

# The HIV and Sex Work Collection

Innovative responses in Asia and the Pacific



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# Contents

|  |  |   |  |
|--|--|---|--|
| Acknowledgements<br>page 2   | Acronyms<br>page 4   | <br>Introduction<br>page 6   | <br>Part 1:<br>Lessons from<br>experience in the<br>Asia-Pacific region<br>page 11  |
| <br>Annex<br>page 30  | <br>Part 2:<br>Case study collection<br>page 35   | <br>Scaling up<br>HIV prevention<br>and Sexual and<br>Reproductive Health<br>among sex workers:<br>TOP, Myanmar<br>page 36 | <br>HIV prevention and<br>treatment services for<br>male and transgender<br>sex workers in Tianjin,<br>China:<br>Dark Blue<br>page 48                       |
| <br>Building community<br>and working with<br>police: SWING's<br>organizational<br>development journey<br>page 57 | <br>Reaching low-fee<br>sex workers with HIV and<br>STI services in Kunming,<br>China: experiences of the<br>Lily Women's Wellness<br>Centre<br>page 68 |    | <br>Sex worker-led HIV<br>treatment, care and<br>support programme:<br>VAMP Plus, India<br>page 78  |
|   | <br>USHA Multipurpose<br>Cooperative Society<br>page 85   | <br>Durjoy Nari Sangha:<br>addressing violence<br>against sex workers in<br>Bangladesh<br>page 94                        | <br>Protecting and<br>promoting the<br>human rights of<br>LGBTI communities in<br>Nepal: experiences of<br>Blue Diamond Society<br>page 106               |
| <br>Community-to-<br>community learning:<br>Experiences of the<br>Ashodaya Academy<br>page 116                  |   | <br>Including migrant<br>sex workers in<br>HIV programming:<br>EMPOWER Foundation<br>page 129                            | <br>Improving sex workers'<br>access to health, rights<br>and freedom from<br>violence: experiences<br>of Fiji's Survival<br>Advocacy Network<br>page 139 |

# Acronyms

|               |   |                    |  |
|---------------|---|--------------------|--|
| <b>ADB</b>    | Asian Development Bank                                  | <b>IUD</b>         | Intrauterine devices                             |
| <b>AEM</b>    | Asian Epidemic Model                                    | <b>KMRC</b>        | Kunming Red Cross Society                        |
| <b>APNSW</b>  | Asia-Pacific Network of Sex Workers                     | <b>KTV</b>         | Karaoke Chinese Style                            |
| <b>ART</b>    | Antiretroviral therapy                                  | <b>Kunming CDC</b> | Kunming Center for Disease Control               |
| <b>BCC</b>    | Behavior Change Communication                           | <b>LGBTI</b>       | Lesbian, Gay, Bisexual, Transgender and Intersex |
| <b>BDS</b>    | Blue Diamond Society, Nepal                             | <b>MAC</b>         | Malaysian AIDS Council                           |
| <b>CBO</b>    | Community-Based Organization                            | <b>MAP</b>         | Foundation-Migrant Assistance Program            |
| <b>CCM</b>    | Country Coordinating Mechanism                          | <b>NACO</b>        | National AIDS Control Organization               |
| <b>DiC</b>    | Drop In Centre  | <b>NACP-III</b>    | The Third National AIDS Control Program, India   |
| <b>DJ</b>     | Disc Jockey   | <b>NAP</b>         | National AIDS Program, Myanmar                   |
| <b>DMSC</b>   | Durbar Mahila Samanwaya Committee                       | <b>NCASC</b>       | National Center for AIDS and STD Control, Nepal  |
| <b>FHI360</b> | Family Health International 360                         | <b>NGO</b>         | Non-Governmental Organization                    |
| <b>GFATM</b>  | Global Fund to Fight for AIDS, Tuberculosis and Malaria | <b>NGU</b>         | Non-Gonococcal Urethritis                        |
| <b>HIV</b>    | Human Immunodeficiency Virus                            | <b>NFE</b>         | Non Formal Education                             |
| <b>IBBS</b>   | Integrated Biological and Behavioral Study              | <b>NHRC</b>        | National Human Rights Commission, Nepal          |
| <b>ICT</b>    | Information Communication Technology                    | <b>NMS</b>         | Nari Mukti Sangha                                |
| <b>IDU</b>    | Injecting Drug User                                     | <b>OI</b>          | Opportunistic Infection                          |
| <b>IEC</b>    | Information Education Communication                     | <b>PACT</b>        | Pact Thailand                                    |
| <b>I/NGO</b>  | International / Non-Governmental Organization           | <b>PE</b>          | Peer Educator                                    |
|               |   | <b>PHO</b>         | Public Health Office                             |

# Acronyms

|                  |  |                   |  |
|------------------|--|-------------------|--|
| <b>PIL</b>       | Public Interest Litigation   | <b>TNCA</b>       | Thai National Coalition on AIDS                              |
| <b>PMTCT</b>     | Preventing Mother to Child Transmission of HIV                             | <b>UNAIDS</b>     | Joint United Nations Programme on HIV/AIDS                   |
| <b>PRAN</b>      | Pacific Rainbow Advocacy Network, Fiji                                     | <b>UNGASS</b>     | United Nations General Assembly Special Session              |
| <b>PROTIRODH</b> | Promoting Rights of the Disadvantaged by Preventing Violence Against Women | <b>UNFPA APRO</b> | United Nations Population Fund, Asia-Pacific Regional Office |
| <b>PSI</b>       | Population Services International  | <b>USAID</b>      | United States Agency in Development                          |
| <b>RH</b>        | Reproductive Health  | <b>VAMP</b>       | Veshya Anyay Mukti Parishad, India                           |
| <b>RI</b>        | Research and Innovation  | <b>VCT</b>        | Voluntary Counselling and Testing                            |
| <b>SACS</b>      | State AIDS Control Society   | <b>WAC</b>        | Women's Action for Change, Fiji                              |
| <b>SAN</b>       | Survival Advocacy Network, Fiji  | <b>WHO</b>        | World Health Organization                                    |
| <b>SANGRAM</b>   | Sampada Gramin Mahila Sanstha, India                                       | <b>Yunnan PHB</b> | Yunnan Bureau of Public Health                               |
| <b>SHAKTI</b>    | Stopping HIV/AIDS Through Knowledge and Training Initiative                |                   |  |
| <b>SRH</b>       | Sexual Reproductive Health   |                   |  |
| <b>STI</b>       | Sexually Transmitted Infection   |                   |  |
| <b>SWHA</b>      | Sex Workers Living with HIV  |                   |  |
| <b>SWING</b>     | Service Workers in Group, Thailand   |                   |  |
| <b>TB</b>        | Tuberculosis   |                   |  |
| <b>TG</b>        | Transgendered Persons  |                   |  |
| <b>TGSW</b>      | Transgendered Sex Worker   |                   |  |
| <b>TI</b>        | Targeted Intervention  |                   |  |
| <b>TOP</b>       | Targeted Outreach Program, Myanmar   |                   |  |

# Introduction

## Context

A wealth of analysis exists on the nature and extent of HIV epidemics in Asia and the Pacific in the context of sex work. These have highlighted the progress and the challenges that must be tackled<sup>1</sup> to realize the targets to which governments have committed,<sup>2</sup> to bring an end to AIDS. Guidance on effective investment and responses is well articulated. For example, the UNAIDS Guidance Note on HIV and Sex Work expresses the need for a comprehensive response that prioritizes evidence- and rights-based HIV prevention, treatment and care programmes for key affected populations. Moreover it addresses the factors that impede these efforts and responds to the underlying causes of vulnerability to HIV infection.<sup>3</sup>



## Key elements of a comprehensive response

The key elements of a comprehensive response to HIV in the context of sex work are:

- community mobilization and organizational development of sex worker-led organizations and networks;
- peer outreach, and education<sup>4</sup> and drop-in services, including linking or providing services within sex worker-specific programmes such as for sexually transmitted infections (STIs), voluntary testing and counselling (VTC), family planning;
- promotion of and access to male and female condoms and water-based lubricants, including strategies to ensure demand, access, utilization and supply – particularly in sites where sex work takes place – community awareness and acceptance of condom use and empowering sex workers to negotiate condom use;
- access to the full range of sexual and reproductive health (SRH) services to meet the needs of sex workers and their clients. This includes diagnosis and treatment of STIs; the full range of contraceptive methods and counselling to prevent unintended pregnancies; access to antenatal, delivery and post-natal care, including access to antiretroviral drugs for mothers and to prevent vertical transmission;
- access to alcohol and drug-related harm reduction, including needle and syringe programmes and opioid substitution therapy;
- HIV voluntary testing and counselling;
- access to HIV treatment, care and support;
- preventing and addressing violence;
- preventing and responding to stigma and discrimination, including in health care settings, through stigma reduction strategies, community legal education and access to legal services;
- economic empowerment programming that expands choices for control over financial resources and generation of additional or alternative income;
- advocacy and leadership building to reform laws, policies and law enforcement practices that undermine rights and impede an effective response and to promote protective laws, policies and practices that support effective responses.<sup>5</sup>



## There is considerable experience in this region about what works in delivering HIV prevention, treatment and care programmes

The elements of a comprehensive response are an elaboration of the three pillars outlined in the UNAIDS Guidance Note on HIV and Sex Work:

- **Pillar 1** — ensure universal access to comprehensive HIV prevention, treatment, care and support
- **Pillar 2** — build supportive environments, strengthen partnerships and expand choices
- **Pillar 3** — reduce vulnerability and address structural issues.

In addition, *Investing for Results, Results for People* emphasizes the need to combine specific HIV prevention, treatment and care programmes with efforts to ensure investment in the ‘critical enablers’. This encompasses social enablers such as stigma reduction and supportive laws, and enabling policies, practices and programmes such as those with community-centred design and delivery.<sup>6</sup>

There is considerable experience in this region about what works in delivering HIV prevention, treatment and care programmes combined with addressing the factors that adversely affect these efforts and responding to the underlying causes of vulnerability to HIV infection. Yet there is a dearth of documentation and analysis of this experience; what works and how these lessons should guide policy, programmes and resource allocations to ensure an effective response in the region.

## Purpose and audience

The purpose of this resource is to:

- document and share programming and advocacy experience from across the Asia-Pacific region that can guide programming and advocacy efforts to respond effectively to HIV in the context of sex work;
- provide detailed case studies that illustrate the ways in which programmes and advocacy interventions were designed and delivered to address various elements of a comprehensive response;
- identify lessons learned, gaps and challenges and key considerations for strengthening and scaling up comprehensive and effective responses in the region.

This resource provides insights into what is an effective response to HIV in the context of sex work in the Asia-Pacific region, and the manner in which programmatic and advocacy interventions have been carried out. It is envisaged that it will be a valuable resource:

- for programming managers, implementers and service providers, including government, NGOs and sex worker organizations, in the design and delivery of programmes;
- to guide policy makers and development partners in planning and allocating resources for strengthening and scaling up effective interventions;
- to advance advocacy efforts for a comprehensive response that focuses on evidence and rights-based interventions.



## Overview of content

*Part 1* provides a brief summary of the key lessons learned and gaps and challenges in delivering and scaling up evidence and rights-based responses in the Asia-Pacific region. This analysis is largely drawn from the experiences, lessons and reflections identified in the case studies, supplemented by a desk review of related programming experience and research.

*Part 2* provides eleven detailed case studies on HIV and sex work interventions from seven countries in the Asia-Pacific region — Bangladesh, China, Fiji, India, Myanmar, Nepal and Thailand. Each of these illustrates one or more elements of the comprehensive response outlined above.

All the organizations documented offer a range of programmes. The case studies examine particular programmes and advocacy interventions for which there is an absence of concrete guidance on approaches to design and implementation and ways to achieve effective outcomes. The table below summarizes the focus of each case study.

Given the diversity of the interventions being documented there are variations in the structure and analysis of each case study. Broadly, they offer information on the following:

- a brief history of organization or intervention;
- synopsis of the local HIV scenario;
- the key interventions;
- the rationale and programme principles that guided design and implementation;
- the intervention design and implementation;
- the accomplishments and challenges encountered in design, implementation, monitoring and measuring results;
- ways that the intervention adapted to challenges and emerging needs;
- means of monitoring and measuring results;
- factors that contributed to progress and/or measurable results;
- lessons learned from the intervention;
- gaps, challenges and future opportunities;

Details about the methodology and processes for the development of this resource can be found in *Annex* at the end of the regional analysis section (page 30).

## Summary of case studies

| Organization   | Focus of documentation  | Country    | Page |
|--|---|------------|------|
| <b>TOP/PSI (Targeted Outreach Programme, Population Service International)</b> | Scaling up an integrated approach to SRH and HIV prevention, testing, treatment and care  | Myanmar    | 36   |
| <b>Dark Blue</b>   | HIV prevention, treatment and care for male and transgender sex workers   | China      | 48   |
| <b>Service Workers in Group (SWING)</b>  | Sex worker organizational development; Partnership with police to foster law enforcement practices that protect rights and supports effective HIV programming                 | Thailand   | 57   |
| <b>Lily Women’s Wellness Centre</b>  | HIV prevention, treatment and care for ‘low fee’ sex workers  | China      | 68   |
| <b>Veshya Anyay Mukti Parishad (VAMP) Plus</b>                                 | Improving access to HIV testing, treatment and care for sex workers living with HIV   | India      | 78   |
| <b>USHA Cooperative/ Durbar Mahila Samanwaya Committee (DMSC)</b>              | Economic empowerment: financial cooperative — savings and loans   | India      | 85   |
| <b>Durjoy Nari Sangha (Durjoy)</b>   | Preventing and addressing violence against sex workers  | Bangladesh | 94   |
| <b>Blue Diamond Society (BDS)</b>  | Advocacy and leadership development for law reform, programmes for legal education and legal services for men who have sex with men and transgender communities               | Nepal      | 106  |
| <b>Ashodaya Academy</b>  | Community-to-community capacity building for sex worker- led HIV interventions  | India      | 116  |
| <b>EMPOWER</b>   | Meeting the needs of migrant sex workers: integrating HIV within holistic education programming; advocacy for labour rights and reform of laws and law enforcement practices. | Thailand   | 129  |
| <b>Survival Advocacy Network Fiji (SAN Fiji)</b>                               | Addressing stigma and discrimination, improving access to health services   | Fiji       | 139  |



# Part 1: Lessons from experience in the Asia-Pacific region

This section examines some of the key lessons that can be drawn from the case studies and integrates an analysis of related programming experience and research.

“Community engagement is vital for advocacy, generating demand and ensuring accountability for results. Civil society organizations play a vital role as enablers and must have the resources and tools to play their role effectively over the long term.”

Investing for Results. Results for People, UNAIDS 2012

## Community empowerment: The foundation of innovative responses

The meaningful involvement of sex workers in the HIV response is often narrowly perceived as ensuring sex workers’ role as peer educators in HIV prevention programmes. This collection of case studies evidences ways in which community mobilization and empowerment builds sex workers’ social capital and provides foundations for:

- effective models for peer outreach, holistic education and social mobilization, so that sex workers can address the challenges they face in their lives;
- addressing the barriers to access HIV, SRH and other health services, including addressing stigma and discrimination, building community demand and confidence to access services;
- encouraging innovative approaches to preventing and addressing violence against sex workers; tackle law enforcement practices that violate sex workers’ rights and undermine effective HIV responses, and expand choices for economic empowerment.

The central principle that underscores most case studies is the empowerment of sex workers to assert their human rights, control their domestic and work environment and improve their social conditions and health. While a focus on HIV prevention is a common thread, these organizations concentrate on the broader issues of health, development and well-being of sex workers and their families.

Community capacity development, organizational strengthening and leadership within sex worker communities are essential elements of an HIV response in Asia and the Pacific. Many of the innovative programmes that have been documented are testament to the critical importance of high-quality, flexible and appropriate technical support for sex worker-led organizations. Such technical support improves organizational development, and design and implementation of effective programmes and develops sex worker community leadership. SWING (page 57), USHA Cooperative (page 85), Durjoy (page 94), TOP/PSI (page 36) and Ashodaya Academy (page 116) exemplify the ways in which organizations have benefited from technical assistance that is tailored to address the strategic priorities of sex worker organizations, often sustained over a considerable periods and is responsive to their changing needs. The technical support provided has come from a variety of sources including the Asia-Pacific Network of Sex workers, the Global Network of Sex Work Projects, international NGOs, research institutions and United Nations agencies.

“Community empowerment is when the community gains control of, and helps to solve, the problems confronting it.”

Terms of empowerment / exemplars of prevention: towards a theory of community psychology, Rappaport, J., *American Journal of Psychology*, 1987.

“As a community, we all say NO to sex without condoms. We will not have sex without condoms, even if it means we do not get clients for the day. This is one of our standards for ourselves and we follow this rule. This is why condom use among sex workers in Mysore has been consistently high over the years.”

Akram, male sex worker, Ashodaya Academy

## Peer-based community outreach and education

Peer-based community outreach and education is vital to reaching sex workers to provide access to prevention commodities and develop sustained relationships that encourage access to HIV programmes and services. Peer outreach interventions have been shown to increase HIV knowledge and condom use and reduce equipment sharing among people who inject drugs.<sup>7</sup> Moreover, effective peer-based outreach and education is crucial in influencing community norms to promote ongoing safer behaviours among sex workers and clients.<sup>8</sup>

Experience across the region demonstrates the critical nexus between effective peer-based outreach and education and facilitating demand for and uptake of HIV testing, STI diagnosis and treatment and HIV treatment, care and support. Partnership between sex worker organizations and health care providers can reduce discrimination and improve health service quality.

Peers play a vital role in generating community demand and confidence to access services, and as a feedback loop to identify and address concerns in access to and quality of health services.<sup>9</sup>

The case study of Dark Blue in Tianjin, China (page 48), illustrates the ways that peer outreach can reach highly mobile and ‘hidden’ groups of male and transgender<sup>10</sup> sex workers. An innovative idea of creating virtual safe space through web-based radio and chat rooms is used as a vehicle for community education and networking. This is used to promote health facilities of Dark Blue and the provincial government. To achieve this, Dark Blue has invested considerable efforts in developing a strong partnership with the provincial health authority in Tianjin.

In some instances, the socio-legal milieu for effective peer outreach is complex and requires alternative approaches, as demonstrated by Lily Women’s Wellness Centre (page 68). Faced with certain complexities for registration and organization of non-governmental organizations in China, the Centre has adopted flexible approaches to reach

sex workers— including through mobile phone technology, advocacy and partnership-building to improve the environment for effective programming.

The importance of scaling up peer-led HIV interventions is highlighted in a case study on the Ashodaya Academy (page 116). This programme has institutionalized capacity building by forming an academy of sex worker leaders. The academy implements training and mentoring of sex workers to equip them with the necessary skills to design and deliver community-led HIV interventions. The programme has provided training and mentoring in India and eight other countries in the Asia-Pacific region.

## Multiple benefits of drop-in-centres

Drop-in-Centres (DICs) are central to effective community empowerment, education and access to health services across the Asia-Pacific region. They assist in building social capital and fostering solidarity; both critical for sex workers to address personal and structural risks that increase their exposure to HIV.<sup>11</sup> Often DICs are the only safe place where sex workers can gather, interact with friends and peers, participate in different learning opportunities and social events, rest and relax, bathe, and be taken care of when they are ill.

TOP/PSI, Myanmar (page 36) has 18 DICs across the country, providing a wide range of activities including English classes, educational sessions on life skills and sexual health, social group meetings and entertainment. Their health services include VCT, STI diagnosis and treatments and family planning advice and commodities. Over eight years, 45 000 sex workers have registered at their DICs— an estimated 75% of all sex workers in Myanmar. DICs run by EMPOWER in Thailand (page 129) support migrant sex workers acclimatising to a new culture, helping them gain language skills, make friends, and learn about HIV and STIs.



“During police crack-down, all of our outreach activities stop for a short period of time. [When this happens] we cannot visit the field and they could not come to us. So, we started using mobile phones to communicate with our community members about their situation, and find ways to provide condoms to them in a discreet manner.”

Outreach worker, Lily Women's Wellness Centre

## Information Communication Technologies (ICT) and accessing young sex workers<sup>12</sup>

Research conducted in the Philippines found that from a sample of 9 316 female sex workers, 62% were less than 25 years of age.<sup>13</sup> Surveillance data in Indonesia from 2007 indicated that one in three people engaging in high risk behaviours were also under 25 and that the percentage of sex workers who ever received an HIV test was lower among those aged below 25 years.<sup>14</sup>

A recent study of 5 498 female sex workers found that 25% used cell phones to solicit clients, a large portion of whom were soliciting clients in home and lodge settings. These sex workers were younger and better educated, yet more likely to report inconsistent condom use and experience STI-related symptoms. The study suggests that their exposure to HIV prevention programmes may be limited and that new strategies are needed to reach these women.<sup>15</sup> In such instances, using ICT as channels for health promotion is a promising and likely cost-effective HIV prevention tool, relevant to highly mobile and hidden populations of sex workers, particularly those who are young.<sup>16</sup> Knowledge about the use of ICT by sex workers is lacking, and yet essential if ICT health promotion programmes are to be effective.

Some progress is being made in the region to capitalize upon sex workers' familiarity with and usage of ICT and to use these technologies to access hard to reach populations. In response to the difficulties they have encountered reaching young male and transgender sex workers Dark Blue (page 48) provides internet-based video and audio chat-room services. Through this, counselling and interactive programmes related to issues of HIV, sexuality and sexual health are made available.



## Integrating HIV with a holistic approach to education

More often than not, HIV is not the sole, or most serious, issue for sex workers. Lessons from the region highlight the value of educational approaches that are holistic, integrating HIV with learning opportunities that address a range of issues. For instance, EMPOWER (page 129) provides spaces for a broader discussion on safety in the workplace, which includes but is not confined to, safer sex. Similarly, while HIV prevention and treatment education is provided in non-formal education classes,

There is an urgent need to better understand the use of Information Communication Technologies (ICT) by sex workers, and ways that ICT can be used effectively as a tool for health promotion, including virtual safe spaces for interactive education and access to service information.



workshops and at social events, SAN Fiji's educational work (page 139) extends to educating sex workers on their legal rights, exploring the practical application of these in situations where police abuse their powers.

### Added value of condom social marketing<sup>18</sup>

Peer outreach has been effectively used for the distribution of condoms and lubricants. However, many organizations, including those documented in this resource, have encountered shortage of good quality male and female condoms and water-based lubricants. This was experienced even when governments or donors were providing these free of cost.<sup>19</sup> Continuity in supply can be seriously affected by funding phase out. This has presented organizations with an immediate challenge of finding an alternative, which for many has meant developing a community practice of purchasing condoms and lubricants.<sup>20</sup>

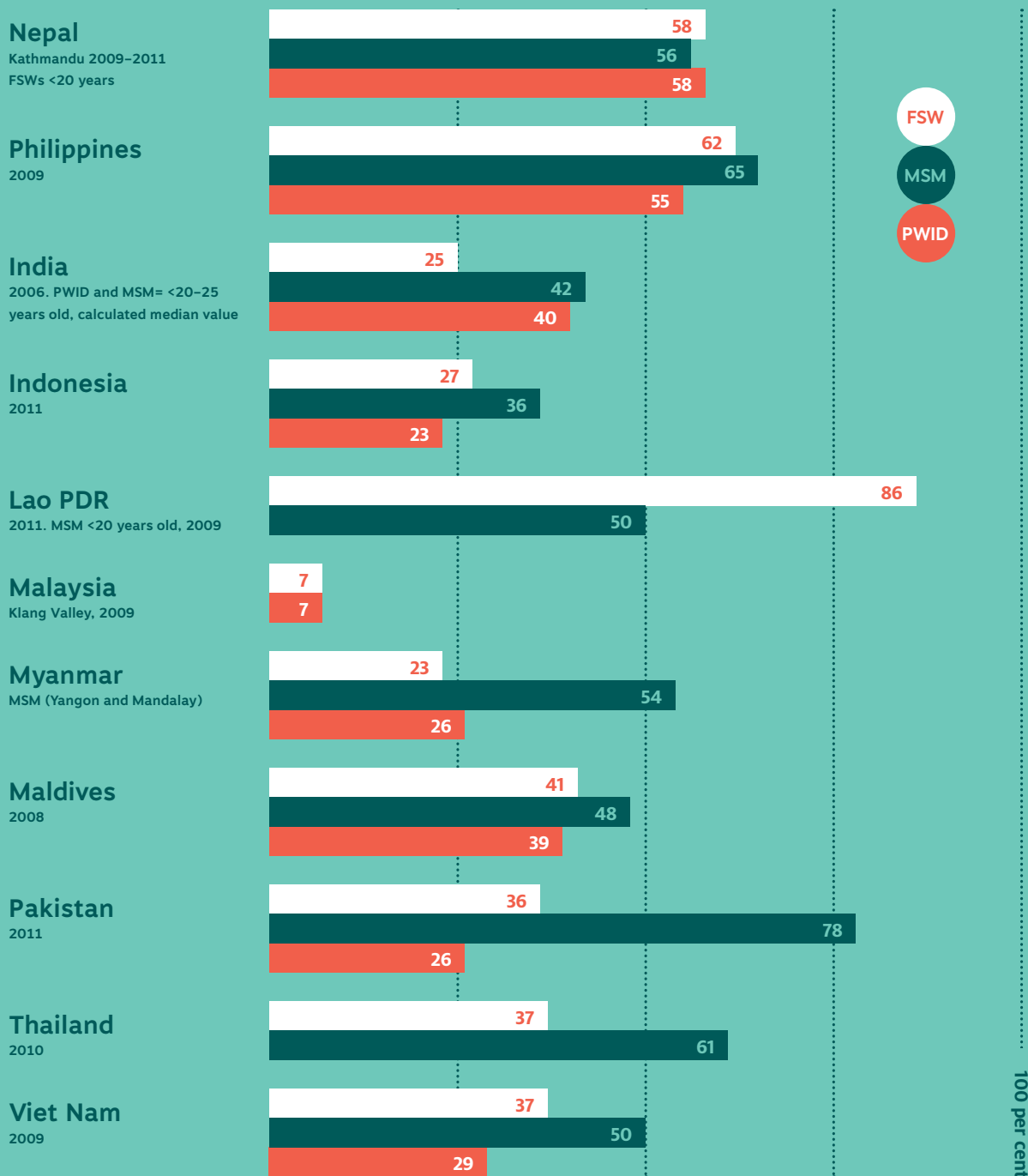
However, even when sex workers are in a position to purchase condoms and lubricants, the commodities are often unobtainable in areas where sex work takes place.<sup>21</sup>

Some organizations including SWING (page 57), USHA Cooperative (page 85) and Durjoy (page 94), and SAUR, Kediri, Indonesia<sup>22</sup> have responded to these challenges by implementing community-led condom social marketing strategies. Addressing the problem of supply, the organizations purchase, brand and sell good quality condoms and lubricants at affordable prices to sex workers and their clients. To promote demand, they carry out social marketing campaigns, community events and educational activities to increase the demand for, and use of condoms. These social marketing strategies take place in and around sex work venues, reaching sex workers and local community members including police, local shopkeepers and street vendors.





# Percentage of female sex workers (FSW), men who have sex with men (MSM) and people who inject drugs (PWID) who are under 25 years of age where data is available



Source: [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Behaviour Surveillance Surveys



## Effectiveness of condom social marketing programmes

A market for the purchase of condom and lubricants by sex workers and their clients can be developed. In 2006, SWING (page 57) initiated a condom social marketing programme. By 2009, a total of 119 000 condoms, 47 300 sachets of water-based lubricants, 42 cans of water-based lubricants and 460 safer sex packages had been sold in 54 entertainment venues in Bangkok, reaching more community members than ever before.<sup>23</sup> Likewise during 2009–2012 Durjoy (page 94) sold more than 10 462 335 condoms to street-based female sex workers in Dhaka and surrounding hot-spots, with a steady annual increment in sales.<sup>24</sup>

These sex worker-led condom social market programmes have often been established through the use of a community-based revolving fund, where seed funds are provided to community organizations to initiate social marketing of condoms and lubricants as an integrated part of their program, and through this they generate resources which are reinvested in programmes addressing sex workers needs.<sup>25</sup>

Such initiatives have been shown to encourage condom use. A meta-analysis of condom social marketing studies found that in general, people exposed to condom social marketing were approximately twice as likely to use a condom as those not exposed.<sup>26,27</sup> A study in Viet Nam found that male clients exposed to a mass media campaign were significantly more likely to consistently use condoms with female sex workers than male clients who reported no exposure.<sup>28</sup> Moreover the study suggested that exposure to social marketing campaigns when combined with outreach

## Features of effective peer outreach and education linked to health services

The case studies point to several identifiable features of effective peer outreach and education linked to health services. These are:

- based on micro-planning, mapping hot-spots and population size estimation in each location;
- well designed and involve conducting regular training that ensure outreach peers have sound knowledge of HIV, STI, SRH and strong interpersonal communication skills;
- using effective systems for managing and mentoring outreach peers, encouraging teams to share challenges and identify solutions to promote continuous improvement;
- incorporating education and social events that are responsive to community needs, including educational opportunities and access to services that address a wide range of sex workers' concerns;
- using knowledge of available services and developing strong relationships between sex worker organizations/outreach peers and health providers to maximize access to services;
- offering incentives for outreach peers, including learning opportunities and career development.<sup>17</sup>

contact increased condom use by clients.<sup>29</sup> Echoing these findings, Durjoy (page 94), USHA Cooperative (page 85), and SWING (page 57) found that social marketing strategies, combined with repeated outreach contact with sex workers and their clients, have the greatest impact on consistent use of condoms.

Another positive outcome of these condom social marketing programmes is that they provide flexible resources for community-based organizations. For instance, from an initial capital investment of US\$ 100, SWING's (page 57) revolving fund from this programme totalled more than US\$ 13 000 by June 2009.<sup>30</sup> During 2010–2011, USHA Cooperative (page 85) made a profit equivalent to US\$ 19 500. Such profits have been used to fund activities that do not receive donor support.

## Effective linkages between HIV and sexual and reproductive health for sex workers<sup>31</sup>

The rationale for improving sexual and reproductive health (SRH) for key affected populations and linking SRH and HIV services is well documented.<sup>32</sup> In June 2011, Member States of the United Nations agreed to achieve bold new targets including:

- reducing sexual transmission of HIV by 50% by 2015 and
- eliminating new HIV infections among children.<sup>33</sup>

To realize these targets in this region, linkages between sexual and reproductive health (SRH) and HIV services to address the SRH needs of sex workers are crucial. For female sex workers, ensuring effective linkages will reduce unintended pregnancies and improve access to antenatal, delivery and post natal care including access to the antiretroviral drugs both for the mothers' own health and to prevent infection to their child during pregnancy, delivery and breastfeeding. However, programmatic experience in doing so is limited.<sup>34</sup> Realizing these synergies in practice makes

'people sense' and ensures effective use of available financial and human resources.

There has been considerable progress in eliminating new HIV infections through integrating Prevention of Mother to Child Transmission (PMTCT) within maternal child health (MCH) services. However, this has led to a focus on HIV testing of pregnant women who attend MCH services, and often female sex workers at higher risk HIV are not accessing MCH services. Criminalization of sex work and high levels of stigma and discrimination undermines sex workers' access to health services including MCH.<sup>35</sup> This underscores the importance of HIV testing within HIV programmes for sex workers and the need to provide effective referral to MCH/PMTCT for pregnant sex workers living with HIV.

Moreover, there are serious gaps in family planning counselling and access to the full range of contraception for sex workers.<sup>36</sup> The provision of condoms alone as protection against HIV, STIs and pregnancy does not address the realities of female sex workers' lives, as workers and women given:

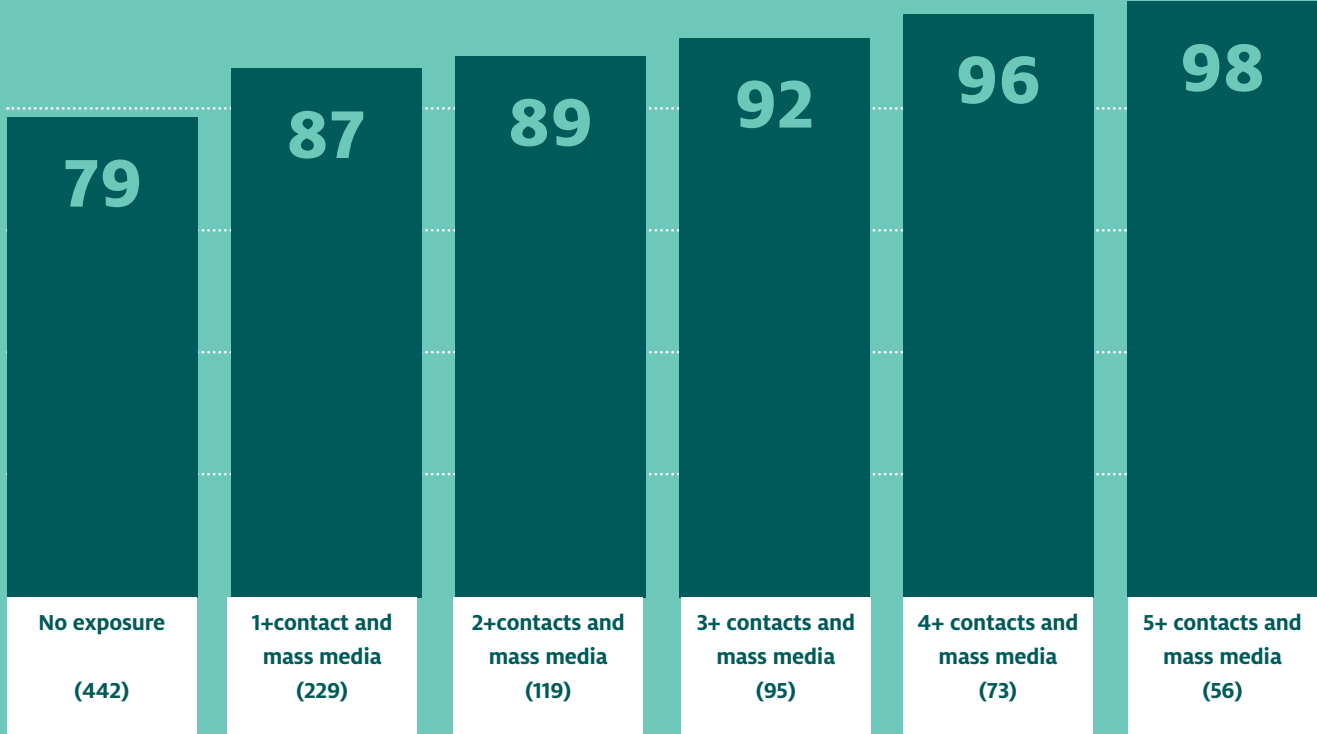
- low condom use among non-commercial partners;<sup>37</sup>
- high rates of abortion, indicating unmet contraceptive need;<sup>38</sup>
- condoms are less effective in preventing unwanted pregnancy compared with other contraceptive methods;<sup>39</sup>
- high levels of sexual violence;<sup>40</sup>

A number of case studies indicate that improving sex workers' understanding of their sexual and reproductive health rights is a focus of their education efforts. However, very few focus on delivering SRH related services or building referral networks with government and private providers of SRH services, beyond STI diagnosis and treatment.



## Consistent condom use and exposure to mass media and outreach (number of respondents in brackets)

100 per cent



Note: All statistically significant compared with no exposure  $p < .05$

Source: Using Formative Research to Promote Behavior Change among Male Clients of Female Sex workers in Vietnam, Ngoc K V, et al, Cases in *Public Health Communication & Marketing* 2011.

TOP in Myanmar (page 36) and Lily Women's Wellness Centre in Kunming, China (page 68), are two such examples that illustrate linking SRH and HIV programmes can successfully deliver both HIV prevention and reproductive health outcomes.

TOP (page 36) started providing a wide range of SRH services in 2005, as part of their DIC clinic services for female sex workers in Yangon. This includes family planning counselling, access to the full range of contraceptive methods including contraceptive pill, injectables, IUDs and pregnancy test kits. They also provide cervical cancer screening. TOP's work demonstrates a strategic focus in delivering aspects of the SRH services that can best be delivered in DICs such as family planning and pregnancy planning linked to a network of quality private providers to meet a range of SRH needs for sex workers. This approach could

be applied to improving sex workers' access to SRH services located within public health systems.

Likewise, through on-site clinic services at their DIC, Lily Women's Wellness Centre (page 68) provides a similar range of SRH services for female sex workers. Accompanied referrals to offsite SRH services are also provided, wherein partnerships have been formed with government doctors in Kunming.

There is a pressing need to ensure that these lessons are applied more broadly in the region. Greater focus is required to ensure SRH and HIV services meet the needs of female sex workers, to reduce unintended pregnancies and improve access to antenatal, delivery and post natal care including access to antiretroviral drugs for mothers and to prevent vertical transmission.

The work of Dark Blue in China and BDS in Nepal, are illustrative of efforts to improve the sexual health

## Lessons learned across the region provide a compelling case for scaling up condom social marketing as an effective strategy for:

- promoting condom use among male clients;
- creating supportive social norms for condom use, both within the sex industry and wider community;
- a sustainable, cost-effective approach to availability of high-quality affordable condoms and lubricants;
- generating flexible resources for community-based organizations.

needs of MSM and transgender people, including sex workers. For example, Dark Blue address the sexual health of MSM and transgender sex workers through ensuring access to STI diagnosis and treatment services and psychosocial support to increase self-esteem and improve health seeking behaviour.

Effectively addressing the sexual health needs of MSM and transgender sex workers includes ensuring:

- taking a sexual history that includes attention to anal sex, particularly to include this in history-taking from men who may not appear to be having male-to-male sex
- counselling about safer sex, including effective approaches to couple counselling for married MSM

- sensitivity to MSM and TG — particularly important for TG who have experienced rejection, humiliation and discrimination in health services
- psychosocial support to increase general health, self-esteem and general capacity to reduce risk of acquiring or transmitting HIV and other STIs
- attention to sexual health beyond HIV/STIs — including anal health, penile and prostate cancer screening and hormone treatment and care for transgender people.<sup>41</sup>

## Improving access and uptake of VCT and HIV treatment

Good quality HIV VCT is important so that people can make an informed decision to test, know their status, reflect on risk reduction strategies for themselves and/or others, and identify their preferred course of action should their test result be positive.

Country-specific data reveals a need to improve uptake of HIV testing among sex workers in many countries in the region. The median reported coverage in 2010 was 34% for female sex workers (range 4%–79%) in 20 countries reporting data.<sup>42</sup> Country data show strong efforts are still required in many countries in the region. For example, the percentage of sex workers who had an HIV test in the last 12 months was 43.8% in Viet Nam and 38.2% in China, 50.4% among venue based workers and 65.2% among male sex workers in Thailand and 54.6% among female sex workers in Nepal. Indonesia at 79.4% in Indonesia, 71% in Myanmar showed better results. Indonesia and Myanmar indicate better results; 79.4% and 71% respectively.<sup>43</sup>

To improve sex workers' access to VCT, and HIV treatment should they require it, there is a need to comprehend the factors that undermine access, and look to the ways these barriers are being addressed. For example, it is well established that stigma is an impediment to testing. It reduces quality of care,

delays testing and hinders adherence to treatment.<sup>44</sup> Concerns regarding mandatory or forced testing and breaches of confidentiality have been widely reported by sex workers in the region, including that disclosure of HIV positive results can lead to sex workers losing their job.<sup>45</sup> These infringements undermine people's willingness to test.<sup>46</sup>

SAN Fiji's innovative work in developing a play as a tool to explore the barriers sex workers face in accessing health services has been a catalyst for sex worker and health care provider engagement. There are indications that this has resulted in reducing discrimination, evident in the significant increase in the number of sex workers accessing health services. Moreover it has provided a strong impetus for creating non-discrimination policy in health care settings.

### Community-based VCT: rapid, confidential and accessible

Community-based VCT is one of the most effective and inexpensive service delivery models.<sup>47</sup> Experience in the region shows a combination of factors help increase sex workers' uptake to VCT in community settings. These include availability of rapid testing; providing services during hours and in locations that are convenient to sex workers; deploying professionally trained community counsellors; and a demonstration of commitment to confidentiality in service design.

In Dark Blue's experience (page 48), sex workers prefer rapid testing delivered by community counsellors. Introduction of this approach into the programme contributed to a doubling HIV testing among male and transgender sex workers over two years — from 2 163 people testing in 2009 to 4 501 in 2011.

