



Implementing Comprehensive HIV/STI Programmes with Sex Workers

PRACTICAL APPROACHES FROM COLLABORATIVE INTERVENTIONS

Implementing Comprehensive HIV/STI Programmes with Sex Workers

PRACTICAL APPROACHES FROM COLLABORATIVE INTERVENTIONS

WHO Library Cataloguing-in-Publication Data

Recommended citation:

World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, The World Bank. Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions. Geneva, World Health Organization, 2013.

1.Prostitution. 2.HIV infections - prevention and control. 3.Sexually transmitted infections – prevention and control. 4.Sexual partners. 5.Unsafe sex. 6.Sexual behavior. 7.National health programs. I.World Health Organization. II.UNFPA. III.UNAIDS. IV.World Bank. V.Global Network of Sex Work Projects (NSWP).

ISBN 978 92 4 150618 2

(NLM classification: WC 503.7)

© World Health Organization 2013

All rights reserved. Publications of the World Health Organization are available on the WHO web site (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press through the WHO web site (http://www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Layout L'IV Com Sàrl, Villars-sous-Yens, Switzerland.

Printed by the WHO Document Production Services, Geneva, Switzerland.

Contents

Acknowledgements	vii
Acronyms and abbreviations	x
Glossary	xii
Introduction	xiii
Chapter 1 Community Empowerment	1
1.1 Introduction	4
1.2 Key elements of community empowerment	5
1.2.1 Working with communities of sex workers	7
1.2.2 Fostering sex worker-led outreach	8
1.2.3 Developing sex worker collectives	9
1.2.4 Adapting to local needs and contexts	10
1.2.5 Promoting a human-rights framework	11
1.2.6 Community systems strengthening (strengthening the collective)	12
1.2.7 Shaping policy and creating enabling environments	14
1.2.8 Sustaining the movement	15
1.3 Monitoring progress	16
1.4 Resources and further reading	18
Chapter 2 Addressing Violence against Sex Workers	19
2.1 Introduction	22
2.1.1 Contexts of violence	24
2.1.2 Values and principles for addressing violence against sex workers	25
Core values	25
Programming principles	25
2.2 Promising interventions and strategies	26
2.2.1 Community empowerment	26
2.2.2 Building the capacity of sex workers	26
2.2.3 Advocating for reforms	27
2.2.4 Fostering police accountability	29
2.2.5 Promoting the safety and security of sex workers	30
2.2.6 Providing health services to sex workers who experience violence	32
2.2.7 Providing psychosocial, legal and other support services	33
2.3 Management, monitoring and evaluation	36
2.4 Resources and further reading	38
Chapter 3 Community-led Services	41
3.1 Introduction	44
3.2 Community-led outreach	45
3.2.1 What community outreach workers do	46

3.2.2	Steps in implementing community-led outreach	47
	A. Map the community and design the outreach strategy with them	47
	B. Recruit and train community outreach workers	50
	C. Implement and manage outreach	54
	D. Foster leadership opportunities for community outreach workers	61
3.3	Safe spaces (drop-in centres)	62
3.3.1	Establishing safe spaces	63
	Setting up the space	63
	Operating the space	64
3.3.2	Other activities in the safe space	65
3.4	Community-led quality improvement	66
3.4.1	Community committees	66
3.4.2	Other community-led approaches to reinforce quality of clinical services	68
3.4.3	Community quality assurance in monitoring and evaluation	68
	Monitoring quality of community service implementation	68
	Monitoring community access to services and community agency	71
3.5	Resources and further reading	72
Chapter 4	Condom and Lubricant Programming	75
4.1	Introduction	78
4.2	Steps in effective condom programming	79
4.2.1	Establishing accessible male and female condom and lubricant supplies for sex workers	82
4.2.2	Multi-level promotion of male and female condoms and lubricants	84
	Community-led condom promotion	85
	Destigmatizing condoms in the broader social environment	87
4.2.3	Creating an enabling environment for condom programming	88
4.2.4	Specific considerations in condom programming	90
	A. Condom programming with male and transgender sex workers	90
	B. Condom negotiation strategies	90
	C. Condom programming with clients of sex workers	90
	D. Condom social marketing programmes with sex workers	91
4.3	Condom programme management	92
4.3.1	Roles and responsibilities in condom programming	92
4.3.2	Programme monitoring	92
4.3.3	Evaluation	92
4.4	Resources and further reading	95
Chapter 5	Clinical and Support Services	97
5.1	Operational principles for clinical and support services	100
5.1.1	Service delivery and integration	100
5.2	Voluntary HIV testing and counselling	102
5.2.1	Introduction	102
5.2.2	Types of HIV testing and counselling and delivery	102
5.2.3	Essential activities for voluntary HTC services for sex workers	103
	A. Preparation	103
	B. HTC service delivery	104
	C. Follow-up	105

5.2.4	Quality assurance of services	106
5.2.5	Voluntary HTC performed by community outreach workers and lay counsellors	106
5.3	Antiretroviral therapy	107
5.3.1	Introduction	107
5.3.2	Essential definitions and prerequisites of ART services	108
5.3.3	Specific considerations for sex workers on ART	108
	Sex worker-specific ART services	109
	Community support for ART	110
	Treatment literacy	111
	Pre-exposure prophylaxis	111
5.4	Tuberculosis and sex workers	111
5.5	Additional services for sex workers who inject drugs	113
5.5.1	Introduction	113
5.5.2	Opioid substitution therapy	113
5.5.3	Needle and syringe programmes	114
5.5.4	Other considerations	114
5.6	STI services	115
5.6.1	Introduction	115
5.6.2	STI services for sex workers	115
A.	Designing STI services	116
B.	Implementing and managing STI services	118
C.	Periodic presumptive treatment	123
D.	Viral hepatitis	124
5.7	Addressing the sexual and reproductive health needs of sex workers	125
5.7.1	Introduction	125
5.7.2	Family planning and contraceptive counselling	126
	Emergency contraception	126
	Safe pregnancy	126
	Abortion and post-abortion care	126
5.7.3	Cervical cancer screening	127
5.7.4	Screening for other cancers	127
5.7.5	Clinical care for survivors of sexual assault	127
5.8	Mental health	128
5.9	Resources and further reading	128
Chapter 6	Programme Management and Organizational Capacity-building	133
Part I: Programme Management		136
6.1	Introduction	136
6.2	Planning and implementing an HIV/STI programme with sex workers	138
6.2.1	Define programme and standards	138
6.2.2	Establish a data monitoring system for management	141
6.2.3	Plan the programme evaluation	149
6.2.4	Define the management structure	150
6.2.5	Prioritize	152
6.2.6	Implement in a staged manner	153
6.2.7	Establish a supervision system	158
6.2.8	Progressively ensure full sex worker participation	161

6.3 Capacity-building/programme learning	161
6.4 Staff development	162
Part II: Building the Capacity of Sex Worker Organizations	163
6.5 Introduction	163
6.6 Forming a registered organization	164
6.7 Organizational capacity-building	165
6.7.1 Governance	166
6.7.2 Project management	166
6.7.3 Resource mobilization	166
6.7.4 Networking	167
6.8 Resources and further reading	168

Acknowledgements

This tool was developed by sex workers, programme managers, researchers and development partners who helped to research, draft and review it in collaboration with a coordinating group. The time and expertise of all the contributors listed below, and of the organizations that contributed case examples, is gratefully acknowledged.

Yadira Almodovar-Diaz, Management Sciences for Health, USA
Camille Anoma, Espace Confiance, Côte d'Ivoire
John Anthony, National AIDS & STI Control Programme, Kenya
George Ayala, The Global Forum on MSM & HIV, USA
Annabel Baddaley, World Health Organization Headquarters
Parinita Bhattacharjee, University of Manitoba/Government of Kenya
Nisha Bin Ayub, PT Foundation/Global Network of Sex Work Projects, Malaysia
James Blanchard, University of Manitoba, Canada
Aleksandar Bodiroza, United Nations Population Fund, Arab States Regional Office
Borche Bozhinov, STAR-STAR/Global Network of Sex Work Projects, Macedonia
Nathalie Broutet, World Health Organization Headquarters
Kholi Nomsa Buthelezi, Sisonke/Global Network of Sex Work Projects, South Africa
Julia Cabassi, United Nations Population Fund, Asia & the Pacific Regional Office
Anna-Louise Crago, Global Network of Sex Work Projects, Canada
Joanne Csete, Open Society Foundations, USA
Anjana Das, FHI 360, India
Michele Decker, Johns Hopkins Bloomberg School of Public Health, USA
Bidia Deperthes, United Nations Population Fund Headquarters
Gaston Djomand, US Centers for Disease Control and Prevention, USA
Fatou Drame, Enda Santé, Senegal
Virginie Ettiègne-Traoré, FHI 360/United States Agency for International Development, Ghana
Gloria Gakii Kimani, Sex Workers Operation Project (SWOP), Kenya
Haileyesus Getahun Gebre, World Health Organization Headquarters
Sarah Gill, Moorat Interactive Society/Global Network of Sex Work Projects, Pakistan
Kimberly Green, FHI 360, Ghana
Mauro Guarinieri, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland
Pato Hebert, The Global Forum on MSM & HIV, USA
Richard Howard, International Labour Organization, Asia and the Pacific Regional Office
Andrew Hunter, Asia Pacific Network of Sex Workers/Global Network of Sex Work Projects, Thailand
Pye Jakobsson, RiksOrganisationen för Sex- och ErotikArbetare (ROSE Alliance)/Global Network of Sex Work Projects, Sweden
Surang Janyam, Service Workers in Group Foundation (SWING), Thailand
Caitlin Kennedy, Johns Hopkins Bloomberg School of Public Health, USA
Deanna Kerrigan, Johns Hopkins Bloomberg School of Public Health, USA
Yves Lafort, International Centre for Reproductive Health, Belgium
Anne Lancelot, Population Services International, Myanmar
Carlos Laudari, Pathfinder International, Brazil
Annie Madden, International Network of People who Use Drugs, Australia
John Mathenge, Health Options for Young Men on AIDS and STIs (HOYMAS)/Global Network of Sex Work Projects, Kenya

Bradley Mathers, University of New South Wales, Australia
Neil McCulloch, Global Network of Sex Work Projects, United Kingdom
Jessie Mwambo, Muhimbili University, Tanzania
Penninah Mwangi, Bar Hostess Empowerment and Support Programme/Kenya Sex Workers Alliance/Global Network of Sex Work Projects, Kenya
Daisy Namakula Nakato, Women's Organization Network for Human Rights Advocacy (WONETHA)/Global Network of Sex Work Projects, Uganda
Aldo Napitu, Organisasi Perubahan Sosial Indonesia (OPSI)/Global Network of Sex Work Projects, Indonesia
Cynthia Navarrete Gil, Asociación en Pro Apoyo a Servidores (APROASE), Mexico
Elizabeth Ngugi, University of Nairobi, Kenya
Dasha Ocheret, Eurasian Harm Reduction Network, Lithuania
Daughtie Ogutu, African Sex Worker Alliance/Global Network of Sex Work Projects, South Africa/Kenya
Ifeanyi Okekearu, Society for Family Health, Nigeria
Aarthi Pai, National Network of Sex Workers, India
Freddy Perez, Pan American Health Organization, USA
Annah Pickering, New Zealand Prostitutes Collective (NZPC)/Global Network of Sex Work Projects, New Zealand
Angela Pires Pinto, United Nations Development Programme, Brazil
Parimi Prabhakar, India HIV/AIDS Alliance, India
Aliya Rakhmetova, Sex Workers' Rights Advocacy Network (SWAN) Foundation, Hungary
Manjula Ramaiah, Ashodaya Samithi/Global Network of Sex Work Projects, India
Sushena Reza Paul, University of Manitoba, India
Anastacia Ryan, Global Network of Sex Work Projects, United Kingdom
Anna Semina, Dignity/Global Network of Sex Work Projects, Tajikistan
Meena Seshu, Sampada Grameen Mahila Sanstha (SANGRAM), India
Kate Shannon, University of British Columbia, Canada
Donna Sherard, Population Services International, USA
Kenneth Sklaw, United States Agency for International Development, USA
Tim Sladden, United Nations Population Fund, Eastern Europe & Central Asia Regional Office
Taweasap Siraprasiri, Ministry of Public Health, Thailand
Miriam Taegtmeyer, Liverpool School of Tropical Medicine, United Kingdom
Anja Teltschik, International HIV/AIDS Alliance, United Kingdom
Rachel Thomas, Open Society Foundations, USA
Marija Tosheva, Healthy Options Project Skopje (HOPS), Macedonia
Tracey Tully, Asia Pacific Network of Sex Workers/Global Network of Sex Work Projects, Thailand
Lander van Ommen, Royal Netherlands Embassy, Ghana
Marco Vitoria de Avila, World Health Organization Headquarters
Beatrijs Vuylsteke, Institute of Tropical Medicine, Belgium
Stefan Wiktor, World Health Organization Headquarters
Kay Thi Win, Targeted Outreach Program (TOP)/Asia Pacific Network of Sex Workers/Global Network of Sex Work Projects, Myanmar
Peter Wondergem, United States Agency for International Development, Ghana
Jason Wright, International HIV/AIDS Alliance, USA
Zhao Pengfei, World Health Organization, Western Pacific Regional Office

Coordinating group

Avni Amin, World Health Organization Headquarters
Gillian Anderson, US Centers for Disease Control and Prevention, USA
James Baer, AIDSTAR-Two/USAID consultant, United Kingdom
Rachel Baggaley, World Health Organization Headquarters
Clancy Broxton, United States Agency for International Development, USA
Jennifer Butler, United Nations Population Fund Headquarters
Alison Crocket, Joint United Nations Programme on HIV/AIDS Headquarters
Gina Dallabetta, Bill & Melinda Gates Foundation, USA
Elizabeth Marum, US Centers for Disease Control and Prevention, Zambia
Ruth Morgan Thomas, Global Network of Sex Work Projects, United Kingdom
Tonia Poteat, Office of the U.S. Global AIDS Coordinator, USA
Michelle Rodolph, World Health Organization Headquarters (consultant)
Annette Verster, World Health Organization Headquarters
Tisha Wheeler, United States Agency for International Development, USA
Teodora Elvira Wi, World Health Organization Headquarters

A number of the contributors attended a consultation in Accra, Ghana, in May 2013, to review and refine a draft of the tool. We thank Henry Nagai, Director of the Ghana Country Office of FHI 360, and his colleagues for their skilful and effective organizing of the consultation, and Bernard Coquelin, United Nations Population Fund Country Representative for Ghana, for graciously opening the meeting.

The development of this tool was supported by the Global Network of Sex Work Projects, the US Centers for Disease Control and Prevention, the Office of the U.S. Global AIDS Coordinator, The Bill & Melinda Gates Foundation, the United Nations Population Fund, the U.S. President's Emergency Plan for AIDS Relief, the World Bank and the World Health Organization.

This tool was edited by James Baer, proofread by Alison Ellis (Management Sciences for Health consultant), and designed by L'IV Com Sàrl.

Acronyms and abbreviations

AfriCASO	African Council of AIDS Service Organizations
AIDS	Acquired immunodeficiency syndrome
APCASO	Asia Pacific Council of AIDS Service Organizations
APNSW	Asia Pacific Network of Sex Workers
ART	Antiretroviral therapy
ARV	Antiretroviral
BHESP	Bar Hostess Empowerment and Support Programme
BOCONGO	Botswana Council of Non-Governmental Organizations
CBO	Community-based organization
CSO	Civil-society organization
DIFFER	Diagonal Interventions to Fast Forward Enhanced Reproductive Health
DOTS	Directly observed treatment—short course
GO	Governmental organization
GRADE	Grading of Recommendations, Assessment, Development and Evaluation
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HOPS	Health Options Project Skopje
HOYMAS	Health Options for Young Men on HIV, AIDS and STIs
HPV	Human papilloma virus
HRT	Hormone replacement therapy
HTC	HIV testing and counselling
IPT	Isoniazid preventive therapy
KASH	Keeping Alive Societies' Hope
KHPT	Karnataka Health Promotion Trust
LDSS	Low dead space syringe
LMIS	Logistics management information system
NAAT	Nucleic acid amplification test
NANGOF	Namibia NGO Forum
NASCOP	National AIDS & STI Control Programme
NGO	Nongovernmental organization
NHOCAT	National Harmonized Organizational and Capacity Assessment Tool
NSP	Needle and syringe programme
NSWP	Global Network of Sex Work Projects
NZPC	New Zealand Prostitutes Collective
OST	Opioid substitution therapy
PADEF	Partnership Assessment and Development Framework
PEP	Post-exposure prophylaxis
PPT	Periodic presumptive treatment
PrEP	Pre-exposure prophylaxis

PSI	Population Services International
PWID	People who inject drugs
SACA	State Agency for the Control of HIV/AIDS
SANGRAM	Sampada Grameen Mahila Sanstha
SHARPER	Strengthening HIV and AIDS Response Partnership with Evidence-based Results
SHiPS	Strengthening HIV Prevention Services
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SWEAT	Sex Worker Education and Advocacy Task Force
SWING	Service Workers in Group Foundation
TB	Tuberculosis
TOP	Targeted Outreach Program
UBRAF	Unified Budget, Results and Accountability Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VAMP	Veshya Anyay Mukti Parishad
WHO	World Health Organization

Glossary

2012 Recommendations: *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach.* Geneva: WHO, UNFPA, UNAIDS, NSWP, 2012.

Agency has two distinct meanings: 1) an organization; and 2) the choice, control and power that a sex worker has to act for her/himself. In chapters where “agency” is used with the second meaning, the definition is given in a footnote at the first occurrence.

Capacity-building: In Chapter 6, the term “organizational capacity-building” is used. However, “capacity development”, “organizational development” or a number of other terms would serve equally well.

Community: In most contexts in this tool, “community” refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to sex workers, “community-led interventions” are interventions led by sex workers, and “community members” are sex workers.

Community outreach worker: In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff may be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”. The terms “community” or “peer” should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Implementing organization is an organization delivering a prevention intervention to sex workers. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes a nongovernmental organization provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

“Indoor” sex workers work in a variety of locations including their homes, brothels, guesthouses, bars, clubs and other indoor sex work venues.

Safe space (drop-in centre) is a place where sex workers may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 3, Section 3.3 for details.

Sex workers: “Female, male and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally” (*UNAIDS Guidance note on HIV and sex work*, updated 2012). Sex work may vary in the degree to which it is “formal” or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities. This publication does not address the sexual exploitation of children, i.e. people under 18 years of age.

Values and preferences survey: A global consultation was conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations. This consultation document, *Female, Male and Transgender Sex Workers’ Perspectives on HIV & STI Prevention and Treatment Services*, is referred to in this tool as the “values and preferences survey”.



Introduction

Introduction

Sex workers have been among the populations most affected by HIV since the beginning of the epidemic more than 30 years ago. In both concentrated and generalized epidemics, HIV prevalence is considerably higher among sex workers than in the general population. There are numerous reasons for this, including the type of work in which sex workers engage, unsafe working conditions, barriers to the negotiation of consistent condom use, and unequal access to appropriate health services. Sex workers often have little control over these factors because of social marginalization and the criminalization of sex work. Violence, alcohol and drug use in some settings also increase vulnerability and risk.

