



## **SEX WORKERS : PART OF THE SOLUTION**

**An analysis of HIV prevention programming to prevent HIV transmission during commercial sex in developing countries**

**Cheryl Overs. 2002**

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## DEFINITIONS

**Commercial sex** is the exchange of money or goods for sexual services. It always involves a sex worker and a client and it frequently also involves a third party.

**Sex work** is the provision of sexual services for money or goods.

**Sex workers** are women, men and transgendered people who receive money or goods in exchange for sexual services, and who consciously define those activities as income generating even if they do not consider sex work as their occupation.

The words “women”, “men” and “people” in this document include sexually active adolescents. Children who have not reached the age of puberty may also engage in sex work but they are not the focus of this document.

**Clients** are people (usually men) who pay with cash or other resources for sexual services either explicitly or within an agreed package that includes other services such as entertainment or domestic service.

**Transgender** describes people with a range of identities and behaviours, including both transvestism and transsexualism. Transgender identities, behaviours, legal status and physical states vary in different cultures and places. For the purposes of discussion of public health issues, transgender is a general term for people whose self-identity crosses gender.

**Third parties** are people who play ancillary roles in commercial sex. These include arranging meetings between sex workers and clients and/or providing resources and services. These roles vary from place to place and in terms of influence and power over commercial sex and sex workers.

The **commercial sex industry** is the combined phenomenon of individuals, establishments, customs and messages – explicit and implicit, desired and undesired – involved in commercial sex.

## SUMMARY

It has become increasingly clear that in many places the role of commercial sex is significant in sustaining and expanding HIV epidemics, albeit in different ways and at different rates.

Knowledge and experience about how to work with sex workers on health issues remains incomplete and controversial. However, by bringing together epidemiological data, operations and behavioural research, project reports and, most importantly, information from communities themselves, practical strategies, guiding principles and measures of success can be identified. A degree of consensus has emerged among frontline projects and key agencies, including many governments, about which combination of policies and programmes reduce HIV transmission during commercial sex.

This paper reviews these ideas and principles and presents examples of how they work in practice. It identifies processes for adapting, combining and implementing strategies to maximise their impact on epidemics locally and nationally and raises a series of challenges and questions for implementing agencies and policy makers.

## COMMERCIAL SEX AND HIV

It has long been recognised that unprotected commercial sex is has a significant role in many HIV epidemics. There is also considerable evidence that HIV transmission can be dramatically reduced during commercial sex and such a reduction makes a significant impact on the broader dynamics of the epidemic. However, gaps in our knowledge regarding the exact nature of transmission during commercial sex, stigmatisation of sex workers, and a failure to identify and work closely with large numbers of clients, have prevented many communities from developing effective prevention campaigns for sex workers and their clients.

### **HIV epidemics**

The World Bank classifies HIV epidemics as ‘nascent’ where infection rates are below 5% in all known risk groups, including sex workers, ‘concentrated’ where rates are above 5% in high risk groups but below 5% in the sentinel populations such as urban antenatal clinics, and ‘generalised’ where rates of more than 5% are found among antenatal clinics attendees.<sup>1</sup>

Nearly half of the 4.8 billion people in developing countries live in areas where HIV infection is not yet widespread, even among people most likely to be exposed to the virus. An effective response in these countries would contain the epidemic within the nascent or concentrated stages and spare billions of people the ravages of the epidemic.<sup>2</sup> That response must include appropriate interventions for sex workers and their clients.

### **The role of sex work**

Preventing transmission among those with high rates of partner change is desirable and cost effective because it prevents more secondary cases per primary case averted than interventions directed at those who practise low risk sex. This applies not only to sex workers, but also to men who acquire HIV during unprotected commercial sex and transmit it during non-commercial sexual networking frequently enough to form a significant “epidemiological bridge” to a broader population.

Where epidemics are already generalised, sex workers are usually more affected than others. Care and treatment that integrates effective prevention activities and protects HIV positive sex workers from discrimination has an important role in reducing the epidemic in the longer term and for future generations.

This means that whatever the state of the epidemic, expanding efforts to prevent HIV transmission during commercial sex should be a high priority. Even in industrialised countries with small epidemics and universal access to health care, maintaining awareness around HIV in the sex industry is still necessary. In such settings, sexual health can and should be integrated into the routine business of occupational health and safety.

## Research gaps

Academics and programme implementers frequently criticise the quality of behavioural and social research into commercial sex. Problems include:

- ?? lack of an agreed definition of 'sex worker': some studies have defined sex workers as people with as few as three sexual contacts per year, even where those involved do not identify those sexual transactions as commercial or even income generating;
- ?? assumption that every client has penetrative sex: condom use rates are frequently interpreted without considering non-penetrative sex and other services that sex workers offer;<sup>3</sup>
- ?? differences in the level of risk posed by unprotected anal, vaginal and oral sex are often not modelled appropriately;
- ?? incidence of sexually transmitted infections among sex workers is often recorded but little is known about the types of STI or duration of infections and virtually nothing about STI patterns in clients.

Qualitative data and anecdotal information can help fill some of these gaps but limited data has been published, at least partly because non-governmental organisations and others working in the field have few resources to do so.<sup>4</sup>

## Rates of infection – women sex workers

It is difficult to quantify HIV among sex workers and clients, partly because it is almost impossible to identify how many people in any one country sell or buy sex, how many of these have HIV, and how many are likely to transmit the virus to others. Commercial sex is frequently clandestine, sex workers and clients are often mobile and many people sell sex only occasionally and away from recognisable commercial sex settings. In some countries statistics are available from law enforcement agencies or health service registers. However, these may not be reliable because they tend to record only women sex workers and there are strong incentives for those selling sex to avoid having their names appear on such registers. Even less information is gathered about clients.

Where information is available, it shows that at one extreme, rates of HIV infection among women sex workers above 80% have been reported in Zimbabwe and Kenya, above 60% in Malawi, Côte d'Ivoire and Ethiopia and above 40% in Tanzania, Benin and Mali. In Asia high rates have been reported among sex workers in parts of India, Cambodia and Thailand<sup>5</sup>. Sampling, however, is often biased and non-random.

In many other countries, however, HIV rates among women sex workers have remained low. These include 1.4% among female brothel workers in Malaysia<sup>6</sup>, 1% in Peru<sup>7</sup>, 0.06% in Bangladesh<sup>8</sup> and none in Mauritius thirteen years after the virus was identified in that country<sup>9</sup>. Reasons for low prevalence are not clear,

although it has been suggested that they result from lower levels of patronage of female sex workers and a lower number of clients per worker in the Philippines<sup>10</sup> and Senegal<sup>11</sup>, and possibly as a result of early, intensive and ongoing prevention interventions.

National seroprevalence data for women sex workers, particularly in large countries, such as Russia (15%) and India (51%)<sup>12</sup>, should be viewed circumspectly, since local realities vary widely. Even in small countries such as Honduras (7.7%) and Madagascar (7.6%) there can be significant variations between sites.<sup>13</sup> Levels of HIV and STI among escort agency workers in Cape Town and brothel workers in Johannesburg are estimated to be much lower than the reported 69% in shantytowns around mines elsewhere in South Africa.<sup>14</sup> Likewise the 67% rate reported in 1991 for the rural province of Chiang Rai<sup>15</sup> was far higher than elsewhere in Thailand. Differences are often due to sites being rural or urban, but economic and cultural differences, mobility, access to services, and other factors can also be responsible.