TOP (page 36) provides pre- and post-test counselling in all their DIC. They provide rapid testing in five sites but rapid test kits are not widely available in Myanmar. For all other sites, TOP transports blood samples daily to the nearest cooperating clinic for screening. Once the results are returned, within one to two days, community counsellors at the DIC provide the post-test counselling. In 2011, of the 12 107 people

accessed VCT services in Myanmar, about 40% were tested through the TOP program.<sup>48</sup>

Designing and implementing community-based VCT programmes has fostered working partnerships with local public health services. Such linkages have assisted access to rapid tests kits and laboratory services, ensured that community counsellors are professionally trained and that diagnostic facilities meet quality assurance standards.<sup>49</sup> This underscores the vital role of the public health system in making HIV treatment and care services a ground reality for sex workers.

EMPOWER's experience in implementing an HIV prevention programme funded through Global Fund resources, sounds a note of caution on the difficulties of applying appropriate performance targets in the context of broad programmes seeking to protect the rights of sex workers and deliver more effective holistic programming. In this case, the target set for VCT was 1 600 sex workers recruited and tested in one year "...although more than this came for counselling, only 500 sex workers went on to have an HIV test. It led to problems because we were not able to 'meet' Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) VCT indicators...Ultimately, we were judged to be not effective..." Noi, EMPOWER. Sex workers' decision to test for HIV must be voluntary and this should not be undermined in order to meet numerical targets. Among the 500 sex workers that decided to test for HIV, 30 tested positive and needed immediate follow-up support for treatment and care.<sup>50</sup> However, as funding was only linked to the testing element, there were no resources for the kind of support that was needed to ensure those testing positive had access to treatment, care and appropriate support.



“Because of fear of discrimination, many sex workers do not want to take HIV test. My CD4 count was 71 when I got HIV tested for the first time; with the right treatment and the support I have received from my friends and community members, it is now 930. Improvements in my health status is a testimony of the positive impact of HIV testing and treatment.”

Shantamma Gollars, Outreach Worker, VAMP Plus

## Making HIV treatment and care real for sex workers living with HIV

Overall antiretroviral therapy coverage in the Asia-Pacific region is only 44%, lower than global average of 54% for low-income and middle-income countries.

Source: *Together we will end AIDS*, UNAIDS, 2011.

For people living with HIV, timely access to antiretroviral therapy not only saves lives and sustains good physical health, fully effective therapy prevents new HIV infections. This provides a compelling case for challenging the barriers to HIV testing and treatment.<sup>51</sup> The vast majority of people living with HIV who are eligible for treatment are not receiving it. Sex workers are particularly disadvantaged in this regard. Unfavourable conditions in health care settings, usually stemming from stigma, threaten their access to HIV treatment.<sup>52</sup>

VAMP Plus has developed a service delivery model that delivers continuity of care, improving access to both VCT and HIV treatment for sex workers who test HIV positive. Their peer-based outreach and education programme encompasses HIV testing and treatment related literacy, pre- and post-test counselling on HIV and accompanied referral for HIV testing. All of the outreach sessions are individualised, focusing on one-to-one personal interaction, the benefits of testing and consequences of results and accompanied referral to VCT centres. This has proved effective in improving uptake of VCT. The key strength of VAMP Plus is their community centered, peer led approach that facilitates understanding of and access to HIV testing and access to HIV treatment, care and support for those who need it.

Two key challenges were identified in the course of documentation: Often there is a disconnect

between HIV prevention and treatment services. This disconnection can be exacerbated by the way programmes are funded. HIV prevention programmes are commonly funded to include condom programming, peer outreach and education, STI diagnosis and treatment and VCT. Organizations that implement HIV prevention programs often do not receive funding support for follow-up support required to facilitate access to HIV treatment for sex workers.

Programmes such as VAMP Plus have developed to address the reality of sex workers lives, having made a decision to test for HIV, yet too often unsupported in accessing HIV treatment and care when the result is positive. The kind of support required, as the VAMP Plus exemplifies, requires considerable time and skills—individual counselling and psychosocial support, accompanied referrals, treatment literacy, support with treatment adherence and engaging with health services to address stigma and create community confidence to access services. Disincentives to HIV testing mean that sex workers living with HIV often only discover their HIV status when they are already seriously ill and the efficacy of treatment is reduced. Efforts to improve sex worker communities' knowledge about the value of timely HIV treatment will encourage sex workers to test for HIV.

Experience in the region indicates that there is inadequate attention to funding this work, a vital connection between sex workers and the health system. Yet, it is precisely this kind of approach that can ensure sex workers living with HIV have access to HIV treatment and care. Community-based interventions that build sex workers' understanding of and facilitate access to HIV treatment and care should be funded as integral part of HIV treatment scale up.

“...a structural intervention must grow from a strong collectivisation process and transformations in sex workers’ relationship with local partners in responding to rapidly changing contexts and addressing multiple risk factors simultaneously”.

Sex worker-led structural interventions in India: A case study on addressing violence in HIV prevention through Ashodaya Samithi collective in Mysore, *Indian J Med Res*, 2012

## Addressing causal factors that hinder effective HIV responses

A feature common to most of the interventions documented is the development of leadership among sex workers. They amply illustrate that investing in sex worker empowerment leads to innovative responses which have become vehicles for social change—challenging inequality, social exclusion and marginalization and tackling law enforcement practices that undermine sex workers’ access to health services. A concrete outcome of these efforts in the region is the many examples of strategic and innovative efforts to address the causal factors for sex workers’ vulnerability to HIV infection.

## Structural interventions often missing in comprehensive response

Rights-based, evidence-informed, and community-owned programmes that combine biomedical, behavioural, and structural interventions, and are attentive to the specificities of communities, will have the greatest sustainable impact on reducing new infections.<sup>53, 54</sup> This is often referred to as ‘combination prevention’. And yet, according to a number of reports, national programmes seldom include robust support for structural interventions to change policies and social norms that block the AIDS response, and existing efforts are insufficiently grounded in human rights or integrated with the broader development agenda.<sup>55</sup> Renewed investment approaches to AIDS emphasize the need for better allocation of national resources for structural interventions to be included as part of comprehensive responses to HIV prevention.<sup>56</sup> In 2009, of all external investments in HIV in the Asia-Pacific region, only 4% was directed to addressing the enabling environment.<sup>57</sup>

Recognizing and harnessing sex worker communities as active agents of change—as opposed to passive recipients of services, Ashodaya Academy in India (page 116), SWING in Thailand (page 57), and TOP in Myanmar (page 36), for example have adopted approaches which respond to the underly-

ing causes of sex workers’ vulnerability to HIV infection. They provide impetus for scaling up structural interventions as an essential part of a comprehensive response.

## Preventing and responding to violence

There is a plethora of evidence about the nature and extent of violence against sex workers and the impact it has on their lives, including on their ability to protect themselves from HIV infection.<sup>58</sup> Violence has been found to be significantly associated with sexual health risk, including reduced condom use and increased risk of STI/HIV.<sup>59</sup> Efforts to address violence against sex workers have demonstrated:

- significant reduction in violence<sup>60</sup>
- increased condom use among sex workers and their clients, reductions in STIs, improved access to HIV prevention and treatment services<sup>61</sup>
- better health and social outcomes for sex workers.<sup>62</sup>

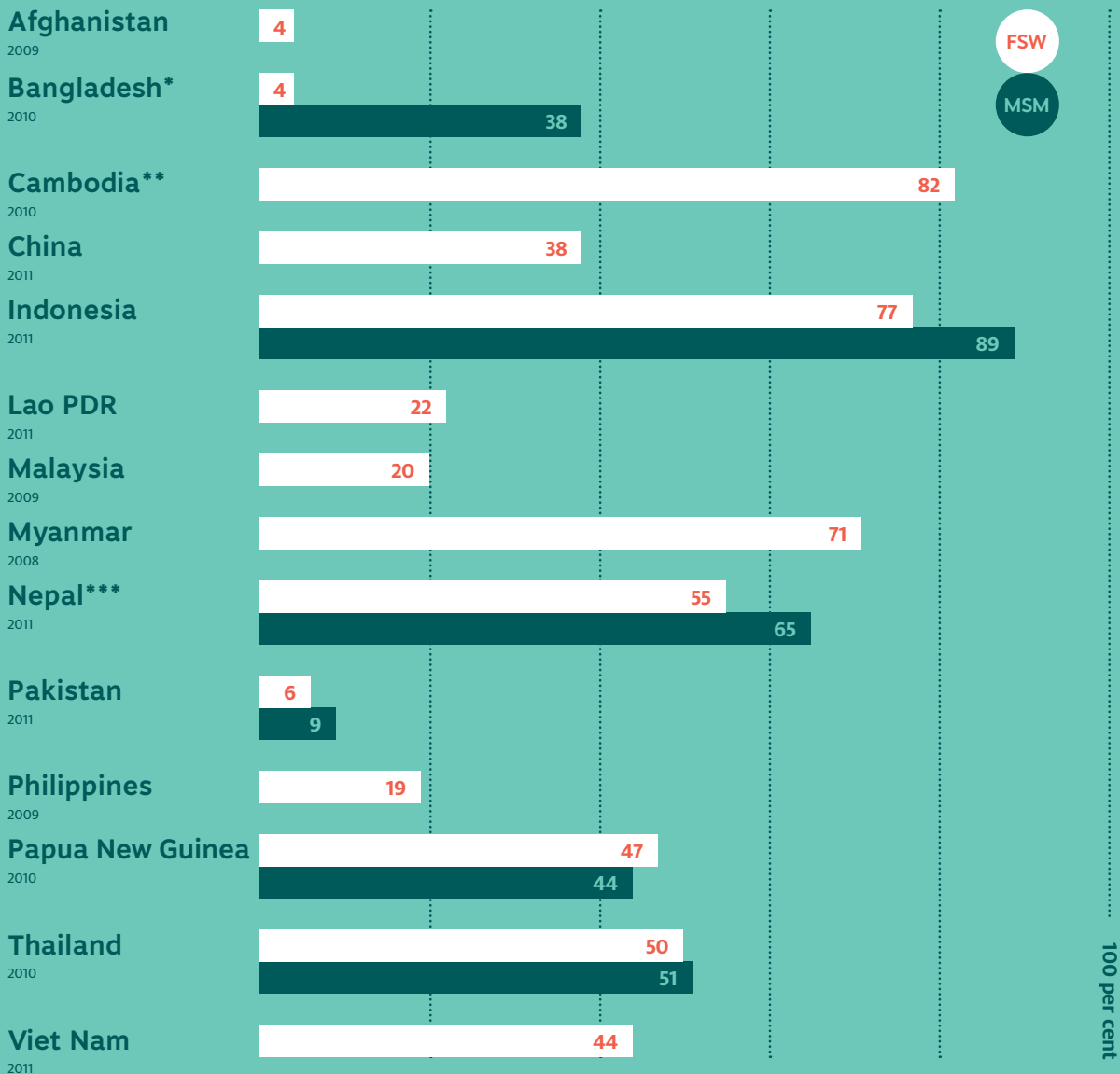
In Bangladesh, Durjoy Nari Sangha’s anti-violence programme (page 94), Promoting Rights of Disadvantaged by Preventing Violence Against Women (PROTIRODH), is multifaceted and seeks to:

- prevent violence by mobilizing and building capacities of sex workers and community partners, including clients, police, local business men, goons<sup>63</sup> and religious leaders;
- mitigate violence by ensuring that sex workers who experience violence can access legal, health and protection support services; and
- respond to violence by tackling barriers to reporting violence, enhancing access to legal support and improving responsiveness of law enforcement and judiciary systems.





# Percentage of sex workers receiving an HIV test in the last 12 months and know the results, 2007–2011



\* 2006–2007 data for female sex workers

\*\* Female entertainment workers who have more than 14 clients per week

\*\*\* Kathmandu Valley, 2009 for female sex workers

Source: [www.aidsdatahub.org](http://www.aidsdatahub.org) based on Global AIDS Response Progress Reports 2012 and UNGASS Country Progress Reports 2010

In the Asia-Pacific region, and across world, there are too many examples of countries with laws, policies and practices that punish, rather than protect, people in needs of HIV services. Where the law does not advance justice, it stalls progress.

*HIV in Asia and the Pacific: Getting to Zero, UNAIDS 2011 p.88.*

PROTIRODH demonstrates the numerous benefits of integrating an anti-violence programme. These include reduction in incidence of violence, increased understanding of rights among sex workers, increased reporting of violence and improved access to legal and health services and social systems.<sup>64</sup>

Ashodaya Samithi's work on addressing violence<sup>65</sup> revealed an 84% reduction in the incidence of violence over five years. Empowerment across social contexts was central to this transformation, particularly in negotiating with police, boyfriends, lodge owners and clients. A concrete outcome was more support and protection from police.

### Features of effective anti-violence programmes

Experience in implementation of anti-violence interventions demonstrates several features that make them effective. These are:

- space for community discussions to understand people's experiences of violence, exchange protective strategies and problem solve according to context;
- partnerships between sex workers and key stakeholders at local level, including police, venue and brothel owners, community leaders, long-term partners and clients of sex workers, lawyers, human rights institutions, and health care service providers;
- capacity development of sex workers to case manage incidences of violence, including counselling and referral;

- mechanisms to document incidents of violence and provide and/or refer individuals to services required to address a range of their needs including:

- health, including emergency contraception, post-exposure prophylaxis (PEP) and diagnosis and treatment of STIs and counselling
- legal assistance
- individual and group psychosocial support
- shelter

- implement community-based education that addresses stigma, exclusion and marginalization of sex workers.<sup>66</sup>

### Tackling laws and policing practices

Stigmatization, and in many cases criminalisation, of aspects of sex work perpetuates an environment that exposes sex workers to violence. This results in their economic and social exclusion, preventing them from accessing essential HIV prevention and care services.<sup>67</sup> Almost all countries in the region currently criminalise some aspect of sex work.<sup>68</sup>

The Global Commission on HIV and the Law undertook 18 months of extensive research and consultation, releasing their landmark report in July 2012.<sup>69</sup> The Commission found that an epidemic of bad laws and human rights abuses is stifling the global AIDS response. The report states that despite the plethora of scientific breakthroughs and billions of dollars of investments, over the past three decades that have led to the remarkable expansion of lifesaving HIV prevention and treatment—benefiting countless individuals, families and communities—many countries squander resources by enacting and enforcing laws that undermine these critical investments.<sup>70</sup>

The Commission stated that countries must reform their approach towards sex work, by ensuring safe working conditions and offering sex workers and their clients' access to effective HIV and health

# An epidemic of bad laws and human rights abuses is stifling the global AIDS response

Global Commission on HIV and the Law – Risks, Rights and Health, July 2012

services and commodities. Among the Commission recommendations were the following:

- repeal laws that prohibit consenting adults to buy or sell sex, as well as laws that otherwise prohibit commercial sex, such as laws against ‘immoral’ earnings, ‘living off the earnings’ of prostitution and brothel-keeping;
- complementary legal measures must be taken to ensure safe working conditions to sex workers;
- take all measures to stop police harassment and violence against sex workers;
- prohibit mandatory HIV and STI testing.<sup>71</sup>

Sex worker organizations including EMPOWER (page 129), Ashodaya Samithi, SWING (page 57), Durjoy (page 94), DMSC, together with the Asia-Pacific Network of Sex Workers have been at the forefront of advocacy efforts to ensure legal recognition of sex work as work, with equal labour rights and occupational health safeguards. The International Labour Organizations’ Recommendation Concerning HIV and AIDS and the World of Work, which recognizes sex work as work, provides an important advocacy tool for lobbying governments and employers.<sup>72</sup>

EMPOWER (page 129) has advanced labour rights for sex workers by ensuring their access to the Thai National Social Security Scheme. Their community-led research documents the negative effects of anti-trafficking raids by police on sex workers and findings suggest that sex workers in Thailand who have not been trafficked are routinely arrested and imprisoned in such raids.<sup>73</sup> The findings are being used to advocate for a review of anti-trafficking laws and law enforcement practices to ensure that they are not used to target consenting adult sex workers.<sup>74</sup>

In Nepal, the Blue Diamond Society’s work (page 106) is a powerful example of combining community-led HIV programming among men who have sex with men and transgender people, with high level political and grass roots advocacy to create an enabling

legal, policy and social environment for sexual and gender variant minorities. Using a blend of advocacy, leadership building, legal education and test case litigation has contributed to increased social, legal and political recognition of rights of Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people in Nepal, including securing a range of civic entitlements for transgender people.

SWING’s partnership with the police in Pattaya, Thailand (page 63), provides valuable insights into ways of overcoming police violence by simultaneously working on two courses of action. The first is building up sex workers’ knowledge of their rights and skills to negotiate with police. Secondly, SWING has been cultivating defenders of sex workers’ rights within the police service. This approach has had a positive impact on curbing abusive law enforcement practices and supporting HIV efforts.

## Economic empowerment

The UNAIDS Guidance note on HIV and Sex Work recommends a range of approaches to economic empowerment. This includes expanding choices for control over financial resources, generation of additional or alternative income, and access to education and vocational skills training.

Efforts to improve the economic security of sex workers and their families are reflected in a range of case studies. The most striking example is USHA Cooperative (page 85)— steered by Durbar Mahila Samanwaya Committee (DMSC), whose work has led to a sustainable economic empowerment intervention, with minimal start-up costs. Realizing that financial insecurity is one of the reasons why sex workers compromise on health and safety, DMSC identified the need to address sex workers’ lack of access to financial institutions, leading to the eventual creation of the USHA Cooperative. The Cooperative provides secure savings and loans to over 16 000 members and innovative income generation programmes through social marketing strategies. The battle to register USHA as a cooperative of and for sex workers had

wider ramifications. Ultimately it led to reform in the Cooperatives Law that now recognizes sex work as an occupation.

Another innovative sex worker's enterprise is Ashodaya Samithi's restaurant and apartment rental service entirely managed by the sex worker community. Both ventures are an employment source for sex workers, the profits of which are kept as special fund for specific situations such as medical emergencies.<sup>75</sup>

Lily Women's Wellness Centre (page 68) has a range of strategies to advance the economic security of sex workers including developing financial literacy and monetary management skills; referrals to cooperating banks to enable sex workers to open savings accounts and make investments; and providing vocational training on marketable skills to generate additional income.

Importantly, several of the organizations running economic empowerment programmes noted that programmes designed to expand livelihoods options must be based on a sound understanding of business viability and the demand for skills in which people are being trained.

For the most part, approaches to economic empowerment in the region appear to be piecemeal, small in scale and there is limited evidence about what is effective. HIV programmes should not be implemented in isolation and better synergies between HIV-specific efforts and development are needed, including access to social protection, education and poverty reduction.<sup>76</sup> Much more needs to be done to ensure that programmes to address economic empowerment meet the needs of and are accessible to sex workers, rather than expecting HIV programmes to deliver on all aspects of a comprehensive response.

All three of the case studies discussed above demonstrate ways that financial security benefits the well-being of sex workers and their families. They provide insight into how economic empowerment can contribute to supporting HIV prevention and improve health outcomes for sex workers living with HIV. For example, acquiring skills in money management,

opening bank accounts and having additional sources of income are activities that gesture being in command of one's situation. This has the cumulative effect of building sex workers' capacities in other areas, such as to negotiate for safer sex and safe working conditions. For sex workers living with HIV, financial security increases quality of life in several measurable ways; enabling regular and continued health monitoring and treatment, balanced nutrition and a healthier lifestyle. ■



## Summary of key themes

- Partnership between sex worker organizations and health care providers can reduce discrimination and improve health service quality and uptake.
- Peer outreach and education plays a vital role in generating community demand and confidence to access services, and act as a feedback loop to identify and address challenges in access to and quality of health services.
- Dics are central to effective community empowerment, education and access to health services. They build social capital and foster solidarity, both critical for sex workers to address personal and structural risks that increase their exposure to HIV.
- There is an urgent need to better understand the use of ICT by sex workers, and ways it can be used effectively as a tool for health promotion.
- There is a compelling case for scaling up condom social marketing as a sustainable, cost effective approach to availability of high-quality affordable condom and lubricants. This promotes condom use among male clients, and creates supportive social norms for condom use, both within the sex industry and the wider community.
- Effective linkages between SRH and HIV services for sex workers make 'people sense' and ensure effective use of available financial and human resources. More attention is required to address the SRH needs of female sex workers.
- A combination of factors help increase uptake of vct in community settings. These include convenient hours for sex workers, trained community counsellors, commitment to confidentiality and the availability of rapid test kits.
- Community-based interventions that build sex workers' understanding of and facilitate access to HIV treatment and care should be funded as integral part of HIV treatment scale up.
- Greater investment in structural interventions is urgently required, to address the factors that hinder effective HIV programmes and the underlying causes of vulnerability to HIV infection.
- Community capacity development, organizational strengthening and leadership within sex workers' communities are central to an effective response to HIV.
- Greater investment in financial and technical resources is required to ensure high-quality monitoring and evaluation, particularly for interventions where there is limited evidence. This will help to build the evidence base about what works in responding to HIV in the context of sex work to ensure the most effective use of resources.
- Greater understanding of what approaches are effective to achieve greater economic empowerment for sex workers is needed, including how to improve access to social protection, education and poverty reduction programmes.

### Limitations and lessons from the process

As outlined above, one criterion for case study selection was ‘demonstrated innovative approaches, strong progress and/or achieved results’. The broad nature of this criterion was deliberate. At the outset, it was not possible to determine the extent to which programmes had demonstrated results until detailed documentation had been done. Secondly, it is difficult to measure the impact of advocacy, such as for law reform or reducing stigma in health care settings, and attribute the contribution of these efforts on improving access to services. This is not a challenge unique to the programmes documented in this resource.<sup>78</sup>

Nevertheless, considerable effort was made during documentation to gather and analyse data that highlighted results. The case studies of Durjoy (page 94), Dark Blue (page 48), TOP/PSI (page 36), Lily Women’s Wellness Centre (page 68) and USHA Co-operative (page 85) provide important insights into ways data was analysed and findings used to improve programming. Hence they are able to demonstrate the extent to which specific programmes have achieved results.

This resource reveals varying degrees of organizational investment in assessing the results of interventions. It underscores the need to allocate financial and technical resources for high-quality monitoring and evaluation. This is critical to building the knowledge base, particularly in areas where evidence is scant, so that decision makers and development partners can ensure effective use of available resources.

One notable gap has become apparent through the documentation process. None of the case studies indicate that they provide and/or refer sex workers who use drugs to drug-related harm reduction programmes, including needle and syringe exchange and opioid substitution therapy.<sup>79</sup> There is evidence that sex workers who inject drugs are at greater risk of HIV infection.<sup>80</sup> Addressing this is critical. Sex workers who inject drugs are at dual risk of HIV infection and there indications that overlapping networks of populations are at higher risk of HIV infection.<sup>81</sup>

With respect to the scope of this resource, many more interventions worthy of documentation and analysis exist in the region. Clearly the human and financial resources available for this work was a necessary consideration when deciding how many case studies could be documented. ■



# Annex

## Methodology

The development of this resource was led by UNFPA Asia-Pacific Regional Office (APRO), Asia-Pacific Regional Support Team of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Asia-Pacific Network of Sex Workers (APNSW).

### Criteria for selecting case studies

The regional partners identified seven countries to be part of an in-country process to identify and agree on case studies for documentation. These countries were chosen because of their creditability in responding to HIV in the context of sex work, and their diverse range of HIV and sex work programming. A combination of these factors, it was felt, would offer a rich sample of the range of programmes in the region.

The regional partners developed criteria and a checklist to guide case study selection at the country level. The criteria determined that the organization or intervention:

- demonstrated meaningful engagement of sex workers;
- applied evidence and rights-based approaches in design and implementation;
- demonstrated innovative approaches, strong progress and/or achieved results; and
- demonstrated interventions which engendered the elements of comprehensive approach, where documentation could provide guidance for others in certain areas including economic empowerment; preventing and responding to violence; integration of SRH and HIV for sex workers.

### Regional and country selection processes

A participatory process took place in the selected countries to identify and decide on case studies for documentation:

UNAIDS country offices convened relevant partners including government, sex worker organizations and United Nations agencies to discuss the criteria, apply the checklist and nominate case studies for inclusion;

The nominated case studies together with the checklists were submitted to the regional partners, who made the final selection using the above criteria.

### Case study development methods

The methods for developing selected case studies included:

- semi-structured interviews over telephone, Skype and personal interviews with key informants including management and programme staff,<sup>77</sup> members of sex work communities and programme partners;
- extensive follow up with organizations in-country to gather programme design documents, research data, evaluation reports and other published and unpublished materials;
- provision of draft case studies and feedback to organizations for review and fact checking; and
- revision of case studies in light of feedback response.

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With respect to the scope of this resource, many more interventions worthy of documentation and analysis exist in the region. Clearly the human and financial resources available for this work was a necessary consideration when deciding how many case studies could be documented. ■



- 1 *HIV in Asia and the Pacific: Getting to Zero*, UNAIDS 2011; *Report of the Commission on AIDS in Asia: Redefining AIDS in Asia, Crafting an Effective Response*, 2008;
- 2 Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, 65th Session of United Nations General Assembly, June 2011; Resolution 66/10: Regional call for action to achieve universal access to HIV prevention, treatment, care and support in Asia and the Pacific, ESCAP, May 2010; Resolution 67/9: Asia-Pacific Regional review of progress achieved in realizing the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS, ESCAP 67th Session, May 2011.
- 3 UNAIDS Guidance Note on HIV and Sex Work, UNAIDS 2009, updated March 2012.
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# Part 2: Case study collection



Case Study

1



# Scaling up HIV prevention and Sexual and Reproductive Health among sex workers: TOP, Myanmar

The map indicates locations of TOP drop-in-centres  
Source: TOP / PSI Myanmar

**P**opulations Services International (PSI) Myanmar launched the Targeted Outreach Programme (TOP) in 2004. The two main objectives were to make HIV prevention and treatment services accessible to sex workers and men who have sex with men and to promote safer behaviour and healthy lifestyles. TOP has four components: peer outreach, clinical services for STI, tuberculosis (TB) and opportunistic infection (OI) management and referral for HIV treatment, drop-in-centres (DICs) and HIV care and support. Advocacy, mentoring and support are overarching aspects of all four components.

TOP has become the single largest provider of HIV prevention services in Myanmar. In 2007 it accounted for 50% of services reaching sex workers and all services for men who have sex with men.<sup>82</sup> It has emerged as an example of effective community-led service delivery for HIV programmes in Asia and the Pacific. TOP's success lies in community participation, empowerment and community ownership. Using a 'learning-by-doing' approach, programmes have been adapted and informed by lessons learnt through the active participation, knowledge and wisdom of these communities. In 2011, TOP had established centres in 18 cities across Myanmar, reaching over 45 000 sex workers and 58 000 men who have sex with men. Out of its 350 staff members, 95% are sex workers and/or men who have sex with men.<sup>83</sup> "TOP's strength is our ability to care and protect our community people. We believe in empowering ourselves and empowering each other. And that's why we have achieved so much so quickly," says Kaythi Win, the Programme Manager of TOP Programme and PSI staff member, and former sex worker who joined TOP as a peer educator eight years ago.

This case study documents the experiences of TOP in scaling up its HIV prevention and treatment programme for female sex workers in Myanmar.

## Context: HIV and sex work in Myanmar

In Myanmar, the adult prevalence is less than 1% and new HIV infections are declining. The epidemic is concentrated among key affected populations: sex workers with prevalence estimated at 10%, men who have sex with men (8%) and people who inject drugs (22%).<sup>84</sup>

The number of female sex workers in Myanmar is estimated at 60 000.<sup>85</sup> There has been a steady decline in HIV prevalence among female sex workers from 33% in 2006 to 9.4% in the 2011 reporting period.<sup>86</sup> Stigma and discrimination and the criminalisation of sex work remain significant impediments to accessibility of HIV prevention, treatment and care services for sex workers.<sup>87</sup>

## Key components of the TOP programme

TOP services are delivered through peer-led outreach and drop-in-centres (DIC). These ensure prevention services are accessible to female sex workers and men who have sex with men at all times. Although services for both groups are similar, they are delivered separately in DICs. Four prevention components work in tandem.

### Peer outreach and education

Peer-led outreach is the backbone of TOP's work. It reaches marginalized and hidden communities and effectively expands the community base. Hot-spots are mapped to identify the geographic spaces that people occupy. This data is continually updated and informs design outreach and DIC intervention strategies. During mapping exercises, peer workers establish trust and friendship with community members. After this, intervention sites are divided into zones to maximize reach. Peer workers distribute IEC materials, male and female condoms and lubricants. They discuss HIV, STIs and other health issues, and inform people of DIC services. Home visits and assisting



## TOP Strategic approaches

### PEER OUTREACH ACTIVITIES

- Friendship/community building
- Education and communication
- IEC materials distribution
- Condom and lube sales
- Information about DiC

### DIC BASED ACTIVITIES

- Socialising
- Entertainment / recreation
- Information / educational activities
- Peer support groups

### CLINICAL SERVICES

- VCT
- SRH services including STI diagnosis and treatment, family planning, contraception, pregnancy testing, cervical cancer screening
- Referral to ART

### HIV CARE AND SUPPORT

- Trained volunteer “buddies” provide support and care
- Saturday Club
- National network of sex workers PLHIV

people with ill health to access mainstream health services is an integral part of outreach. By the end of 2010, the cumulative number of female sex workers reached by outreach was approximately 196 500, representing a significant proportion of the overall estimated population of these groups.<sup>88</sup> In 2010 alone the outreach programme made contact with 47 215 female sex workers of the 60 000 in Myanmar.<sup>89</sup>

TOP follows a peer-progression model<sup>90</sup> to enrol community members as volunteers and staff. Staff and volunteer performance is continually monitored. Promotion results from good performance and this encourages leadership from within the communities. Currently, almost all field and core staff members are either men who have sex with men or sex workers, with the exception of technical specialists. The peer model provides vital material and emotional support.

Peer educators are paid approximately US\$ 30 per month to cover transportation and expenses. They are trained twice a year on peer education, interpersonal communication skills and technical knowledge related to HIV, STIs and SRH, including social marketing of condoms and VCT.

### Drop-in-centres (DiC)

A primary attraction of the 18 DiCs is the ambience; they are a safe space for socialising and entertainment. All activities play a significant role in the process of collectivisation and self-help group formation and

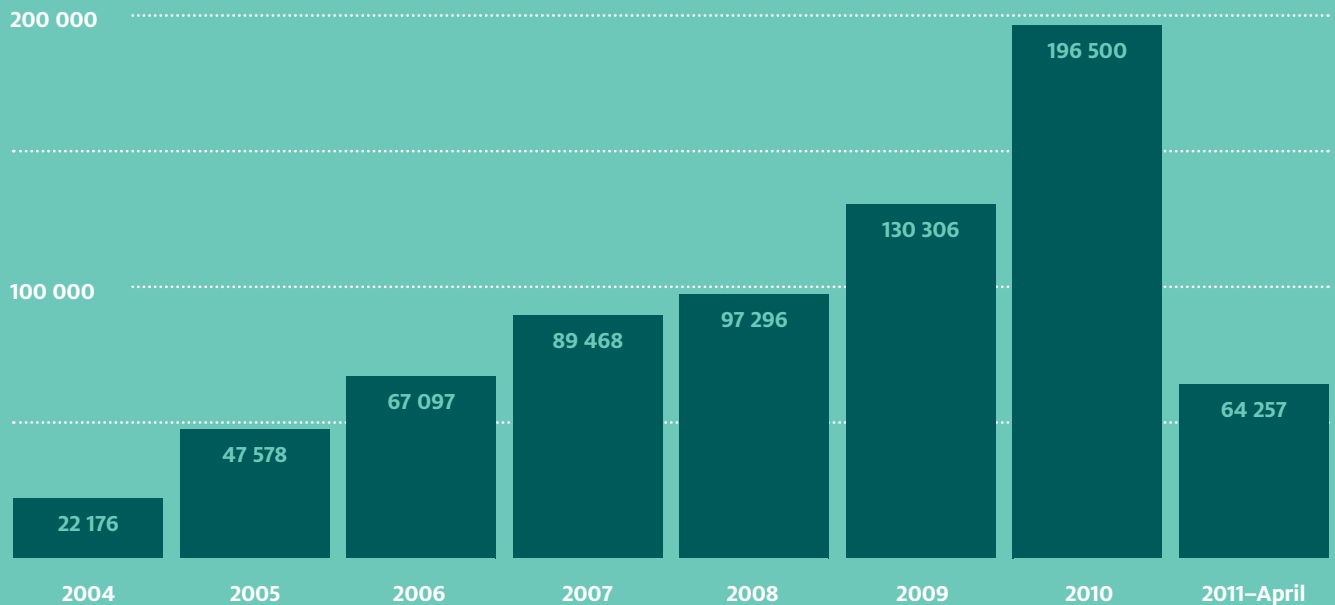
are conducted in response to identified needs. DiCs offer daily, weekly, monthly activities and annual events and clinical services for female sex workers and men who have sex with men. Daily activities include watching TV and video, providing space for bathing and grooming, sessions on sexual health, and condom and lubricant demonstrations. Weekly activities consist of spoken English classes, small social gatherings, counselling and medical treatment. Discussing movies, sharing experiences and information from readings, health discussions and problem solving are some of the activities. Monthly activities include life skills education and large social meetings with entertainment. Annual events such as World AIDS Day, the Water Festival and Valentine’s Day provide a platform for advocacy. Over eight years, the registration of female sex worker across all DiCs has grown exponentially, with more than 45 000 female sex workers registered and regularly participating in activities. This amounts to approximately 75% of the total estimated population of female sex workers in Myanmar.<sup>91</sup>

### VCT and clinical services

TOP offers a wide range of clinical services in fifteen DiCs and the remaining DiCs offer VCT and referrals to private clinics for HIV/STI diagnostic and treatment, in particular those run by PSI supported Sun Quality Health Clinics networks.

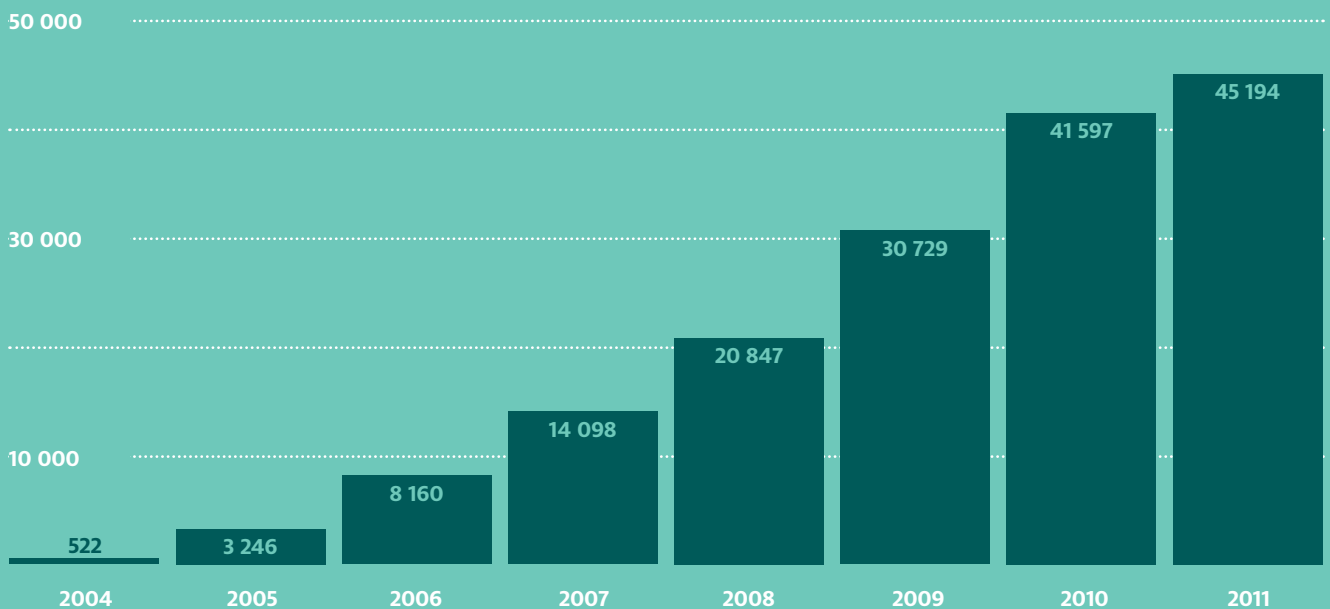


## Total female sex workers reached by outreach activity through TOP, 2004–April 2011



Source: TOP, PSI Myanmar, USAID, UNFPA 2011

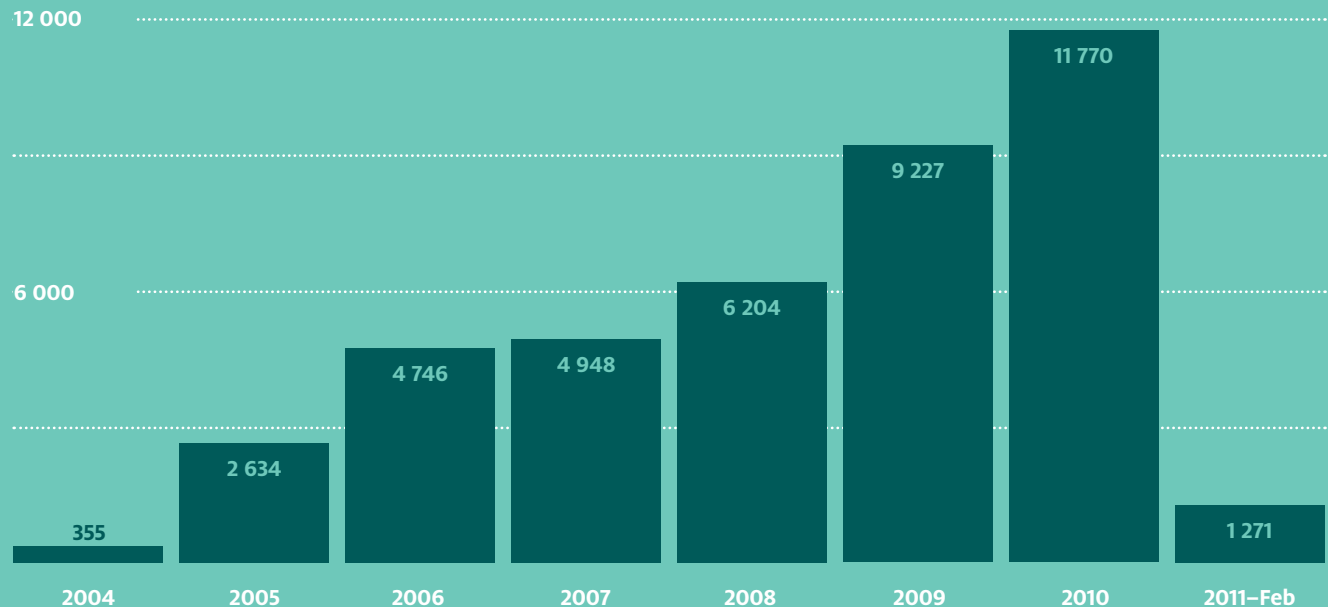
## Enabling a safe space for female sex workers: Total members at TOP DiCs, 2004–2011



Source: TOP, PSI Myanmar, USAID, UNFPA, 2011.



## TOP STI consultation and treatment service uptake by female sex workers, 2004–February 2011



Source: TOP, PSI Myanmar, USAID 2004–2011.

### Voluntary counselling and testing

Free VCT services are provided in a friendly, confidential and non-judgemental environment by two trained community counsellors. Peer outreach workers encourage female sex workers and men who have sex with men to test periodically. In Yangon, Mandalay, Patheingyi, Bago and Pyaw Oo rapid testing is available at the DIC but confirmatory tests are done externally. Blood screening in all other sites is carried out in collaboration with local hospitals and clinics. Every day, TOP transports blood samples for screening to the nearest clinic. DICs are intentionally located close to hospitals to minimise transportation time. Accompanied referral is provided for those taking confirmatory tests. In 2010, 12 107 sex workers and men who have sex with men reportedly accessed VCT services in Myanmar. Of these people, 40% had done so via TOP programme.<sup>92</sup>

### STI diagnosis and treatment

In 16 sites TOP offers free diagnosis and treatment services for STI.<sup>93</sup> Diagnostic tests include diagnosis RPR (Rapid Plasma Reagin), treponema pallidum haemagglutination test, smear test, wet mount test

and speculum examination. STI treatment is provided for syphilis, ulcers, urethral discharge, anal discharge, genital warts, genital herpes and chlamydia. Treatment of more complex STI is referred to partnering clinics and hospitals. TOP is the largest STI clinical service provider in Myanmar.<sup>94</sup> In 2009, it provided STI diagnostic and treatment services to 84 500 people out of a total number of 135 000 cases attended by all implementing organizations.

### Management of OI and diagnosis and treatment of TB

At the DIC, doctors from partnering health care facilities offer free diagnosis and treatment for OI. Diagnosis for most OI, including TB, is carried out in the on-site laboratory facility. DOTS treatment is provided free of cost.

