it can be seen in the following graph.

---

<sup>10</sup> For the inferential statistical analysis the Chi square test was used

**Graph 1: To which ethnic group do you belong? (n=454)**



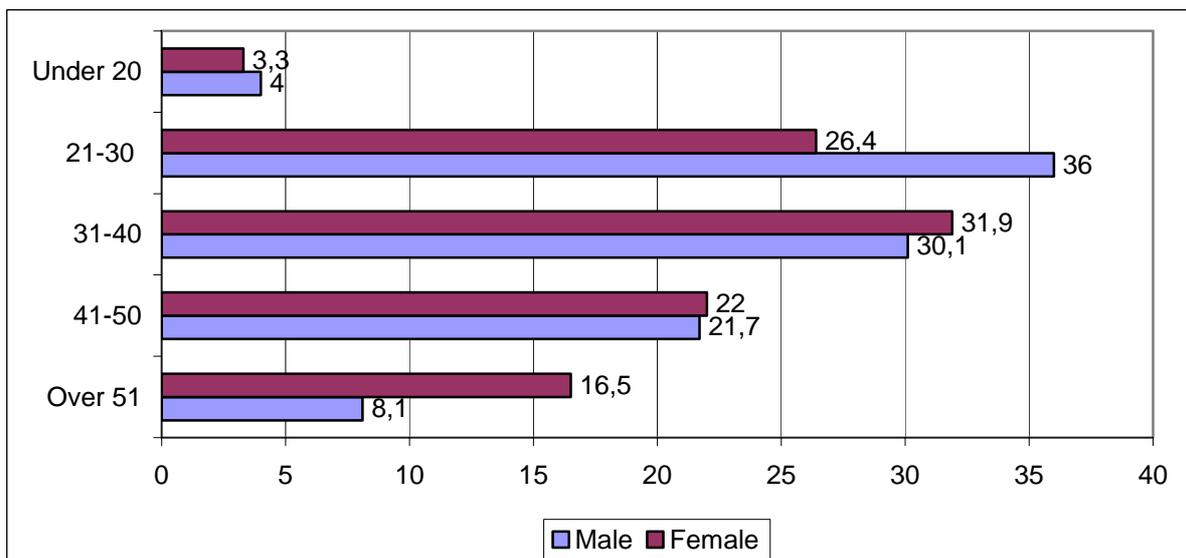
### 3.1.2 Age

The age range of the respondents was predefined as sample recruitment criteria, 16 to 60 years. In average, the interviewed migrant is 35,9 years old. The men are younger than the women, being the average age of the former 34,6 years and of the women 37,7 years.

The biggest group is the group of the young adults (32,2%, 146) between 21 and 30 years old, followed by the group between 31 and 40 years old (30,8%, 140). Over 20% (21,8%, 99) are between 41 and 50 years old, 11,5% (52) over 51 and the smallest group is under 20 (3,7%, 17).

The next graph shows the distribution of the respondents in age groups according to the sex.

**Graph 2: Distribution of the respondents according to age and sex (men n=272, women n=182)**

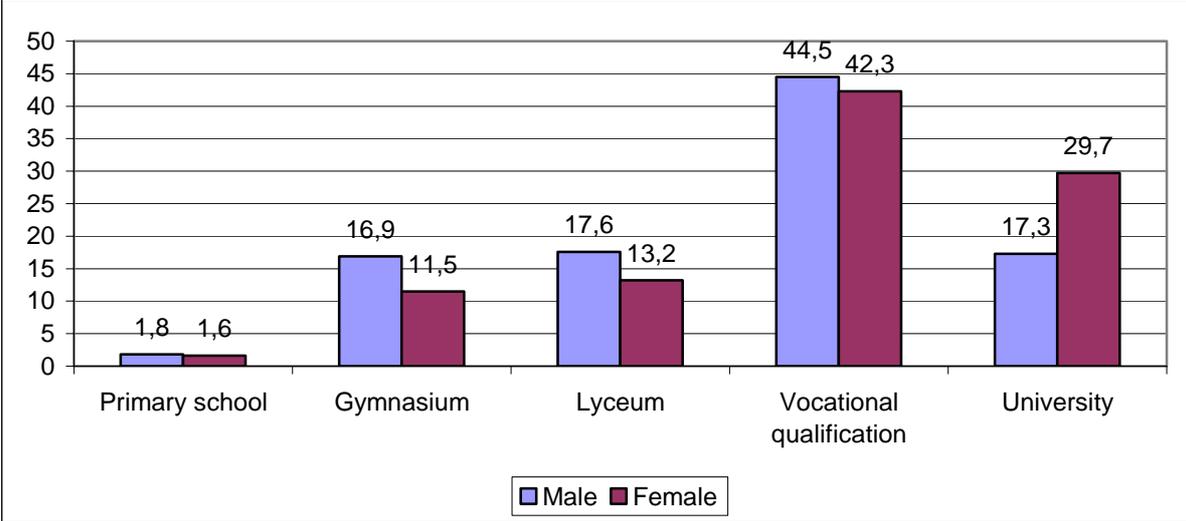


As it can be seen in the graph, the biggest differences of sex among the age groups are the groups between 21-30 years old, where significantly more men and the age group over 51, where significantly more women were interviewed.

**3.1.3 Education**

The interviewed persons are well educated in comparison with the general population and also slightly better than the sample of the survey on migration and remittances. Over 40% (43,6%, 198) have a vocational qualification, followed by the group that has a higher qualification diploma (22,2%, 101). 15,9 (72) have a lyceum certificate and 14,8% (67) a gymnasium certificate. Looking at the next graph, it becomes visible that female interviewees are better educated as the male.

**Graph 3: Education level, % (male n=267, female n=179)**

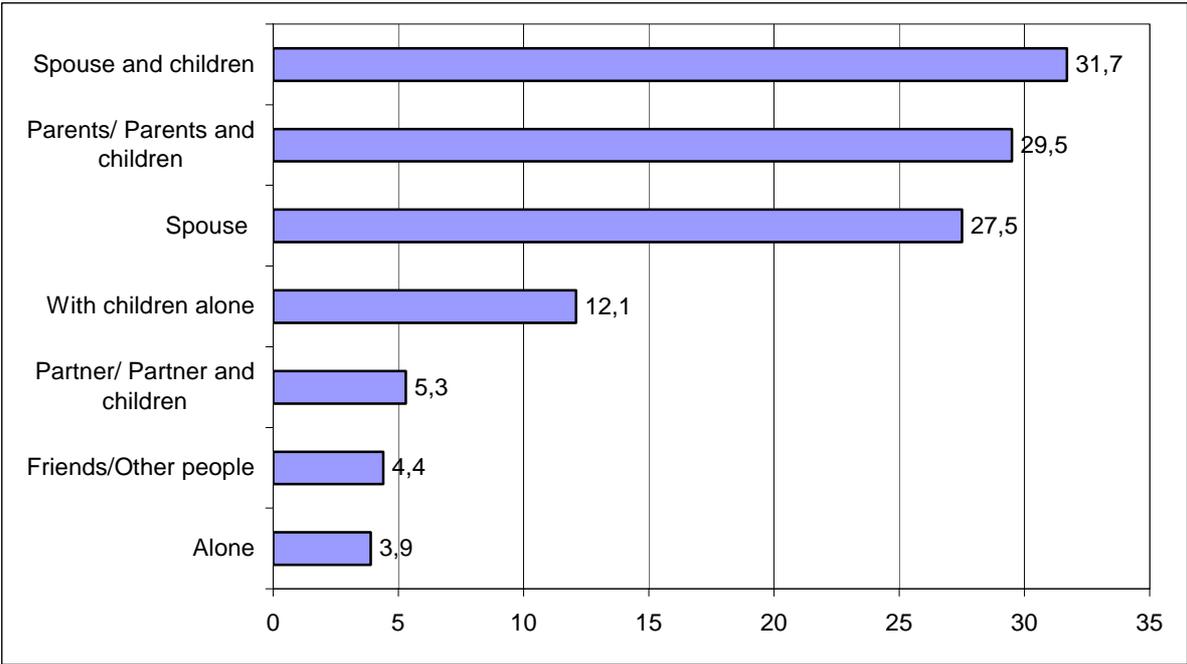


**3.1.4 Living and work situation/Children**

Asked about with whom the respondent is living at the moment, most of the respondents answered to be living with their spouse (or other family members) and children (31,7%, 144), followed by those who live with their parents or with their parents and their children (29,5%, 134) and those who live only with their spouses (27,5%, 125), as the following graph shows.

<sup>11</sup>IOM (2006)

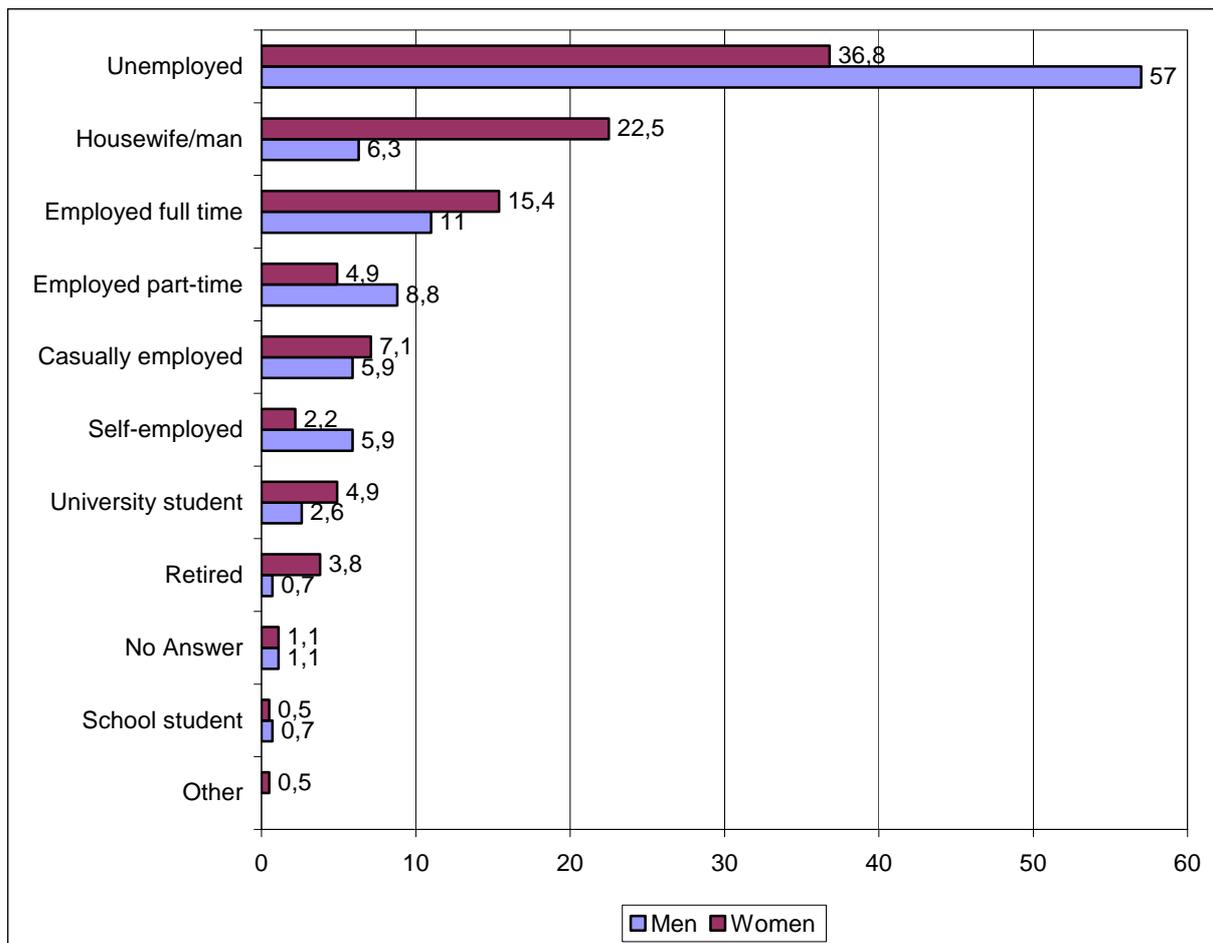
**Graph 4: Living situation (%), n=454**



The majority of the respondents have children (71,1%, 323), and 80,5% of the persons who have children have 1 to 2 children. The age range of these children reaches from new-born to 39 years old.

Concerning the work situation, almost half of the respondents are unemployed (48,9%, 222), which can be seen as a strong “push” factor for the decision to work abroad. 12,8% (58) of the interviewees are full-time employed. The same number of persons are housewives or housemen. In the following graph the different employment situations according to the sex of the respondents can be seen.

**Graph 5: Employment situation (%), male n=272, female n=182**



As it can be seen, almost 60% of both sexes are in Moldova without a paid job outside the family or household, if we count the categories “unemployment” and “housewife/man”, but more women than men are full time employed.

Taking into account the education level of the respondents, there is, despite the high unemployment rate among all education levels, a significant correlation between employment situation and education level ( $p=.004$ ). The percentages of unemployment decreases the higher the education level is. The age group most affected by unemployment are the respondents under 30 years old.

Asked about the field of work activity in Moldova, the most given answer was housekeeping (24,4%, 53), followed by those who work as constructors (20,7%, 45) and those who work in education (9,2%, 20). Discerning between men and women, the three most given answers by the men (132) are constructor (29,5%, 39), housekeeping (21,2%, 28) and driver (10,6%,

14). The most given answers by the women (85) are housekeeping (29,4%, 25), sales and education, with 15,3% (13) each.

### 3.1.5 Mobility

All the respondents fulfilled the selection criteria, thus they were at least one month long abroad in the last three years. A total of 27 countries were named as travel destinations, most of them being European countries.

The three most common destination countries are Russia, Italy and Ukraine, which means that CIS countries are the most preferred countries of destination for Moldavians. This fact can be easily explained through the possibility of a common language, the relatively short distance and the lack of travel restrictions, such as visa obligation. Apart from these destinations, other countries were mentioned more frequently, such as Romania (n=30), Turkey (n=21), Portugal (n=20), Spain (n=10) and Germany (n=9) were named.

The respondents were asked to name up to three countries in which they had been during the last three years. All the respondents were abroad in the last three years, 60 were in two countries and only 20 were in three countries. The following table shows the answers given by the respondents who were in one to two countries, concentrating on the most named countries. The answer “first country” refers to the answers of the first destination country, the “second country” refers to the cases in which the respondents were in more than one country, so to say the choice of a second country of destination.

**Table 1: Country of destination, n=454**

	<b>As a first country of choice</b>	<b>As a second country of choice<sup>12</sup></b>
Russia	53,3%, 242	5%, 3
Italy	14,8%, 67	16,7%, 10
Ukraine	6,2%, 28	16,7%, 10
Other countries	25,6%, 116	60%, 36
No answer	0,2%, 1	0,2%, 1
<b>Total</b>	<b>100%, n=454</b>	<b>100%, n=60</b>

Taking into account the first country that the respondents named, it is interesting to observe that there is an important difference in the travel destination according to the sex. Russia is

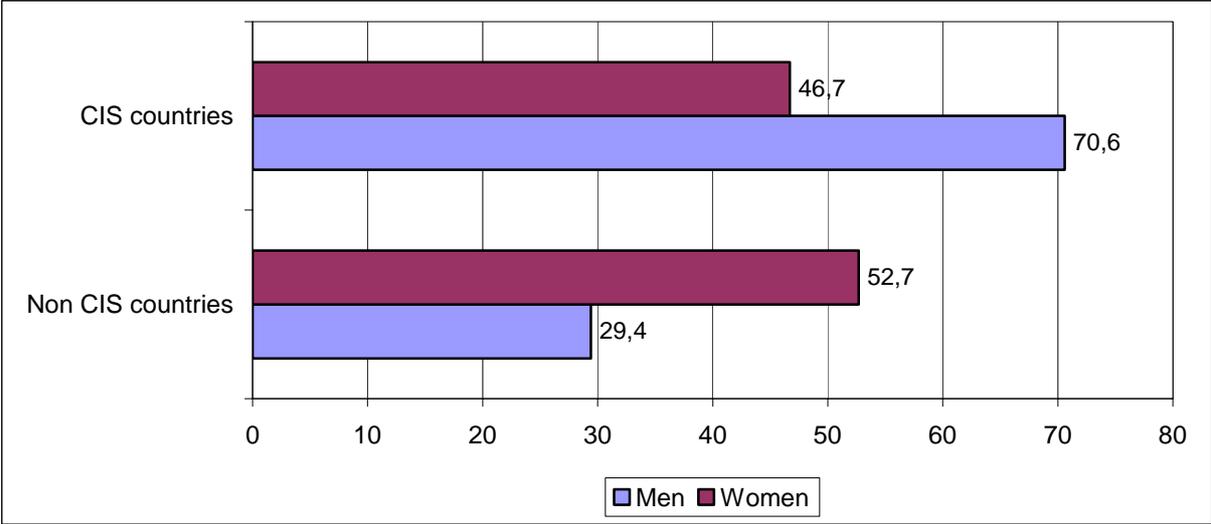
---

<sup>12</sup> As the answers for second and third countries were only few, most of the analysis base on “first country” answers

the choice for 62,5% (170) of the men, but only for 39,6% of the women (72). Italy, the second most named destination, is more a destination for female Moldavians - over a fourth of the women (25,8%, 47) named this country, whereas only 7,4% (20) of the men did. Regarding the respondents who travelled to the Ukraine, there is no significant difference between men and women (6,3% of the men and 6% of the women) and the same can be said concerning the travellers to other countries (23,9% of the men and 28% of the women).

The destination countries will be further divided in “CIS countries” and “Non CIS countries” to simplify the analysis of the data. According to this new classification, 277 respondents (61%) travelled to CIS countries and 176 (38,8%) to Non-CIS countries. One person (a woman) did not state the destination country. The next table shows the travel destination groups according to the sex of the interviewee.

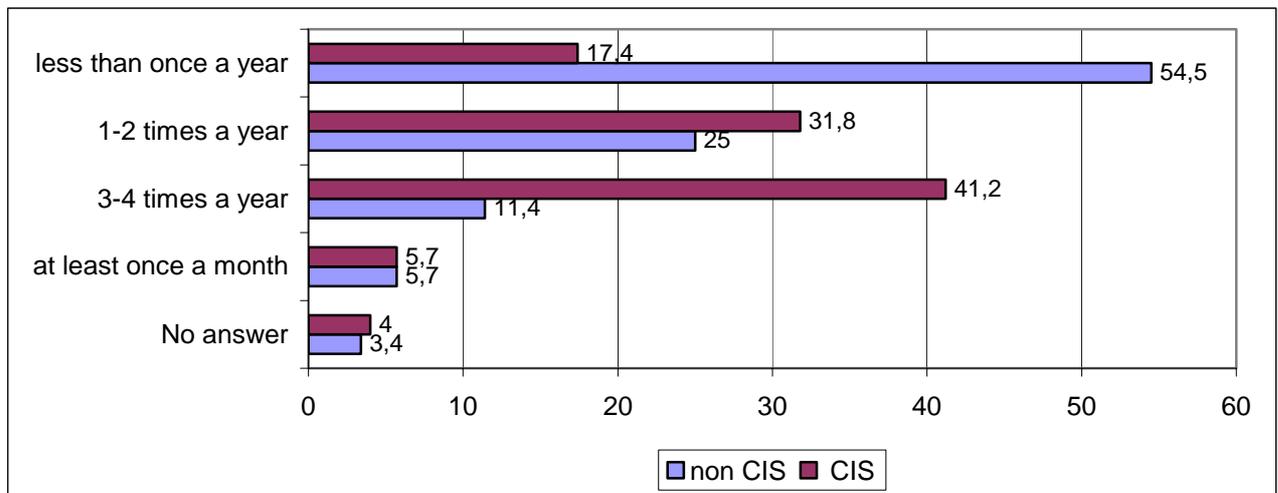
**Graph 6: Travel destination according to sex, % (n=454) male n=272, female n=182**



There is a significant relationship between the travel destination CIS/Non CIS and education ( $p=.000$ ). The higher qualified Moldavians travel to Non CIS countries, and this significant correlation is stable between both sexes.

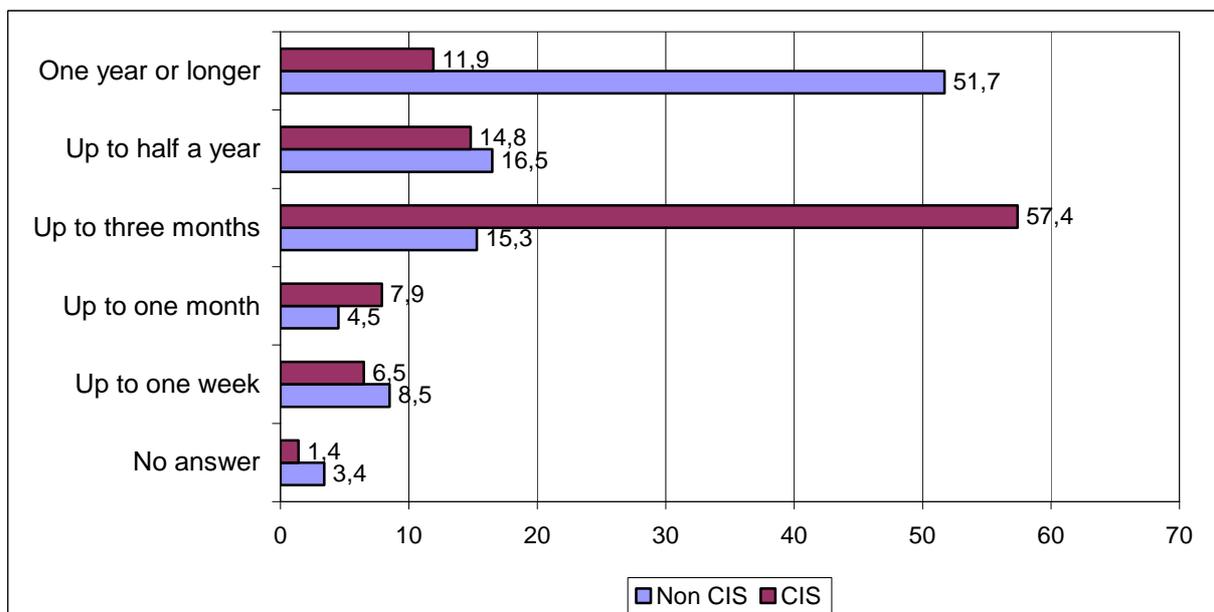
The respondents were asked about their travel frequency to the country they had named. Most of them (29,7, 135) travelled three to four times a year, followed by the ones that do this once to twice a year (29,1%, 132). 16,1% said to travel rarely (73) and 71 travelled once in two years (15,6%). As it was expected, there is an important difference in the frequency of travelling between CIS and Non CIS countries.

**Graph 7: Frequency of travels to CIS/Non CIS countries in the last three years, % (CIS n=277, Non CIS n=176)**



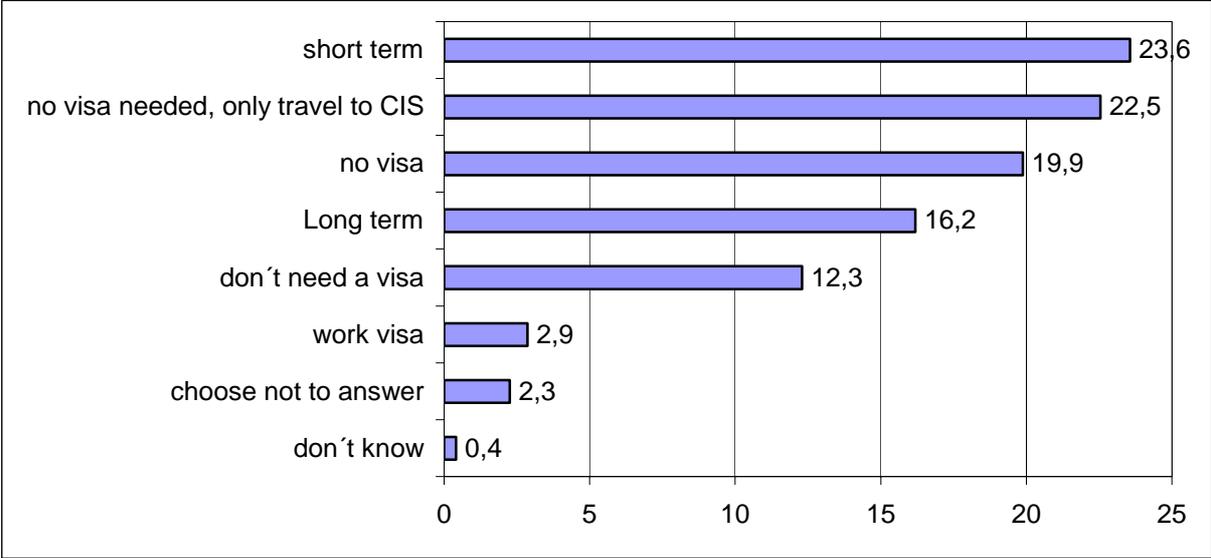
This difference between the frequencies of travel of these two groups repeats itself in the answers to the question about the length of the stay in the respective country. The stays in CIS countries are shorter than the stays in Non CIS countries. It means that the travels to CIS countries are shorter and more frequent and the travels to Non CIS countries are more seldom but much longer, as the following graph shows.