### **Rates of infection – men and transgendered sex workers**

Although data pertaining to male and transgendered sex workers are not gathered as frequently as for women who sell sex, there is nonetheless evidence that these groups are particularly vulnerable. Some of the factors that determine women's vulnerability also affect men who sell sex, and may be compounded by factors such as sexual identity issues and homophobic violence and repression.

In Uruguay 9% of young male sex workers and 21% of transgendered sex workers are estimated to be HIV-positive, compared with 2% of female sex workers.<sup>16</sup> In Brazil one study showed seroprevalence of 40% among transgendered and 22% among male sex workers.<sup>17</sup> A Mexican survey showed 12.5% of men infected with HIV compared with 0.025% of women.<sup>18</sup> "Male transvestites" are identified as the group in Indonesia at highest risk of both HIV and syphilis.<sup>19</sup> A 1997 study of 76 boys and young men (11 to 17 years) in St Petersburg, Russia, found no condom use and frequent receptive anal sex. Fifty of the boys and men in the sample had STIs.<sup>20</sup>

### Rates of infection – clients

There are few studies of prevalence of HIV and STI among clients, perhaps because the sex industry is usually structured to preserve client anonymity. Methods such as collecting used condoms from brothels to test semen for HIV and STIs have sometimes been used but they are not regarded as cost effective or accurate. It is clear however that the extent to which men have unprotected sex with both high and low risk groups has a role in amplifying epidemics<sup>21</sup>.

In Thailand it has been suggested that 25% of truck drivers act as a bridge of infection between sex workers and their wives and girlfriends who are presumed to have few sexual partners.<sup>22</sup> Similar patterns have been observed among police, mototaxi drivers (pictured below) and the military in Cambodia<sup>23</sup>. In both Thailand and Cambodia it is very common for men to purchase sexual services, illustrating the significance of the size of this “epidemiological bridge” from high to low risk partners.



**Negative factors** impacting on HIV epidemics among sex workers and clients include:

- ?? social exclusion and low social capital among sex workers
- ?? poor working conditions determined by employers and others
- ?? mobility and migration
- ?? high number of clients per day
- ?? history of STIs
- ?? injecting drug use
- ?? exposure to violence <sup>24</sup>

**Positive factors** impacting on HIV epidemics among sex workers and clients include:

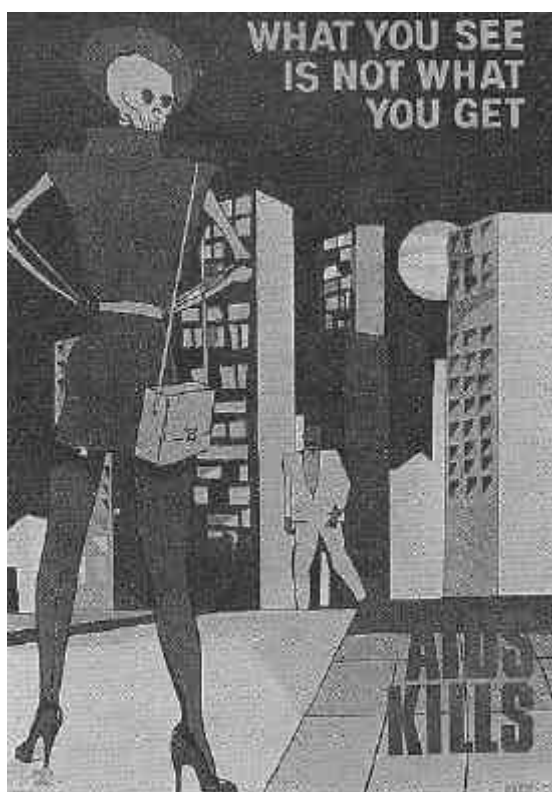
- ?? protective behaviours including condom use and non penetrative sex
- ?? access to primary health care and STI diagnosis and treatment.



## A PARADIGM SHIFT

In the early years of the epidemic, the association between multi-partner sex and HIV transmission led to sex workers and others, such as homosexual men, being labelled 'high risk groups'. Many early targeted interventions among high risk groups were not only unsuccessful, but often contributed to an increase in discrimination against already vulnerable people. They may also have contributed to complacency among general populations who mistakenly viewed HIV/AIDS as a disease of others. It is also likely that approaches that labelled sex workers as vectors of HIV infection also led to resistance and resentment from the very individuals whose co-operation and mobilisation were essential to successful responses.

These factors led to a backlash against "risk group" discourse in the 1990s. Unfortunately, the result was often not improved programmes but decreased and less effective investment in the populations who were both most vulnerable and who had a key potential role in slowing the growth of epidemics. Greater awareness of the size and shape of HIV epidemics has now generated a compelling case for re-focusing on commercial sex and other populations and environments that most affect epidemic dynamics, whilst avoiding the mistakes of the past.



*Women sex workers demonised in an early poster from Kenya*  
Kenya Ministry of Health

## A new conceptual universe

Relocating sex workers within a new conceptual universe of “people who participate in commercial sex” is central to the notion of this shift. This enables us to extend our focus to include clients, sex business managers, sex workers’ private partners and families, police, ancillary sex industry workers and others. Relocating sex workers in this way redistributes the responsibility to “use condoms” or “insist on condom use” that has too often been disproportionately assigned to sex workers. As well as being less stigmatising, this approach can lead to important new strategies such as sex workers functioning as educators for clients and others and negotiating work conditions. It can also involve a much wider range of stakeholders and extend and improve the quantity and quality of information and exert appropriate legal, political and social influence.

The key principles of a renewed approach to targeting include:

- ?? Responsibility for sexual health lies not only with sex workers but also with clients and third parties, government and the broader society.
- ?? The health and human rights of sex workers must be seen as both essential elements of overall HIV prevention strategies, and legitimate ends in themselves.
- ?? Commitment to working in partnership with sex workers requires a commitment to address social marginalisation, economic exclusion and violence, as well as a focus on health.

This means building programmes on strategies that address the “situations and structures which create vulnerability and deprive sex workers of their perceived right to live and work safely”<sup>25</sup>, such as violence and other human rights violations. Given the right inputs and an improved legal and policy framework, sex workers claim they can have a valuable role as educators and may even function as “part of the solution.”<sup>26</sup>



*Thai sex workers talking to clients about HIV*

Empower Foundation

## STRATEGIES

Three strategies currently characterise most programmatic responses to HIV and commercial sex:

- ?? individual / cognitive interventions
- ?? participation and empowerment
- ?? structural, policy and environmental interventions

### Individual / cognitive interventions

These are strategies that aim to increase preventative behaviours during commercial sex by influencing individuals' attitudes and normative perceptions and increasing their skills and knowledge. They include

- ?? providing accurate, easily understood information about how HIV and STIs are transmitted and how transmission can be prevented;
- ?? teaching risk reduction methods and skills such as the correct use of condoms, negotiation and communication skills; information about non-penetrative and lower risk sexual practices; what to do when condoms break; recognition of STI symptoms and where and how to access STI diagnosis and treatment;
- ?? increasing people's capacity to act on issues around sexual health by raising health expectations, encouraging self efficacy for behaviour change and reducing negative outcome expectancies concerning safe sex.<sup>27</sup>



*This peer educator in the Sonagachi project uses a flip chart and a condom demonstrator to talk to sex workers about their lives, health, families and sexual health*

DSMC Calcutta



*In Mongolia an easy to understand leaflet explains the basics of HIV and STI transmission to female sex workers.*

National AIDS Foundation, Mongolia

There is some evidence that these approaches alone can lead to some increases in protective behaviours. Like all marketing, success probably depends on reaching the right audience with the right message at the right time. However, it is important to remember that a high and sustained level of health promotion campaigns is required to prompt a sufficiently high rate of behaviour change in enough individuals participating in commercial sex to reach the critical mass that makes protective behaviours the social and industry standard.