### Referral for HIV treatment

TOP refers individuals to partnering hospitals for CD4 count, viral load testing and antiretroviral therapy access services. For those not yet on antiretroviral treatment, co-trimoxazole prophylaxis is provided at DICs. Every effort is made to ensure female

“We can raise issues to our peers and get information on how to solve problems. Moreover, we can get treatment at any time at the centre. If I feel frustrated, I come to this centre and rest or talk to friends or sing songs or watch movies.”

#### Female sex worker from Patheingyi, Myanmar

sex workers living with HIV who are pregnant are accompanied to antenatal clinics and have access to PPTCT programmes to prevent vertical transmission. In 2011, 945 sex workers living with HIV were referred for antiretroviral therapy.<sup>95</sup>

#### HIV care and support

Although referrals are provided, currently antiretroviral treatment is not available at the DICS themselves, however, there are plans to provide it in the near future. Around 40% of TOP community staff, and a sizable number of community members, are people living with HIV. With the support of APNSW, a peer support programme—the ‘Saturday Club for HIV Positive People’—was initiated at all DICS. This is a social group where ‘buddies’ exchange ideas and information on positive living. Over 1 000 people currently attend. This has led to establishing a national network for female sex workers and men who have sex with men living with HIV that has over 2 000 active members. The network is a forum for referral to antiretroviral treatment and other health services, peer support and advocacy for people living with HIV.

#### Effective integration of SRH and HIV services

In 2005, TOP began SRH services for female sex workers in Yangon. These include:

- family planning counselling, including the need for condoms combined with other forms of contraception to ensure HIV prevention and preventing unwanted pregnancies;
- access to full range of contraceptive methods;<sup>96</sup>
- pregnancy test kits; cervical cancer screening commenced in Yangon in June 2011;<sup>97</sup>
- VCT as integral part of pregnancy planning and information about prevention of vertical transmission (PPTCT);

- referral for antenatal, delivery and postnatal care including PPTCT.

Clinical services are provided three times a week in Mandalay and five times a week in Yangon by a staff of 18 doctors. Over the years, TOP has developed a strong referral network of health care providers, providing affordable treatment. These include doctors trained by PSI Myanmar on the specific needs and vulnerabilities of female sex workers and men who have sex with men. Training follows the national protocols and guidelines for case management of HIV, STI, TB and SRH. TOP monitors community members’ experiences at health care facilities and this information is used to address any issues that may arise.

#### Tha Nge Chin: TOP microcredit programme

In 2005, TOP initiated a microcredit project *Tha Nge Chin* (meaning ‘friend’). Every month, individuals deposit 1 000 Myanmar kyats (around US\$ 1) into the *Tha Nge Chin* account. Funds collected are used to provide interest-free loans to people in emergency situations. Funds are issued for:

- releasing sex workers from police custody;
- rebuilding homes due to damage caused during rainy season;
- children’s school fees;
- emergency costs related to HIV treatment and hospice care.

If surplus funds are available, loans are offered to female sex workers to start small businesses. *Tha Nge Chin* has a committee of community members who approve loans. Two full-time staff manage the funds.

#### Scaling up services

The overall effectiveness of TOP’s programme lies in the scale of coverage combined with high-quality and



## Peer progression and leadership development within the female sex worker programme: Story of Kaythi Win, TOP Programme Manager



Kaythi was born in Yangon in a middle class family. She is the oldest of four sisters. Her father was a taxi driver until he passed away in 1998 and her mother stayed at home taking care of the family and household. After the demise of her father, the family faced financial hardship. Kaythi was a good student in the 10th grade at that time. When the financial situation worsened she dropped out of school. Soon the family were evicted from their house, as they could not pay rent. In 2000, when Kaythi approached a friend to lend her some money for the family, she suggested Kaythi consider doing sex work. Kaythi initially felt ashamed and reluctant. But her family needed the money and she finally decided to be a sex worker. She moved out of her house and stayed with the friend who introduced her as a sex worker. Kaythi used to go out in the late in the day to find clients for fear of being identified. She kept her occupation a secret from her family, telling her mother that she was working in a factory near the Burma-Thai border. Kaythi was able to earn enough money to support the education of two younger sisters and a niece who was staying with her mother. She regularly sent money to her home.

In 2003, Kaythi met a Behaviour Change Communicator (BCC) from PSI in a restaurant. She informed her about HIV, STI and importance of using condoms. Kaythi was intrigued by this information, as she had no prior knowledge about HIV, sexual health and safer sex practices. She was eager to learn more. By the end of 2003, Kaythi joined PSI as a volunteer for a BCC programme. When TOP began in 2004, she started working as a peer worker. In less than nine months, she was promoted to Interpersonal Communicator

(IPC). In 2006, she rose to become a community organizer and in 2007 became a project officer for female sex workers in TOP Yangon.

In 2005, APNSW came to Yangon to conduct the first human rights training for sex workers. This was an eye opener for Kaythi. She later became one of the board members of the Network and got the opportunity to travel across the region. She interacted and learned from other sex worker organizations and spoke on sex workers' issues. Through this exposure she learned about the principles of human rights, rights of sex workers and sex workers' collective strength and agency.

Currently Kaythi is Programme Manager for the TOP programme at PSI and is one of the most prominent leaders of sex worker community in Asia and the Pacific region. She serves as the Chairperson of the APNSW board.

“Advocacy is critical to our work [for scaling up]...when we open a centre, we invite local community members to see our services. This creates a supportive environment...”

TOP's Senior Programme Manager,  
Kaythi Win

accessibility of services and programmes. In July 2004, TOP began with one intervention site in Yangon; a DIC with an STI facility for female sex workers. A DIC for men who have sex with men was launched in August 2004. By the end of the year, a group of peer outreach workers were trained to start building a network that today reaches thousands of sex workers and men who have sex with men.

Scaling up services required mapping and Rapid Situational Assessments (RSA), carried out by trained volunteer community members. The RSA identify risk factors for female sex workers and men who have sex with men around each intervention site and the findings of the RSA and mapping exercises inform decisions about the appropriateness of location for a DIC, service needs and a context-specific advocacy strategy involving key stakeholders such as community leaders, government officials and health care providers. Approximately, three to six months of fieldwork is required for effective planning and set up of a new DIC. Clinical services are established once outreach and DIC services have been in place in for one year.

TOP staff regularly meet with local authorities and INGOs, furnishing updates of their work. This is part of a concerted effort made to maintain good relations with people living in the neighbourhood where DICs are situated. Meticulous planning, community-led advocacy and collaboration with local partners and local community have been a recipe for successful DICs in each location.

“Advocacy is critical to our work. When we assess an area for opening a DIC, we repeatedly visit the relevant government officials (i.e. the NAP Team Leader, health care providers, and local community leaders) in that particular township, and advocate with them on issues facing community people, share our plan and seek needed support to open an intervention site,” explains TOP's Programme Manager, Kaythi Win. “Once we open a centre, we invite local community members in that locality to come and see our services. This creates a supportive environment for us to imple-

ment our programmes and seek help to solve problems we might face,” she adds.

The rapid scale up of TOP services has been made possible by a strong staff capacity development programme. A mobile team comprising community members from Yangon, regularly visits each site to monitor local advocacy, financial and programme management. They provide regular support and supervision.

TOP has received on-going technical assistance from PSI Myanmar. An advisor provides technical assistance to the local team establishing the DIC from inception to implementation. The team's role is to build community capacity to enable effective management by the community. In addition, there has been invaluable technical support and advice from various regional partners, such as APNSW and sex worker organizations in other countries. Kaythi Win, has used guidance and support of APNSW to ensure service delivery is grounded in a human rights approach.





## Sun Quality Health Clinics Networks<sup>98</sup>

The private sector is the major provider for people seeking basic health products and services in Myanmar, with about 80% of health care visits made in the private sector. In a country where the average income is less than us\$ 2 per day, people pay for health care. According to a study by PSI,<sup>99</sup> there were 5 578 general practitioners in Myanmar in 2009, with 2 400 new doctors joining the private sector every year. The Myanmar Medical Council issues licenses to all doctors, however, there is no regulatory system to assess or monitor the quality of care provided.

In 2001, PSI Myanmar launched Sun Quality Health (SQH), a network of private clinics run by highly qualified doctors specialising in reproductive health, TB, pneumonia, diarrhoeal diseases, Malaria and sexually transmitted infections, including HIV. PSI Myanmar provides training, patient education materials, access to high-quality products, and supervision and monitoring. The providers commit to specified service standards and a price structure that makes their services affordable to people on limited income. PSI Myanmar collaborates with the Myanmar Medical Association offering continuing medical education to these doctors.

Building on the success of SQH, in 2008, PSI Myanmar launched a second franchise, Sun Primary Health, to increase access to health care in rural areas, where about 70% of the country's population lives. This network includes midwives, lower-level medical staff and farmers. They are trained and supported to provide education, services and products for reproductive health, diarrhoeal diseases, Pneumonia and Malaria, and they refer clients to SQH clinics for TB and other acute illnesses. By February 2011, PSI had 1 229 SQH providers in 169 of Myanmar's 325 townships and 1 029 Sun Primary Health providers in 45 townships. In 2010 alone, PSI provided more than 1.2 million reproductive health consultations, tested 205 439 people for Malaria and provided treatment to 44 739 people, and contributed to registering and treating about 11% of the country's TB cases. In Myanmar, this model has emerged as an important way to strengthen health systems; by building local capacity in the private sector and scaling up access to health care for marginalized and poor communities, such as female sex workers and men who have sex with men.<sup>100</sup>



## Lessons

- **HIV prevention programmes can be effectively scaled up by being communityled.** TOP has emerged as the largest HIV programme for men who have sex with men, covering 70% of this population in Myanmar, and one of the largest for female sex workers with 55% benefiting from its services.<sup>101</sup> Mobilizing and empowering these communities to be in control of programme design, delivery and monitoring have been critical to achieving impressive scale up.
- **Peer-progression outreach model can pave the way for sustainable community leadership.** Female sex workers and men who have sex with men regard peer outreach workers as leaders. The incentive of this model promotes community leadership development.
- **Investing in capacity training is crucial to scaling up and programme effectiveness.** Capacity building of peer outreach workers is not limited to effective communication about HIV prevention and learning how to conduct condom demonstrations. It is about learning ways to mobilize, motivate and bring together communities to assert their human rights. Peer workers are trained to be catalysts; bridging the gap between isolated community members and available services. Hence, formal, classroom-based trainings are inadequate to develop the necessary skills. Informal sessions that include discussions, sharing and learning among peer workers have been more effective, generating demand for and fostering stronger relationships between the community and service providers.
- **Providing VCT through trained community counsellors increases uptake of HIV testing.** Early experiences revealed that female sex workers were reluctant to access VCT when counsellors were not from the community.
- **Peer outreach work can improve health-seeking behaviours.** The number of female sex workers seeking a wide range of sexual and reproductive health services at the PIC and/or in the partnering clinics has steadily increased partly due outreach which has built awareness of and demand for HIV and SRH services.
- **Public-private partnership for health care delivery can improve use of health care services.** The network of Sun Health Clinics provides subsidized SRH, STI and HIV-related health services. This has improved access to and use of health care services by rural, poor and marginalized communities. The involvement of government bodies such as the Myanmar Medical Council has further improved health care services.



## Gaps, challenges and opportunities

Sex work is illegal in Myanmar under the Suppression of Prostitution Act 1949, including soliciting and owning and managing a brothel. The Act provides heavy penalties for soliciting including imprisonment for between one year and three years, and female sex workers may be detained in a 'prescribed centre'.<sup>102</sup>

Violence against sex workers is a major concern and sex workers in Myanmar are generally silent on the abuses they face.<sup>103</sup> Though some headway has been made with the police to address such violence, it has not significantly reduced harassment. According to Kaythi Win, "We even have an in-house lawyer at TOP, who is also a member of our community, but we have found it difficult to provide legal aid and take legal action." The Myanmar Government has recently started collaborating with TOP and UNFPA and UNDP to undertake research on violence against sex workers to inform policy and programmes to prevent and respond effectively to violence against sex workers.<sup>104</sup>

Enforcement practices under the Suppression of Prostitution Act 1949 and lower socioeconomic status of women in Myanmar contribute to high levels of stigma and discrimination against female sex workers. This in turn hinders their access to HIV prevention, treatment and social protection services. Through its community approach TOP has, to an extent, addressed internalised stigma. However, more needs to be done with and for sex workers, men who have sex with men and people living with HIV in the wider society.

Sustainability is a constant concern, especially in the context of declining funding for HIV. Resources mobilized by PSI Myanmar currently fund TOP's service delivery. Without sustained funding, the efficacy and



scale of TOP will be compromised. The need to plan for different revenue models is a priority and communities need to be at the forefront of this planning.

Moving forward, staff members envision TOP as an independent Community-based Organization (CBO). The changing political climate in Myanmar, increased demand for democracy, and more civil participation in development of the country present concrete opportunity for this vision to become a reality. While the organization could continue as a HIV programme of PSI Myanmar, the challenge is to develop and sustain it independently. Essential to this process is consensus building at all levels to transfer the responsibility to the community, and continued financial and resource support from partners. ■

“My dream is to build my community beyond addressing the issues of HIV. I want to make sure that, at TOP, we as a community of men who have sex with men and female sex workers can empower each and every member of our community to build their own lives, solve their own problems and behold ourselves as dignified and equal citizens of Myanmar. This is my hope and I am working hard with our community people to make this happen.”

**Kaythi Win, Programme Manager, TOP**

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- 95 The data of sex workers receiving the ART through TOP is not available.
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Case Study

2

# HIV prevention and treatment services for male and transgender sex workers in Tianjin, China: Dark Blue



In 2004, a small group of volunteers in Tianjin, a city east of Beijing, People's Democratic of China, formed the Tianjin Dark Blue Voluntary Working Group (Dark Blue), with the common vision that all sexual minorities — lesbians, gay men, bisexuals, and transgender (LGBT),<sup>105</sup> have the right to lead healthy lives with equality, respect and dignity.

Although Dark Blue is a LGBT organization, their support services are mainly for gay men, men who have sex with men and transgender people. It started providing services for male sex workers locally referred to as 'money boys', and transgender sex workers in 2008.<sup>106</sup> Now with nine full-time staff and 31 outreach workers, Dark Blue has emerged as the only support system and primary HIV service provider for male and transgender sex workers in Tianjin. Services and programmes include a drop-in-centre with HIV and STI testing and treatment facility, outreach services, internet-based radio and chat-room programmes, training and education as well as health service referrals.

Dark Blue's constant engagement with the LGBT community and rigorous monitoring of programmes ensures that emergent needs of this community are addressed. Dark Blue has mobilized many male and transgender sex workers who now regularly participate in programmes and benefit from its services. In addition to imparting skills and fostering confidence among sex workers and sexual minorities to live healthier lives, sexual minorities living in Tianjin can now access health services that do not discriminate against them.

This case study documents Dark Blue's evolving experience in providing HIV and STI prevention and treatment services for male and transgender sex workers in Tianjin.

## HIV among male and transgender sex workers in Tianjin

Dark Blue estimates that there are currently between 300 and 500 transgender people and 3 000 to 5 000 males selling sex in Tianjin, in a diverse range of venues

and locations.<sup>107</sup> In Tianjin, there are approximately 20-30 brothels,<sup>108</sup> one public bathhouse, two saunas and more than 20 areas where business is conducted in specific streets and along the Haihe River.

In 2008, initial efforts to reach men who have sex with men and transgender people in Tianjin revealed that large numbers had male and female commercial sexual partners. In 2009 Dark Blue undertook a baseline survey among 89 male sex workers that also included mapping the male and transgender sex worker population in Tianjin.<sup>109</sup> Key findings were that:

- the average age of male sex workers was 21 years, with 29% self-identifying as gay, 18% as heterosexual and 52% as bisexual;
- the male sex workers moved in and out of sex work regularly, depending on financial circumstances;
- they had low awareness of HIV and limited skills to negotiate safer sex;
- the large majority of the sample had alcohol and drug-related problems, exacerbated by poverty;
- prevalence of HIV among the sample was almost 7%.<sup>110</sup>

The high levels of HIV in the sample are consistent with findings in other studies. These have suggested that prevalence of HIV and syphilis among male sex workers is much higher than among the general population of men who have sex with men in Tianjin.<sup>111</sup> While in 2009 the prevalence of syphilis among men who have sex with men in Tianjin was 19%, it was 29% among male sex workers.<sup>112</sup>

The baseline study findings and community engagement, laid the foundations for developing Dark Blue's HIV services. These services are informed by the issues faced by male and transgender sex workers, which often radically differ from those of the general populations of men who have sex with men.



## Dark Blue's model for HIV prevention, care and treatment services

During 2009 alliances were formed with bathhouse and pub owners, hospitals and the local Centre for Disease Control (CDC) in Tianjin. Simultaneously, Blue Dark sought funding to work with male and transgender sex workers.

With a grant from UNFPA in 2010, Dark Blue developed an integrated scheme of HIV and STI prevention, care and treatment services for sex workers within the existing programme for men who have sex with men. Although UNFPA funding ceased in 2011, funding from other organizations and individual donors enabled the work to continue.<sup>113</sup>

### A safe space for community networking, education, services and support

Dark Blue offers a safe space at its drop-in-centre (DiC) for community members to interact with each other. At the centre, people can access HIV testing and treatment facilities, condoms, lubricants and sexual health information.

Noting that many young men who have sex with men, transgender people and male and transgender sex workers used social networking media to interact with each other and search for partners and clients, in 2004 Dark Blue initiated a web-based programme with the aim of reaching younger people.

### Building partnerships for effective programmes

Establishing partnerships have been crucial to the success of Dark Blue's programmes. Long-standing partnerships with the Tianjin Centre for Disease Control and Prevention (CDC), health service providers and owners of sex clubs<sup>114</sup> has been instrumental in ensuring the provision of high-quality, non-discriminatory HIV/STI prevention, treatment and care services for sex workers.

“At the centre, everyone is treated equally and with respect. I don't have to be afraid of being gay or being a sex worker and worry about how others will judge me. The health services they offer are of great quality, better than at some hospitals where I am afraid to go. Because of the friendly and relaxed environment, I feel comfortable here and don't feel ashamed talking about my issues, discussing my problems, as I am around so many others with similar issues. We are all friends here.”

#### A male sex worker who regularly attends the DiC

“The cooperation from the CDC helps us get medicines on time, get our community members tested and treated quickly; the cooperation from sex club owners gets us access to the most vulnerable sex workers who need HIV services; the cooperation from the health service providers gets our community get treated for STI, opportunistic infections (OI) and HIV in a non-threatening and non-discriminatory environment,” a Dark Blue outreach worker explained. “Without working with them, we would have never been able to maintain the reach and the quality of services we provide for our community,” the worker added.

Across the country, CDCs are increasingly recognizing the benefits of community engagement in HIV prevention.<sup>115</sup> The Tianjin CDC is committed to HIV prevention among sex workers. “It is a mutually beneficial relationship between CDC and us; we need their support and resources to run our Programmes that benefit the community and in return, we support them on their public health efforts by encouraging community members to test and treat early,” said Dark Blue's founder, Gaga.

The cooperation of owners and managers of sex clubs is also critical to reach the most vulnerable



## Use of interactive communications technologies: Gay Radio

'Gay Radio' is a web-based, virtual interactive safe space or platform for sexual minorities and male and transgender sex worker communities run by Dark Blue. It provides:

- interactive one-on-one audio-visual chat room for counselling and access to information on HIV/STI and other health issues, health services and entertainment;
- group interaction on various relevant topics.

The principles underlying the platform aim to foster friendship provide support and create a non-threatening environment to reinforce messages on safer sex and discuss issues relevant to the community. Trained counsellors moderate Gay Radio with up-to-date information. In 2012, Dark Blue estimated that more than 20 000 community members log in each month. It runs round the clock and can be accessed by subscription from anywhere in the world.

While Gay Radio began as a platform to empower LGBT people, it has evolved into a discussion forum on topics such as sex and sexuality, lifestyle matters, marriage and family relations. Gay Radio hosts an interactive 'Guest House' programme, inviting domestic and foreign scholars and activists to speak on subjects concerning LGBT communities.

"Through the Gay Radio platform, we talk about discovering our sexual identities, overcoming self-stigmatization and fear in addressing societal discrimination, our need for healthy lifestyle and ways to develop one; we talk about our sex lives, our relationships and focus on safe sex practices. We talk about HIV treatment, care and support for each other," said Dark Blue founder, Gaga, outlining central elements of the interactive platform that Dark Blue report have led to a broad community of support built within the chat rooms. "This has led to the creation of a 'safety net' for people using the platform, especially for those who frequently travel

and find themselves without any support system and without access to critical information that a circle of friends helps bring about so as to facilitate disclosing inner feelings, asking questions, seeking advice, and so on," Gaga added.

The accessibility of the Gay Radio chat room and services has been effective in raising HIV awareness among male and transgender sex workers, even though they are a highly mobile population. Gay Radio provides anonymity. The privacy of the chat room encourages people to seek advice on sexual health and related problems.

"Providing an opportunity to hear and interact with role models and motivational speakers from the LGBT community can be a life changing experience, especially for overcoming self-stigma and reinforcing safe sexual practices and healthy living."

**A member of the Gay Radio programme**

populations. Partnerships with owners and managers are built through repeated contact, advocacy meetings, training, and awareness raising. Dark Blue organizes training that brings owners and managers together with sex workers to discuss issues like safer sex, STI/HIV prevention, the importance of early testing and treatment of HIV/STI, and to strategize ways to ensure the health and safety of workers.

Consequently, sex clubs in Tianjin have become a major outreach site for HIV and STI prevention, and for on-site treatment of some STIs such as syphilis. The partnership has fostered understanding that preventing HIV and STI among sex workers and their clients not only benefits individuals, but also makes good business sense. “If one of the clients discovers that a sex worker at this bathhouse has a STI, news rapidly spreads among the clients and then we become unpopular. The business suffers. It is good to have these services for sex workers here. Because of Dark Blue, more use condoms consistently; they are protected and healthy,” a public bathhouse owner in Tianjin explained.

The partnership has made both sex workers and owners better equipped to handle crisis situations and present a united front.<sup>116</sup>

“Without working with [the CDC], we would have never been able to maintain the reach and the quality of services we provide for our community,”

**Outreach worker, Dark Blue**

Collaboration with health care providers has also been important to Dark Blue’s efforts. Recognizing sex workers had low uptake of STI/HIV treatment and follow-up services, CDC and Dark Blue identified three key health service delivery centres to collaborate with. Doctors in sexual health, HIV treatment and care centres that were sensitive on issues of sexuality were identified. CDC and Dark Blue trained them to deliver

“It is good to have services for sex workers here [in the bathhouse]. Because of Dark Blue, more [clients and sex workers] use condoms consistently; they are protected and healthy,”

**A public bathhouse owner, Tianjin**

services in a non-discriminatory manner. Community members are then referred to these professionals, when needed.

The partnership has had resulted in increased numbers of community members receiving treatment for STIs, getting timely CD4 and viral load count and early treatment of HIV. In the past, community clinics were closed on Saturdays but are now open for certain hours every Saturday, making it easier for sex workers to visit. “The doctors kindly run a special clinic for sex workers every Tuesday afternoon between 1.30 and 5pm which is perfect time for sex workers to visit. Syphilis treatment only costs 75 yuan at these clinics for sex workers as opposed to the 4 000 yuan at other hospitals,” Dark Blue’s founder Gaga explained. “This is made possible because of the lasting cooperation between us.”

## Outreach

All thirty-one staff members conduct outreach and peer-education activities across 15 selected sites in Tianjin. Most of these sites are sex clubs. Outreach volunteers receive 50 Chinese yuan to cover transport costs. Prior to outreach, micro-planning and mapping exercises are undertaken to identify sites and determine the number of sex workers that would benefit. Outreach workers are expected to maintain contact with 50–60 male sex workers, reinforcing safer sex messages and motivating them for early testing and treatment.

“Repeat contact helps us to provide individual support to each of the members of our community in a holistic way and throughout the period they wish to maintain contact with us.”

Outreach worker, Dark Blue

“Repeat contact helps us to provide individual support to each of the members of our community in a holistic way and throughout the period they wish to maintain contact with us. Because the same outreach worker is responsible for maintaining contact with the same member throughout the period of their interaction, right from when they meet to when they seek help to be tested or treated, a standard quality of service provision and personalised care is made possible, which are not usually found in hospitals otherwise,” explained a Dark Blue outreach worker.

Gay Radio, the Dic, Voluntary Testing and Counselling (VCT) at sex clubs and other health service providers are discussed during outreach.

Outreach workers receive periodic training to update their knowledge and skills. The training includes interpersonal communication skills, use of IEC materials and technical knowledge on HIV and STI. Short orientations are organized every week to share problems and build knowledge and skills.

According to Dark Blue’s estimates, the number of community members contacted through outreach has increased from 9 000 in 2010 to 20 000 in 2011. Outreach to sex work locations where previously

there had been little or no HIV interventions, such as in the public bathhouses, has significantly contributed to increasing HIV awareness and condom use.

### Training and orientation on skills in sex work and occupational safety

Training and orientation programmes for community members are organized and designed for fun and education. Topics of training programmes are decided collectively by outreach workers, based on concerns raised by sex workers in the community. Staff members facilitate the Programmes along with external experts, if needed. Occupational safety is part of the training. Sex workers have gained practical knowledge and skills in negotiating safer sex and fair prices, pleasure enhancing for improving business, methods and techniques in sexual positions and sex acts and dealing with abusive clients.

### Personalized on-site and referral services for HIV and STI counselling, testing and treatment

Dark Blue provides the following comprehensive sexual health services:

#### On-site VCT using rapid HIV testing

Dark Blue receives free HIV rapid test kits from CDC and other donor organizations. Rapid HIV tests, voluntary and confidential pre and post-test counselling are provided in brothels, bathhouses and at Dics. Availability of these in community locations has made HIV testing more accessible and convenient for sex workers. As a result, there has been a marked increase in uptake of VCT. In 2009, 2 163 people tested at on-site VCT, rising to 4 501 in 2011.<sup>117</sup> Approximately, 80% of male sex workers and their clients had their initial HIV test in bathhouses.<sup>118</sup>

Dark Blue counsellors are certified by the CDC. They receive periodic refresher courses on counselling skills and updates on new testing technologies. The benefits of testing and early treatment are reinforced on Gay Radio and its chat room programmes, through

“Partnership has had resulted in increased numbers of community members receiving treatment for STIs, getting timely CD4 and viral load count and early treatment of HIV”

Gaga, Dark Blue founder

“When other community members see that their fellow positive friends are being treated with kindness, care and compassion, it encourages them to seek help, because they know that they are also going to be treated well. “

Outreach worker, Dark Blue

outreach, in training and orientation programmes, and by disseminating IEC materials.

### Continuity of support for people living with HIV

Confirmatory tests are conducted at CDC. If the result is positive, counselling includes discussing treatment and care options, available health care services and healthy living. When requested, the counsellor coordinates with the designated outreach worker for accompanied referral for an initial health check-up, including CD4 and viral load and commencement of treatment.

“When other community members see that their fellow positive friends are being treated with kindness, care and compassion, it encourages them to seek help, because they know that they are also going to be treated well. Since we started providing personalised care to the positive sex workers, treatment adherence has also improved,” a Dark Blue Outreach worker explained.

Dark Blue outreach workers provide continuity of care and support for people living with HIV for as long as they wish to remain in contact.

Dark Blue has demonstrated that an integrated approach to community-based rapid HIV testing, combined with support to sex workers who test HIV positive, improves access to HIV treatment and care. In 2011, over 80% of those who tested HIV positive at Dark Blue sites required HIV treatment. In 2010 and 2011 a total of 172 people tested HIV positive and were successfully referred for an initial health check-up.<sup>119</sup>

### STI diagnostics and referrals for treatment

Apart from HIV tests, diagnostic tests for seven STIs are available at on-site locations. Blood samples are collected and sent to the local CDC for testing. Symptomatic treatment for minor STIs are provided at the centre free of charge and complex STI cases are referred to partner hospitals and clinics. Follow-up support is offered. The number of men who have sex with men and male sex workers referred for STI

services increased from 33 in 2008, 219 in 2009 to 421 in 2010.<sup>120</sup>

### Emergency shelter for sex workers

Dark Blue observed that sex workers, particularly those living with HIV, are frequently homeless, due to critical ill health, family estrangement, violence and social ostracism. To ameliorate this, Dark Blue opened a temporary emergency shelter. Ideally, the shelter should be able to accommodate people until alternatives can be found. In reality, it is constantly full with some residents requiring long-term stay. This puts enormous constraints upon the availability of place at the shelter, indicating the urgent need to create a wider social protection system for sex workers, positive people and sexual and gender minorities.

### Mobilizing clients of male sex and transgender sex workers

Seven clients have been trained as volunteers to reach out to other clients. They regularly distribute IEC materials, condoms and lubricants and share information on HIV, STIs and Dark Blue's services. Clients are invited to participate in twice-a-month training and orientation programmes on topics chosen by clients such as safer sex, healthy living, and enhancing sexual pleasure. The involvement of clients in implementing the programme has promoted consistent use of condoms in brothels and among clients' regular sex partners. A total of 170 clients regularly visit the various centres.



## Lessons

- **Long-term partnership provides sex workers' sustained access to high-quality health services.** Synergies between partners have contributed to the sustainability of HIV and STI services for male and transgender sex workers. Building effective partnerships requires persistence and an investment of time and resources. To sustain the partnership, it is important that both partners benefit and that there are overlapping areas of interest and concern. For example, bathhouse owners needed condoms and lubricants that Dark Blue was able to supply. In the case of CDC, they recognized that partnering organizations such as Dark Blue enabled them to reach male and transgender sex workers. By linking with CDC, Dark Blue has ensured that communities have access to government health services.
- **Providing integrated health services for sex workers requires a supportive policy environment, committed leadership and CBO-government partnership.** China's national and local policies prioritize HIV prevention among male and transgender sex workers. "There has to be a will and commitment from the leaders of the local CDC to work with small CBOs like us," Dark Blue's founder Gaga said. Almost all aspects of Dark Blue's service delivery have required support and cooperation from the CDC; including verification for social insurance applications for people living with HIV. Moreover the Chinese government ensures that good quality health facilities, an abundant supply of condoms and lubricants and free HIV treatment are provided in rural and urban areas. This has provided an excellent basis for developing linked and integrated services.
- **On-site availability of HIV rapid tests increase uptake of VCT services.** The ease of rapid HIV testing has encouraged a culture of HIV testing among men who have sex with men and male and transgender sex workers. Availability of rapid test kits has reduced logistical problems of inadequate laboratory facilities and blood transportation.
- **Friendly, non-judgmental staff and privacy for HIV counselling improves uptake.** Ensuring that counselling follows the established protocols has been a key to improving the communities' confidence to test.
- **Ensuring quality of care and a comprehensive range of health services for sex workers living with HIV requires investment in time and resources.** Sex workers often require immediate and sustained support from the time they test positive. Considerable investment of financial and human resources and capacity is required to provide individuals with continuity of care.
- **Facilitating networks is critical to community mobilization and health promotion.** Dark Blue's work provides a strong model of integrating peer outreach with innovative community education and networking.



## Gaps, challenges and opportunities

Dark Blue has been unable to register the organization and this has prevented its growth and ability to act autonomously. It has not been able to receive funds directly from the government or other donors, and has to rely on registered organizations to route funds. Dark Blue currently receives funding support from 11 organizations and has six organizations routing their funds. A service fee of 5% is levied and has been borne by Dark Blue's programmes.

It is difficult to reach male and transgender sex workers doing business over the Internet and to maintain regular contact with this highly mobile population. Getting health services to hidden populations such as male sex workers who are HIV positive poses a great challenge. Despite difficulties, Dark Blue has made considerable progress.

Countering social stigma and discrimination against sex workers and sexual minorities, and organizations that work with them, remains a struggle. In the last five years, the Dark Blue office has relocated seven times due to this problem. Male sex workers living with HIV are particularly vulnerable to social and familial ostracism and they often withdraw from

social interactions and services on learning that they are HIV positive. When associated treatment costs are too high, sex workers may terminate contact with health and support services.

Nevertheless, Dark Blue has an excellent relationship with the local CDC in Tianjin and is increasingly becoming an example across China of improving male and transgender sex workers' access to HIV testing, treatment and care. In July 2012, the national CDC consultation was hosted in Tianjin and Dark Blue was invited as the main resource organization to provide training and share experiences of their model. This is a great achievement and a new beginning.

Dark Blue is looking forward to evolving into a national resource centre for men who have sex with men and male and transgender sex workers. They are planning to register as a CBO renaming it "Tianjin Dark Blue Health and Development Service Centre." All indications point towards a journey that will continue to make a significant improvement in the lives of sex workers and sexual minorities in China. ■

105 The acronym 'LGBT' is used as an umbrella term for groups and/or individuals whose sexual orientation or gender identity differ from heterosexuality and who may be subject to discrimination, violence and other human rights violations on that basis. Information and data presented in this article may not apply equally to all the groups represented by this acronym.

106 Male sex workers or 'money boys' includes all males who are involved in selling sex to male clients. Reference to transgender sex workers refer to both pre-op and post-op male to female transgender persons who sell sex.

107 Dark Blue, 2009. Mapping of MTSW populations in Tianjin.

108 Brothels, bathhouse and saunas are often temporary in nature. They tend to shut down as new clubs open. Recently, some brothels have been temporarily moved from Beijing to Tianjin, due to police crackdown on sex work in Beijing.

109 Dark Blue, 2009. Mapping of MTSW populations in Tianjin.

110 Ibid.

111 Zhongquan, LIU et al., 2009. The prevalence of HIV and syphilis infection among money boys in Tianjin. *Chin J AIDS STD* Vol. 15 No 3 Jun. 2009.

112 UNAIDS. MSM Country Snapshot China. August 2010: Version 2.

113 Individual donors include major contributions from financially secure China-based men who have sex with men living with HIV.

114 Otherwise known as 'entertainment venues', Dark Blue refers to these as 'sex clubs', since no activity other than sexual activity takes place in them. There are five types of 'sex clubs' in Tianjin where male and TG

sex workers either solicit male clients and/or have engage in paid sex with them. These are brothels, public bathhouses and massage parlours, pubs and streets. Soliciting also takes place over the Internet. While the street is not usually a venue for having sex, sex workers who solicit clients on the street tend to move to other venues to provide them with sexual services. In China, sex clubs are legally registered as small businesses.

115 Hui Li et al. 2010. From spectators to implementers: civil society organizations involved in AIDS programmes in China. *International Journal of Epidemiology* 2010; 39: ii 65–ii71 doi:10.1093/ije/dyq223. Accessed on 3 June, 2012 from [http://ije.oxfordjournals.org/content/39/suppl\\_2/ii65.full.pdf+html](http://ije.oxfordjournals.org/content/39/suppl_2/ii65.full.pdf+html) in Bangkok Thailand.

116 At the time of this documentation, Dark Blue reported that police crackdowns were not as frequent as in some of the other cities such as Kunming. In the last two years, there has only been one police crackdown in Tianjin according to staff.

117 These figures include testing of men who have sex with men. Approximately 10-20% of the total number is male and transgender sex workers.

118 Dark Blue, 2009. Mapping of MTSW populations in Tianjin. For more information about this study, contact: [tjgaga@gmail.com](mailto:tjgaga@gmail.com).

119 As reported by Dark Blue during documentation interviews.

120 Ibid.



Case Study

3

“Small ants like us will keep working together to build a ‘wall’ as a shield for sex workers to have their own standing in society with safety and good quality of life.”

Ms. Surang Janyam, founder, Service Workers in Group

# Building community and working with police: SWING’s organizational development journey

**S**ervice Workers in Group (SWING) was established in September 2004 with the core vision to protect and promote the human rights of sex workers. In November 2009, it was registered as a foundation in the Kingdom of Thailand (Thailand).

### Transforming lives: Nim's story

At first, Nim did not trust SWING's peer educators, but warily accepted to go on a retreat with the organization. It was there that she saw that SWING truly cared. "Within only a couple of days I got my sense of human being back after looking down on myself for a long time." Inspired, Nim joined the organization and soon was selected to become a Peer Educator. By 2006, Nim had become a full-time staff member, and her outlook on life had changed dramatically. "I am more confident, in talking and communicating with people, in expressing my thoughts. I can lead Peer Education—before I could not make decisions, but now when members come to me with problems I am ready to help."<sup>121</sup>

## The HIV epidemic in Thailand

Sex workers and their clients were a critical part of Thailand's early success in reversing the HIV epidemic in the 1990s. New HIV infections and AIDS-related deaths are declining and there is a stable trend in HIV prevalence.<sup>122</sup> HIV prevalence remains concentrated among people who inject drugs (21.9% in 2010), female sex workers (1.8% in 2011) and men who have sex with men (20% in 2010).<sup>123</sup> The Asian Epidemic

Model (AEM) has estimated that 43 040 new infections will occur during 2012–2016. Among the estimated number of new infections, 62% will be through transmission among men who have sex with men, female sex workers and their clients and people who inject drugs.<sup>124</sup>

A rapid escalation of HIV among men who have sex with men has been observed in 3 cities. In a 2010 survey, HIV infection among men who have sex with men was high in Bangkok (31.3%). Lower prevalence was observed in Chiang Mai and Phuket. HIV prevalence among men who have sex with men below 25 years was 12.1%. In 2010, HIV prevalence among the transgender population was estimated at 10% and 16% among male sex workers in the sentinel sites. HIV prevalence among male and transgender sex workers has not declined in subsequent years.<sup>125</sup>

## The journey of SWING<sup>126</sup>

In the course of her work with female sex workers in Bangkok in the 1990s, Ms. Surang Janyam, the current director of SWING, noticed an increasing number of male and transgender sex workers needing HIV services. Surang, Chamrong Phaengnongyang, the deputy director of SWING and a team of like-minded people (mainly former sex workers) started informal networking with this community. With technical assistance from Family Health International 360 (FHI360), they began mapping male sex work hot-spots and interviewing male and transgender sex workers to assess their needs. The needs that emerged were for services to diagnose and treat STIs, including HIV, non-formal education and English classes. Based on this, they approached FHI360 for funds to commence a project: this became known as Service Workers in Group (SWING). SWING is the first organization in Thailand to focus on meeting the needs of HIV services for male and transgender sex workers.

With limited funds to cover operational costs at the outset, the core group approached community members and former clients for donations. Raising



“Developing partnership with common grounds and shared responsibility is undoubtedly a slow process and takes a lot of persistence, hard-work, diplomacy and commitment to the community we serve.”

**Chamrong Phaengnongyang, the deputy director of SWING**

over US\$ 3000 in two months this mobilization of resources from the ground up firmly established SWING as a community-based organization (CBO).

## SWING as a CBO: challenges and strategies

Initially, SWING had difficulty renting an office as it openly identified as an organization of sex workers. Finally, a space was found in Soi Patpong, an area of Bangkok where many sex workers congregate. Once the space (a storage room) was cleaned and set up as a working office, SWING started non-formal education and an HIV prevention programme for male sex workers.

At this time Thailand was witnessing a forceful AIDS response. SWING was one of many organizations competing for funds to provide HIV prevention, care and support services. There was widespread ignorance or denial that male and transgender sex workers even existed in Thai society. At meetings and conferences, SWING representatives were seldom taken seriously. They struggled for recognition and support in this environment. A founding staff member recollects the complex considerations that had to be taken into account. “When people asked me if I was a sex worker — if I answered no, they would think I am not a peer and not qualified to work with male sex workers, but if I were to say yes, they would look down on me,” he said.

These adversities affected staff morale and the overall development of the community. The need for building organizational capacity became obvious.

## Organizational and staff capacity development

### The early days

Stigma, discrimination and the need to gain credibility required SWING to demonstrate they were capable of delivering good quality HIV prevention services. To

achieve this, in 2008 they developed a two-pronged strategy:

- Nurture each other to boost morale and confidence; encourage patience and persistence in advocacy and offer proactive rather than reactive responses to questions raised by community. In SWING’s view, once there was solidarity, the community would be better able to counter stigma and discrimination.
- Focus on building effective communication skills. SWING provided staff and volunteers with opportunities to learn public speaking, diplomacy skills and technical knowledge on HIV programming. English classes were provided to equip staff with skills to write proposals and raise funds.

Through these efforts, SWING observed a significant improvement in communication among staff. Deputy director Chamrong recalls how SWING dealt with such challenges: “There are many times when we are extremely hurt and angry because of the rejection and exclusion we face, but we have to swallow it in order to get our issues resolved, solving problems and safeguarding our community. We cannot do everything on our own and need to work with different partners. Developing partnership with common grounds and shared responsibility is undoubtedly a slow process and takes a lot of persistence, hard-work, diplomacy and commitment to the community we serve.”