Much has changed in the response to HIV over the last three decades, especially in the areas of prevention, testing and treatment. What remains missing is a respectful and inclusive response to marginalized and vulnerable populations, including sex workers. This is seen in countless individual stories, as well as in discriminatory laws, regulations and policies, including those that prohibit non-citizen, migrant and mobile sex workers from receiving life-saving medications.

All sex workers have a fundamental human right to the highest attainable standard of health. Health-care providers have an obligation to provide services to sex workers, regardless of the legal status of sex work and sex workers. Health workers, programme managers and national leaders should ensure that all sex workers have full, adequate and equal access to HIV prevention methods and commodities, and HIV testing services and HIV treatment, guided by the principle of health for all and human rights.

The purpose of this tool

In 2012 the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Network of Sex Work Projects (NSWP) developed a guidance document on *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries*.¹ This document, referred to in this publication as the “2012 Recommendations”, sets out technical recommendations on effective interventions for the prevention and treatment of HIV and other sexually transmitted infections (STIs) among sex workers. The recommendations are summarized following this Introduction.

Following the dissemination of the 2012 Recommendations, many parties expressed a need to know *how* to implement them. This publication responds to that need by offering practical advice on implementing HIV and STI programmes for sex workers. It contains examples of good practice from around the world that may support efforts in planning programmes and services, and describes issues that should be considered and how to overcome challenges.

¹ *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach*. Geneva: WHO, UNFPA, UNAIDS, NSWP, 2012.

This tool is the product of collaboration among sex workers, service providers, researchers, government officials and nongovernmental organizations (NGOs) from around the world, as well as United Nations agencies, and development partners from the United States. The tool is aligned with the 2012 Recommendations. It also refers to a global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations. This consultation document is referred to in this tool as the “values and preferences survey”.²

Definition of sex workers

Sex workers include “female, male and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally.”³ Sex work may vary in the degree to which it is “formal” or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities. This publication does not address the sexual exploitation of children, i.e. people under 18 years of age.

How to use this tool

This tool is designed for use by public-health officials and managers of HIV, AIDS and STI programmes; NGOs, including community and civil-society organizations; and health workers. It may also be of interest to international funding agencies, health policy-makers and advocates.

The authors recognize that the tool may not be read from cover to cover. However, the reader is urged to at least look over all six chapters rather than concentrating only on those that may be of most immediate interest, in order to understand how each contributes to the goal of comprehensive programmes for sex workers. Each chapter explicitly or implicitly addresses one or more of the 2012 Recommendations. The first three chapters describe approaches and principles to building programmes that are led by the sex worker community. These community-led approaches are themselves essential interventions. Chapters 4 and 5 describe how to implement the recommended health-care interventions for HIV prevention, treatment and care. Chapter 6 describes how to manage programmes and build the capacity of sex worker organizations. (See Figure 1.)

² *Female, Male and Transgender Sex Workers' Perspectives on HIV & STI Prevention and Treatment Services*. Edinburgh, United Kingdom: Global Network of Sex Work Projects, 2011.

³ *UNAIDS guidance note on HIV and sex work*. Geneva: Joint United Nations Programme on HIV/AIDS, updated 2012.

Figure 1. Structure of the tool



Chapter 1 Community Empowerment is the foundation of the tool. This chapter describes how empowerment of the sex worker community is both an intervention in itself, and also essential to effective planning, implementation and monitoring of all aspects of HIV and STI prevention, treatment and care.

Chapter 2 Addressing Violence against Sex Workers focuses on one of the most urgent needs of sex workers: to be protected from violence, discrimination, abuse and other forms of human-rights violation. The effectiveness of HIV/STI prevention interventions is often compromised when interventions to address violence are not implemented concurrently.

Chapter 3 Community-led services: Like community empowerment, a community-led approach to planning, delivering and monitoring services for sex workers is essential to make programmes more effective and sustainable. This chapter describes the principles of community-led services and shows how they are applied to outreach, safe spaces (drop-in centres) and programme oversight.

Chapter 4 Condom and Lubricant Programming presents a detailed description of how to plan and implement the provision of male and female condoms and lubricants, using the approaches outlined in the previous chapters. The chapter covers planning for and managing adequate supplies, multi-level promotion of the commodities, and creating an enabling environment.

Chapter 5 Clinical and Support Services presents detailed descriptions of fundamental prevention, treatment and care interventions, incorporating the approaches outlined in the previous chapters. The services described include voluntary HIV testing and counselling, antiretroviral therapy, treatment of STIs and co-infections, such as tuberculosis and viral hepatitis, and additional services, such as for sexual and reproductive health, harm reduction for sex workers who inject drugs, post-rape care and mental health.

Chapter 6 Programme Management and Organizational Capacity-Building provides practical guidance on planning, starting, scaling up, managing and monitoring an effective programme from two perspectives: (1) a large multi-site programme with centralized management and multiple implementing organizations, and (2) local community groups seeking to start or expand services.

What are the key elements of each chapter?

Each chapter begins with an introduction that defines the topic and explains why it is important. The introduction presents one or more of the 2012 Recommendations, where relevant, and in some chapters underlying principles are also presented. Interventions are described in detail, broken down into stages or steps, wherever possible, to make them easy to follow. Topics or points of particular interest are presented in text boxes. Case examples from programmes around the world are presented in shaded boxes. These examples do not describe an entire programme in detail, since numerous publications address common programmatic issues, but they highlight specific aspects related to sex worker programming that have worked well in their contexts. The purpose of the case examples is to illustrate how an issue or challenge has been addressed, and to inspire ideas about approaches that could work in the reader's own context. The forms, charts, etc. presented from various programmes have the same purpose. Each chapter ends with a list of resources—tools, guidelines and other practical publications—that are available online; and further reading—journal articles and other publications—that provide a research or academic perspective on some of the points made in the chapters.

Navigating within and between chapters

Although each chapter is subdivided to make it easier to find and use information, the reader is urged not to view the various services and interventions described in a chapter as separate and independent of one another. In the same way, the content areas of each chapter are also linked and should not be considered in isolation. Cross-referencing is provided in each chapter to assist the reader in making these connections.

Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries

The 2012 Recommendations include technical, evidence-based recommendations following the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodology, as well as recommendations for good practice. The evidence-based recommendations are supported not only by scientific evidence but also by the real-life experience of sex workers around the world. The good practice recommendations are overarching principles derived from common sense, ethics and human-rights principles. These recommendations are not based on scientific evidence and did not go through a formal GRADE process, but were informed by the experience of sex workers and should be strongly promoted in all interventions with sex workers.

Good practice recommendations

1. All countries should work toward decriminalization of sex work and elimination of the unjust application of non-criminal laws and regulations against sex workers.
2. Governments should establish antidiscrimination and other rights-respecting laws to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Antidiscrimination laws and regulations should guarantee sex workers' right to social, health and financial services.
3. Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.
4. Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker-led organizations.

Evidence-based recommendations

1. Offer a package of interventions to enhance community empowerment among sex workers.
2. Promote correct and consistent condom use among sex workers and their clients.
3. Offer periodic screening for asymptomatic STIs to female sex workers.
4. Offer female sex workers, in settings with high prevalence and limited clinical services, periodic presumptive treatment for asymptomatic STIs.
5. Offer voluntary HIV testing and counselling to sex workers.
6. Use the current WHO recommendations on the use of antiretroviral therapy (ART) for HIV-positive general populations for sex workers (and refer to the latest ones published in 2013, i.e. begin ART below a CD4 count of 500).
7. Use the current WHO recommendations on harm reduction for sex workers who inject drugs (in particular needle and syringe programme and opioid substitution therapy).
8. Include sex workers as targets of catch-up hepatitis B immunization strategies in settings where infant immunization has not reached full coverage.

Principles for implementing comprehensive HIV and STI programmes with sex workers

Several principles underlie the 2012 Recommendations and the operational guidance given in this publication. These principles are described in the 2012 Recommendations (pp.37–8) and are articulated in more detail in this tool. They may be summarized as follows:

- **Community empowerment** is the process whereby sex workers are empowered and supported to address for themselves the structural constraints to health, human rights and well-being that they face, and improve their access to services to reduce the risk of acquiring HIV. Community empowerment is an essential approach that underlies all the interventions and programme components described in this tool, and is inseparable from them.
- **Community participation and leadership** in the design, implementation, monitoring and evaluation of programmes are also essential. Participation and leadership help to build trust with those whom programmes are intended to serve, make programmes more comprehensive and more responsive to sex workers' needs, and create more enabling environments for HIV prevention and sex work.
- Programmes should **address structural barriers**. Sex workers have detailed knowledge of the legal, social, cultural and institutional constraints that block their access to services and deny them their rights. Their participation is essential in strategizing to overcome these barriers.
- Programmes must **operate at multiple levels**, from the front line to the national policy arena. Programmers should take into account how and where operational and policy decisions are made about funding, health care, social benefits, education, law enforcement or media coverage. All of these areas affect HIV prevention programmes as well as the lives of sex workers. Programmes and the communities they serve must be part of the decision-making process. Sex workers can participate and offer leadership at all levels.
- Programmes should be **holistic**—considering the full range of sex workers' service needs—and **complementary**—finding ways to coordinate and integrate service delivery—as far as possible, to make them more accessible and effective for sex workers, and to build strong referral links to other service providers. This includes clinical and non-clinical services, which should not be seen as separate realms.
- Although based on the 2012 Recommendations for sex workers in low- and middle-income countries, the principles that underlie this tool, and the operational approaches it presents, are no less **relevant to high-income countries** and should be seen as a minimum global standard.



1

Community
Empowerment



What's in this chapter?

Community empowerment is the foundation for all of the interventions and approaches described in this tool. This chapter:

- **defines community empowerment** and explains why it is fundamental to addressing HIV and STIs among sex workers in an effective and sustainable way (Section 1.1)
- describes **eight elements of community empowerment**, with examples from a number of programmes (Section 1.2).

The chapter also presents:

- examples of **indicators** to measure the empowerment of sex worker organizations (Section 1.3)
- a list of **resources and further reading** (Section 1.4).

1.1 Introduction

2012 Recommendations:¹ Evidence-based Recommendation 1

Offer a package of interventions to enhance community empowerment among sex workers.

In the context of sex work and HIV programming, community empowerment is a process whereby sex workers take individual and collective ownership of programmes in order to achieve the most effective HIV responses, and take concrete action to address social and structural barriers to their broader health and human rights.²

The interventions delivered through a community empowerment model include sustained engagement with local sex workers to raise awareness about sex worker rights, the establishment of community-led safe spaces (drop-in centres),³ the formation of collectives that determine the range of services to be provided, as well as outreach and advocacy.

The 2012 Recommendations state that community empowerment is a necessary component of sex worker interventions and should be led by sex workers. The benefits are high, there are no harms and the required resources are relatively low. The values and preferences survey⁴ found that sex workers see community empowerment as an “absolutely necessary component” of health interventions for improving their living and working conditions, developing strategies for health and rights interventions, and redressing human rights violations.

Sex workers take charge of the community empowerment process by mobilizing with other sex workers to develop solutions to the issues they face as a group, and by advocating for their rights as sex workers and as human beings.

Community empowerment is also a broader social movement that supports the self-determination of sex workers. It requires governmental, nongovernmental, public, private, political and religious institutions and organizations to address and remove the social exclusion, stigma, discrimination and violence that violate the human rights of sex workers and heighten associated HIV risk and vulnerability.

Community empowerment includes working towards the decriminalization of sex work and the elimination of the unjust application of non-criminal laws and regulations against sex workers, and recognizing and respecting sex work as a legitimate occupation or livelihood.

Investing in community empowerment is not only the right thing to do but makes good sense. Female, male and transgender sex workers are disproportionately affected by HIV. Strategies for

1 *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach.* WHO, UNFPA, UNAIDS, NSWP, 2012.

2 In most contexts in this tool, “community” refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to sex workers, “community-led interventions” are interventions led by sex workers, and “community members” are sex workers.

3 A safe space or drop-in centre is a place where sex workers may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 3, Section 3.3 for details.

4 A global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations.

HIV prevention among sex workers (such as peer-led education and control of sexually transmitted infections) are more effective and sustainable when conducted within a community empowerment framework. From Kenya to Ukraine, Brazil to Thailand, India to the Dominican Republic, investment in community-led organizations of sex workers has resulted in improved reach, access, service quality, service uptake, condom use and engagement by sex workers in national policies and programmes. Scaling up comprehensive, community empowerment-based HIV interventions helps prevent significant numbers of new HIV infections, particularly in settings with high rates of HIV.

Community empowerment for sex workers means:

- sex workers coming together for mutual assistance
- removing barriers to full participation
- strengthening partnerships among sex worker communities, government, civil society and local allies
- addressing collective needs in a supportive environment
- leading the process themselves: sex workers know best how to identify their priorities and the context-appropriate strategies to address those priorities
- meaningful participation of sex workers in all aspects of programme design, implementation, management and evaluation
- providing money and resources directly to sex worker organizations and communities, which become responsible for determining priorities, activities, staffing, and the nature and content of service provision. Ultimately, sex worker-led organizations may become the employers of relevant staff (doctors, nurses, social workers, outreach workers), rather than sex workers being solely volunteers, community outreach workers⁵ or employees.

Community empowerment is more than a set of activities; it is an approach that should be integrated into all aspects of health and HIV programming. It is the cornerstone of a human-rights-based approach to HIV and sex work and, as such, underpins all the recommendations and components presented in this tool.

1.2 Key elements of community empowerment

The process of community empowerment is, by definition, driven by sex workers themselves. It is therefore impractical to adopt a prescriptive, inflexible approach to implementing community empowerment initiatives. However, various sex worker groups throughout the world have identified some key elements of community empowerment (Figure 1.1).⁶

The approach is flexible and adaptable to individual community needs. There is no fixed order in which the elements should be addressed; the process may flow from working with communities of sex workers to community-led outreach, the development and strengthening of collectives (sex worker-led organizations and networks) and, consistent with local needs and contexts, shaping human rights-based policies and creating an enabling environment for a sustainable movement.

⁵ In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”. The terms “community” or “peer” should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.

⁶ Particular acknowledgement for some of these elements is made to Veshya Anyay Mukti Parishad (VAMP—Sex Workers Collective against Injustice) and Sampada Grameen Mahila Sanstha (SANGRAM—Rural Women’s Organization: Meena Seshu, General Secretary) in India.

1 Community Empowerment

This process represents a paradigm shift, from sex workers being recipients of services to the self-determination of sex worker communities. Community empowerment builds a social movement where the community—sex workers—collectively exercise their rights, are recognized as an authority, and are equal partners in the planning, implementation and monitoring of health services.

Figure 1.1 Key elements of community empowerment among sex workers



1.2.1 Working with communities of sex workers

Community empowerment is a process that takes significant time and effort, especially since in many contexts sex work is stigmatized and criminalized. Trust, empathy and respect are important for all partners. Building trust involves treating sex workers with dignity and respect, listening to and addressing their concerns, and working with them throughout the process of developing and implementing an intervention. The goal is to cultivate a programme that is eventually run entirely by sex workers, and where sex worker-led organizations are respected as partners by officials and service providers in health, law enforcement and social services.

Box 1.1

Meaningful participation

Meaningful participation means that sex workers:

- choose how they are represented, and by whom
- choose how they are engaged in the process
- choose whether to participate
- have an equal voice in how partnerships are managed.

The meaningful participation of sex workers is essential to building trust and establishing relationships and partnerships that have integrity and are sustainable (see Box 1.1). This may be challenging for service providers who are more accustomed to establishing the parameters within which services are provided, and prescribing how relationships or partnerships are to be conducted. As sex workers and sex worker organizations become more empowered, there will be greater expectations of power-sharing and power-shifting (see Chapter 6, Section 6.2.8). In the initial stages of community empowerment, sex workers may have less experience in organizing as a group. National, regional and global sex worker-led networks are able to provide essential technical assistance and support (see Chapter 6, Section 6.6). Allies also have an important role in facilitating meaningful participation of sex workers, with community self-management the shared goal.

Partnerships are crucial but must be built and maintained in a way that does no harm to sex workers. Social exclusion, punitive laws, violence, stigma and discrimination not only impact the daily lives of sex workers but influence policy-makers and affect the attitudes of officials and service providers. All partners should share the responsibility for supporting the shift from sex worker disempowerment to sex worker empowerment. Given that 116 countries criminalize some aspects of sex work, and the vast majority of countries have other punitive laws that are used against sex workers, safeguards need to be built into partnerships to ensure that sex workers do not face a backlash for organizing, do not fear that identifying themselves as sex workers will lead to arrest and harassment, and do not experience further stigmatization from health-care providers.

1.2.2 Fostering sex worker-led outreach

There is a difference between programmes that are done *for* sex workers and those led *by* sex workers (Table 1.1). This element in the community empowerment process requires service providers to reflect on how they can support a move from providing services to sex workers to sex worker organizations themselves ultimately becoming the employers of service providers.

Sex worker-led initiatives operate under the principle that sex workers are best equipped to help each other learn not only to protect themselves from risks to their health and safety, but also to promote and protect their human rights.

Sex workers should be the driving force in targeted programmes addressing HIV and sex work. It is not enough to “consult” with sex workers before creating a programme. Rather, programmes should be based on sex workers’ needs, perceptions and experiences.

Table 1.1 Comparison of programme approaches from a community empowerment perspective

Done for sex workers	Done with/Led by sex workers
<p>Programmes sometimes focus on how sex workers can protect <i>others</i> from disease, and how society can be protected <i>from</i> sex workers.</p> <p>Often assume that knowledge and power reside with the programme staff and managers.</p>	<p>Programmes focus on sex workers’ collectively identified needs and develop appropriate solutions.</p> <p>Community discusses its needs before developing a programme, and sex workers are engaged in all stages of planning and implementation.</p>
<p>Involve sex workers in programme implementation commonly as volunteers, not as equal partners.</p>	<p>Involve sex workers as equal partners in programme implementation, more commonly as paid employees or as community outreach workers working with the community, not for an external organization.</p>
<p>Monitoring focuses on goods and services delivered and targets to be achieved.</p>	<p>Monitoring focuses on quality of services and programmes, community engagement, community cohesion and community acceptance, as well as adequacy of service coverage.</p>
<p>Focus on building relationships within the health system with health-care providers. Less emphasis is placed on building relationships among sex worker groups.</p>	<p>Focus on building relationships within sex worker communities as well as between sex workers and other organizations, service providers, human rights institutions and similar groups.</p>

Box 1.2

Sex worker-led outreach programmes

Sex worker-led outreach programmes focus on:

- the needs and experiences of sex workers themselves, not what programmers think sex workers need
- the sex worker-led outreach process itself, with an emphasis on ways of protecting sex workers, rather than an emphasis on process indicators (for example, counting the number of condoms distributed is part of a programme, but should not be seen as an end in itself)
- stimulating community empowerment and creating a collective identity among sex workers.

