



Photo: Shunya, 2005

Overcoming barriers to delivery of effective health services for fisherfolk

Janet Seeley & Edward Allison

The mobility of fishermen and fish traders, long absences from home, cash incomes in the context of poverty, gender inequality, easy availability of commercial sex in ports and at landing stations, and a masculine culture that condones or encourages casual sexual encounters have been highlighted as increasing vulnerability to infection. These same life-style characteristics of fishermen also affect attitudes and access to treatment.

A study in Thailand among 818 fishermen of Thai, Khmer and Burmese origin found that access to health care was difficult for fishermen not only while they were at sea, but also when they came on shore. Because of their mobility, they do not know what services are available in the places they stay. Difficulties in accessing health-care services were even greater for non-Thai fishermen, because of language and cultural barriers or their status as illegal workers in Thailand.¹

Either as sex workers, girl-friends, partners or as wives, women in developing countries' fishing communities that have high HIV and AIDS prevalences are generally in a subordinate social position to men. This limits their ability, for example, to negotiate for the use of condoms for sex but also limits their access to treatment and care.

Access to HIV/AIDS testing and treatment facilities may be difficult for mobile populations. Mobility coupled with irregular working hours poses an even greater hindrance to adherence to treatment regimes. There is also a problem for poor patients who cannot afford the time off from wage-earning to attend appointments, particularly because of the long wait for treatment in busy health centres. A study in Uganda, for example, found that the distance from hospitals of the 21 fishing communities studied was up to 67 km and the journey could take up to six hours. A fisherman told the researchers: "I went to be tested but they said when I got there that it was the wrong day. I can't fish for another day, and I don't have 3000 shillings to go again."²

Adherence concerns

Possible failure to take all doses of antiretroviral drugs is of concern because adherence to therapy is essential for successful management of HIV. The WHO guidelines, *Scaling up antiretroviral therapy in resource-limited settings* (2004), recommend treatment for people diagnosed with AIDS and people with HIV who have a CD4 cell count below 200. Because of concerns about the ability of health services to meet demand as well as ensure adherence, further criteria such as catchment area to define the population served and assessments of a person's ability to keep in regular contact with the antiretroviral therapy (ART) provider have been introduced in some places.

Criteria based on length of residence, a minimum of three months, and ability to keep booked appointments, were instituted because of the highly mobile nature of the population using the Médecins Sans Frontières (MSF) programme clinic in Khayelitsha (South Africa). In addition, the WHO guidelines suggest "continuous involvement of relatives, friends and/or community support personnel." People who are mobile cannot keep regular appointments, or fulfil residence

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requirements and they do not always have family and community members on hand to provide support. The high degree of mobility among fisherfolk can affect the nature of the communities in which they reside. Mamadou Baro, for example, observes that in Uganda "fishing communities tend to lack any form of resilience to AIDS impacts due to the lack of community initiative to offer counselling, support or health care."³

Fishing may require being out at sea or on a lake for long periods of time, which means meals may be scanty and irregular, and keeping

Missing out on 3 by 5?

- The WHO/UNAIDS '3 by 5 initiative' aims to provide life-long antiretroviral therapy to three million people living with HIV/AIDS in poor countries by the end of 2005.
- At the end of 2004 only 12% of the 5.8 million people currently needing treatment in developing and transitional countries had access to antiretroviral therapy. Even if the target of three million is reached by the end of 2005, that is still only half of those who need the therapy.
- Among the nearly three million 'left out' will be many mobile workers, like fisherfolk, because the same circumstances and activities that may put someone at risk of infection also affect people's access to treatment, care and support.

Source: *Impact of HIV/AIDS on fishing communities – Policies to support livelihoods, rural development and public health* (see Note 3)

to any form of medication schedule will be hard. While ART medications like Combivir and Nevirapine do not need to be taken with food it is recognised that without good nutrition people living with HIV/AIDS do not respond so well to drug treatment and may be prone to diseases like tuberculosis. So it is not only a matter of maintaining compliance in taking medications; a lifestyle that involves irregular meals and poor diet may impair the effectiveness of treatment. Consumption of alcohol, as a part of that diet, may also be problematic.

Likely to be left out

For mobile workers, and remote rural communities, the inequities in access to services are a continuing fact of life. Issues of access to care and the mitigation of the impact of HIV/AIDS are just the latest among the challenges of making a livelihood for many such workers. For settled populations there have been recent successes in supplying ART in resource-poor settings. Well-known examples are the services provided by the HIV Equity Initiative in Haiti (see the article by Arachu Castro and Paul Farmer in this issue) and the Khayelitsha programme of MSF in South Africa. Considerable progress has been made in facilitating access to affordable treatment in sub-Saharan Africa and elsewhere. However, people with mobile livelihoods, such as fishermen, remain among those not only vulnerable to infection but also among those likely to be left out of the provision of care.

Long overlooked, the susceptibility of people in fishing communities to HIV infection and their vulnerability to AIDS-related illnesses is now being recognised and addressed. At global, regional and national levels, there is increasing recognition of the need to address HIV and AIDS among fisherfolk. The UN Food and Agriculture Organization (FAO) has recently produced a policy brief outlining the issue and suggesting ways to overcome the barriers to effective treatment and care outlined in this article.⁴ The Asian Development Bank is funding HIV prevention initiatives among fisherfolk and seafarers in the Mekong River basin area.

The UK Department for International Development (DFID) supports the government of Gujarat (India) in targeting populations at risk (including fisherfolk) with access to condoms and sexual health services. Numerous NGOs, often working in partnership with fisherfolk's socio-professional organizations, are providing prevention advice and livelihoods support, such as the Médecins Sans Frontières programme in Zambia that trains men who are too ill to fish in less physically demanding tasks, such as tailoring. In Uganda, it is the fisherfolk themselves who have lobbied government for support in HIV/AIDS prevention and care. In Congo, community theatre has been used as a means to raise awareness about HIV/AIDS and to challenge existing norms of behaviour that make people vulnerable. With appropriate external support, fisherfolk are beginning to find their own solutions to the AIDS crisis. ■

A more thorough discussion of the issues raised in this paper can be found in J. Seeley & E. Allison, HIV/AIDS in fishing communities: Challenges to delivering antiretroviral therapy to vulnerable groups. AIDS Care, 2005, 17 (6), p. 688-697: <http://taylorandfrancis.metapress.com> (free pdf, search on author)

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2. A. Entz, V. Prachuabmoh, F. van Griensven & V. Soskolne, STD history, self-treatment, and healthcare behaviours among fishermen in the Gulf of Thailand and the Andaman Sea. *Sexually Transmitted Infections*, 2001, 77, p. 436-440: <http://sti.bmjournals.com> (free pdf, search on author)
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