**Graph 8: Length of stay in CIS/Non CIS countries, % (CIS n=277, Non CIS n=176)**



The legal status in the country of destination is most important for the social situation and for the eventual needs and the access to the health care system of the respective country. Most of the respondents stated to have a short-term visa when they travel (23,6%, 115), followed by the ones who say not to need any visa because they only travel to CIS countries<sup>13</sup> (22,5%, 110). 16,2% (79) possesses long-term residence permits for the respective countries of destinations. 19,9% (97) say that they do not have any visa, meaning they are not working abroad legally. The next graph illustrates this question:

**Graph 9: Type of visa for travelling abroad, % (n=488), multiple answers<sup>14</sup>**



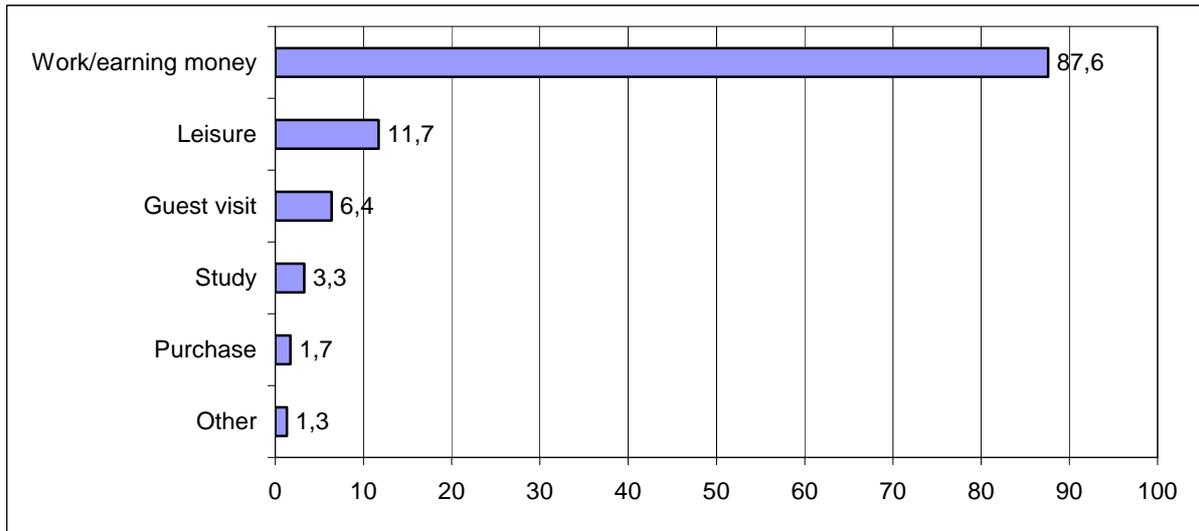
46 respondents (21 men and 25 women), 26,1% of the respondents who travel to Non CIS countries, stated to have travelled to a non CIS country with a short term visa, but stayed there more than three months. This means that they entered the Non CIS country with a valid short term visa and stayed in the country after the visa expired.

The vast majority of the respondents travels abroad with the purpose of working, earning money and/or doing business, followed by the ones that travel for leisure. This percentage seems to be very high and is not explainable through the qualitative data as the following graph shows:

<sup>13</sup> Moldovan citizens do not need a visa to travel to a CIS country

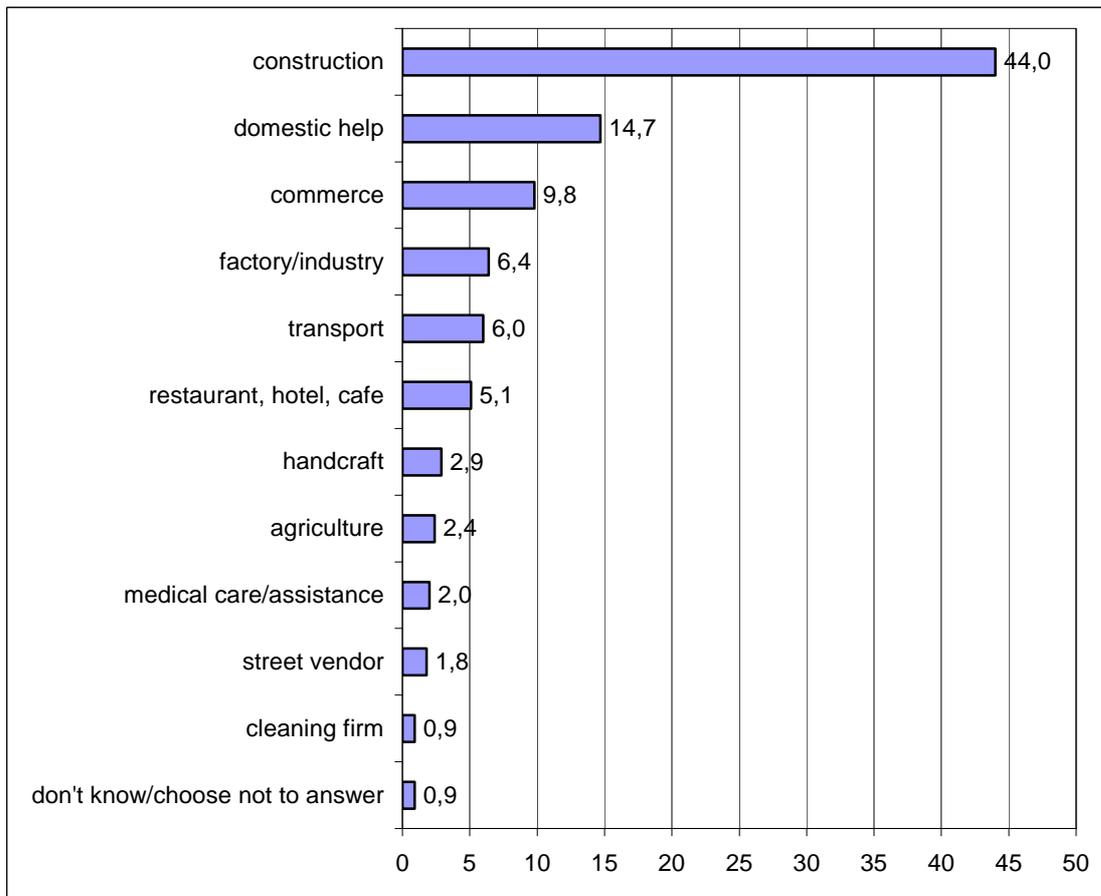
<sup>14</sup> In the case of multiple answers the denominator for the percentages has been the number of total answers given, otherwise some answers would have been chosen by more than 100% of the respondents

**Graph 10: Purpose of the travel, %, (n=454) multiple answers**



Asked about the sector of activity in which they work when they are not in Moldova, the most given answers were “construction”, domestic help and commerce.

**Graph 11: Sector of activity abroad, % (n=450), multiple answers**



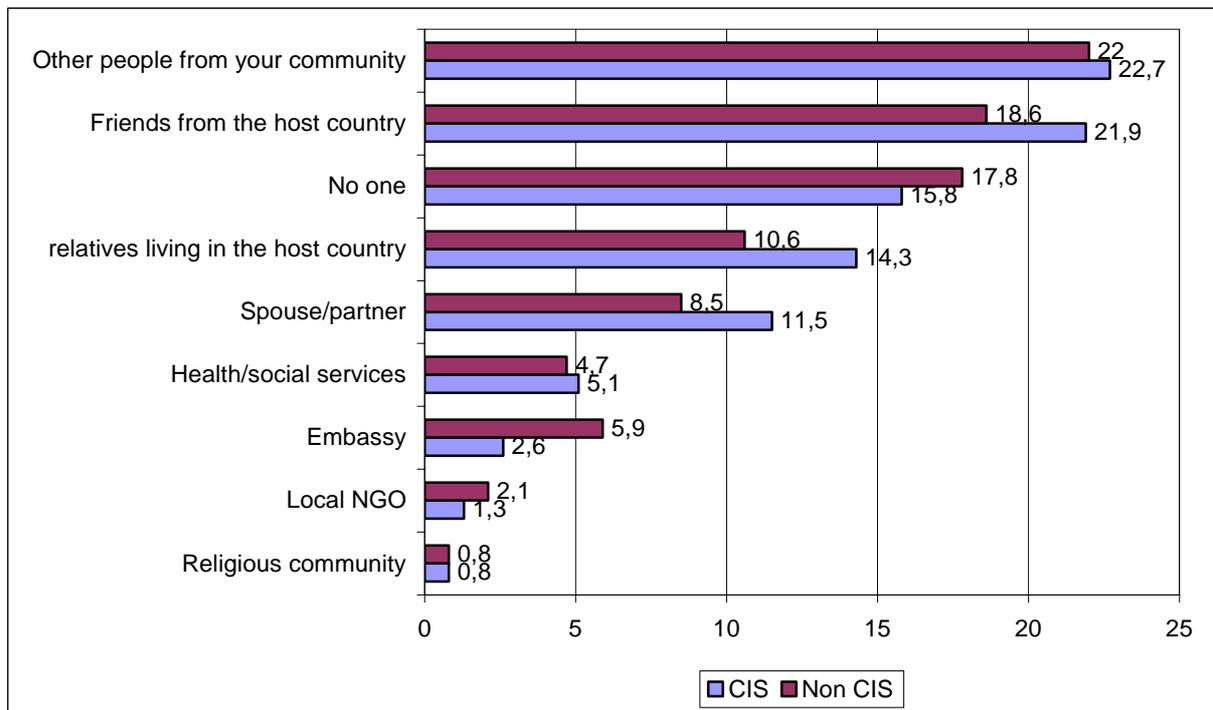
To assess the social network of the migrants in the country of destination, the respondents were asked with whom they spend spare time when they are abroad. Most of the respondents live in a Moldovan social network, even if they are abroad. Over half of the respondents (55,7%, 248) spend their spare time with other people from Moldova, followed by the group that state to spend their spare time with members of their family (26,3%, 117). This means that at least one fourth of the interviewees travels with a family member, or they have a family member living in the country of destination. Dividing the destination in CIS/Non CIS, 30% of the respondents spend their spare time with family if they are in a CIS country, but only 18% do so in a Non CIS country. Especially the shorter but more frequent travels to CIS countries were undertaken in groups of other Moldavian people or together with family members.

20,4% (91) of the respondents spends their leisure time with friends of the country of destination followed by 16,4% (73) who do this with other foreigners. 61 (13,7%) respondents spend their spare time alone.

If the respondents have a problem that they cannot solve themselves abroad, the first address to seek help in a CIS country is to ask help from other Moldovans living in the country, this is contradictory to the statements of the participants of the focus groups (FG report, p. 19). The other most answered options are to ask for help from friends from the country of destination. The next answers are for the option “no one” (see Graph 12).

If help is needed in a Non CIS country, fellow Moldovans is also the first address to ask for it, followed by friends from the host country. 17,8% of the answers go to the option “no one”. In the case of Non CIS countries, only 10,6% of the answers correspond to asking for help of family members, which could be a further fact that shows more respondents have family in CIS countries. In the following graph the difference in the help seeking behaviour can be observed:

**Graph 12: If you have a problem abroad, to whom do you turn for help? %, (CIS n=392, Non CIS=236), multiple answers**



Asked about the plans for the future, over the half of the respondents wishes to keep traveling abroad and coming back to Moldova (54,2%, 246). 23,1% (105) wish to stay in Moldova and not travel anymore. 12,1% (55) wish to emigrate, and here the difference between the sexes is visible: this answer is given by 16,5% of the women and 9,2% of the men. As a country of choice, Russia is in the first place for both sexes, followed by Italy in the case of the women and Portugal in the case of the men.

### 3.1.6 Summary of demographic results and mobility

There are more men than women in the sample and in average the men are younger than the women. Over the half of the respondents (55,3%) is between 30 and 50 years old. The interviewed Moldovans are well educated, and it can be said that women are better educated than men. Most of the respondents live with their partner and families. Over 70% of the sample has children.

Almost half of the sample are unemployed in Moldova, which represents a strong push factor for the decision to migrate, a thesis that is corroborated by the fact that the most given answer to the question of the reason of migration is “work/earning money”.

Overall 27 different countries of mainly European destinations were mentioned, the three most common destinations are Russia, Italy and the Ukraine. Men tend to migrate more to CIS countries, whereas women tend to travel to Non CIS countries. The travels to CIS countries take place more often and are relatively short and the travels to Non CIS countries, which are further away, are less often but the length of the stay is longer.

Concerning social networks abroad, the Moldovans that travel to CIS countries have often family in those countries or travel with family members and thus spend their spare time abroad with their family. Fellow Moldovans are the ones that would be asked first for help whether in CIS or a Non CIS country.

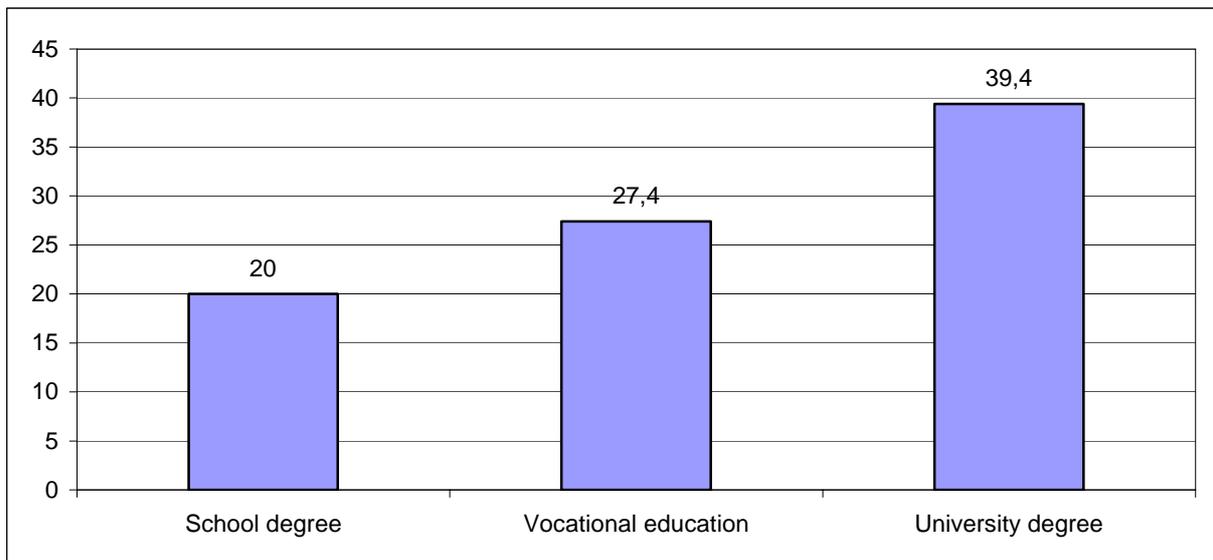
Over the half of the sample stated to have the wish to keep travelling back and forth between the destination countries abroad and Moldova.

#### **4 Health status and behaviour and experiences with the health services**

Health insurance coverage is a further field in which the social situation of the respondents is desolate as well. Only 27,3% of the respondents stated to have a health insurance in Moldova, even though in the Republic of Moldova there is a mandatory Health Insurance since December 2003. As a rule, in Moldova all the persons that are regularly employed are health insured. However, in our sample only 56,8% (63%) of the employed persons are health insured, which could be a sign that a high percentage of the respondents that stated to be employed are not regularly employed.

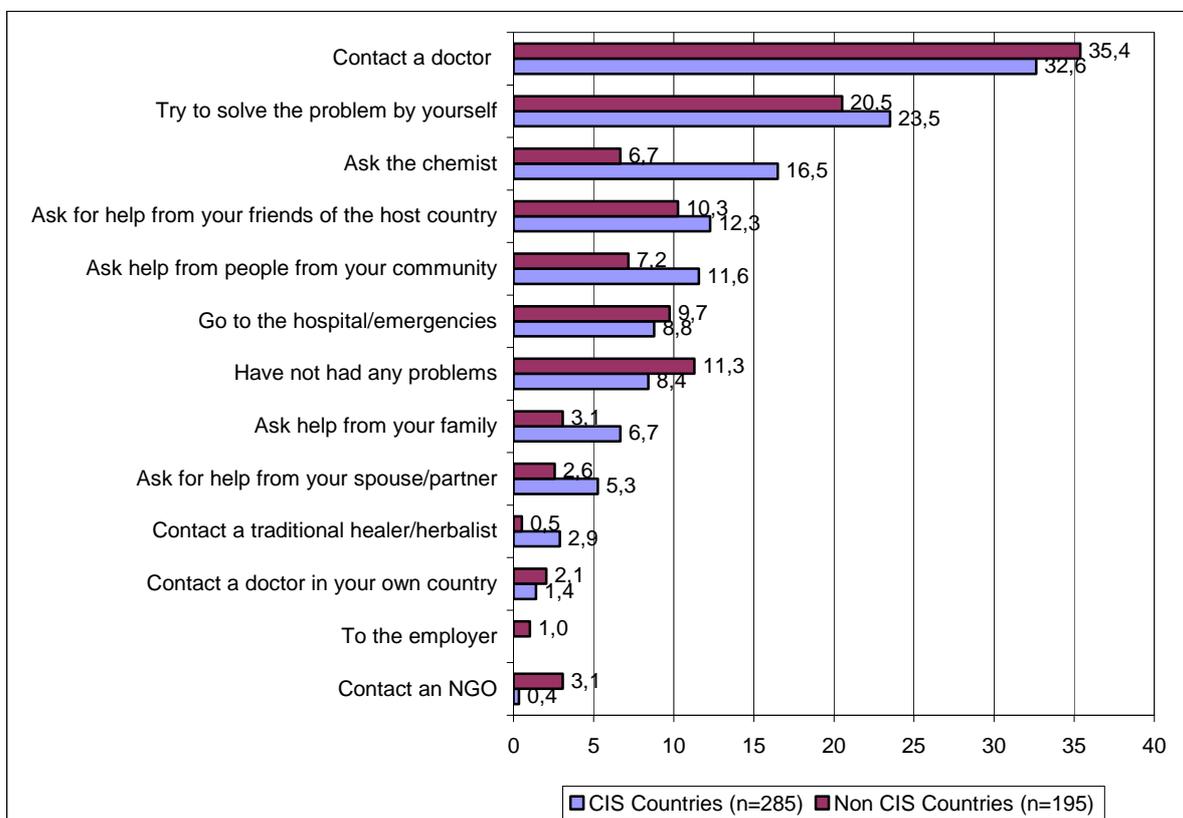
In the destination countries as well, the health coverage in an eventual case of illness is not secured for the majority of the respondents. However, there are some differences between CIS and Non CIS countries. In a CIS country, only 25,6% of the respondents have a health insurance, but if they travel to a Non CIS country, 30,1% have a health insurance. This difference is not statistically significant; it is a tendency that can be explained through the sample size of the groups. The sex of the respondent has a significant influence ( $p=.005$ ) on the fact whether the respondent is health insured, being the women the ones who are more often health insured than the men (35,4%, 62, of the women against 23,2%, 62, of the men). The education has an influence on the possession of a health insurance ( $p=.004$ ). In the graph it can be observed that the higher educated respondents have more often a health insurance than the ones that are lower educated.

**Graph 13: Health insurance according to education degree, %, (school deg. n=145, voc. ed. n= 190, univ. deg. N= 99)**



Despite the lack of a health insurance, most of the respondents in the case of an illness use the medical service in the destination country. The graph shows as well the answers divided into CIS and Non CIS countries.

**Graph 14: What do you do in the case of a health problem abroad? (% , multiple answers)**

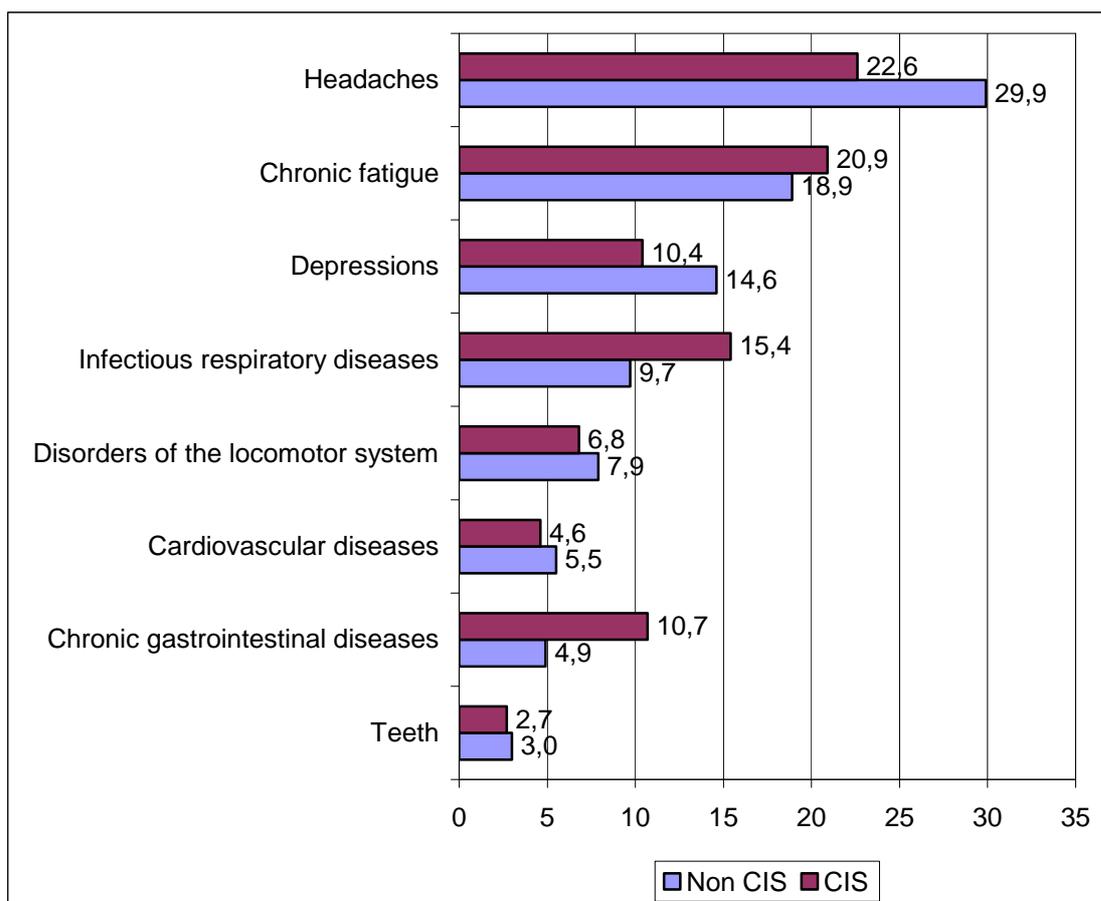


As it can be observed in the graph after visiting a doctor, the chemist, friends from the host country and persons from Moldova are more of an option in the CIS countries, and the same is the case with family members and spouses.

Over three hundred of the respondents (317, 73,9%<sup>15</sup>) have already used the health system abroad. The majority of these interviewees stated not to have had any difficulties within the health system (57,4%, 260). The answers in this respect do not differ whether it is a CIS country or not.

The most frequent health problem that the respondents have had during their stays in Non CIS and CIS countries are headaches, chronic fatigue and depressions, as shown in the following graph:

**Graph 15: Most frequent health problems abroad (Answers Non CIS n=164, Answers CIS n=279), multiple answer**



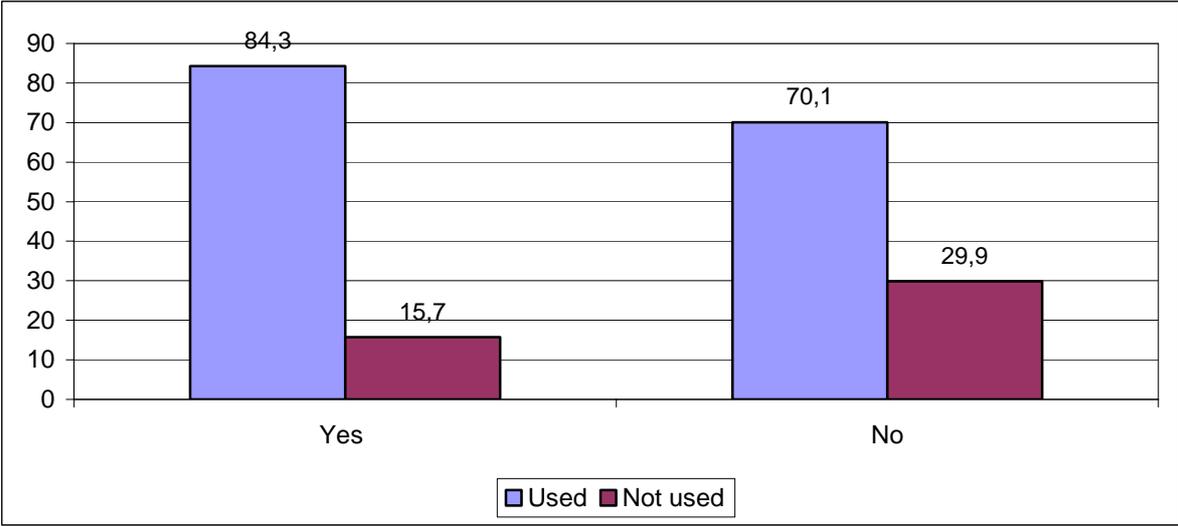
<sup>15</sup> Excluding 29 respondents that chose not to answer

A total of 231 respondents stated to have had an illness during his or her stay abroad. From these respondents, 78% (180) have used the health system abroad, even though the majority of them did not have a health insurance (68,9%, 124). This pinpoints to a precarious situation concerning the health situation of the migrants. In the case of a serious illness the migrant would be in a very difficult situation. One fourth of the respondents who have a health problem and do not possess a health insurance have never used the health system abroad.