## SWING today

Although SWING began with a focus on providing services to male and transgender sex workers, currently they work with all sex workers. From eight staff in 2004, SWING now employs 39 full-time staff, has 150 volunteers, and over 200 peer educators. They operate from three locations; Bangkok, Pattaya, and the island of Koh Samui.<sup>127</sup> Almost all staff members are former or current sex workers. SWING’s services directly reach thousands of individuals every year. Their success has been bolstered by their ability to maintain focus on



## Number of project versus number of staff

|   | 2004 | 2008  | 2011  |
|---|------|-------|-------|
| Number of project                         | 1    | 5     | 9     |
| Number of staff                           | 8    | 32    | 39    |
| Ratio between project and number of staff | 1:8  | 1:6.4 | 1:4.3 |

## Level of funding versus number of staff

|   | 2004       | 2008      | 2011       |
|---|------------|-----------|------------|
| Funding level                             | \$216,819  | \$225,741 | \$557,458  |
| Number of staff                           | 8          | 32        | 39         |
| Ratio between funding and number of staff | \$27,102:1 | \$7,054:1 | \$14,294:1 |

and commitment to the community and their rapid organizational growth.

When SWING started in 2004, FHI360 was their only funding partner. As programmes have expanded, so too have commitments from new donors. Consequently SWING has been able to scale up community mobilization and HIV prevention, establishing the Pattaya and Koh Samui branches and several new projects. In 2008, five projects were running in Bangkok and Pattaya. By 2011, this number had increased to nine.

The development of SWING is grounded in a systematic and strategic approach. However, a strategic plan was not formalized until 2009. With support from PACT Thailand, SWING conducted its first organizational capacity assessment in 2008, which led to drafting the organization's first strategic plan. In 2011, they concentrated on organizational development, so they could expand their activities and geographical reach.

The strategic plan for 2011–2013 focuses on four areas:

- 1 organizational and staff capacity development
- 2 resource mobilization
- 3 human rights and legal environment
- 4 innovations in outreach and services

### SWING's approach to organizational and staff capacity development

- **Transparent organizational structure, open communication and clarity of roles and responsibilities:** SWING is hierarchical in structure. However, decision-making processes, related to future direction, are democratic. It regularly

evaluates organizational efficiency and modifies accordingly. For example, in 2008, each of SWING's offices had their own administrative and financial units. This was not cost effective and it proved difficult to ensure standardised procedures. This led to centralizing the administrative and financial management system.

- **Human resource management and staff capacity development policy and plan:** From inception, SWING has developed staff capacity in a variety of ways. Experienced staff members of SWING play an active role in mentoring new staff. Staff are periodically assessed on technical knowledge, organizational principles and commitment to the community and work. Regular staff performance appraisal, that involves partners and stakeholders, is conducted. Outstanding staff members are rewarded. This system has helped retain efficient staff and volunteers. In addition, SWING arranges staff training every three months, based on assessed needs.
- **Transparent financial management:** SWING developed a financial regulation manual in 2004, revising this in 2007 for the organization's registration. Financial and programmatic audits are carried out regularly.
- **Public relations and marketing:** Using various marketing strategies and IEC materials such as brochures, information leaflets, posters, T-shirts, SWING publicises the organization, its services and programmes nationally and internationally. Staff members receive training in public relations and marketing skills.
- **Monitoring and evaluation:** Supported by PACT Thailand, an organizational evaluation was conducted in 2009. This identified the need to strengthen the monitoring and evaluation (M&E) system for programmes. This was instituted with a subsequent grant from PACT Thailand.

## Growing with SWING: Preecha's story:

"I have grown [at SWING] so much that I couldn't believe I would come this far. I told my friends in my hometown that I gave lecture to nurses and police officers. They did not believe me. I only went to junior high school. Before I joined SWING, I couldn't use a computer... I can use Excel and Word now...I have developed so much in many ways. My analytical thinking has improved. I have more responsibilities... Now I take care of other staff making them think."

Preecha, SWING Manager, Pattaya <sup>128</sup>

- **Inclusive governance structure:** SWING has a governing board that meets once a year. It comprises members who are from different backgrounds in Thai society, including sex workers. Board members are also available when SWING needs their advice and support. The board does not have decision-making power over financial or programmatic matters.





Because our staff work with utmost sincerity and dedication, we have gained more recognition in Thailand beyond what a community-based organization generally receives in this region. For example, we were recently invited by the Malaysian AIDS Council (MAC) to provide technical support for the formulation of its strategic plan for 2008-2010; of which two key strategies were to reduce HIV vulnerability among men who have sex with men and among sex workers as well as transsexuals. In Pattaya, everyone knows SWING and when the community members say that they belong to SWING, the treatment they receive changes.”

**Male sex worker and staff member, SWING**



## Lessons

- **Creating solidarity among community and staff is critical for organizational development.**

This solidarity arises from developing common goals, ownership of these goals and joint commitment to achieve them.

- **Nurturing staff can lead to scale up of programmes and organizational growth.**

Effective team work and unity are a result of staff being empowered and nurtured by the organization. This motivates people to work beyond their job description and contributes to the growth of the organization.

- **Donor investment in staff capacity building supports organizational growth.**

SWING has been fortunate to receive donor support for capacity building. This has enabled the development of its organizational policy and procedures and contributed to strengthening programming quality.

- **Forging partnerships with key stakeholders contributes to organizational growth.**

Win-win partnerships have been established with police and health service providers and entertainment venue partners<sup>129</sup> that have led to expanding services for sex workers. With the latter, the cooperation was founded upon:

- Understanding that healthy workers means better business.
- Earning trust with venue owners that fostered trust across the sector.
- Permitting access to venues to reach sex workers with services.
- Cultivating friendship with venue owners. This was achieved by meeting them often to jointly discuss solutions to problems that concerned them, such as business, HIV prevention and raids.



## Special section: Innovative partnerships with police

**T**he Prostitution Prevention and Suppression Act 1996 criminalises various aspects of sex work, including prohibiting soliciting, sex work in brothels, managing sex work businesses.<sup>130</sup> Police raids on sex work premises are common.<sup>131</sup> In SWING's experience, police violence is an unrelenting problem for sex workers. Sex workers are frequently picked up by the police for carrying condoms, which are used as evidence of sex work. During the first needs assessment conducted in 2004, male sex workers living in Bangkok reported recurrent abuse by the police. The severity of the violence was documented and attempts were made to raise this with the police department. However, there was little sign of any improvement. This impasse continued until 2005, when SWING embarked upon a new partnership with the National Police Cadet Academy<sup>132</sup> of Thailand when they were invited to provide training sessions on HIV prevention for newly recruited cadets. Each annual programme hosted nine volunteer police cadets over a three-week training period. The programme ran for three years and ended in 2008. The success of this partnership opened up fresh opportunities such as conducting training programmes for the Police Nurse College and joining the Police Cadet Community Involvement Programme.<sup>133</sup>

With regards this programme SWING were convinced that if young police cadets were given the opportunity to interact with sex workers in a neutral setting, this would eventually turn out police officers with an empathetic attitude, who would be more likely to treat sex workers humanely. This could potentially transform policing practices.

Initially, there was some scepticism that SWING would be able to adequately manage the internship scheme initiative. However, concerns were soon dispelled on completion of the first cadet internship programme. The experience of interning police cadets within SWING was extremely encouraging. During the internship period, cadets worked alongside outreach staff, promoting condoms and teaching English and Thai at drop-in-centres. Interns received orientation

“Even when we did not have any money, we decided to place police cadets as our interns, hoping that we would make allies and friends and that would help us stop and address the violence. There was no donor support for this programme. We did it on our own and it became so successful.”

Surang Janyam, Director of SWING

in outreach and counselling skills. Each evening, a debriefing session was held to share learning, observations and assess their level of understanding. To put knowledge into action, every Wednesday, SWING's office was turned into a simulated police station. Cadets had to perform their duties as police officers while sex workers were invited to drop in to the 'police station' to experiment with ways of approaching the police and filing complaints.

“We put a lot of hard work and effort in being part of this programme. We really wanted this partnership with the police. And therefore, even when we did not have any money, we decided to place police cadets as our interns, hoping that we would make allies and friends and that would help us stop and address the violence. The cadets received very limited per diem by the academy and we paid for their housing and food from our own pockets. There was no donor support for this programme. We did it on our own



“SWING taught us how to be open-minded and to make friends. [SWING is] a home full of friendly and supportive brothers and sisters.”

**Police cadet ‘Dome’ who took part in the SWING internship programme**

and it became so successful,” SWING’s director, Surang recounted.

Tee, Deputy Director of SWING adds: “We did all of this because we really believe that working with them, will help change their attitudes about us. Not only has that happened we have also made good friends.” A total of 36 cadets completed the SWING internship programme during the four years that it ran. As a result, SWING gained credibility in many of the police stations across Bangkok.

### The cadets’ perspective<sup>134</sup>

Police cadets, Paeh, Sorn, and Dome, interned with SWING in September 2007. Prior to joining the programme, all three reported having negative attitudes towards male sex workers and men who have sex with men. “On my first day with SWING, I felt uncomfortable working with the MSM staff and was quite shocked to go into male sex work hot-spot areas. It was a community that I didn’t even think existed,” Paeh recalls. Sorn, who used to “walk away from men who have sex with men and male sex workers”, also noted a significant shift in his feelings: “Now I feel male sex workers are ordinary people living in the same society as we do,” he remarked. Paeh remembers the satisfaction of helping to organize a camping trip for a group of sex workers. “I was simply happy when I saw them happy. For some, it was the first camping trip in their life.” Explaining the valuable lessons he learned through interning with SWING, Dome says: “SWING taught us how to be open-minded and to make friends. I felt like I could discuss my problems and issues with the staff. To me SWING is not an organization, but a home full of friendly and supportive brothers and sisters.”



### Impact on preventing violence

Sensitizing 36 cadets was a step forward but it has not stopped the violence against sex workers in Bangkok or elsewhere in Thailand. However, addressing violence has become easier, as one staff member shares: “We have not been able to prevent violence every time before it occurs but we can certainly use the help of cadets and their friends and networks to get us the help we need to report on any violent incident, to release sex workers who are randomly arrested and to be freed from paying fines.”

Positive changes have been noted in the behaviour of police officers in Bangkok and at other constabularies where interns are stationed.<sup>135</sup> One staff member reported fewer arrests and incidents of harassment and a more helpful approach towards sex workers. Another SWING member noted that sex workers have benefited from the programme by developing practical skills to deal with police officers.

Although the SWING internship initiative ended in 2008, SWING still depends on support from its network of cadets:

“Just few days ago [in 2012], a sex worker was fined in one of the cities where SWING works; the police officer dealing with her used abusive language and demanded a lot of money to release her. She knew that she had the right to ask for help and call anyone if she wishes. So, she rang up one of the cadets in another station and asked him to talk to the police officer. Upon briefly chatting on the phone with the cadet, he released her without any fine. She did not even call the SWING office for help; she called the cadet.”

Surang Janyam, Director of SWING

### Continued efforts to address violence

Working in partnership with police continues to inform SWING’s efforts to address violence against sex workers, one of the greatest challenges for sex work organizations in Thailand.

In 2011, SWING initiated The Rights Protection Volunteers for Sex Workers in Pattaya.<sup>136</sup> This collaboration between SWING, the Pattaya Tourism Police Division and the Pattaya Municipality Administration aimed to decrease stigma and discrimination by improving community liaisons between sex workers and tourist police. A baseline survey on types and severity of violence was conducted between June 2011 and February 2012 with 443 transgender, male and female sex workers.<sup>137</sup> Findings included that 87.1% of sex workers surveyed reported being humiliated by officials, 86.4% reported being forced to have unpaid sex, 86.7% reported that clients refused to use condoms and 92.2% were forced to perform sexual acts against their will.

Sixty two sex workers were trained as ‘Rights Protection Volunteers’ and conducted outreach reaching 2769 sex workers on the streets and in entertainment venues. Volunteers worked with tourist police, police informers (such as motor-cycle taxi drivers) and responded to crisis situations involving sex workers. One of the biggest challenges during this project was ensuring access to legal aid. A lawyer was hired and some local organizations providing legal services offered their support. However, lack of knowledge surrounding the legal and social issues of sex workers made it difficult for sex workers to access the appropriate legal assistance. Despite these challenges, in seven months the programme gained support in Pattaya among sex workers, the police, and the municipality and bar owners.





## Lessons

- **Improving police liaisons with the sex work community through cadet internship increases mutual understanding and enhances sex workers' confidence in dealing with the police.**
- **Developing partnerships with police, health care providers and entertainment venue owners requires trust and understanding divergent perspectives.**
- **Developing allies within the police force is as important as working to alter the oppressive aspects of law enforcement structures.**
- **Cooperating with the police can lower incidence of police violence.** Sex workers involved in the cadet internship programme reported a reduction in verbal abuse, fewer arrests and shorter time periods in police custody. Sex workers anecdotally reported that bail was easier to access, as was official reporting of violent incidents.

## Gaps, challenges and opportunities

Lack of rigorous data collection and analysis of interventions are a limitation of the programme. This is not unique to SWING, as discussed in section 1, there is a need for greater investment of financial and technical resources to ensure high-quality monitoring and evaluation. There is much to be gained from investing in strong sex worker organizations such as SWING that have demonstrated their capacity to build a strong organization, engage in effective mobilization of sex workers and design innovative programmes that address the existing and emerging needs of their communities. Technical support to build capacity for within sex worker led programmes for effective monitoring and evaluation, particularly for interventions where there is limited evidence, builds the evidence base about what works, critical to ensuring the most effective use of resources.

In their work addressing violence against sex workers, SWING has faced challenges in securing access to legal assistance and ensuring sex workers are aware of their legal rights and are working to develop partnerships to address this.

Over eight years, SWING has transformed from a project into a legally registered foundation that is recognized for serving the sex work community across multiple locations in Thailand. Increasingly, organizational sustainability is a concern due to the diminishing funds available for HIV programming. With regards to the cadet internship programme, limited funds prevented enrolling more interns. SWING is working to diversify its sources of funding and increase its organizational capacity to raise funds, so that resources are well aligned with its commitment to innovative strategies that mobilize and engage communities themselves to address the issues of concern they experience. ■

- 121 Pact Thailand/USAID, 2011. SWING — A CBO Success Story. Unpublished.
- 122 UNAIDS, 2011. *HIV in Asia and the Pacific: Getting to Zero*. UNAIDS.
- 123 Thailand UNGASS Report, (reporting period 2010–2011) published 2012.
- 124 Ibid.
- 125 Ibid.
- 126 This section has largely drawn upon PACT Thailand’s 2011 documentation of SWING — A CBO Success Story. Unpublished.
- 127 SWING, 2011. SWING’s Organizational Profile, 2011. SWING. Unpublished.
- 128 PACT Thailand’s 2011 documentation of SWING-A CBO Success Story. Unpublished.
- 129 For example, proprietors of massage parlours and bars.
- 130 *Sex Work and the Law in Asia and the Pacific*, UNDP and UNFPA, October 2012, Section 4.9 Thailand.
- 131 Ibid.
- 132 National Police Cadet Academy is the training institution of Ministry of Interior responsible for planning and implementation of pre-service and in-service training programmes for the newly enrolled police cadets. In 1990s when Thailand’s HIV epidemic rapidly spread among the uniform services, the Ministry of Interior in collaboration with the Ministry of Health introduced an HIV in the Workplace programme. Since then, the national police cadet academy provides training on HIV prevention, treatment, care and support to all the newly recruited cadets.
- 133 This is an internship programme that the Police Cadet Academy provides to third-year police cadets. It gives them the opportunity to work with a community-based organization of their choice. The objective is to expose the cadets to a range of social issues and broaden their understanding of social inequality. Since 2009, the programme has been suspended for reasons unknown to SWING. All cadet internships now take place in government-run social facilities.
- 134 PACT Thailand’s 2008 summary documentation of the Police Cadet Internship Programme at SWING. Unpublished.
- 134 PACT Thailand’s 2008 summary documentation of the Police Cadet Internship Programme at SWING. Unpublished.
- 135 Turning an enemy into an ally: SWING’s police cadet internships on HIV prevention among sex workers, PACT 2007, [http://www.pactworld.org/cs/reach\\_news\\_and\\_media\\_swing\\_story](http://www.pactworld.org/cs/reach_news_and_media_swing_story).
- 136 SWING, 2011. Survey of Violence against Sex workers in Pattaya. The survey was conducted with technical support from the Institute of Population and Social Research (IPSR), Mahidol University. Its key findings include that 92.9% of surveyed sex workers were wrongly arrested, 86.9% were arrested for allegedly having condoms, 87.1% reported being humiliated by officials, 40.7% were fired from their jobs when found HIV positive, 43.2% forced to reveal HIV status, 52.9% forced to test for HIV, 86.4% forced to have unpaid sex, 86.7% reported that clients refused to use condoms and 92.2% were forced to perform sexual acts against their will. This reporting was based on sex workers’ experiences of violence in the last three months.
- 137 SWING, 2011. Project report on Rights Protection Volunteers for Sex workers in Pattaya. Unpublished.





Case Study

# 4

## Reaching low-fee sex workers with HIV and STI services in Kunming, China: experiences of the Lily Women's Wellness Centre

**T**he Lily Women's Wellness Centre started as a drop-in-centre (DIC) for female sex workers in 2005. It is now a community-based organization (CBO), though not yet registered. It provides HIV and STI prevention and treatment services for female sex workers at 64 sites in Kunming, including at the Kunming Municipal Women's Compulsory Shelter and Education Centre.<sup>138</sup>

In September 2005, the Kunming Red Cross Society<sup>139</sup> (KMRC) began implementing HIV prevention interventions among female sex workers in the Xishan District of Kunming City, with support from the China/UK Project and Futures Group, Europe. One outcome of this was the establishment of the Lily Women's Wellness Centre.

In 2007, KMRC, Kunming Centre for Disease Control and Prevention (CDC)<sup>140</sup> and FHI360<sup>141</sup> decided to focus on reaching the most vulnerable groups of sex workers with HIV and STI prevention programmes and to strengthen community-led approaches in outreach and service provisions. Female sex workers with low fees were identified as one such group. This led Lily Women's Wellness Centre transforming from a DIC to a CBO. Kunming CDC has played an important role in the growth of the organization. Due to being unable to legally register and receive and manage funds, KMRC is currently responsible for the financial management of Lily Women's Wellness Centre, and provides support for monitoring. Otherwise, the organization designs and implements its programme independently. The Wellness Centre currently has nine full-time staff members, seven of whom are sex workers.

## HIV and sex work in Kunming

The capital city of Yunnan province, Kunming, has a flourishing tourism industry and a population of 5.7 million, of which 1.7 million are migrants. Yunnan is among the six provinces with the highest number of reported HIV cases in China.<sup>142</sup>

Kunming has more than 14 000 female sex workers working in 14 districts.<sup>143</sup> In 2007, the CDC undertook a large-scale mapping exercise that highlighted that:

- most female sex workers in Kunming (and other cities) came from rural areas, and were highly mobile;
- a majority are illiterate and have negligible awareness of HIV;
- many had lower levels of condom use and expressed an urgent need for sexual and reproductive health services;
- most worked on the streets and in 'touch-touch' dancing halls,<sup>144</sup> hair salons, saunas and massage parlours, rented rooms, night clubs and cheap hotels.<sup>145</sup>

This study found that HIV prevalence among female sex workers was 2% but the STI prevalence was alarmingly high, at 30%. Low-fee sex workers were found to have a higher turnover of clients than other sex workers, were more vulnerable to contracting HIV, had the lowest literacy levels and awareness on HIV and had limited access to condoms and HIV prevention services. The CDC study was ground-breaking in that it identified the places where low-fee sex workers worked, therefore enabling an outreach strategy for providing them with HIV and STI prevention and treatment services.

In response to these findings Kunming CDC, FHI360 and KMRC decided to concentrate on addressing HIV and STI prevention and treatment needs of low-fee sex workers through the Lily Women's Wellness Centre. This work was undertaken between October 2007 and September 2011. As a result of changes in USAID financial support, funding provided through FHI360 was phased out in late 2011. At the time of documentation (May 2012), Lily Women's Wellness Centre was operating in Kunming with support from another funding agency. It continues to provide female

sex workers with a range of services and referrals to government health services.

## The Lily model

### DiC: safe space for community networking, education and outreach

Between 2007 and 2011, a total of 4 459 female sex workers visited the DiC. This is strategically located close to numerous dancing halls, massage parlours, hair salons, night clubs and cheap hotels, thus providing easy access for low-fee sex workers and their clients.<sup>146</sup>

While the DiC is a place for sex workers to network with each other, it also serves as a base for outreach staff to plan activities, solve problems, stock up on condoms and lubricants, and share updates from the field.

Every Wednesday, the centre hosts a variety of training programmes for sex workers based on their interest and needs. These are free of cost and open to all sex workers. A schedule of regular activities is posted at the centre. “Our DiC and these trainings are really popular among our community members. This is our only space for sharing and learning from each other, making friends and resolving our problems. Otherwise, we would have had nowhere to go. Even though Kunming is rapidly changing and many of our community members go in and out of the city, they keep visiting us here [the DiC] and participate in different event,” said an outreach worker from the Centre.

### Peer-based outreach

All outreach workers are trained in peer-education techniques. They participate in other periodic training opportunities organized by KMRC and

“This is our only space for sharing and learning from each other, making friends and resolving our problems. Otherwise, we would have had nowhere to go.”

Outreach worker, Lily Women’s Wellness Centre

### Peer-based outreach

All outreach workers are trained in peer-education techniques. They participate in other periodic training opportunities organized by KMRC and Kunming CDC. Outreach is a central part of the centre’s work. During the period of 2007–2011, the programme reached over 21 654 female sex workers in Kunming.

Seven outreach workers conduct regular outreach activities across 63 sites in and around Kunming city and at one re-education centre where sex workers are detained during police crackdowns.<sup>147,148</sup> Mapping exercises are conducted every six months, and outreach plans are altered accordingly. Outreach workers work in pairs, building trust with sex workers through several methods, such as sharing personal stories and ensuring information is conveyed in accessible language.

Outreach workers keep a log of dates, venues and contacts established and maintained. At each site, particularly where low-fee sex workers operate in groups, the outreach workers identify a team leader amongst the sex workers.

### Lily peer teams in action

“During police crackdowns, all of our outreach activities stopped for a short period of time. We could not visit the field and they could not come to us. So, we started using mobile phones to communicate with our community members about their situation, and find ways to provide condoms to them in a discreet manner. Before we did not have a team leader and it was difficult to keep track of what happened to sex workers during crackdown, but now that we have a team leader for each small group of sex workers, the team leader keeps us informed about their situation and we find ways to provide condoms to them.”

Outreach worker,  
Lily Women’s Wellness Centre





Kunming CDC. Outreach is a central part of the centre’s work. During the period of 2007–2011, the programme reached over 21 654 female sex workers in Kunming.

Seven outreach workers conduct regular outreach activities across 63 sites in and around Kunming city and at one re-education centre where sex workers are detained during police crackdowns.<sup>147, 148</sup> Mapping exercises are conducted every six months, and outreach plans are altered accordingly. Outreach workers work in pairs, building trust with sex workers through several methods, such as sharing personal stories and ensuring information is conveyed in accessible language.

Outreach workers keep a log of dates, venues and contacts established and maintained. At each site, particularly where low-fee sex workers operate in groups, the outreach workers identify a team leader amongst the sex workers. Lily Women’s Wellness Centre has developed a wide array of sex worker-friendly advocacy and information materials and interactive training tools. Outreach activities include both one-on-one and group interactive sessions. These sessions focus on discussing a wide range of issues including HIV and STI prevention and treatment, sexual and reproductive health and financial literacy to help sex workers manage their personal finances. Participation in outreach activities

is voluntary. During the project period supported by FHI360, 12 outreach workers conducted 16 outreach sessions every month. Since then, both the number of outreach workers and outreach sessions per month has decreased.

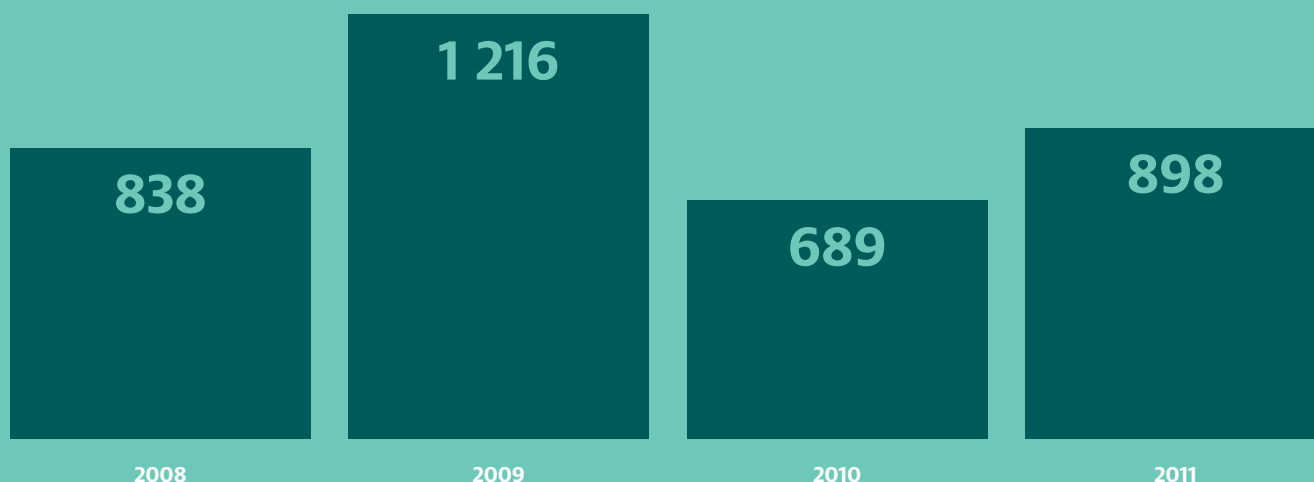
### Provision of regular STI and reproductive health check-up and referral for diagnosis and treatment

Lily Women’s Wellness Centre collaborates with CDC to provide health services on-site in the DIC and through CDC clinics. Free STI and reproductive clinical services are provided at the DIC with the assistance of the local doctors from CDC Kunming. Up until September 2011, these were provided twice a week and subsequently, once a week.

STI and reproductive clinical services at the DIC include physical and gynaecological examinations; pregnancy testing; periodic presumptive treatment (PPT) for sex workers at their first visit and subsequent check-up and treatment at three month intervals;<sup>149</sup> referral for STI treatment to the Kunming CDC Sexually Transmitted Diseases (STD) clinic; referral to Maternal Child Health clinics for reproductive health services including contraception counselling and full range of



## Number of female sex workers referred to the Kunming CDC for STI services



Source: KMRC, 2012, First Narrative Project Report.

contraceptive methods; and, accompanied referral on request.

In cases where sex workers are unable to receive clinical services at the DIC, they can visit the STD clinic at Kunming CDC or seek accompanied referral from the Lily Women's Wellness Centre. The Kunming CDC STD clinic is open five days a week, providing simple STI check-up, diagnostic and treatment services.

As part of a collaboration between FHI360 and Kunming CDC, FHI360 conducted training on STI management for clinical staff of the CDC STD clinics to ensure that the China National STI Guidelines 2007 and FHI360's STI standards were strictly adhered to. Quality of service was assessed annually. This collaboration between FHI360 and CDC Kunming included providing STI diagnostics and some treatment services<sup>150</sup> at a subsidized rate of one-time fee of 70 Chinese yuan per sex worker.<sup>151</sup>

Testing and treatment for other STIs are at extra cost and usually referred to government general hospitals or private clinics. There were plans to forge links between Kunming CDC, the Lily Women's Wellness Centre and government-run facilities. However, this could not be initiated due to lack of funding.

Providing STI diagnostic and treatment services has been one of the key components of the programme. An average of 800 female sex workers were reached annually.<sup>152</sup> Although the numbers referred to STI services was below the numbers of sex workers reached during outreach activities, the programme was able to achieve more than its set targets for 2008 and 2009. In 2010, the service uptake declined by 57% compared with 2009. In 2011, although it increased slightly, uptake has not returned to 2009 level. Police crackdowns, which began in 2010, are noted as a major factor for the substantial drop in service uptake.<sup>153</sup>

The end of USAID funding through FHI360 has created uncertainty regarding the continuation of this collaboration. Although an interim funding solution had been found in 2012 for other aspects of the Lily Centre's work, it is unclear how the STI and SRH services will be provided and who will be responsible for maintaining and monitoring the effectiveness of service delivery in the future. This illustrates some of the challenges in building the long term sustainability of programme efforts, especially if they are reliant on one external funding source.

“We have seen an increase in uptake of vct services at the centre since the introduction of rapid test kits... More sex workers are coming to use this service because it’s quick, requires less blood, doctors from the CDC are not involved and tests are completely anonymous”

VCT counsellor, Lily Women’s Wellness Centre

## On-site Voluntary Counselling and Testing (VCT) services for HIV and syphilis

Before the availability of HIV rapid test kits at the centre, the Lily Women’s Wellness Centre provided on-site vct services including pre-test and post-test counselling. However, reaching female sex workers with vct services presented a major challenge. Although the numbers of those who tested for HIV increased from 127 in 2008 to 229 in 2009, the numbers remained constant at 247 in 2010 and 2011.<sup>154, 155</sup> While the project was able to reach over 21 000 sex workers through outreach services, only 850 female sex workers received vct services during the project cycle.<sup>156</sup>

Towards the end of 2011, Lily Women’s Wellness Centre was able to provide rapid testing for HIV and syphilis. This had the immediate effect of increasing service uptake. As previously, trained counsellors provide pre- and post-test counselling. The centre strongly emphasizes the importance of privacy and confidentiality during the process of testing and a non-threatening and friendly environment. For sex workers who receive a positive test result, referrals for confirmatory tests at Kunming CDC are provided on request.

“We have seen an increase in uptake of vct services at the centre since the introduction of rapid test kits. For example, between the periods of January to April 2012, more than 130 sex workers have already received vct services at the centre. This is already half of the total HIV tests done in the entire year of 2011,” explained a vct counsellor from the Centre. “More sex workers are coming to use this service because it’s quick, requires less blood, doctors from the CDC are not involved and tests are completely anonymous,” the counsellor added.

## Referral to HIV treatment, care and support services

The aim of the Lily Centre referral system is to ensure that sex workers living with HIV have immediate access to a health assessment and subsequent health monitoring, care and support. The initial assessment involves testing for CD4 and viral load and commencement of HIV treatment where required. Information about these services is disseminated to sex workers through outreach and training programmes. One outreach worker is appointed to provide on-going support to a group of sex workers living with HIV.

Outreach workers at the centre noted the challenges exist in ensuring effective referral for HIV treatment, care and support services available in Kunming.

“Female sex workers, especially the positive sex workers, face high levels of stigma and discrimination and so, they don’t want to go to public health care facilities although services provided there are of good quality,” said one outreach worker at the DIC

Although these concerns have been reported to public health officials in Kunming, the problem remains unresolved. There is a need for commitment from all partners to address all barriers to accessing health care settings. This includes overcoming the human and financial resource constraints to ensure community-based support and referrals, and a collaborative approach to addressing stigma and discrimination in health care settings.



Anecdotal evidence suggests that economic empowerment programmes are highly beneficial for sex workers, as increased control over finances offers greater security and hope.

## Economic empowerment initiatives

### Capacity development in financial literacy and money management

In 2010, Lily Women's Wellness Centre began offering services that help female sex workers realize their financial goals. The Director of the centre, Lhang Yu said that during interactions with female sex workers, they found that a majority "have dreams of making money, getting rich and accumulate savings but they don't have the knowledge and skills or the means to do so." A financial literacy programme was developed in response, which focussed on enhancing knowledge and skills in personal finance, particularly in tracking income and expenses, savings and investment strategies. Interestingly, financial logic was used to promote safer sex and condom use during these trainings, making the link between financial securities and maintaining health as an important aspect of a sex worker's work.

### Referral to banks for savings and investment in mutual funds

Sex workers rarely have access to banks. The Lily Women's Wellness Centre initiated a referral programme with cooperating banks where sex workers could open savings accounts or invest in a mutual-fund scheme.<sup>17</sup> Professionals from cooperating banks provided advice to female sex worker about investing money in mutual funds. "It is very successful. Many female sex workers have already bought mutual funds. Due to popular demand, the same orientation was repeated twice in 2011," the Manager said.

### Vocational training

Vocational training is provided by external experts and focuses on enhancing other marketable skills of sex workers. This is not without challenge, as often initial outlay costs required for the making of products (for example handicrafts) is expensive and on-sale of products is never guaranteed. As the deputy manager of the Lily Centre explains, "Some of the sex workers become skilled quickly and begin

producing beautiful handicrafts. But the cost for making such products is expensive. For example, it could cost about 200 yuan to buy the materials needed to make a cross-stitch. Although the sex worker could then sell the same for up to 500 yuan, earning a profit of 300 yuan, getting the actual sale concluded is always difficult. Sometimes it takes up to two months to sell one cross-stitch."

Lily Women's Wellness Centre currently lacks adequate resources to strengthen these additional support services. However they recognize the need to forge partnerships with business entrepreneurs, recruitment agencies, financial backers and retail sellers and ensure sex workers can access existing social protection, education and poverty reduction programmes. Anecdotal evidence suggests that economic empowerment programmes are highly beneficial for sex workers to increase control over their financial resources and improve their financial security.

**"[Referral to banks] is very successful. Many female sex workers have already bought mutual funds."**

**Manager of the Lily Women's Wellness Centre**



## Lessons

- **An enabling environment is critical to sustain outreach activities and maintain service provision for sex workers.** This has been achieved by collaborating with the police department, and the buy-in of sex work venue owners, managers and the local community. Nonetheless, police crackdowns have been shown to impact on the effectiveness of programmes and attention must be paid to addressing the structural factors that shape risk and vulnerability to HIV infection.
- **In a challenging socio-political environment service delivery through a community-led approach is a necessity.** The combination of high levels of stigmatization of sex workers and police crackdowns create a complex and challenging environment for addressing HIV among sex workers. Lily Women's Wellness Centre has responded to new and emerging needs of sex workers in this complex context, underscoring that the most effective way to reach low-fee sex workers in this environment is through community-led peer outreach.
- **Availability of HIV rapid tests on-site helps increase demand for VCT services.** Community members prefer rapid tests; they are quicker, easier to provide in community settings and do not involve multiple points of contacts or require paying a visit to a health clinic. Combined with friendly, non-judgmental and confidential counselling, this leads to greater uptake of VCT.
- **Programmes aimed at strengthening partnerships between CBO and key stakeholders need adequate resources.** Partnership-building activities require human and financial resources for both planning and implementation.
- **CBO-led female sex worker intervention models can be scaled up through replicating in similar socio-political contexts.** More than 170 people from national, provincial and local level CDCs, the Women's Federation of China and from several NGOs in Hong Kong and Lao People's Democratic Republic have visited the centre to learn from its experience.<sup>158</sup> Staff members have been invited to provide technical assistance in designing and implementing similar programmes in other parts of China.

## Gaps, challenges and opportunities

The registering and mobilization of CBOs in China is complex and the Lily Women's Wellness Centre is not registered as an organization.<sup>159</sup> This has contributed to the hampering of its growth, ability to function autonomously, and operate with protection afforded by a legal status. Due to this, the centre is not able to receive funds directly from the government or other donors.

According to the Centre, frequent crackdowns by police have often driven female sex workers in Kunming into hidden locales, increasing their vulnerability to violence and limiting their access to HIV prevention and treatment services. The fear of arrest and detention increases the likelihood of sex workers relocating frequently. A reported strong presence of mafia, illegal gangs and criminals in new locations can present additional risks. These factors have severely hindered Lily Women's Wellness Centre's efforts to provide HIV prevention and treatment services for sex workers.<sup>160</sup>

Compulsory detention and rehabilitation centres raise serious human rights concerns for sex workers, threatening the health of detainees, including through increased vulnerability to HIV and tuberculosis (TB) infection.<sup>161</sup> There is no evidence to suggest that these centres provide an effective environment for the 'rehabilitation' of sex workers. Lily Women's Wellness Centre reports that most sex workers return to sex work upon release from compulsory detention as they have no other means by which to generate income. "In the re-education centre, it's not like sex workers have the opportunity to participate in trainings that enhance their vocational skills or there are any efforts in placing them in other jobs. So, one cannot expect the sex workers to come out of the centre charged and ready to take up new jobs and earn a living. Inevitably, they end up going back to sex work," reported a sex worker at the Lily Women's Wellness Centre. ■

"We have built an effective service delivery model for sex workers. Now we need technical assistance and financial resources to expand our services in greater amount and in more places."

Gaizi, staff member, Lily Women's Wellness Centre

"One cannot expect the sex workers to come out of [rehabilitation] centres charged and ready to take up new jobs and earn a living. Inevitably, they end up going back to sex work."

A sex worker, Lily Women's Wellness Centre.

- 138 Kunming Municipal Women's Compulsory Shelter and Education Centre, also known as the Women Re-education Centre in Chang Po, is a detention centre for female sex workers to live in and work when they are arrested during police crackdowns. It is the only such centre in Kunming, housing on average 1 000 sex workers per year. A large majority are low-fee sex workers, who are particularly targeted in police crackdowns. Sex workers are required to stay at the centre for a period ranging between six months to two years, where they study and do menial jobs like peeling beans. They get paid for this work and receive free accommodation and food along with routine health check-ups, which includes screening for HIV and STI. Although STI treatment is paid for, sex workers in the Re-education Centre have to pay for their personal care items, such as toothbrushes, sanitary napkins and make-up etc. According to the Lily Women's Wellness Centre, the prevalence of HIV and STI among female sex workers living at the Re-education Centre could be significantly higher than that of sex workers in the city, thus the need to provide continued HIV/STI prevention and treatment services. For a critique of such institutions see the United Nations Joint Statement on Compulsory Drug Detention and Rehabilitation Centres, March 2012, which calls on States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community. It notes that the deprivation of liberty without due process is a violation of internationally recognized human rights standards. It further notes that where a State is unable to close such centres rapidly, it is urged to undertake a range of action including immediately establishing health care, social and education services.
- 139 The Kunming Red Cross, established in April 1922, is a government-affiliated organization operating independently, but in cooperation with the local Department of Health. KMRC has been active in HIV prevention in Yunnan province since 1997.
- 140 The Centre for Disease Control and Prevention (CDC) is an arm of the Ministry of Health in China, operating at the central and provincial levels with branches in the cities and towns across the country. Kunming CDC has an HIV/AIDS department, which implements HIV policy and programmes across Yunnan province.
- 141 Previously known as Family Health International.
- 142 2012 China AIDS Response Progress Report, Ministry of Health People's Republic of China, 2012.
- 143 CDC Kunming. 2007. Surveillance and mapping of female sex workers in Kunming, Yunnan, China.
- 144 Touch-touch dancing halls are entertainment venues where a dancer is paid to dance with clients for 15 minutes or longer in complete darkness. During this period, the client can fondle, kiss, touch and engage in other sexual activities with the chosen dancer. According to sex workers at Lily Women's Wellness Centre, when the lights are turned on used condoms can be found on the dancing floor.
- 145 CDC Kunming. 2007. Surveillance and mapping of female sex workers in Kunming, Yunnan, China.
- 146 Lily Women's Wellness Centre does not implement any programmes for the male clients of female sex workers. However, it has witnessed increasing numbers of regular clients of female sex workers visiting the drop-in-centre to receive HIV and STI information.
- 147 As noted, USAID funding through FHI360 ended in November 2011. Since then the number of outreach workers has reduced from twelve to seven.
- 148 Research on the Impact of 2010 Crackdown on Sex Work and HIV Interventions in China, China Sex Worker Organization Network Forum, 2010. See also Protecting Sex workers Key to Preventing Spread of HIV, which discusses the impact crackdowns by law enforcement authorities targeting sex work as a threat regularly faced by sex workers, particularly, low-level street-based sex workers. UNAIDS, <http://www.unaids.org.cn/en/index/topic.asp?id=783&classname=Photo%20Stories&class=2>. Accessed 27 August 2012.
- 149 Inclusion of this case study in this collection is not an endorsement of the use of PPT, as normative guidance on this issue is currently unclear. WHO, UNFPA and UNAIDS are working together with the Global Network of Sex Worker Projects to finalize global guidance on prevention and treatment of HIV and other sexually transmitted infections for sex workers, including on the issue of PPT. It is hoped this guidance will be released in the last quarter of 2012.
- 150 Treatment services include syphilis, gonorrhoea, genital warts PV, genital herpes and chlamydia.
- 151 Kunming Red Cross Society. 2011. Final Narrative Report, HIV/STI Prevention and Care for FSWs in Kunming. Submitted to FHI360, 2012.
- 153 Ibid. See also Research on the Impact of 2010 Crackdown on Sex Work and HIV Interventions in China, China Sex Worker Organization Network Forum, 2010.
- 154 Ibid.
- 155 It is noted that HIV testing among sex workers in China is improving but remain low. The percentage of sex workers who received at least one test during the last 12 months and received their results increased for 36.9% to 38.2% during period 2010 – 2011, 2012 China AIDS Response Progress Report, Ministry of Health People's Republic of China, 2012.
- 156 Ibid.
- 157 In mutual-fund scheme, a sex worker is required to invest between 300 to 600 Yuan every month. The deposit earns a higher interest rate than any other saving and investment schemes. Funds can be withdrawn anytime.
- 158 Ibid.
- 159 See for example: NGO Law Monitor China for an analysis of legal issues for NGOs and COS in China. [www.icnl.org/research/monitor/china.pdf](http://www.icnl.org/research/monitor/china.pdf)
- 160 Worker Organization Network Forum, 2010. See also Protecting Sex workers Key to Preventing Spread of HIV which discusses the impact 'crackdowns' by law enforcement authorities targeting sex work as a threat regularly faced by sex workers, particularly, low-level street-based sex workers. UNAIDS, <http://www.unaids.org.cn/en/index/topic.asp?id=783&classname=Photo%20Stories&class=2>. Accessed 27 August 2012.
- 161 The United Nations Joint Statement on Compulsory drug detention and rehabilitation centres, March 2012, calls on States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community. It notes that the deprivation of liberty without due process is a violation of internationally recognized human rights standards.