### **Participation and empowerment**

Resources and co-ordination are required for communities to come together to plan and carry out specific activities. The priority should be for sex workers, rather than outsiders, to identify those factors that contribute to their vulnerability and marginalisation.

This means that a key strategy is building capacity in local NGOs to enable them to provide technical support that assists communities to identify issues and mobilise to change them effectively. Increased access to resources, raised collective self worth and solidarity are among the desired outcomes that help to reduce risk taking.

One of the key aims of community mobilisation is to increase the sustainability of projects by reducing the need for external inputs as capacity within communities increases. Examples of activities that aim to empower sex workers and stimulate community mobilisation include:

- ?? providing spaces where sex workers can meet and discuss issues and, ideally, communicate with others and gather information;

- ?? ensuring that peer support extends beyond sexual health education to include psychosocial support, referral and advocacy (peer education may be seen as a more limited cognitive intervention, although in fact it often also contributes to empowerment and mobilisation);
- ?? encouraging self-help groups and facilitating discussion processes by providing support for travel, one-off events such as World AIDS Day and cultural activities;
- ?? providing appropriate training and support for sex worker leaders so they develop the skills they need to organise in their communities and advocate on their behalf.

### **Enabling environment**

An enabling environment is where sex workers can live and work in ways that are most conducive to protective behaviours, including safe sex and accessing STI treatment. At work this means having access to condoms, supportive management, proper lighting, sanitation and security. Importantly it also means clients who know they will be expected to use condoms for penetrative sex and fellow workers who also provide only low risk services. Outside of work it can mean access to primary health care, adequate housing, equitable credit facilities, child care and freedom from various kinds of abuses. Where these are not in place, pressure on sex workers to provide risky services is far more difficult to resist.

Enabling environments can be stimulated by structural and policy interventions such as :

- ?? policy, law reform and actions that aim to make commercial sex workplaces safer and increase sex workers control;
- ?? policy, law reform and actions that reduce violence and corruption;
- ?? strategies for reducing the impact of violence, such as self-defence;
- ?? improved sanitation;
- ?? liaison with police and other influential authorities.;
- ?? ensuring sustained access to condoms, lubricants
- ?? ensuring access to appropriate STI diagnosis and care;
- ?? ensuring access to voluntary counselling, testing and HIV care and treatment;
- ?? childcare;
- ?? systems for generating and managing income.



*Sex workers at a self-defence class in Bangladesh*  
CARE

Structural interventions can be developed in different ways. Some prioritise the participation of sex workers and supporting them to mobilise around human rights and health within the context of the issues they define as most important. This is the approach in Sonagachi described elsewhere in this article. Other approaches involve police, brothel owners, local health authorities and others who already play key roles in determining how commercial sex operates, in enforcing compulsory condom use and mandatory STI diagnosis for sex workers. Operations research is currently examining the relative value of these approaches.<sup>28</sup>



*Sex workers and uniformed men attend an HIV/AIDS awareness-raising workshop in the Philippines.*  
HIV/AIDS Alliance.

## The Voice of Life

*Social capital is “the ability to secure benefits through membership in networks and other social structures.”<sup>29</sup>*

In Rio de Janeiro Horizons worked with a local sex worker community organisation, an NGO and a local research partner to establish and evaluate a community development project that aimed to increase solidarity and social capital among sex workers in three sites. Sex workers participated in all stages of the project. As well as designing and implementing the community development strategy and activities, they worked in teams that developed indicators and the instruments for qualitative and quantitative data collection.

Consistent with theories of social capital, the sex workers speculated that women who remained most connected to their families, neighbours and local clubs and institutions were most likely to consistently achieve protective sex while working and to access health care. The study’s baseline data also confirms claims by the sex workers’ rights movement that health outcomes are significantly affected by stigma and discrimination and that the causes of vulnerability are not addressed by a traditional health promotion approach. There is a clear association between safe sex and social inclusion defined as successful management of resources, maintaining relationships with family and community possession of official documents, savings accounts, health insurance and home ownership.<sup>30</sup>



*Sex workers in Rio de Janeiro have formed a choir called Voz da Vida – Voice of Life*

O Povo

## Operationalising

Success in operationalising a combination of the approaches outlined above depends on three main factors. The first is recognition that it is not enough to inform only sex workers about sexual health; clients and others must also be convinced of the value of safe practices. The second is that the working environment must change in ways that enable sex workers to put these ideas into practice. For “enabling environments” to exist, profound changes of policy, culture and law are required. The third is to involve sex workers at all stages of planning and implementing interventions, including where this participation requires substantial support and possibly adaptation of procedures.

Most interventions use some combination of approaches and many activities fall into more than one of the categories. For example, well managed participation of individual sex workers can lead to their empowerment which in turn leads to community mobilisation that stimulates changes toward a more “enabling environment”. However, information about *how* programme planners identify and implement the right mix is limited. Although several projects include health information, condom distribution, cultural events, outreach and advocacy, few can identify the cost of the various elements or their respective roles in project outcomes.<sup>31</sup>

While most agencies agree that sex worker participation is useful, and most would probably agree that in theory sex workers can be board members and researchers and international consultants, in practice few extend participation beyond peer education and some unpaid low skill services or perhaps home care.

Furthermore, intervention outcomes may be affected by external factors such as police raids, violence, mass media campaigns or high profile AIDS related deaths but the impact of these events is seldom analysed.

Nevertheless there are many examples of how combinations of these three strategies can achieve more protective behaviour and fewer STIs. These include:

?? A 1999 survey of 125 studies on casual sex in Latin America and the Caribbean concluded that there was an especially impressive high level of condom use with clients in countries where outreach peer education – an individual / cognitive strategy – and condom social marketing – an environmental / structural approach – were strongly coupled and implemented as complementary prevention strategies.<sup>32</sup>

?? A mix of the three approaches operates in a programme in India that promotes behaviour change among truck drivers, combining interactive education, street theatre, improving condom supply from non traditional outlets on truck routes, and



mobilising secondary stakeholders (sex workers) as peer educators. Condom use among the truck drivers during commercial sex rose from 27% to 67% over two years of operation.<sup>33</sup>

?? The Transex project in Papua New Guinea simultaneously addressed sex workers, clients and police by supporting formation of a sex workers organisation, initiating workplace policy development for private sector companies, establishing a hotline for clients and sex workers and advocating against violence by raising awareness of the links between violence and sexual health.<sup>34</sup>

?? A Nigerian initiative increased condom use and reduced STIs by addressing oil workers and the sex workers from whom they purchase services with lectures and interactive workshops on safer sex, while advocating around environmental issues with employers and mobilising the community through cultural activities and peer education.<sup>35</sup>



***Making Sex Work Safe: a guide for programme managers, field workers and policy makers.***

International Network of Sex Work Projects

The Asia Pacific Network of Sex Workers and the Alliance are currently producing a multi-media pack of Making Sex Work Safe. It will be for use by sex work projects throughout the region, including those who have little access to English translation. Alliance Ukraine's sex work project partners are also adapting the resource.