As it can be seen in the graph, there are some differences between the mentioned illnesses in CIS and NON CIS countries. A comparison is not possible without taking into account additional indicators such as sex, age, work place and length of stay abroad. In general the differences between the problems that the respondents have suffered abroad in CIS or Non CIS countries.

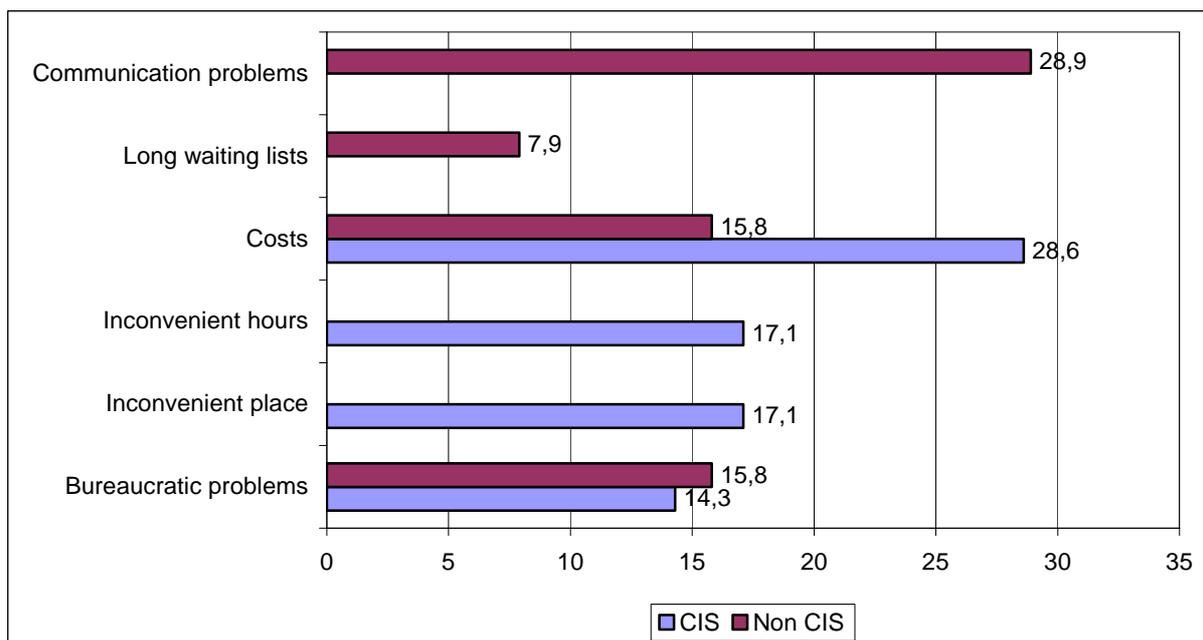
From the respondents with health insurance abroad (124), 20,3% stated to have had problems in CIS countries, and 13,3% had problems with the health system in a Non CIS country. The next graph shows the use of the health system whether the respondent has a health coverage or not. In it, it can be seen that the respondents that have a health insurance use the health system more often.

**Graph 16: Use of the health system according to the possession of a health insurance, %, health insurance possession n=115, without health insurance n=291)**



The most frequent difficulties with the health system in a CIS country were the costs, inconvenient place and inconvenient opening hours. In the Non CIS countries, the most frequently named difficulties were communication problems, bureaucratic problems (including lack of health insurance) and costs, as it can be seen in the following graph:

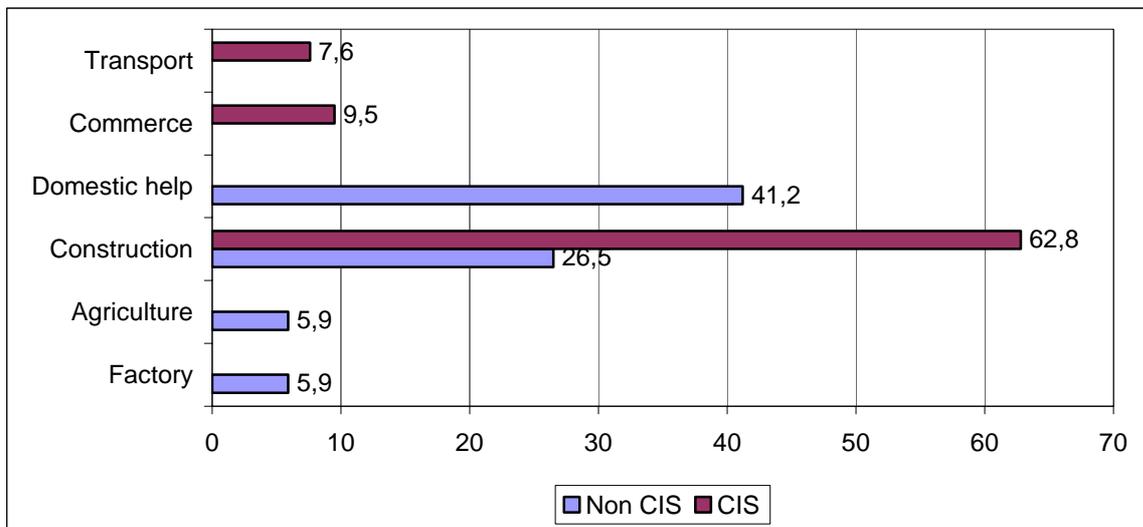
**Graph 17: Difficulties with the health system in CIS (n=70) and Non CIS countries (n=38)**



In the focus groups the issue of the costs of the health system abroad was brought up as well. Here, the statements of the participants reflect the variety of the answers given by the respondents of the survey. They stated that they would consult a doctor only in an extreme case, otherwise they would try to solve the problem themselves. Examples were presented, in which the respondents came back to Moldova to treat their teeth or for surgical operations. On the other hand, the medical services abroad are perceived as being more qualitative as in Moldova, especially referring to Non CIS countries. The majority of women that worked in Italy were very satisfied with the medical services of that country and the opportunities they were offered, independent from their legal status. The health services in Russia are not trusted (FG report, p.16ff).

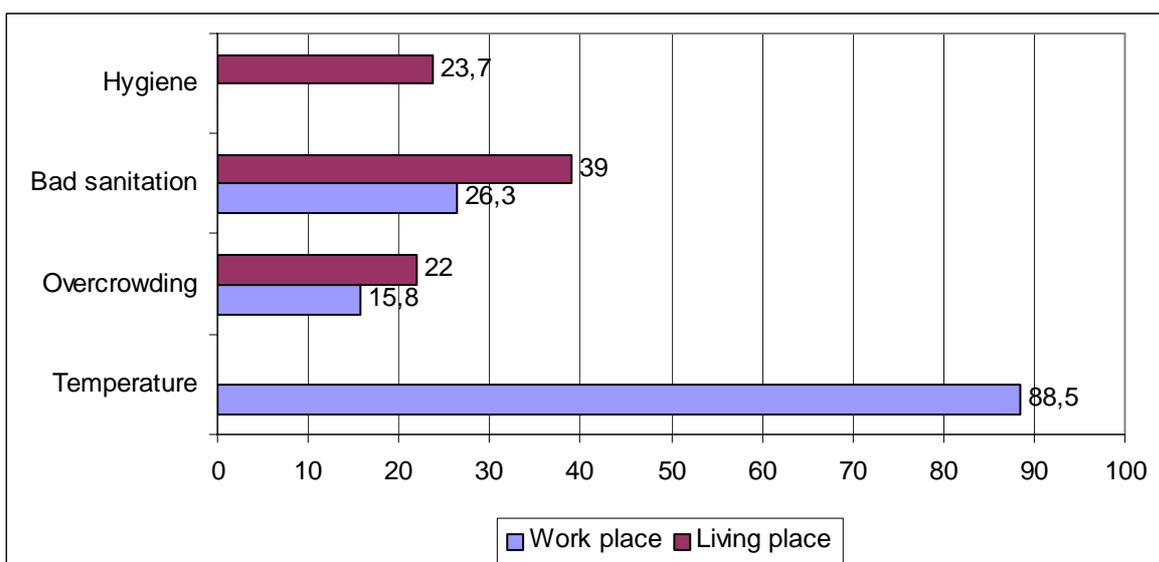
Almost one third of the respondents (28,7%, 130) think that the work/ living conditions abroad take place under bad health conditions. From these interviewees, 71,5% (93) refer to CIS countries and only 28,5% (37) to Non CIS countries. Particularly the construction and the domestic help (23,5%) sectors were mentioned in connection with bad health conditions.

**Graph 18: Sector of activity of the respondents that work/live under bad health conditions, %, (Non CIS n=34, CIS n=105), multiple answers**



The most frequent named problems in CIS countries at the work place (76, multiple answers) are exposure to high or low temperatures (38,5% of the answers), no/bad sanitation (26,3%) and overcrowding (15,8%). Concerning the living place, the most given answers (59) were no/bad sanitation (39%), no/bad hygienic conditions (23,7%) and overcrowding (22%).

**Graph 19: Complaints about work place/living conditions in CIS countries, % (work place n=76, living place n=59), multiple answers**



Only 37 respondents of Non CIS countries stated that their work- and living conditions abroad take place under bad health conditions and only 17 (multiple answers) respondents

answered in detail. Most mentioned were: high/low temperatures (9), followed by the exposure to height (5) and no/bad sanitation (4). Concerning the living spaces, the most common problems are exposure to high/low temperatures (5), no/bad sanitation (4), and no/bad hygienic conditions(3) <sup>16</sup>.

Problems with work or living conditions abroad were also a topic in the focus group discussions. The participants named problems such as exploitation of work force in terms of having to work more than it was stipulated for less money, or not getting paid at all. According to the focus groups, women are more at risk concerning sexual abuses and men are more at risk to be physically aggressed or not to be remunerated for the performed work (FG report, p.18).

### **Summary of health status and behaviour**

Most of the respondents have no health insurance, neither in Moldova nor when being abroad. Less than a third of the respondents have a health insurance in Moldova. If the respondents travels to a CIS country, only 20,7% have a health insurance, but the travellers to Non CIS countries are insured in 41,1% of the cases. Even though at the presence of a health problem the first one to contact would be a doctor, the second option would be to try to solve the problem him or herself.

If the health system abroad had to be used and problems arose, the most common problem in a CIS country were the costs and in a Non CIS country were communication problems. Almost one third of the respondents consider that working abroad does not take place under healthy conditions. The most common complaints are exposure to high or low temperatures and bad or no sanitation. Over half of the respondents stated to have had health problems while being abroad. The most named problems are headaches, chronic fatigue, infectious respiratory diseases and depressions.

---

<sup>16</sup> Because of the very low number of respondents, these statements should only valued as individual statements

## 5 HIV/AIDS and Sexual Practices

The questions battery in this part of the survey follows the international standards for KAB surveys, which means that knowledge on HIV/AIDS and STIs, attitudes and sexual behaviour were the subjects of the questions.

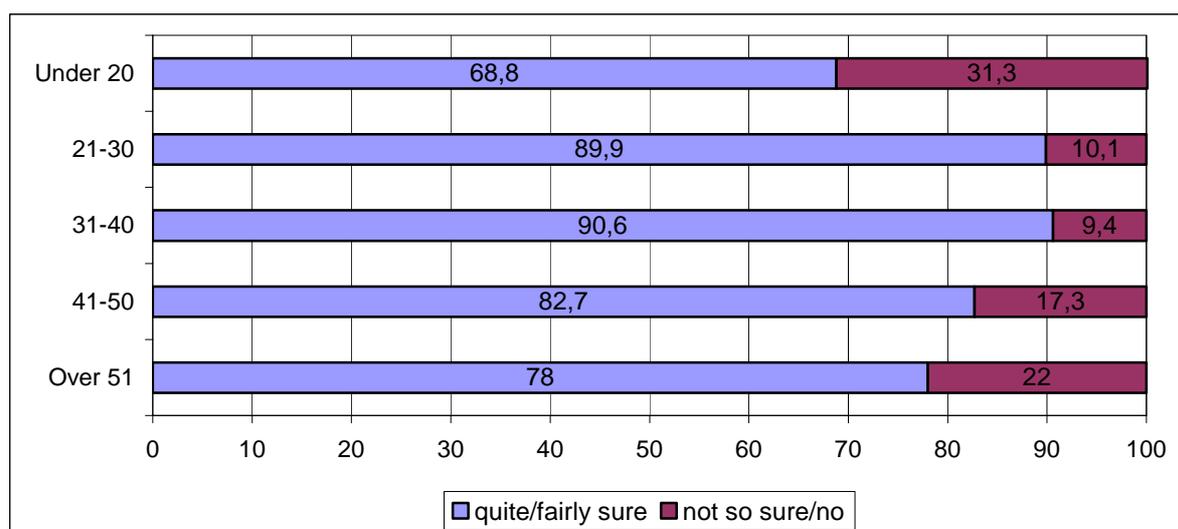
### 5.1 Basic knowledge of HIV transmission ways

At first, the respondents were asked to evaluate their own knowledge on HIV/AIDS. The own belief of the knowledge level is a basic precondition for both the wish to seek further information and for the sexual behaviour itself.

Over the half of the interviewees (54,8%, 249) is quite sure to know, 28,9% (131) are fairly sure. 13,2% (60) are not so sure or do not know. 14 respondents (3,1%) chose not to answer. There are no differences between the sexes concerning the answers to these questions. The education of the interviewees does not influence the answer to this question either, nor does the fact whether they live in a rural or an urban setting.

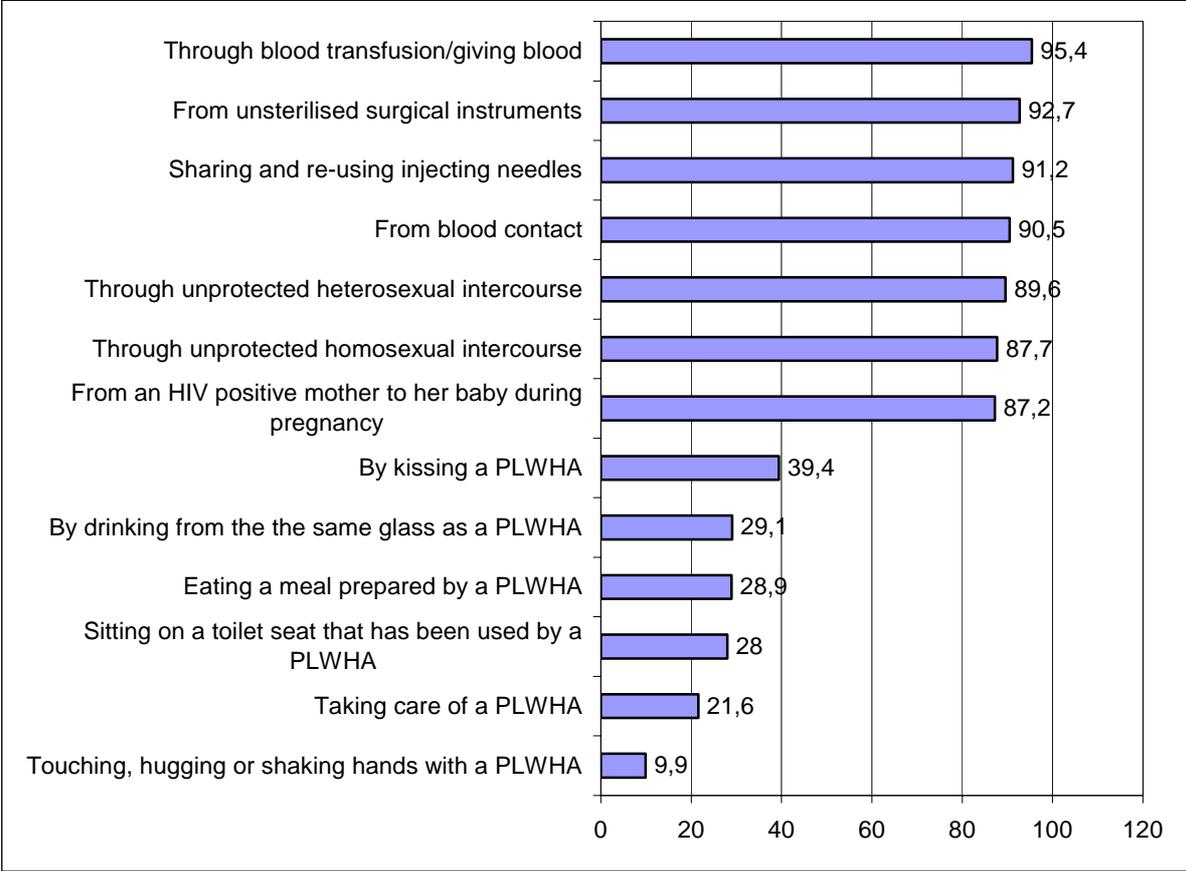
A variable that does have a significant influence ( $p=.019$ ) in this question is age. As it can be seen in the following graph, the age groups 21-30 and the 31-40 year olds are the groups most sure to know, what HIV/AIDS is.

**Graph 20: "I am quite/fairly sure to know what HIV/AIDS is" according to age, % (n=440)**



The concrete basic knowledge about HIV was measured through a thirteen statement long basic HIV knowledge battery (“How can HIV/AIDS be transmitted in your opinion?”). The general answers are shown in the following graph:

**Graph 21: “How can HIV/AIDS be transmitted?”, %, (n=454)<sup>17</sup>**

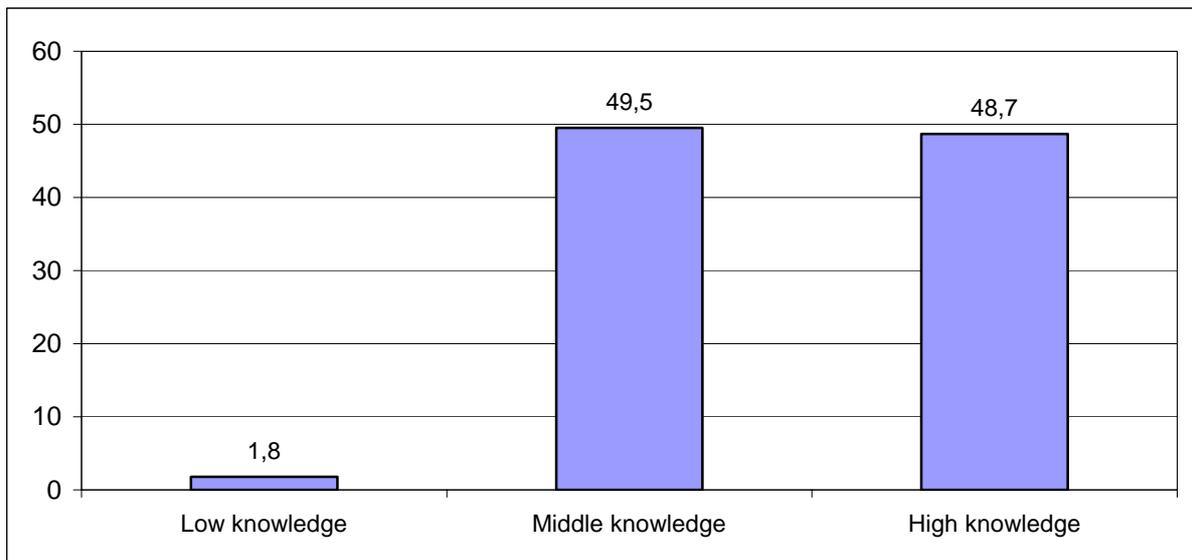


For in-depth and comparative analyses the statements were recoded in three categories: high knowledge (11 to 13 correct answers), middle (6 to 10) and low knowledge (0 to 5). Almost 44% of the respondents (43,9%, 193) showed a high level of knowledge, but the largest group is formed by the respondents that have a middle knowledge about the transmission ways of HIV/AIDS (50,9%, 224). Over 5% (5,2%, 23) of the respondents have a low knowledge on the subject.

Coming back to the question whether the respondents knew what HIV/AIDS is, from those who stated to be fairly/quite sure to know, 48,7% showed a high knowledge of the transmission routes of HIV/AIDS, 49,5% a middle knowledge and 1,8% a low one.

<sup>17</sup> PLWHA: Person living with HIV/AIDS

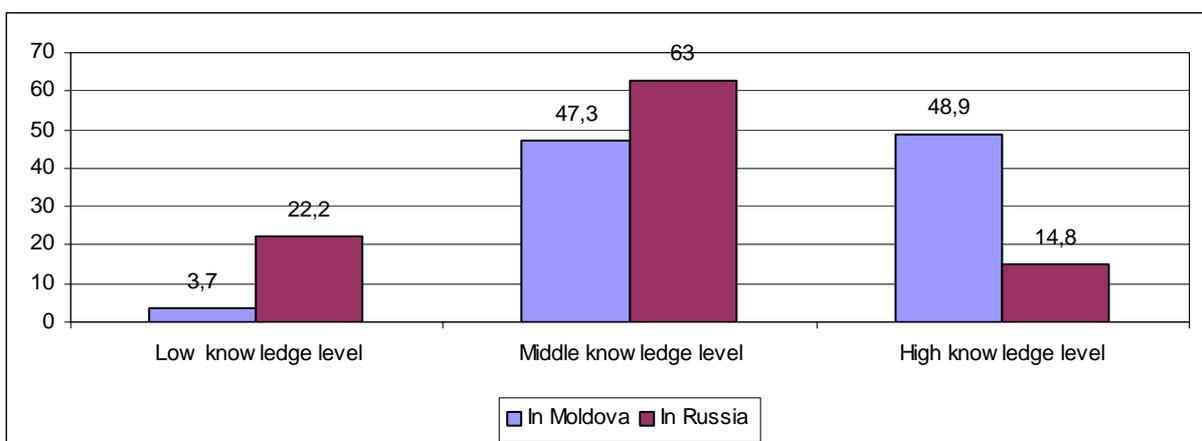
**Graph 22: Knowledge of HIV/AIDS among the respondents who stated to fairly/quite sure to know what HIV/AIDS is (n=380)**



The level of knowledge about the transmission routes has neither relation to the sex of the respondent nor with their education. It is very interesting that in the case of actual knowledge, age does not have any influence either. This does not correspond with other international literature and survey studies on the topic<sup>18</sup>.

The only found correlation ( $p=.006$ ) is to the fact whether the interviewees were questioned in Moldova or in Russia. The ones questioned in Russia show a lower knowledge, as it can be observed in the next graph.

**Graph 23: Knowledge level of HIV/AIDS transmission ways and myths of respondents in Moldova (n=427) and respondents in Russia (n=27)**



<sup>18</sup> See Rispel et al, 2006; SPI Research, 2005

Most of the respondents are aware that a healthy looking person can be HIV infected. This is something that 66,3% (301) answered, being sex a variable that does not affect this answer, and the country where the respondents were questioned neither.

## 5.2 Wrong believes about HIV transmission routes (myths)

Even respondents that can confidently name the main transmission ways of HIV/AIDS show greater uncertainties regarding some of the widespread beliefs about the risks of HIV transmission. The statements with the lowest rates of correct answers are those referring to the myths of HIV transmission, in other words – the ways in which it cannot be transmitted. These uncertainties do not lead actually to transmission risks, but they are important indicators of the emotional attitude towards HIV/AIDS in general, especially towards infected persons. Irrational fears of possible infection through social contact can lead to strong exclusion and discrimination of affected individuals and foment the fear of an own infection. Thus these irrational fears influence negatively the own help seeking behaviour.