In order to ensure the trust and confidence of sex workers, it is important to employ educators and outreach workers who are themselves sex workers. This is because sex workers:

- share a common experience that may decrease internalized stigma and increase self-worth and collective solidarity
- are likely to be more comfortable discussing intimate details associated with sex work with someone who is experienced and knowledgeable
- are more likely to follow up on referrals to services, adhere to treatments and engage in health-seeking and health-protective behaviours if they trust the person providing the advice
- have knowledge of the sex work industry that can inform outreach activities to clients, managers, law enforcement and health-care providers.

However, sex workers should not be limited to these roles in community-led programmes. Rather, they should be given the opportunity to participate in all other levels of the programme, including decision-making on programme implementation, management and governance. Capacity-building and mentoring should be a priority to enable sex workers to take up these positions.

1.2.3 Developing sex worker collectives

Forming any type of sex worker group or organization will only be successful if the process is initiated and led by the community. A common first step in developing community cohesion is providing a safe space (drop-in centre) where sex workers can come together to socialize and discuss issues. This can be an empowering exercise in and of itself (see Box 1.3) and helps sex workers identify common issues and a sense of purpose and connectedness. However, safe spaces are only one way to initiate group processes. Sex workers may also come together over key issues that affect them individually but that require a group response, such as addressing violence, bribes and harassment; or they may identify common needs such as child care; or seek information as new (and frequently undocumented) migrants.

The recommended kind of sex worker organization is a collective. This means that sex workers organize themselves together as a group. They jointly (collectively) decide on priorities for the whole group, agree on a group process for making decisions, and on a common set of rules for being together as a group. Ultimately a collective (i.e. a sex worker-led organization or network) acts in the interest of the whole group rather than for individual benefit. It is up to sex workers to decide when a collective should be formed, and there is no standard timeframe for doing so.

It is crucial to note that community-led (i.e. sex worker-led) processes and organizations are not synonymous with generic community-based organizations (CBOs). In community-led organizations, power and decision-making lie in the hands of community members (sex workers), whereas in a CBO, power may reside only with some members of the community, or with non-community members who act as administrators. It is the self-determining and self-governing nature of an organization, and its commitment to pursue the goals that its own members have agreed upon, that make it a collective.

Box 1.3

Bringing sex workers together

- Organize group activities at safe spaces (drop-in centres) based on the interests of the group members.
- Plan activities for special occasions, such as the International Day to End Violence against Sex Workers (17 December).
- Invite sex worker activists or community outreach workers from neighbouring areas to speak at a gathering of local sex workers.

Sex worker organizations come into being in various ways. Two primary ones are:

- growing out of a community empowerment process or other process supported by another organization, including national, regional or global sex worker-led networks
- sex workers independently forming an organization.

The advantage of the first is that the partner organization may be able to support the process through funding, the provision of space, assistance with activities and advocacy to remove any barriers. This support is often necessary and welcome and should include connecting the local group to existing national and regional sex worker-led networks. However, if a sex worker organization is to be a true collective, ownership must rest with the community, and its form and function should be based on the needs and priorities identified by its members. It is crucial that the outside partner understand that the organization needs to be given the freedom to find its own way.

In some cases, sex worker groups hire consultants to lead them through the process of forming an organization, or receive crucial support from one or two nongovernmental organization (NGO) employees. Alternatively, they may do it themselves with the help of a partner NGO's lawyer, or with support from national or regional sex worker-led networks. An organization experienced in project management, financial management, monitoring and reporting, communication and fundraising can help build the capacity of sex workers by providing training and opportunities to practise skills.

1.2.4 Adapting to local needs and contexts

Sex workers face diverse legal, political, social and health environments. Sex work may be criminalized or an accepted occupation; it may be predominantly establishment-based or street-based. Sex workers may be undocumented migrants, highly mobile or selling sex in their own locality. HIV programmes need to be sensitive to the diversity of cultures of people working in the sex industry. What it means to be part of a sex work "community" varies depending on the culture, ethnicity, language, location and socioeconomic position of the particular sex workers. As a result of these different contexts,

different sex work communities have different needs and challenges that may be addressed through community empowerment initiatives.

Flexibility, responsiveness and adaptability are essential in implementing community empowerment initiatives. Intervention goals need to be aligned with and address sex workers' needs, even if these change over time. Box 1.4 shows how sex worker organizations in India and Kenya have adapted their programming to local needs and contexts.

Box 1.4

Case example: Local needs and contexts in India and Kenya

VAMP (Veshya Anyay Mukti Parishad), an sex worker organization in southern India supported by SANGRAM (Sampada Grameen Mahila Sanstha, an HIV organization), has adapted its programmes to directly address the needs of sex workers, who face financial exclusion and significant stigma and discrimination from health authorities. Community-led processes have resulted in sex workers being trained to support community members' access to non-stigmatizing, subsidized health care. This is done by negotiating access to a range of government service providers and providing support for sex workers in financial difficulty. The result is strong collectives of sex workers empowered to claim and exercise their rights, improving the health and welfare of individual sex workers, their communities and their families.

In Kenya, frequent problems with law enforcement officers became an issue for collective action by sex workers. The Bar Hostess Empowerment and Support Programme (BHESP) developed a programme in Nairobi to train local sex workers as paralegals. They studied local and national laws that affect sex work and the human rights of sex workers. The paralegals now educate other sex workers about their rights, help those who need legal advice and document human-rights violations, such as arbitrary arrest. Each paralegal works as an advocate responsible for 10–15 other sex workers. They are trained to identify the specific issues group members may have and to request additional resources from BHESP staff when needed. The result is strong and empowered sex workers who know the law and the rights of sex workers and are able to mount straightforward challenges to arbitrary arrest and detention. Similar paralegal systems are being implemented by the Women's Legal Centre, which is funded by the Open Society Foundations in Cape Town, South Africa, among others. Such programmes addressing local needs and contexts build individual competencies and community resilience.

1.2.5 Promoting a human-rights framework

Promoting and protecting the human rights of sex workers is central to all community empowerment processes. The 2012 Recommendations specifically address the human rights of sex workers.

2012 Recommendations: Good Practice Recommendation 2

Governments should establish antidiscrimination and other rights-respecting laws to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Antidiscrimination laws and regulations should guarantee sex workers' right to social, health and financial services.

The strength of the collective and the partnerships that have been built are crucial to promoting a human-rights framework. Challenging stigma and discrimination, mobilizing support, educating community members on the universality of human rights, and changing the attitudes of the wider (non-sex worker) community are activities that test the most robust of organizations and networks. Two examples (Box 1.5) illustrate the importance of partnerships and the centrality of community empowerment in achieving structural shifts.

Box 1.5

Case example: Promoting human rights and social entitlements with police and government in Thailand and Brazil

Criminalizing the possession of condoms violates sex workers' right to health, but in Thailand it is a common practice of local law enforcement, despite a government directive intended to prevent it. Sex Workers in Group (SWING), a community-led organization, has developed an innovative and pragmatic partnership to involve police cadets in its outreach programme. Cadets are offered three-week internships working alongside SWING volunteers to promote condom use. At the end of the internship, the cadets give a presentation to all 1,200 police academy students. As a result of this programme, sex workers have experienced less police harassment and fewer arrests. Furthermore, the police interns have become promoters and protectors of the human rights of sex workers, changing police culture from the inside.

In Brazil, the sex worker-led organization Davida—Prostituição, Direitos Civis, Saúde has for years fought stigma and discrimination surrounding sex work. It has partnered with the Brazilian government to establish policy committees, run mass media campaigns to change community attitudes and has been instrumental in shaping the government's response to AIDS. One of Davida's most important successes has been its advocacy with the government to recognize sex work as a profession, guaranteeing sex workers the same rights as all other workers, including receiving a pension upon retirement.

1.2.6 Community systems strengthening (strengthening the collective)

Forming any collective is challenging, but maintaining and strengthening it is even more difficult. Community-led movements around the world face significant barriers, including inadequate funding, too few paid staff, complex community needs, political opposition to their existence, competition for resources from within and outside their communities and lack of recognition of the importance of their populations. Sex worker organizations and networks, as collectives, face all of these challenges and more. The marginalization and lack of visibility of sex workers within legal, social and economic structures at all levels of society means that their organizations and networks are typically underfunded and undervalued.

A strong community-led organization is characterized by vibrant membership, increasing financial independence, greater political power and wider social engagement. There are several ways this is achieved (see Box 1.6). When implementing an HIV response, governments, donors, the broader civil society movement, local organizations and multilateral agencies have a responsibility to provide sustainable support to sex worker organizations and networks. Such support should not be tied to particular donor-driven ideologies that conflict with the needs and priorities determined by the community. This risk can be mitigated—and more productive funding strategies negotiated—if the community empowerment process has progressed to the stage where decision-making power is vested within the community-led organization.

Community systems strengthening is a mechanism to ensure meaningful participation of community-led organizations within the wider policy and programmatic systems of the state, and to address and resolve internal issues and conflicts. At the local level, this means sex worker organizations and networks participate as members on planning, funding and implementation committees and other relevant bodies, ensuring that the needs of the sex worker community are addressed. It may also mean that within a sex worker organization, or across a number of organizations, community-led structures are put in place to monitor, decide upon or otherwise address key issues of concern to the community. These may include violence-reduction strategies, allocation of community housing or functioning of community financial cooperatives.

Box 1.6

Strengthening management and organizational capacity

- Create a fair and transparent method for making decisions within the organization.
- Ensure that the process for carrying out and managing activities is participatory, transparent and has accountability.
- Establish a transparent operational system for managing human and financial resources.
- Sex workers should be in control of the planning, implementation and monitoring of the collective and its activities, including identifying indicators for monitoring.
- Support the growth of group membership and advancing of the group’s goals and objectives.
- Encourage cooperation and learning from other sex worker-led organizations and networks nationally and internationally.

To help achieve sustainability, it is important to invest time and resources into building leadership among sex workers through their involvement in trainings, conferences, project design, implementation, evaluation, research and fundraising activities, and their participation in the wider sex worker rights movement. (See also Chapter 3, Section 3.2.2, part D.)

It is also essential to develop the organizational skills and capabilities of the collective as a whole. This may involve enhancing business and management skills among group members, strengthening leadership and management or developing resource mobilization activities (Box 1.7). The guidance of allies and partners, as well as other sex worker-led organizations, may assist with the process.

Box 1.7

Case example: Generating income as a collective

Enhancing business and management skills among group members may lead to income-generating activities for the collective:

- Sex workers from Ashodaya Samithi in Mysore, India used World Bank funding to start a restaurant staffed by sex workers, which helps challenge the stigma and discrimination they face. Profits support a home-care programme for sex workers living with HIV.
- In Brazil, the sex worker organization Davida created its own fashion line, Dapsu, whose proceeds help fund the organization’s social, cultural and HIV prevention activities.
- In India, leaders of the Sonagachi Project registered a consumer cooperative to increase sex workers’ economic security through access to credit and savings programmes, handicraft production, condom social marketing and evening child-care centres.

1 Community Empowerment

Financial management is another key component of organizational sustainability. It can be developed in a number of ways depending on the potential capacity of the organization, its resources and the complexity of its finances. An organization may manage its finances in-house or may outsource the work to another local organization. Regardless of the size of the organization, important components of a strong financial management system include:

- well-documented financial systems and financial controls
- financial files documented and audit-ready
- financial reporting procedures known and understood by members
- an adequate number of qualified financial staff, depending upon the complexity and size of the organization.

Community systems strengthening—strengthening the collective—also involves developing procedures to sustain group operations, including a transparent and democratic process to elect leaders, as well as the mentoring of new leaders and planning for succession. Sex worker organizations are often started by a small number of dynamic individuals. However, to be sustainable, these organizations must ensure strong leadership and organizational management and invest in developing future leaders. This requires resources for leadership training and capacity-building as well as connections with national, sub-regional, regional and global networks of sex workers to exchange knowledge, experience and support. Organizational leadership and management activities include:

- strategic planning that reflects the organization’s vision and mission
- leadership that includes a broad range of staff and other community members in organizational decision-making and ensures sharing of information across the organization
- processes in place to manage change and seek new opportunities.

Developing a wider base of skills and leadership within the collective and linking with other organizations can help ensure the sustainability of a sex worker organization in the face of changing donor funding or changing leadership in other governmental or nongovernmental organizations.

1.2.7 Shaping policy and creating enabling environments

2012 Recommendations: Good Practice Recommendation 3

Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.

Community empowerment processes reach beyond the community to influence policy and create enabling environments. For example:

- HIV programmes should take affirmative steps to promote the universality of human rights for sex workers, including their rights to health, dignity and lives free from violence, discrimination and stigma. (For details on addressing violence, see Chapter 2.)
- National strategic health plans should recognize sex workers’ heightened HIV risk and vulnerability and ensure that integrated, high-quality health services are available, affordable and accessible for female, male and transgender sex workers.

- Law enforcement authorities must be involved in the promotion and protection of the human rights of sex workers, and programmes to create enabling legal and policy environments should be funded and supported.
- Economic empowerment of sex workers is essential: sex workers should be accorded the same rights as all other informal workers⁷ to safe and fair working conditions, with skills training and education for life, access to bank accounts and fair credit programmes, and the same potential to support their families and plan for their future as all other members of the wider community.
- Donor organizations may support the process of sex worker empowerment by funding initiatives to increase capacity among sex workers and support organizational development. It is important to note that international agreements and policies at a global level may either facilitate or hinder community empowerment among sex workers by allowing or restricting access to financial resources by sex worker groups and collectives.

Box 1.8

Case example: South-South partnerships between sex worker-led organizations

The Global Network of Sex Work Projects has spearheaded initiatives to strengthen South-South cooperation among sex worker-led organizations. The rationale is to partner stronger, longer-established sex worker-led organizations and networks with those in the process of strengthening their movement. This enables sharing of experiences, learning new ideas and forming new alliances.

Following the Kolkata Sex Worker Freedom Festival in India in 2012, African sex workers undertook a study tour to the Ashodaya Academy in Mysore, and the programmes of SANGRAM and VAMP in Sangli. This study tour was followed up by a return visit by the Indian organizations to Kenya to discuss the establishment of a learning site there and to participate in the African Sex Workers Alliance Strategic Planning Meeting.

Similarly, Bridging the Gaps, an international HIV programme, provides opportunities for sharing lessons from HIV-related projects in Asia and Africa, including on community empowerment, capacity-building of programme managers and identification of examples of good practice.

Such partnerships connect the local with the global, stimulating important knowledge-sharing and contributing to strengthening the sex worker rights movement.

1.2.8 Sustaining the movement

To sustain themselves, sex worker-led movements should operate in solidarity with other social movements, particularly those that also advocate for human rights. This may include movements of other key populations who have similar experiences of heightened HIV risk and social exclusion, such as men who have sex with men, people who use drugs and transgender people, some of whom are sex workers, as well as organizations and networks of people living with HIV. Collaboration between movements strengthens the collective response and ensures that communities are at the centre of that response.

It is essential that development partners in lower- and middle-income countries, and governments and national partners in all countries, actively support the sustainability of sex worker-led organizations and networks. It is unreasonable to expect any group to grow from a small collection of individuals to a movement whose members actively contribute to the national HIV response unless it receives

⁷ The International Labour Organization's *Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200)* covers "all workers working under all forms or arrangements, and at all workplaces, including: (i) persons in any employment or occupation" (Paragraph 2(a)).

sustained support. The marginalization of sex workers within the broader economic and social discourse makes sustainability of sex worker-led organizations and networks more challenging. It is essential that, at this point in the community empowerment process, power has been transferred to the community and that community advocates are respected partners in policy-making, irrespective of the legal status of sex work.

A strong, healthy and vibrant civil society working in genuine partnership has been the backbone of the HIV response for 30 years. As we move forward, sex worker organizations and networks should be core members of that partnership.

1.3 Monitoring progress

It is important that communities monitor progress to improve the services they provide and shape the services they receive. HIV programmes based on human rights and community empowerment require that sex worker-led organizations set the parameters for monitoring and evaluation of programmes across all stages of development, including the monitoring and evaluation of the sex worker movement itself.

Short- and long-term objectives and goals need to be established that specifically address the community empowerment process. As an example, monitoring community empowerment in relation to HIV prevention, treatment, care and support and health services would measure sex worker involvement in each of the following: how services are run, quality assurance, funding allocations, training of health personnel to address stigma, and advocacy to address discrimination; rather than simply whether a target percentage of sex workers has accessed a particular service.

In a community empowerment-based programme, monitoring and evaluation should not only include services provided and health outcomes achieved, but should also attempt to monitor and evaluate whether and to what extent the community empowerment process is occurring. Frequently, programme indicators measure quantitative outputs, such as sex workers contacted and condoms distributed, rather than documenting sex worker-led organizational progress and social inclusion. Box 1.9 and Table 1.2 describe approaches to monitoring community empowerment.

Box 1.9

Case example: Monitoring community empowerment of sex worker organizations in India

Monitoring empowerment is challenging because numbers alone do not convey the complex interaction of factors that define empowerment. In the Avahan India AIDS Initiative, where NGOs worked with community leaders to establish formally registered CBOs, it was found that simply reporting the number of community groups or meetings held was inadequate, because these data did not capture the quality of the capacity-building and the functioning and autonomy of the groups. To address this, special surveys were developed to capture the various aspects of community empowerment, using an index with multiple groups of indicators. The surveys were administered over a period of several days by trained facilitators with leaders and members of each CBO as well as staff of the NGO implementing the programme, using a small-group discussion format. Initial survey results were immediately reported to the CBO and NGO and discussed with them, with a detailed analysis following later. It was found that a combination of qualitative and quantitative indicators and approaches to monitoring and evaluation was needed to document the complex process of community group formation and the development and sustainability of each collective.