Case Study

5

# Sex worker-led HIV treatment, care and support programme: VAMP Plus, India

**V**AMP—Veshya Anyay Mukti Parishad<sup>162</sup> —is a registered collective of about 5 000 female sex workers from seven districts in Western Maharashtra and North Karnataka, the Republic of India (India). VAMP uses rights-based approaches to empower and collectivise sex workers to claim, promote and protect their rights to live and work in safety, prevent exposure to HIV and other STIs, address violence, and increase access to public services.

In 1996 VAMP started as an outreach programme of Sampada Gramin Mahila Sanstha (SANGRAM), a NGO based in Sangli. It originally focused on HIV prevention through peer-based interventions and condom use promotion among sex workers in two high density sex work areas in Sangli. In 2000, it began advocating for community-led support systems to increase sex workers' access to health and other social services. That same year, VAMP began addressing violence against sex workers and the broader issues of social exclusion, marginalization and discrimination as well as the urgent treatment, care and support needs of sex workers living with HIV.

In 2007, a group of sex workers living with HIV came together to form VAMP Plus, a wing of VAMP that aims to address socioeconomic, health and psychological needs of sex workers living with HIV. VAMP Plus focuses on three key areas:

- facilitating access to HIV testing and treatment services through awareness, education, outreach and accompanied referral;
- creating a community care and safety net that helps sex workers living with HIV advocate, seek and receive treatment, care and support and address problems related to health and well-being including nutrition, shelter and safety;
- creating a safe space for sex workers living with HIV to discuss their rights, the legal and social issues affecting them and their families, and develop collective action to assert and claim their rights.

VAMP Plus conducts individualised outreach, counselling and accompanied referral services. Through these services they have ensured that almost all sex workers from their collective who have tested HIV positive and need treatment, are supported to access health services, and receive ART and/or other treatment for opportunistic infections (OI) from civil hospitals<sup>163</sup> and private clinics across seven districts in the two states. A total of 629 sex workers living with HIV currently receive continuing care and support, including supplementary food supply. VAMP Plus supports treatment adherence by providing psychosocial support and counselling, monitoring of side effects and facilitating access to required health services. Foster care and hospice facilities are provided for those who are ill and need support during the recovery period.

## HIV and sex work context and the beginnings of VAMP Plus

When HIV first became apparent in India, its prevalence was high in the States of Maharashtra and Karnataka. These were among the priority states for HIV prevention and treatment programmes. When initially rolled out, many of the treatment programmes did not adequately reach women, sex workers and men who have sex with men. By mid-2000s, a large number of sex workers (and other key affected populations) in these states were testing HIV positive and at varying stages of illness. In the absence of treatment, care and support services, and given the high levels of stigma and discrimination against sex workers, access to the limited services that existed was seriously delayed and as a result, many sex workers died unnecessarily of AIDS-related illnesses.

Illnesses related to HIV had become the subject of routine discussions among the sex worker community in Sangli. Regular clients, who constituted a major source of income for sex workers, stopped visiting due to ill health. Sex workers struggled with their friends and colleagues dying; attending and organizing weekly funerals and managing their orphaned



children became a part of life. The dire situation facing sex workers was the impetus for starting VAMP Plus, a support group for sex workers living with HIV.

### The shifting environment of treatment, care and support

Since VAMP Plus began its work, the situation in India has improved considerably with regards to HIV treatment, care and support. The availability of and access to affordable HIV drugs has significantly improved throughout India due to policies implemented by the government, with support from international partners, to provide HIV testing and antiretroviral treatment free of charge and to make it widely available.

Although stigma and discrimination continue to be a challenge, dissuading HIV positive sex workers from accessing health services, determined and relentless advocacy by SANGRAM and VAMP with the local government hospitals in the areas where they work have resulted in a changed environment. With support from SANGRAM, VAMP Plus has, over the years, had many individual meetings and consultations with senior health officials, health workers and other relevant partners to discuss strategies to address stigma and discrimination in health care settings.

An important part of the work of VAMP and VAMP Plus is the conduct of sensitization workshops and training programmes for health care providers. These focus on building an understanding of the impact of stigma and discrimination on sex workers' access to HIV prevention and treatment, and on sex workers' rights to health and other public services.

Female sex worker and VAMP Plus outreach worker Anita Terdale, describes the change she has witnessed first-hand: "Before, we [sex workers] were treated like animals. We were not even allowed in the [civil] hospital to receive any kind of medical check-up. When we had to be admitted, we were given rooms near the toilets or in isolated corners, separated from others. But now we are treated like anyone else. We are accommodated in the same rooms as other patients. Hospitals and doctors are more respectful and sen-

sitive to our needs. And we feel comfortable going to these hospitals."

Sex workers have made themselves part of the solution. When the civil hospital did not have adequate resources to develop the required infrastructure for ART programmes in Sangli, SANGRAM provided financial support to build an ART centre within the hospital premises.<sup>164</sup> This was a strategic move to improve sex workers' access to broader health services, including HIV treatment services. As noted by Meena Seshu, General Secretary of SANGRAM, "this signified our continued fight for the protection of sex workers' rights and commitment to addressing HIV." Apart from developing the centre's infrastructure, the finance supported the purchase of laboratory and other hospital equipment required for running the centre.

As a result, sex workers are more empowered and organized in their responses to HIV. The efforts made by VAMP Plus to facilitate sex workers' collective action in claiming, promoting and protecting their rights, has led to an increased recognition of sex worker rights and wider social acceptance. The sex worker community's perceptions about health and well-being have changed. They are more knowledgeable about the importance of early testing and treatment, and more willing to test.

"Before, we [sex workers] were treated like animals. We were not even allowed in the hospital to receive any kind of medical check-up ... Now we are treated like anyone else. We are accommodated in the same rooms as other patients. Hospitals and doctors are more respectful and sensitive to our needs."

Female sex worker and VAMP Plus outreach worker  
Anita Terdale

This has resulted in a significant improvement in their health-seeking behaviour. An awareness of rights coupled with this has, in turn, created the demand for friendly and affordable health services.

Over the years, VAMP Plus has adapted its approaches and introduced new programmes to ensure that the services provided are responsive to the emerging needs of sex workers living with HIV and their families. For example, in response to the growing numbers of children orphaned due to HIV, and single mothers who are too ill to care for their children, in 2009 VAMP Plus established Mitra, a hostel for children of sex workers living with and/or affected by HIV.

## Key programme strategies for VAMP Plus

### Outreach, counselling and accompanied referral

VAMP Plus implements a peer-based outreach programme for education and awareness on HIV testing and treatment, pre- and post-test counselling on HIV and accompanied referral for HIV testing. Outreach sessions are individualised, prioritizing one-to-one personal interaction, discussion and counselling. Counselling focuses on the benefits of testing, testing procedure and consequences of results.

Outreach workers accompany sex workers who wish to test for HIV to the civil hospitals. They receive pre-test counselling and a free HIV test. The test results are available on the same day. If a test result is negative, individuals are counselled on strategies to remain so and advised to come back for routine testing every three months. If the result is positive, initial counselling is provided and individuals are referred for an immediate health check-up, including CD4 count to determine treatment eligibility. Once this assessment is completed, and when a sex worker who receives a HIV positive result is ready, peer-outreach workers provide another round of post-test counselling, specifically designed for sex workers living with HIV.



### Follow-up support, determination of treatment eligibility and treatment adherence

Providing post-test counselling as part of follow-up support encourages sex workers living with HIV to access other care and support services and improves adherence to treatment. In VAMP's experience, two levels of counselling—by peer outreach workers and health care providers—is a more effective way to increase uptake of HIV treatment services. Combined with accompanied referral, it helps in addressing the common challenge of people who test HIV positive being 'lost to follow-up' and assists sex workers to access health care services for OI and commencing and monitoring HIV treatment when required.

Peer-outreach workers provide on-going psychological and practical support to sex workers living with HIV. Outreach workers are assigned to support individuals from the point they are considering taking an HIV test, to commencing and managing treatment if they test HIV positive. This allows mutual trust to build between the sex worker and outreach worker, which has the benefit of helping outreach workers manage cases effectively.

Follow-up health checks include testing for CD4 count, sonography, sputum test for TB, chest X-ray and haemoglobin test. This health check-up package is provided free of cost by the various departments at the civil hospital. Not only is it more convenient to have all these tests performed under the same roof, it accelerates the process for determining treatment eligibility. Furthermore, locating the treatment centre in the civil hospital makes coordinating, monitoring and following up any emerging treatment-related issues, including managing OI and illnesses related to HIV, far more efficient.

At the commencement of treatment, sex workers living with HIV are advised to visit the ART centre every fifteen days for regular check-ups, including monitoring side effects. The check-up intervals decrease as the sex workers adjust to the drug regimen and their health conditions improve. Throughout this period, the assigned outreach worker goes with the sex worker for these health visits.

### Community-based care and support

A large majority of sex workers living with HIV, and their family members, receive care and support services through VAMP Plus home-based and foster care programmes, which are located within the community. VAMP Plus has also established a referral system with two other AIDS care centres.

Most sex workers living with HIV are cared for at their homes. Peer outreach workers have become de facto 'families' and caregivers of sex workers who become unwell. Trained in home-based care techniques, these designated peer-outreach workers constantly ferry sex workers living with HIV back and forth from the hospital, organizing food and child-care and even supporting ailing lovers. Their counselling skills are put to use in supporting sex workers and their families through anxiety and grief. They are responsible for mobilizing support to address any immediate medical or social needs of sex workers living with HIV or their family members.

“Because of fear of discrimination, many sex workers do not want to take HIV test. My CD4 count was 71 when I got HIV tested for the first time; with the right treatment and the support I have received from my friends and community members, it is now 930. Improvement in my health status is a testimony of the positive impact of HIV testing and treatment. Using personal stories to encourage and motivate sex workers to get tested is very effective in my experience.”

**Shantamma Gollars, outreach worker, VAMP Plus**

In India, hospitalized patients are expected to organize their own helpers to bring food and water. Many sex workers do not have family members who can do this. Therefore, VAMP Plus has a roster of sex workers who provide 24-hour support as care workers. They carry food, clean clothes and clean drinking water for the patient. If a mother is admitted in hospital, in the interim her children are cared for by the community—from sending them to school, to supporting them physically and emotionally.

In 2008, VAMP Plus started a hospice care service for critically ill sex workers who cannot care for themselves, due to AIDS-related illness or other reasons such as disability. When Renukaambi, a female sex worker based in Sangli died, she left her savings to VAMP. With this money, VAMP constructed a multi-purpose hall and a room. The multi-purpose hall is used for holding health clinics every morning and evening, and supplementary education for children of sex workers, while the room has been turned into a hospice care centre. VAMP Plus members similarly provides 24-hour care for those living in the hospice centre.



## Lessons

- **Individualized peer-outreach support is effective in facilitating access to HIV testing and treatment services and in reducing 'lost to follow-up' sex workers.** In VAMP's experience, an individualised support facilitates conversation and trust more effectively than a group outreach session. It fosters privacy and confidentiality whereby sex workers can share their inner fears about HIV testing and facilitates access to HIV treatment and care.
- **Continued counselling and psychosocial support for sex workers living with HIV can reduce psychological distress.** This support has had an extremely positive effect on the members of VAMP Plus, helping dealing them with stigma and develop coping strategies. Anita Terdale, VAMP Plus outreach worker living with HIV explained that such support has given sex workers courage and confidence to face difficulties and live healthier and happier lives: "Sex workers willing to receive support and help to deal with stress, anxiety and fear are able to access health and social services on time. They are the ones living healthy and happy. Those who feared and ran away from these services have all died. Sex workers can see this around us. This bitter truth helps us to motivate our community and develop coping mechanisms for emotional and health problems."
- **Locating key HIV treatment-related services under one roof can improve service uptake.** Locating services together saves time, money and is easier than visiting multiple hospitals for different tests and treatment. According to VAMP, this arrangement appeals to sex workers and may contribute to improving service uptake.

"Thanks to the ART, very few sex workers are actually falling sick these days. But at times, we do face situations wherein sex workers do not have any family support, get critically ill and cannot care for themselves. In such situations, they need our help 24/7 and they need medical care every day. That's why we needed a hospice care centre. Here [in the hospice care centre], we organize doctor's visit every day and also help around the clock.'

**Anita Terdale, outreach worker living with HIV, VAMP Plus**

## Challenges, gaps and opportunities

Lack of funding for implementing HIV treatment, care and support services is a major challenge for VAMP and VAMP Plus. Peer outreach workers are paid 1 500 Indian rupees per month (equivalent to US\$ 27) to cover expenses of transportation and lunch, through Global Fund resources. All other services provided by VAMP and VAMP Plus operate through voluntary contributions by community members. Funding support for the supplementary food supply comes directly from SANGRAM. Meena Seshu, General-Secretary of SANGRAM reports that financial support for implementing community-led referral services for treatment, care and support programme is virtually non-existent and that post-test follow-up support is often not funded under prevention programming. “Sex worker communities have been dumped with the responsibility to not only find ways to take care of ourselves, and make these disjointed programmes work, but to do things that should be guaranteed by the government,” she says.

Resources for HIV treatment programmes focus on procurement, and delivery of ART. Very limited resources are available for community-led outreach and support to facilitate access to treatment and provide follow-up support services. The experience of VAMP Plus clearly demonstrates that such programme interventions tackle barriers to treatment service uptake and increase treatment adherence.

While acknowledging the important role played by community-based organizations like VAMP in improving access to HIV treatment, the challenge is to ensure that such programmes articulate with wider public sector efforts and that government as well as development partners allocate adequate resources to supporting and scaling up interventions that ensure treatment uptake and support treatment adherence. Such interventions need to be systematically monitored and evaluated to provide clear evidence of

their effectiveness in order to advocate for replication of such programmes.

Investing in developing sex workers’ knowledge about their right to health, building their confidence to claim rights and providing necessary support, improves sex workers’ health-seeking behaviour and access to health services, including adherence to treatment. The VAMP Plus experience indicates that strengthening and scaling up CBO-government partnership to improve uptake of treatment through building community capacity, contributes to achieving better health outcomes which are more likely to be sustainable.

Despite the lack of external financial support, through collective action the VAMP Plus sex workers have successfully created a community mechanism to provide care and support for sex workers living with HIV. VAMP Plus has united as a group to provide the much needed care and support for their friends and colleagues and aspires to continue and broaden this work to its best ability. ■

“Sex worker communities have been dumped with the responsibility to not only find ways to take care of ourselves, and make these disjointed programmes work, but to do things that should be guaranteed by the government.”

Meena Seshu, General-Secretary of SANGRAM

<sup>162</sup> The exact translation from Hindi is “Sex workers freedom from injustice”.

<sup>163</sup> Government hospitals are also called civil hospitals in India.

<sup>164</sup> For this, SANGRAM mobilized funds AVERT, an INGO based in the United Kingdom.





Case Study

6

# USHA Multipurpose Cooperative Society

“It’s our own bank, not for non-sex workers or outsiders... We are proud in the only sex worker cooperative...I am proud of myself that through USHA, I met so many people and am well known. I got trained, learned to talk to others, and learned how bank is run.”

Julie, daughter of a sex worker, daily collector

**U**SHA<sup>165</sup> Multipurpose Cooperative Society is the largest sex worker-led financial institution in Asia, steered by Durbar Mahila Samanwaya Committee (DMSC), a sex worker collective in West Bengal, India. DMSC, a collective of 65 000 sex workers, is a forum for all sex workers. In 1995, a group of sex workers from DMSC created USHA as their own financial institution.

The cooperative’s goals are to enable sex workers to become financially secure; establish worker’s recognition and rights of sex workers; and to ensure education and career development opportunities for sex workers’ children.

USHA has a current membership of 16 228 female and transgender sex workers. Four to five thousand members receive loans annually. Female and transgender sex workers or their daughters over 18 years can open accounts and are eligible for loans. USHA has one of the best loan recovery rates in the state of West Bengal (over 90%) with an annual turnover of US\$ 2.7 million and capital assets of more than US\$ 1 million.<sup>166</sup>

USHA’s core services are:

- savings accounts, daily collection accounts and fixed deposits, and a tie-in product with the Life Insurance Corporation of India;
- providing loans to members;
- supporting self-employment schemes for sex workers;
- social marketing strategies generate resources for DMSC to better meet the community’s needs.

## History behind the cooperative

Sex workers in West Bengal were denied access to financial institutions and could not open bank accounts, as they were unable to produce the necessary documents. As a result, the majority of sex workers deposited their money in unauthorised financial institutions (such as chit funds)<sup>167</sup> or left it in the care of their madams, risking mismanagement of their money and sometimes outright loss of savings. Common experiences among sex workers in DMSC were being cheated by these agencies and having their savings taken away by their lovers (babus), local goons and the police. Many did not know how to save money from their daily incomes and usually spent all their earnings. Moreover, there was the prospect of financial insecurity for aged sex workers. They had a declining income, increased health-related expenses along with often financially supporting the family. During a financial emergency, sex workers were generally at the mercy of loan sharks who charged exorbitant interest rates, sometimes as high as 300% per annum. Sex workers were often caught in an inescapable spiral of debt, compounding often fragile financial situations.

At the same time DMSC was consolidating its learning from the HIV prevention programmes they had been implementing since 1992. One of the lessons was that structural barriers limited sex workers’ access to health, social and financial support services. They learned that financial insecurity prompted sex workers to compromise their safety, such as being unable to insist that a client use a condom for fear of losing business. Increasing the likelihood of an STI/HIV infection, this ultimately spiralled into greater expense on health care. USHA cooperative was formed to address these socioeconomic and health vulnerabilities of sex workers.

## Why a cooperative?

DMSC had the option of opening a bank account, engaging with a life insurance company or initiating a microcredit or cooperative scheme. Based on discussions with community members, it became apparent that there was a need to create a financial institution, exclusively of, and for, sex workers. The community wanted an institution to address the underlying factors which prevented them from accessing financial support elsewhere. Community involvement throughout the process of forming a cooperative ensured their needs were met and priorities respected. An additional, extremely helpful, factor was that the Indian government provides assistance to cooperatives by giving working capital loans and infrastructure development support.

## Early struggles

When the sex workers from DMSC approached the Government Cooperative Department seeking support to start a cooperative, they realized that they could not register the cooperative under the West Bengal Cooperative Law. Firstly, they did not have the required start-up funds. Secondly, sex workers were considered immoral under the Cooperative Law and only people with 'good' moral character could register a cooperative. DMSC decided to advocate for a change in clause in the law regarding 'immorality'. What followed was an intense lobbying and advocacy campaign. Finally, in August 1995, DMSC succeeded in persuading the Government of West Bengal to remove the notion of 'morality' from the Cooperative Law. USHA could be legally registered as a cooperative of, and for, sex workers.

The registration of USHA marked a victory on two accounts. First, the changes to the Cooperative Law had the effect of recognizing sex work as an occupation. This was used to bolster wider advocacy campaigns for sex workers' rights. Second, it challenged the power relations between money lenders and sex workers by

disempowering the system that upheld exploitative economic conditions.

The local money-lending loan sharks were aggravated by the formation of USHA. They lodged complaints to local city councillors accusing them of misappropriating funds. DMSC advocated at the state and local levels to counter these false allegations.<sup>168</sup>

Initially there was also resistance from within the community. Bitter experiences had taught sex workers to be wary of any 'new deals' involving money. Time was spent in building trust. As members realized that their money in USHA earned a good interest and they could access loans against their deposits at very low interest rates, their trust grew, as did the membership. Seed funding, of approximately US\$ 1800, secured from the State Department of Cooperatives, contributed to boosting USHA's credibility.

## Elements of success: Key components of the cooperative programme

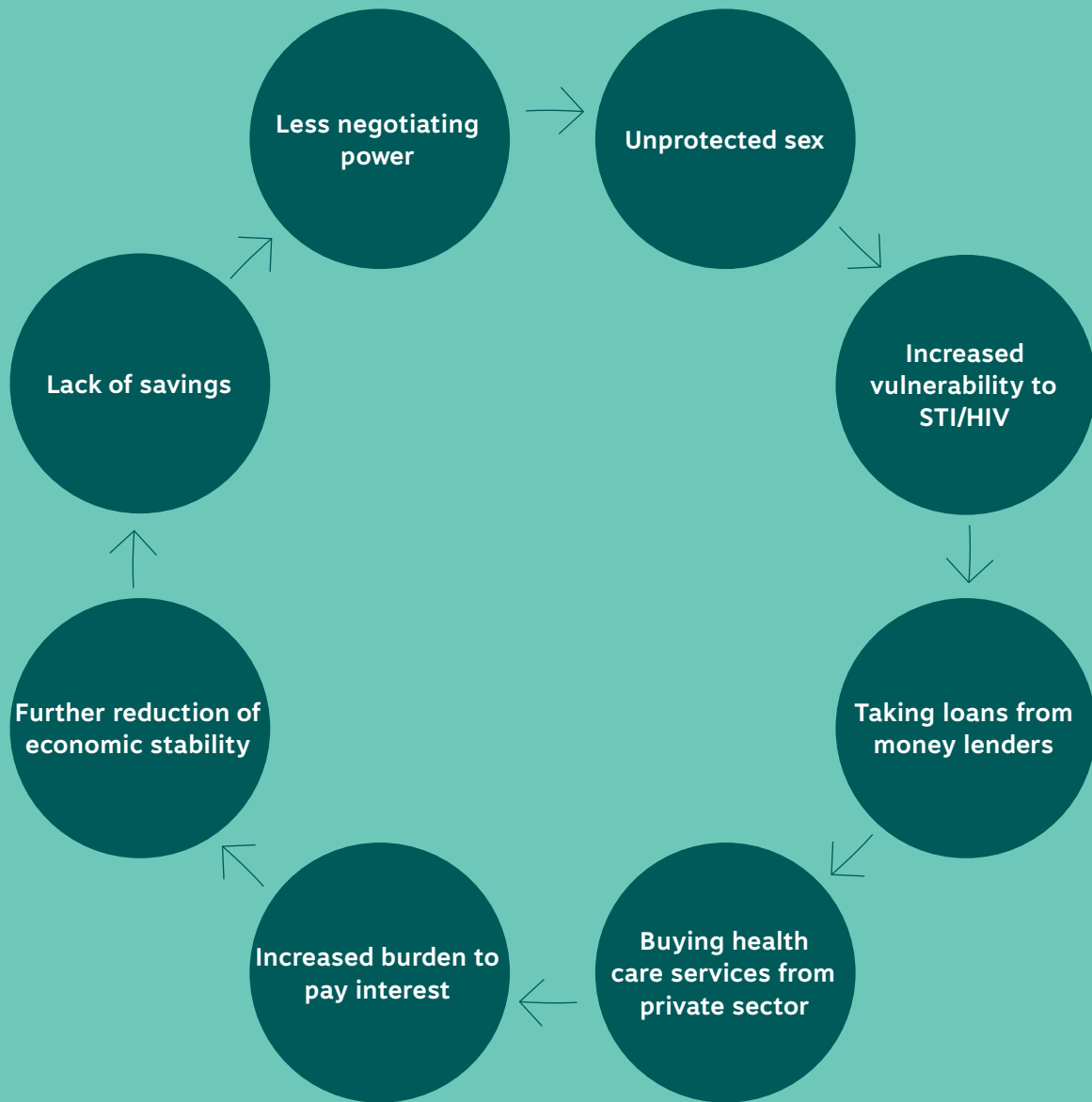
### Governance and management

A board of nine directors, all of whom are sex workers, governs USHA's management and operations. They are elected by a two-tier system. In the first phase, all the general members vote for forty-five representatives. The elected representatives then elect the board members who hold office for three years and no more than two consecutive terms. The president, secretary and treasurer are elected from the board members. As the executive committee, they make all key and final decisions. This democratic approach has encouraged community members to participate in the decision-making process. "The most important thing is that all our services are directed towards members' well-being and they can aspire to be on the board to make decisions one day," says USHA's President at the time of documentation, Abida Begum.

As a member of the steering committee of DMSC, USHA participates in the joint policy making forum of



# The cycle of economic insecurity and vulnerability to HIV





“The most important thing is that all our services are directed towards members’ well-being and they can aspire to be on the board to make decisions one day,”

**Abida Begum, USHA President**

sex workers of DMSC. This addresses potential conflict of interest between financial management issues and interests of the community.

USHA has developed three operational policy guidelines focussing on:

- staff recruitment: priority is given to sex workers and the daughters of sex workers for all positions;
- loan disbursement: priority is given to the poorest of the community;
- flexible working hours: the working hours are determined by the needs of the community.

There are 47 employees of USHA and the ratio for male to female staff is 1:2.

### Services offered

Primarily USHA gives loans to its members, some of whom have taken loans of up to 2 500 000 Indian rupees (US\$ 40 000) to start their own businesses. “I took loans three times: once to buy land, then to

build a house and finally for my daughter’s marriage,” explained an elderly sex worker. USHA provides vocational training to members who want to start small business ventures. This ensures that businesses set up by sex workers run effectively and are able to generate income.

Furthermore, financial empowerment has enabled sex workers to independently approach external financial institutions for borrowing, as citizens with rights and as workers.

### Making services responsive to community needs

In USHA’s experience, a financial institute with a human face is critical. “Other banks are concerned about money, we are concerned about our members,” stated a member of USHA. This is achieved by raising awareness about services offered and by providing reliable and friendly saving schemes to encourage sex workers to create a culture of saving. “I can deposit my daily earnings which can be later used. In the past, babu used to take away my money” commented Jyotsna, another member of USHA.



“Other banks are concerned about money, we are concerned about our members.”

#### A member of USHA

USHA constantly updates their services to cater to the needs of their members. They make their services user-friendly by:

- Ensuring that transactions are quick and easy,
- Offering attractive interest on savings that motivate sex workers to save more;
- Maintaining a caring approach through personalised contact with members. As one member explained, “It’s the love and care from USHA, the daily collectors and board members, who make me feel that USHA is mine. When I was ill, the president delivered the loan at the hospital, which other banks can never do for me;”
- Introducing a daily collection system. This offers sex workers a more efficient financial transaction and creates jobs. USHA was granted permission by the Cooperative Department to undertake daily collection. This boosted membership and the amount of money deposited increased five-fold in one year.<sup>168</sup> USHA trains and employs daughters of sex workers as daily collectors, broadening their engagement in the DMSC movement. As Julie, daughter of a sex worker recounted, becoming a daily collector has boosted her feeling of ownership and empowerment: “It’s our own bank, not for non-sex workers or outsiders... We are proud in the only sex worker cooperative...I am proud of myself that through USHA; I met so many people and am well known. I got trained, learned talk to others, and learned how bank is run.”

An unforeseen but significant positive impact of USHA is that member’s registration cards are now used to obtain voter ID cards and rations cards, enabling sex workers to access other civil entitlements.

#### Moving beyond microcredit programming

Since its inception, USHA has emphasized income generation through various social marketing strategies.

Marketing of businesses helps generate income for sex workers. The condom social marketing programme is the most profitable venture of USHA, selling around 3.5 million condoms per annum.<sup>170</sup> In 2010–2011 alone, USHA sold 9 432 458 condoms, generating a profit of 1 086 298 Indian Rupees (approximately US\$ 19 636).<sup>171</sup>

USHA currently acts as DMSC’s primary financial agent, building up an assets base to safeguard its sustainability.<sup>172</sup> The financial success of USHA has enabled it to take bank loans, investing the surpluses to build DMSC’s capital assets. Greater financial independence has allowed DMSC to be more proactive in meeting the needs of the community. For example, they have been able to establish new health clinics and education centres for sex workers and their children. The income generating capacity of USHA demonstrates the programmes’ effectiveness and in turn assists in mobilizing additional resources from donor agencies.

Through experience USHA has developed technical expertise and a robust infrastructure equipping it to act as the financial institution for other sex workers’ organizations affiliated to DMSC. At present, USHA has more than 5 000 registered members and its increasing turnover is hailed as a success story of the Cooperative movement in West Bengal by the Department of Cooperatives.<sup>173</sup>

#### Condom social marketing

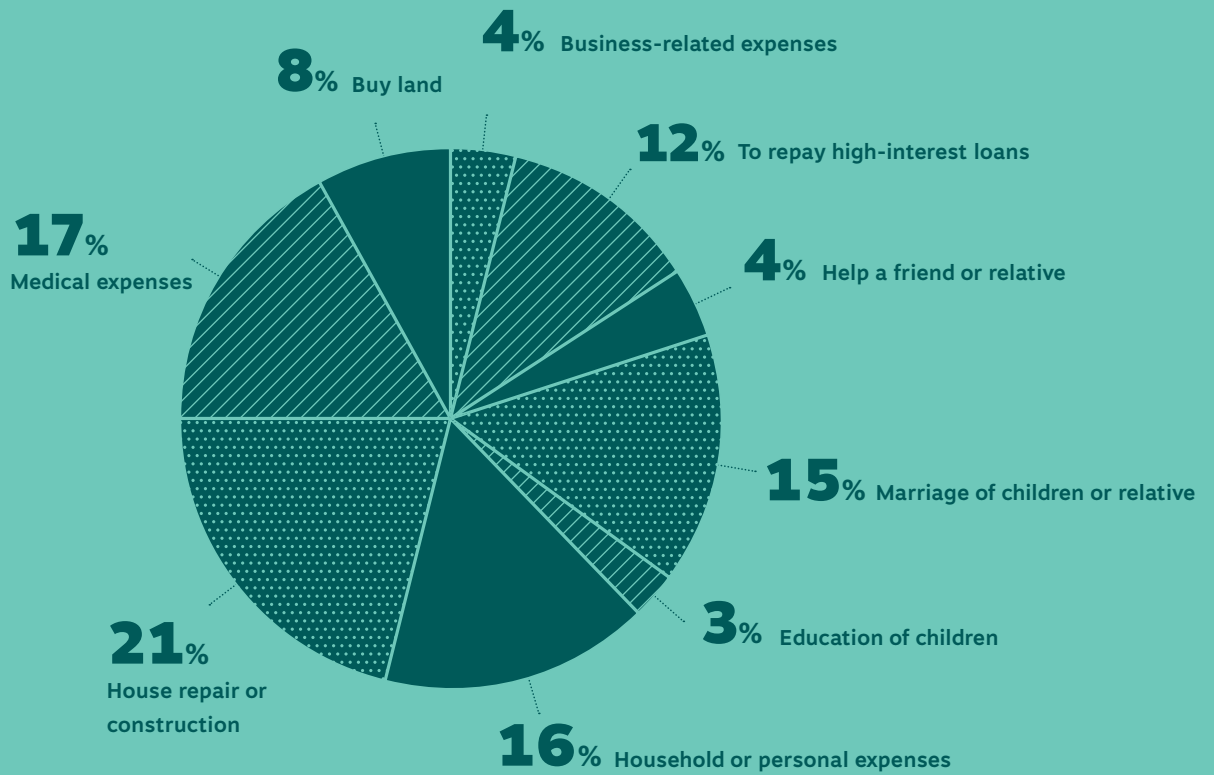
The Condom Social Marketing Programme, referred to as *Basanti Sena*, started in 1998, in response to the phase out of DMSC’s HIV programme. With this, distribution of free condoms stopped and sex workers

“It’s the love and care from USHA, the daily collectors and board members, who make me feel that USHA is mine. When I was ill, the president delivered the loan at the hospital, which other banks can never do for me.”

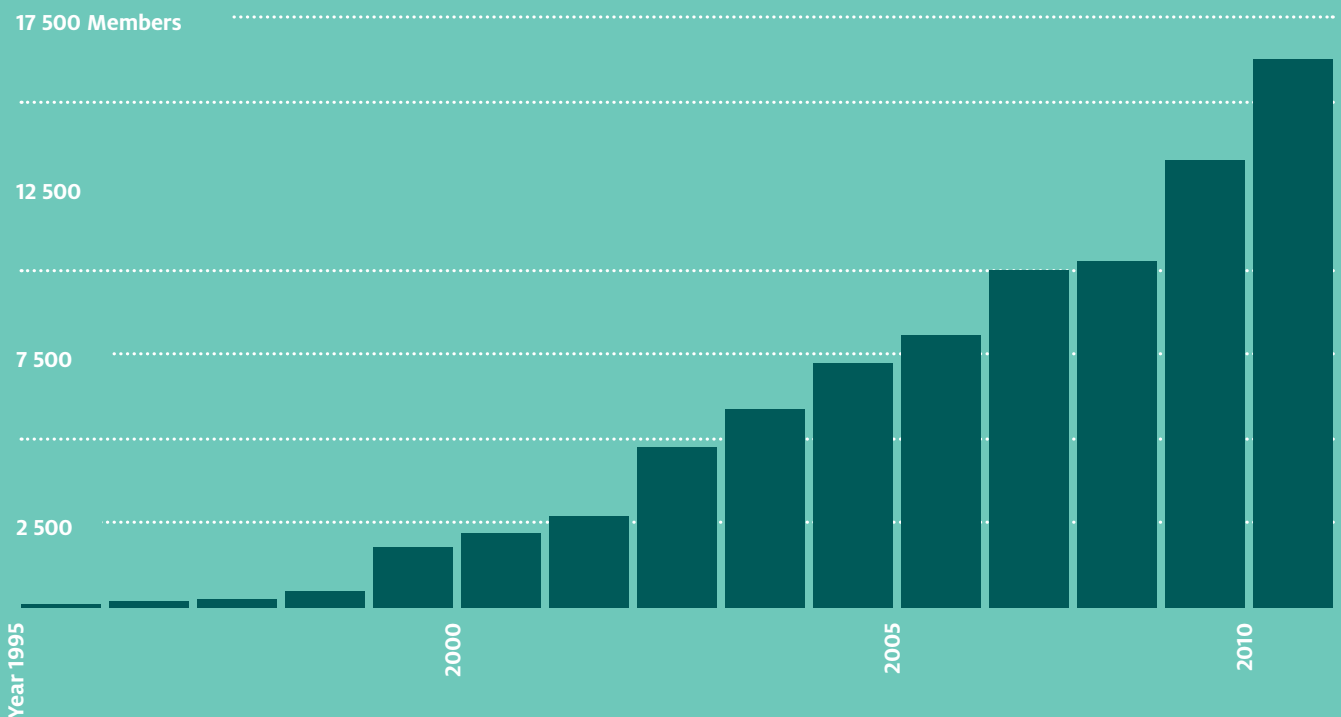
#### A member of USHA



## Loan purposes



## Growth in USHA Cooperative Membership 1995-2011





## Lessons

had to buy them. This was a strategy for sustainability of condom distribution and safer sexual practices. The main objectives of the programme are to create a demand for condoms through awareness raising and counselling, and ensure availability of good quality and affordable condoms.

Initially, social marketing was conducted in high-density sex work areas of Kolkata. Later, a three-level marketing strategy was adopted:

- one-on-one and group counselling to highlight the importance of condom use and developing condom use negotiation;
- advertising condoms and promoting its use by distributing leaflets, through cultural programmes like street plays and large-scale community awareness campaigns;
- establishing outlets for selling and storing condoms in each sex work area.

Two teams of Basanti Sena, each comprising of five members and a team leader, coordinate the programme. Limited social marketing of lubricants is conducted, as this is provided free for male and transgender sex workers by the State AIDS Control Society.

• **Economic empowerment increases sex workers' morale and self-confidence, improves standard of living and is empowering for the community as a whole.**

• **A sex worker-led financial institution has wider social and political implications.** It legitimizes sex work as an occupation and sex workers' right to control their own economic resources. Moreover, this has influenced other collectives of marginalized communities to replicate the model, taking technical help from USHA. Another effect is the reduction of interest rates by moneylenders.<sup>174</sup>

• **Economic security improves sex workers' control over their work environment, including the ability to negotiate safer sex.** Sex workers experience less financial exploitation when they manage their own finances. Since social marketing of condoms is tied to the visits made by daily collector, the message of consistency in condom use is constantly reinforced. For sex workers living with HIV, access to USHA means being able to better take of their health.

• **Financial services must be responsive to the everyday needs and realities of sex workers.** USHA's responsiveness to the need for daily collection improved savings and increased membership.

• **Investing in capacity building of sex workers in financial management and public relations is critical to efficacy of a sex worker-led financial institution.** Various local banks, experts and advisors of DMSC have given technical inputs to plan, run and monitor USHA cooperative.

## Gaps, challenges and opportunities

It was not an easy journey to introduce regular savings schemes for sex workers or new concepts of social marketing. Moneylenders and chit funds posed a constant challenge. Many moneylenders are friends of sex workers and many sex workers are still unaware of USHA's services. In financial emergencies, they tend to go to moneylenders. To raise awareness about the inherent dangers of this, USHA distributes information through pamphlets, daily collectors and disseminates warnings issued by the Reserve Bank of India.

Another challenge can be the madams and lovers appropriating sex workers' income. Dealing with this requires more tact because they are the sex worker's 'family'. USHA depends on the strong field presence of DMSC for this.

Low-levels of literacy and lack of expertise in finance and accounting among the USHA staff, including the collectors, continues to make USHA dependent on technical advisors and DMSC for support. They are aware of the need to consider sustainable approaches to building capacity of the sex worker community in these areas. Continued efforts are required to expand USHA's business initiatives.

The keystone of USHA's future plans are strengthening and expanding its business ventures and continuing to provide financial and social support to more sex worker communities across a wider geographical area.

There is concern about the safety and security of elderly, retired sex workers and those living with HIV. USHA plans to set up an old age home and a large-scale production unit for generating employment for workers who opt out of sex work, or retire. They will continue to bolster campaigns for the recognition of sex work as work and assert sex workers' human rights.

USHA has emerged as an inspirational financial institution. Currently, staff members provide technical support and guidance to initiate a similar financial institution model in Tangail, a brothel in Bangladesh, for TOP in Myanmar and Ashodaya in Mysore, India. With technical and financial support from USHA, a cooperative for male sex workers in West Bengal will start in August 2012. The success of these will demonstrate USHA's impact and its potential for replication. ■

164 In Hindi, the word means dawn, as it is the dawn of financial support initiated for sex workers, by sex workers.

165 Jana, Samarjit, 2011. The Political economy of Sex workers Cooperative. Presentation made at University of Pennsylvania, USA on 14 April, 2011. DMSC: West Bengal, India.

166 Chit funds are private and often unregulated financial institutions that give loans at exorbitant interest rates.

167 See [http://www.durbar.org/html/micro\\_credit.asp](http://www.durbar.org/html/micro_credit.asp). Accessed on 28 May, 2012 in Bangkok, Thailand.

168 DMSC and TAAH Research Team. Meeting community needs for HIV prevention and more, Intersectoral action for health in the Sonagachi red-light area of Kolkata. Date, Unknown. Accessed from [http://www.who.int/social\\_determinants/resources/isa\\_sonagachi\\_ind.pdf](http://www.who.int/social_determinants/resources/isa_sonagachi_ind.pdf) on 28 May, 2012 in Bangkok Thailand.

169 Jana, Samarjit, 2011. The Political economy of Sex workers Cooperative. Presentation made at University of Pennsylvania, USA on 14 April, 2011. DMSC: West Bengal, India.

170 DMSC, 2012. Social Marketing of Condoms by USHA Cooperative Society, Ltd. Internal Document, unpublished.

171 [http://www.durbar.org/html/micro\\_credit.asp](http://www.durbar.org/html/micro_credit.asp)

172 From [http://www.eugad.eu/wiki/index.php?title=India\\_-\\_Living\\_with\\_Dignity\\_-\\_Kolkata](http://www.eugad.eu/wiki/index.php?title=India_-_Living_with_Dignity_-_Kolkata) accessed on 28 May, 2012 in Bangkok Thailand.