The discrimination of PLWHAs was an issue among the participants of the focus groups, in which it was stated that *“HIV infected persons are condemned to isolation”* (FG report, p.3) and further *“(with an) HIV positive diagnosis [...] everything is lost, this means you have no family, no life, nothing”* (FG Report, p.3). All participants agreed upon the fact that a PLWHA will be rejected from the community to which he or she belongs. As mentioned before, the help seeking behaviour is negatively influenced by this, forcing the HIV infected person to hide his or her status, for as a respondent put it *“if you live on the 9<sup>th</sup> floor, then even the first will know”*.

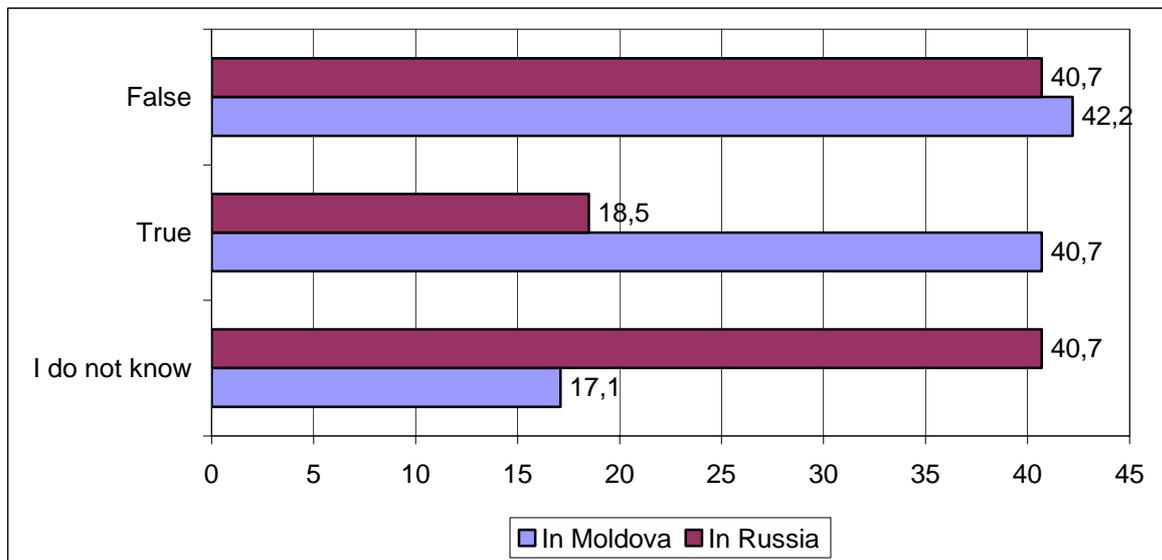
Less than half of the respondents (42,1%, 191) answered correctly that there is no HIV infection risk by *kissing* or coming into contact with *saliva*. The fear of getting infected with HIV/AIDS through kissing was also a topic in the focus groups. As a participant put it: *“even, the same kiss, may be you did not have sexual contacts, you can get infected [...]”*(FG report, p. 9)

Concerning this myth, there is significant correlation between place of the interview and myth ( $p=.004$ , see graph) but none concerning the sex of the respondent<sup>19</sup>.

---

<sup>19</sup> As a matter of fact, none of the myths of HIV infection means correlates with sex

**Graph 24: You can get infected with HIV/AIDS by kissing/coming into contact with saliva according to the country in which the respondents were interviewed, % (In Moldova n=427, in Russia n=27)**



Even though comparing the percentage of right answers there is no difference between the respondents interviewed in Russia or in Moldova, there is a significant difference between these two groups concerning the answers “there is a risk” and “I don’t know”. 40,7% of the respondents in Moldova answered that this is in fact an infection route, but only 18,5% of the Moldovans in Russia. On the other hand, more respondents in Russia were uncertain (40,7%) than respondents in Moldova (17,1%). It is very interesting to note, that this is a pattern that repeats itself in all the other items concerning myths: The respondents questioned in Moldova are more resolute about their myths and give a false answer while the Moldovans questioned in Russia are more conscious about their possible lack of knowledge and prefer an irresolute answer thus choosing rather “*I do not know*”.

### **Every day activities**

Almost  $\frac{3}{4}$  (74,4%) of the interviewees in total answered right that there is no infection risk *through touching, hugging or shaking hands* with someone who has HIV/AIDS. Here again there is a very significant relationship ( $p=.000$ ) between the country where the interview took place and the statement, as the next table shows:

**Table 2: Can one get infected by touching, hugging or shaking hands with someone who has HIV/AIDS?(n=454, from which in Moldova n=427 and in Russia n=27)**

	Respondents in Moldova	Respondents in Russia	Total
There is no infection risk	75,9%	51,9%	74,4%
One can get infected	10,3%	3,7%	9,9%
I do not know	13,8%	44,4%	15,6%

Taking care of a PLWHA raises similar fears. Here, only 61,5% of the respondents are sure that it is not a risk of infection as it can be seen in the following table:

**Table 3: Can HIV be transmitted through social contacts? (n=454, from which in Moldova n=427 and in Russia n=27)**

		Respondents in Moldova	Respondents in Russia	Total
Taking care of a PLWHA	There is no infection risk	63,2%	33,3%	<b>61,5%</b>
	One can get infected	22,0%	14,8%	21,6%
	I do not know	14,8%	51,9%	17,0%
Sitting on a toilet seat used by a PLWHA	There is no infection risk	51,3%	18,5%	<b>49,3%</b>
	One can get infected	28,1%	25,9%	28,0%
	I do not know	20,6%	55,6%	22,7%
Drinking from the same cup as a PLWHA	There is no infection risk	52,0%	29,6%	<b>50,7%</b>
	One can get infected	30,0%	14,8%	29,1%
	I do not know	18,0%	55,6%	20,3%
Eating a meal prepared by a PLWHA	There is no infection risk	48,5%	14,8%	<b>46,5%</b>
	One can get infected	30,2%	7,4%	28,9%
	I do not know	21,3%	77,8%	24,7%

The highest fears are raised by normal every day activities such as eating a meal that has been prepared by someone who has HIV/AIDS and sitting on a toilet seat that has been previously used by a PLWHA.

These fears were corroborated in the focus groups. A further fear that was very present in the focus groups was the fear of getting infected through medical procedures, including going to the dentist: “[...] if you go to a polyclinic you are not sure that you won’t get infected there” (FG Report, p.3). Some participants are sure that this fear has reasons: “I am afraid to go to a dentist because I got infected (there) with hepatitis [...] and I am afraid to go for the second time” (FG Report, p.3).

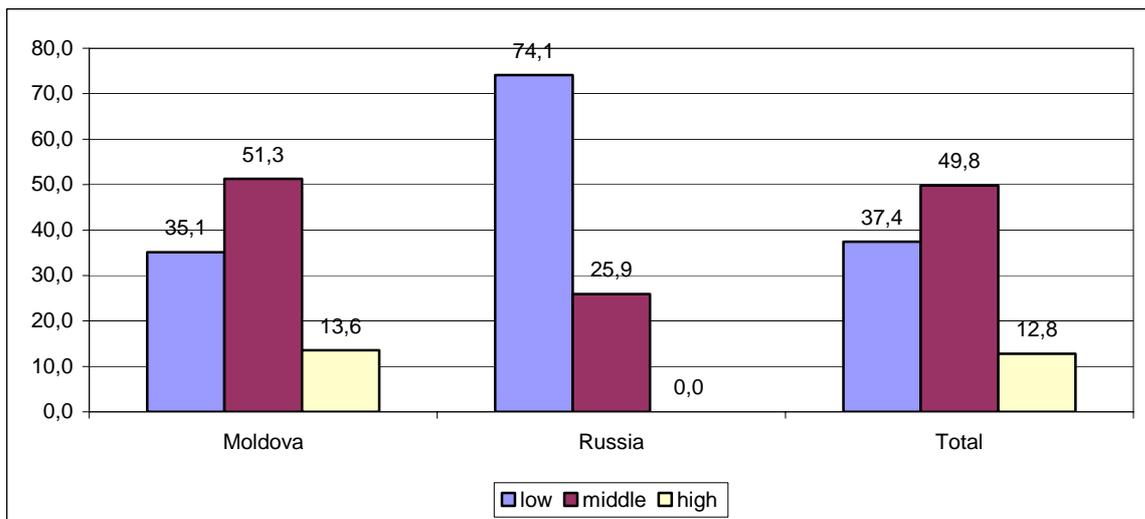
### 5.3 Knowledge of HIV protection

Next to knowledge about transmission routes of HIV is the knowledge of protection measures a basic condition for a health consciousness that reflects this topic. Health consciousness builds the ground for an appropriate preventive behaviour, which is nevertheless influenced by many other factors. However, without knowledge on transmission and protection ways self-conscious prevention behaviour is not possible.

Therefore, the question battery that follows focuses on the information of the respondents on protection means. The majority of the respondents (78,2%) answered that one can protect oneself by having sexual relations with only one stable partner, followed by 74,4% who stated that one can protect oneself by using condoms during intercourse. However, in the focus groups the participants stated that the “condom continues to be a “shame” (...) especially for the older person (30-45 years old)” (FG report, p.10). The purchase of a condom is also problematic: *“you know what I think when I buy condoms in the drug store? Was there someone that made a hole in it, moreover, when I see that they are sold in open air markets as well (...)”* (FG report, p.10)

To the item “Can one protect oneself by getting vaccinated against HIV/AIDS?”, only 46,3% of the respondents answered correctly with “no”. The correct answers to this question battery were recoded in a new variable, as it was the case with the possible transmission ways of HIV/AIDS, to be able to create a more in-depth data analysis. The respondents were divided into three categories: high knowledge of protection ways (5 to 6 correct answers), middle knowledge (3 to 4 correct answers) and low knowledge (0 to 2 correct answers). The following graph shows the respondents divided into this new category and considering whether they were interviewed in Russia or in Moldova. This relationship is highly significant ( $p=.000$ ):

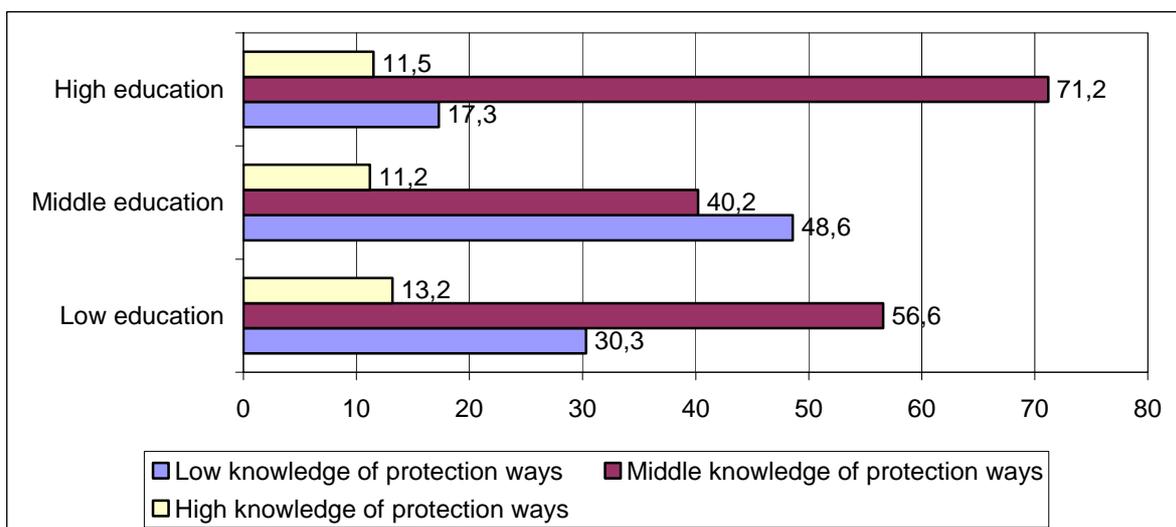
**Graph 25: Level of knowledge of protection ways, % (n=454)**



As it can be seen in the graph, almost the half of the respondents in total have a middle knowledge of protection ways from HIV/AIDS, but also here there is a highly significant difference in the knowledge level between the respondents interviewed in Russia or in Moldova ( $p=000$ ).

The knowledge of protection ways does not differ between the sexes, but is significantly influenced by the education of the respondents ( $p=.002$ ). Higher educated respondents possess a better knowledge of protection ways than low educated ones. A low knowledge was shown by 30,3% of the respondents with a low education, by 48,6% with a middle qualification and by 17,3% of the ones with a high education, as it can be seen in the following graph.

**Graph 26: Knowledge on protection ways according to education (n=235)**



Other indicators do not have any influence on the knowledge of protection ways. This means that the country in which the interview took place, in contrast to the very close topic of knowledge on transmission ways, has no influence in this case.

#### **5.4 Received information about HIV/AIDS**

We have treated in the two last chapters the information level of the respondents of the transmission of and protection ways against HIV/AIDS. Under the point of view of prevention it is very interesting to learn through which channels the respondents got their information from.

Most of the interviewees (71,4%, 324) have already received information about HIV/AIDS. This statement can be somewhat high, for the respondents that were interviewed in Russia were reached through an NGO that works in the field of HIV/AIDS thus all these respondents stated to have received information on the subject. For all the other analysed indicators (sex, rural/urban, CIS/Non CIS) no influence on the answer to this question could be found, except for one: The higher the education level, the more information was received. The correlation of having received information and education is significant ( $p=.045$ ).

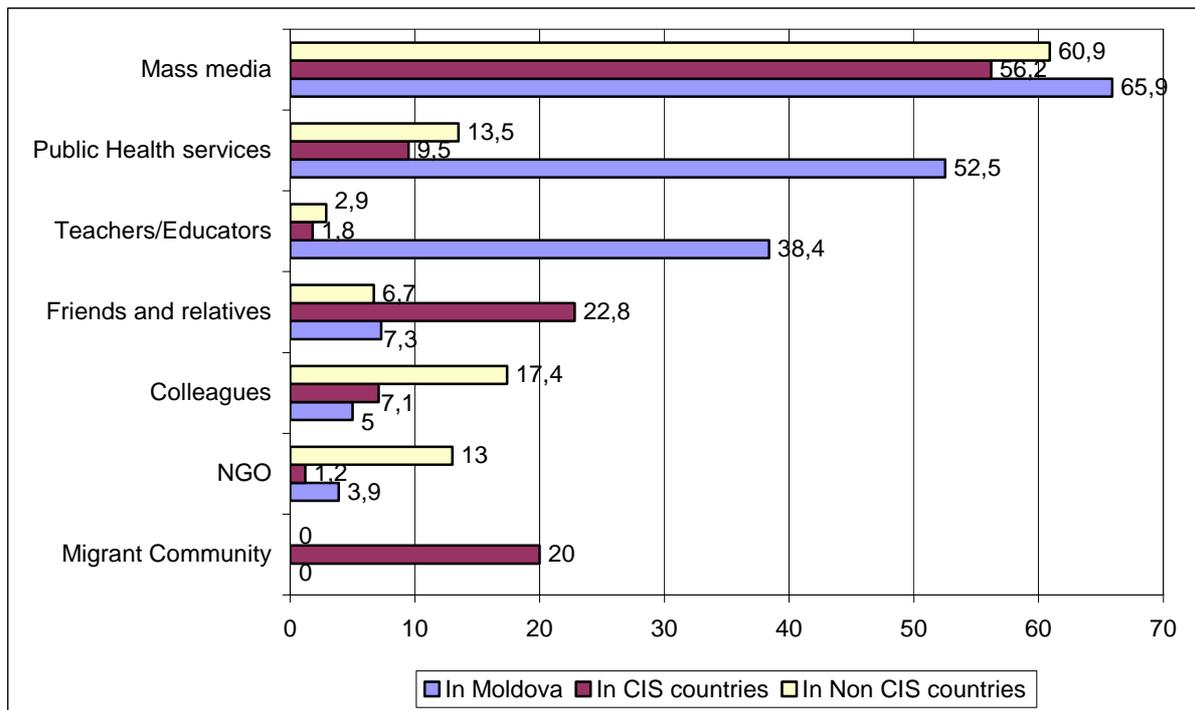
To be able to assess the access of the respondents to this topic better, we also asked in which country did they receive the information and from whom. Those (641 - multiple answers) who got information about HIV/AIDS in Moldova, the most named source of information is the mass media (65,9% of the answers), followed by public health services (52,5%) and teachers or educators (38,4%). Friends and relatives come in fourth place with only 14,7% of the answers. Obviously, HIV/AIDS is not a big topic within peer groups in Moldova.

Of the respondents who got information in CIS countries (169) the most named sources of information were the mass media (56,2%) again, followed by friends and relatives (22,8%). The migrant community is in the third place with 20% of the answers. In CIS countries the face-to-face discussions on the topic played a relatively bigger role as in Moldova.

In a Non CIS country, from 104 of the answers of the respondents who got information there, the mass media takes the first place as well as a source of information with 60,9% of the answers, followed by colleagues and employers (17,4%) and NGO services with 13%.

In the following graph, the ways of obtaining information are illustrated, according to the countries.

**Graph 27: Ways of obtaining information on HIV/AIDS, % (Moldova n= 641, CIS country n= 169, Non CIS country n=104), multiple answers**

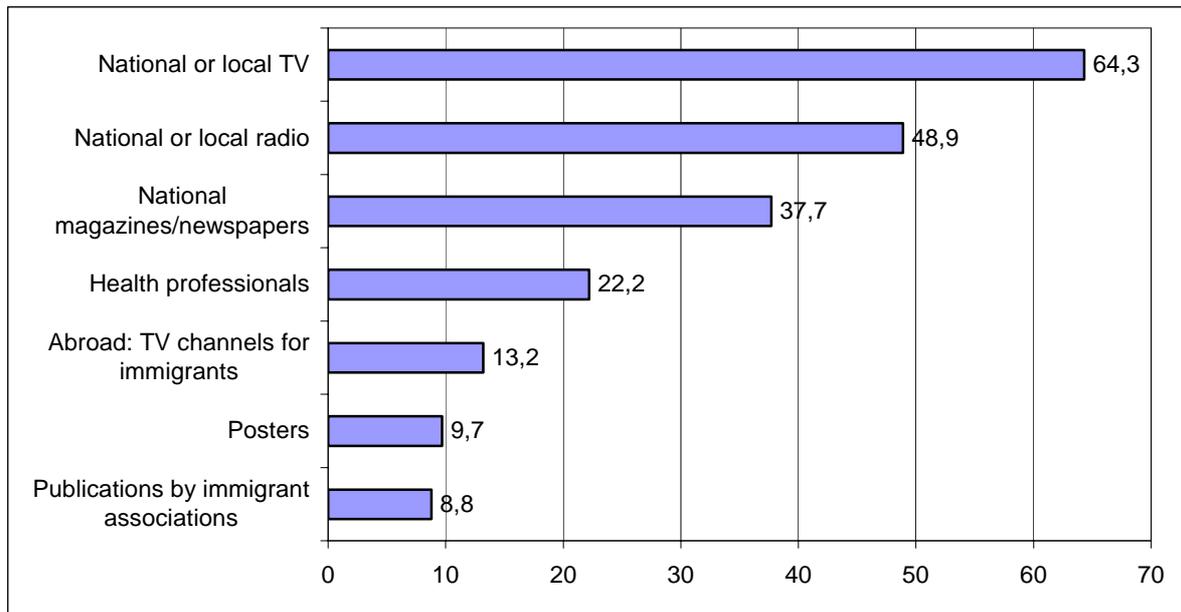


As it can be seen, mass media is the most important source of information at home and abroad.

Having got some information does not consequently mean to be or to feel well informed, as our results of knowledge of HIV Transmission routes and Protection methods clearly showed. Over the half of the respondents (57,3%) stated to need more information about HIV/AIDS in order to protect themselves effectively.

Asked about the way they would like to receive more information about HIV/AIDS, the national or local TV is by far the most named source of information, with 64,3% of the answers. The second most preferred source of information is the national or local radio (48,9%). As a participant of a focus group put it *“radio and TV because we cannot live without radio and TV, it is a possibility that is close to us, more accessible”* (FG Report, p.15). National magazines or newspapers follow, with 37,7% as the following graph shows.

**Graph 28: What would be the best way to receive information on HIV/AIDS, % (n=454), multiple answers**



This result shows accordingly that mass media in general is the most preferred way to receive information on the subject. Most of the respondents prefer to get such kind of information in a non-personal way. After mass media, health professionals are named (22,2% of the answers), followed by TV channels for immigrants when they are abroad (13,2%).

The participants of the focus groups made other suggestions as to how information could be disseminated, such as distribution of information leaflets before the departures abroad, or through transport agencies that carry parcels (FG report, p.16).

### **Fear to be at risk for HIV**

That HIV/AIDS is for Moldovan citizens not a subject they like to discuss very openly is also shown by the next results. Only few respondents 7,9% (36) know someone who is HIV positive or has AIDS. The respondents interviewed in Russia tend to know more PLWHAs than the ones interviewed in Moldova. From the respondents interviewed in Russia, 14,8% (4) and 7,5% (32) of the ones interviewed in Moldova stated to know an HIV positive person.

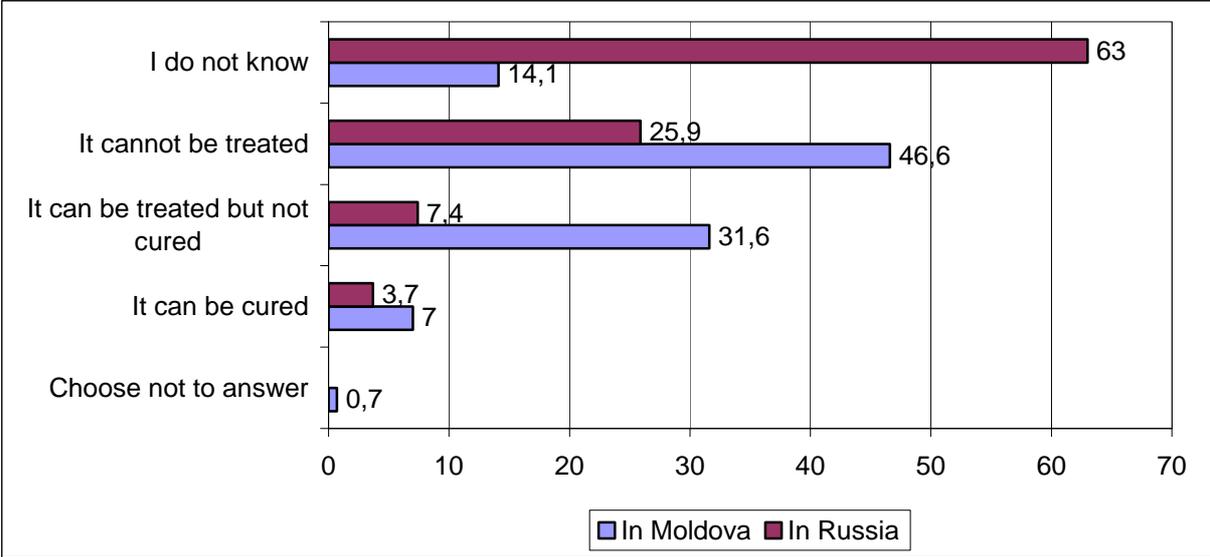
Alarmingly, 35% (159) of the respondents are very or rather afraid of becoming infected with HIV. This shows the high level of uncertainty concerning HIV/AIDS. Even though the sample scored high in the scale of knowledge of basic infection routes, it showed important lacks in the knowledge about how HIV cannot be transmitted through social contacts. This insecurity is not influenced either by the sex of the respondent, nor their age or their education. It is,

though, influenced by the country in which the respondents were interviewed (p=.000). 32,8% of the respondents who were interviewed in Moldova stated to be very or rather afraid, an answer given by 70,4% of the respondents in Russia.

**Knowledge about AIDS treatment**

Around the half of the respondents (45,4%, 206) does not know that HIV/AIDS can be treated, followed by 30,2% (137) who know that there is a treatment but not a cure. 17% (77) stated not to know and 6,8% (31) think that HIV/AIDS can be cured definitively. Again in this case, the only variable that influences this knowledge is the country in which the respondents were interviewed, as the following graph shows:

**Graph 29: Do you know if HIV/AIDS can be treated?, %, (In Moldova n=427, in Russia n=27)**



Also here these surprisingly large knowledge gaps pinpoint to uncertainties and explain the great fear of becoming infected.

**5.4.1 Summary of HIV/AIDS knowledge**

Over the half of the respondents feel very sure to know what HIV/AIDS is. But only 43,6% of the respondents showed a high knowledge of transmission routes and 51,1% middle level and also the knowledge about protection methods is quite low. Large insecurities exist especially regarding the question how HIV cannot be transmitted. Here, several uncertainties and fears come to light, showing that there is a large need for information campaigns that should focus on this point. The knowledge of the respondents from Moldova concerning HIV/AIDS

proved to be quite poor in relation to the knowledge of EU citizens documented in the last special EUROBAROMETER<sup>20</sup>.