## Issues arising

Sometimes the individual / cognitive approach alone appears to work, as with well designed and funded educational strategies supported by trained peer educators and client demand for protected sex stimulated by mass media or other targeted campaigns. However, when analysing the results of interventions, a broad range of factors must be taken into account.

After a peer education intervention among transport workers in Senegal, sex workers from whom the target group purchased services reported a rise from 2.2% to 42.2% of clients agreeing to condom use and fewer offering more money for unprotected sex.<sup>36</sup> However a Mumbai project with a similar approach did not produce the expected results, which was attributed to a lack of access to services.<sup>37</sup>

In Cambodia, prescriptive or “top down” educational methods were identified as having limited the success of a campaign that reached 10,000 female sex workers in 800 establishments but failed to increase protective behaviours to the expected levels. Sporadic coverage and targeting sex workers but not the many other people who influence commercial sexual transactions were noted as problematic.<sup>38</sup> And in KwaZulu-Natal, South Africa, high rates of STI persisted among HIV positive sex workers despite monthly STI treatment and condom counselling, suggesting that this approach may be too limited.<sup>39</sup>

There are several possible explanations where projects do not achieve their aims. Some lack intensity and fail to reach enough people in a sufficiently sustained way, for example in terms of frequency of visits by outreach workers and numbers of condoms distributed. In Bali a multi-site study showed that while a mass media campaign and sexual health promotion activities for sex workers increased HIV knowledge among sex workers and clients in all sites, the largest increases in knowledge and declines of STIs among sex workers occurred where the intervention was most intensive.<sup>40</sup> A well established intervention for male sex workers in Morocco that offers counselling, psychological support and solidarity building activities has resulted in a steady increase in condom use (from 22% to 69%) among young men using the project over a five year period. Service users who use condoms least were those with the least exposure to the “empowerment” aspects of the project, often as a result of their mobility.<sup>41</sup>

Sometimes where successful projects appear to have a single approach, closer examination reveals that other components are also functioning. For example a programme in Mexico City that raised condom use in a group of more than three thousand female sex workers was reported as condom social marketing (structural / environmental); however there was strong participation from a sex workers’ organisation, an empowerment / mobilisation element that almost certainly had a strong impact.<sup>42</sup>

## Community Mobilisation in Calcutta

A group of sex work projects in the Sonagachi district, Calcutta's largest red light area, has strong elements of all three approaches. Features include: involvement of sex workers from the outset, support for the workers' demands for human rights and recognition of sex work as a valid occupation, and support for several self-help initiatives.

Community organisations involving partnerships of sex workers, health professionals, technical advisors and sex workers' private partners have emerged. These focus on raising social capital through increased solidarity as the key to increasing workers' access to resources and reducing their social and legal exclusion. Activities include literacy classes for sex workers and their children; a peer outreach programme; an STD and general health clinic; social support services; a cultural programme; a credit co-operative; and a human rights organisation that advocates and mobilises on sex worker issues locally, nationally and internationally. The sex workers have also formed a self-regulatory body to reduce child and forced prostitution in the brothels. The age of workers has risen and there are less women being bought to the area by traffickers. These initiatives, claim the women, are far more effective and popular than police and NGO effort to "rescue" women by conducting violent raids.

During the first five years of the project STI rates fell from 75% to 49% while condom use rose from 35 % to 52%.<sup>43</sup> The project has gradually expanded to bring street sex workers into the various cultural, educational and clinical services. The incidence of condom use rose from 3% to 52% and STIs declined from 75% to 49% in the first year of this expansion.<sup>44</sup>



More than 30,000 women are members of a credit co-operative that offers financial services

Asia Pacific Network of Sex Workers

### **Common components of successful programmes**

- ?? effective identification of the target group, including clients and third parties
- ?? accurate situation analysis
- ?? participation of community or target group
- ?? technical support for community mobilisation
- ?? new and different ways of presenting information
- ?? reaching sex workers early in their worklife
- ?? neutralising negative impact of third parties or enlisting them in the programme
- ?? promotion of safer sex including negotiation skills
- ?? ensured supply of condoms, lubricants and basic medications (antifungals, contraceptives, syringes etc)
- ?? social support to increase bargaining skills and negotiation power, including attention to human rights and supplementary sources of income
- ?? promotion of health-seeking behaviours and accurate health-related knowledge and beliefs
- ?? sensitisation of relevant professionals including NGOs, medical staff and police
- ?? advocacy at policy level supported by recognised health, human rights and women's organisations.
- ?? linking care with prevention and addressing the rights of people living with HIV/AIDS
- ?? effective monitoring and evaluation with community involvement

### **Impact on the community**

Despite many examples of local level success, such as behaviour change among service users, there are few examples of programmes targeting commercial sex having reduced HIV nationally except in industrialised countries such as New Zealand, Canada and north western Europe. In such settings the rule of law generally applies, sex workers and others have access to affordable primary health and STI care, and clients are reached through sustained campaigns directed at the general public. Nonetheless, there are examples from developing countries where reducing or containing HIV transmission during commercial sex has had a significant impact on the broader community. These result from appropriate policy and interventions which achieve an appropriate and intense combination of strategies and activities.

Since 1991 Senegal has reported substantial risk reduction and lowered STI rates in its general population. These have been attributed to a combination of factors, including interventions targeting sex workers; universality of male circumcision; lack of alcohol use; less sexual networking than in many other countries and a tradition of community involvement in health and development issues. Crucially, this approach involves many layers of the community, including religious leaders and the government, which invested in HIV prevention from an early stage by strengthening STI services, supporting educational programmes and ensuring that condoms were freely available.

In Senegal sex workers report condom use of 99% with the last client and an impressive 60% with private partners. However, sex workers report an average of 2.2 clients per week<sup>45</sup>, suggesting that many earn income from other sources. This supports the notion that vulnerability is lower where commercial sex is not the sole source of income and illustrates an important role for socio-economic interventions which are unlikely to lead to the end of sex work but can form part of a comprehensive risk-reduction strategy. This is a particularly important issue in places where stigmatisation of sex workers means that they are excluded from earning income from any other source.

Meanwhile, improved health among sex workers has been associated with reduced STI rates. Rates in men attending clinics outside the capital city, Dakar, are higher than among men attending clinics in the capital, where education and support services interventions have been strongest and reached more sex workers.<sup>46</sup>

In South Africa a study examined STI rates among miners following presumptive STI treatment of 'high risk women' (defined as women with at least three non-regular partners and women who are paid for sexual services). Rates among men in the intervention area were far lower than rates among those far from the intervention site<sup>47</sup>. A similar trend has appeared in West Bengal where preliminary findings show men in closer proximity to the Sonagachi red light district have fewer STIs than in other parts of the state.<sup>48</sup>

Despite these promising signs, tools for measuring the wider impact of reduced risk taking during commercial sex remain weak. Thailand, among other countries, has interpreted reduced rates among military recruits as evidence that interventions among sex workers are successful.<sup>49</sup> In Cambodia epidemiologists rely on perceived decreases in sales of antibiotics to men in and near commercial sex intervention sites to indicate reduced STIs among clients of sex workers.<sup>50</sup>

## 100% condom use policy



*Sex workers demonstrating against UN support for 100% condom use programmes*

International Network of Sex Work Projects



*Sex workers arrested during raids on the Boeung Salang brothels in Phnom Penh, Cambodia which have a 100% condom use programme including regular mandatory STI examinations for sex workers, despite assurances by the authorities that co-operation with the programme would prevent such raids.*

Programmes mandating 100% condom use in brothels have been highly praised by such organisations as UNAIDS but they have been censured by sex workers organisations who dispute claims that the policy has successfully reduced HIV/STI rates among sex workers and their clients in Thailand and Cambodia. They allege that the policy places sex workers at increased risk and threatens their human rights as well as being rendered ineffective by police and political corruption.