173 [http://www.durbar.org/html/micro\\_credit.asp](http://www.durbar.org/html/micro_credit.asp) accessed on 29 May, 2012 from Bangkok Thailand.





Case Study

7

# **Durjoy Nari Sangha: addressing violence against sex workers in Bangladesh**



**D**urjoy Nari Sangha<sup>175</sup> is a CBO governed by female sex workers in Bangladesh. Its vision is to empower freelance female sex workers<sup>176</sup> to secure rights of equality, dignity, health and safety. Currently 3 500 sex workers from Dhaka and other towns are registered members.

In 1997, CARE Bangladesh (CARE) pioneered an intervention amongst street-based sex workers — ‘Stopping HIV/AIDS through Knowledge and Training Initiative’ (SHAKTI). Key activities were outreach, drop-in-centres, STI referrals, condom promotion and rights awareness among sex workers. Community empowerment and sex worker participation were cornerstones of SHAKTI’s approach.

A few months into the project, 20 sex workers visited Durbar Mahila Samanwaya Committee (DMSC) in Kolkata, India to study sex worker collectivisation. This was their first exposure to a large-scale programme led by sex workers who viewed themselves and their work positively. It was an eye opener to realize the commonality of their experiences and inspired the sex workers of Bangladesh to move forwards towards building a strong community and sex worker-led organization.

In 1998, the sex workers decided to form Durjoy Nari Sangha (Durjoy) and an eleven-member committee<sup>177</sup> was democratically elected. In 2005, Durjoy registered with the NGO Affairs Bureau enabling it to receive foreign funds. In 2009, it expanded services to include home and hotel-based sex workers.

As of 2012, Durjoy is the largest sex worker organization in Bangladesh and a strong advocate for sex workers’ rights. It reports implementing HIV prevention programmes in four divisions and 26 districts of Bangladesh, providing services to more than 14 000 sex workers.<sup>178</sup> Services include legal rights education for sex workers rights and legal advice and referrals. This case study focuses on Durjoy’s programme to prevent and respond to violence against sex workers.

## HIV prevalence and violence against sex workers in Bangladesh

HIV prevalence in Bangladesh is less than 0.1% in the general population.<sup>179</sup> HIV prevalence among female sex workers, men who have sex with men, transgender people and people who use drugs is 0.7%.<sup>180</sup> However, national HIV prevalence figures often mask higher prevalence in specific districts. For example, in Hili, a small border town in the northwest, HIV prevalence is estimated at 1.6% among female sex workers.<sup>181</sup> Syphilis rates are estimated at 13% among street-based sex workers in Hili, 10% in Chittagong and 9% among hotel-based sex workers in Sylhet.<sup>182</sup>

During the first half of 2011, violence against women and girls topped all crimes reported to the police. A total of 7 285 cases of violence against women were registered of which 1 586 were rape.<sup>183</sup> The levels of violence against female sex workers<sup>184</sup> are higher than in the general female population.<sup>185</sup> In 2007, CARE, Durjoy and Nari Mukti Sangha carried out a base-line survey among 381 female sex workers in Dhaka, Khulna and Tangail.<sup>186</sup> The key findings were:

- 94% experienced violence. The types of violence included verbal, physical and mental abuse and sexual assault. Among those who experienced violence, 65% faced sexual violence during pregnancy.
- In Dhaka, 81% of street-based sex workers and 62% in Khulna reported local gang members (mastan) and police as the main perpetrators. In brothels, the perpetrators were madams (sardanis) (69%), clients (48%) and lovers (babus) (38%).
- Street-based sex workers face slightly higher violence than brothel-based sex workers. On average a street-based sex worker in Dhaka faced eleven incidents of mental violence, six of sexual violence, five of economic and five of social violence from their clients, per month.

The extent and severity of violence against sex workers does not result in public outcry; rather, it is normalized. Often, prevailing stigma against sex workers means they are not considered worthy of support and protection.

- Among 351 sex workers who faced violence, a majority attempted to report it; 15% to the police and 71% sought NGO assistance.
- About 50% experienced barriers in reporting. This included social stigma, reluctance by the police to register a complaint, demands for money, lack of privacy, poor quality of services, verbal abuse and misbehaviour.
- Sex workers often experience psychological problems due to limited support to deal with violence, and inability to access legal recourse.<sup>187</sup>

The extent and severity of violence against sex workers does not result in public outcry; rather, it is normalised. Often, prevailing stigma against sex workers means they are not considered worthy of support and protection. Internalised stigma among sex workers themselves was also evident, with many sex workers in Bangladesh considering violence normal or ‘part of their job’.<sup>188</sup> This has an adverse impact on the health of sex workers and their families, particularly children. Stigma, the threat of violence and low self-esteem was found to contribute to mental ill health and impede access to health care services. The study indicates a connection between violence and low condom use, and hence increased vulnerability to HIV and STIs.

### **PROTIRODH project: a model for addressing violence against sex workers**

In response to the baseline findings from the SHAKTI project, CARE in partnership with Durjoy designed and implemented a project to address violence against women, highlighting female sex workers as a particularly vulnerable group. The project, ‘Promoting Rights of the Disadvantaged by Preventing Violence Against Women’ (PROTIRODH),<sup>189</sup> aimed at preventing and responding to violence and improving women’s access to legal and health services. The project component focussing on street-based sex workers

commenced in 2007 and was implemented for three years in Dhaka and Khulna.

The programme objectives were to:

- prevent violence by mobilizing and building capacities of sex workers and community partners, including clients, police, local businessmen, goons and religious leaders;
- ensure that sex workers who experience violence can access legal, health and protection services;
- address violence by addressing barriers to reporting violence, enhancing access to legal support and improving responsiveness of law enforcement and judicial systems.

The baseline findings informed the design of PROTIRODH. CARE facilitated capacity building for Durjoy, provided technical guidance and support to develop partnerships between the community, district level government bodies, NGOs and community leaders. It helped advocate with police and judiciary to improve their understanding the nature of violence against sex workers and to ensure police were following correct procedures for prosecuting cases of violence against sex workers.

Activities during the first phase of project implementation were:

- Thirteen sex workers were recruited as project staff in Dhaka, and nine in Khulna.
- Mapping the availability of legal, health and social services to street-based sex workers who experience violence. During this, partnerships were forged with potential service providers.
- A tool kit was developed for individual case management of violence.
- CARE trained PROTIRODH staff in team building; community mobilization and networking;

counselling; human rights and gender including violence against sex workers; individual case management; programme management and monitoring.

- Members of the wider community were identified and trained to act on Violence Against Sex Workers committees (VASW), watchdog committees and support group committees.

## Community and committee mobilization, with focus on men

Given that one of the key findings of the study was that violence faced by sex workers was often perpetrated by men in the sex workers' local community, including the local police, the local gangs, their intimate partners, working with this group of men was deemed critical in preventing and responding to violence against sex workers.

Community mobilization—with an important focus on men within the sex workers' community—was a critical component of PROTIRODH's work to achieve zero tolerance of violence against sex workers. The VASW, watchdog and support group committees' functions were to prevent violence against sex workers from recurring, and to mobilize support and access to services for those affected.

The VASW committee consisted of 15–20 street-based sex workers. A total of 1 275 sex workers volunteered on these committees throughout the project period. The function of the committee was to:

- Mobilize street-based sex workers through outreach and education and enable them to address violence, to access legal, health and other social services with a rights-based approach.
- Carry out individual case management. As a first point of contact VASW committee coordinated with the watchdog and support group committees to ensure that survivors of violence received immediate

attention and accessed the required services. Committee members were responsible for providing accompanied referral to other agencies.

- Conduct a social mobilization campaign on stigma and discrimination using performance art, and carry out police sensitization programmes.

### Watchdog committees

The watchdog committees comprised of men who had connections with the sex industry such as rickshaw pullers, truck-drivers, shop keepers, local gang members, and security guards. Some men involved in these committees had previously perpetrated violence. A total of 410 men volunteered on watchdog committees. Their role was to ensure:

- Monitoring and protecting sex workers from violence in the community. Committee members often defused potentially violent situations.
- Case management by informing the VASW committee, and providing emergency shelter, and a witness in case reporting.
- Raise awareness about violence against sex workers during social mobilization campaigns. This included enlisting support from influential men in the community, such as religious leaders.

Support group committee members included both individuals and organizations with influence in the health sector (i.e. doctors and hospitals) and the police force (i.e. Chief Inspectors); mental health professionals; NGOs providing emergency shelter; lawyers and prominent dignitaries, including the Mayor of Dhaka. The role of the support group committee was to facilitate access to services for sex workers who experienced violence, in collaboration with VASW, and act as a pressure group to ensure that cases of violence against sex workers were managed correctly and attended to by service providers.

## Referral linkages to free services

A unique and cost-effective feature of the programme was that it built partnerships with existing service providers to provide free services to sex workers. These partners included designated health care providers in government hospitals, two lawyers, shelter homes and NGOs offering psychosocial services. The following facilities were made available free of charge to sex workers:

- Emergency medical treatment and health check-up at government hospitals. CARE provided financial assistance to cover medication costs for up to seven days. Thereafter in the case of insolvent patients, the VASW and watchdog committee mobilized resources from within the community.
- Legal aid for complainants of violence, including counselling on rights and legal options and assistance in reporting at the local police station. With the help of the committees, a large number of cases were resolved out of court. Four cases went to court.
- Counselling, psychosocial care and support for complainants of violence by trained VASW committee members. Twenty-two community counsellors were certified in psychosocial counselling.
- Referrals to emergency shelter run by NGOs.
- Access to a hotline telephone service. The number was widely distributed to sex workers encouraging them to call for help and committee members responded to distress calls.

## Creating a supportive legal and policy environment for sex workers

Creating a supportive legal and policy environment for sex workers was a key objective of PROTIRODH.

### Advocacy campaigns to address wider stigma and discrimination

Committees periodically organized awareness raising campaigns on issues of stigma and violence faced by sex workers, at the community, sub-district and district levels. Key messages focussed on raising awareness of the nature and extent of violence against sex workers, the rights of sex workers to safety, protection, dignity and freedom from violence. Campaigns were organized to coincide with events such as International Women's Day and World AIDS Day. Forum Theatre was also used to promote messages.<sup>191</sup> Campaigns targeted local government bodies, civil society organizations, human rights groups and community and religious leaders.

Police officers were trained to understand violence against sex workers as a human rights violation and the role of law enforcers in curbing it and prosecuting offenders. Quarterly meetings were organized to ensure that police were performing their duties humanely, documenting cases and supporting the case in court.

National advocacy workshops were organized annually for PROTIRODH stakeholders and champions to disseminate information and lessons learnt from the project.

## Impact and reactions: life improvements

Independent qualitative and quantitative evaluations carried out at the end of the project revealed significant improvements in sex workers' quality of life.<sup>192</sup> This could be seen as a direct result of improving the quality and immediacy of response by institutions and services for survivors of violence. Key achievements of the project were:



## Cases attended between July-October 2009 and service referrals made<sup>189</sup>

| Area   | Type of violence |               |        |          |        |
|--------|------------------|---------------|--------|----------|--------|
|        | Physical         | Psychological | Sexual | Economic | Social |
| Dhaka  | 106              | 106           | 49     | 45       |        |
| Khulna | 65               | 65            | 86     | 62       | 46     |

| Area   | Types of service referral made |             |       |          |         |        |
|--------|--------------------------------|-------------|-------|----------|---------|--------|
|        | Health                         | Counselling | Legal | Economic | Shelter | Salish |
| Dhaka  | 63                             | 106         | 0     | 2        | 0       | 0      |
| Khulna | 29                             | 65          | 0     | 16       |         | 22     |

### Incidence reduction

A significant reduction in all forms of violence experienced by both brothel and street-based sex workers was reported at the end of the project, when compared with the baseline.<sup>193</sup> Violence by clients had declined sharply. Economic violence by clients had reduced by 57%, sexual violence by 55%, mental violence by 47% and physical violence by 39%. Social and political violence remained unchanged at 14%.

### Increased reporting of violence and access to services

Sex workers reported a deeper understanding of their rights. They indicated more willingness to report cases of violence at police stations and seek legal assistance and health care. Street-based sex workers in Khulna reported that their ability to protest against violence increased by 75% and 41% in Dhaka. Sex workers reported significant improvement in the availability

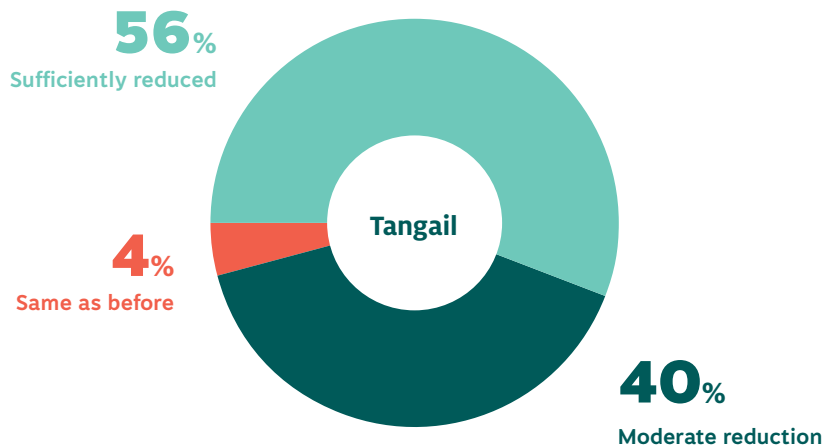
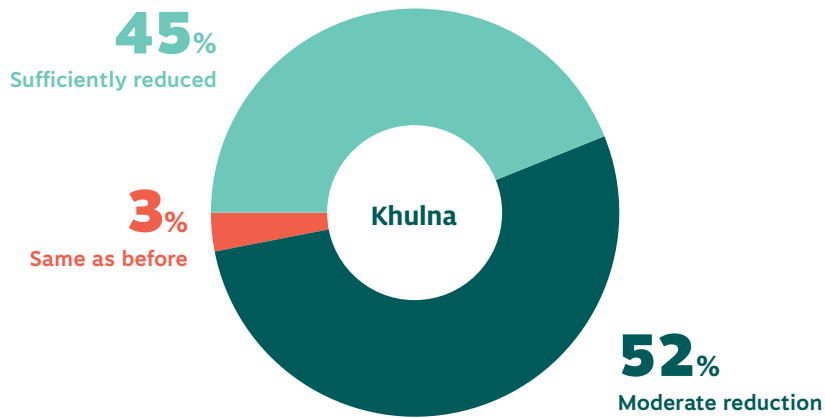
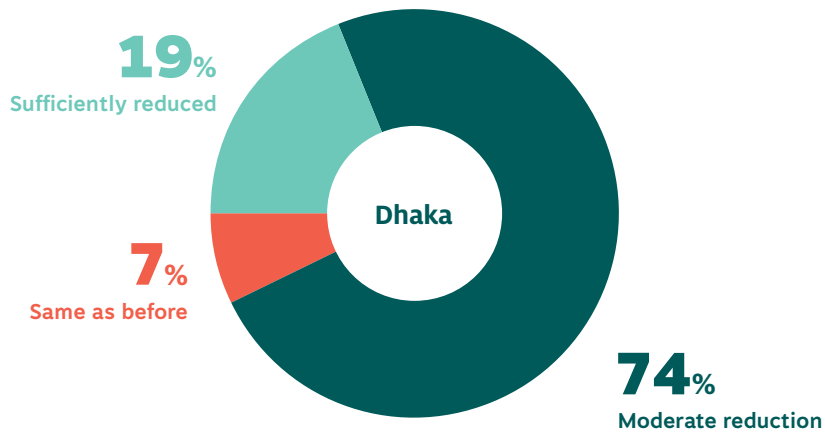
and quality of health care services. In Khulna, 79% of sex workers accessed health care services at government facilities. In Dhaka, 34% reported accessing government hospitals and 47% private clinics. Others reported accessing health care facilities run by NGOs. A significant change in the attitudes of health care service providers was noted. This is likely to account for the improved health-seeking behaviours of sex workers.<sup>195</sup>

### Reduction in stigma and discrimination, particularly among male community members

Through its approach in mass mobilization of relevant community members, service providers, government institutions and most importantly the sex worker community themselves, PROTIRODH has had a meaningful impact on reducing the overall stigma and discrimination towards sex workers. This has led to an improved social environment more



## Opinions of sex workers on reduction in violence by area<sup>194</sup>



Note: The figures in the graphs above have been averaged from responses over ten categories. Rounding has been applied to the averaged figures. For the full dataset see page 107, footnote 196.



## Opinions of sex workers on improvement in environment in and around work area<sup>197</sup>

| Indicators          | Whether any change in the status by area |        |         |                         |        |         |
|---------------------|--|--------|---------|-------------------------|--------|---------|
|                     | Sufficiently improved (%)                |        |         | Moderately improved (%) |        |         |
|                     | Dhaka                                    | Khulna | Tangail | Dhaka                   | Khulna | Tangail |
| Police raid         | 13.0                                     | 39.0   | 73.0    | 77.5                    | 61.0   | 25.0    |
| Violence by mastan  | 12.5                                     | 40.0   | 81.0    | 66.5                    | 59.0   | 18.0    |
| Overall security    | 15.0                                     | 47.0   | 86.0    | 77.5                    | 53.0   | 13.0    |
| Brothel environment | -  | -      | 83.0    | 17.0                    | -      | 15.0    |
| Others              | 1.5                                      | 1.0    | 1.0     | 2.0                     | -      | 1.0     |

empathetic and supportive to sex workers and their families. Given the patriarchal society in Bangladesh, the involvement of key male figures at the local level was an astute strategy. Sex workers and watchdog committee members reported improvement in the following areas:<sup>196</sup>

- mechanisms for reporting violence at local police stations;
- access to birth registration and school enrolment for children of sex workers;
- increased participation by sex workers in social events and community gatherings (i.e. weddings, festival, birthday parties);
- better social perception of sex workers and their families.

### Improvements in the material conditions of sex workers<sup>197</sup>

Sex workers reported higher self-esteem and greater confidence as a result of gaining knowledge of their rights and developing skills to protest against violence. The project resulted in building solidarity among those who had taken a lead role in its implementation. A marked increase in sex workers' control over finances and an improvement in health and social conditions were noted. Specifically, sex workers reported experiencing:

**Greater independence and control over situations when dealing with clients, local goons and intimate partners.** Sex workers reported greater ability to circumvent sexual exploitation. For example, 72% of sex workers in Khulna, and 66% in Dhaka said they were better able to collect payment for sexual services in cases of defaulting clients. They were more able to resist forced sex. The ability to make decisions of when, where and with whom they did business improved by over 50%. At all intervention sites, the demand for free sex reduced by more than 50%. Their ability to save increased marginally from 54% in the baseline to 67% in the end-line survey. Sex workers reported having



## Lessons

more control over earnings and better financial management skills. Significantly, 85% said they enjoyed greater control over how they spent their earnings.

**Increased use of condoms with clients indicates that creating safety mechanisms to respond to violence has a direct effect on HIV prevention.** On average, 89% of clients used condoms at every sexual encounter with sex workers, 96% in Dhaka and 84% in Khulna.

**Reduction in drug use:** Baseline findings suggested almost one-fifth of the respondents used drugs. By the end of the project, 70% reported 'reasonable reduction', 10% 'significant reduction', while 20% reported continued usage.

- **Building social capital and alliances within the community, particularly among men, reduces incidence of violence.** Widespread violence against sex workers in Bangladesh is a reflection of the broader societal and community norm that has made violence an acceptable feature of its culture. Addressing such norms requires active participation of those who contribute to violence perpetuation. Involving critical community actors — particularly men — to prevent and alleviate violence contributed to the success of PROTIRODH. Engaging with police, lawyers and health care service providers on committees to monitor and respond to violence ensured sustainability.
- **Linking sex workers to health and legal services improves case reporting and results.** Ensuring that sex workers had immediate access to health and legal services after experiencing incidents of violence was critical to the success of the project. The combination of support from the community members, and being able to seek health services encouraged sex workers to report violence, seek legal aid and demand justice.
- **Creating support systems to respond to violence enhances decision-making power among sex workers.** The project showed that a supportive social environment for sex workers makes a significant difference in sex workers' ability to negotiate with clients, refuse sex, handle financial transactions more assertively and insist on condoms.



## Lessons

- **Providing legal education builds understanding of rights and gives greater voice for sex workers.**

PROTIRODH used legal education to augment the sex workers' knowledge of rights and to create an understanding in the wider community about inequalities faced by sex workers and their families. This had the effect of fostering empathy towards sex workers. A strong indicator of this was sex workers' ability to register births and enrol their children in schools. Building sex workers' understanding of legal rights and strategies address violence also led to increased likelihood of case reporting and improved police responsiveness.

- **Sex worker-led projects are more effective and promote sustainability.**

Almost all sex workers who participated in PROTIRODH reported increased self-confidence.<sup>199</sup> Building sex workers' capacity to become agents of change, claim rights and solve problems improves their ability to protest against violence and develop partnership with other stakeholders to prevent and respond to violence. Most critically, sex worker involvement created sustained capacity to continue addressing violence after completion of the project. Durjoy report that the vasw and watchdog committees are still functional, even after the project ended, and sex workers continue to have access to services as a result of services linkages developed during the project.

- **Building a partnership network strengthens advocacy and action.** Building capacity of sex workers to solve problems in partnership with key community actors including police, health service providers and community leaders, improves sex worker agency to take charge of their lives, find solutions to their problems, access legal, health and social support services and play a central role in advocacy to bring about change within communities to reduce stigma and violence. Capacity building of all partners not only enabled the effective management of the project; it facilitated partners to become powerful advocates for the protection and promotion of rights of sex workers. Capacity building was both a means and an outcome of the project. Partnership network building strengthened advocacy efforts. It enabled negotiation with institutions that are generally unsympathetic to sex workers, so that they gain access to social, economic and psychological resources. CARE played an essential role in leveraging these partnerships.

There is a continuing need to address this through scaling up the approaches that have been successful in improving police-sex worker relations.

## Gaps, challenges and opportunities

The greatest challenge faced by Durjoy was reducing police violence. While a reduction of violence by other perpetrators was evident, sex workers continued to face police violence, especially in Dhaka. One possible explanation is the legal environment. If conducted privately and voluntarily by an adult sex worker, sex work is not illegal in Bangladesh. However, there are laws that criminalise aspects of sex work, including prohibiting soliciting in public and keeping a brothel.<sup>200</sup> Lack of awareness among police is another reason for continued violence. Sensitized policemen are a small number who had undergone training. There is a continuing need to address this through scaling up the approaches that have been successful in improving police-sex worker relations. Another challenge was seeking legal recourse in cases of severe violence. Most reported cases were managed out of court. However, all four cases that did go to court were fraught with problems. The court considers the evidence of the complainant but often requires presenting a witness to the violence. Due to stigma surrounding sex work it was difficult to secure a witness. Secondly, due to the high mobility of street-based sex workers, attendance at court hearings was low. Further, sex workers are often reluctant to appear in court due to fear of more stigma and high financial costs.

A major gap in the programme was its inability to respond to the range and severity of mental health issues among sex workers. Although counselling was always available, it was clear that mental health services for sex workers must extend to diagnosis and comprehensive treatment facilities. The project was unable to adequately help those with substance addiction. Harm reduction programmes for sex workers urgently need to be developed.

Looking to the future, sustainability of impact is critical. A major outcome of PROTIRODH is that concrete and sustained mechanisms to address violence against sex workers in Bangladesh, though limited, are now in place. The Durjoy sex workers are all trained counsellors and vasw committee members and continue to network with watchdog committee

members and health, legal service providers on violence against sex worker issues. Based on learning from PROTIRODH, Durjoy is currently implementing another project funded by CARE Bangladesh called Solidarity and Empowerment through Education, Motivation and Awareness (SEEMA). This project strengthens existing service linkages developed to address violence against sex workers and aims to improve service delivery. The focus of this project is on reducing poverty among sex workers and improving their working conditions. ■



175 English translation: 'From distance, we win'.  
 176 Beneficiaries include street, home and hotel-based sex workers.  
 177 All members are sex workers. Their term is for two years.  
 178 Durjoy is a sub-recipient of a Global Fund Grant, Round 6.  
 179 UNGASS Country Progress Report, Bangladesh, 2012.  
 180 Ibid; National HIV Serological Surveillance, 2011 Bangladesh—9th Round Technical Report. IEDCR and ICDDR, B, 2011. Accessed online at: [http://www.aidsdatahub.org/dmdocuments/HSS\\_9th\\_round\\_2011.pdf](http://www.aidsdatahub.org/dmdocuments/HSS_9th_round_2011.pdf). Accessed on 24 September, 2012.  
 181 UNGASS Country Progress Report, Bangladesh, 2012.  
 182 National HIV Serological Surveillance, 2011 Bangladesh—9th Round Technical Report. IEDCR and ICDDR, B, 2011. Accessed online September 2012 at: [http://www.aidsdatahub.org/dmdocuments/HSS\\_9th\\_round\\_2011.pdf](http://www.aidsdatahub.org/dmdocuments/HSS_9th_round_2011.pdf).  
 183 According to Amnesty International Annual Report for Bangladesh, 2011. See: <http://www.amnesty.org/en/region/bangladesh/report-2011#section-12-3>.  
 184 Violence against sex workers is defined as any act of violence that results in, or is likely to result in verbal, physical, economical, sexual or psychological harm or suffering to sex workers.  
 185 Bangladesh Institute for Development Studies (BIDS), 2007. Final Report, the final evaluation of CARE Bangladesh's PROTIRODH Project.  
 186 CARE Bangladesh, 2007. Final Report on Baseline Survey for Assessing the Knowledge, Attitude and Practices with Regard to Violence against Women and Sex workers. Bangladesh Institute of Development (BIDS).  
 187 Ibid.  
 188 Ibid.  
 189 PROTIRODH project had two components. One component focussed on reducing violence against women in rural settings of Bangladesh and the other focussed on addressing violence against street-based and brothel-based sex workers. Both of the programme components used the same framework and strategies but partners were different. The implementing partners for the sex worker component were Durjoy and CARE Bangladesh for street-based sex workers and Nari Mukti Sangha for brothel-based sex workers. The focus of this documentation is on the Durjoy/CARE collaboration for street-based sex workers.  
 190 DNS, 2009. Project PROTIRODH Periodic Project Update. Internal document, not published.  
 191 A theatre technique that involves audiences in the narrative.  
 192 Bangladesh Institute for Development Studies (BIDS), 2007. *Final Report, the final evaluation of CARE Bangladesh's PROTIRODH Project*.  
 193 PROTIRODH evaluation data for reduction in incidences of violence has not been disaggregated by street-based and brothel-based sex workers.  
 194 Bangladesh Institute for Development Studies (BIDS), 2007. *Final Report, the final evaluation of CARE Bangladesh's PROTIRODH Project*.  
 195 Ibid.  
 196 Ibid.

| By whom / perpetrators | Dhaka                |                    |                | Khulna               |                    |                | Tangail              |                    |                |
|------------------------|----------------------|--------------------|----------------|----------------------|--------------------|----------------|----------------------|--------------------|----------------|
|                        | Sufficiently reduced | Moderate reduction | Same as before | Sufficiently reduced | Moderate reduction | Same as before | Sufficiently reduced | Moderate reduction | Same as before |
| Client                 | 19.00                | 71.30              | 9.70           | 38.40                | 60.60              | 1.00           | 64.10                | 34.80              | 1.10           |
| Police                 | 13.90                | 74.20              | 11.30          | 38.40                | 61.60              | -              | 57.00                | 43.00              | -              |
| Mastan                 | 10.90                | 67.90              | 20.70          | 32.30                | 63.50              | 4.20           | 60.20                | 39.80              | -              |
| Sardarni / madam       | 8.10                 | 86.30              | 5.60           | 33.30                | 63.90              | 2.80           | 37.40                | 56.00              | 6.60           |
| Husband                | 13.10                | 74.90              | 11.00          | 28.10                | 66.70              | 5.30           | 56.90                | 41.40              | 1.70           |
| Babu / lovers          | 15.70                | 77.30              | 5.90           | 32.60                | 67.40              | -              | 49.40                | 47.20              | 3.40           |
| Dalal / pimps          | 20.00                | 76.40              | 2.90           | 38.60                | 61.40              | -              | 31.90                | 47.30              | 6.60           |
| Journalist             | 30.20                | 66.50              | 2.80           | 70.40                | 29.60              | -              | 58.00                | 42.00              | -              |
| Shop owners            | 20.40                | 77.00              | 2.00           | 54.10                | 45.90              | -              | 58.20                | 35.80              | 4.50           |
| Other sex workers      | 36.80                | 60.00              | 3.20           | 85.50                | 14.50              | -              | 83.70                | 16.30              | -              |

197 Ibid.  
 198 Ibid.  
 199 Ibid.  
 200 *Sex Work and the Law in Asia and the Pacific*, UNDP and UNFPA, October 2012.



Case Study

8

# Protecting and promoting the human rights of LGBTI communities in Nepal: experiences of Blue Diamond Society

**B**lue Diamond Society (BDS) was founded and registered in 2001. It is the leading community-based organization (CBO) of the Federation of Sexual and Gender Minorities (FSGMN), a network of lesbian, gay bisexual and transgender and intersex<sup>201</sup> (LGBTI) people in the Federal Democratic Republic of Nepal (Nepal). This network comprises of 37 CBOs in 25 districts. The mission of BDS is to improve the immediate and long-term social and economic conditions of sexual and gender minorities in Nepal, ensuring that these communities have equal rights, access to health services, social protection and economic opportunities. The key strategies for achievement of this mission are:

- advocacy at the national level to create a supportive legal and policy environment;
- delivery of HIV prevention, treatment and care and support services;
- human rights programming for the legal empowerment of LGBTI;
- building leadership among individual LGBTI and CBOs.

Responding to what they saw as appalling social, economic and health conditions for LGBTI in Nepal, Director and founder member of BDS Sunil Babu Pant and six men who have sex with men, and transgender colleagues decided to form an organization to address these issues.<sup>202</sup> Largely hidden, the community of men who have sex with men and transgender was highly stigmatized and experienced discrimination in many aspects of their lives. It was observed by BDS that in this environment of social exclusion, health-seeking behaviour was poor, and many, particularly transgender people, had few income generating options, causing many to engage in sex work. Violence and lack of social support was common. As a result, low self-esteem and depression was rife among LGBTI people. Like other LGBTI and sex worker

organizations in the Asia-Pacific region, BDS initially experienced difficulties in registering an LGBTI organization. They therefore decided to register as an organization for promoting reproductive and health rights of a marginalized community.

Early discussions among the founding team focussed on the need for a comprehensive approach to the problems faced by LGBTI and ways of helping them assert their legal rights. Given the socio-political context at that time, there was indifference to LGBTI rights as a political issue and the idea of community mobilization was premature. Strategically, the team decided to focus on advocating for the right to health within an HIV prevention framework. BDS began networking and building partnerships with various stakeholders—government and non-government organizations, donors, other members of civil society and, most importantly, within their own community. Very soon, BDS was involved in drafting the National HIV and AIDS Strategy. They used this opportunity to advocate for the rights of men who have sex with men and transgender people to have access to HIV prevention, treatment and care services.

BDS embarked on a journey of providing HIV prevention, treatment and care services for men who have sex with men and the transgender community, including male and transgender sex workers. In doing so, BDS strategically leveraged the HIV agenda to build the capacity of these communities to form CBOs in various parts of the country. While delivering HIV-related information and services was the stated agenda, there was a strong commitment to empowering the community, through self-acceptance, to achieve better health and move towards building their capacity to claim their rights. Early experiences in HIV prevention had demonstrated to BDS that a supportive legal and social environment was vital in order to make HIV prevention for men who have sex with men and transgender people effective. For example, BDS noted that violence was extreme and extensive and acted as a barrier to people accessing essential services. This information was used to advocate with police,



lawyers, donors and other partners, that strategies for HIV prevention must include creating an enabling environment. This holistic approach to HIV guaranteed that the human rights concerns of LGBTI communities in Nepal were heard at national and international forums.

BDS HIV programmes, funded by various donors, reach more than 300 000 men who have sex with men and transgender people annually, including those who are sex workers.<sup>203</sup> This is achieved through outreach, drop-in-centres and professionally staffed clinics in 38 districts in Nepal. In addition, BDS implements a legal empowerment programme and has a strong advocacy component for improving the legal, policy and social environment for LGBTI.

BDS is not a sex worker organization and does not implement programmes exclusively for sex workers. However, a significant proportion of men who have sex with men and transgender people, sell and buy sex in Nepal.<sup>204</sup> BDS takes an integrated approach to meeting the community's needs and advocating for the rights of male and transgender sex workers and ensuring access to services.<sup>205</sup>

This case study documents the efforts of BDS to secure legal and policy change and implementation of their legal empowerment programme and leadership development among sexual and gender minorities, and male and transgender sex workers in Nepal.

## HIV among men who have sex with men and transgender sex workers in Nepal

Nepal's HIV epidemic is concentrated among key affected populations (KAPS) including men who have sex with men,<sup>206</sup> people who inject drugs, female sex workers and their clients, and migrant labourers and their spouses. In 2009, the Nepal IBBS Survey reported national HIV prevalence among men who have sex with men in Kathmandu at 3.8%.<sup>207</sup>

These surveys indicated that 25% of men who have sex with men were married and that a consid-



erable proportion had sexual relationships with men and women other than their spouses.<sup>208</sup> A 2011 national level mapping and size estimation study found that 54% of male and transgender sex workers in Nepal had engaged in paid sex during six months prior to the survey, and had an average of five commercial sexual partners during this time period.<sup>209</sup>

The environment of stigmatization and discrimination, including extreme forms of violence that undermine access to HIV information and services, further compounds the risk of HIV among male and transgender sex workers.<sup>210</sup> BDS has primarily addressed these risks and vulnerabilities by advocating for supportive legal, policy and social environments for sexual and gender minorities.

## Central programme components of BDS

### Advocating for human rights of LGBTI

The impact of sustained advocacy efforts by BDS has led to increased socio-political recognition of LGBTI rights and securing of a range of civic entitlements for transgender people. These include:<sup>211</sup>

- A landmark decision by the Supreme Court of Nepal in 2007 ordering the Government of Nepal to grant citizenship rights to sexual and gender minorities.<sup>212</sup>
- Two constitutional sub-committees referred to the legal recognition of and protective provisions for sexual and gender minorities in their preliminary drafts of the Constitution.

- The recognition of sexual and gender minorities as a ‘marginalized community’ in the allocation of national resources from the 11th Development Plan of Nepal for improving socioeconomic conditions of marginalized communities.<sup>213</sup>
- Recognition of the third gender category by the Human Rights Commission and banks. For example, on registration and complaint forms, a box mentioning ‘others’ rather than only ‘male’ and ‘female’ has been added.
- Central Bureau of Statistics (CBS) of Nepal has included a third gender category in its census form. This provides an opportunity for transgender people to access government schemes.
- The third gender category has been included in the voter’s list since elections held in 2010.
- Prioritization of support in the social development of sexual and gender minorities in a Memorandum of Understanding held between the Nepal and Norwegian government in March 2009.
- An eminent publishing house, Nai Prakashan, has established an award to recognize the social contributions of LGBTI people in Nepal.
- In the Bachelors and Master’s Degree Social Science textbook, produced as part of the government education curriculum, a definition of LGBTI was introduced.
- Allocation of resources to men who have sex with men and transgender populations in the National AIDS Policy and Plan.

Several factors have contributed to the efficacy of BDS advocacy work, as outlined in the below sections.

### Community capacity building

BDS has a methodical approach to advocacy ensuring that it is needs-based, effective and sustainable. Advocacy, for BDS, is both a means to multiple outcomes and a valuable process. As a process, it builds community leaders, and engages the community in advocating for their rights. Community capacity building has been integral to achieve this. “Unless and until we can have a collective voice to speak out against the marginalization and social discrimination we face, we cannot advocate for our rights or count on someone else to do so,” explained Manisha, a transgender woman and Deputy Director, BDS.

BDS provides regular capacity-building training for community members in several areas including HIV awareness, life-skills and counselling skills, legal and human rights education and advocacy. Those showing particular interest and commitment are trained to work in HIV programme management. Through this experience, some activists have taken up important positions in decision-making bodies. For example, Bhumika Shrestha is now the General Convention Member of the Nepali Congress Party. Manisha Dhakal is a Member of the Asia-Pacific Transgender Network and Pinky Gurung is a member of the Global Fund Country Coordinating Mechanism.

### CBO and leadership development

Advocacy is more effective when organizations rather than individuals carry it out. Over the years, the governance and management of BDS has become participatory, more inclusive and transparent. As the community grew in numbers and capacity, BDS decentralized branch offices and networks and transformed into locally governed CBOs. This is an illustration of successful community and leadership building, allowing communities’ autonomy and flexibility to adapt activities and responses to the local context. “In the beginning, we were not empowered and we did not have full understanding and knowledge of issues. So Sunil [BDS’ founder] took the lead in making the decisions. But over the years, we have become empowered and have a good understanding of the issues, so now we are involved in



“Unless we have a collective voice to speak out against the marginalization and social discrimination we face, we cannot advocate for our rights or count on someone else to do so.”

**Manisha, a transgender woman and Deputy Director, BDS**



the decision-making. Important decisions at BDS are taken in coordination of the staff and board members,” explained Pinky Gurung, a transgender woman and BDS board member.

As of 2012, 37 CBOs with their own governing body and constitution have formed through leadership development efforts. Legal recognition of these CBOs has given them credibility with district level government bodies, enabling better local resource mobilization and less dependence on BDS head office in Kathmandu. In 2011, seven new CBOs were formed and registered.

BDS invests in CBO capacity development, offering training in leadership development, literacy, managerial skills, proposal writing and fund raising. It provides opportunities for potential community leaders to participate in formal leadership training, public speaking courses and higher education. BDS provides CBOs advice and support on governance, management and programmes. As a result, seven CBOs are currently represented in the District AIDS Coordination Committee. This participation provides opportunities to influence local governments to include men who have sex with men and transgender communities when planning for HIV prevention and treatment service delivery. To improve the social and economic conditions of their LGBTI communities, 16 CBOs have mobilized resources from the district level Local Development Committees.

“Important decisions at BDS are taken in coordination of the staff and board members.”

**Pinky Gurung, a transgender woman and BDS board member.**

### Advocacy campaigns

BDS conducts nationwide campaigns to sensitize the broader society to issues affecting the LGBTI community. These have taken shape as rallies, mass meetings, seminars, workshops, publications, media campaigns, and TV and radio broadcasts. They are generally organized around important festivals. Gay Pride, for example, is organized on the festival of Gaijatra,<sup>214</sup> a local carnival.

### Use of media

Media has contributed significantly to countering negative representation of LGBTI people and raising general awareness on their socioeconomic conditions. LGBTI issues have featured in print and electronic media every week. In collaboration with the national television channel, BDS broadcasted ‘Third Sex’ — a weekly programme that explored issues of the transgender community in the current political, social and cultural context of Nepal, and in relation to other communities.<sup>215</sup>

“With responsibilities comes confidence as leaders and increased commitments.”

**Manisha, Deputy Director, BDS**

### Specialized policy and law reform strategies

BDS’s advocacy strategies involves review of laws and policies which discriminate against the LGBTI community, documenting human rights abuses, developing advocacy messages and forming alliances with human rights bodies, such as the National Human Rights Commission (NHRC), to support lobby and advocacy for change.



## Advocacy to action: impact of law and policy reforms strategies

### Constitutional rights of transgender people

BDS hired three lawyers to review the existing Constitution, laws and policies of Nepal regarding the third gender. It partnered with key allies to sensitize and lobby members of the Constitutional Assembly (CA). It organized sit-ins, mass rallies and media campaigns, and held meetings with the judiciary to ensure that the constitution recognizes and includes transgender people as citizens of Nepal. At present, drafting of the new constitution has come to a temporary halt due to political problems. However, there has been a de facto agreement on recognition of transgender persons and fulfilment of their rights in the new constitution that will be formed in the future. “When the constitution drafting process will start again, we will ensure that earlier commitments to grant constitutional rights for TG persons are fulfilled, our efforts for advocacy will continue until such rights are guaranteed by the new constitution,” said Sunil Pant, Director, BDS.

### Ending discrimination against LGBTI students in the higher education system

LGBTI students, particularly those who are transgender, are subjected to stigma and discrimination in higher education. This leads to early drop-outs from school. BDS has documented these as violations of the right to education. LGBTI Student Forum, a CBO under FSGMN, recently initiated dialogue with the Ministry of Education. This has led to the establishment of a committee of relevant stakeholders including government officials, human rights bodies, politicians, NGOs and INGOs to jointly lead an investigation.

“Having legal rights sends a strong message to the authorities that they can no longer discriminate.”