It is very peculiar that some of the variables that are known and have been repeatedly proven in several national and international surveys<sup>21</sup> to influence the knowledge of transmission ways of HIV/AIDS do not play a role in the sample. These answers are neither influenced by the education nor by the age or by the sex of the respondent. The only influence that could be found is the significant influence of the place where the respondent was interviewed, the respondents questioned in Russia show a much lower knowledge than the ones interviewed in Moldova.

Consequently, more than the half of the respondents stated to need more information on HIV/AIDS to protect themselves even though almost three quarters of the interviewees have received information on HIV/AIDS already. HIV/AIDS seems not to be a topic discussed within peer groups of friends or families. Most Moldavian respondents wish to get more information through mass media channels like TV, radio and news papers<sup>22</sup>.

## **5.5 HIV Test**

HIV Voluntary Counselling and Testing (VCT) settings offer usually the unique possibility, in which individuals with risky sexual behaviour utilize personal counselling. Therefore, an effective, and professional HIV VCT plays an important role in the frame of prevention, as recent surveys state. Within the frame of this KAB survey the respondents were asked about their experiences with HIV tests and counselling.

Over 60% of the respondents have never been tested for HIV/AIDS (60,6%, 275). 31,9% (144) have been tested, from which 20% (91) in the last year and 11, 9% (54) more than one year ago. 4,4% did not know and 3,1% chose not to answer. In this case, the fact of having been tested is not influenced by where the respondent was interviewed, but whether he or she travels to a CIS or Non CIS country ( $p=.000$ ). 42,6% (75) of the respondents who travel to Non CIS countries have had an HIV Test, but only 24,9% (56) of the travellers to CIS countries. There is also a significant correlation between having been tested and sex ( $p=.001$ ). Over 40% (40,7%, 74) of the women have taken a test, something that 26,1% of the men have done.

---

<sup>20</sup> European Commission, 2006

<sup>21</sup> SPI Forschung, 2005

<sup>22</sup> idem

The fact of having been tested correlates with education as well ( $p=.002$ ): 25,5% of the respondents with a low education level have been tested, 35% of the ones with a middle education and 48,4% of the ones with a high education.

The assumption that the HIV test activity correlates with the level of knowledge of HIV/AIDS was also confirmed. There is a correlation ( $p=.005$ ) between the ones who scored a high knowledge on HIV transmission routes and those who have taken an HIV test. 41% of the ones that have a high knowledge have taken a test, something that 31,2% of the respondents with a middle knowledge have done and only 5,9% of the ones with a low knowledge of HIV transmission routes

There is also a significant correlation between having been tested and the subjective fears of getting HIV infected of the respondents ( $p=.003$ ). 45,2% of the respondents that are very/rather afraid of becoming infected have tested themselves, something that 28,8% of the respondents that are a little and 28,4% of the respondents that are not afraid or do not think about it have done.

Almost every respondent that had an HIV test knows the result (96,6%).

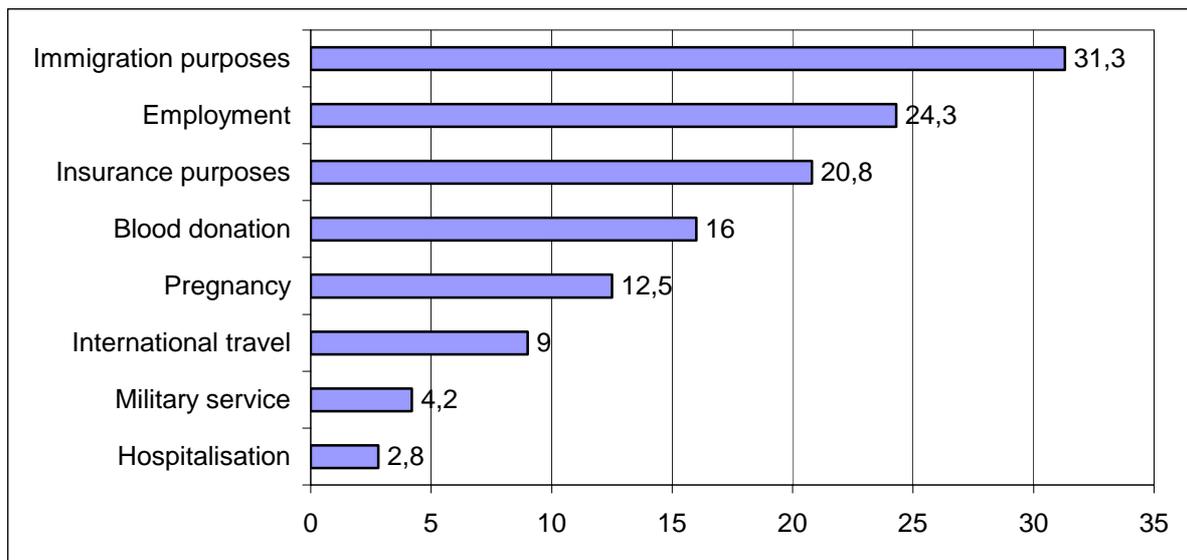
The vast majority of these tests were carried out in Moldova (77,2%, 112), 10,3% (15) each were carried out in CIS and in Non CIS countries. Three persons chose not to answer (2,1%).

The HIV tests that were carried out in Moldova were mostly carried out by a doctor or a general practitioner (34,5%, 39), a specialised clinic on HIV/AIDS and STDs (31,9%, 36) or a general hospital (20,4%, 23). The tests in a CIS country were mostly carried out in a specialised clinic (31,3%, 5), a hospital (31,3%, 5) or by a doctor (18,8%, 3). In Non CIS countries, most of the tests were carried out in a specialised clinic (40%, 6), followed by a general hospital and a doctor (both 20%, 3). There is no difference in the testing behaviour between men and women.

The next graph illustrates the reasons for having been tested<sup>23</sup> if the test was required:

---

**Graph 30: Reason for required HIV Testing, % (n=144, multiple answers possible)**



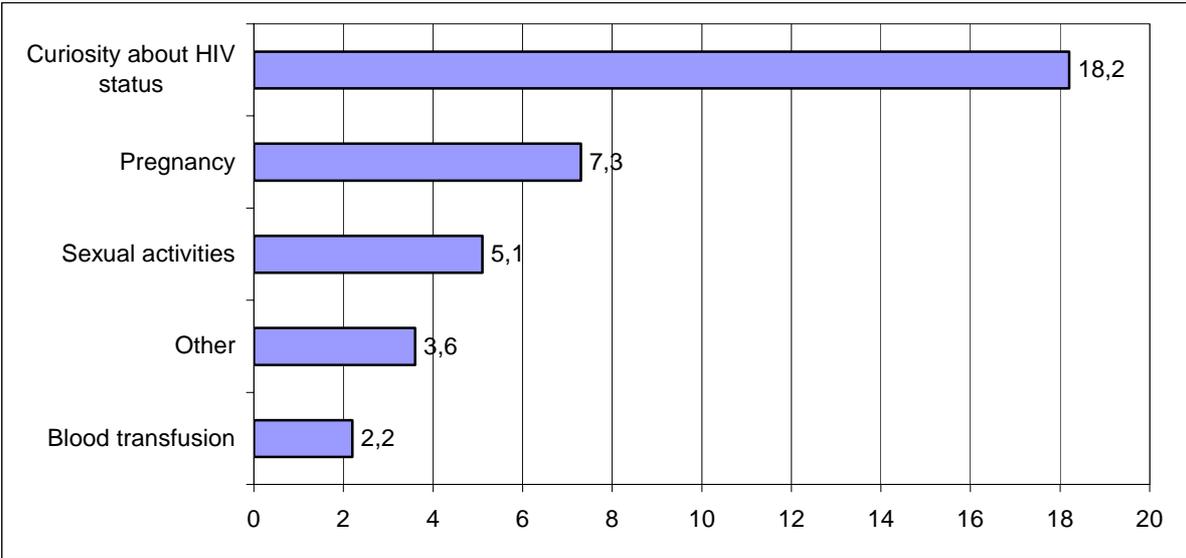
In the cases where the test was done out of immigration purposes, there is a significant correlation with the fact if the respondent travels to a CIS or to a Non CIS country ( $p=.000$ ). 46,7% of the respondents that travel to Non CIS countries and took an HIV test did it out of immigration reasons<sup>24</sup>, compared to 13,2% of the respondents that travel to CIS countries and had to take a test out of the same reason. If the test was done out of insurance reasons, here again there is a significant relationship with the country to which the respondent travels to ( $p=.001$ ). In this case, 9,3% of the Moldovans that travel to Non CIS countries got tested for insurance reasons, compared to 32,4% of the Moldovans that travel to CIS countries.

The next graph shows the reasons for taking an HIV test in the case that the test was a personal decision:

---

<sup>24</sup> According to legal regulations of Moldova, not of the hosting countries

**Graph 31: Reason for HIV Testing as a personal decision, % (n=137, multiple answers possible)**



An issue of special consideration when handling the topic of HIV testing is its accompaniment by counselling according to the Voluntary Counselling and Testing Concept, recommended by UNAIDS/WHO<sup>25</sup> as an intrinsic component of an HIV test.

It was decided to inquire about HIV Test counselling only for the tests carried out abroad due to the decision of carrying out face-to-face interviews combined with the knowledge that an HIV test is compulsory in Moldova in various circumstances, such as immigration purposes and marriage. Due to the setting of the interview it was decided upon not to ask for the result of the HIV test in the cases in which a test was done, and based on this decision we wanted to avoid the situation that the respondent might have the feeling that the inquiring about counselling and test result in Moldova could be interpreted as a control question. In the focus groups interviews, the statements of the participants let assume that the tests carried out in Moldova are not always accompanied by counselling, for *“there is a possibility to buy this certificate (the certificate of being HIV-negative), a quick and comfortable procedure”* (FG report, p.14). This issue needs further and deeper analysis to be able to meet the international standards of UNAIDS/WHO.

71% of the 14 interviewees (10) that were tested in a CIS country answered that they were counselled before taking the test. Only six respondents answered the question about counselling after the test in CIS countries. Out of these six, only 2 did receive post-test counsel-

<sup>25</sup> UNAIDS/WHO, 2004

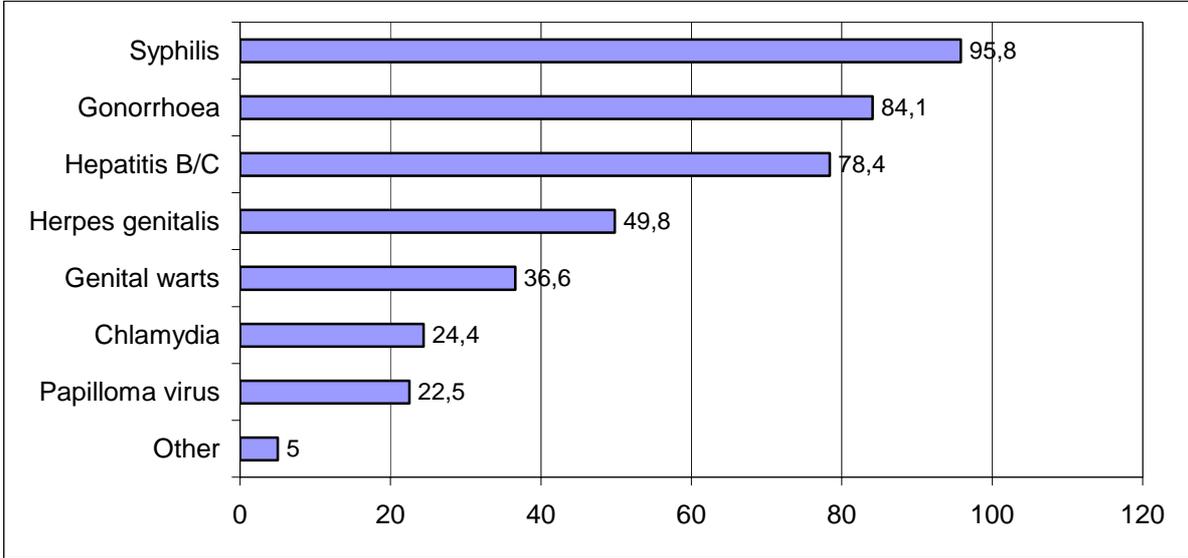
ling. Concerning the HIV tests in Non CIS countries, eleven interviewees answered the question of pre-test counselling. 9 respondents out of these eleven did receive counselling, one did not and one did not know. The question of post-test counselling was answered by 9 persons, out of whom 5 did receive post-test counselling, 3 did not and one person did not know.

**5.6 STI knowledge and diagnosis**

The knowledge of STIs was not asked in detail, as it was the case of the knowledge of HIV/AIDS, for this would go beyond the scope of the survey. However, STIs are important markers for the assessment of the infection risk of HIV and are more widespread than HIV. Independently from HIV, some STIs are severe diseases with serious consequences for the health of the affected person. Due to this, in the frame of this survey we have asked at least which names of STIs do the respondents know. Knowing the name does not say anything about the knowledge of infection probability and prevalence of the infection.

As expected the knowledge regarding some of the various STIs is lower (except for syphilis) than the HIV/AIDS one, but astonishing high in comparison to surveys in EU countries, e.g. Germany<sup>26</sup> The most known infections are syphilis, gonorrhoea and hepatitis B/C

**Graph 32: Which STI do you know?, % (n=454, multiple answers)**



In the case of knowledge of STIs it was proceeded the same way as with the analysis of HIV knowledge and a new scale was recoded. In this new variable, the respondents who did not know about any STI, or up to only three belong to the group of “low knowledge”. Those who

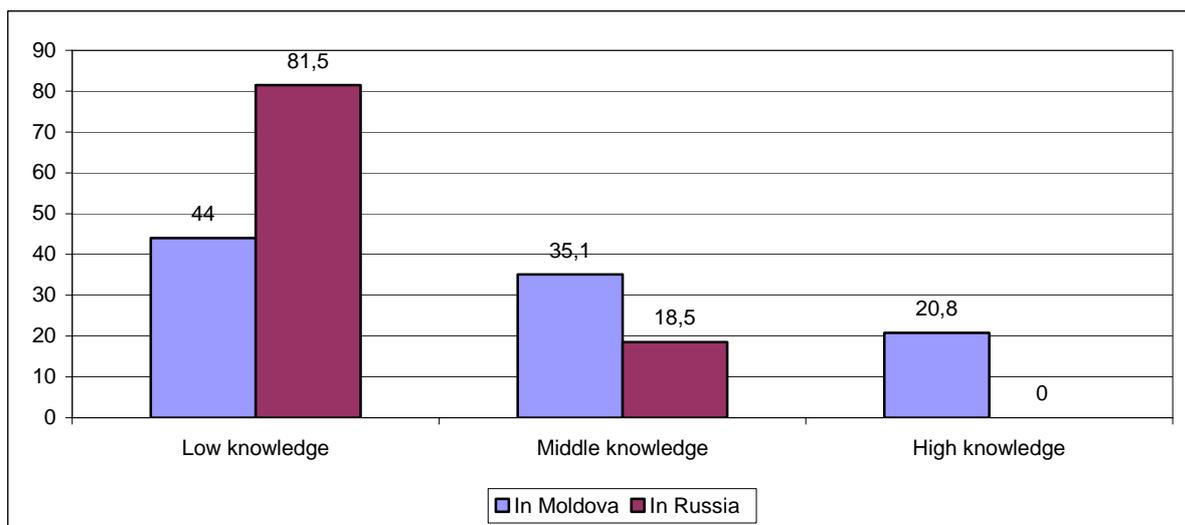
<sup>26</sup> In Germany, the knowledge of the general population regarding STIs is very low (Bzga, 2006)

know 4 or 5 belong to the group of “middle knowledge” and those who know 6 or 7 have a “high knowledge”.

Almost half of the respondents (46,3%, 210) showed a low knowledge, followed by 34,1% (155) that has a middle knowledge. Around 20% (19,6%, 89) of the interviewees have a high knowledge of STIs.

There is a very significant correlation between knowledge of STIs and the country in which the interviews took place ( $p=.000$ ), as the following graph shows:

**Graph 33: Knowledge of STIs of respondents in Russia (n=27) and in Moldova (n=427), %**



As it can be seen in the graph, the vast majority of the Moldovans that were interviewed in Russia have a low knowledge of STIs. The sex of the respondent does have an influence ( $p=.023$ ) on the knowledge of STIs in this case, where women show a better level. 25,8% (47) of the women scored a high knowledge, something that 15,4% (42) of the men did.

The respondents that travel to Non CIS countries showed a better knowledge than the ones that travel to CIS countries, and this correlation proved to be significant ( $p=.003$ ). 27,3% (48) of the respondents that travel to Non CIS countries showed the highest level of knowledge, something that 14,4% (40) of the travellers to CIS countries did.

Education is a further variable that influences the knowledge. 28,7% (29) of the respondents with a high education showed a high level of knowledge, compared to 19,7% (39) of the ones with a middle education and 14,3% (21) of the ones with a low education ( $p=.020$ ).

A similar relation is to be observed between the knowledge of HIV transmission routes and the information about STIs. The more the respondent knows about HIV transmission routes, the more STIs can he or she name.

According to the good knowledge of STIs, Moldavians with working experiences abroad show a relative high degree of STI check ups in relation to KAB surveys in other European countries. Almost 30% (28%, 127) of the respondents have had an STI check in the last three years<sup>27</sup> There is no correlation between the sex and the fact of having had an STI test. 25,7% of the men and 31,3% of the women stated to have had an STI test. Other indicators have no influence either. However, there is a very significant relationship between the knowledge of STIs and having had a test in the last three years ( $p=.000$ ): The ones that have had an STI test are the ones that have the highest knowledge of STIs. This could possibly indicate that the test was accompanied with some sort of counselling.

Only 1,6% (8) of the respondents stated to have actually had an STI in Moldova in the last three years, 0,8% (2) stated to have had an STI in a CIS country and 0,6 (3) in a Non CIS country.<sup>28</sup> These STIs were mostly treated in a specialised clinic or by a doctor.

It is very interesting to note that STIs are a taboo topic in the Moldovan society; it is a subject that it is not discussed among the population, according to the participants of the focus groups. The participants stated that they got their information through the radio, newspapers, magazines and books, they even appeal to the doctor, but they would never speak to anyone about this. As a participant expressed this: "*maybe there is something I am interested in, but if I ask, someone may think I am infected*" (FG report, p.3).

### **Tuberculosis**

The tuberculosis (TB) epidemic in Eastern Europe and Central Asia, which peaked in 2001, has declined slightly over the past few years. Nevertheless, multidrug-resistant TB and TB-HIV co-infection continue to seriously hamper the work to control the disease, and the situation can still be described as a TB emergency, according to the World Health Organization (WHO). Of the 20 countries with the highest rates of multidrug resistance among previously treated cases, 14 are in the CIS region. The region also reports the highest rate of treatment

---

<sup>27</sup> BORDERNET KAB survey "Young adults (Germany, Poland, Austria, Slovak republic, Italy, Slovenia), SPI Forschung (in print 2007) Bzga (2006), Migration und HIV (SPI 2005)

<sup>28</sup> These remarkably small numbers can be an indicator that the atmosphere in which the interview took place did not allow any empathy and trust between the interviewer and the respondent

failure (seven percent) and the second highest rate of death as a treatment outcome (six percent)<sup>29</sup>

Over one third of the respondents (31,9%, 145) has had a TB test in Moldova, 5,1% (14) stated to have had one in a CIS country and 10,3% (20) in a Non CIS country.

### **Summary of STI knowledge**

The respondents showed a relatively high knowledge concerning STIs in comparison with other KAB surveys, especially syphilis, gonorrhoea and hepatitis B/C. Although the questions were restricted to remembrance of the name of the respective STIs, questions about transmission routes, protection, symptoms and epidemiological dissemination were not asked because of practical reasons. Almost 30% of the respondents have had an STI check, and only around 3% of the total of the respondents have had an STI in the last three years. Unfortunately we don't know anything about whether or not the STI check ups were accompanied by counselling offers.

### **5.7 Alcohol and drugs consumption**

Heavy or uncontrolled alcohol and drug consumption could be connected with risk taking in sexual behaviour, as recent surveys showed.<sup>30</sup> Consequently, we included a battery of questions regarding these topics in the survey. In order to assess the alcohol consumption behaviour of the respondents, these were asked to indicate how often do they drink alcohol. The biggest group are those who say to drink alcohol less than once a week, with 44,5% of the respondents (198), followed by the group that never drinks alcohol (20,2%, 90).

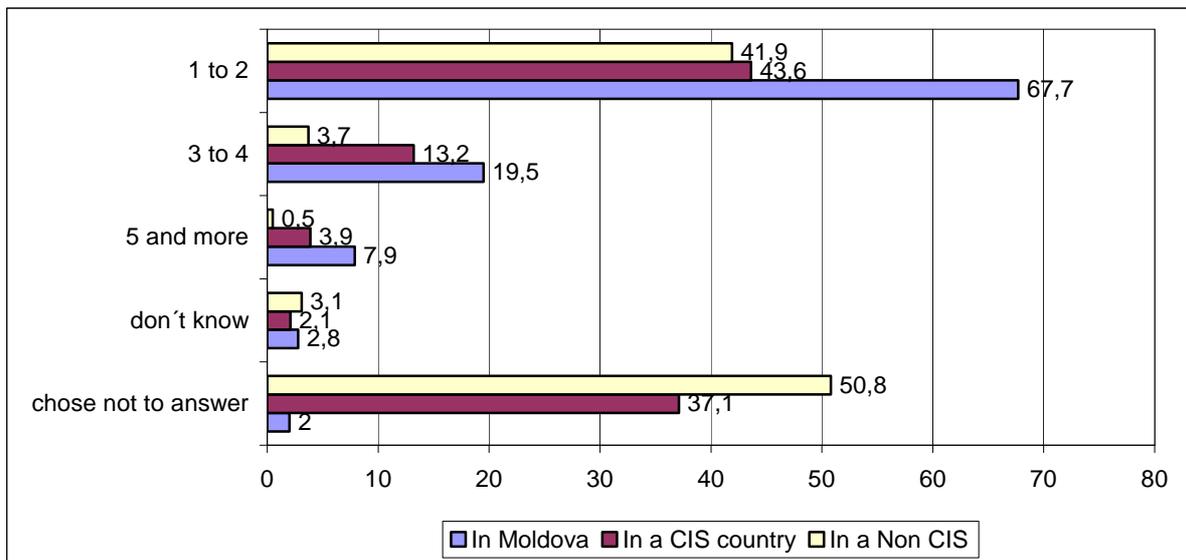
If the respondents do drink alcohol, in Moldova the majority (a total of 346 respondents answered this question about the alcohol consumption in Moldova) of them take one to two drinks (67,7%, 239) per occasion, followed by the ones who have three to four drinks (19,5%, 69). Only 7,9% (28) say to consume 5 and more drinks per occasion.

---

<sup>29</sup> WHO, 2005

<sup>30</sup> SPI Forschung, 2007; Bellis et. al, 2007

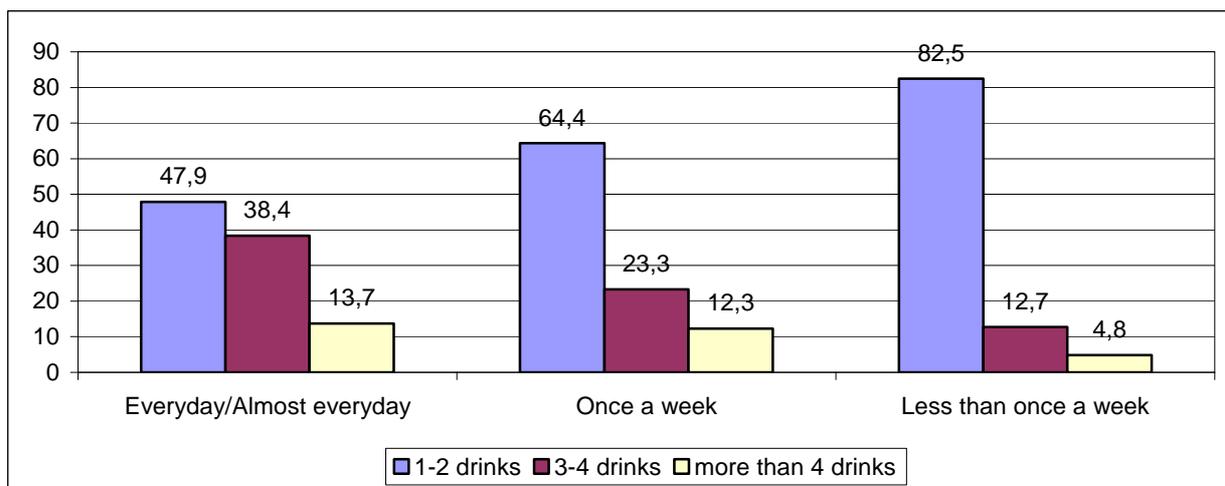
**Graph 34: Alcohol consumption in Moldova and abroad, % (Moldova n= 353, CIS country n= 280, Non CIS country n= 191)**



In a CIS country (280 respondents), 43,6% (122) of the interviewees have one or two drinks, 13,2% (37) have three to four and only 3,9% (11) more than four. Concerning the drinking habits of the interviewees in a Non CIS country (94 respondents answered this question), the biggest group drinks one or two drinks (41,9%, 80), 3,7% of the respondents (7) have three or four drinks and only one person stated to drink five or more drinks.