Table 1.2 Monitoring indicators for sex worker empowerment

Level	Empowerment activities	Empowerment indicators
Central	<ul style="list-style-type: none"> • Strengthen and expand sex-worker-rights networks to promote sex workers’ rights at a global level • Prioritize and invest in community-led HIV prevention approaches • Include sex workers in policy, programming and funding decisions 	<ul style="list-style-type: none"> • Inclusion of sex worker movement in national policies and programmes • Amount of funding allocated to sex worker-led groups • Inclusion of sex worker-led groups in policy-making on such issues as HIV prevention • Recognition of sex worker-led organizations at the national level
State/province/district/county	<ul style="list-style-type: none"> • Recognize sex work as work • Incorporate sex worker participation in formation of local/district/state-level policies and programmes • Train health-care providers, police and social service agencies in sex worker rights and needs • Involve sex workers in planning, implementation and service delivery of health, legal and social services 	<ul style="list-style-type: none"> • Inclusion of sex worker movement in state/district policies and programmes • Number of health-care providers, police and social service agents trained in sex worker rights and needs • Level of sex worker involvement in service design and delivery, including health care, legal services and social services • Changes in attitudes and practices of health-care providers, police and social service agents towards sex workers • Changes in degree of discrimination perceived by sex workers from health-care providers, police and social service agents
Municipality/Sub-municipality	<ul style="list-style-type: none"> • Raise awareness of sex worker rights in communities • Forge relationships with sex worker-led organizations and other community groups 	<ul style="list-style-type: none"> • Amount of participation of sex workers in public life • Degree of social acceptance of sex workers by members of the general community • Number of outside organizations that report contact and partnering with sex worker-led organizations
Frontline worker	<ul style="list-style-type: none"> • Create safe communal spaces • Identify common priorities, needs and goals • Establish and sustain sex worker-led organizations • Hold meetings, marches and rallies for sex worker rights, to the extent the legal context allows • Train legal advocates to document and challenge human-rights violations 	<ul style="list-style-type: none"> • Number of safe spaces created • Degree of social cohesion among sex worker groups • Number of sex worker-led organizations/collectives established • Number of meetings, marches or rallies held to promote sex worker rights • Percentage of sex workers who report participation in a sex worker-led group/collective • Number of sex workers trained as legal advocates • Documentation of human-rights abuses

1.4 Resources and further reading

1. *UNAIDS guidance note on HIV and sex work*. Geneva: Joint United Nations Programme on HIV/AIDS, 2012.
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf
2. *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach*. Geneva: WHO, UNFPA, UNAIDS, NSWP, 2012.
http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf
3. *The Global HIV Epidemics among Sex Workers*. Washington, DC: World Bank, 2013.
<http://www.worldbank.org/content/dam/Worldbank/document/GlobalHIVEpidemicsAmongSexWorkers.pdf>
4. *SANGRAM's Collectives: Engaging Communities in India to Demand their Rights*. Arlington, VA: AIDSTAR-One/John Snow, Inc., 2011.
http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_CaseStudy_GenderMARPs_SANGRAM_India.pdf
5. *Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200)*. Geneva: International Labour Organization, 2010.
http://www.ilo.org/aids/WCMS_142706/lang-en/index.htm
6. *Sex Work and the Law in Asia and the Pacific: Laws, HIV and human rights in the context of sex work*. Bangkok: United Nations Development Programme Asia-Pacific Regional Centre, 2012.
<http://www.undp.org/content/dam/undp/library/hivaids/English/HIV-2012-SexWorkAndLaw.pdf>
7. *Community Mobilization of Female Sex Workers: Module 2, A Strategic Approach to Empower Female Sex Workers in Karnataka*. Bangalore, India: Karnataka Health Promotion Trust, 2008.
http://www.khpt.org/Community_Mobilization.pdf
8. Scamell D. Legal help for sex workers—from sex workers. Open Society Foundations, March 5, 2013.
<http://www.opensocietyfoundations.org/voices/legal-help-sex-workers-sex-workers>
9. *HIV and the Law: Rights, Risk and Health*. New York, NY: Global Commission on HIV and the Law, United Nations Development Programme, 2012.
<http://www.hivlawcommission.org/index.php/report>
10. *The HIV and Sex Work Collection: Innovative responses in Asia and the Pacific*. Bangkok: United Nations Population Fund, Joint United Nations Programme on HIV/AIDS and Asia Pacific Network of Sex Workers [no date].
http://www.unaids.org/en/media/unaids/contentassets/documents/document/2012/20121212_HIV_SW.pdf
11. *Building Partnerships on HIV and Sex Work: Report and Recommendations from the First Asia and the Pacific Regional Consultation on HIV and Sex Work*. Bangkok: Asia Pacific Network of Sex Workers, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, 2011.
<http://asiapacific.unfpa.org/public/pid/7491>
12. The Global Network of Sex Work Projects (NSWP).
www.nswp.org
13. Bar Hostess Empowerment and Support Project (BHESP).
www.bhesp.org
14. Healthy Options Project Skopje (HOPS).
www.hops.org.mk/programs.htm
15. The Yogyakarta Principles on the Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity (2007).
<http://www.yogyakartaprinciples.org/>
16. The Denver Principles (1983).
http://data.unaids.org/Pub/externaldocument/2007/gipa1983denverprinciples_en.pdf



2

Addressing Violence against Sex Workers



What's in this chapter?

This chapter explains:

- the **different kinds of violence** that sex workers may experience, and how violence increases vulnerability to HIV (Section 2.1)
- the **places and contexts** in which violence occurs, and the **social and legal conditions** that make sex workers vulnerable to violence and other human-rights violations (Section 2.1.1)
- **core values and principles** for effective programmes to address violence against sex workers (Section 2.1.2)
- **promising interventions and strategies** to address violence (Section 2.2)
- approaches to **monitoring and evaluation** of interventions (Section 2.3).

The chapter also provides a list of **resources and further reading** (Section 2.4).

2.1 Introduction

2012 Recommendations:¹ Good-practice Recommendations

1. All countries should work toward decriminalization of sex work and elimination of the unjust application of non-criminal laws and regulations against sex workers.
2. Governments should establish antidiscrimination and other rights-respecting laws to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Antidiscrimination laws and regulations should guarantee sex workers' right to social, health and financial services.
3. Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.
4. Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker-led organizations.

Female, male and transgender sex workers face high levels of violence, stigma, discrimination and other human-rights violations. Violence against sex workers is associated with inconsistent condom use or lack of condom use, and with increased risk of STI and HIV infection. Violence also prevents sex workers from accessing HIV information and services.

Violence is defined by the World Health Organization (WHO) as the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that results or has a high likelihood of resulting in injury, death, sexual or psychological harm, mal-development or deprivation of liberty (see also Box 2.1).

Male, female and transgender sex workers may face violence because of the stigma associated with sex work, which in most settings is criminalized, or due to discrimination based on gender, race, HIV status, drug use or other factors. Most violence against sex workers is a manifestation of gender inequality and discrimination directed at women, or at men and transgender individuals who do not conform to gender and heterosexual norms, either because of their feminine appearance or the way they express their sexuality.

Modelling estimates in two different epidemic contexts (Kenya and Ukraine) show that a reduction of approximately 25% in HIV infections among sex workers may be achieved when physical or sexual violence is reduced.² More HIV prevention programmes are implementing strategies to address violence against sex workers and protect their human rights as an integral part of HIV prevention, treatment and care. Addressing violence can make it easier for sex workers to access services and make their own choices about their long-term health and welfare.

¹ *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach.* WHO, UNFPA, UNAIDS, NSWP, 2012.

² See Decker et al (Section 2.4, Further reading No. 3).

This chapter provides practical suggestions for HIV programme managers on how to implement strategies that address violence. It builds on the 2012 Recommendations and the values and preferences survey,³ in which sex workers highlighted the role of violence, criminalization and other human-rights abuses in compromising their access to HIV and STI services.

Box 2.1

Forms of violence faced by sex workers

Physical violence: Being subjected to physical force which can potentially cause death, injury or harm. It includes, but is not limited to: having an object thrown at one, being slapped, pushed, shoved, hit with the fist or with something else that could hurt, being kicked, dragged, beaten up, choked, deliberately burnt, threatened with a weapon or having a weapon used against one (e.g. gun, knife or other weapon). These acts are operationally defined and validated in WHO survey methods on violence against women. Other acts that could be included in a definition of physical violence are: biting, shaking, poking, hair-pulling and physically restraining a person.

Sexual violence: Rape, gang rape (i.e. by more than one person), sexual harassment, being physically forced or psychologically intimidated to engage in sex or subjected to sex acts against one's will (e.g. undesired touching, oral, anal or vaginal penetration with penis or with an object) or that one finds degrading or humiliating.

Emotional or psychological violence: Includes, but is not limited to, being insulted (e.g. called derogatory names) or made to feel bad about oneself; being humiliated or belittled in front of other people; being threatened with loss of custody of one's children; being confined or isolated from family or friends; being threatened with harm to oneself or someone one cares about; repeated shouting, inducing fear through intimidating words or gestures; controlling behaviour; and the destruction of possessions.

Human-rights violations that should be considered in conjunction with violence against sex workers are:

- having money extorted
- being denied or refused food or other basic necessities
- being refused or cheated of salary, payment or money that is due to the person
- being forced to consume drugs or alcohol
- being arbitrarily stopped, subjected to invasive body searches or detained by police
- being arbitrarily detained or incarcerated in police stations, detention centres and rehabilitation centres without due process
- being arrested or threatened with arrest for carrying condoms
- being refused or denied health-care services
- being subjected to coercive health procedures such as forced STI and HIV testing, sterilization, abortions
- being publicly shamed or degraded (e.g. stripped, chained, spat upon, put behind bars)
- being deprived of sleep by force.

³ A global consultation conducted with sex workers by NSWSP as part of the process of developing the 2012 Recommendations.

2.1.1 Contexts of violence

There are several contexts, dynamics and factors that put sex workers at risk for violence. Understanding them is key to designing appropriate programmatic responses.

- **Workplace violence:** This may include violence from managers, support staff, clients or co-workers in establishments where sex work takes place (e.g. brothels, bars, hotels).
- **Violence from intimate partners and family members:** Stigmatization of sex work may lead partners or family members to think it acceptable to use violence to “punish” a woman who has sex with other men. It may be difficult for sex workers to leave an abusive relationship, particularly when perpetrators threaten them, or have control due to ownership of a home, or the power to harm or refuse access to their children.
- **Violence by perpetrators at large or in public spaces:** In most contexts, the antagonistic relationship with police creates a climate of impunity for crimes against sex workers that may lead them to be the targets of violence or of other crimes that may turn violent, such as theft. Some perpetrators specifically target sex workers to “punish” them in the name of upholding social morals, or to scapegoat them for societal problems, including HIV. Sex workers may also face violence from individuals in a position of power, e.g. nongovernmental organization (NGO) employers, health-care providers, bankers or landlords.
- **Organized non-state violence:** Sex workers may face violence from extortion groups, militias, religious extremists or “rescue” groups.
- **State violence:** Sex workers may face violence from military personnel, border guards and prison guards, and most commonly from the police. Criminalization or punitive laws against sex work may provide cover for violence. Violence by representatives of the state compromises sex workers’ access to justice and police protection, and sends a message that such violence is not only acceptable but socially desirable.

Laws and policies, including ones that criminalize sex work, may increase sex workers’ vulnerability to violence. For example, forced rescue and rehabilitation raids by the police in the context of anti-trafficking laws may result in sex workers being evicted from their residences onto the streets, where they may be more exposed to violence. Fear of arrest or harassment by the police may force street-based sex workers to move to locations that are less visible or secure, or pressure them into hurried negotiations with clients that may compromise their ability to assess risks to their own safety.

Violence against sex workers is not always defined or perceived as a criminal act. For example, laws may not recognize rape against transgender individuals as a crime, or police may refuse to register a report of sexual violence made by a sex worker. Sex workers are often reluctant to report violent incidents to the police for fear of police retribution or of being prosecuted for engaging in sex work.

Laws and policies that discriminate against transgender individuals and men who have sex with men increase the vulnerability of male and transgender sex workers to abuse. Laws criminalizing HIV exposure may prevent HIV-positive sex workers from seeking support in cases of sexual violence, for fear of being prosecuted. Even where sex work is not criminalized, the application of administrative law, religious law or executive orders may be used by police officers to stop, search and detain sex workers. This creates conditions in which sex workers face an increased likelihood of violence.

Sex workers may also be made more vulnerable to violence through their working conditions or by compromised access to services. Some may have little control over the conditions of sexual transactions (e.g. fees, clients, types of sexual services) if these are determined by a manager.

The availability of drugs and alcohol in sex work establishments increases the likelihood of people becoming violent towards sex workers working there. Sex workers who consume alcohol or drugs may not be able to assess situations that are not safe for them.

Violence or fear of violence may prevent sex workers from accessing harm reduction, HIV prevention, treatment and care, health and other social services as well as services aimed at preventing and responding to violence (e.g. legal, health). Discrimination against sex workers in shelters for those who experience violence may further compromise their safety.

2.1.2 Values and principles for addressing violence against sex workers

Core values

- **Promote the full protection of sex workers' human rights.** This includes the rights to: non-discrimination; security of person and privacy; recognition and equality before the law; due process of law and the highest attainable standard of health; employment, and just and favourable conditions of employment; peaceful assembly and association; freedom from arbitrary arrest and detention, and from cruel and inhumane treatment; and protection from violence.
- **Reject interventions based on the notion of rescue and rehabilitation.** Even when ostensibly focused on minors (who are not sex workers), such raids deprive sex workers of their agency (the choice, control and power to act for themselves) and increase the likelihood that they will experience violence.
- **Promote gender equality** by encouraging programme planners and implementers to challenge unequal gender roles, social norms and distribution and control of resources and power. Intervention strategies should aim for more equitable power relationships between sex workers and others in the wider community.
- **Respect the right of sex workers to make informed choices** about their lives, which may involve not reporting or seeking redress for violence, not seeking violence-related services, or continuing in an abusive relationship.

Programming principles

- **Gather information about local patterns of violence** against sex workers, and the relationship of violence to HIV, as the basis for designing programmes (see Chapter 3, Section 3.2.2, part A).
- **Use participatory methods.** Sex workers should be in decision-making positions where they can engage in processes to identify their problems and priorities, analyse causes and develop solutions. Such methods strengthen programme relevance, build enduring life and relationship skills and help ensure the long-term success of programmes.
- **Use an integrated approach in designing interventions.** Holistic programmes that include provision of health services, work with the legal and justice sectors and are community-based⁴ can have a greater impact on violence against sex workers and the risk of HIV. Such programmes require establishing partnerships with a wide range of groups and institutions.
- **Build capacity of programme staff** to understand and address the links between violence against sex workers and HIV. Programme staff should be able to respond sensitively to sex workers who experience violence, without further stigmatizing or blaming them. (See also Chapter 6, Section 6.2.6, sub-section on hiring and training staff.)

⁴ In most contexts in this tool, "community" refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to sex workers, "community-led interventions" are interventions led by sex workers, and "community members" are sex workers.

2 Addressing Violence against Sex Workers

- **Recognize that programmes may have unintended harmful impacts** for sex workers, such as retaliatory or “backlash” violence. Prepare for this possibility and monitor programmes for such unintended consequences.
- **Evaluate programmes** to identify strategies that reduce risk factors and levels of violence faced by sex workers, in order to build the evidence base and ensure that resources are directed to the most beneficial strategies. Include measurable objectives that articulate results to reduce violence against sex workers.

2.2 Promising interventions and strategies

This section suggests strategies to prevent and respond to violence against sex workers. Many of these strategies were developed as good practices by sex workers. Unless explicitly stated, these strategies have not been formally evaluated for their impact on reducing risk factors or levels of violence against sex workers. It is recommended that before any of the strategies suggested below are scaled up, they are monitored for any unintended consequences and evaluated to establish whether they work in preventing or reducing violence against sex workers.

2.2.1 Community empowerment

Stages of community empowerment are detailed in Chapter 1. Community empowerment can contribute to violence reduction by:

- providing a mechanism for sex workers to engage in critical reflection on their rights, their problems, including violence, and the root causes of these problems
- building collective solidarity for sex workers to mobilize and advocate to challenge and change behaviours of powerful groups or institutions that deny them their rights and perpetuate violence and other abuses.

2.2.2 Building the capacity of sex workers

Several kinds of activities build sex workers’ knowledge of their rights in relation to sex work and violence, and their confidence to claim these rights.

Training and sensitizing sex workers about sex work-related laws and their human rights

This generates awareness and encourages sex workers to report and challenge violence. Activities may include training and advocacy workshops, production and dissemination of written and visual materials about violence and the human rights of sex workers, community meetings and face-to-face counselling from community outreach workers⁵ (see Box 2.2). Training and print materials should factor in the differing learning needs and literacy levels of sex workers. Topics covered may include: sources of and reasons for violence faced by sex workers; knowledge of sex work laws and laws that affect sex workers (e.g. municipal statutes, laws related to homosexual sex, drug use); sex workers’ rights when arrested, charged or detained by the police, and correct police procedures; and legal services.

⁵ In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”. The terms “community” or “peer” should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Box 2.2

Case example: Human Rights Defenders programme, South Africa

The Human Rights Defenders programme has been implemented by the Sisonke sex workers movement and the Sex Worker Education and Advocacy Task Force (SWEAT) in South Africa since 2008. It trains sex workers as paralegals in basic rights and how to defend them.

Paralegals document cases of human-rights abuses through a toll-free helpline, outreach and weekly community meetings with sex workers. They also offer counselling support to those who report incidents of abuse.

Community meetings with sex workers are used to raise awareness of their rights and how to access justice.

Sex workers who need legal services are referred to lawyers accessed through the Women's Legal Centre and weekly legal clinics. They are also offered court support.

SWEAT also undertakes strategic litigation to address root causes of violence against sex workers.

Documenting violence faced by sex workers and defending their human rights

Activities could include:

- gathering data or information on different forms of violence faced by sex workers
- documenting abuses and incidents of violence faced by sex workers
- facilitating their access to justice through legal services.

In some settings, careful and systematic documentation of violence against sex workers has been used to develop resources for sex workers to promote their safety. For example, in 2002 the Italian sex worker-led NGO Comitato per i Diritti Civili delle Prostitute documented violence against sex workers and used this information to produce a magazine for sex workers to encourage them to report violence and seek support and services.

Data on violence faced by sex workers have also been used to advocate with police, local authorities, media and national policy-makers about the extent of the problem and the need to change the application of laws, policies and police practices to reduce violence faced by sex workers (see Section 2.2.3). Note that there are ethical and safety concerns around collecting research data on violence against sex workers that should be carefully considered; see Section 2.3 for further information.

2.2.3 Advocating for reforms

Advocacy for legal and policy reforms can contribute to preventing or reducing violence against sex workers by:

- aiming to change laws and policies that criminalize sex work and administrative laws that are used to harass and abuse sex workers
- aiming to change law-enforcement practices that harass or abuse sex workers and deny them their human rights
- building institutional accountability for existing laws and policies upholding the human rights of sex workers
- countering stigma and discrimination against sex workers and promoting sex work as work (see Box 2.3).

Box 2.3

Case example: “Someone you know is a sex worker” campaign, San Francisco, USA

The St. James Infirmery developed a campaign to convey that:

- sex workers are everyday people and valued members of the community
- sex workers are equal members of society, and their rights are human rights
- sex work is real work and sex workers deserve labour rights.

The campaign involved interviewing and photographing sex workers, their partners and service providers affiliated with the St. James Infirmery. The campaign messages were reviewed by sex workers and others not involved in sex work.

Large advertisements were displayed on the sides of city buses for one month. Posters were also distributed to social and health-care agencies.



Source: Barbara DeGenevieve and Rachel Schreiber, media campaign for the St. James Infirmery, San Francisco, USA

Target audiences of such advocacy and sensitization may include: local and national government officials responsible for law enforcement; justice, military and security personnel; media (e.g. print, television, radio, social); religious and political leaders; parliamentarians; local, municipal, district and provincial governments (e.g. mayors, local councils); NGOs that work on human rights more broadly; women’s organizations; health-care providers and health-care professional organizations; United Nations organizations; and international NGOs.

Advocacy efforts may need to strike a balance between targeting frontline staff in different sectors (e.g. police or health workers) and decision-makers (e.g. administrators and managers), as frontline staff may respond to pressure from decision-makers.