A recent Horizons study in the Dominican Republic measured and compared different structural interventions. In the capital, Santo Domingo, 34 sex establishments were involved in peer education, condom distribution and health promotion, with solidarity building activities among sex workers, owners and staff. The aim was to create an enabling environment where condom use would become the norm. In the city of Puerto Plata, these elements were implemented in 34 sex establishments together with a regional governmental policy requiring condoms to be used in each commercial transaction and monthly STI tests for sex workers. The policy is enforced with a graduated sanction system against establishment owners, including inspections, fines for repeated non-compliance and certificates for compliance.

Condom use increased and STI rates decreased impressively in both places, clearly indicating the success of the core intervention of components. There was also a slightly greater reduction of STIs among sex workers in Puerto Plata (29% – 16%) than in Santo Domingo (25% – 16%). However this discrepancy may be due to increased condom use with regular partners (, from 15% to 18% in Santo Domingo and from 13% to 19% in Puerto Plata) which would suggest that government sanctions may not be primarily responsible for positive outcomes as had been anticipated .<sup>51</sup>

## CHALLENGES

Prevention programmes that only focus on the broad categories of “commercial sex” or “sex worker” may miss key sub-populations. As much as possible, interventions should research, increase understanding of and respond to the characteristics, behaviours and issues of sex workers made more vulnerable by social status, youth, drug use, culture, religion and other factors that may compound HIV risk and / or present opportunities for service delivery and community mobilisation.

### Gender

It is important to remember that transgender and male sex workers have specific vulnerabilities to HIV as well as to violence and other abuses of their rights. They are routinely excluded from health care and from safer workplaces. Access to surgery, injectable hormones and other feminising products also raise specific prevention challenges. However, transgender sex workers have made significant contributions to community mobilisation for HIV prevention in many places, not just amongst themselves but as leaders in broader communities of sex workers and men who have sex with men.

Men sex workers face particular challenges, including lack of structure (male brothels exist in relatively few countries), sexual identity issues, less networking and therefore lack of mutual support, and vulnerability to violence and blackmail resulting from perceptions of their adopting “unmasculine” behaviour. Embarrassment often prevents male sex workers from seeking care for sexual health problems, in particular infections in the mouth or anus and medical personnel often do not recognise infections or are unwilling to treat them.



*Transgender sex workers are often community leaders*

*P.Longo.*

One way to approach health issues related to commercial sex is to understand sex work as an occupation in which HIV prevention is a logical part of a health and safety package. In all industries, conditions are most dangerous where workers are powerless and there is no effective regulation or control over employers. This is the case in commercial sex almost everywhere, as the economic and social powerlessness that may precipitate the decision to sell sexual services also renders people powerless and vulnerable in the sex industry.

While health professionals have seen sex workers within many different sociological frameworks, recent experience shows that sex workers are more likely to self-identify as workers and to mobilise for labour and civil rights. In many places this process is being informed by the experience of trade unions, which have generations of experience of mobilising people whose primary linking factor is their work.



*This pamphlet provides advice on working conditions, law, health and other issues for women who have migrated from Africa to Europe.*

TAMPEP



## Migration and mobility

Migration (from one place to another) and mobility (to one place then another and another) for commercial sex is as old as history. In recent years it has increased, both between and within countries. Migration and mobility for commercial sex may be voluntary or forced, independent or through agents. It may even be legal and organised, as when armies openly send sex workers to their soldiers, or involve bonded labour and slavery-like practices in which people are either tricked, coerced or consent to different degrees.

Unfortunately the issues around migration and mobility of sex workers are clouded by moral and philosophical debates that focus on “trafficking in women” and the data is accordingly unreliable. Information is often limited to women under arrest and / or threat of deportation and is further complicated by policies that accord benefits such as repatriation and welfare payments to “innocent” victims of trafficking but not to “voluntary” sex workers.

Sex workers who migrate or are mobile are often at higher risk than local sex workers<sup>52</sup>. They often work in those parts of the sex industry where workers are least powerful. Their access to services and information is often limited by lack of civil and legal status; restricted freedom where they are bonded or trafficked; language limitations; as a result of cultural barriers; or as a result of mistrust and fear of authorities.

In some places migration patterns are well established and sex workers can join relatively supportive communities that provide some access to information. Ukrainian women, who are estimated to make up 90% of sex workers in Moscow, benefit from such a community.<sup>53</sup> The same is true of women from Côte d'Ivoire in Ghana<sup>54</sup> and for Latin American transgendered sex workers and young male sex workers throughout Europe<sup>55</sup>. However, many sex workers do not benefit from such support and many are abused<sup>56</sup>.

Some programmes have found ways to build on existing support and information dissemination systems among mobile sex worker populations.<sup>57</sup> TAMPEP in Western Europe has pioneered a system of “cultural mediators” who contact sex workers from developing countries and provide useful information about local language and culture and link them with health providers and other services. They also work with mobile sex workers to develop and distribute information and provide support during legal proceedings and repatriation.<sup>58</sup> In less developed settings it may not be possible to provide services as costly as TAMPEP's, but more work could be done on adapting such methods to resource poor settings.

Client mobility also has an important role in transmission of HIV during commercial sex. Truck drivers, military and labourers working away from home and staying in barracks or hostels have

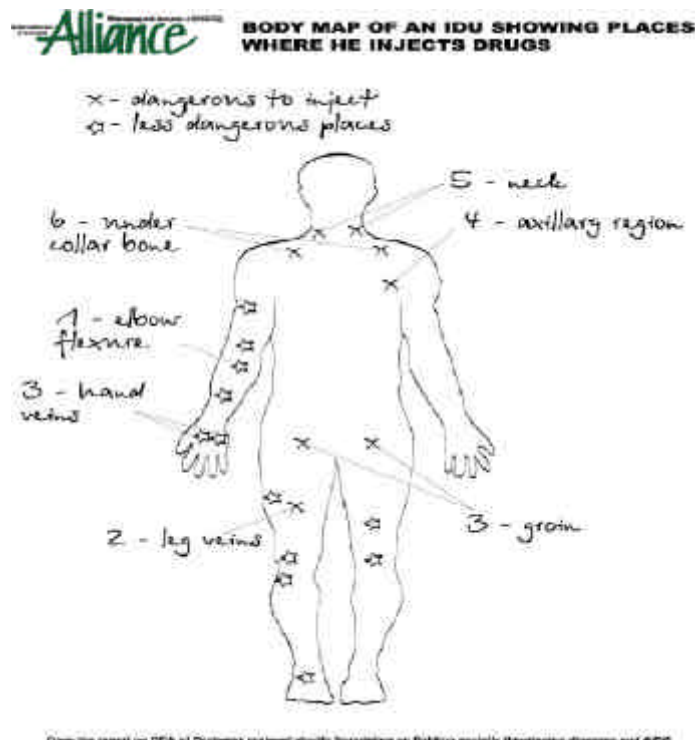
all been identified as having a significant role in increasing HIV and STI levels among sex workers and their wives and regular sexual partners, often in the communities to which they move on or return.<sup>59</sup> One exception is Uganda, where travellers' higher sexual risk appears to be offset by greater knowledge and acceptance of condoms.<sup>60</sup>

## Drug Use

Many sex workers inject drugs for pleasure or to administer medicines. In many places harm reduction measures need to be specifically developed to ensure that sex workers are able to access syringes and information about how to avoid infection.