Sunil Pant, Director, BDS

### Forming alliances with legal institutions

Significant legal challenges for the LGBTI community in Nepal have meant forming alliances with recognized legal institutions and senior lawyers. The Nepal Bar Association and NHRC have been providing support to BDS in their legal interventions. BDS has full-time staff in Kathmandu responsible for collaborating with NHRC. This ensures that rights violations are regularly reported to a recognized human rights body. In 2011, a transgender member took up an internship at NHRC. This helped BDS generate a better understanding of the Commission and its working, thereby improving communities’ access to it and ability to influence the Commission’s work.

### Provision of legal services

In addition to building alliances with legal institutions, BDS has a legal department in each of its office branches housing two lawyers.<sup>216</sup> The legal department is responsible for implementing human rights programmes and running legal services. Their work includes:

- Legal advice and counselling for individuals who have experienced human rights violations. Complainants are assisted to consider legal and non-legal options and the consequences of taking legal action.
- Legal referral service. Around 50 cases are being pursued under both criminal and civil laws in different courts around Nepal.<sup>217</sup> People seeking legal redress for violent attacks make up the majority of cases. Such cases have to be registered in the human rights cell within local police stations. When perpetrators are police officers, reports of assault made by individual sex workers are often not taken forward. However, police officials are more responsive to registering cases when approached by BDS; hence BDS is involved in assisting people in reporting violence to police. BDS provide follow-up advice and support until the case is resolved. Where complaints are against police, these are filed with the NHRC for investigation. Based on its findings NHRC makes recommendations to the relevant ministries. These recom-

“[Legal] training has transformed our communities’ perspective on their rights and their capacities to claim it. From feeling like they are nobody to being able to stand up for their rights as a transgender person or a man who has sex with men is an indication of empowered community and real a measure of success.”

**Manisha, Deputy Director, BDS.**

recommendations need to be implemented within three months and compensation must be paid by the government or perpetrator/s. Civil cases usually concern property rights. If such cases cannot be resolved out of court by the community, BDS files the case with the relevant court.

- Documentation of human rights violations. Documenting human rights violations including cases such as discrimination in health care settings, violence and denial of housing, help to build an understanding about the nature and extent of such incidents. This informs legal and non-legal options of redress, and is an advocacy tool to address systemic discrimination in specific settings, and for advancing law and policy reform and social change.<sup>218</sup>
- Filing public interest litigation (PIL). The Supreme Court Decision in 2007 to grant citizenship rights to sexual and gender minorities has provided a powerful tool for pursuing cases regarding civic entitlements such as including third gender as a category for gender identity in identification documents. At the international level, BDS used the International Convention on Civil and Political Rights (ICCPR), to which Nepal is signatory, to lobby for the provision of a separate box for identifying people of third gender in the election ballot. Many hearings have been in favour of the transgender community and some have influenced changes in law and policy.

### Legal empowerment training

Between 2010 and 2011, over 10 000 community members participated in human rights and legal trainings provided across five regions. The trainings were designed to increase community knowledge of human rights and build skills about how to claim these rights. A concrete outcome of these training programmes is the increased capacity of CBOs to solve a large majority of cases at the district levels. “These trainings have transformed our communities’ perspective on their rights and their capacities to

claim our rights. From feeling like they are nobody to being able to stand up for their rights as a transgender person or a man who has sex with men is an indication of empowered community and real a measure of the success of the trainings,” explained Manisha, Deputy Director, BDS.





## Lessons

- **Cooperation with media can positively alter representations of the LGBTI community.** Typically, the media has represented the LGBTI community as being sexually promiscuous and disease carriers. This has fuelled stigma and discrimination against this community. However, a steady transformation has occurred in the attitudes of media by engaging with media groups, confronting their prejudice and holding sensitization campaigns. This has resulted in more accurate portrayals of the LGBTI community and promotion of their rights.
- **Addressing violence, stigma and discrimination requires safe space for speaking out.** Fear of violence, marginalization and social exclusion keeps the LGBTI community underground and silent. Without verbalising their experiences of violence and discrimination, it is impossible to build alliances and document human rights abuses — both of which are critical for advancing the rights of the LGBTI community. Creating a safe space for speaking out is therefore fundamental.
- **Documenting human rights violation is essential to fighting social injustice.** The process of documenting human rights violations includes a thorough description of the incident, where and when it occurred, the names of those involved, including witnesses, and photographs, if available. Documentation illustrates the nature and magnitude of social, familial and state violence against the LGBTI community. This is a powerful advocacy tool for legal, policy and social change.
- **Developing group leadership is important in large-scale advocacy campaigns.** Group leaders share responsibilities for guiding advocacy actions. Consistency in leadership is critical to ensuring continuity throughout a campaign.

## Gaps, challenges and opportunities

Unfortunately conflicting legislative frameworks in Nepal, coupled with an unstable political situation, continues to maintain a hostile legal and social environment for LGBTI people. Although sex work itself is not specifically criminalised, in practice, sex workers are often arrested for public order offences under the Public Offences and Penalties Act, 1970. It is paradoxical that while the Trafficking and Transportation (Control) Act 2007 states that it is an offence to purchase sex, the courts have recognized the constitutional rights of sex workers. At the time of documentation, the draft Criminal Code still contained provisions that criminalise ‘unnatural’ sexual acts, including same-sex relationships, prescribing jail terms up to sixteen years and fines.<sup>219</sup>

Criminalisation of same-sex relationships exacerbates stigma, discrimination and violence against LGBTI, seriously threatening their access to critical health services, including HIV prevention, treatment, care and support.

Providing follow-up legal support can be challenging, particularly after a case is filed. Some sections of the LGBTI community tend to be highly mobile; this is particularly true of sex workers. They fear that lodging a complaint will lead to more stigma and/or violence by perpetrators, or his or her supporters. These fears persist even with the offer of police protection. Aside from community members, BDS staff members have been known to receive threats of more violence if they report crimes to authorities.<sup>220</sup>

Transgender people experience the worst forms of violence, discrimination and social exclusion. They are frequently denied access to educational and employment opportunities, disowned by families, evicted by landlords, and denied property rights.<sup>221</sup> Many transgender people work as sex workers and end up living on the streets. As Sofi, Dic Manager from CruiseAid Nepal,<sup>222</sup> recounted, even as sex workers, they do not have a place for providing sexual services because most entertainment venues do not allow transgender entry into their territory. “So, they operate



“We have joined hands with Dalits, women’s groups and other socially marginalized groups to fight the injustice. This sense of equal opportunity and openness will continue to support our movement.”

Sunil Pant, Director, BDS

on the streets, move from place to place, which makes them more susceptible to police violence and timely access to condoms becomes difficult,” Sofi said.

These factors contribute to making it exceedingly difficult to reach and maintain contact with transgender people and ensure their access to health services. Despite continued outreach by BDS, the number of transgender persons accessing VCT and STI clinics remains relatively low. “The health and social needs of transgender sex workers are colossal but there is a limitation to how much BDS can do. Greater effort is required to bring together other organizations who work on sex workers’ issues, including the third gender sex workers.” CruiseNepal DiC Manager Sofi added.

In surveillance and behavioural surveys, it is common for data on male sex workers to be subsumed under the ‘men who have sex with men’ category.<sup>223</sup> This reduces understanding of the specific needs of male and transgender sex workers. Although condom use at last anal sex and STI treatment have reportedly increased slightly among men who have sex with men,<sup>224</sup> the lack of disaggregated data makes it difficult to know the degree to which safer sex is practiced among male and transgender sex workers. In 2011, a mapping and size estimation study and behavioural data was collected as part of the mapping and size estimation exercise in Nepal among men who have sex with men, transgender persons and male and transgender sex workers. This indicated that 67% of male and transgender sex workers and their clients had been tested for HIV. Among those who had undergone HIV testing, 25% reported that they had taken the test one or more years before the survey.<sup>225</sup> Building on the experience of BDS and other CBOs, and the recognition of the specific risks and vulnerabilities of male and transgender sex workers by the government, United Nations and donors, an opportunity is emerging to prioritize HIV prevention programmes for this population.

In 10 years, BDS has transformed the landscape of LGBTI issues in Nepal. Being part of a national LGBTI network, male and transgender sex workers now

have access to legal aid, HIV prevention and treatment services. They are actively involved in running CBOs under the Federation of Sexual and Gender Minorities, and participate in its governing body. There is no doubt that this has contributed immensely to empowering the lives of many male and transgender sex workers. BDS will continue to nurture leaders and strengthen alliances already formed with other marginalized communities in Nepal to fight discrimination and injustice.

Although BDS has been successful in raising substantial funds for HIV programmes, and expanding its donor base to include funders of human rights work, programme sustainability is still a major concern for the future. A decrease in HIV funding threatens the organization’s progress, particularly with a resource-heavy infrastructure of multiple offices, DiCs and clinics that have been the backbone of community mobilization, advocacy and programme implementation.

Addressing funding challenges, BDS has begun collaborating with the National Centre for AIDS and STD Control, under GFATM Round 10, to pilot a project that links BDS-led community outreach to HIV and STI clinics at government health facilities. ■



201 BDS defines intersex individuals as those who are born with an atypical combination of physical features that usually distinguish female from male, hence whose biological sex cannot be classified as clearly male or female.

202 Sunil subsequently became the first openly gay member of the now dissolved Constitutional Assembly of Nepal.

203 See BDS, 2010. Annual Report on HIV Program, January-December 2010. Internal document, unpublished and BDS, 2011. Semi-Annual report on HIV Program, January-July 2011. Internal document, unpublished.

204 See 2008 UNAIDS Report on Review of Existing and Emerging Patterns of Sex Work in Nepal in Context of HIV/AIDS from HIV and AIDS Data Hub for Asia-Pacific at <http://www.aidsdatahub.org/en/bhutan-reference-library/item/19750-review-of-existing-and-emerging-patterns-of-sex-work-in-nepal-in-context-of-hiv/aids-iyengar-s-and-rout-s-2008>. Accessed on 10 May 2012.

205 It may be of importance to note that BDS explicitly emphasizes protection of its constituents' rights as sexual and gender minorities. The emphasis on their rights as sex workers is implicit in its mission statement and advocacy efforts.

206 As stated earlier, in the National Strategy for HIV and AIDS, the phrase 'men who have sex with men' include male and transgender sex workers.

207 IBBS survey results, 2011.

208 Ibid.

209 HIV/AIDS and STI Control Board (HSCB) & National Center for AIDS and STD Control (NCASC), 2011. Mapping & Size Estimation of Most-At-Risk-Population in Nepal -2011. Vol. 1 Male Sex workers, Transgender and their clients. The Nielsen Company Nepal/UNAIDS/World Bank.

210 BDS, 2011. Annual report on Human Rights Programs. BDS, Internal Report. Unpublished.

211 See [http://www.bds.org.np/human\\_rights.html](http://www.bds.org.np/human_rights.html) accessed on 17 June 2012.

212 Two transgender men, Bishnu Adhikary and Badri Pun, were able to get their citizenship ID using their own gender identity as transgender men, as ruled by the Supreme Court.

213 BDS has been receiving these allocated funds from the government since 2009. Since 2011, the funding allocation has increased to NRS 30 lakh (around US\$ 38 500) annually.

214 Gajatra, is the festival of cows, celebrated mainly in Kathmandu Valley by the Newari community, in the month of Bhadra (August-September).

215 The programme has been now phased out and similar new programme 'Pahichan' has been launched through another government TV channel.

216 BDS lawyers are also members of the LGBTI community.

217 Criminal charges are prosecuted by the state against the offender. BDS provides support, legal advice and assistance to people who have reported violence to police and where charges have been laid.

218 All documentation of cases is undertaken with consent of the person concerned. Where experiences are used in advocacy, identifying information is removed.

219 *Sex Work and the Law in Asia and the Pacific*, UNDP and UNFPA, October 2012.

220 BDS, 2011. Human Rights Program Report 2011. Internal document, unpublished.

221 Ibid.

222 CruiseAid Nepal is one of the CBOs under the Federation of Sexual and Gender Minorities.

223 MSM is the acronym used to denote men who have sex with men.

224 National Center for AIDS and STD Control/MoH and UNAIDS, 2010. Nepal National UNGASS Report, 2010.

225 HIV/AIDS and STI Control Board (HSCB) & National Center for AIDS and STD Control (NCASC), 2011. Mapping & Size Estimation of Most-At-Risk-Population in Nepal -2011. Vol. 1 Male Sex workers, Transgender and their clients. The Nielsen Company Nepal/UNAIDS/World Bank.



# 9

# Community-to-community learning: Experiences of the Ashodaya Academy

“I am no less than an officer in a government office. I have excellent facilitation skills, research skills; I can teach well and communicate with impact; I can analyse problems and articulate my concerns. Because of the opportunity to teach and learn, I have an identity.”

Jaya Lakshmi, sex worker and Ashodaya faculty member



**A**shodaya Academy is the capacity development wing of Ashodaya Samithi,<sup>226</sup> a CBO of sex workers in Mysore, the Republic of India (India). It functions as a 'learning site' for community-led HIV interventions and implements community-to-community<sup>227</sup> capacity development programmes in India and in the Asia-Pacific region. The approach is to use the 'inherent ability of sex workers to learn from each other'.<sup>228</sup> The objective is to empower communities to address their needs, take positional power, and assume greater responsibility in the design and implementation of HIV programming and advocacy.

Ashodaya Academy's pedagogical approaches are:

- Conducting a combined classroom and field based training programmes. Lessons from the field are used to inform training content, and apply classroom based concepts to the on ground realities.
- Using first-hand experiences. This successfully bridges the gap between theory and practice and makes community-led action for HIV prevention and other community issues more responsive to specific community needs.
- Using sex workers as trainers. Personal testimony and sex workers' experiences in community-led HIV intervention are particularly useful tools that can mitigate the power imbalances that exist between teacher and student. This contributes to an ethos of shared ownership of the learning process.

Ashodaya Academy has trained over 5 000 people over five years, including community members, NGO staff and government officials in India. It collaborates with National AIDS Control Organization (NACO), State AIDS Control Societies and Avahan.<sup>229</sup> The Ashodaya model has led to mobilization and empowerment of sex workers in Gujarat, Maharashtra, Rajasthan and Andhra Pradesh. Additionally, the Academy has successfully trained people from the community, NGOs and government officials in eight countries in Asia and the Pacific.

## Beginnings

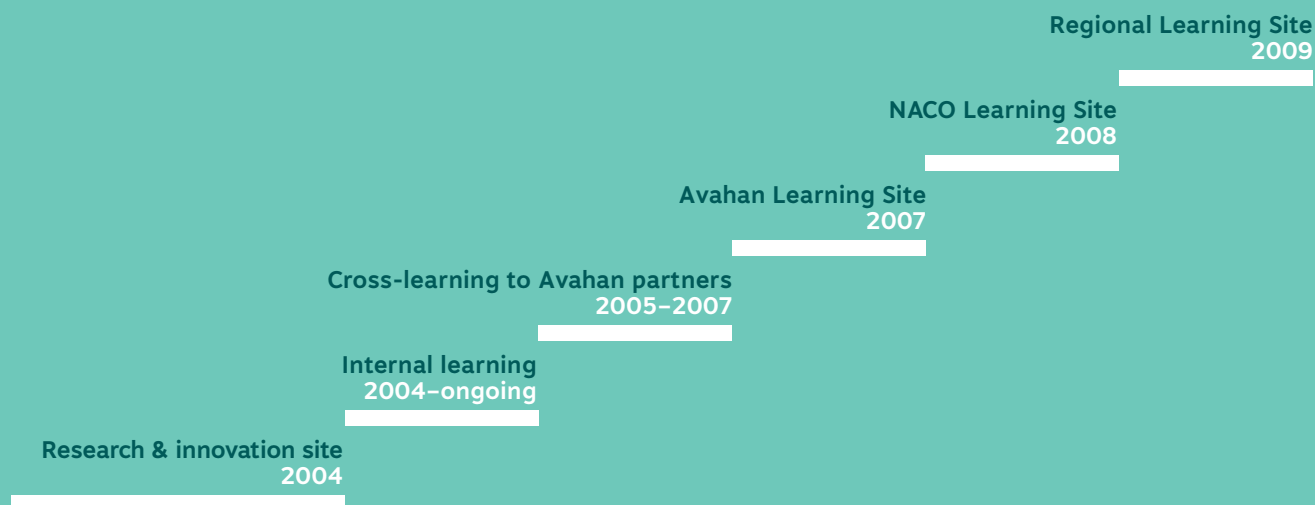
In 2004, supported by Avahan, the Bill and Melinda Gates Foundation's India programme, the University of Manitoba initiated a research project in Mysore as a 'research and innovation' site.<sup>230</sup> The aim was to identify the processes for developing a community-led structural intervention among sex workers in Mysore. The available information on sex worker populations in Mysore had been collected by external researchers and epidemiologists. This project brought about a significant shift in control over the generation of knowledge. Sex workers were trained to use methodologically sound, community-friendly approaches for mapping, population estimation and HIV programme planning for the sex work community. The project supported sex workers to acquire new skills in collectivising, managing crises and learn ways to assert control over various aspects of life, including addressing violence, control over finances and retaining custody of children. Those involved started consolidating what they had learnt to articulate the elements of effective community led structural interventions for responding to HIV among sex workers.

In 2005, the sex workers who had been part of this research project decided to form Ashodaya Samithi, which became highly successful in implementing community-led HIV programmes, achieving improved condom use and reducing risky sexual behaviours.<sup>231</sup> Within a year, several NGOs began sending staff to visit the organization to obtain knowledge about peer education techniques. While members of Ashodaya were still in a learning mode, they simultaneously began sharing their newly acquired knowledge with other NGOs and CBOs. This laid the foundation for a systematic and institutionalized community-to-community capacity development programme.

In 2007, Ashodaya Samithi formally became Avahan's first learning site for a community-led structural intervention. In 2008, it was officially recognized as the national learning site by NACO and implemented a comprehensive capacity development programme under NACP-III.<sup>232</sup> A year later, Ashodaya Samithi was



## Progress in development of the Ashodaya Academy



Source: Ashodaya Academy, 2010

selected as the regional learning site on HIV and sex work-related interventions in the Asia-Pacific and received a one-year grant from the UNAIDS-Asian Development Bank (ADB) Cooperation Project. Under this grant, Ashodaya Academy designed and conducted regional training for sex worker groups from eight countries in the region.

### Context: community capacity development within HIV prevention

The vital role of building community capacity in achieving effectiveness in health and development programmes has been well documented.<sup>233</sup> It is common for capacity-building tools and interventions to be developed and implemented by non-community actors. They are not always based on the needs of local organizations or communities.<sup>234</sup> As a result, too often communities become passive recipients of capacity building programmes, raising concerns about the responsiveness, ownership, and sustainability of HIV interventions.<sup>235</sup>

In the context of HIV programming, evidence shows that building capacity of the beneficiary community ensures appropriateness and sustainability of HIV prevention programmes and improve service

uptake.<sup>236</sup> In Asia and the Pacific, there is recognition that community-to-community programmes can produce considerable results.<sup>237</sup> In India, using community led interventions have led to rapid mobilization, enabling significant scaling up of effective HIV prevention interventions among populations most at risk, including sex workers.<sup>238</sup>

### Core components of Ashodaya's capacity development programmes

#### Selection and capacity development of faculty members

Currently, there are 35 trainers, all sex workers, who form the faculty of Ashodaya Academy, and implement the Academy's training and mentoring programme. Occasionally, the Academy draws on non-community resource people and members of sex work communities in other parts of India to provide training. For example, members and advisors from Durbar Mahila Samanwaya Committee (DMSC) in West Bengal have been invited on several occasions to facilitate sessions on designing and implementing economic empowerment programmes, such as the USHA Cooperative model (see page 85).



The faculty's development training focuses on strengthening knowledge and skills regarding HIV programming and advocacy and developing training skills including:

- exploration of attitudes, expectations, beliefs of the trainers in order to assess and develop their ability and commitment to the work and community;
- technical knowledge of HIV prevention and treatment;
- knowledge of programmes including economic empowerment and social protection schemes; human rights and legal issues;
- methodology for HIV programming development;
- training skills and translating these into action;
- self and group reflection to solve problems they encounter and as a part of an on-going learning process;
- periodic training programmes aimed at increasing technical knowledge and developing new skills based on emerging needs. For example, when trainers felt the need to enhance their technical knowledge of laws

and legal environment affecting sex workers rights, Lawyers Collective, India were called as a resource.

Specific criteria were used to identify faculty members including that they were empowered enough to openly identify as a sex worker, experienced in community-led interventions and had demonstrated community leadership skills reflected in having support within the community, demonstrated commitment to work in the community and exceptional communication and interpersonal skills.

### Formative assessment

Ashodaya Academy conducts a formative assessment to identify programme gaps and gauge the socioeconomic and legal environment where the intervention will take place. This includes assessing the attitudes and expectations of partners, resources available to the community, and factors that might inhibit start up that need to be addressed. Formative assessment also identifies the community trainees' learning expectations this helps in adapting the training curricula to meet each particular communities' needs. The process of the formative assessment is entirely participatory. As a result, it provides trainees with their first exposure to understanding the importance of formative assessment and how to conduct it.





## Training curriculum

The curriculum is designed to address the environmental context and needs of trainees. Sometimes, during an assessment the trainers discover that the specified interest of the trainees is not what is actually needed (see box 'Adapting to changing environments').

Nevertheless, the training curriculum comprises of some non-negotiable elements. These are:

- Perspective building of sex work and sex workers. This helps build self-awareness and is an integral part of the training. It helps trainees gain an understanding of the socioeconomic contexts affecting sex workers and the implications of these for HIV intervention strategies. Moreover, it fosters sensitivity and understanding towards sex workers, which is essential to bridge the gap between the community and service providers.
- Putting core values into practices. Recognizing the value of sex workers' inputs in HIV intervention is vital. Learning to imbibe core values of mutual respect, supporting each other to resolve problems, developing trust and friendship are a key aspect of training.
- Role of non-community members in community-led interventions. Non-community members often facilitate sessions on specific technical areas such as legal issues, social protection programmes among others.

An essential part of the Ashodaya Academy's work has been developing tools that provide a sound methodology for use by communities in assessing, planning, implementing and monitoring HIV programmes. Ashodaya Academy has developed the following tools with technical support from the University of Manitoba:

The 'capture-recapture' tool used to map sex work 'hot-spots' and estimate the size of the population for planning;

## Adapting to changing environments: an example of how training curriculum was readjusted based on external environment issues

"We were asked to provide capacity building support to conduct outreach among sex workers in Mandya. The trainees wanted to learn outreach techniques for HIV prevention but when we went there for a formative assessment, we realized that there was a huge backlash against sex workers from the police, the local goons and the broader community members. In this situation, using outreach techniques alone would not be effective in reaching sex workers with HIV prevention services. The external environment needed to be improved. So, we trained communities to understanding the interconnectedness between outreach and the external environment and to apply skills and techniques build alliance and partnerships with key stakeholders such as police and local leaders. The focus of the training curriculum was on building relationships with the key non-community partners in order to gain the support needed for implementing a robust outreach programme and at the same time, on building trust and relationships with the community members in order to mobilize them and conduct outreach. In this case, learning the technique of outreach was not the first step in capacity building."

**A male sex worker, Ashodaya Academy Community Faculty**



- outreach planning;
- conducting stakeholder analysis;
- community mobilization;
- community monitoring systems and programme competency building.

### Training methodology

Ashodaya Academy bridges the gap between theory and practice in their approach to community-to-community learning. Training programmes combine both classroom and field-oriented. For example, if the topic is building rapport with the police, trainees are taken on a field visit to the police station learn about engaging with the police.

The classroom-based training conducted in the Ashodaya Academy is designed to enhance technical knowledge and skills of trainees. Community-friendly visual aids, personal stories, role-play and group exercises are some of the methods used.

In the field-based training, the focus is to apply the ideas from the classroom in the 'real world'. Trainees are assisted to think through and discuss translating

classroom learning in to action in their own communities. Where training takes place at Ashodaya Academy, field visits are conducted in and around Mysore. Where training takes place in other places, locations for field-based learning are identified as part of the formative assessment. Fieldwork can take the form of visits to government hospitals, community clinics, HIV prevention interventions sites such as outreach or drop in centres and police stations.

The length and content of training programmes vary considerably, ranging from three days to one month in duration. The standard package of a three-day training course focuses on providing comprehensive knowledge and developing the skills set to design, implement and monitor the critical components of an HIV programme. A one-month course typically focuses on building capacities for a holistic approach to community empowerment and development. Some of the key components of a training programme include:

- developing self-awareness as a sex worker;
- designing and implementing a community-led HIV prevention programme (a twelve-week course);



## Example of a programming tool: 'capture-recapture', mapping and enumeration methods

With slight modifications, Ashodaya uses the 'capture-recapture' method to investigate the number of sex workers in different hot-spots and ascertain their needs. This was first used by the organization in 2004, when they initially needed to determine the size of the street-based sex worker population. Using a mathematical formula this method enabled Ashodaya to calculate the total size of the sex work population in Mysore—including scattered sex work populations—providing an entry point to establish a relationship with the community before starting interventions. Ashodaya has since trained many sex worker organizations in this method.

"In Imphal (Manipur, India) an NGO had problems in finding and reaching men who have sex with men [the target population for the intervention]. They did not know the numbers of men who have sex with men needing services or where to conduct outreach. So, they came to Ashodaya to learn about the 'capture-recapture' method. We trained them after doing a formative assessment and provided support to conduct the mapping in Manipur. It was a great success. With this method, the NGO was able to identify the hot-spots for intervention sites and also estimated the size of the populations of men having sex with men to inform their programme design."

### Prathima, a female sex worker and faculty member

The active participation of sex workers in the capture-recapture method creates confidence, unity and a sense of responsibility. Other methods taught have included zone and time-wise analysis which helps analyse where, when and how to best reach target beneficiaries and assists in planning outreach timings in specific locations, and timings for clinics and drop-in-centres.

- identifying specific needs of community members living with HIV and providing support;
- building community support systems and mechanisms to respond to crises;
- advocacy skills for promoting and protecting sex workers' human rights;
- legal education;
- developing skills in networking, public relations and partnerships with relevant stakeholders;
- CBO development and management; and
- leadership development.

### Support through mentoring

Over the years, Ashodaya has learned that training needs to be implemented side by side with other interventions. Trainees need on-going support to reflect upon how they are practically applying their knowledge and skills, identifying the challenges and strategize to find solutions. The practice of mentoring was introduced by Ashodaya Academy at the request of trainees. It involves trainers maintaining contact with and supporting trainees' learning beyond the initial training interaction. This helps individuals apply their learning according to ground realities. "We never say no when community asks us for help. Even when we did not have funds to provide handholding support, we found a way to provide help needed," explained Jaya Lakshmi, a female sex worker and faculty member

In 2008, mentoring support became institutionalized as a core component of Ashodaya Academy's work. Five individuals— two Academy faculty members, two community members and one non-community staff member, provide mentoring.

### Monitoring

Ashodaya has two methods of monitoring the implementation of training:



## Reflections on classroom and field-based training

“No community member likes being talked down to and if, as a faculty, we create this hierarchy than we cannot develop trust with our trainees. Without this trust on each other, we cannot properly learn and teach. So, we use a lot of personal stories, build empathy, share and exchange our ideas, create an environment of trust and friendship to make learning a two-way process. Although the topics we discuss are often technical, we simplify these concepts based on our lived experiences, which helps to gain understanding about the practical use of these technical concepts. This makes teaching and learning process much more effective.”

### A transgender sex worker and faculty member

“There are a lot of differences between theory and practice. We did not know if what they are saying [in the classroom] is truly there in the field, or not? But when we went to the field [in Mysore], and we saw with our own eyes, then we understood and believed in the power of community interventions.”<sup>239</sup>

### A female sex worker, Ashodaya Academy trainee

“We want the academy to become a national level university with proper accreditation and certification.”

Prathima, female sex worker and faculty member

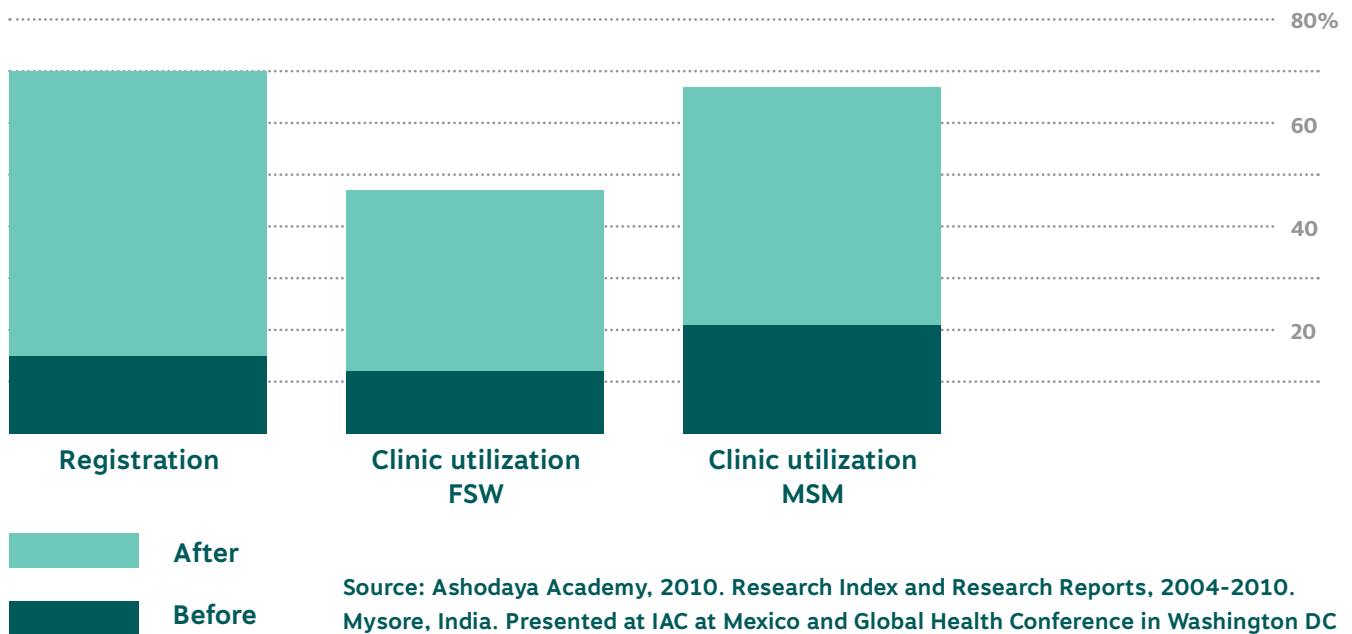
**Work plan tracking.** All trainees develop a time-bound work plan. This outlines the follow-up activities to be implemented and identifies support needed from Ashodaya and other partners. The work plan has a dual purpose; it guides the follow-up to be undertaken by trainees and assists in monitoring each trainee's individual progress.

**Enquiry-based monitoring.** Periodically, the Academy informally contacts the programme partners, and sometimes stakeholders, to enquire about the implementation of the training. This form of informal monitoring helps in identifying challenges, informing ongoing mentoring support and assistant to find solutions.

“We never say no when community asks us for help. Even when we did not have funds to provide handholding support, we found a way to provide help needed.”

Jaya Lakshmi, a female sex worker and faculty member

# Increase in service utilization following introduction of community-to-community mentoring



## Impact snapshots

### Community-to-community mentoring in Kolhapur, Maharashtra

Ashodaya Academy faculty members spent a week visiting the Kolhapur district in Maharashtra, India, where an HIV prevention programme was underway among female sex workers. The team held discussions with sex workers, peer educators and staff, to identify gaps in their programme. A detailed twelve-week work plan was formulated, which included addressing violence and discrimination, as well as an outreach plan to increase community mobilization, service utilization and build an enabling environment.

The results were striking. Within six weeks, female sex worker registration with the HIV programme had increased to 70%, compared with 15% at the baseline. At the end of 12 weeks, clinic utilization by sex workers registered with the programme had soared from 12% to 50%. Furthermore, there was a visible improvement in community cohesiveness to respond to crisis. This was evident in the ways that sex workers began taking an active role in advocacy and programme management. A clinic-based intervention for men who have sex with men also noted utilization increasing from 21% to 67% in the 12-week period.<sup>240</sup>





### Prevention scale up in Andhra Pradesh

Ashodaya Academy built the capacity of CBOs in Kakinada, Peddapuram and Warangal to design and implement targeted intervention programmes for female sex workers under NACP-III. This led to rapid scale up of prevention programmes in Andhra Pradesh.<sup>241</sup>

### Community mobilization in Rajasthan

During 2010–2011, Ashodaya Academy with support from UNFPA organized a capacity building programme for sex worker communities in selected targeted intervention (TI) sites where HIV prevention programmes were being implemented by NGOs in Rajasthan. In seven months, Ashodaya was able to facilitate community mobilization in two areas. This resulted in the formation of two sex worker CBOs where the TI was being implemented. In the first year, there was a clear shift from communities being passive recipients of services to being actively engaged in processes.<sup>242</sup> By the second year, the sex workers were able to form CBOs and mobilize their own community, which resulted in more sex workers accessing services and condoms.<sup>243</sup> At the second site, Ashodaya Academy worked with the sex work community to restructure existing CBOs to become community led. In both places, the relationship of CBOs with other stakeholders such as service providers and police improved significantly.<sup>244</sup>

These examples demonstrate the rapid application and impact of the community-to-community learning programmes. Sex workers with experience in handling the challenges inherent to running HIV prevention interventions with sex work communities and with training and mentoring skills have been highly effective in transferring their knowledge and skills.



## Lessons

- **Community-to-community capacity development is effective in rapid mobilization and empowerment of key affected communities.** It improves coverage and quality of HIV prevention programmes.
- **Ashodaya Academy has helped build the capacity of CBOs of men who have sex with men, people who inject drugs and sex workers in many locations across India.** This has had a significant impact on increasing coverage of HIV prevention programmes and service uptake (see *Impact snapshots* box on page 124).
- **The community-to-community capacity development approach fast tracks the learning process and encourages sustainability.** Effective community capacity development requires active participation and continuity and be firmly located in the lived experiences of the community and the principle of equality. As Sushena Reza-Paul, Assistant Professor, University of Manitoba, Canada outlines: “In the process of capacity development, there are either individuals or organizations that play the role of a catalyst. If the catalyst is the member of the same community, the process of capacity development becomes quicker and is more effective.”
- **Since Ashodaya became the national learning site, it has built capacities of many other CBOs that are now recognized as state-level learning sites.** In turn, these learning sites have trained CBOs at the district levels.<sup>245</sup> Hence, the learning process has been continuous and sustained.
- **Empowerment-oriented capacity development significantly contributes to strengthening community systems to handle HIV prevention.** Ashodaya Academy’s aim is to provide knowledge and skills that can be holistically applied to empower individuals and communities. These efforts generate more resources for community-led programmes and enhance programme implementation and management skills.<sup>246</sup> They are indicators of a ‘capable community’.<sup>247</sup>
- **Capacity building programmes must be driven by the needs and priorities of the implementing organizations.** More often than not, capacity development in the context of HIV programming is driven by external factors and often do not build the skills that implementing organizations require. To increase quality of HIV programmes, needs and priorities of implementing organizations must be taken into consideration.<sup>248</sup>
- **Measure and advocate for community-to-community capacity building as both a means and an end.**<sup>249</sup> The deeper impact of Ashodaya’s capacity development programme has been personal transformation among a large number of sex workers. As Jaya Lakshmi, sex worker and Ashodaya faculty member underlines: “I am no less than an officer in a government office. I have excellent facilitation skills, research skills; I can teach well and communicate with impact; I can analyse problems and articulate my concerns. Because of the opportunity to teach and learn, I have an identity.”
- **Non-community actors play an important role in making community-to-community capacity development effective.** Ashodaya Academy receives a variety of support from partners including the Bill and Melinda Gates Foundation, the Government of India, the University of Manitoba, UNAIDS and ADB. Moreover, cooperation and inputs from police officers, health care providers and lawyers add to the success of the Academy’s training programmes.

“We want to inspire, empower and build these communities so that they also become socially conscious about their rights, know how to claim these rights and assert a social position. This is our dream.”

Jinendra, a male sex worker and faculty member

## Gaps, challenges and opportunities

Ashodaya reports that one of the greatest challenges they face is power dynamics between NGOs and CBOs. In some instances, Ashodaya reports that NGOs regulate the relationship with the sex work community to a degree that obstructs the process of community mobilization.

Male sex worker and faculty member Shivaram details some of the challenges faced: “NGOs do not want to let go their role as the custodians of HIV prevention programmes. They feel threatened by the presence of Ashodaya, especially when they see that with the capacity development support from us [the faculty members], community members start to ask NGOs questions and assert their opinions about the programmatic approaches used. This sometimes threatens the NGOs because it challenges the roles of NGOs in HIV prevention for us and ultimately takes away the financial resources they have been receiving to provide services for us.”

Male sex worker and Director of the Ashodaya Academy concurs: “In one city in another state, when we initially started providing capacity development support, we were supported in our efforts. But as the NGO implementing the female sex worker intervention realized that we were working with the community to empower them through self-actualisation process and assertion of their rights, it started perceiving our work as threats, and not only stopped us from contacting the community, but asked us to leave. So we had no choice but to go.”

The financial sustainability of Ashodaya Academy is uncertain as support by Avahan comes to an end in 2012. Hereafter the Academy faces the challenge of sustaining its current programmes. In preparation, it is exploring the feasibility of introducing a user-fee. However, this may prove to be difficult for CBOs who usually do not have an operational budget for capacity building. Ashodaya has already put into action a new strategy of trainees sharing the cost of food and accommodation during training programmes.

In recent years, the use of social marketing to promote social, behavioural and environmental

change has grown in the field of public health. Ashodaya has been discussing the feasibility of implementing a social marketing strategy for the community-to-community capacity development approach.<sup>250</sup> Principles of the ‘community-based prevention marketing model’ could inform the design of this marketing strategy to ensure relevance for community members.<sup>251</sup> Marketing its approaches could increase demand for Ashodaya Academy’s training services.

The Academy aspires to becoming a national level university with a formal accreditation system. Ashodaya Samithi has a long-term vision for the Ashodaya Academy. It wants to extend the community-to-community approach to empower other marginalized groups and communities in India. “We want the others to learn what we learned by the process of coming together and providing support to each other and learning about new things as we implemented HIV programmes. We want to inspire, empower and build these communities so that they also become socially conscious about their rights, know how to claim these rights and assert a social position. This is our dream,” explained Jinendra, a male sex worker and faculty member.