Advocacy and sensitization activities may include:

- public campaigns to highlight sex work as work (see Box 2.3)
- sensitization workshops
- highlighting the issue of violence against sex workers on specific international and national days and in campaigns relevant to HIV, sex work, gender-based violence and human rights
- disseminating print and other multimedia materials about violence against sex workers

- working with journalists and other members of the media to promote positive stories and language use about sex work
- building partnerships and networks with organizations that work on human rights and HIV, for joint advocacy efforts (see Box 2.4)
- supporting collective action by sex workers to demand redress for violence faced by their community members
- building programme managers' understanding of laws affecting sex workers' rights.

Box 2.4

Case example: Building partnerships for advocacy in Karnataka, India

Addressing violence against sex workers is complex and requires partnership with like-minded organizations. The Karnataka Health Promotion Trust (KHPT) has been working on HIV prevention among sex workers in Karnataka, India for the last 10 years. Preventing and responding to violence emerged as a strong “felt need” among sex workers.

KHPT sensitized and advocated with law enforcement (police) and judiciary not to perpetrate or condone violence against sex workers. In partnership with KHPT:

- The state's Women and Child Welfare Department made services for violence against women available to sex workers as well.
- Community-based organizations worked with sex workers in 30 districts to sensitize them about their rights.
- The Alternate Law Forum and the National Law School of India developed and conducted legal literacy training for sex workers.
- The Centre for Advocacy and Research, an NGO, did media advocacy and trained sex workers as media spokespersons to talk about the violence they face, their resilience and actions to prevent and respond to violence.

2.2.4 Fostering police accountability

Working with the police has been a key element of efforts to reduce violence against sex workers. Activities may include:

- **Sensitization workshops with the police** that raise their awareness of laws related to sex work and sex workers' rights. These workshops also build relationships between sex workers and police in order to minimize police harassment and violence. In some settings such workshops have been led by sex workers (see Box 2.5); in other places they have involved lawyers (e.g. India); and in some settings sex workers, police and NGOs have jointly conducted trainings (e.g. Keeping Alive Societies' Hope [KASH] in Kenya, and Tais Plus in Kyrgyzstan). Training topics that are covered in various manuals (see Section 2.4) may include: basic introduction to HIV and HIV programming; laws and law enforcement practices that affect sex worker rights, including those related to violence; role of the police in HIV prevention; and human rights of sex workers.
- **Advocacy** (e.g. regular meetings with police as well as with high-level government officials responsible for law enforcement) to reduce police harassment of sex workers and community outreach workers (e.g. getting letters of support from the police that are carried by the outreach workers), and to ensure the commitment of frontline officers to the trainings.

Box 2.5

Case example: Training police in Peru

Movimiento de Trabajadores Sexuales del Perú conducts workshops to raise awareness about human rights among regional and municipal officials and civil servants, especially the rights of sex workers. It also conducts trainings with police and security forces, local authorities and health-care workers in order to change discriminatory attitudes and practices towards sex workers and encourage them to defend the rights of sex workers, particularly in relation to gender-based violence.

A curriculum has been developed for online workshops with these groups, to improve their knowledge, skills, attitudes and capacity to respond to cases of gender-based violence against female, transgender and transsexual sex workers. While there has been some backlash against sex workers from some police who continue to oppose their rights, the training has helped open dialogue with senior police officers and other policy-makers.

- **Building institutional accountability** with police to uphold the rights of sex workers. For example:
 - › In India, advocacy with the police resulted in getting police administrators to issue a circular to police stations requiring them to follow the rule of law and ensure due process when arresting sex workers. Civil society groups could then monitor adherence.
 - › In Kyrgyzstan, a project by the AIDS Foundation East-West in partnership with Tais Plus (a sex worker-led organization) focused on collaborating with police on trainings, publicizing a ministerial order on police and HIV, establishing a team of “friendly police” to be liaisons for HIV service providers and developing an incentive system to reinforce police behaviour supportive of HIV programmes. The ministerial order forbade police officers from obstructing HIV prevention programmes and obliged them to inform key populations about the availability of HIV services.

Evaluations of police training efforts to assess whether they have reduced violence against sex workers are ongoing in a few settings (e.g. in Kyrgyzstan by Tais Plus and in Kenya by KASH). Reflections on police training from organizations involved in these efforts suggest that:

- Police training and working with the police may provoke a backlash against sex workers by some officers. Hence, this needs to be monitored.
- It may be important to gain support at senior levels in the police hierarchy in order to get and sustain support from police lower down and hold them accountable for their actions.
- Building relationships with police and educating them about sex worker rights has to be a continual process due to turnover in staff.

2.2.5 Promoting the safety and security of sex workers

Strategies to promote the safety and security of sex workers in their workplaces and communities may be formal or informal. The following should be considered:

- **Maintaining and sharing lists or reports of aggressors** or incidents of violence against sex workers. In some settings this is called an “Ugly Mugs programme”. The list includes physical descriptions of perpetrators and vehicles involved. Reporting sheets can be made available online, by fax, e-mail, mail or at safe spaces (drop-in centres).⁶ The reports are compiled and distributed to sex workers through monthly bulletins, SMS or e-mails so that they know to avoid potentially dangerous individuals.

⁶ A safe space or drop-in centre is a place where sex workers may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 3, Section 3.3 for details.

- **Promoting workplace security** by negotiating with owners and managers of sex establishments to protect sex workers from perpetrators of violence. For example, the sex worker-led organization Ashodaya in Karnataka, India, incentivized hotel or lodge owners to protect sex workers from abuse by offering the owners access to free health services. Similarly, the KASH sex worker project in Kenya partnered with bar managers and staff to display a hotline number, and initiated an SMS-based system that enables sex workers to send messages about experiences of violence and receive feedback and support from KASH staff.
- **Disseminating information or tips about safety to sex workers** (e.g. asking sex workers to carry mobile phones, inform friends before they go with clients, keep numbers to call in case they are in dangerous situations; see Box 2.6). For example, sex worker organizations from five European countries have developed a safety brochure in six languages as part of the “INDOORS” project that supports the empowerment of sex workers in Europe, including migrant sex workers. The brochure, titled “Safer Work”, includes practical tips for sex workers to stay safe from violence and protect their health, as well as information about legislation in the five countries.

Box 2.6

Case example: Safety tips for sex workers from SWEAT, South Africa



Source: Sex Workers Education and Advocacy Taskforce (SWEAT), South Africa

- Always take down the car registration number, colour and make.
- Try to check the boot of the car and the back seats before you climb in.
- Don't get into a car with more than one client in it.
- Don't lean into the car when negotiating with a client—if he means trouble, he can hurt you.
- Check that the car door handles work.

- **Creating safe spaces (drop-in centres)** or shelters that allow sex workers to come together and discuss common issues and problems they face, including violence, and develop and exchange solutions. For example, the Brazilian sex work organization Fio da Alma opened a drop-in centre where sex workers were encouraged to meet and to participate in workshops and activities such as classes on violence prevention. The evaluation of the project's broad set of interventions showed an increase in the reported ability of sex workers to manage client risk behaviours related to drugs and alcohol.
- **Integrating violence prevention in HIV prevention counselling interventions with sex workers.** In settings such as Mongolia, South Africa and the USA, HIV prevention counselling interventions that have integrated a safety-planning component have been evaluated and shown to reduce violence against sex workers. Counselling strategies are broadly focused on information and skills-building related to STI and HIV prevention. The violence prevention component includes:
 - Working with sex workers to assess potentially violent situations and develop a “safety plan” to get out of such situations. For example, the Women's Health CoOp project in Pretoria, South

2 Addressing Violence against Sex Workers

Africa offered individualized counselling sessions to sex workers that included discussions on safety strategies, including in relation to: use of alcohol and drugs; communication and negotiation skills for different situations to avoid precipitating conflict; and ways to exit unsafe situations.

- › Collaborative counselling with trained counsellors, using reflective listening to support individual sex workers in identifying feasible steps to make themselves safer, and available local resources in case they experience violence. The approach is supportive, non-judgemental and respectful of the autonomy of the individual in making behaviour changes. In Mongolia, this approach was found to reduce sex workers' risk of violence from both clients and intimate partners.

2.2.6 Providing health services to sex workers who experience violence

Sex workers who experience physical, sexual and psychological violence may need medical care in both the short and long term. In most settings there are hardly any specialized medical services for those who experience violence. Therefore, it may be useful to consider integrating services for those who experience violence into the broader set of HIV prevention, treatment and care and other health services for sex workers. WHO has developed clinical and policy guidelines for the health-sector response to violence against women (see Section 2.4). While focused on all women, the guidelines are also relevant to female sex workers, and some aspects are also relevant to male and transgender sex workers.

Box 2.7

Topics for training health-care providers in addressing violence against sex workers

- Basic information about violence, including laws and policies against violence with a focus on sex workers.
- Identifying those who may be experiencing violence based on physical or psychosocial symptoms (e.g. depression, anxiety, post-traumatic stress disorder, suicidality or self-harm, substance use, injuries).
- When and how to inquire about violence.
- Collecting forensic evidence for investigating sexual violence.
- Providing clinical and psychological care and treatment as per WHO recommendations.
- Where to refer for support services in the community.
- Providing non-judgemental care that does not stigmatize those who experience violence.
- Implications of mandatory reporting of violence (not recommended in the WHO guidelines).

Although not in the WHO guidelines on health-sector response to violence, in the context of sex work, training may also include:

- human rights of sex workers
- laws and policies pertaining to sex work that make sex workers vulnerable to violence
- violence faced by sex workers in health-care settings and obligations of health-care providers not to discriminate, stigmatize or perpetrate violence against sex workers
- providing clinical and psychological care to male and transgender sex workers who experience violence.

Recommendations for clinical care, psychological support and health services to those who experience partner violence and sexual assault are:

- Provide immediate support to those who experience violence who present at a health facility. Providers should ensure confidentiality, be non-judgemental, provide practical care, ask about the history of violence, listen carefully without pressuring the person to talk, facilitate access to social support, resources and services (e.g. legal if needed) and help develop a safety plan.
- Provide clinical care for those who experience sexual assault, including emergency contraception, HIV and STI post-exposure prophylaxis (dosage and timing as per the recommendations in the 2013 WHO guidelines mentioned above) and access to abortion to the fullest extent of the law for those who become pregnant. See also Chapter 5, Section 5.7.5.
- Provide psychological care, including information about symptoms of trauma and stress. For symptoms such as depression, inability to carry out daily functions, or suicidal feelings, provide care in accordance with WHO clinical protocols for mental-health problems.
- Health-care providers should be trained to provide services to those who experience violence (see Box 2.7 for recommended training topics).
- A directory of medical, legal and social services for sex workers who experience violence should be compiled and working arrangements established with service providers to accept referrals and provide high-quality services.

2.2.7 Providing psychosocial, legal and other support services

Sex workers who experience violence often need a further range of immediate and longer-term services. Services that may be provided according to local need and capacity include:

Community members trained to respond to sex workers who experience violence

Sex workers who experience violence or any other crisis may need a trained person to provide immediate support and referrals. For example:

- In Kenya, KASH has a phone hotline that sex workers may call for immediate and ongoing support in response to violence or other crises they may experience.
- In South Africa, the NGO Sisonke offers follow-up counselling and support to those who experience violence.
- In India, as part of the Avahan AIDS Initiative, an integrated crisis response system has been implemented, along with community empowerment of sex workers. The system has been evaluated and shown to work (See Box 2.9).

Training in these types of activities may be led by knowledgeable sex workers and may cover: listening and communication skills; prioritizing safety of sex workers; advocacy skills to work with the police, social and health services, and media; knowledge of sex workers' rights; dealing with police and local government officials; counselling those who may be under psychological duress; and assessing risks of harm. Training should take into account different learning needs and the diversity (e.g. ethnicity, migrant status) of sex workers.

Legal support

This may require engaging or linking with lawyers or trained paralegals (e.g. sex workers trained as paralegals) who can help negotiate with legal and judicial authorities about incidents of violence, advocate on behalf of sex workers, and support training and sensitization of sex workers and others on laws related to sex work.

Shelter or safe space

Those who experience violence may need to get away from the environment or the specific person(s) that is a threat to them. In Kyrgyzstan, the sex worker organization Tais Plus offers shelter to sex workers in crisis, at risk of violence, fleeing violence or fearing retribution.

These support service models vary in terms of their complexity, the amount of financial and human resources required to operate them (see Box 2.8), and whether they have been evaluated and shown to work. Support services should also be based on assessments of informal practices already established by sex workers themselves, and on their existing priorities. Some models, such as comprehensive crisis response systems, are resource-intensive, while others may require fewer resources. The following activities should be considered in order to support these services:

- **Provide necessary infrastructure:** This may include local mobile phone numbers and/or hotlines staffed by trained community members. The availability of support services may need to be advertised through word of mouth, fliers and other communication channels.
- **Document incidents of violence:** Recording incidents of violence enables programme staff to analyse the incidents, ensure follow-up, monitor efforts and improve services. For sex workers who want to file legal cases in response to violence, such documentation helps to provide necessary evidence for courts. Data on violence faced by sex workers may also be used for advocacy with local, state and national policy-makers and for planning services to address violence against sex workers.

Box 2.8

What are the potential resources needed for providing legal, psychosocial and other support services?

Resource people:

- Designated and trained sex workers to operate the helplines or hotlines
- Community outreach workers
- Trained peer and/or professional counsellors for psychological support
- Lawyers or paralegals (could be trained sex workers) who can provide legal support

Materials and venue:

- Access to a venue
- Mobile phones and time credit
- Hotlines
- Internet access
- Print materials to advertise services
- Data collection and reporting forms
- A space to operate hotlines, conduct trainings and meetings
- Safe space (drop-in centre) or shelter

Costs:

- Remuneration for staff (including lawyers if not pro bono)
- Start-up and maintenance costs of sex workers to use mobile phones, hotlines
- Advertising the services
- Transport costs
- Training

Box 2.9

Case example: Avahan's crisis response system in India

A crisis response system provides rapid on-the-spot support to sex workers who face violence or some other crisis. The sex worker accesses support by calling the mobile phone of a member of a crisis response team. The team includes trained community members who:

- assess the nature and urgency of the crisis
- take steps to address immediate danger
- facilitate access to medical services, psychosocial and other relevant support
- provide access to a lawyer in case of arrest to support negotiations with the authorities
- provide counselling
- report and document incidents of violence and the team's response
- assist in resolving family or community issues affecting sex workers
- report back to the community on a regular basis on incidents that have occurred and their resolution (while respecting the confidentiality of those who have experienced violence).

1. The team includes a person to receive calls, other community members who are on call 24/7 to respond to incidents, and a data person to document the incidents of violence.
2. The team is supported by a social worker from the local implementing organization⁶ to provide referrals, and one or more lawyers (working pro bono or on a small retainer) who can negotiate with authorities on behalf of sex workers who have been wrongfully arrested or detained, and who can support training for sex workers about their rights.
3. A response protocol specifies the steps for rapid follow-up in the case of physical or sexual violence; for preventing police harassment, or unlawful detention after arrest; or for rapid intervention if someone is contemplating suicide.
4. The infrastructure includes local mobile phones and/or helplines that people may call, and outreach to promote the service.
5. Details of incidents of violence and the actions taken are recorded as soon as possible after the incident. This information may be helpful as evidence for legal purposes, to provide data on the scale of violence faced by sex workers for advocacy, and for planning services.
6. The system builds links with health care, legal services, temporary housing or shelter, transport and other social services through a directory of services and establishes working arrangements with service providers to accept referrals and provide high-quality services.

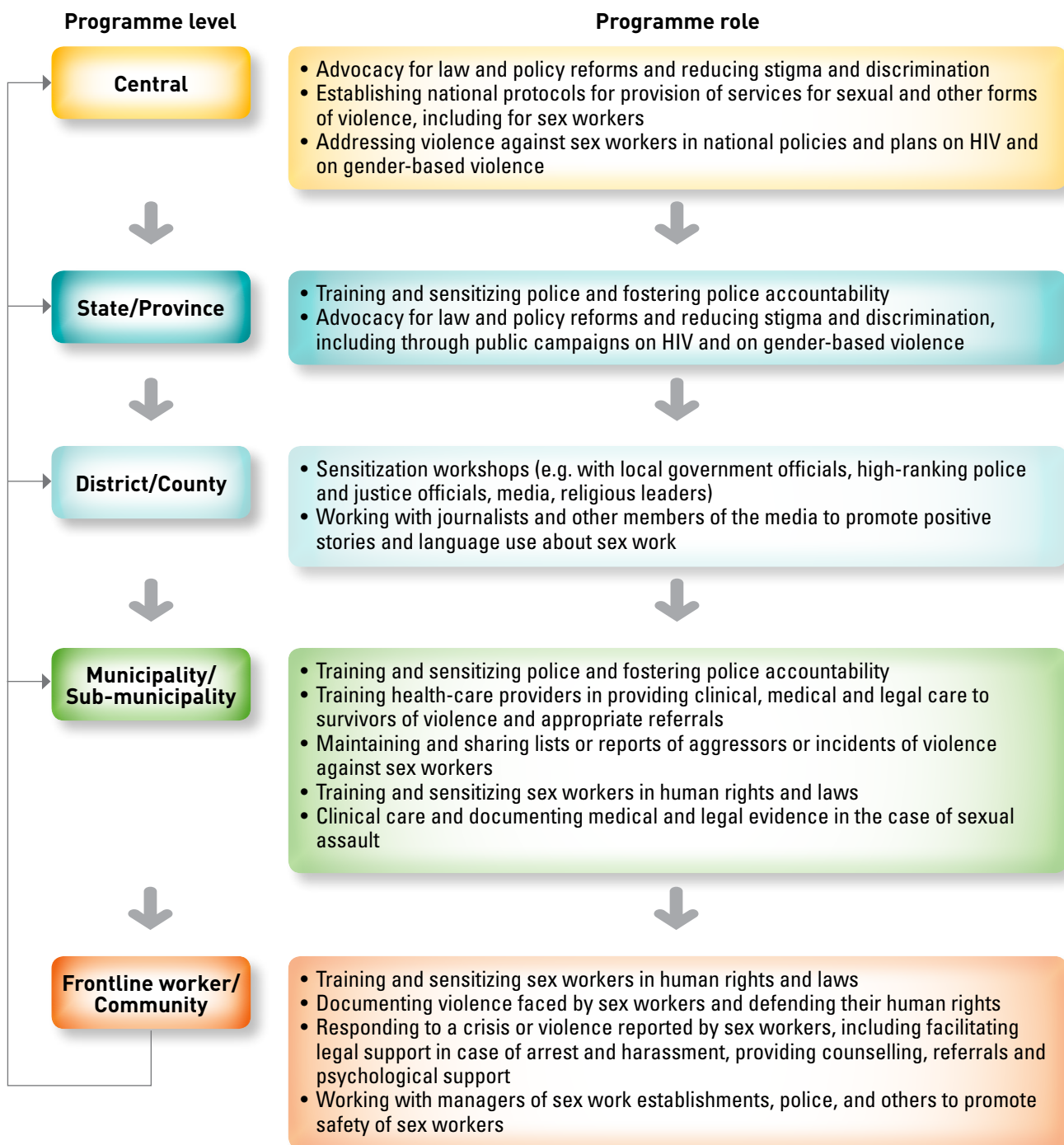
In the Avahan programme, the system has been scaled up from a few dozen teams to several hundred in six states of India, using common minimum standards and adapting programmes to the local context. The system is managed by sex workers, although financial resources (usually from the implementing organization) are required to sustain it.