The frequency and the quantity of alcohol consumption has a statistically significant relationship only in the case of the alcohol consumption in Moldova. Here, the respondents that drink more often alcohol (everyday to several times a week) are the ones that drink more heavily compared to the respondents that drink alcohol once a week or more seldom, as can be seen in the next graph.

**Graph 35: Frequency and quantity of alcohol consumption in Moldova, % (n=335)**



### **Frequency and quantity of drug consumption in Moldova and abroad**

A total of eight interviewees have used drugs in the past three years. Two of them only in Moldova, two in Moldova and a CIS country, one in Moldova and a Non CIS country, two only in CIS countries and one only in a Non CIS country. All these respondents use drugs occasionally. This small number of persons might once again be a hint to the biases in the questioning because of the setting.

Out of the five respondents in Moldova, one has used cocaine, one opium, two marihuana and one chose not to answer. From the respondents that have used drugs in a CIS country, one has used cocaine, one steroids and one marihuana. In the Non CIS countries two respondents have used marihuana.

Only one respondent, a 21-year-old man, has injected drugs in the past three years.

The answers to this block of questions seem also to be very influenced by social desirability due to the biases of the questioning in general.

### **5.8 Sexual Behaviour and condom use**

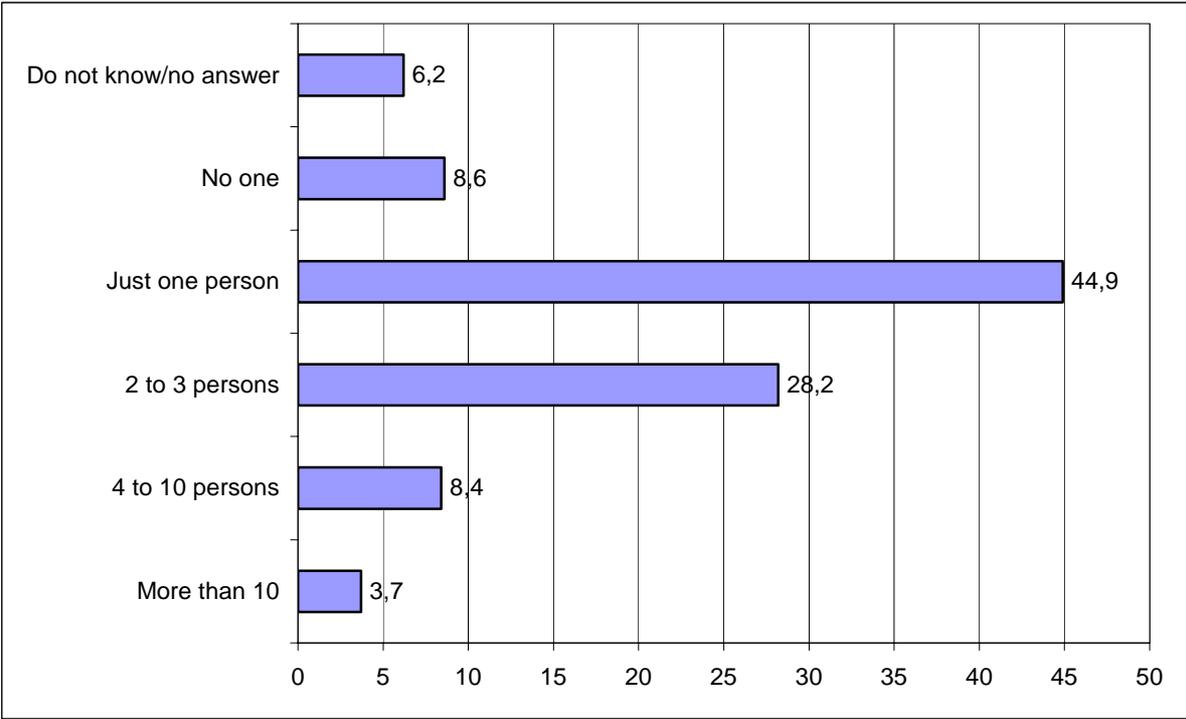
In this section information was gathered about the sexual contacts, preferences and relationships of the respondents, as well as about safer sex, HIV/STI risk exposure and management. The reported experience regarding sexual behaviour covered the period of the last three years.

**5.8.1 Sexual Behaviour**

More than half of the respondents (52,4%, 238) have had a stable sexual relationship in Moldova during the last three years, but only half of this respondents stated that they have no other sexual relationship beside their relationship in Moldova. Additional eight respondents stated to have had a stable sexual relationship only in a CIS country and only seven in a Non CIS country.

A new variable was created in which the numbers of sexual partners in all the countries were added to obtain the picture of how many sexual partners the respondents had in total. As it can be seen in the graph, 44,9% of the respondents in total (204) have had sexual relationships with only one person and 40,3% with more than one (adding the percentages of respondents who had sexual relationships with a few, with several and with many persons).

**Graph 36: The number of sexual partners in total over the last three years, % (n=454)**

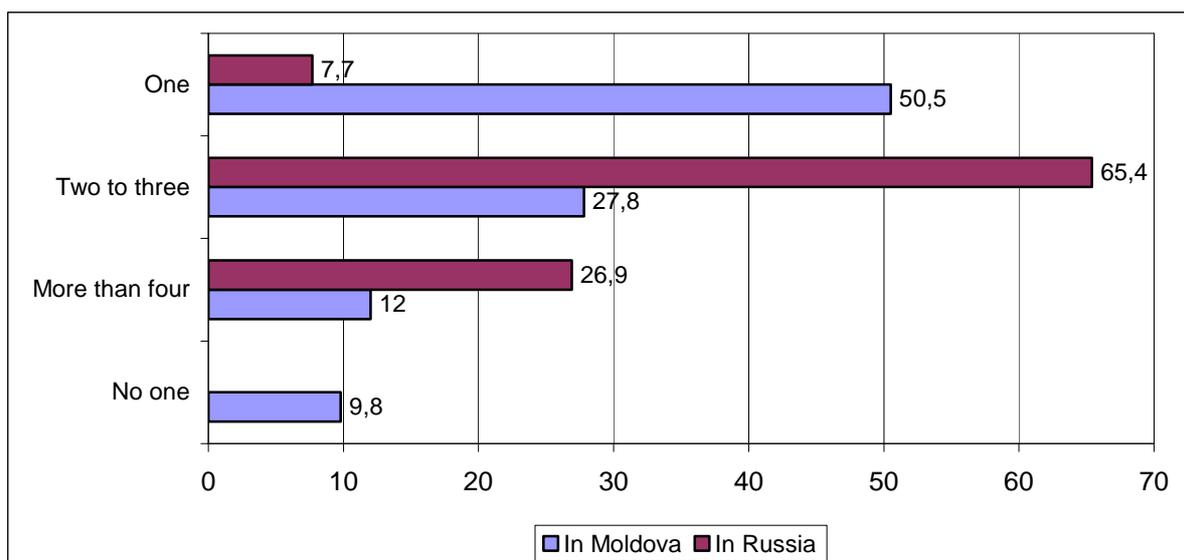


The number of sexual partners has a very significant relationship with the sex of the respondent (p=.000). The sexual behaviour differs especially concerning the categories “2 to 3 partners” and “more than 4” (this category is the sum of “between 4-10” and “more than 10”). 26,9% of the men (68) and 34,7% (60) of the women stated to have had between 2 and 3 sexual partners, but in the category “more than 4”, men are represented with almost 20% (19,4%, 49) and women with only 3,5% (6). In the focus reports some comments were made on this subject, such as: “*Women can refuse, while men never!*” (FG report, S. 5)

Age is a factor that significantly influences the number of sexual partners ( $p=.000$ ). Over half of the respondents aged between 30-50 (55,5%, 132) and the ones over 51 years old (57,1%, 28) state to have had only one sexual partner, an answer given by 31,7% (44) of the ones between 15 and 29 years old. Concerning the category “more than 4” sexual partners, over 30% (30,2%, 42) of the respondents between 15-29 stated this answer, but only 4,2% of the ones between 30 and 50 and 4,1% of the ones over 51 years old.

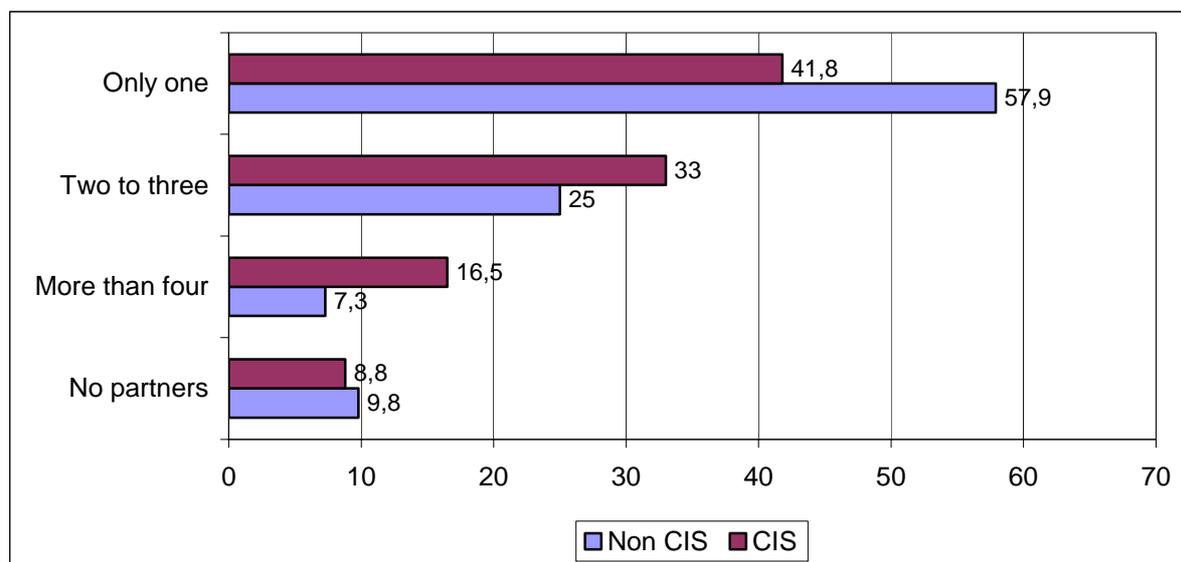
The country in which the respondents were interviewed has also a significant influence ( $p=.000$ ) in the number of sexual partners. Half of the respondents interviewed in Moldova (50,5%, 202) say to have had only one sexual partner in the last three years, something that only 7,7% (2) of the ones interviewed in Russia say. While 65,4% (17) of the respondents who answered in Russia stated to have had between two and three partners, only 27,8% (111) of the ones interviewed in Moldova says so. Only 12% of the latter had sexual contacts with more than four persons (48), but 26,9% (7) of the Moldovans in Russia. This answer behaviour could be a further hint to the bias of the interviewing techniques in Moldova and the lack of trust of the respondent toward the interviewer. It seems appropriate to take the answer percentages of the respondents questioned in Russia and Moldova as two corner points of the description of the real sexual behaviour of the sample.

**Graph 37: Comparison of number of sexual relationships between respondents interviewed in Moldova and in Russia, % (In Moldova n=400, in Russia n=26)**



The country of destination is a further factor that influences the number of sexual partners ( $p=.003$ ). The respondents that travel to CIS countries have in general a larger number of sexual partners, as it can be seen in the following graph:

**Graph 38: Number of sexual partners in the last three years concerning the countries of destination, % (n= 425)**



As it can be seen in the graph, over twice as many (seen in percentages) respondents that travel to CIS countries compared to the ones that travel to Non CIS countries have had sexual contacts with more than 4 persons.

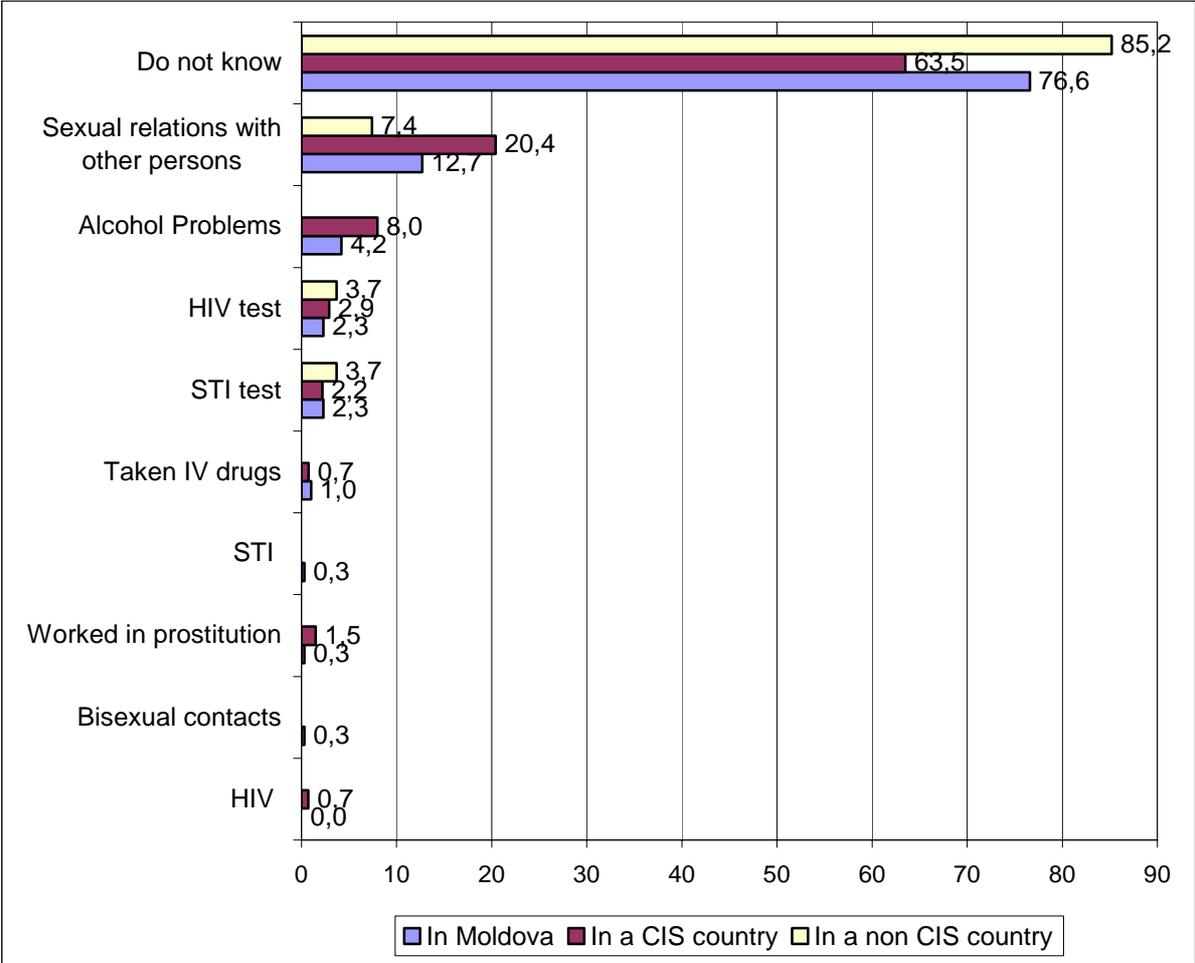
The knowledge about the transmission ways of HIV/AIDS has no influence on the number of sexual partners, nor does the fear of becoming infected with HIV/AIDS.

Concerning the choice of the sexual partner, when the respondents are in Moldova 96,8% of the men have sexual relationships only with women, and 92,5% of the women only with men. 1,2% of the men and 5,4% of the women stated to have had sexual relationships with persons of the same sex only. The rest chose not to answer. In a CIS country (in this case 139 respondents answered the question), 78,7% of the men and 92% of the women have had heterosexual relationships only. 5,6% of the men had homosexual relationships. Homosexuality is a taboo subject in Moldova. In the focus groups some of the participants even rejected to talk about this subject (FG report, p. 13).

In a Non CIS country (64 interviewees answered this question) 93,9% of the men and 96,8% of the women stated to have had only heterosexual contacts, but here again, the number of “chose not to answer” statements is high (6,1% of the men and 3,2% of the women).

The respondents were asked if they knew about the sexual behaviour, drug problems or STIs of their partners in Moldova, in a CIS or Non CIS country<sup>31</sup>, and it is remarkable – as it can be seen in the following graph- that the most given answer is “Do not know”.

**Graph 39: Do you know if your partner has had any of the following?, %, more than one option possible.**  
**Moldova n= 308, CIS country n=137, Non CIS country n=54**



**Prostitution**

Prostitution is a big taboo in families and peer groups, especially for women. Most of the migrant prostitutes questioned in several surveys in Germany stated<sup>32</sup>, not to inform their families and friends at home about their real work abroad. Most of them said they work in the

<sup>31</sup> These groups are not mutually exclusive, for many respondents stated to have partners in Moldova and abroad.

<sup>32</sup> In Germany, the number of female migrant sex worker increased according to the regions from 30 – 50 % in the mid 90ies to 60 to 70 % nowadays. Up to 70 % of these migrant prostitutes come from central- and east European countries.

private sector as house keeping or nursery. To ask this kind of questions in the home country is an even more difficult subject, because of the lack of confidentiality. The discussion in the focus groups about this brought up commentaries such as: *“some women are disposed to have sexual relations just to earn more money, the behaviour is freer due to the fact that there is no community control – they can do anything they want, no one discusses them”* (FG report, p.19).

So we wouldn't say the following description gives a realistic picture of the real situation, but of course we can neither say, it does not. What is astonishing under the circumstances the interview took place is not that the numbers are so low but that there are any answer on these questions at all.

4,4% of the men (12) and 1,1% (2) of the women have paid for having sex in Moldova in the last three years. Only one of the men answered the question how many times, and he stated that it happened only twice. In a CIS country, 11,2% of the men that travel to these destinations (22) and 1,1% (1) of the women have paid for sex. Here, the number of the respondents that chose not to answer is again conspicuously high (13,2% of the men – 26 - and 13,6% of the women – 12). Only four men stated how many times had they paid for sex, and the number ranged from 1 to 10 times. In a Non CIS country only three men (3,2%) and one woman (1%) stated to have paid for having sex. Here again, 14% (13) of the men and 19,4% (20) of the women chose not to answer. One man stated to have paid for sex twice.

Only one man has been paid to have sex in Moldova, and this only once, but 8 men (2,9% and 12 women (6,6%) chose not to answer. In a CIS country, 2 women have been paid to have sex, one of them only once. 26 men (13,2%) and 11 women (12,5%) chose not to answer. In a Non CIS country, only one woman has been paid to have sex, but 10 men (10,9%) and 21 women (20,8%) chose not to answer.

### **Summary of sexual behaviour**

Especially the respondents between 15 and 29 years old stated to have had several sexual partners, and the respondents that were questioned in Russia have had more sexual partners than the ones interviewed in Moldova. In general, the Moldovans that travel to CIS countries tend to have more sexual partners.

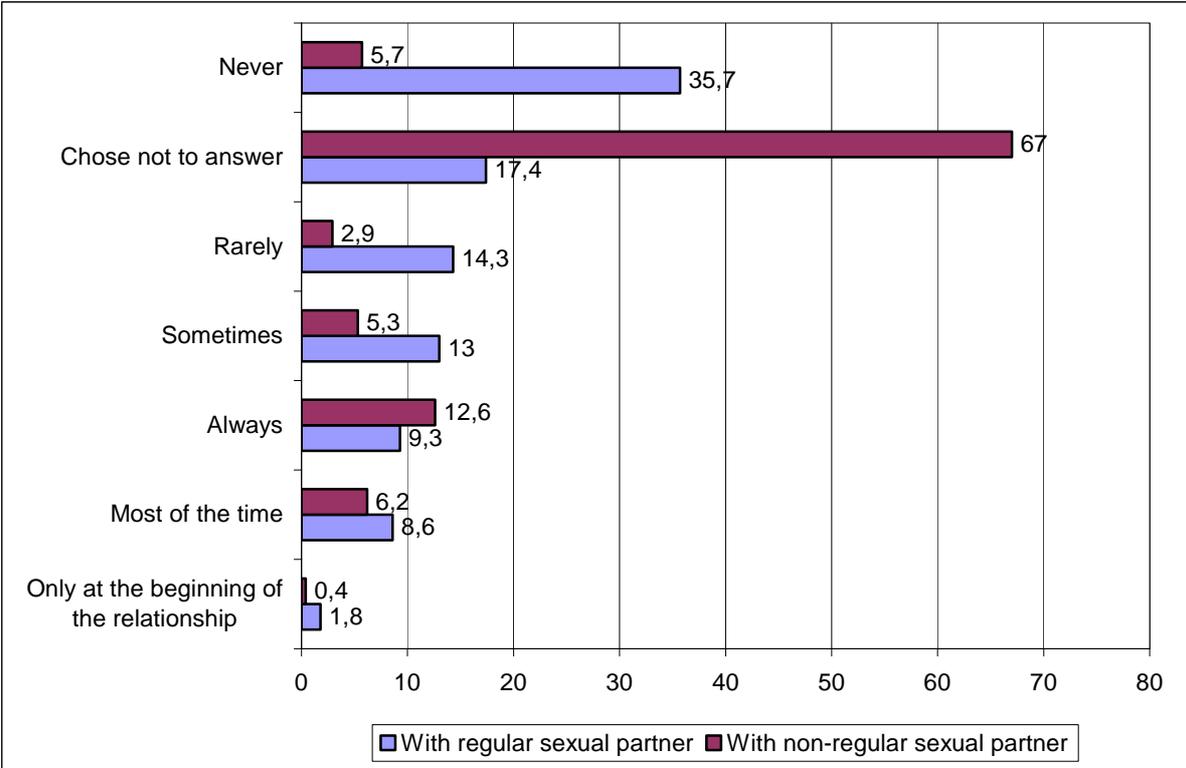
Men have in average more sexual partners than women. Most of the respondents answered not to know about the sexual behaviour of their partner, if they have one. This prevention hindering kind of lack in communication within intimate sexual partnerships is unfortunately

very common worldwide and - in this survey – fits to the Non-communication of the topic HIV/AIDS in groups of peers and families. “To break the silence” is one of the biggest efforts in intercommunicative HIV and STI prevention Concerning commercial sex, an expected low percentage of respondents stated to have paid or to have been paid for sex in the last three years.

**5.8.2 Condom use**

Asked about condom with regular and non-regular partners, the answers were again very influenced by the biases of the questioning, especially concerning the condom use with non-regular partners. Condom use in general seems to be an avoided topic for Moldovan citizens, as a participant in one of the focus groups stated: *“I haven’t bought any condoms, and I don’t think I would ever,...”* (FG report, p.11). Corroborating this, 67% of the respondents chose not to answer. We had the feeling that the respondents did not feel free enough to divulge this sort of information to the interviewer. In the next graph the condom use with a regular and with a non-regular sexual partners is shown.

**Graph 40: Condom use during sexual intercourse with regular and Non regular partners, % (n=454)**



As it can be observed, with the regular sexual partner the most given answer is to never use condoms. This answer, considering the very high percentage of respondents who stated not

to know anything about the sexual behaviour of their partner, is very problematic. 27,3% answer to use rarely/sometimes condoms and only 15,9% most of the times/always.

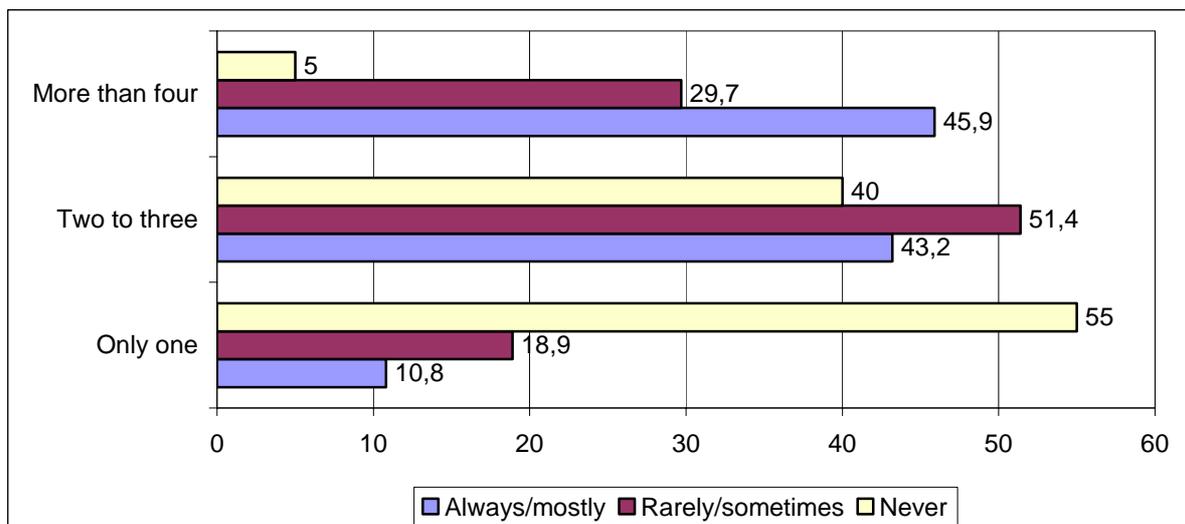
Taking into account the condom use with non regular partners, the most given answer (after “choose not to answer”) is to always use condoms, but only 12,6% answered this, together with “most of the time” it comes to 18,8% of the answers.