In the future, Ashodaya Academy plans to establish a learning network in the Asia-Pacific region with a diverse range of actors to bring about social change. This network could serve as a referral system for Ashodaya Academy to attract new participants to take part in the training programme. ■

- 226 Ashodaya Samithi implements HIV prevention, care and community support programmes in five districts of Southern Karnataka, with Mysore still functioning as the organization's hub. Over 7 000 female, male and transgender sex workers from in and around Mysore are represented in the Samithi and benefit from its services.
- 227 The term 'community-to-community' capacity building refers to sex worker-led capacity building designed for and by sex workers.
- 228 This is one of Ashodaya Academy's working principles.
- 229 Avahan is an initiative of the Bill and Melinda Gates Foundation that has been providing funding and support to targeted HIV prevention programmes in India's high HIV prevalence states.
- 230 Research and Innovation (RI) is an approach to design and implement a rapid response to HIV prevention among marginalized populations within a span of twelve weeks. The RI approach utilizes community-driven HIV programme initiation, implementation and service delivery based on concrete understandings of the local contexts where interventions are to be implemented, and is in partnership with the local community in identifying and assessing needs to monitor and evaluate service delivery. Avahan started this initiative in the State of Karnataka and Mysore was the first city where this approach was piloted.
- 231 Reza-Paul, S. et al, Declines in risk behaviour and sexually transmitted infection prevalence following a community-led HIV preventive intervention among female sex workers in Mysore, India, *AIDS* 22 Suppl 5:S91-100 (2008) PMID 19098483; Dixon, V. et al, Increasing access and ownership of clinical services at an HIV prevention project for sex workers in Mysore, India, *Glob Public Health* 7(7):779-91 (2012) PMID 22424476.; Argento,E. et al, Confronting structural violence in sex work: lessons from a community-led HIV prevention project in Mysore, India, *AIDS Care* 23(1):69-74 (2011) PMID 21218278.
- 232 This is the current phase of the National AIDS Control Programme in India.
- 233 See for example, Wheeler, T. et al, Learning about scale, measurement and community mobilization: reflections on the implementation of the Avahan HIV/AIDS initiative in India, *J Epidemiol Community Health* 2012: 66 and references in endnotes 6 and 13.
- 234 Position paper, Challenges Encountered in Capacity Development: Review of literature and selected tools. Management Sciences for Health/USAID, No.10 April, 2010.
- 235 Ibid.
- 236 Centers for Disease Control and Prevention. (2011). Capacity Building Assistance Portal for HIV Prevention. Accessed from <http://www.cdc.gov/hiv/topics/cba/CDC> on 2 June 2012; Dixon, V. et al, Increasing access and ownership of clinical services at an HIV prevention project for sex workers in Mysore, India, *Glob Public Health* 7(7):779-91 (2012) PMID 22424476; Motamed, et.al.,2005; HIV prevention capacity building: A framework for strengthening and sustaining HIV prevention programs. Academy for Educational Development, Center on AIDS and Community Health. Accessed from [http://coach.aed.org/Libraries/Capacity\\_Building/HIV\\_Prevention\\_Capacity\\_Building.sflb.ashx](http://coach.aed.org/Libraries/Capacity_Building/HIV_Prevention_Capacity_Building.sflb.ashx) on 2 June 2011.
- 237 Ghose et al.,2008. Mobilizing collective identify to reduce HIV risk among sex workers in Sonagachi, India: The boundaries, consciousness, negotiation framework. *Social Science @ Medicine*, 67:311-20; Blankenship et al., 2010. Factors associated with awareness and utilization of a community mobilization intervention for female sex workers in Andhra Pradesh, India. *Sexually Transmitted Infections*, 86 (Suppl 1):i69-i75.
- 238 Wheeler, T. et al, Learning about scale, measurement and community mobilization: reflections on the implementation of the Avahan HIV/AIDS initiative in India, *J Epidemiol Community Health* 2012: 66. Report of the Working Group on AIDS Control for 12th five year plan, Government of India, 2011. <http://www.scribd.com/doc/73748037/1/NACP-III-Implementation-and-Achievements#page=10> accessed on 12 June, 2012;.
- 239 As quoted in Community capacity building for HIV prevention: Lessons from a community-led sex worker initiative in Mysore, India by Elayne Vlahaki (2011).
- 240 Programme data reported by Ashodaya as part of documentation interview.
- 241 Andhra Pradesh State AIDS Control Society conducted an annual evaluation of these CBOs based upon which they decided to continue funding. This indicates efforts in CBO capacity development have been effective.
- 242 A project update on Rajasthan Project supported by UNFPA India, Ashodaya Samithi, 2011. Internal document, Unpublished.
- 243 Ibid.
- 244 See Annual Review Report, Capacity Building in Rajasthan. Supported by UNFPA, India.
- 245 Vlahaki, E., 2011. Community capacity building for HIV prevention: Lessons from a community-led initiative in Mysore, India" Unpublished.
- 246 Ibid.
- 247 Laverack, G., 2004. The domains of community empowerment. In *Health promotion practice: Power and empowerment*, 86-98. London: Sage Publications.
- 248 Management Sciences for Health/USAID, 2010. Position paper. Challenges Encountered in Capacity Development: Review of literature and selected tools. No.10 April, 2010.
- 249 Ibid. p.17.
- 250 Ibid.
- 251 Bryant, et al., 2007.Community-based prevention marketing: Organizing a community for health behavior intervention. *Health Promotion Practice*, 8, 154-163.





# Including migrant sex workers in HIV programming: EMPOWER Foundation

“We are sex workers. We are workers who use our brains and skills to earn an income. We are proud to support ourselves and our extended families. We look after each other at work; we fight for safe and fair standards in our industry and equal rights within society. We are a major part of the Thai economy, bringing in lots of tourist dollars. We are active citizens on every issue — politics, economics, environment, law and rights. We try and find the space in society to stand up and be heard. Some see us as the problem makers but actually, we are part of the solution.

We are sex workers, we are EMPOWER.”<sup>252</sup>



**E**stablished in 1984, EMPOWER Foundation (EMPOWER) is the first sex worker organization in the Kingdom of Thailand (Thailand) and, most likely, the oldest in the Asia and Pacific region outside of Australia. Started by a group of sex workers and women's right activists, its goals are to promote the human rights of sex workers and provide a space owned by the community; to belong, organize and assert their rights. While it promotes the human rights of all sex workers, it provides health and social services for female sex workers living and working in Thailand. With more than 50 000 members, these include sex workers from Thailand, and migrant sex workers from Lao People's Democratic Republic, Myanmar, China and Cambodia. EMPOWER currently has centres in eleven provinces of Thailand—all managed by sex workers—reaching over 30 000 sex workers annually.

EMPOWER has been one of the driving forces behind the founding of networks such as the Thai NGO Coalition on AIDS (TNCA) and APNSW. Recipient of numerous awards, including the Thai National Human Rights Award for Best Human Rights Organization 2006 and the Freedom to Create Prize 2009, EMPOWER is recognized for its expertise in promoting the labour rights of sex workers and the equal rights of migrant sex workers.

### Working with migrant sex workers

In 1991, EMPOWER opened an office in Chiang Mai which emerged as an inclusive and safe space for all female sex workers, regardless of their nationality, ethnicity or age. This began to attract many migrant sex workers. The space prides itself upon several core values: mutual support, friendship and respect. It ensures the opinions of migrant sex workers are expressed and heard, and their needs are addressed both in advocacy and services. It has nurtured some migrant sex workers to become leaders, alongside their local counterparts. Migrant sex workers comprise 33% of EMPOWER's total membership.<sup>253</sup> In some locations, such as Chiang Mai, Samut Sakon, Mahan Chai, more than 50% of participants are migrant sex workers.

The SWING case study provides an overview of the HIV epidemic in Thailand, see page 57.

## Key programme components

EMPOWER provides its members access to wide range of education and health programmes and services and a safe space for mobilization and collective strengthening and action. The organization undertakes both community level and national level advocacy to create an enabling legal and policy environment for sex workers.

### Education services

Prevention of HIV is an important theme of all educational activities. Over the last two decades, more than 30 000 sex workers have participated in educational programmes and for many, it has been their first occasion to study. EMPOWER provides a range of educational opportunities to meet the identified needs of their members.

### Non-formal Education (NFE)<sup>254</sup> centre

In 1990, EMPOWER registered as an official NFE centre, authorised to conduct NFE day schools. This was the first school for sex workers in Thailand. Non-formal education classes follow the regular Thai curriculum and focus on increasing basic literacy skills. Subjects include health and environment. Sex workers teach most classes and the pedagogy is participatory. Sex workers who complete the NFE programmes receive certification. The curriculum enables students to participate in study tours and camps. These are usually three-day thematic learning events approved by the NFE government department. Past themes for learning events have included environment, health, political participation, art, history, drama and self-defence. Some sex workers find these difficult to attend, as they do not get paid leave.<sup>255</sup> However, these opportunities are highly valued by sex workers as a time to make new friends, relax and enjoy a hassle-free environment. For migrant sex workers, study tours are occasion to

“In order to live and work safely and avoid exploitation we need to be literate in the local dominant language [Thai]... We also need to know about and access Thai health services, public transport, shopping, and understand Thai law and culture.”

Goy, EMPOWER language class student.



learn about Thai culture and tradition that helps in cultural integration. Moreover, enrolment of migrant sex workers in NFE programmes is strategic. It provides them with a study card—sometimes recognized by authorities—which can be used to access the Thai health care system or to avoid arrest.

### Language classes

Attentive to the local context and needs of sex workers, EMPOWER conducts a range of language classes in its centres. These improve sex workers' ability to communicate with employers and customers. Thai literacy classes are provided for migrant sex workers.

“For those of us who are the family breadwinner, who dream of buying land, building a house, owning a business, sex work offers us the best opportunities. In order to live and work safely and avoid exploitation we need to be literate in the local dominant language Thai. Our bosses are Thai and most of our customers are Thai. We also need to know about and access Thai health services, public transport, shopping, and understand Thai law and culture,” explained Goy, an EMPOWER language class student.<sup>256</sup>

### Skills-building workshops and training programmes

Workshops and trainings provide space and resources for sex workers to be together, have fun and develop new skills or ideas. Workshops have been on numerous topics including condom use, preparing cocktails and computer skills. The community decides the topics, duration and frequency of these workshops. In addition, EMPOWER offers ‘learning by doing’ training programmes which build sex workers' practical skills:

- The ‘Staying Healthy’ training programme covers safer sex methods, testing and STI treatment; occupational health and safety; managing emotional and psychological health; legal entitlements as workers and citizens in accessing the universal health care scheme, and social security.
- ‘Leadership, media, research and public speaking’: Advocating for the protection of sex workers' human rights is central to EMPOWER's work. This training is designed to build leadership among sex workers to advance their rights. It focuses on hands-on activities to develop skills in dealing with media, understand and critique research for use in advocacy interests and master the art of public speaking.

### Health services

EMPOWER is source of a wide range of accurate information—be it related to the occupation of sex work or otherwise. It provides peer counselling on a range of health issues. Work-related health concerns are the focus of monthly workshops. At EMPOWER centres, sex workers have access to free condoms and lubricants and IEC materials on various aspects of women's health such as menstruation, HIV/STI and SRH. EMPOWER provides accompanied support to those accessing HIV and STI diagnostic and treatment services at government hospitals and clinics.

“We believe that providing information and education to enable sex workers make decisions about HIV testing is more important than providing the actual testing facility,” said Noi, EMPOWER's founder.



## EMPOWER radio programme

To reach migrant sex workers who are unable to access centres, EMPOWER operates a local community radio programme which broadcasts out of Chiang Mai. It provides information about living and working in Thailand, and ways of accessing health care and social insurance. For this, EMPOWER negotiated with MAP Foundation,<sup>257</sup> an NGO that broadcasts multi-lingual radio for migrants in Thailand, for a time slot which would reach the migrant sex worker community. The radio programme is broadcast in Burmese and Shan (Tai Yai)—languages spoken by most migrant sex workers in Chiang Mai. It runs for two hours, three times a week and is managed entirely by sex workers trained in broadcasting. An array of health-related topics is discussed during interactive spots including HIV prevention, beauty tips, and social issues facing migrant sex workers. Once a week, the session focuses entirely on local services operating HIV prevention and treatment of HIV and STI. Listeners can dial in to ask questions, request music and leave messages for friends. EMPOWER also invites guest speakers onto the programme to discuss particular topics.

In 2012 EMPOWER started sharing broadcasting time with M Plus and Violet Home, two CBOs based in Chiang Mai. Both organizations run an hour-long radio programme once a week and provide information to men who have sex with men and male and transgender sex workers about living with HIV, sexual health and rights.

EMPOWER community radio programme has been a cost-effective tool to reach hidden populations of sex workers, including migrants. Its running costs are approximately us\$ 100 per month. Five DJs are paid an honorarium of approximately us\$ 20 per month.

“When I listen to the radio programme, it gives me a sense that I am not alone and there are many like me out there.”

Muen, migrant sex worker, Chiang Mai

“We ensure our community members have the right information and are properly counselled before they decide to get tested at the health care facilities.”

Noi, founder, EMPOWER

“Often this [information and education] is lacking at the government hospitals and so, we ensure our community members have the right information and are properly counselled before they decide to get tested at the health care facilities,” she added.

Between 2009 and 2011 EMPOWER implemented an HIV and STI prevention project with support from Global Fund. This project provided HIV education, condoms and lubricants as well as counselling and facilitating access to HIV testing.

However, EMPOWER report a number of problems that were encountered due to target monitoring indicators imposed within the project. “As a part of the project, we were required to recruit and test 1 600 sex workers every year but although more than this came for counselling, only 500 sex workers went on to have an HIV test. It led to problems because we were not able to meet Global Fund VCT indicators. Ultimately, we were judged to be not effective, and among many others reasons, this led us to lose the grant we received,” recounted Noi. EMPOWER report that this situation stemmed from a fundamental disagreement with the Global Fund on the principle of sex workers’ right to self-determination while accessing VCT. EMPOWER strongly believes that sex workers should neither be convinced nor recruited for testing in order to meet imposed targets.

### Holistic approach to HIV, health and social issues

Although EMPOWER has been a solid partner in the movement against HIV in Thailand since the early 1990s, it does not implement stand-alone HIV projects.<sup>258</sup> Rather, their guiding principle of sex workers’ right to self-determination has led to an integrated system of support for sex workers. For example, they do not provide clinical services at their centres and outreach to sex workers is not conducted solely for the purpose of HIV prevention. In contrast, outreach aims to build friendship, trust and awareness, and offer training opportunities as well as provide referrals and support to access HIV services.<sup>259</sup> EMPOWER collaborates with health care providers to ensure friendly and non-judgmental facilities are available to sex workers, and

offer referral services to HIV and STI testing, diagnosis and treatment.

## Creation of safe spaces for mobilization and collective strengthening

### ‘Can Do’ Bar

A large majority of sex workers in Thailand work in entertainment venues.<sup>260</sup> Their work involves serving drinks, dancing and singing, chatting with customers, massage and providing sexual services.<sup>261</sup> However, as workers their labour rights are seldom protected. They incur pay cuts for infringing rules and often work under an oppressive system of imposed quotas on the number of customers and drinks bought for them. They do not receive paid or sick leave, and rarely get time off at weekends or for vacations.<sup>262</sup> The criminalisation of sex work undermines efforts to ensure safe and fair working conditions in accordance with Thai Labour laws. Sex workers are often targets of raids and migrant sex workers face added rights violations if they are undocumented.<sup>263</sup> In response to this, EMPOWER decided to establish the ‘Can Do’ Bar.

Established in 2006 the Can Do is a bar owned and managed by a group of sex workers from EMPOWER in Chiang Mai. Disillusioned by the conditions in sex work venues, the group decided to pool resources to create a work place that is fun, safe and fair. The bar is financially supported by a community fund: any sex worker who contributes to this fund automatically becomes a collective owner. Can Do Bar is a unique model of an entertainment venue with safe and reasonable working conditions for both bar staff and sex workers.



It follows Thai labour laws and operates a social security policy in the management of the bar and its employees which include stipulations that:<sup>264</sup>

- all workers are paid at or above the minimum wage;
- staff work a maximum of eight hours per night and have one day off per week;
- workers have 10 paid holidays and 13 days public holiday per year;
- overtime is voluntary and fully paid
- no staff salary cuts or withholding of wages for any reason;
- staff are encouraged to form a worker's association or union;
- workers are entitled to paid sick leave and can enrol in the Thai Social Security scheme;<sup>265</sup>
- any disputes over working conditions are settled in the labour court;
- premises comply with Thai building standards including for fire safety, cleanliness and hygiene.

Can Do Bar promotes the safety and well being of its employees and customers. Staff members are trained in first aid. Resting areas, first aid supplies and clean drinking water are provided to workers. Alcohol consumption by bar staff or visiting sex workers is not promoted or encouraged. Employees, visiting sex workers and any other women leaving the premises with new friends are encouraged to use the Can Do security system for their safety.<sup>266</sup> Condoms and lubricants are provided free of cost and all workers are trained in safer sex education.

The experiences of operating Can Do Bar amply illustrate that it is possible to apply labour standards in the entertainment industry and develop strategies to minimise occupational hazards. EMPOWER reports

that working in a healthy environment that promotes labour rights of all workers, including migrant workers, reduces health risks, including exposure to HIV. In collaboration with the Ministry of Labour, and using the knowledge they have gained, EMPOWER is advancing Can Do Bar as a precedent in the drafting of new policy and proper standards for health and safety at entertainment venues. With this, the model is being piloted in other parts of the country.

### Legal assistance

EMPOWER has two full-time in-house lawyers based in Bangkok and Chiang Mai, who specialise in legal issues affecting sex workers and migrant workers. They provide legal assistance in cases of arrest and rights violations by the police, and are available to sex workers free of cost.

### Advocacy for protection and promotion of sex workers' human rights

EMPOWER's primary advocacy message is the recognition of sex work as work and equal access to protection and benefits. These messages have emerged through conversations with sex workers about their realities. They are conveyed creatively, powerfully and simply, often using art, humour and performance to deliver the facts.

One of EMPOWER's biggest advocacy achievements is securing social insurance and benefits for sex workers working in entertainment venues through the National Social Security Scheme. This involved sustained lobbying with the Ministry of Labour and Ministry of Social Protection and Welfare. For this campaign to be effective, EMPOWER formed alliances with other people who were excluded from the scheme including tuk-tuk drivers, motorcycle taxis, factory piece workers and domestic workers. In 2005, sex workers and two thousand other workers from these sectors, met with the Department of Social Security to lobby for the inclusion of sex workers in the scheme, which specifically secures the benefits of paid sick leave and social insurance at retirement age.





## The journey of Kumjing

The journey of Kumjing is an international art project that narrates the stories of migrant sex workers' and advocates for change in the way that society views and treats migrants. The project started in 2003 and involved making 250 papier-mâché dolls, all given the name Kumjing. These 'Kumjings' were taken to Bangkok to symbolically mark the places that migrant workers can only dream of. They were presented and exhibited at various platforms to convey the message that migrant sex workers have rights. Over time, 150 Kumjing dolls 'migrated' overseas, adopted by organizations, artists, sex worker groups and academics. Their journeys were emblematic of migrants' right to free movement across national borders. This project won an International Freedom to Create Prize in 2009.



## Advocacy to address the anti-trafficking lobby

In 2011, EMPOWER conducted a community-led research that highlights the negative impact of anti-trafficking policy and practice on HIV programmes and sex workers' human rights in Thailand. The research is the first of its kind in Asia. One of its key findings is that raids, rescue and rehabilitation in the name of anti-trafficking target adult consenting sex workers, including migrant workers, and inhibits sex workers' access to HIV prevention and treatment. The research highlights in detail the wide range of human rights violations that commonly occur as a result of these raids including unlawful detention and mandatory HIV testing.<sup>267</sup>

EMPOWER mobilized 206 sex workers, trained 36 sex worker researchers and collected and analysed qualitative and quantitative data from 13 provinces of Thailand. EMPOWER has presented the findings and recommendations to numerous stakeholders including the police, the National AIDS Programmes and the United States Government which funds anti-trafficking programmes in Thailand. EMPOWER will continue to build coalitions and advocate for law reform in this area and for sex work to be recognized as work.



## Lessons

- **Multi-sector and integrated approaches are more effective in sustaining migrant sex workers' access to health care and social services.** This approach has reduced costs associated with operation and programmes, and enabled migrant sex workers to participate in the same forums as other Thai sex workers. It has helped EMPOWER to lobby with a range of stakeholders including various government departments to secure social and health benefits for migrant sex workers.
- **Funding for HIV prevention programmes need to ensure resources for effective support to enable sex workers who test HIV positive to access HIV treatment and care.** In EMPOWER'S experience there is a need for greater attention and to ensuring that sex workers who test positive are supported to access HIV treatment and care.
- **According to Noi, founder of EMPOWER, "The funds that we received for HIV programming through Global Fund resources did not cover the costs associated to providing referral and treatment services, such as CD4 count, viral load, access to HIV treatment leaving sex workers who found out that they are HIV positive in a desperate situation.** Most of the 30 sex workers were migrants and because of this, it is very hard to find affordable HIV treatment schemes. We have to work hard to find referral services for affordable treatment and support them to receive timely treatment."
- **Migrant workers are more responsive to programmes that are holistic in addressing health and social issues.** For migrant sex workers, HIV prevention of HIV is only one of the many concerns they face. Holistic education programmes, that integrate HIV within a wider approach, that is responsive to wide range of issues migrant sex workers, is more effective than stand-alone HIV interventions.
- **Improving working conditions of sex workers enables them to negotiate safer sex.** In the experience of the Can Do Bar, it is possible to adhere to occupational health and safety standards in entertainment venues at nominal cost. Better working conditions reduce mental stress and significantly improve the psychological and physical well being of workers. This enables better evaluation of risk, and creates a supportive environment for sex workers to negotiate condoms use and prevent violence.
- **Providing education, information on labour rights and health issues increases self-esteem and confidence of sex workers.** The EMPOWER experience sufficiently illustrates that sex workers provided with educational opportunities rapidly achieve greater self-confidence. As a result, they communicate more effectively, better understand their labour rights and entitlements, and are in a stronger position to bargain for safe working conditions and fair treatment by managers and customers.



## Gaps, challenges and opportunities

The criminalisation of sex work continues to be a major barrier to effective HIV response among sex workers<sup>268</sup> and complicates using a labour rights framework for the protection of sex workers. Without legal recognition that sex work is work, sex workers in Thailand continue to face exploitative situations in the workplace. Exploitative work environments and police corruption fuel economic and social vulnerability, increasing the risk of HIV transmission.<sup>269, 270, 271</sup>

EMPOWER reports that mandatory HIV testing of sex workers — and especially migrant workers — without follow-up support and treatment continues to be practised in Thailand.<sup>272</sup> Interacting with government health facilities is precarious for undocumented migrants; even those who are officially registered face challenges accessing ART under the Universal Health Insurance.<sup>273</sup> When sex workers are arrested it is common for possession of condoms to be used as evidence of soliciting. As a result sex workers are often reluctant to carry condoms, and this poses serious challenges for ensuring safe sexual practices.

The year 2012 marks 27 years of EMPOWER. During this time as a leading sex worker organization, it has gained a plethora of experience, developed leadership skills of many sex workers, managed and operated successful programmes and conducted invaluable advocacy. EMPOWER has continued to evolve and expand to meet the changing needs of its members despite the many challenges, of which finance is one. EMPOWER believes in finding creative solutions to overcome these challenges, as explained by founder Noi: “We don’t receive specific budget for the operation of our office, it is generally allotted from the pro-



gramme money. We have been proactive to expand our donor base and we don’t only go to the traditional HIV donors. If we need to build our office, we might seek donors who help build infrastructure for our office.

EMPOWER envisions the future inclusion of migrant sex workers in the migrant worker registration policy.<sup>274</sup> Though this scheme has many pitfalls, being registered would provide some respite from fear of arrest and extortion, and would possibly open up accessing Universal Health Insurance and social welfare benefits. It would require employers to abide by Thai labour laws when employing migrant sex workers. However, EMPOWER cautions that registration must not be linked to sex work either directly or by implication. They recommend that migrant sex workers be recorded under the term ‘general worker’ which currently covers other informal work domains.

Finally, providing treatment to migrant sex workers living with HIV is urgently needed. While EMPOWER raises funds to cover treatment costs at the community level, this support is limited. ■

- 252 See EMPOWER website at [http://www.empowerfoundation.org/index\\_en.html](http://www.empowerfoundation.org/index_en.html) accessed on 28 May, 2012 in Bangkok, Thailand.
- 253 Currently EMPOWER has approximately 50 000 members across the country.
- 254 Non-formal education is a distance education programme of the Ministry of Education in Thailand. It provides education to those unable to access mainstream schooling e.g. adult learners, children in remote areas, people in prisons etc.
- 255 [http://www.empowerfoundation.org/education\\_en.html#](http://www.empowerfoundation.org/education_en.html#) accessed on 28 May in Bangkok, Thailand.
- 256 Ibid.
- 257 MAP Foundation (formally known as Migration Access Programme) is an NGO that seeks to empower migrant communities from Myanmar living and working in Thailand. Their mission is to improve the health and social well-being of migrant communities in Thailand by increasing their participation in advocacy and policy making, thus creating space for them to exercise their rights and eliminate discrimination and exploitation.
- 258 The exception to this was the GFATM project referred to above.
- 259 EMPOWER reports that their outreach activities are mainly to mobilize community, building trust and friendship so they have a support system for help and emergencies. They also conduct condom outreach activities at the community level, which is not only for sex workers but for employers and managers of entertainment venues as well as customers of sex workers.
- 260 EMPOWER Foundation, 2012. *Hit @ Run, Sex Worker's Research on Anti-trafficking in Thailand; Sex Work and the Law in Asia and Pacific*, UNDP & UNFPA, October 2012, see Section 4.9 Thailand.
- 261 Ibid.
- 262 Ibid.
- 263 Ibid.
- 264 See [http://www.empowerfoundation.org/barcando\\_en.html](http://www.empowerfoundation.org/barcando_en.html)
- 265 This is jointly paid by the bar owners, employee and the government.
- 266 This is a system using local contacts and mobile phones to safeguard workers.
- 267 EMPOWER Foundation, 2012. *Hit @ Run, Sex Worker's Research on Anti-Trafficking in Thailand*. EMPOWER Foundation: Bangkok, Thailand.
- 268 *Sex Work and the Law in Asia and Pacific*, UNDP & UNFPA, October 2012, see Section 4.9 Thailand.
- 269 See Aids 2031 Social Driver Working Group working papers series on Social Driver Synthesis Report and Addressing Social Drivers of HIV: Some Conceptual, Methodological and Evidentiary Considerations from <http://www.aids2031.org/working-groups/social-drivers>. Accessed on 18 May, 2012.
- 270 Commission on AIDS in Asia Report, 2008. *Redefining AIDS in Asia, Crafting an Effective Response*. Report of the Commission on AIDS in Asia. Oxford University Press, New Delhi.
- 271 EMPOWER Foundation, 2012. *Hit @ Run, Sex worker's Research on Anti-trafficking in Thailand*. EMPOWER: Bangkok Thailand.
- 272 *Sex Work and the Law in Asia and Pacific*, UNDP & UNFPA, October 2012, see Section 4.9 Thailand.
- 273 During the documentation some organizations reported that only a limited numbers of documented workers can access ART, and only under programmes supported by GFATM, not under the government scheme. Other groups said that documented skilled migrant workers can access ART under the government scheme but unskilled workers cannot. There does not appear to be an articulated government policy on migrant access to ART under Universal Health Insurance.
- 274 Under the migrant worker registration policy, undocumented migrants from three neighbouring countries — Cambodia, Lao People's Democratic Republic and Myanmar — were given legal status to live and work in Thailand as employees strictly limited to six sectors; fishery, construction, plantation (agriculture), factory, domestic work and manual labour. Their right to stay and work in Thailand is contingent upon being employed. There is anecdotal evidence of abuse of migrants working in these sectors by employers and corrupt officials. Although there is little this policy can do about this, it does provide some protection and benefits. For instance, documented migrants have access to social insurance and universal health scheme (excluding ART treatment). Unfortunately, it is not yet possible for migrant workers in the entertainment industry to access worker registration documents. As a result they have no access to Thai social welfare and remain undocumented.





Case Study

**11**

# **Improving sex workers' access to health, rights and freedom from violence: experiences of Fiji's Survival Advocacy Network**



**S**urvival Advocacy Network (SAN) is one of two networks of transgender and female sex workers founded by and for sex workers in the Republic of Fiji (Fiji).<sup>275</sup> Established in 2009, SAN's mission is to gain social recognition for sex workers, ensuring their equal rights as citizens particularly in the area of health care. Although SAN is in its early stages of development, its leaders and staff have been actively engaged in the sex workers' movement in Fiji for many years. Rani Ravudi, SAN's Transgender Project Coordinator, and a transgender sex worker, has been working consistently on the issue of violence against sex workers. Women's Action for Change (WAC)<sup>276</sup> a grassroots feminist organization has mentored many of SAN's leaders and continues to guide the organization's development. WAC have helped SAN gain skills in performance art and social media to mobilize the sex worker community and promote their rights.

Although WAC provides administration and technical support for resource mobilization, SAN has its own governance, organizational and management structures and functions as an autonomous organization. In its short journey, SAN has played on critical role in mobilizing sex workers in Fiji and advocated for policy and legal changes and sex workers' human rights. It has become a nationally recognized voice for sex workers in Fiji representing them at international and national levels.<sup>277</sup> However, challenges remain given the criminalisation of sex work in Fiji, including that SAN Fiji is unable to be registered as an independent organization.<sup>278</sup>

This case study documents SAN's efforts in mobilizing and empowering sex workers highlighting two key programmes — legal rights education and addressing stigma and discrimination in health care settings.

## Sex work and HIV in Fiji

Fiji is classified as a low HIV prevalence country. The estimated number of people living with HIV in 2009 was about 500 and prevalence rate for 15–49 age groups approximately 0.12%.<sup>279</sup> HIV prevalence continues to be low with 43 new confirmed cases of HIV infection in 2009. However this was about one third higher than the annual figures for the previous six years.<sup>280</sup> The number of new infections in 2010 and 2011 were 33 and 54 respectively.<sup>281</sup>

Very little data exists on HIV and AIDS among sex workers in Fiji. At present the country's first Integrated Biological and Behavioral Study (IBBS) is underway, which will examine HIV prevalence and the risk and vulnerability factors of sex work. This is a collaborative effort involving the Ministry of Health, SAN with technical support from WHO and UNAIDS. The IBBS will generate data that will assist in guiding effective HIV prevention, treatment and care and support interventions among sex workers.

As is common in many countries in the region, criminalisation of sex work fuels stigma and discrimination, including in health care settings.<sup>282</sup> It is unfortunate too, that the Crimes Decree 2009 undermines the effectiveness of supportive provisions in the HIV/AIDS Decree 2011. The HIV/AIDS Decree, for example, prohibits discrimination against people living with or affected by HIV, it provides the right to voluntary testing and counselling and has made it unlawful to deny a person access, without reasonable excuse, to a means of protection from HIV.<sup>283</sup>

## Key elements of the SAN programme

### Addressing stigma and discrimination at health care settings

One of SAN's most successful projects has been training health care providers to enable sex workers' access to health care without stigma and discrimination. The project was initiated in 2011 in collaboration with Fiji School of Medicine and the Australian HIV Consortium, rolled-out in three phases:

#### Developing training material

Sex workers developed a play as a tool to explore the barriers sex workers face in accessing health services. A highly participatory approach was used for developing content and songs and throughout the production rehearsals. The process took three months starting with the selection of three stories. Involving sex workers in developing the material brought the group together and increased their self-esteem.

#### Training health care providers

The goal of this project was to increase health service providers' understanding of sex workers' human rights and the effects of stigma and discrimination on sex workers access to health services. Initially a three-day training programme was piloted in Suva with twenty-five community health care workers from regional government clinics and hospitals. The play was used as a catalyst for sex worker and health care provider discussion and engagement. Within a few months, the training programme was conducted in Lautoka and Suva, involving health care workers from four districts — Ba, Lautoka, Nasinu, and Nausori. Initially, the health care workers were resisting their portrayal as intolerant and discriminating of sex workers. Now, Rani Ravundi says, "they are more open-minded, friendly towards us and our community feels more comfortable in accessing services where these providers work."

SAN reports that there has been an increase in the number of sex workers accessing VCT and sexual and reproductive health services in the clinics where the doctors who were involved in the training are located.

The Fiji School of Medicine is collaborating with SAN to integrate this training into their curriculum in the near future. This gives hope for improved quality of services for sex workers in Fiji.

#### Developing referral linkages for STI and HIV, VCT, diagnosis and treatment.

The training has helped establish referral linkages with a pool of sensitized health care workers. SAN Coordinator Rani Ravundi reports that, "all it takes is a phone call from us and this is a direct result of our raising awareness with the health care providers."

Another important outcome of the project is the establishment of a working group to develop a non-discrimination policy in health care settings. The working group involves representatives from the Ministry of Health, the Fiji School of Medicine, Key Affected Populations (KAP) and the church. Thirdly, a night clinic for sex workers has opened in Suva. Commencing in March 2012 at a local government hospital, the clinic functions between 5 and 9 pm, making it convenient for sex workers to drop in when they are working. This has proved a success with over 10 people attending on the first day. The Ministry of Health is planning to establish these clinics in other locations.

#### Legal rights education and provision of legal aid services

The Government of Fiji enacted the Crimes Decree 2009 commencing in 2010, making many aspects of sex work illegal including soliciting, living on the earnings of prostitution and keeping a brothel.<sup>284</sup> Although few sex workers have been prosecuted under the decree,<sup>285</sup> recent research has found that the intensity and frequency of violence by the police and military has increased<sup>286</sup> and the safety conditions of sex workers have worsened.<sup>287</sup> Due to concerns for the safety of outreach workers, HIV outreach activities, particularly the distribution of condoms and lubricants, were severely impeded. SAN Fiji found that many sex workers had limited knowledge about their human rights including relevant laws and mechanisms for redress in case of unlawful arrest, harassment and violence including rape.

“[Our legal training] educates sex workers on topics such as what is Crime Decree and how does it affect us sex workers... we teach our members ways to respond using legal language.”

**SAN Coordinator Rani Revundi**

It is in this context that SAN pioneered a legal rights project in collaboration with WAC. This aimed to reduce violence, improve sex workers’ knowledge of their rights and access to legal redress and police protection when their rights were violated.

The programme focuses on three components, legal rights training, access to legal services and working with police.

### Legal rights training

A five-day training programme was designed to raise sex workers’ awareness of human rights, legal issues in relation to sex work and avenues for redress when their rights were violated. Training programmes were organized in the six cities where SAN works. They are jointly planned and facilitated by SAN and lawyers at WAC. The training demystifies the law, imparts practical knowledge of laws and develops sex workers skills to use this knowledge in practice.

“[The training] educates sex workers on topics such as what is Crime Decree and how does it affect us sex workers,” explained Rani Ravundi, SAN Transgender Project Coordinator. “If police ask a sex worker to strip, as is common practice for transgender sex workers, we teach our members ways to respond using legal language. For example, sex workers could say, ‘Sorry if you need to search me, please take me to the other room so others can see what is going on. According to this law, you cannot search me here,’” she said.

The methodology for training is participatory. “During trainings, we rehearse these situations using role plays so they are better prepared to deal with such situations in real life,” said a transgender staff member.

### Referral to legal services:

SAN provides referrals, where needed, to lawyers at WAC’s legal aid centre. Legal assistance is provided free of charge.

### Working with police

Sex workers experience considerable violence within the community and at the hands of police. With the help of WAC’s Director Peni Moore, a well-known



## Impact: Empowerment, respect and self-determination

The challenge of reaching and mobilizing sex workers in Fiji is significant. However, there are clear indications that sex workers are networking in towns and centres, have greater access to their rights, information on HIV, better health care, and are more engaged in processes and programming that affect their lives. This has contributed to building a more empowered community, who demand respect and will access health care if they are confident it will be provided in a safe environment and in a non-discriminatory manner.

Another indication of change is that sex workers in Fiji are asserting their right to ‘self-determination’ – the exertion of free choice of one’s own acts without external compulsion. SAN and Pacific Rainbow Advocacy Network (PRAN), sex workers have decided to be independent from parent organizations. This symbolises a new movement of community empowerment in Fiji. Further, sex worker networks are working together to form a coalition. This alliance has brought about changes in ways that sex workers relate to one another; allowing each member the space to speak, be heard, share opinions and develop shared vision and common goals.



figure in Fiji, SAN has begun collaborating with the police to curb both police and public harassment of sex workers, and establish mechanisms for ensuring police protection. At the time of this documentation, plans were underway to conduct training of police officers in two districts. SAN is adapting the model used with health care providers for this.

Sex workers report that physical violence by the police has reduced. This is, in part, a direct outcome of sex workers having better knowledge of their legal rights and being able to negotiate with police, making them less vulnerable to unlawful arrest and detention and exploitation and extortion.<sup>288</sup> As Rani Ravundi remarks, “sex workers are more tactful in handling situations related to arrest and harassment by now. They know how to stand up for themselves and tell a police officer to stop harassing and beating.”



## Lessons

- **Comprehensive training for health care providers reduces discrimination against sex workers seeking health services.** This has the potential of changing attitudes over time, improving quality of health services.
- **Fostering partnerships with non-HIV organizations creates a broader structure to alleviate violence against sex workers.** Forging a strong relationship with wac has had multiple advantages including an influential partner and ally who can support their advocating efforts, provide mentoring and support, and has improved sex workers' access to resources including legal services.
- **Providing legal rights education impacts at micro and macro levels.** This directly contributes to advancing sex workers' rights, both systemically and individually, including improving sex workers ability to negotiate with police and prevent extortion and unlawful arrest.

## Gaps, challenges and opportunities

The criminalised nature of sex work and high levels of stigma and discrimination in Fiji are significant barriers to improving sex workers' access to health, rights and freedom from violence.

According to a 2011 study exploring the impacts of the Crimes Decree 2009 on sex work and HIV prevention, although there have been few prosecutions, police harassment of sex workers occurs, and abuses by the military in particular have been documented.<sup>289</sup> Sex workers in Lautoka reported that the military have been involved in numerous abuses of sex workers since the Crimes Decree was introduced. Military officers were reported to have rounded-up sex workers and inflicted summary punishments, including sleep deprivation, humiliation, sexual assaults and forced labour.<sup>290</sup> The Crimes Decree has put an enormous strain on HIV prevention service delivery,<sup>291</sup> with programmes coming to a complete standstill, albeit temporarily.

Stigma and discrimination further impedes ensuring the safety and well being of sex workers. "In Fiji, there is so much stigma against us, everywhere. From the church to the media, we are viewed as the 'sinners'. We face psychological and physical violence. It limits everything we are and can do as human beings. It limits our entitlements of freedom, dignity, and respect. It limits the work we want to do within our community and it limits our protection and safety," explained SAN's Transgender Project Coordinator Rani Revundi.

The HIV/AIDS Decree 2011 does have significant supportive factors for people living with HIV and key affected populations. For example, the 2011 Decree provides that it is unlawful to deny a person access to a means of protection from HIV, includes provisions prohibiting discrimination against a people living with or affected by HIV, and provides rights to voluntary HIV testing and confidentiality. However, more work is needed to ensure that the potential protections offered through the HIV Decree are effectively implemented and not mitigated or compromised by provisions of the Crimes Decree.<sup>292</sup>

In contrast to constraints encountered by sex work organizations in other parts of Asia, SAN's donors have tended to fund projects on human rights. Presumably, because Fiji is considered a low-prevalence country it has been difficult to access money for HIV prevention. Consequently, serious gaps exist in the provision of affordable and accessible HIV services for key affected populations. Condoms are expensive, VCT services are inefficient, not always available and do not reach communities who need it the most. Given this scenario, SAN has been unable to deliver HIV prevention and services to sex workers to necessary scale.

Nevertheless, SAN has come a long way in developing effective partnerships, using a holistic approach to improve conditions for sex workers. SAN's future efforts will focus on strengthening its HIV service delivery and developing economic empowerment programmes for sex workers. Fulfilling its potential as an independent organization lies in strengthening its network through organizational capacity building and gaining legal status as a registered CBO. ■



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**SAN Coordinator Rani Revundi**



- 275 The other network is Pacific Rainbow Advocacy Network (PRAN). This is a charitable trust of sex workers, borne out of a HIV project called ‘Sekoula Project’ implemented by Pacific Counselling and Social Services (PCSS) in the Western Division of Fiji. Sekoula Project was started in 2007 and will continue until 2013. In 2010, sex workers involved in this project decided to form their own organization called the PRAN. Since then, PRAN has been registered as a charitable trust with the support from PCSS and received its first funding support 2011. PCSS is also providing support to build organizational and leadership capacity of PRAN.
- 276 Women’s Action for Change (WAC) is a collective of feminist women in Fiji. Established in 1993, its main vision is to provide a safe space for women, girls and marginalized communities, to network and advocate around their issues, concerns and rights using creative media and communication techniques such as street theatre, drama, blogging, mime etc. WAC has offices in six cities and is renowned in Fiji for its activism and advocacy.
- 277 For example, SAN is part of a high-level working group of Key Affected Populations (KAP) set up by the Ministry of Health of Fiji.
- 278 Under the Crimes Decree 2009 sex work in private is not specifically criminalised. However, many aspects of sex work are, including soliciting and keeping a brothel. See *Sex Work and the Law in Asia and the Pacific*, section 5.2 Fiji, UNDP and UNFPA, October 2012.
- 279 Fiji UNGASS Report 2012 (for reporting period 2010-2011). This report notes that there have been no epidemiological HIV sero-surveys of the general population conducted, but the number of HIV positive results detected among thousands of HIV tests undertaken each year supports the estimated prevalence of 0.12%.
- 280 Ibid.
- 281 Ibid.
- 282 *Sex Work and the Law in Asia and the Pacific*, section UNDP and UNFPA, October 2012.
- 283 Ibid.
- 284 Ibid.
- 285 Ibid.
- 286 McMillan, K. et al., 2011. *Sex workers and HIV Prevention in Fiji – after the Fiji Crimes Decree 2009*. International HIV Research Group, UNSW, Sydney, 2011.
- 287 Bates, Nicholas, 2011. Evaluation of the counselling training program implemented by the Pacific Counselling and Social Services (PC&SS) in selected Pacific Island Countries and Territories (PICT). International Health Services, Albion Street Centre. Sydney, Australia.
- 288 In addition the introduction of the HIV/AIDS Decree 2011 may also be a supportive factor. The Decree prohibits discrimination against people living with or affected by HIV. It also provides the right to voluntary testing and counselling and has made it unlawful to deny a person access, without reasonable excuse, to a means of protection from HIV. This provision may discourage police from confiscating condoms as evidence of sex work. See *Sex Work and the Law in Asia and the Pacific*, UNDP and UNFPA, October 2012.
- 289 McMillan K., Worth H., 2011. *Sex workers and HIV Prevention in Fiji – after the Fiji Crimes Decree 2009*, Sydney: International HIV Research Group, UNSW.
- 290 Ibid.
- 291 *Sex Work and the Law in Asia and the Pacific*, UNDP and UNFPA, October 2012.
- 292 Ibid.