⁷ An implementing organization is an organization delivering a prevention intervention to sex workers. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes an NGO provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

2.3 Management, monitoring and evaluation

The interventions described in this chapter are not only implemented at a local level but also require engagement at subnational and national levels. This is particularly true for sensitization and advocacy work. Figure 2.1 shows the roles of each of the levels of implementation.

Figure 2.1 Illustrative multi-level approach to addressing violence against sex workers



Monitoring and evaluation of violence prevention and response efforts are important because:

- Data on violence faced by sex workers provide a basis for planning and designing appropriate strategies.
- Including indicators on violence faced by sex workers in the routine monitoring framework allows programmes to monitor whether there are any unintended consequences of sex work interventions, e.g. “backlash” violence.
- Evidence on violence faced by sex workers is a powerful tool for advocacy efforts to change laws and policies related to sex work and create an enabling environment for promoting the rights of sex workers.

Evaluation of violence prevention and response strategies with sex workers is necessary before most of the options presented in Section 2.2 are scaled up. Gathering accurate information about violence requires that sex workers have trust and be comfortable disclosing their experiences of violence. Care should be taken that collection of data or documentation of incidents of violence does not further endanger the safety of sex workers or stigmatize them. Building trust depends on the ethical and safety measures included in data collection, and the skills of data collectors in sensitively asking relevant questions. WHO ethical and safety guidelines for researching violence against women are recommended as a standard to be followed in gathering data on violence against sex workers (see Section 2.4). Sex workers must be equal partners in the design, implementation and dissemination of results from any data collection activity related to violence and other human rights violations against them.

There are currently no validated and internationally agreed-upon population-based impact indicators or programmatic indicators that are specific to violence faced by sex workers. Indicators for monitoring and evaluating interventions that address violence against sex workers would therefore need to be developed or adapted and validated based on existing indicators on violence prevention and response with the general population of women.

In some settings, such as India, integrated bio-behavioural surveys on STIs and HIV implemented with key populations, including sex workers, have included indicators on violence faced by sex workers, e.g:

- Percentage of sex workers surveyed who were physically beaten or forced to have sexual intercourse by an individual against their will in the past one year.

However, these surveys do not capture the range of physical and sexual violence experienced by sex workers as defined in Box 2.1. Data collected based on such terms as “beaten or raped” may underreport the violence experienced by sex workers. It may therefore be useful to conduct additional research, including qualitative research, to better understand the context, dynamics and factors that fuel violence against sex workers.

In India, where the Avahan AIDS Initiative included crisis response systems to address violence, programmes have also collected data on reported incidents of violence faced by sex workers. These indicators include:

- Number of sex workers who report incidents of physical violence
- Number of sex workers who report incidents of sexual violence
- Perpetrators of any violence reported by sex workers, by category (e.g. police, intimate partner, client)

2 Addressing Violence against Sex Workers

Programme monitoring data that rely on self-reported incidents of violence are sensitive to bias. It may therefore be challenging to interpret monitoring efforts that track increases or declines in reported incidents over time. Some forms of violence may be more likely to be reported when programme monitoring systems are established than others, and this will vary across different contexts over time. For example, in one setting, incidents of partner violence reported by sex workers increased as the intervention matured, which may have been due to sex workers feeling more empowered to recognize and report it as violence, or a consequence of “backlash” violence as sex workers became more assertive in their relationships. Self-reporting of incidents to programme monitoring systems also depends on the level of trust and confidence sex workers have in programme staff and in the monitoring system, especially since the act of disclosure may endanger a sex worker’s safety.

Another indicator for monitoring availability of post-rape care services that could be adapted for sex work programmes is:

- Number or percentage of service-delivery points providing appropriate medical, psychological and legal support for women and men who have been raped or who have experienced incest.

This indicator is included in the UNAIDS Unified Budget, Results and Accountability Framework (UBRAF) for measuring progress of countries in addressing sexual violence in the context of the AIDS response.⁸

2.4 Resources and further reading

Resources

2. *Mee Nestam: Strengthening Partnerships for Public Health*. Hyderabad, India: India HIV/AIDS Alliance, 2012. www.allianceindia.org/publications/51625-Mee%20Nestam%20Book.pdf
3. *Sex work, violence and HIV: A guide for programmes with sex workers*. United Kingdom: International HIV/AIDS Alliance, 2008. www.aidsdatahub.org/dmdocuments/Sex_Work_Violence_and_HIV_A_Guide_for_Programmes_with_Sex_Workers_2007.pdf.pdf
4. *Community Led Crisis Response Systems—A Handbook*. New Delhi: Bill & Melinda Gates Foundation, 2013. [http://docs.gatesfoundation.org/no-search/Documents/Community%20Led%20Crisis%20Response%20\(Web\).pdf](http://docs.gatesfoundation.org/no-search/Documents/Community%20Led%20Crisis%20Response%20(Web).pdf)
5. *Safer Work*. Marseille, France: INDOORS Project, Autres Regards, 2010. http://www.indoors-project.eu/documents/saferwork_english.pdf
6. *Work Wise: Sex worker handbook on human rights, health and violence*. Cape Town, South Africa: Sex Worker Empowerment, Advocacy and Training (SWEAT), 2004. www.sweat.org.za
7. Gender Strategies in Concentrated Epidemics: Case study series. AIDSTAR-One, The U.S. President’s Emergency Plan for AIDS Relief and United States Agency for International Development. www.aidstar-one.com/focus_areas/gender/marps_concentrated_epidemics_series
8. Spratt K. 2011. *Integrating PEPFAR Gender Strategies into HIV Programs for Most-at-Risk Populations*. Arlington, VA: AIDSTAR-One, Task Order 1. www.aidstar-one.com/sites/default/files/AIDSTAR_One_Report_IntegratingGenderStrategies_MARPs.pdf
9. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva: World Health Organization, 2013. <http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/index.html>

⁸ In UBRAF, this indicator is defined as the percentage of countries reporting availability and use of one or more service-delivery points that provide appropriate medical, psychological and legal support to women and men who have been raped or experienced incest. Use of the number or percentage depends on whether a facility-based survey has been conducted in the intervention area as a baseline.

10. *Integrating Multiple Gender Strategies to Improve HIV and AIDS Interventions: A Compendium of Programs in Africa*. 2009. Arlington, VA: AIDSTAR-One, 2009.
http://www.aidstar-one.com/sites/default/files/Gender_compendium_Final.pdf
11. *mHGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010.
http://www.who.int/mental_health/evidence/mhGAP_intervention_guide/en/
12. *The power to tackle violence: Avahan's experience with community-led crisis response in India*. New Delhi: Bill & Melinda Gates Foundation, 2009.
http://docs.gatesfoundation.org/avahan/documents/avahan_powertotackleviolence.pdf
13. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence against Women*. Geneva: World Health Organization, 2001.
http://www.who.int/gender/documents/violence/who_fch_gwh_01.1/en/
14. *Measuring sexual health: conceptual and practical considerations and indicators*. Geneva: World Health Organization, 2010.
http://www.who.int/reproductivehealth/publications/monitoring/who_rhr_10.12/en/
15. *Unified Budget, Results and Accountability Framework: Indicator Reference*. Geneva: Joint United Nations Programme on HIV/AIDS, 2012.
http://jpmis.unaids.org/sites/default/files/JPhelp/2012-2015_UBRAF_Indicator_Definitions.pdf

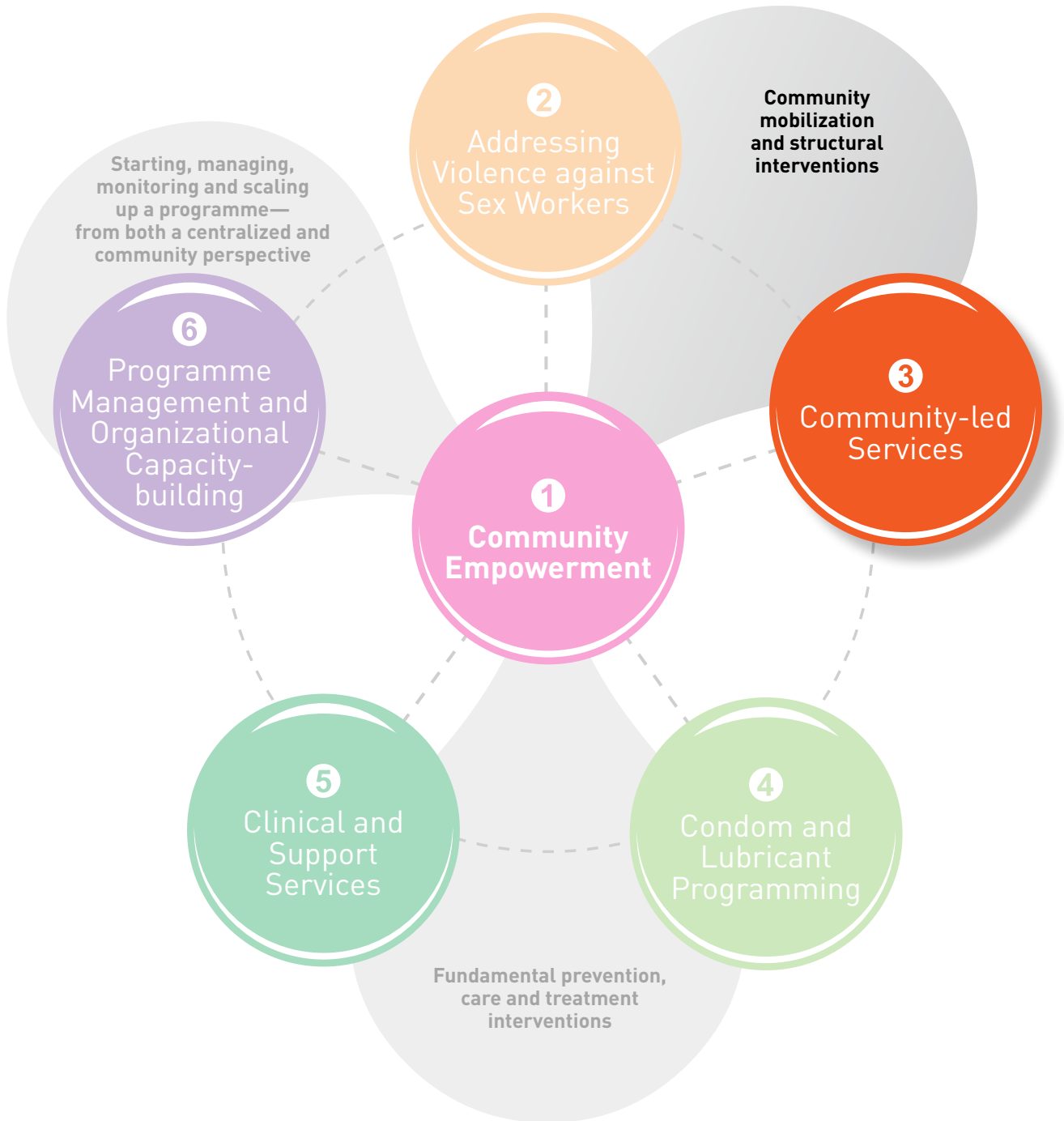
Further reading

1. Beletsky L, Thomas R, Smelyanskaya M, et al. Policy reform to shift the health and human rights environment for vulnerable groups: the case of Kyrgyzstan's Instruction 417. *Health and Human Rights*, 2013; 14(2):34–48.
2. Carlson CE, Chen J, Chang M, et al. Reducing intimate and paying partner violence against women who exchange sex in Mongolia: results from a randomized clinical trial. *Journal of Interpersonal Violence*, 2012 Jul; 27(10):1911–1931.
3. Decker M, Wirtz AL, Pretorius C, et al. Estimating the impact of reducing violence against female sex workers on HIV epidemics in Kenya and Ukraine: a policy modeling exercise. *American Journal of Reproductive Immunology*, 2013; 69(Suppl 1):122–132.
4. Kerrigan D, Telles P, Torres H, et al. Community development and HIV/STI-related vulnerability among female sex workers in Rio de Janeiro, Brazil. *Health Education Research*, 2008 Feb; 23(1):137–145.
5. Penfold C, Hunter G, Campbell R, et al. Tackling client violence in female street prostitution: inter-agency working between outreach agencies and the police. *Policing and Society*, 2004; 14(4):365–379.
6. Reza-Paul S, Lorway R, O'Brien N, et al. Sex worker-led structural interventions in India: a case study on addressing violence in HIV prevention through the Ashodaya Samithi collective in Mysore. *The Indian Journal of Medical Research*, 2012; 135:98–106.



3

Community-led Services



What's in this chapter?

This chapter:

- **defines community-led services** (Section 3.1)
- describes **how to design and implement** three kinds of community-led services:
 - › community-led outreach (Section 3.2)
 - › safe spaces (drop-in centres) (Section 3.3)
 - › community committees and advisory groups (Section 3.4).

The chapter also provides a list of **resources and further reading** (Section 3.5).

3.1 Introduction

Community-led services, in which sex workers take the lead in delivering outreach and overseeing an HIV prevention programme, have demonstrated significant benefits in terms of HIV outcomes.¹ They also enable sex workers to address structural barriers to their rights, and empower them to change social norms to achieve a sustained reduction in their vulnerability that goes beyond HIV.

Community-led services are interventions designed, delivered and monitored by sex workers (or with sex workers) that:

- build adequate and reliable access to commodities (condoms, lubricants, and needles and syringes) and clinical services through outreach and referrals
- respond to violence against sex workers and implement other structural interventions
- offer a progressive approach to behaviour and social change that strengthens not only knowledge but also skills and systems, in order to make prevention, care and treatment viable and sustainable
- feature formal and informal systems for the community to provide feedback to enhance the quality of clinical and other services and to engage in other ways, such as with social services beyond the HIV prevention programme.

Involving sex workers as individuals and as a community creates a foundation for strong HIV interventions, for a more enabling environment and for community empowerment. It also makes programmes more efficient and effective. With sustained support, community-led services may develop into strong initiatives that address structural barriers and underlying conditions of vulnerability and risk.

Community-led services incorporate tools and methods for frontline workers that also support programme management. A community-led approach ensures that sex workers have a leading role in interventions, including in their design, implementation and oversight. Many kinds of interventions can incorporate a community-led approach. This chapter describes three of the most important for scaling up HIV prevention programmes with sex workers: community-led outreach, safe spaces (drop-in centres) and community committees and advisory groups (Figure 3.1).

Box 3.1

Implementation of best practice for sex worker programmes

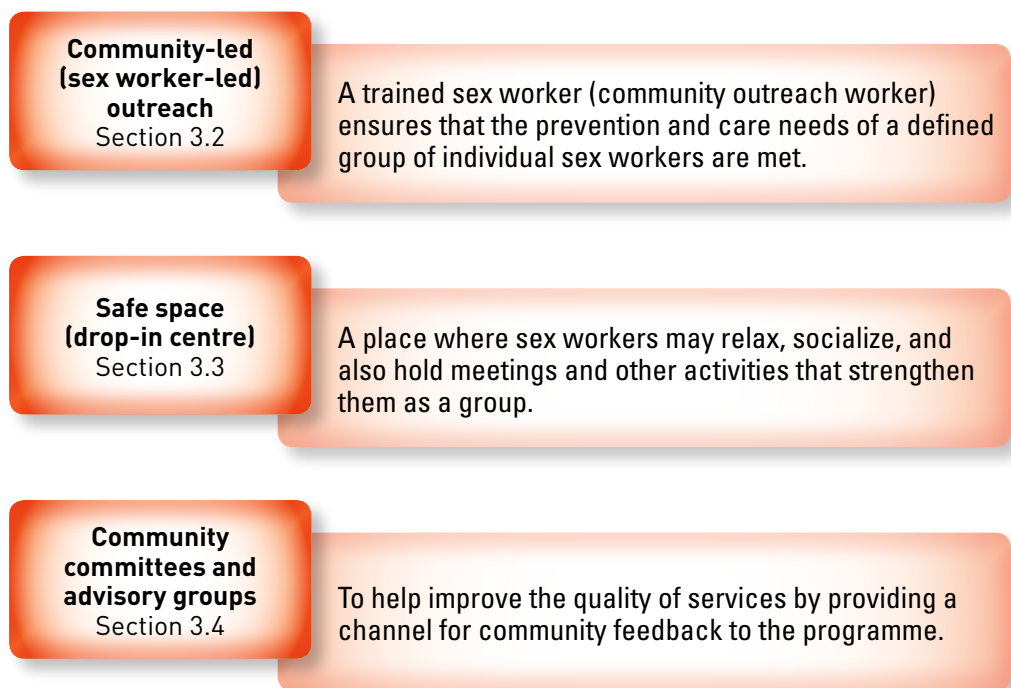
HIV prevention interventions are often implemented by nongovernmental organizations (NGOs). In some contexts it is challenging to immediately engage sex workers to do outreach with the sex worker community, and in the initial phase of a programme (the first year, for example), NGO staff may need to take a lead role in outreach. Where this is the case, the programme should be designed so that sex workers are recruited, trained and involved as quickly as possible and take on increasing responsibility within the programme.

Some of the guidance in this chapter is written assuming that the implementing organization² is an NGO that is not formed entirely of sex workers. The guidance should be interpreted differently if implementation is being done by sex worker community-led organizations. Chapter 1 offers a vision and examples of high-quality, sustainable programmes run by community-led organizations.

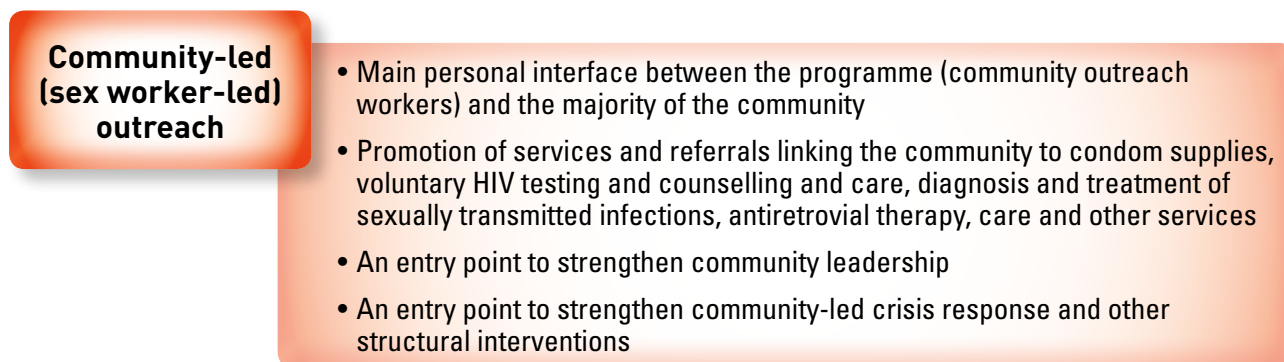
1 In most contexts in this tool, “community” refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to sex workers, “community-led interventions” are interventions led by sex workers, and “community members” are sex workers.