Where sex workers are addicted to drugs there are clearly increased risks of contracting HIV through needle sharing and transmitting it during unprotected sex. Increased access to drug services such as detoxification and drug substitution programmes that are appropriate for women is crucial. These may need to take childcare and reproductive health issues into consideration in ways that services for men do not. Separate services, especially residential treatment may be necessary to ensure that women are treated without threat of harassment.

In recognition of the male emphasis on education for women who inject, the Alliance Ukraine held a series of sessions where women adapted a tool (the body map below) that had been designed for men to learn more about safe injecting. The women's map (see photo overleaf) extended to include reproductive health and parts of the body most vulnerable to violence.



From the report on PCA of Dismantling Harmful Industry Practices on Fighting sexually transmitted diseases and AIDS



*Women in Ukraine with their adapted body map*

International HIV/AIDS Alliance Ukraine

### **Other factors**

Many other factors affect health-seeking and sexual behaviours. Access to STI and HIV treatment is affected by long journeys to clinics and long waiting times, judgmental attitudes of health workers, unsuitable hours, lack of attention to other primary health care issues, and lack of appropriate medicines and diagnostic techniques. Sex workers' reluctance to describe STI symptoms and prejudice that makes doctors unwilling to examine sex workers frequently limit the effectiveness of STI diagnosis, particularly in syndromic management.<sup>61</sup> Self-medication, including antibiotic use for STI prophylaxis and treatment and the use of "folkloric" medicines to prevent or cure AIDS, can be harmful and can detract from motivation for barrier protection<sup>62</sup>.

Cultural attitudes may affect sexual behaviour. In Sub-Saharan Africa and parts of the Americas more than thirty substances have been identified for inducing vaginal tightening and abrasion, which are associated with increased likelihood of HIV transmission.<sup>63</sup> Transgender sex workers in Bangladesh and Malaysia cite religious taboos as a reason for a preference for anal rather than oral sex.<sup>64</sup> In Niger sex workers often wear "gris – gris" amulets in the belief that this would protect them from disease.<sup>65</sup>

## Repackaging Safety and Pleasure

Safe sex messages are often limited to stressing the importance of using condoms and their correct use. This information may be too limited for sex workers, even when it is delivered by their peers. When faced with the apparent option of safer sex but fewer clients or unsafe sex and high income, sex workers almost invariably, and understandably, opt for the latter.

For safer commercial sex to take place, sex workers need a range of skills and information that maintains, or even increases, income, while reducing vulnerability to HIV through unprotected vaginal and anal sex. This means promoting and negotiating a variety of services that reduce physical and psychological wear for the sex worker at the same time as maximising the client's pleasure and being STI and HIV protective, such as oral sex and external ejaculation. Popular notions about sex workers' powerlessness to sell safer sex should be tempered by the fact that adventurous and innovative non-penetrative sex is often very popular with clients as well as being safe.

The kind of skills required to repackage safety and pleasure cannot be learned in prescriptive sessions that train peer educators in the mechanics of condom use. Such skills can only be achieved by sex workers and peer educators regularly sharing ideas gained from experiences with clients. The Alliance has developed a series of participatory tools sex workers can use for such skills sharing that help overcome barriers such as stigma, embarrassment and lack of sexual vocabulary. Humour is always a key tool.



*Practising safe sex positions at a training session in Bangladesh to share “tricks of the trade”*

International HIV/AIDS Alliance

## Linking prevention and care

Making appropriate care and treatment accessible to all people with HIV not only minimises suffering and reduces deaths but is central to HIV prevention. Care settings present an opportunity to provide condoms, health information, STI services and counselling. As access to antiretroviral drugs increases, treatment that reduces viral loads and improves general health results in reduced transmission. The challenge of increasing access to antiretroviral drugs in developing countries will extend in the coming years to increasing access for sex workers and other marginalised populations.

These challenges begin with testing sex workers for HIV. Voluntary confidential testing and counselling which is helpful and relevant rather than directive and condemnatory, is not available to most sex workers in developing countries, despite many years of studies that demonstrate its importance.

For sex workers who test positive for HIV a complex range of issues arise, some universal and some specific to the setting. The primary issue is undoubtedly stigma and discrimination against people living with HIV/AIDS, arguably at its worst when directed at sex workers, particularly women. Throughout the HIV pandemic there has been a consistent stream of media coverage condemning HIV-positive sex workers, regardless of their attempts to use condoms and other protective behaviours, while seemingly overlooking male clients' role in commercial sex and responsibility for sexual health. Similar views have been repeatedly expressed by courts and many jurisdictions punish women living with HIV/AIDS for selling sex.<sup>66</sup> The idea of the sex worker as a "grim reaper" spreading death to apparently innocent men has even appeared in HIV prevention campaigns. Male sex workers are not usually subject to the same condemnation, perhaps because their clients are perceived as less valuable than the men who buy sexual services from women.

As with others living with the virus, HIV-positive sex workers often need counselling and support through the process of making difficult decisions about work, family and personal issues and how to access treatment and care. The decision to continue working or change occupation is often influenced by the fact that an HIV diagnosis does not increase employment opportunities, even for those who would prefer to discontinue sex work or those in the wealthiest countries. Periodically NGOs and governments have tried to create alternative employment for HIV-positive sex workers but these have not been sustained. In addition, sex workers may sometimes be denied access to care and support unless they promise to stop selling sex. This excludes a group which may benefit most from linked care and prevention<sup>67</sup>.

The increasing availability of antiretroviral drugs in developing countries, even though still limited, raises an important opportunity to link prevention and care, not least because they can reduce the amount of HIV to levels that significantly reduce the chance of transmission. However sex workers' organisations have raised concerns that sex workers will have less access to antiretrovirals than others, as they do to most resources. The need for medication to be taken with full compliance, often in regimes that are difficult to manage, may play an important role in how they are delivered to sex workers. Stigma could lead to sex workers not accessing antiretroviral drugs where doctors perceive them as potential "non-compliers".

Non-compliance is associated with low literacy, injecting drug use and other factors that lead some people living with the virus, including some sex workers to "default" on health care agreements. This raises the need to develop both commitments to delivery and strategies to overcome reduced compliance among sex workers and other marginalised groups such as injecting drug users. The success of such strategies depend on developing knowledge, understanding and communication between health workers and people living with HIV. Innovative planning, based on knowledge of the community should be underway even before antiretrovirals are fully available. The model of treating tuberculosis by direct observation contains some relevant lessons about adapting the treatment to the needs of the community. Perhaps the most important of those lessons is the success of any strategy will be determined to a large extent by the attitudes of the health workers who deliver it and the degree of empathy they have for the community and the individual people living with HIV/AIDS.

### **Informal commercial sex**

Much more is known about how to promote sexual health among sex workers in the formal sex industry such as brothels and recognised "red light" districts than to those who sell sex informally or occasionally.