A new variable about condom use was created, adding together the options “always” and “most of the time” on one side and “rarely” and “sometimes” on the other. “Never” and “only at the beginning of the relationship” was left as it was. For this variable the ones who chose not to answer were left out.

Looking closer at the relationship between sex and condom use, men use more condoms than women. Concerning the regular partner, over half of the women (51,4%, 76) say to never use condoms, something that 38,1% of the men state (86). There is a significant relationship ( $p=.001$ ) between using a condom with a casual partner and the sex of the respondent. In this case, again, the men use more often condoms than the women: 11,3% (12) of the men state to never use condoms with a casual sexual partner, something that 31,8% (14) of the women say.

Reducing the variable of condom use with the casual partner to the answer options “always/mostly”, “rarely/sometimes” and “never” and then looking at the condom use relating to the number of sexual partners, then the following picture becomes clear:

**Graph 41: Condom use according to the number of sexual partners, % (n=131)**



Looking at the respondents who say never to use a condom, 55% have had only one sexual partner, 40% had two to three and 5% had more than four. The answers of those who rarely or sometimes use condoms are more striking. 18,9% of these respondents have only one partner, but 51,4% have two to three and almost 30% (29,7%) have had more than four sexual partners in the last four years.

Asked who took the decision when a condom is used, 41,1% (106) of the respondents answered that it was the respondent him or herself. 34,1% (88) made this decision together with their partners, 10,5% (27) stated that the decision to use a condom is a decision by the partner alone. This variable has a very significant correlation with the sex of the respondent ( $p=.000$ ). In this case, as expected the men are the ones who make the decision to use a condom much more often than a woman does (50,3% of the men compared to 23% of the women). The answer that the decision is usually taken by the partner is something that 7,6% of the men responded but 16,1% of the women. There is also a significant relationship between the question who decides to use condoms and the country in which the respondents were questioned ( $p=.005$ ). The respondents that were questioned in Russia take much more often the decision to use a condom by themselves than the Moldovans questioned in their home country (65,4% compared to 38,4%).

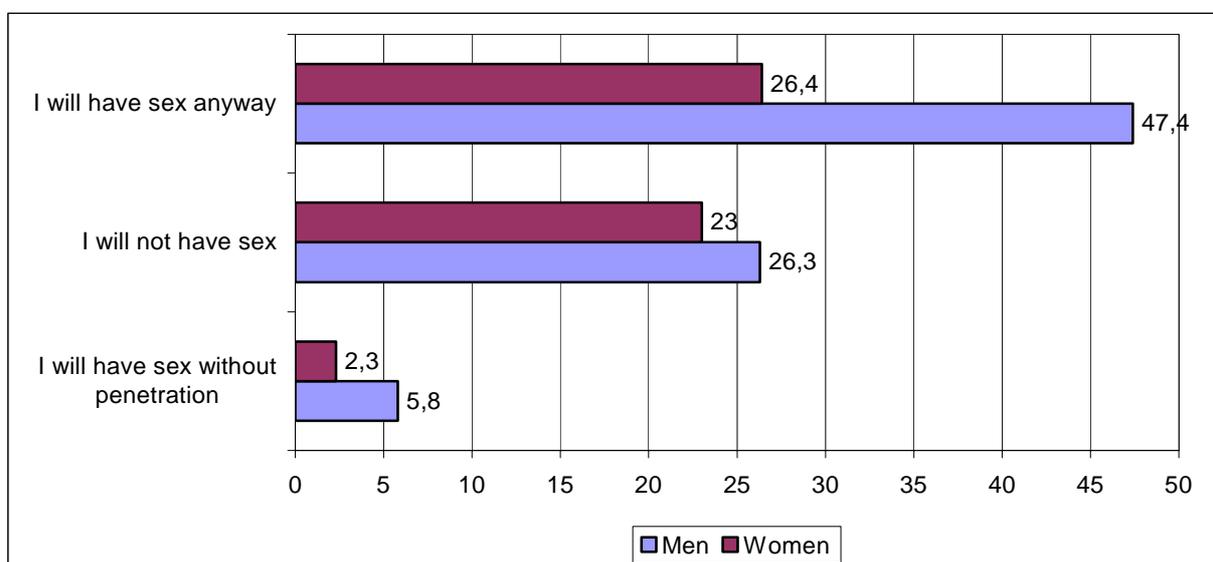
Dividing the respondents into three age groups (15-29, 30-50 and over 51), a very significant relationship becomes visible ( $p=.000$ ) between who takes the decision to use a condom and the age of the respondent. The youngest group is the one who takes the decision him/herself more often and the eldest more seldom (60,8% compared to 25%). The decision is taken by the partner more often in the case of the older respondents (20%) compared to 11,8% of the 30-50 years old and 6,9% of the youngest group.

The negotiation of condom use is a strategy that is more chosen by the eldest group, where 40% of this group stated that the decision of using a condom is a common decision between the partners. This answer was given by 39,7% of the respondents aged 30-50 but by only 25,5% of the ones aged 15-29.

The negotiation of condom use was a discussed issue in the focus group. Here, the initiation of a discussion in a couple is perceived by the respondents as an offense to the other partner, as a manifestation of distrust. A participant stated that the partner *"may get angry, may say: don't you trust me?"*. For couples who know each other for a long time the answer was *"they don't even think about that"*. In the case of occasional partners, the general statement was *"when you get to that moment you don't think or ask anything"* (FG report, p.12).

The multiple choice question “*what do you do when your partner does not want to use condoms?*” intended to assess the risk exposure and the various self-protection measures inclusive negotiation skills the interviewees adopt in their sexual relations. It is striking to see how high the percentage of respondents is that do not use any risk reduction strategy and *would have sex anyway*, (40%, 104). Only ¼ (25,2%, 65) of the respondents answered that they would *refuse to have sex* in the case that the partner does not want to use condoms. Only 4,7% (12) of the interviewees would opt for *sex without penetration*. The following graph shows the sexual risk management according to the sex of the respondent.

**Graph 42: How do you act when your partner does not want to use condoms? %, (n=258)**

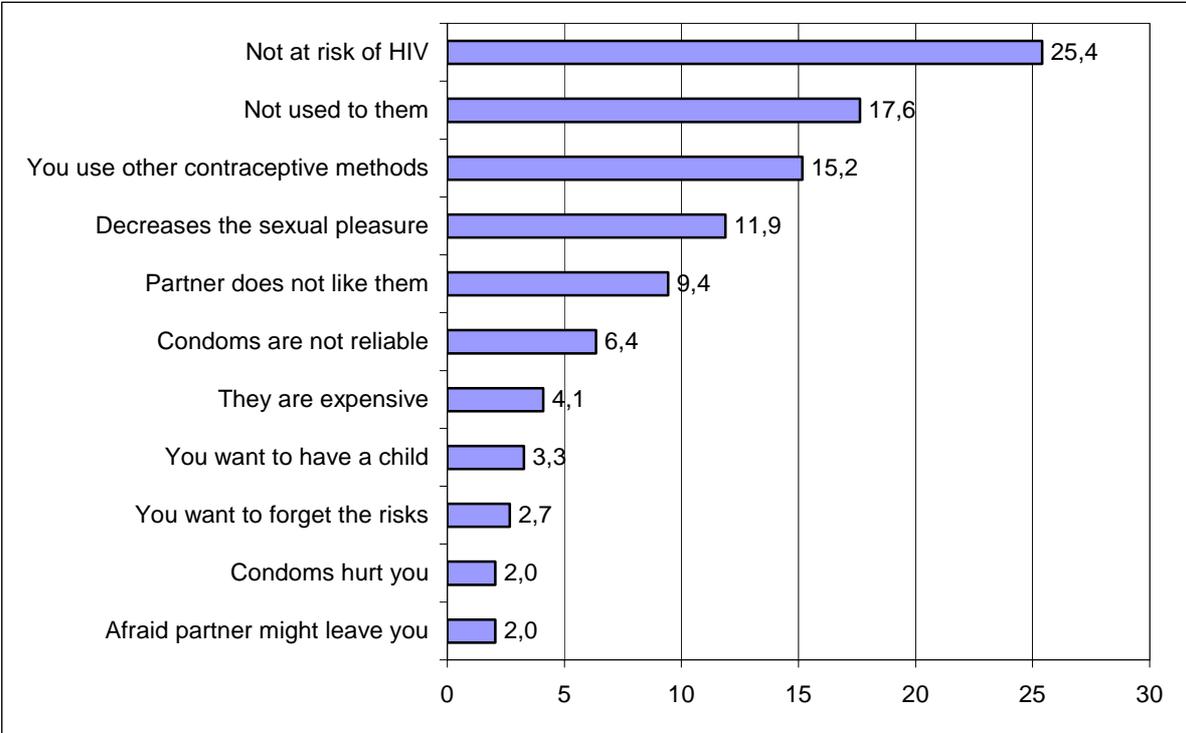


There is a significant relationship between the answer “*will have sex anyway*” and the sex of the respondent ( $p=.004$ ), this can be also clearly seen in the graph. Almost half of the male respondents of the answer *will have sex anyway*, regardless of the condom use. Women appear more decided to insist on safer sex and more ready to refuse having sex if it is not safe. The presence of the lack of risk reduction strategies is not related to the age of the respondent or the level of knowledge of HIV/AIDS transmission ways, or whether the respondent is afraid of becoming infected with HIV/AIDS. Education does not have an influence either.

The answers outlining the major reasons for condom refusal provide further hints to the meaning and contextualisation of the risk in the sexual relationships of the respondents. However, only 49 respondents answered this question. Over a quarter of the answers show that a high percentage of respondents see the condom as a protection against HIV, but they

do not see themselves at risk of contracting it. This is very problematic considering again the large quantity of interviewees that do not know anything about the sexual behaviour of their partners. Almost 20% of the answers correspond to the option not to be used to using condoms. For 15,2% condoms are predominantly perceived as a contraception measure. 11,9% of the answers corresponds to respondents that have the opinion that condoms decrease the sexual pleasure. Even though the condom is also in Moldova the most common preventive measure, some participants stated in the focus group: using condoms is “as if eating ice-cream through a plastic bag” or “having sex with a condom is like smelling a flower with an anti-gas mask”. (FG report, p. 11)

**Graph 43: Reasons for not using condoms, %, (n=49)**



Comparing the answers of men and women, the three most given reasons for condom refusal by the men were *not to be at risk of HIV* (29%, 82), *not to be used to using them* (17%, 48) and the opinion that they *reduce sexual pleasure* (14,5%, 41). Among the women, the most given answers are *not to be at risk of contracting HIV* (20,5%, 42), to use *other contraceptive methods* (18,5%, 38) and *not to be used to using condoms* (18,5%, 38).

Asked about which method of contraception the respondents usually use, the most named by the men were condoms (42,9%, 115), the contraceptive pill (13,1%, 35) and IUD (8,6%, 23). It is very interesting to note that 17,9% of the men (48) stated not to know which contraception method is used in the relationship. Among women, the most used contraception method

is the contraceptive pill (23,9%, 53), followed by condoms (20,7%, 127) and safe days count (14,9%, 33). What astonishes here is that 16,7% of the women (37) stated not to know which contraception method they use.

### **Summary of condom use**

In general, it can be said that condom use is low among the respondents, but this cannot be said for sure due to the very large number of respondents that chose not to answer to these questions. However, there is the tendency to use condoms more often the more sexual partners the respondent has. Low levels of sexual risk management were shown in the answers to the question “what is the reaction if the partner does not want to use condoms”. Almost half of the men responded that they would have sexual intercourse anyway. The “no condom, no sex” risk management strategy is more largely supported by the women. The most stated reason not to use a condom is not to be at risk of getting HIV/AIDS, not being used to them or using other contraceptive methods. These answers make clear that the condom is not seen as a protection measure not only against HIV/AIDS but also against several STIs.

## 6 Conclusions and recommendations

It is very important to bear in mind that being a migrant in itself it is not a risk factor for HIV. The risk factors are the various situations that the migrant encounters and the activities undertaken during the migration process. Successful prevention is therefore linked not only to health issues, but also structural ones, including the social and legal situation.

Health issues in general seem to be an important topic that Moldovans who work abroad are concerned about. Over half of them stated to have had already health problems while being abroad. Even though most of the respondents do not possess a health insurance (neither in Moldova nor abroad), in the case of a health problem the first choice was to see a doctor, even though no health coverage existed. This pinpoints to a very precarious situation concerning the health situation of Moldovans abroad.

Moldovans live, work and travel mainly within a network of other Moldovans including family members, even if they are abroad. **It should be analysed whether these networks could be or already are a good possibility to implement HIV/AIDS and STI- education and prevention measures following the method of peer education.**

**In order to provide information in an effective way, we must stress that it is necessary to involve the Moldovans with work experiences abroad from the beginning of the process, not only on the practical delivery level, but also on the decision-making level and in the development of appropriate prevention strategies.**

Regarding the knowledge about HIV/AIDS, more than half of the respondents are very insecure about the ways that HIV cannot be transmitted. Only 43,6% of the respondents showed a high knowledge of transmission routes and the knowledge about protection methods was relatively low compared with the knowledge of HIV/AIDS of EU citizens. However, the knowledge of STIs is relatively high, compared with e.g the general population in Germany. **Information about HIV/AIDS and STIs should be embedded in general information about the access, structure and the rights in the health system of the respective destination countries. These information materials should be disseminated – anonymously - in places frequented by Moldovans in a particular country.**

HIV/AIDS and STIs are taboo subjects within the communication among peers and family members. Although most of the respondents already got information on HIV/AIDS in

Moldova, they stated to need more information to protect themselves effectively. They would like to have more information on these subjects through mass media channels – in Moldova and abroad - such as TV, radio and newspapers. **Mass media campaigns on HIV/AIDS and STI should focus not only on basic information but also on the wrong beliefs of transmission ways so as to reduce irrational fears and insecurities. This would be also a step towards the reduction of discrimination of PLWHA.**

Many respondents stated to have several sexual partners, especially the ones between 15 and 29 years old. Concerning destination countries, especially the respondents that travel to CIS countries state to have more than one sexual partner. It is striking that most of the respondents were not able to give information about the risk exposure of their partners outside the partnership, which shows a lack of communication. Our results state this lack not only within intimate sexual partnerships but also among peers and family members. **This prevention hindering communication pattern is unfortunately very common worldwide. “To break the silence” is one of the biggest efforts in intercommunicative HIV and STI prevention. Therefore projects should be implemented to raise the acceptance of open communication on the subject, like e.g. the German “AIDS circuit” or using Moldovans “stars” (famous people) as role models.**<sup>33</sup>

The already mentioned lack of intimate partner communication and a stated low condom use may point to (often) exposure to risk situations. Condoms are largely seen as a mean of disease protection and not as an anti-conceptive measure, consequently the respondents do not make use of them when they don't feel at risk. **A public campaign to raise the acceptance of condoms might be helpful.**

The subject of HIV-test-counselling could not be handled in this survey in the depth that it requires, opening the field for further and detailed investigation on this particular subject. Nevertheless, we know that the testing rate is not low in Moldova, and we assume that the tests in Moldova were not guided by adequate counselling offers, not following the VCT recommendations of the WHO. But what we do know through other surveys is that quality, setting and extent of the test counselling need to be improved in most European countries. **Test counselling plays an important role within the frame of prevention because it is a unique situation in which a person who might have been at risk of HIV/AIDS or STIs is open for face-to-face individual risk reduction counselling.** In this survey, HIV test activ-

---

<sup>33</sup> See annex for more examples: Steffan E. , Sokolowski, S: Reaching migrants: information strategies in: Hughes,J.et al (2004)

ity correlates with the level of knowledge of HIV/AIDS and the subjective fears of getting HIV infected. Both aspects should be considered in the frame of prevention and testing service provisions regarding HIV. **HIV Test counselling should be able to take the already existing knowledge of the patient as a starting point of the counselling and be able to give attention to possible fears that might influence negatively the individual risk concept.**

## 7 Bibliography

- Atkinson, R. et. Al, 2001: Accessing Hidden and Hard-to-Reach Populations: Snowball Research Strategies. In: Social Research Update, Department of Sociology, University of Surrey.
- Bellis, M et. al, 2007: Strategic use of substances by young people for sex and related behaviours and its implications for sexual health; a cross sectional study in nine European countries. Not yet published.
- BzgA, 2006: AIDS im öffentlichen Bewusstsein der Bundesrepublik Deutschland.
- European Commission, 2006."AIDS Prevention." Special Eurobarometer 240, Wave 64.1 & 64.3. Brussels: [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_240\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_240_en.pdf)
- Hughes, J. et. Al.(Eds.), 2004 : Migrant-Friendly Health Services and HIV/STI prevention: A Handbook for Health Practitioners, Managers and Policy Planners. Veneto Regional Centre for Health Promotion: Verona
- IOM, 2006: "Migration and Remittances in Moldova Report" CBS-AXA Consultancy
- IREFREA (2007): The Nightlife survey, not published yet
- Rispel, L.; Letlape, L.; Metcalf, C., 2006: Education sector responses to HIV and AIDS: Learning from good practices in Africa:  
<http://www.adeanet.org/downloadcenter/education%20HIV-AIDS%20doc.pdf>
- SPI Forschung, 2005: HIV/AIDS und Migranten/innen, Gesundheitsrisiken, soziale Lage und Angebote einschlägiger Dienste. BMGS, Bonn
- SPI Forschung, 2007: KAB survey „MSM“ in the frame of the BORDERNET project.  
[www.bordernet.eu](http://www.bordernet.eu)
- UNAIDS Best Practice Collection, 2001: Population Mobility and AIDS, UNAIDS Technical Update: [data.unaids.org/Publications/IRC-pub02/JC513-PopMob-TU\\_en.pdf](http://data.unaids.org/Publications/IRC-pub02/JC513-PopMob-TU_en.pdf)
- UNAIDS, 2005 (2) Informative bulletin regarding the HIV/AIDS situation in 2004 and measures of control for 2005 in Moldova: <http://www.aids.md/information/library/d482/>
- UNAIDS, 2005: AIDS Epidemic update. [data.unaids.org/Publications/IRC-pub06/epi\\_update2005\\_en.pdf](http://data.unaids.org/Publications/IRC-pub06/epi_update2005_en.pdf)
- UNAIDS, 2006: Informative bulletin regarding the HIV/AIDS situation in Moldova in 2005, AIDS Centre: [www.aids.md/information/library/d666/](http://www.aids.md/information/library/d666/)
- UNAIDS/WHO, 2004 Policy Statement on HIV Testing:  
[www.who.int/rpc/research\\_ethics/hivtestingpolicy](http://www.who.int/rpc/research_ethics/hivtestingpolicy)
- UNGASS, 2006: Progress report 2003-2005, Chisinau
- WHO, 2005: Global tuberculosis Control Report: [www.searo.who.int/LinkFiles/Reports\\_tb-report05.pdf](http://www.searo.who.int/LinkFiles/Reports_tb-report05.pdf)

## **8 Annex**

## Reaching migrants: information strategies

### 4.1 INTRODUCTION

"Migrants should not be seen as a single target group but as a heterogeneous part of the population with special needs due to their socially and often economically disadvantaged situation. Only well-informed people are able to protect themselves and others from HIV/AIDS infection."

Source: Petra Narimani, 1988<sup>34</sup>

In this short but eloquent statement, Petra Narimani, a well known activist in the field of migration and health in Germany for many years, puts her finger on the central dilemma in providing migrant-specific prevention measures. She observes that *"Migrants should not be seen as a single target group but as a heterogeneous part of the population"*. Yes, we agree, the specific situation of migrants could be defined as that of non-nationals who are connected by and through a different legal and cultural background, one which is different from the background of the host country nationals. Yet despite this, migrants in general are not a specific target group, but rather *"a heterogeneous part of the population"*. Yes, we agree again! So couldn't migrants then be reached by mass media campaigns addressing the population in general? Many activists, non-governmental organisations (NGOs) and professionals working directly in the field of migrants' health, and also the results of our survey, would dispute this. It is a paradox that on the one hand, more culturally and linguistically specific materials are needed, but on the other hand this is not enough.

Many migrants are not sufficiently reached by mass media campaigns because they have *"special needs due to their socially and often economically disadvantaged situation"*, as Petra Narimani puts it. So what is to be done? How can we create specific information for a heterogeneous part of the population? And moreover, one which is *"a heterogeneous part of the population with special needs due to their [migrants'] socially and often economically disadvantaged situation?"* How can we focus on these special needs without concentrating on specific groups and yet at the same time not forgetting the differences?

This chapter endeavours to shed light on these issues and to offer some answers. We start by setting out some selected research findings from our quantitative survey in order to show which channels of information are the ones preferred by the migrants interviewed and what the current needs are in terms of information about the transmission of HIV/AIDS and availability of testing. The chapter then looks more closely at various aspects of migrant-specific information strategies, including planning and assessment, the need to take account of the structural context (social, economic, political and legal factors) and the design of tools and materials. It goes on to discuss two essential components of any information strategy addressed to migrant communities: peer education and community networking. The chapter concludes by summarising key suggestions and giving additional bibliographic references and contact details of relevant organisations.

---

<sup>34</sup> Narimani, Petra, 1998: *Zur Notwendigkeit kulturspezifischer Angebote in der HIV/AIDS-Primärprävention*. In: *Handbuch Migration für AIDS-Hilfen, AIDS-Fachkräfte und andere im AIDS-Bereich Tätige*. DAH, Berlin.

## 4.2 THE RESEARCH FINDINGS

### 4.2.1 Sources of information on health and social services

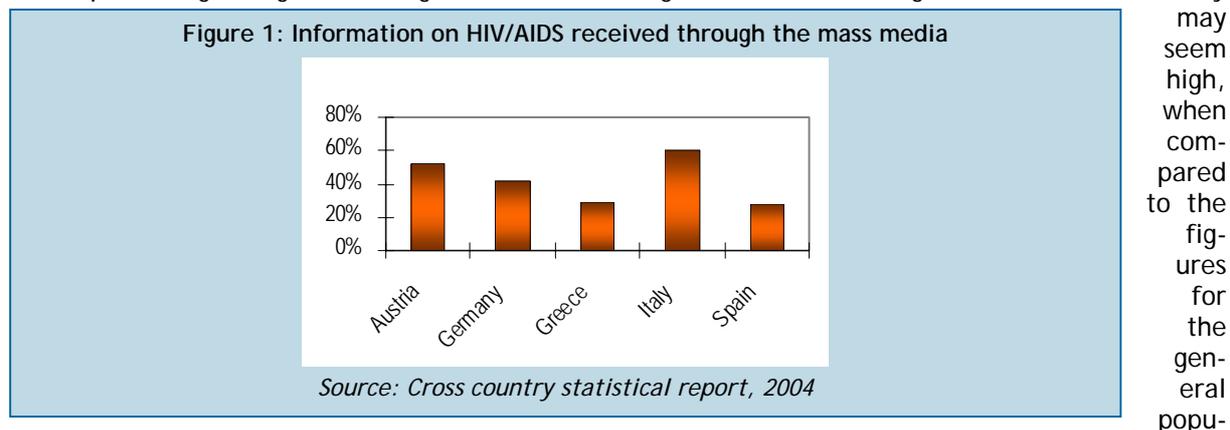
In all the project countries, the majority of the migrants who took part in our survey said they had received information about social and health care facilities and services first and foremost through family and friends, a fact which underscores the importance of the direct social environment.<sup>35</sup> This potential has to be taken into account at all levels of information dissemination.

In Austria, information about health services was most frequently gained through friends (67%) and family/partner (38%). In the case of the social services, friends were the most important source of information for 78% of the respondents, followed by NGOs (38%) and family members or partners (35%).<sup>36</sup> The German results are very similar: friends and family were the main source of information on both the health services (51,5% and 38,8% respectively) and the social services (56.5% and 29.2% respectively). The same was also true in the other project countries.

### 4.2.2 Sources of information about HIV/AIDS

In contrast to family and friends as the primary source of information about the health and social services in general, the main source of information about HIV/AIDS in all five project countries was not the close social environment but the mass media (see Figure 1 below).<sup>37</sup>

These percentages might at first glance be misleading because even though in some countries they



may seem high, when compared to the figures for the general population they are relatively low.