2 An implementing organization is an organization delivering a prevention intervention to sex workers. It may be a governmental, nongovernmental, or community-led organization, and may work at a state, district or local level. Sometimes an NGO provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

Figure 3.1 Types of community-led services



3.2 Community-led outreach



Community-led outreach is an essential link between the community and the HIV prevention, care and treatment offered by a programme. It empowers sex workers to draw on their first-hand knowledge of vulnerability and risk to problem-solve with members of their community, strengthening access to services and making HIV prevention, care and treatment viable. Community outreach workers³ build rapport with other sex workers, understand their needs as individuals, and on a regular basis provide them with (or link them to) appropriate high-quality services. By monitoring the relative vulnerability and risk of each individual sex worker, community outreach workers also supply the first level of data collection for the programme.

³ In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”.

Box 3.2

Community-led outreach and community empowerment

When done well, community-led outreach is the part of the programme that reaches the largest proportion of the community, most regularly and with the most direct personal rapport. Community outreach workers' understanding and personal investment in the welfare of their community is as essential to the success of an intervention as the services they offer. Therefore they should be respected and engaged meaningfully. This has two important implications:

- The term "community" should never be understood or used to imply that community outreach workers are less qualified or less capable than non-community staff outreach workers.
- Community outreach workers are not volunteers; they should be remunerated for their work at a rate comparable to that of other staff, and should have the opportunity to progress to permanent paid positions in the implementing organization.

3.2.1 What community outreach workers do

Community outreach workers typically perform a number of key functions:

- Meet regularly (e.g. monthly) on a one-to-one basis with sex workers in their assigned area. Depending on the density of the sex worker community, a ratio of one community outreach worker to 35–65 sex workers is feasible (see also Chapter 6, Table 6.4).
- Assess the HIV prevention, care and support needs of each sex worker and develop a plan to address these needs through the programme and the community.
- Assess how many condoms the sex worker requires based on their usual sexual activities, and distribute the required number to cover the period until the next contact with the sex worker.
- Promote safe spaces (drop-in centres) with the community (see Section 3.3 below).
- Encourage sex workers to visit clinics for sexually transmitted infection (STI) check-ups, explain the services, refer STI cases from the field and accompany those referred to clinics if requested to do so. Advocate for sex workers' access to services if they encounter difficulties.
- Support sex workers to get voluntary HIV counselling and testing (HTC), and ensure that they are accompanied to referrals if requested. (See Chapter 5, Section 5.2.)
- Accompany HIV-positive sex workers to treatment centres if requested, and track and encourage their adherence to antiretroviral therapy. (See Chapter 5, Section 5.3.)
- In programmes that provide services to people who inject drugs, provide clean needles and syringes and other harm reduction commodities to sex workers who inject drugs, and provide referrals to medical services as needed. (See Chapter 5, Section 5.5 for detailed information.)
- Provide information on sexual and reproductive health and refer sex workers to services as needed.
- Help to manage crisis response systems (see Chapter 2, Box 2.9). Give information on additional support systems for sex workers facing violence.
- Take part in community committees and advisory groups (make recommendations to improve clinic/staff relations, outreach, safe spaces) and community mobilization activities, and provide feedback from the field on ways to improve the programme.

3.2.2 Steps in implementing community-led outreach

Several steps are required to establish community-led outreach in a community of sex workers:

- A. Map the community and design the outreach strategy with them
- B. Recruit and train community outreach workers
- C. Implement and manage outreach
- D. Foster leadership opportunities for community outreach workers

A. Map the community and design the outreach strategy with them

Establishing a strong community-led outreach system involves the programme team, sex workers and other people at sex work locations. Reliable data collection and meaningful consultations with sex workers and other key individuals and institutions help to ensure that the programme provides acceptable and accessible services to the greatest possible number of community members, and that it is seen as useful by the community and receives its support.

Understanding where sex workers are and how to reach them is essential. This starts with programmatic mapping and size estimation (see Chapter 6, Box 6.4 and Figure 6.5). Once mapping focuses on individual sex work locations within a coverage area, the participation of community members is needed to help assess the quality of services and characteristics of the environment, as well as the relative risks and vulnerabilities of individual sex workers.

The steps for local consultations to inform mapping are:

1. Recruit a core group of sex workers to participate in the mapping. They should be people with detailed knowledge of the locations and preferred working habits in the community.
2. Work with the sex workers to develop maps that identify sex work locations (such as bus stations, brothels, bars, military barracks, etc.) in the most densely populated locations in the coverage area (Figure 3.2). Also identify service points, e.g. places where condoms are available (or a commercial establishment where they could be sold if there is a condom social marketing programme) (see Figure 3.3).
3. With the core group of sex workers, identify and build rapport with “key informants” in these locations, including other sex workers and brothel or bar owners and managers. Through group discussions with the key informants, arrive at consensus estimates of the number of sex workers at each location (see Figure 3.4). Record this information for follow-up to recruit community outreach workers once strategic planning for outreach is done.
4. Plan services using the information from the key informant meetings, including where to locate them, and the best timing for them. In order to maximize access to services, clinics and drop-in centres should be located near the areas with the greatest density of sex workers. Additional service components should also be considered. For example, if many sex workers in an area have children, a low-cost health check-up for children may be added to services offered by the clinic; and if police are considered to be a major problem, violence response interventions should be prioritized.
5. Through the key informants, meet and build rapport with additional sex workers who could become community outreach workers.

Safeguarding sex workers in mapping

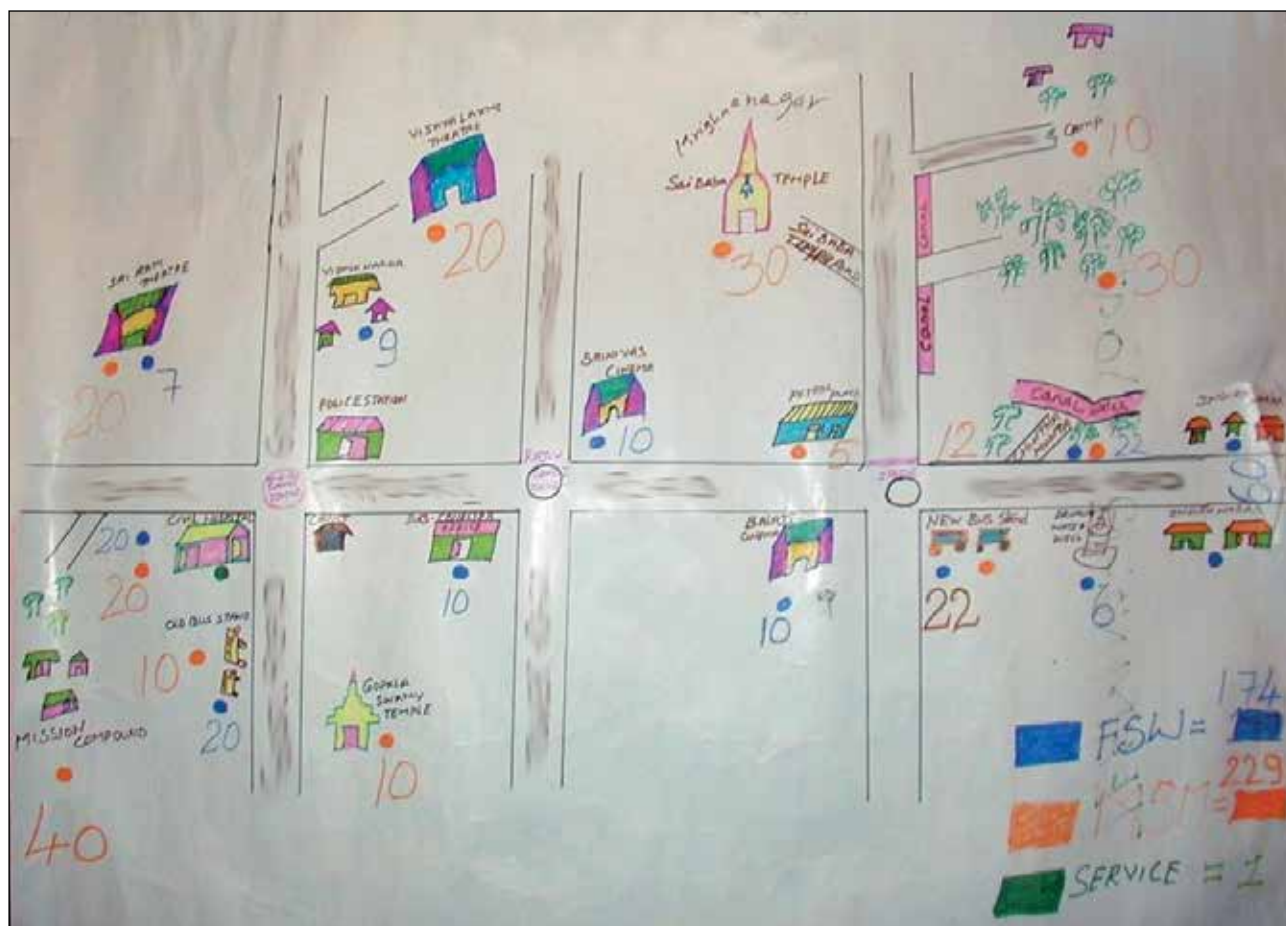
Key informants: The influence of key informants, such as brothel or bar owners and managers, on the lives of sex workers should always be considered when doing mapping. While they may be able to promote condom use and service referral and offer protection against harassment and violence,

3 Community-led Services

it is also possible that they will oppose services. Care should therefore be taken to ensure that sex workers make decisions about any efforts to engage these people, and that activities cause no pressure, harm or unwanted exposure to sex workers.

Maps: Maps containing information about the location and/or identity of sex workers should be considered confidential and stored securely at a central location. Programme planners and implementers should guard against the possibility of maps being obtained by law enforcement authorities or other groups who might use them to locate and close sites or otherwise cause harm to sex workers. If these confidential materials are disclosed, it is likely that the programme will lose the trust of the community.

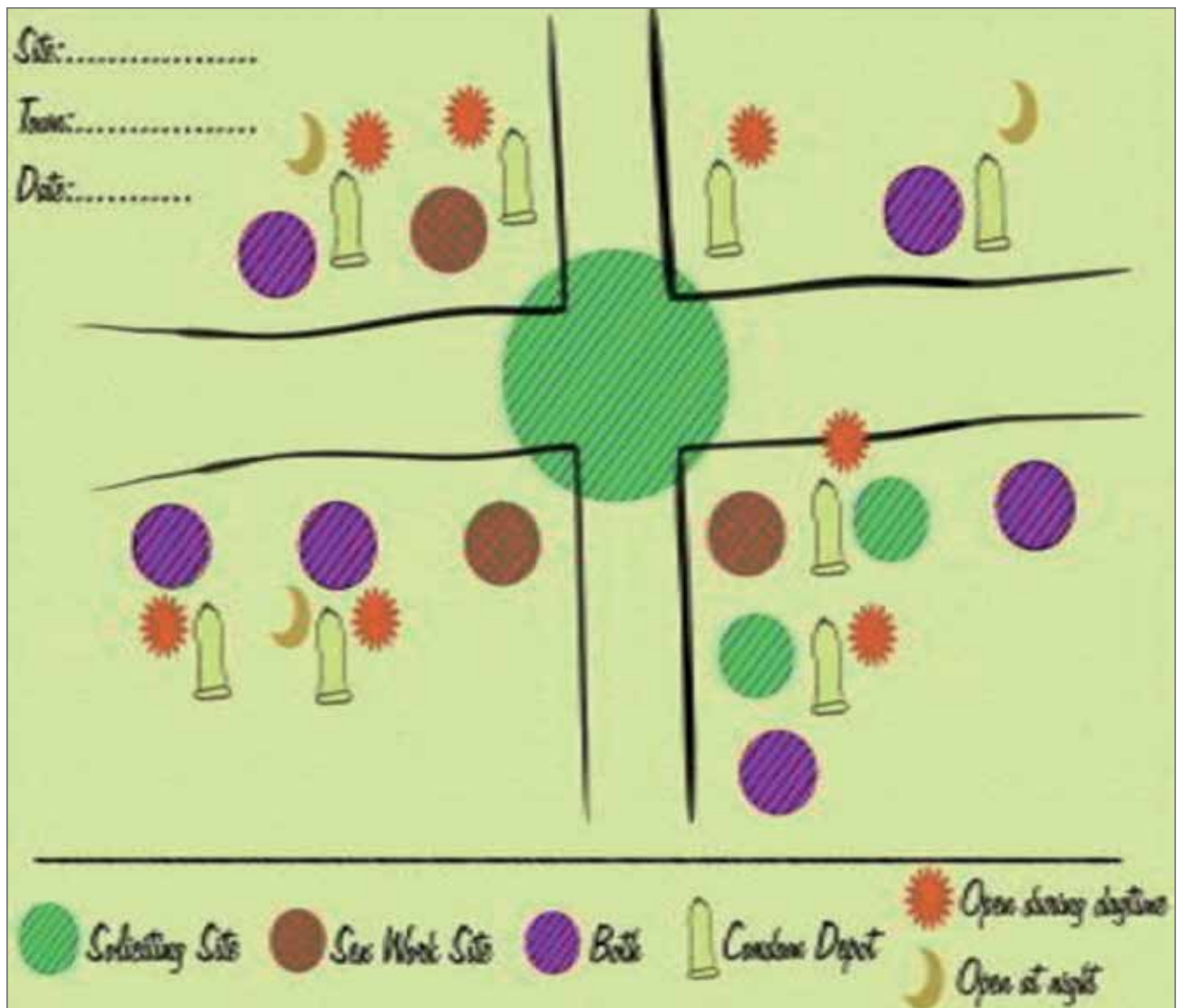
Figure 3.2 Community map



This map, created by a sex worker, shows the locations and numbers of community members in a town, as well as places where services are available.

Source: India HIV/AIDS Alliance, Andhra Pradesh, India

Figure 3.3 Condom service point map



This map, based on one created by sex workers, shows condom distribution locations by hours of operation.

Source: Karnataka Health Promotion Trust, Karnataka, India

Figure 3.4 Sex worker information chart

No.	Name of sex worker/Symbol denoting sex worker	Place of residence	Place of soliciting	Place of sex	Time when available			
					Morning	Afternoon	Evening	Night
		Home/Street Bustle/Lodge	Home/Street Bustle/Lodge	Home/Street Bustle/Lodge				

This chart gives information about sex workers in a particular area for the purpose of planning outreach. It is designed to be completed by sex workers who are not literate. Simple drawings are created by the sex worker to identify the individual sex workers whom she knows, and to show where the sex worker lives, solicits clients and has sex with clients. Similarly, symbols identify the time of day when the sex worker is best available for conversation. The chart can be used by the sex worker to help recall each person in greater detail, when needed.

Source: Karnataka Health Promotion Trust, Karnataka, India

B. Recruit and train community outreach workers

The steps presented below represent an optimal process for recruiting and training community outreach workers. If a new intervention is being established, these steps may be implemented over time, as the programme reaches out to a greater number of community members. In practice, a programme might start with a small number of community outreach workers and a more informal organizational structure, but formalize as it starts to reach more sex workers.

1. **Develop terms of reference** for community outreach workers that outline the necessary selection criteria (see Box 3.3) and roles and responsibilities. Include policies on remuneration, travel allowances, per diem, etc.
2. **Develop guidelines for recruiting, retaining, assessing and promoting** community outreach workers. The selection process should be well publicized in the community so that all those interested in being community outreach workers may be considered. Collaborate with other programmes in the state/country to ensure that, where possible, remuneration for community outreach workers is consistent and transparent across programmes.
3. **Training curriculum:** check whether a curriculum is available and appropriate for the particular outreach setting. Ideally, the curriculum should be developed and standardized at the central/regional level, but it may need to be adapted to address local language and cultural issues (see Box 3.4 and the resources listed in Section 3.5). Check whether trainers are available.

4. **Adapt outreach tools for community outreach workers.** These may include daily and monthly tracking forms that assess each individual's risk and vulnerability factors as well as their access to services. Outreach tools should be pictorial for community outreach workers with low literacy (see Figure 3.7).
5. **Develop a tiered training plan** to enhance community outreach workers' skills, confidence and leadership (see below, and Box 3.4). This should incorporate regular training of new community outreach workers to ensure that an adequate number is always available. Training should also advance community outreach workers' skills and exposure to all components of the programme, e.g. making sure that community outreach workers are able to explain clinic procedures to sex workers.
6. **Develop a career progression** plan for community outreach workers to ensure they have the opportunity to take on greater leadership responsibility for programme activities, and to oversee outreach and other aspects of the programme, including roles that may have belonged to NGO staff. Link this to activities that enable community outreach workers to demonstrate leadership through outreach, safe-space activities, community committees, etc.
7. **Explain sex worker progression** in the NGO to non-sex worker staff if necessary, to ensure there is no perception of competing interests (see Chapter 6, Section 6.2.8).

Recruiting community outreach workers

In the initial stages of a programme, selecting community outreach workers may be an informal process: the implementing organization may invite sex workers who have been involved in the initial mapping and planning stages to remain involved in the new programme as community outreach workers, and/or to identify other sex workers with the potential to fulfil this role. In either case, the selection criteria listed in Box 3.3 should be considered. It is also important to observe the rapport between sex workers involved in mapping and other members of their community.

Box 3.3

Suggested selection criteria for a community outreach worker

- Currently active as a sex worker, and has time to do outreach
- Committed to the goals and objectives of the programme
- Knowledgeable about the local context and setting
- Accepted by the community
- Accountable to the community as well as to the programme
- Tolerant and respectful of other sex worker communities where differences may exist
- Able to maintain confidentiality
- Good listening, communication and interpersonal skills
- Self-confident and with potential for leadership
- Potential to be a strong role model for the behaviour she/he seeks to promote with others
- Willing to learn and experiment in the field
- Committed to being available to other sex workers if they experience violence or an emergency

3 Community-led Services

As the programme matures, a more structured process for selecting new community outreach workers may be adopted:

1. An informal committee of community leaders and programme staff, including current community outreach workers, defines the criteria for new community outreach workers, identifies potential community outreach workers, contacts them to see if they are willing to serve and conducts a basic interview with them. The candidates are ranked based on the criteria listed in Box 3.3.
2. The candidates are asked to take part in a social network mapping exercise, facilitated by outreach co-ordinators, to determine the size of their social networks of sex workers (see Figure 3.5).
3. Current community outreach workers talk to some of the potential community outreach worker's contacts to see whether the candidate would be acceptable to them as a community outreach worker.
4. Based on the interviews, social network mapping and consultations, the committee selects the appropriate number of new community outreach workers.
5. The committee discusses methods for community monitoring of the community outreach worker's performance. (This could be through a formal community committee: see Section 3.4.3.) Community members should be able to contact the project if they have any issues related to the community outreach worker.

Figure 3.5 Social network map



A social network map represents how sex workers at a particular location are linked by relationships of acquaintance or friendship. The map is created by a sex worker to show his or her degrees of connection to other sex workers. Each circle represents an individual sex worker, and the arrows point to other sex workers whom that individual knows. Effective community outreach workers have large networks. The map may be used to assign a community outreach worker to a group of sex workers for outreach, and to ensure that each community outreach worker is contacting the sex workers they know best.