Informal sex work is less structured and less likely to be carried out with fixed hours, services and prices. Even where the formal sector is well established, people buy and sell sex informally for many reasons, including when their drug use, age, mobility or legal or gender status prevents them working in the formal system.<sup>68</sup> Sexual services may not be "marketed" – offered in hope of a sale – but sold only when the opportunity arises or as a supplement to another 'legitimate' service such as hairdressing or bar work.

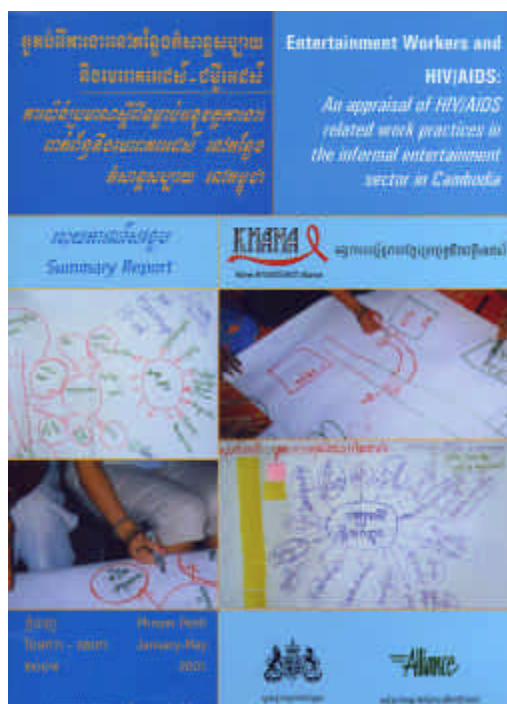
The various physical, environmental and psychological factors involved in informal commercial sex have important implications for both policy and programming.

There are various incentives for buyers and sellers to avoid identifying certain behaviours as prostitution or sex work, so participants may or may not recognise the commercial nature of transactions. Women who want to avoid stigma perhaps spend

more time with each man, often integrating the time into social life or other services. Clients may want to reinforce the non-commercial aspect of the relationship, including maintaining the rituals of desire or affection. The characteristics of a private rather than commercial transaction may be preserved in such situations by the exchange of gifts and other resources in place of cash, and by unprotected sex. For some men the division between commercial and recreational sex is even less clear, with less attractive potential clients more likely to be asked for money than those deemed attractive.

Even for those who self-identify as sex workers there can be substantial incentives to avoid the formal sex industry. Working informally may help avoid overhead costs, legal risks, poor work conditions and, in some cases, compulsory medical examinations.

There is evidence for example that the informal sex industry has grown in Thailand during the years since the introduction of the 100% condom policy<sup>69</sup>. Calcutta has, in addition to the large brothels with successful prevention programmes, many “floating” sex workers outside that system<sup>70</sup>. Even where formal commercial sex is legal or tolerated, informal systems often continue to expand. This means that programmes for formal sex industry sectors will often need to be complemented by services that reach people in these less structured relationships. It also means that claims of success in HIV prevention in formal sex industries should be carefully analysed, in view of the possibility that some of the success may be attributable to vulnerable sex workers having relocated to informal and more hidden forms of sex work.



*Informal sex workers used participatory tools in the process of planning an intervention with KHANA, the Alliance linking organisation in Cambodia.*

KHANA

Providing services to informal sex workers is a particular challenge, partly because of the more clandestine nature of the work and partly because the demographic and behavioural information that programme planners usually require may not be available. The situation itself is often fluid and programmes that reach the formal sex worker sector, such as peer education outreach visits and dedicated clinics, may not be appropriate.<sup>71</sup> Informal sex workers are therefore often reached by programmes targeted at proxy groups such as “bar girls”, “hairdressers”, or “garment workers”. Young men who sell sex are sometimes reached by projects aimed at out of school youth, drug users and others.<sup>72</sup>

Identifying a proxy group can avert the need for detailed investigation and labelling, which is potentially expensive, intrusive, stigmatising and alienating. Prevention agencies may therefore be able to more effectively and quickly develop services and programmes for populations described by the Network of Sex Work Projects as “hard to reach because they want to be hard to reach.”

For focused programming to be worthwhile, a sufficient percentage of the proxy group should have the behaviours or characteristics of interest. Programmes may fail if information about STIs offends or alienates members of the group who do not have those behaviours or characteristics. Another way to focus is to treat everybody at a particular place as a proxy for sex workers, clients and third parties. This is only appropriate in certain circumstances, for example in truck stop/nightclub/motel complexes or entertainment areas that double as a red light zone. Military bases and other places where men stay away from their families are often a good example of a tight proxy for “clients of sex workers”.

In a country such as Cambodia, where there is evidence of a large and fluid population of informal sex workers and “sweethearts”, primary health care providers may have an important role in reducing STIs and referring women for voluntary counselling and testing and other support. For this to work well, awareness-raising and skills training among health workers has to take place. This may be easier said than done where convincing health workers to recognise and deal in a non-judgemental manner with women who may have multiple sexual partners symbolises a significant departure from the value of women’s chastity in the broader culture.



## Rehabilitation or Rights?

There is considerable pressure on NGOs to help women leave the sex industry. At best, this recognises women's fundamental right to choose with whom and how they have sex. However, its role as an HIV prevention strategy requires closer examination in the light of what we know about the impact of partner reduction. It is problematic to assume that people are automatically less vulnerable when they simply stop charging for sex. In all but the lowest seroprevalence environments, partner reduction delays HIV acquisition, but not sufficiently to prevent expansion of the epidemics.

Rehabilitation, or "exiting", interventions are particularly difficult to justify in terms of HIV prevention because they do not take into account the likelihood that sex workers who leave the industry will be replaced by others who will acquire the virus in a market where demand has not changed. Rescue and rehabilitation of female sex workers is controversial because often women are abused during police raids and held in very bad conditions against their will. The Sangram project in Sangli, India, raises issues about women's choices in the concept of rehabilitation, questioning whether there is any discussion on choices, the options given to women facing rehabilitation, whether they are asked where they want to be relocated and with what resources<sup>73</sup>.

This is not to say that there is no role in HIV prevention for programmes that support sex workers to generate income from sources other than sex work. "Sex workers who do not rely on sex work as their only source of income are less likely to acquire HIV than those who do. Additional sources of income are particularly important where sex work is seasonal or very poorly paid and where there is no social welfare system."<sup>74</sup> On this analysis the value of supplementary income is not in partner reduction in itself, but on placing sex workers in a better position to refuse clients or only work in places they feel safest.