Given that in Germany, 91% of the national population was reached by the messages in the national AIDS prevention campaign in the German mass media,<sup>38</sup> the percentage of migrants (41%) reached through the same intervention is extremely low - less than half compared to the general population. This result provides a first hint that in Germany, the information channels for the general population may be different from those for the migrants we interviewed.

### 4.2.3 Knowledge of HIV/AIDS and information needs

From the analysis of the survey findings, Germany is the country with the highest percentage of migrants who said they had received information in Germany in their mother tongue or in a language that they understood well (54.4% of interviewees). Figures were less than half this in the other project countries: Greece 25%, Italy 23.4%, Spain 19.5%, Austria 17.8%. However, this fact does not automatically mean that the migrant population in Germany is better informed about

<sup>35</sup> The main sources of information on health were: friends, community or religious representatives (71.5%) and family/partner 28.3%. 19.5% said they had received information directly from health and social services (multiple response question).

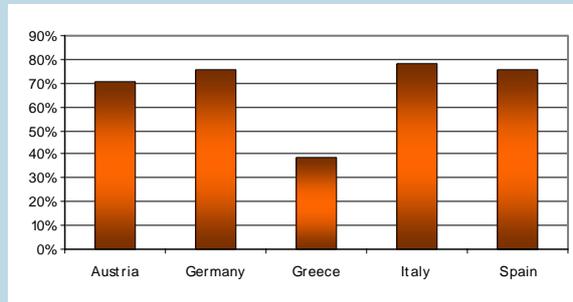
<sup>36</sup> The figures contained in this and the following paragraphs are taken from the national and cross-country statistical reports, summarised in Appendix 1 and available on-line from the organisations which participated in the research project.

<sup>37</sup> In some countries, for example Italy, many immigrants said they had received most information from the media in their home country or, in the case of English-speakers, from satellite TV stations in the host country, rather than from campaigns in the national host country media.

<sup>38</sup> BZgA (2004): *Aids im öffentlichen Bewusstsein der Bundesrepublik Deutschland 2003*, Köln.

HIV/AIDS than migrants in the other countries. We can see the discrepancy in the answers to the question concerning migrants' perception of their own knowledge of HIV/AIDS - see Figure 2 below.

Figure 2: Perceived knowledge of HIV/AIDS



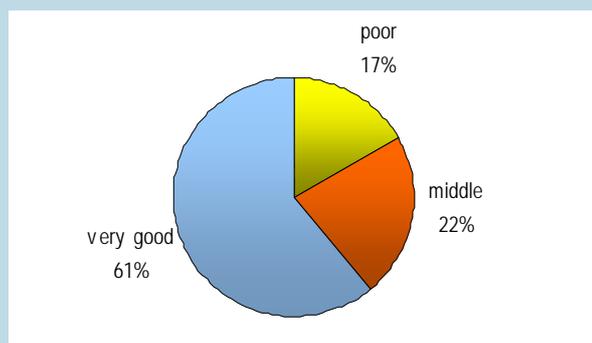
Source: Cross country statistical report, 2004

These data need to be interpreted very carefully: it could be seen as a sign of the success of prevention campaigns for migrants in some countries, but if we scrape beneath the surface, the reality is very different. Even though in Germany 75.6% of the migrants interviewed stated that they knew what HIV/AIDS was, when asked about the means of transmission the results look very different (see Figure 3 below).

The basic level of knowledge of the means of transmission and prevention of HIV/AIDS among the general population in Germany is almost 100% (99%),<sup>39</sup> whereas among the respondents of our research, the quota was "only" 61%.

When asked if they needed more information on HIV/AIDS, migrants' responses ranged from 81.5% in Italy to 51.4% in Austria. The expressed need for more information in the whole sample was highest among North Africans (86.2%) and people from the Middle East (74.7%). When immigrants were

Figure 3: Knowledge of the means of HIV/AIDS transmission among migrants in Germany



Source: German National Statistical Report, 2004

asked about what would be the best way to receive information on HIV/AIDS, the first and most common response was the mass media, showing how important it is to include the mass media in any overall information and prevention strategy for migrants.<sup>40</sup>

<sup>39</sup> Id.

<sup>40</sup> The preferred channels of information were: television 55.4%, health professionals 48.3%, schools 41.1% and written information 40.2% (multiple response question).

These figures provide evidence, once again, that the existing strategies and sources of information for migrants are less efficient than those addressing society in general. As suggested above, the information channels in migrant communities seem to be different from the channels for reaching the general population. This can also be seen also from our data: chlamydia, the most common STI in Germany (and probably in Europe) among young adults, was better known by the respondents of our study than by the general population in Germany. Almost 30% of respondents said they knew about this STI (Italy 35%, Spain 20.6%, Austria 22%), in contrast to the general population in Germany, of whom only 1% could name this disease.<sup>41</sup> Why? The answer is simple: most of the respondents had already received this kind of specific information in their home countries, and in Germany (and all the other project countries), as mentioned above, “word of mouth” - other people from the community (family and friends) - is the main source of information.

Knowledge of the right to an anonymous and free HIV test in the 5 project countries was as follows: Spain 45.6%, Italy 44.9%, Austria 33.6%, Germany 24% and Greece 16.5%. Among the immigrant groups, Latin Americans had the highest percentage of correct knowledge (52.6%) followed by Sub-Saharan Africans (40.2%).

### 4.3 Information strategies

#### 4.3.1 Planning and assessment

As emerged throughout our research project in all five countries, it is important to acknowledge the need to produce information that accurately and appropriately informs migrants: (a) of their right to access the health and social system; (b) about HIV/AIDS and STIs; and (c) of the possibility of free HIV testing and the possibility of treatment, whilst simultaneously dissipating fears and distrust among those who are irregular or live in precarious conditions.

A preliminary communications assessment has to be made to ensure the effectiveness of an information campaign/material. The “rapid assessment process” is recommended for developing effective communication strategies for migrants.<sup>42</sup> The objectives of this assessment are to:

- Synthesise and analyse existing HIV/AIDS social and behavioural related research data among the general public and migrants;
- Assess HIV/AIDS communication related obstacles and opportunities (as experienced by the migrants themselves) ;
- Collect lessons learned during the implementation of HIV/AIDS communication related activities over the last 2 to 3 years; and
- Identify political, institutional and societal entry points for strengthening HIV/AIDS related communication with and for migrants.

One of the most important principles of rapid assessment methods is “triangulation”. This involves obtaining data from a variety of sources at the same time, so it becomes possible to check the validity and representative nature of the information collected. This method allows checking for contradictions, conflicts and consensus between different data sources before conclusions are reached.

#### Planning an information campaign: some key questions<sup>43</sup>

- Information need: what are the main misconceptions?
- Target group size and location: how many people are we trying to reach and where are they?

<sup>41</sup> See above BZgA (2004).

<sup>42</sup> See for example rapid assessment (RAR) guide on psychoactive substance use and EVYP, WHO/UNICEF, 1998.

<sup>43</sup> Müller, Wolfgang: *HIV-Prävention für MigrantInnen durch die BzGA: Konzepte, Erfahrungen, Status, Ausblick*. In: Fachtagungsreihe *Gesund in eigener Verantwortung?* [www.dhmd.de](http://www.dhmd.de)

- Which cultural characteristics have to be considered?
- How explicitly can issues such as sexuality, sexual practices and contraceptives/condoms be addressed or visualised?
- Which media reaches the target group best: written leaflets, pictograms, photo-stories, comics, posters, videos or on-line and other new forms of media?
- What is the importance of personal, face-to-face communication for the group?
- Are there any meeting points of this specific group? What are they?
- Does this group have an established association? What kind?
- Are there any forms of ethnic media (radio or television channels or programmes, newspapers) which could be involved?

From the very outset of developing a prevention strategy, the extent of available resources should be taken into account, determining whether it makes sense to invest efforts in developing yet another glossy and attractive brochure if it will be only distributed without being accompanied by counselling and support. As one migrant put it: "*It is a shame to waste all that nice money*" and "*No-one will read it anyway.*"<sup>44</sup>

#### 4.3.2 Structural context

The effectiveness of a strategy is not only a question of language, but depends on cultural and, even more importantly, structural issues. Anyone who wants to create lasting behaviour change, by assisting a person in internalising information messages, must be prepared to remain closely in touch with the situation on the ground and the environment in which the behaviour takes place.<sup>45</sup> Information campaigns cannot be divorced from the structural components (economic, social, cultural, legal etc.) of the target community's environment. The context in which people live (society, culture and family) is as important as their knowledge and attitudes regarding what they actually do.<sup>46</sup> Strategies to prevent the spread of HIV/AIDS and STIs should attempt to improve the social and political context in which migrant groups live in order to enable the individual to better manage his or her specific life-style and risks.

The City of Munich (Germany) has commissioned a survey to investigate the living conditions, including health care, of undocumented migrants in Munich. The City has committed itself to following up the recommendations drawn up.<sup>47</sup>

The director of the Swiss National AIDS Campaign, has recently suggested distributing a leaflet containing basic information on the Swiss health care structure to all foreigners at the moment of entering the country, independent of the purpose of entry.<sup>48</sup>

The government of Germany has produced a handbook called "Handbook Germany" in six languages, designed to help migrants to find their feet in private and public life in Germany. Aspects of German social and political life are explained, together with information on access to the health care system.<sup>49</sup>

In Andalucia (Spain), the Regional Health Authority has also produced a manual in six languages explaining immigrants' entitlement to public medical assistance, how the NHS works and how to gain access, and available services and programmes in primary and specialised care.

<sup>44</sup> See above Narimani, Petra, 1998.

<sup>45</sup> Etgeton, Stefan (2000): *Structural Prevention. The basis for a critical approach to health*. In: Rosenbrock, Rolf; Wright, Michael (Eds.): *Partnership and Pragmatism*. Routledge, London.

<sup>46</sup> Ibid.

<sup>47</sup> The survey "*Dass Sie uns nicht vergessen...*" - *Menschen in der Illegalität in München* by Philipp Anderson (2003) can be ordered from the Service for intercultural cooperation, Department of Social Affairs, City Council of Munich [yasemin.uzunk@muenchen.de](mailto:yasemin.uzunk@muenchen.de).

<sup>48</sup> Staub, R. (2004): *Prävention - alte Probleme, neue Ideen?* in: Hoffmann/Jäger(ed.): *HIV/AIDS: Bedrohungen und Lösungen, Chancen und Herausforderungen*. For more information see also: Bundesamt für Gesundheit.

<sup>49</sup> *Ein Handbuch für Deutschland - A Reader for Germany* is available free of charge in six languages: German, English, French, Russian, Spanish and Turkish. It can be obtained from: [www.handbuch-deutschland.de](http://www.handbuch-deutschland.de)

Successful prevention is therefore linked not only with health issues, but also structural ones, including the social and legal situation. Many migrants live in very difficult conditions created, for example, by the lack of legal status (this subject is addressed in Chapters 2 and 5). Approaches that take structural problems into account are needed as a matter of urgency (see Chapter 1 for recommendations on the general migrant-friendly health context).

### 4.3.3 Design of tools and materials

The design of information materials targeted to a migrant group has to take into account the way in which the group concerned is accustomed to receive information. Some migrant groups have a strong verbal tradition, which greatly influences the gathering and exchange of information. For these particular populations, written information alone is almost certainly not enough.

“You should introduce an element of humour, do things that make people laugh. In Africa there are comedians who do sketches on HIV transmission and prevention, and people like them.”

*Sub-Saharan African male migrant, Focus Group, Verona*

To be able to reach the various migrant populations accurately, a high level of differentiation is required. Techniques and materials should be differentiated according to the social situation (legal status and economic situation), the gender-specific aspects in the respective groups, the cultural values and social class aspects.<sup>50</sup> These materials need to be produced in such a way that they can be easily and quickly adapted to local needs.

In order to provide information in an effective way, we must stress once again that it is necessary to involve the migrant target group from the beginning of the process, not only on the practical delivery level, but also on the decision-making level and in the development of strategies to ensure that materials are culturally appropriate. Information materials should therefore be created, developed and evaluated together with representatives of the various migrant communities by means of workshops, street work contacts or other kinds of regular meetings. In this way, the materials also become an important didactic tool for use during the training of peer educators. At the same time, they serve to empower through raising awareness and increasing solidarity within and among the migrant groups.<sup>51</sup>

Many things can be said about the need for culturally sensitive information campaigns, and this is of course of paramount importance (we refer again to Chapter 3 on cultural sensitivity). However, what is needed most is not new concepts for new campaigns, but the creation of a platform of awareness that has the effect of “ringing a bell” every time the issue is brought up on a poster.

“Information campaigns should help create a situation where using a condom is just as self-explanatory as brushing your teeth”.

*Doctor from the Austrian AIDSHILFE organization, Workshop with service providers, Vienna*

The German mass media campaign based on the slogan “Mach´s mit” (a play on words, meaning both “Do it with” and “Join in”) has been very successful in raising awareness by “ringing a bell”. In this campaign very short slogans, sometimes funny, sometimes cheeky, sometimes serious, have been enormously successful in raising awareness about HIV/AIDS in the general population, but have not been able to reach the different migrant populations to the same extent, as already pointed out above. The slogans of this campaign are in German and English only. Just as an example of how well slogans in different languages work, in the focus groups with migrants in the qualitative part of our research, many participants could literally quote every slogan they had seen in their mother tongue concerning totally different topics (one example given was that of slogans for a project for involun-

<sup>50</sup> Müller, Wolfgang: *HIV-Prävention für MigrantInnen durch die BzGA: Konzepte, Erfahrungen, Status, Ausblick*. In: Fachtagungsreihe *Gesund in eigener Verantwortung?* [www.dhmd.de](http://www.dhmd.de)

<sup>51</sup> See for example the TAMPEP information for sex workers, also discussed in Chapter 5 [www.tampep.com](http://www.tampep.com)

tarily pregnant teenagers). This is a valuable piece of information, showing us that one effective approach to raising awareness could be to use simple slogans in different languages that work as “eye-catchers” for the different ethnic groups.

In Granada, the local STI clinic has produced stickers with contact information and phone numbers to stick in places frequented by young people such as bars, restaurants, discos and university toilets. This simple intervention has proved effective and successful with the general youth population, and during the Spanish workshop with providers it was proposed that the stickers be translated and stuck in places frequently used by immigrants, such as NGOs, certain restaurants and bars, shelters and hostels.

Printed materials are of course essential instruments for raising awareness of issues and clarifying specific questions. However, it is crucial to understand - and even more important to accept (and act accordingly) - that the mere distribution of leaflets is not enough: a comprehensive approach is needed. It is absolutely fundamental to draw on the resources of the target population group to clarify doubts, answer additional questions, dissipate possible fears and above all, ensure that information is comprehensible, relevant and culturally acceptable. Two key ways of doing this are through peer education and community networking, discussed below.

#### 4.4 Peer Education

The data collected from all five countries shows a pressing need to promote information that effectively communicates to migrants their right of access to health and social services. In order to do this, information needs to be made available where these groups live, work and spend their free time. Outreach work has been found to be most successful in communicating with groups who are otherwise hard to reach (again, see also Chapters 3 and 5).<sup>52</sup>

Migrants often find it difficult to obtain clear and correct information on certain health-related issues such as access to health and social services, sexuality, substance use, reproductive health, HIV/AIDS and STIs. As already mentioned at the beginning of this chapter, the underlying reasons are not only due to language problems, but also to cultural and especially structural ones. In order to tackle these concerns effectively, it is crucial to employ cultural mediators and peer educators to translate language codes and interpret cultural values.

Peer education has been proven to be extremely effective because it is a dialogue between equals. It involves members of a particular group educating others of the same group. A successful peer educator can emphasise and understand the emotions, thoughts, feelings, language and culture of the particular group and therefore relate better to it.

Numerous studies have demonstrated the effectiveness of peer education programmes in health promotion and prevention of HIV/AIDS.<sup>53</sup> The importance of peer support and information was also clear from our research on migrants. This important fact indicates that peer education programmes on a large scale would be very successful in facilitating the access of migrants to the health and social services, as well as in disseminating information on HIV/AIDS through a combination of personal contact, printed information and media campaigns. Peer education would obviously be very successful in communities where word-of-mouth communication is a very important source of information, to try to dissipate fears and prejudices, even between the different ethnic groups.

“There’s something that’s really important for us Nigerians (...) we have a lot of trust in information given by word of mouth. For example, someone tells you the pill is bad for you, if you take it you can’t have children. Women believe more in what their friends say, and this way messages by the doctor could also spread rapidly.”

*Female Nigerian cultural mediator, Focus Group, Verona*

<sup>52</sup> Luger, Lisa (1998): *HIV/AIDS prevention and “class” and socio-economic related factors of risk of HIV infection*. WZB, Berlin.

<sup>53</sup> See for example [www.unescap.org](http://www.unescap.org)

It is very important to be aware of some prerequisites if the use of peer education is to be used to its full potential:

- Peer educators should be accepted by, connected to or embedded in community networks;
- The prejudices and taboos of the specific community should be discussed in the framework of community networking;
- Specific communications structures of the communities should be taken into account;
- The peer educators have to be carefully selected and trained, and have good knowledge of both the health system and HIV/AIDS/STIs;
- Peer educators need to be non-judgmental and open minded.

In this context, it was suggested by immigrants interviewed that famous figures from the different communities could act as role-models, an approach that could also be successful for youth-friendly campaigns. This could also be valuable in dissipating the stigma associated with HIV/AIDS. A number of immigrants, particularly from Sub-Saharan African countries, felt that the host country media projected only a negative image of their countries and communities.

The combination of specifically developed written information and well-trained and integrated peer educators would ensure that the language and messages used are relevant, appropriate and reach their target.

**MiMi (Mit Migranten für Migranten):** Interkulturelle Gesundheit in Niedersachsen und Nordrhein Westfalen (Intercultural Health in the Federal States of Lower Saxony and Nordrhein Westfalen). MiMi trains migrants to become intercultural health mediators, introducing them to health promotion and prevention issues. After the training, the migrants organise information events independently in the different communities. This promotes empowerment of migrant populations.

[ethno@onlinehome.de](mailto:ethno@onlinehome.de)

#### 4.5 Community Networking and policy ADVOCACY

There have been many initiatives that have dealt with the issue of health prevention and migration, but not all have been truly successful. These initiatives have come from the most diverse levels, leaving the impression that they have been working parallel to each other and not together. Only a joint and co-ordinated effort by governments, local health authorities, health professionals, NGOs and migrants themselves can be successful. A number of networks link such efforts throughout European Countries, such as the European Union-funded AIDS and Mobility Project.<sup>54</sup>

The AIDS and Mobility Project launched pilot projects for migrants and ethnic minorities in its early years, and now serves as a co-ordinating centre bringing together national focal points from 14 European countries. It commissions case studies and produces background documents, organises conferences, seminars and networking meetings of people working in the field and serves as a documentation service, increasingly through the internet.

[www.aidsmobility.org](http://www.aidsmobility.org)

As has already been mentioned (see Chapter 3), grass-roots, community-based organisations (CBOs) need to be nurtured and supported if they are to reach their full potential in terms of role and target. In our survey, it emerged that only 16.3% of the whole immigrant sample participated in some form of ethnic association (cultural, religious or solidarity/self-help). In some areas there were none, or they had become “dormant” owing to lack of human resources to keep them active. The Sub-Saharan African community appeared to be the best organised in all countries, with 40.4% of participants saying that they participated in an association. 23.4% of immigrants from North Africa said that they participated in community associations, mostly of a cultural nature.

---

<sup>54</sup> See Mary Haour-Knipe: *Migration and HIV/AIDS in Europe*, AIDS Infothèque, Sida Info Doc Suisse 5/00, October 2000, pp.4-14.

It is very important to focus not only on the grass-roots level, but also to strengthen policy and advocacy work at regional and national level. Immigrants have the right to speak out in defence of their needs, and should be assisted where necessary in advocating for their health and other rights. An example of good practice here is the African HIV Policy Network (AHPN) in the UK (see box below).<sup>55</sup> Joint projects could be a good answer: one side would provide the institutional and epidemiological knowledge and experience (government, NGOs) and the other side the cultural knowledge (CBOs).

#### *African HIV Policy Network (UK)*

This is a national organisation that focuses on policy and lobbying only, not direct service delivery, and serves as the conduit for the transmission of information from the grass-root to policy makers and vice-versa. It also serves as a national forum and voice for African communities.

[www.ahpn.org](http://www.ahpn.org)

## **4.6 Conclusions and suggestions**

We conclude by summarising a number of key points which have emerged in this chapter:

- *Target group*: the term “migrants” does not denote a specific target group in itself, but rather a set of heterogeneous groups which are different from the host country population;
- *Information campaigns*: information campaigns must be part of a strategy which addresses underlying structural issues (economic and social determinants of health) and involves representatives of the targeted communities at all stages;
- *Information materials and interpersonal counselling*: information materials should be developed in cooperation with the target communities and used in conjunction with interpersonal counselling through counselling centres, outreach work and peer education programmes;
- *HIV/AIDS/STI prevention*: interventions need to be based on sound knowledge of the cultural, social and psychosocial conditions of migrants;
- *Distribution strategies*: HIV/AIDS/STI information needs to be included in general information on the right to health care and how the NHS works, and distributed inter alia in places frequented by immigrants, local media and at border crossing points, for example. Migrants use channels of information which may be different from those used to reach the local population;
- *Mass media*: national awareness campaigns should use short, catchy slogans translated into all the relevant languages (including the host country language) with the aim of “ringing a bell” in people’s minds;
- *Strengthening networks of CBOs*: community-based organisations for immigrants need to be set up, strengthened and enabled to act in partnership with each other in order to develop and disseminate information in their communities, interact with health services and undertake advocacy initiatives to influence policy.

## **4.7 Additional resources**

Excellent international webpage with practical information on health communication including HIV/AIDS/STI and many useful links:

[www.comminit.com](http://www.comminit.com)

---

<sup>55</sup> See Dr. Max Sesay (2004), Chief Executive of the AHPN. In: *HIV/AIDS-Prävention für Afrikanerinnen und Afrikaner in Berlin*, Dokumentation der Fachtagung.

*Health-related Resources for Black and Minority Ethnic Groups*, Health Education Authority, London, 1994. Excellent resource by and for people from ethnic minorities, addressing HIV/AIDS and many other health issues.

[www.hda-online.org.uk/Documents/healthres\\_black.pdf](http://www.hda-online.org.uk/Documents/healthres_black.pdf)

*Partnership and Pragmatism. Germany's Response to AIDS*, Rosenbrock, Rolf; Wright, Michael (Eds.), 2000, Routledge, London

*Gut versorgt? Migrantinnen und Migranten im Gesundheits- und Sozialwesen*. Mabuse Verlag: Börde, Theda; David, Matthias, 2003: Frankfurt a.M.

*AIDS-Bekämpfung in Deutschland*. Bundesministerium für Gesundheit, 1996: BMG: Bonn

*AIDS im öffentlichen Bundeszentrale für gesundheitliche Aufklärung*, 2004: Bewusstsein der Bundesrepublik Deutschland 2003. BZgA, Köln

*Fachkräfte und andere im AIDS: Handbuch Migration für AIDS-Hilfen*, AIDS-Bereich Tätige, 1998. Deutsche AIDS Hilfe: Berlin.

*Wegweiser Migration HIV und AIDS*, Frankfurt/Main, Cochem: Bremm Verlag, Herkommer, H. 2000

*HIV und AIDS*, Deutsche AIDS-Hilfe, 2001: a handbook for those affected by HIV/AIDS and their counsellors, with basic information on HIV/AIDS in six languages.

Information and explanations on migration and health for everyone working in the field.

[www.infodienst.bzga.de](http://www.infodienst.bzga.de)

On-line health guidelines for migrants in Germany, as well as telephone counselling and information.

[www.patienteninfo-berlin.de](http://www.patienteninfo-berlin.de)

*AIDS-Information für Ausländer und Ausländerinnen - ein Projekt der Steirischen AIDS-Hilfe 1995-1997* AIDS Hilfe Styria: AIDS Information for foreigners - a project description by the Stryrian AIDS Help organization.

*Sozial benachteiligte Gruppen - MultiplikatorInnenschulung: Gesundheitsförderung von sozial benachteiligten Gruppen*. 2. Österr. Gesundheitsförderungskonferenz *Partizipative Methoden in der Gesundheitsförderung*, Baldaszti, E.: Innsbruck. Fonds Gesundes Österreich, 2000

F.E.M. Süd Frauengesundheitszentrum: a health care centre for women, parents and girls offering health education and counselling in different migrant languages. The centre is a WHO model project in Vienna, Austria.

[www.fem.at](http://www.fem.at)

M.E.N : A health care centre for men offering health education and counselling in different migrant languages. The centre is a WHO model project in Vienna, Austria.

[www.men-center.at](http://www.men-center.at)

Omega: Health care centre for migrants in Graz, Austria.

[www.omega-graz.at/homeEN.html](http://www.omega-graz.at/homeEN.html)