*"Don't talk to me about sewing machines. Talk to me about workers' rights". Asian sex workers express their preference for workers' rights over rehabilitation programmes.*

Asia Pacific Network of Sex Workers

## REPLICATION AND EXPANSION

Despite agreement that well conceived and implemented interventions can play a key role in reducing transmission of STIs and HIV during commercial sex, and that doing so will prevent significant numbers of AIDS cases in broader populations, interventions do not currently reach enough people involved in commercial sex to have the required impact. Individual interventions such as those in Calcutta and Mumbai give impressive results, but such interventions reach only approximately 20% of sex workers.<sup>75</sup> Unless that changes, HIV rates among sex workers, clients and general populations will continue to rise.<sup>76</sup>

To meet the challenge of implementing and sustaining successful interventions on the scale required to reduce epidemics, lessons must be learned from current programmes and adapted to new places. Lessons are beginning to emerge about how to adapt programmes to take forward this process of 'scaling up'. A project in Yaounde, Cameroon, was replicated in five other cities throughout the country. Savings on start up costs were identified as a key benefit but varying levels of cost effectiveness and outputs were attributed to inherent differences between the sites that had not been properly considered.<sup>77</sup>

Project workers have made similar observations in South Asia about replication of the Sonagachi project. The 'inherent features' of Sonagachi include a relatively homogeneous target group, who mostly live and work in the project area, and who self-identify as sex workers. The project attracted adequate financial resources and considerable political and NGO support both from within India and internationally. Additionally, West Bengal has more favourable political and cultural traditions of human and labour rights than many other places. In the different conditions of Bangladesh, replication of the Sonagachi 'model' has not been as successful as was hoped and substantial adaptation has had to take place in the course of the project.<sup>78</sup>

### **Participatory Site Assessment**

The International HIV/AIDS Alliance has developed a method for involving communities in understanding and responding to their vulnerabilities to HIV and STIs. Participatory Site Assessment (PSA) is both a process of identifying appropriate interventions and an intervention in itself, mobilising representatives from populations central to the HIV epidemic, such as sex workers, men who have sex with men, injecting drug users and people living with HIV/AIDS. These representatives work with NGOs, preferably in teams where the population representatives are in the majority, in a number of activities designed to generate and analyse information relevant to the target population and their environment.

Site assessments generate both quantitative and qualitative information, such as a geographic definition of the site, estimates of numbers and types of key populations, patterns of mobility and

behaviour. They also identify existing service providers, their coverage and the perceived quality of services provided. HIV prevalence and STI rates are accessed where possible through secondary sources and from service provider records. Information about attitudes and behaviour of the general public to the key populations is also generated to determine issues such as levels and types of stigma and violence.

Information from participatory site assessment not only informs NGO, public and private sector focused HIV prevention planning and promotes collaboration, but stimulates the confidence and growth of supportive networks and groups of people from the key populations themselves.

The advantages of a participatory approach in site assessment for sex workers are that:

- ?? the assessment helps to develop project ownership, contributing towards individual and group empowerment;
- ?? numbers are likely to be more accurate - sex workers on the research team know who to approach and where to go;
- ?? mechanisms such as interactive visual tools mean greater triangulation — gaps and double counting become evident;
- ?? without the insider knowledge provided by sex workers, standard methods of observation and counting will miss key secret and taboo behaviours.

### **Participatory Research and Action**

Allied to PSA is Participatory Research and Action (PRA), a set of methods and tools enabling communities to articulate their objectives and priorities, describe and analyse their environment and develop strategies for action.<sup>79</sup> PRA workshops use mapping, drawing and performance rather than didactic learning techniques such as lectures. These methods are particularly well suited to make the mechanisms of developing and operating projects - committees, proposals, reports, meetings etc. - more accessible to sex workers who have local knowledge but little or no formal education.

By promoting and consolidating community ownership of what might be perceived as imposed and even threatening initiatives, productive and fair relationships between “insiders” and “outsiders” can be fostered. The potential benefits of such an approach are clear in the commercial sex milieu where outsiders are routinely treated with suspicion and where “social capital” is often very low.<sup>80</sup>

## **PRIORITIES AND POLICIES**

HIV transmission during commercial sex in less developed countries could be reduced in the long term by poverty eradication and democratic institutions ensuring social and economic justice, especially for women. Clearly this will not occur quickly enough to curb the pandemic. Nevertheless, the tested strategies outlined in this paper have been shown to reduce HIV transmission risk behaviour sufficiently to minimise local and national epidemics.

Key interventions include:

- ?? Health education and information about HIV and sexual health that reaches sex workers, clients and the broader population.
- ?? Peer education and community mobilising efforts that build “social capital” and positively influence community norms regarding protected sex.
- ?? Social, legal and psychological support for female, male and transgender sex workers, including specialised support for those who are subject to debt bondage or other constraints such as illiteracy, mobility or drug addiction.
- ?? Access to appropriate medical services, condoms, lubrication, water and other prevention tools.
- ?? Policies and laws that reduce sex workers’ marginalisation and vulnerability to exploitation. Such policies include: fair and ethical regulation of health and safety in the sex industry; formal recognition and protection of civil rights and equal access to housing and education for themselves and their children.

### **Working with governments**

Given the subject matter it is understandable that there are many differences of opinion and gaps in knowledge about how to prevent HIV transmission during commercial sex. Moral and political resistance to policy that may be construed as supporting commercial sex frequently underpins lack of political will. Raising awareness among governments about the value of investment in locally appropriate ways of preventing HIV during commercial sex is a key process in which the International HIV/AIDS Alliance has considerable experience.

Service providers and policy makers need to develop tools for analysing and responding to the health issues involved in commercial sex. In a few countries the capacity building needed to scale up national programmes appears to be primarily technical. In Brazil, for example, established sex work projects throughout the country and sex workers form an advisory committee to the National Aids Programme.<sup>81</sup> In such countries technical support should include improving access to tools for information exchange and providing training support and equipment for partnerships of sex workers, health professionals (in both targeted interventions and general health agencies) and policy makers.

In other places traditions, stigmas and environmental features place severe limits on programme and policy development. In the Russian Federation doctors in STI clinics frequently forbid sex workers to sit on chairs used by other people and there are reports from Bangladesh that doctors cover their mouths when speaking with sex workers to avoid “contamination”.<sup>82</sup> To build programmes under these conditions attitudinal and human rights issues must be first addressed by local people, including sex workers, who have had the opportunity to develop responses to obstacles of this kind.

### **Networking and participation**

New and innovative techniques are required to develop research and evaluation methods. Protocols should be standardised and better dissemination of results should take place at local and national levels so that the benefits of lessons learned are further distributed. With the exception of some research and prevention projects in the European Union, no regional network of sex worker projects has been sustained. Only a handful of meetings and conferences about sex work have been held at regional or national level since the beginning of the pandemic. Two global conferences of sex worker organisations have taken place since 1986 but developing countries were hardly represented at either. Most reliable literature about commercial sex and health is in English-language medical journals and there are few training manuals. *Making Sex Work Safe*, the Network of Sex Work Projects 1998 handbook guide to programme development in English, Spanish and Russian, is an exception but demand for this basic manual outstrips supply<sup>83</sup>.

Meaningful sex worker participation can help stimulate demand from the commercial sex milieu for sustainable sexual health programmes. To be effective, sex worker involvement in programme planning and implementation must have genuine support from health professionals and relevant others and be based on partnerships in which sex workers’ actual and potential expertise and human rights issues are recognised. Ongoing and thorough informal education, rather than one-off training events, for sex workers who are interested in policy and programmes but who have had little or no formal education, should be developed and integrated into a broad range of health and development interventions.

At targeted intervention level, innovative methods of situation assessment and project implementation that have been used among recognisable and/or fixed sex worker communities should be expanded. This expansion should be to both more places and broader target groups, including fluid or mobile populations that sell and buy sex away from formal commercial sex settings. The value of building local capacity to advocate on policy issues and to deliver services that meet community priorities should be recognised alongside more traditional approaches to public health. Together, these approaches should elicit the support of enough people engaged in commercial sex world-wide to “buy in” to sexual health projects to make a difference to global outcomes.

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