Source: India HIV/AIDS Alliance, Andhra Pradesh, India

Training community outreach workers

Training should take place regularly and may be done at several levels:

1. basic training at the beginning of engagement in the programme
2. advanced training sessions at least quarterly to build knowledge and skills
3. informal mentoring by an outreach supervisor/manager to support community outreach workers (daily)
4. group discussions and mentoring with community outreach workers (weekly).

Training curricula should be interactive. The strength of community outreach workers in bringing their own experience and initiative to their work should be emphasized. This means that training may be most effective when facilitated by trainers who are themselves sex workers. (Trainers should be remunerated.)

Basic training may include:

- interpersonal communication skills to build confidence and individual agency (the choice, control and power to act for oneself), including discussion of the need to be tactful and non-judgemental, and to ensure confidentiality as a professional requirement
- condom gap analysis (to identify gap between demand and supply), condom negotiation and distribution rationale
- social network mapping
- managing prevention and care, micro-planning tools, record-keeping
- STI symptoms and disease processes, referrals and treatment of STIs, HIV, AIDS and TB
- promotion of voluntary HTC
- identifying and discussing violence, providing psychosocial support
- community mobilization.

Advanced training may include:

- advanced communication and counselling skills
- leadership skills
- dealing with stigma, discrimination and harassment
- legal literacy, negotiating with police and calling upon the community for support
- violence and crisis intervention
- counselling for drug and alcohol abuse
- creating links to other services (e.g. reproductive health)
- care and support for HIV-positive people
- interacting with the media (to promote a positive image of the community).

Box 3.4

Case example: Approaches to training community outreach workers

Kenya's National STI and AIDS Control Programme has developed a toolkit for male and female community outreach workers (peer educators) consisting of a reference manual, a training manual and a participant notebook (not currently available online). The toolkit uses simple language and drawings. The manual consists of seven modules:

1. Peer educators: Who we are and what we do
2. All we need to know about HIV, STI and sexual and reproductive health
3. How to prevent HIV and STIs
4. Knowing our HIV status: promotion of HIV counselling and testing
5. Planning our future
6. Creating an environment for behaviour change
7. Recording and reporting our progress

In Macedonia, Health Options Project Skopje (HOPS) has a less formal training programme and curriculum that are tailored in content and duration to the background, education level and skills of each group of community outreach workers. Topics include:

- History of HOPS, its mission, programmes, organizational structure
- The role of the community outreach worker in HOPS
- HIV and AIDS and STIs
- Outreach work and principles of outreach work
- Human rights and sexual rights
- Human trafficking and sexual exploitation
- Introduction to HOPS' harm reduction programme
- Types of drugs and consequences of drug use
- Site visit to sex work location and to the programme's safe space (drop-in centre)

Awarding participation certificates to community outreach workers for completing training or other courses encourages them, and acknowledges their efforts to learn and build professional skills. This is especially true for sex workers who have not had basic formal education.

C. Implement and manage outreach

How community outreach workers promote access to services

Condoms and lubricant: Community outreach workers support behaviour change (i.e. adopting and/or adhering to safer sex behaviours) by demonstrating, promoting and distributing condoms and lubricants. They are often the most relied-upon source of condom distribution in areas where programming is new and sex workers have not adopted consistent condom use with clients and regular partners. Even in longstanding programmes, sex workers' need for relatively large numbers of condoms gives community outreach workers an essential role in the supply chain.

Clinical services: Community outreach workers form a link between the community and clinical services. Upon the request of sex workers, they may accompany them to clinical services and advocate for them as needed. Community outreach workers promote, explain and record STI clinic and voluntary HTC referrals and visits. Community outreach workers provide essential insights to the

programme about how to make services more available and accessible, and how to ensure that sex workers use them regularly. They also ensure that the quality of services is high and that there is no coercion at the facility. Community outreach workers may also offer ongoing post-test counselling and ensure that those who test positive and disclose their status are linked to care.

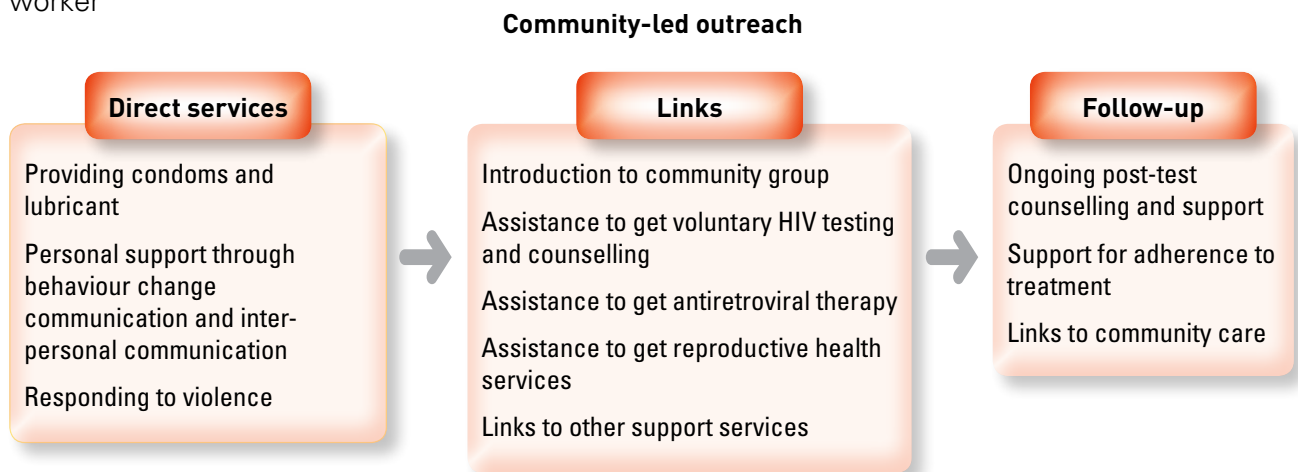
Structural interventions: Community outreach workers mobilize members of their community to take part in initiatives to address stigma and discrimination, confront violence and harassment by police, and create social support systems, e.g. securing access to schooling for sex workers’ children.

Community-led services: Community outreach workers offer insights from their direct contact with the programme and the community that are essential for programme planners and policy processes at local, national and global levels.

Managing outreach

Management of outreach happens at two levels: the community outreach worker manages his or her own outreach to sex workers; and programme staff supervise and support the community outreach workers.

Figure 3.6 Illustrative example of management of a sex worker’s needs by a community outreach worker



Community outreach workers as outreach managers

The community outreach worker uses a prevention and case management approach for each sex worker, consisting of several steps that are re-assessed and repeated, as circumstances require.

1. Assess the range of needs of the individual sex worker, using a standardized tool (see “Micro-planning” below).
2. Develop a plan of action with the sex worker based on needs that can be addressed.
3. Provide commodities, information and counselling to ensure that the sex worker is committed to addressing those needs with community support.
4. Facilitate referrals to other services, as needed.
5. Follow up referrals with support and information, as needed.
6. Re-assess and evaluate the needs of the individual on a regular basis.

Figure 3.6 above presents an example of the ways a community outreach worker may support a sex worker through direct services, links and follow-up.

Box 3.5

Case example: Sexual health diary

In Thailand, the Service Workers in Group Foundation (SWING) has worked with male sex workers to develop a sexual health diary as a tool to help them monitor their own sexual risk and engage regularly in self-diagnosis for STI symptoms. The diary gives them a way to track and maintain their preventive behaviour, including STI screening and treatment. The sex worker records the following information on a daily basis:

- number and type of sexual encounters (anal/oral/other):
 - › whether with customer or partner
 - › whether without condoms
 - › whether without lubricant
 - › whether with a condom used incorrectly
- STI symptoms (yes/no/not sure, for a list of different symptoms)
- any medical test or treatment (and for what symptoms), including STI screening and HIV test.

Each diary has enough pages for a month. The sex worker fills in a weekly summary sheet in the diary and gives this to his outreach worker from the programme, and they discuss it. The information is also recorded in the database and used for risk assessment and to customize services for the sex worker. When STI symptoms are reported, the sex worker is encouraged to see a doctor for testing and treatment. Using the diary is not a pre-condition for receiving any services from the programme, but it is widely used, and the male sex workers report that they like it. SWING plans to adapt the tool for use by female sex workers.

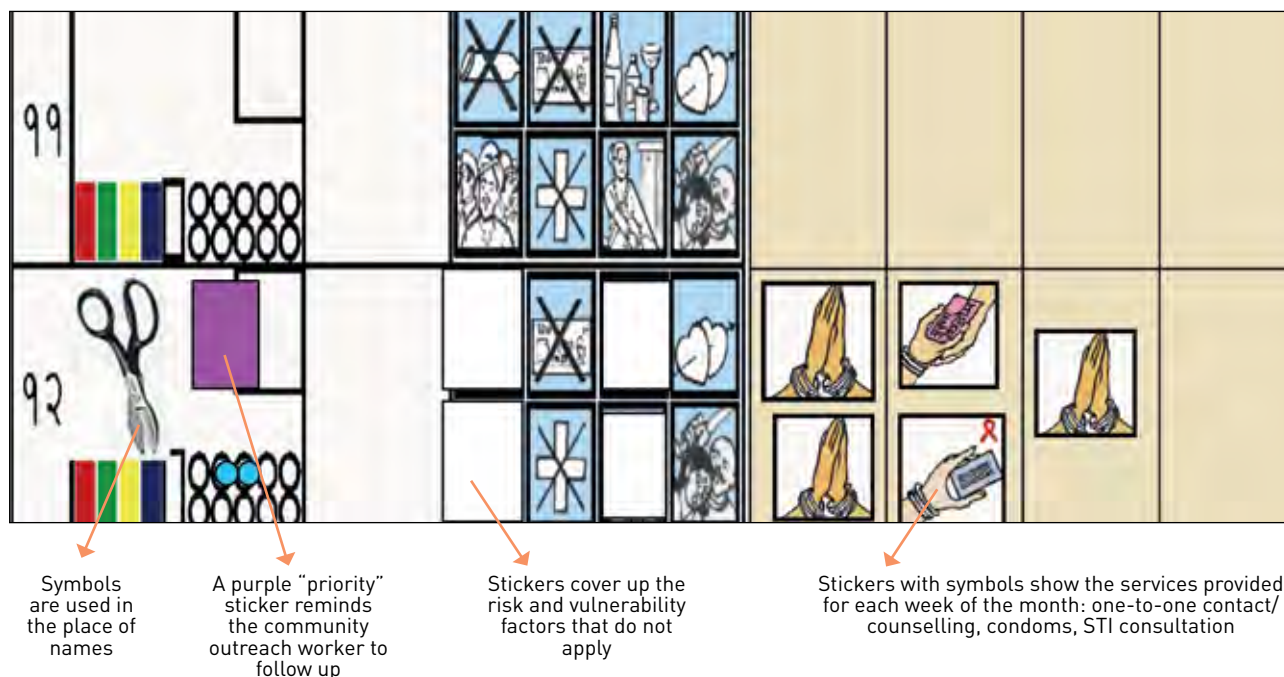
Micro-planning

Micro-planning gives community outreach workers the responsibility and authority to manage their own work. In this approach, community outreach workers use their knowledge of the community, and the information they record during their contacts with sex workers, to prioritize and manage outreach.

In micro-planning, community outreach workers are trained to use tools to capture data on the vulnerability and risk of each individual they serve, and the services they deliver. Micro-planning tools are designed to be user-friendly, e.g. they are pictorial and can be used by people with low literacy skills (see Figure 3.7). They may be adapted so that routine monitoring can be reported using a mobile phone, in addition to recording data on paper.

Community outreach workers record data at each encounter with the sex worker, and aggregate them onto a weekly or monthly reporting form (unless the data have already been submitted electronically), with the assistance of a supervisor/manager, if necessary. Some of the aggregated information may be reported by the programme according to regional or national reporting requirements, but its primary purpose is to enable community outreach workers to analyse their outreach efforts and plan their outreach according to the most urgent needs of the sex workers they are serving (e.g. those with the highest risk or vulnerability, or those who have not been met for a significant period of time). The community outreach worker may do this planning in the context of weekly review sessions with the supervisor/manager (see “Supervising and supporting outreach” below).

Figure 3.7 Micro-planning tool



This micro-planning tool is used by a community outreach worker to capture information about individual sex workers' risk and vulnerability and the services they receive from the programme over the course of a month. The top row of this calendar has not been completed by the community outreach worker; the lower row shows how information on an individual sex worker is recorded.

- In the far left column the individual sex worker is identified using a colour-coded ID system (bars and circles), supported by a sticker with a symbol (e.g. pair of scissors) as a memory aid for the community outreach worker.
- In the middle of the chart, eight blue squares represent different risk and vulnerability factors (e.g. the top left square shows a condom with a cross through it, meaning inconsistent condom use). When the tool is being designed, such factors are decided upon through consultations with community outreach workers about risk and vulnerability in the community they are serving. The community outreach worker uses white stickers to cover the factors that do not apply to the individual sex worker, leaving the relevant ones exposed as a reminder to discuss them with the sex worker.
- When an individual sex worker has more than three risk and vulnerability factors, the community outreach worker adds a purple sticker to mark the individual for priority follow-up.
- In the four columns (one for each week of the month) on the right-hand side of the calendar, the community outreach workers uses stickers to record the services provided at each contact.

Source: Mukta Project, Pathfinder International, Maharashtra, India

Further considerations for outreach

Using IDs:

A form of identification for community outreach workers can help them in their work. For example, a credit card-sized programme ID card endorsed by a recognized public official, such as a senior police officer, can be shown to police who stop them.

However, some incentives for community outreach workers, such as t-shirts or other clothing that identify them as working for the programme may cause other sex workers to feel separate from them. Visible identifiers may also by association expose the sex workers they are meeting with.

Setting:

- In urban areas, programmes should consult with community outreach workers to decide whether outreach to sex workers who work on the streets should be conducted in pairs for safety.
- It may be difficult to reach sex workers who work in urban bars, brothels or lodges. Outreach to managers and owners, to encourage them to allow community outreach workers access into the establishments, should be undertaken in pairs, with other programme staff if necessary. Since these sex workers often live together in groups, outreach to them in their residences may be more productive, but only if welcomed.
- Outreach to home-based sex workers or those who choose not to self-identify as sex workers requires a discreet approach, such as framing it as health promotion for low-income women.

Age:

- Younger sex workers may have concerns about family planning and maintaining their physical appearance, while also wishing to maximize their client load.
- Older sex workers may be more concerned with protecting their children, providing support for HIV-positive family members and participating in programme management.

Gender:

The needs of male, transgender and female sex workers may overlap, but also differ in some respects:

- Male sex workers may require counselling and referrals for such issues as sexual dysfunction.
- Transgender sex workers may need information on the risks associated with injecting hormones.
- Female sex workers may need support related to family planning and abortion services.

Supervising and supporting outreach

An outreach supervisor/manager has the responsibility to train, motivate and monitor the work of five to twenty community outreach workers. The role may be filled by a community outreach worker who has progressed into this supervisory role or by an NGO staff member until community outreach workers are trained.

The outreach supervisor/manager observes community outreach workers in their day-to-day outreach work, reviews their data on components of the service package (number of one-to-one contacts, group contacts, referrals or accompanied visits, condoms distributed, etc.), and may input the data into a computerized management information system if there is no dedicated data entry officer. The supervisor/manager has weekly meetings with his or her group of community outreach workers, usually at the safe space (drop-in centre), to discuss high-priority individuals and any problems the community outreach workers may be encountering, and to provide informal training.

Box 3.6

Case example: Opportunity gap analysis

In Karnataka, India, community outreach workers use a simple tool to analyse the specific barriers that hinder individual sex workers' access to programme services. Gaps in access are identified, whether due to internal factors that the programme can control (e.g. the working times of community outreach workers) or external factors (e.g. high mobility of sex workers resulting in dropouts from the programme). Site-specific action plans are then developed to overcome these barriers.

Figure 3.8 shows an opportunity gap analysis by a community outreach worker responsible for 140 men who have sex with men at a particular site. (Although these men are not necessarily sex workers, and although the ratio of community outreach workers to men who have sex with men is very high due to the density of the urban area in this example, the principle is the same.) The community outreach worker has assessed his activity during the month by listing the number of men who have sex with men who are enrolled, the number whom he regularly contacts, the number who have visited a clinic in last three months, and the number who were tested for HIV in the last month. The community outreach worker then analyses with his supervisor/manager those community members who were not reached by various services and the reasons for this, and a plan is developed to address these gaps.

The opportunity gap analysis helps both the community outreach worker and the supervisor/manager to assess whether the programme is reaching the community members with specific project services. The exercise identifies areas where the community outreach worker needs to focus and areas where the supervisor/manager needs to support the community outreach worker.

Figure 3.8 Opportunity gap analysis

OPPORTUNITY GAP ANALYSIS				
Zone: _____		Supervisor: _____		
Site: _____		Community outreach worker: _____		
Hotspot: _____		Date: _____		
	Actual number	Target	Gap	Reasons
Estimation	137	140	—	—
Registration	137	100% 140	—	—
Regular contact	125	80% 120	(+5)	—
Clinic visit	40	35% (monthly) 42	2	—
Syphilis	8	50% of target for clinic visits 20	12	[Community outreach worker and supervisor discuss and list reasons and action plan here.]
Integrated Counselling and Testing Centre (ICTC)	0	50% of target for clinic visits 20	12	[Community outreach worker and supervisor discuss and list reasons and action plan here.]

Source: Karnataka Health Promotion Trust, Karnataka, India

Remunerating community outreach workers

Community outreach workers should always be remunerated for their work. However, certain approaches may be problematic: for example, paying community outreach workers for each individual they persuade to come to the clinic or drop-in centre for services can distort demand and lead to coercion. Less coercive and more effective incentives include phone credit, non-monetary gifts, leadership opportunities and recognition that is not linked to the number of sex workers who are brought to the programme. Offering the chance to participate in national or international trainings and meetings, where possible, may also be an effective way of recognizing outstanding community outreach workers.

Table 3.1 shows the various activities for which community outreach workers may require remuneration.

Table 3.1 Remuneration of community outreach workers

Resource spent by community outreach worker	Remuneration	Rationale
Time on outreach (includes time for travel, meeting with sex workers, reporting, planning further outreach)	Salary	Agree upon a rate that is acceptable to community outreach workers and feasible for programme sustainability. If possible, rates should be set consistently across state and national programmes.
Time on extra training	Stipend	Hours spent in training are lost work time, and programmes should recognize that community outreach workers have another job and personal obligations that cannot be fulfilled when they are in training.
Travelling between venues, for referrals, training, etc.	Bus, train, taxi charges, as required	It is usually most efficient to map travel routes and fix travel allowances for groups of community outreach workers depending on the requirements. They should be given travel stipends in advance on a routine basis (since most may not be able to pay first themselves and then wait for reimbursement).
Mobile phone airtime	Mobile phone airtime (predetermined is usually best)	Whether using text messages or limited talk time, community outreach workers should be remunerated for on-the-job phone use.
Mobile phone batteries	Chargers, access to power and safe charging	Community outreach workers need their phones for outreach, and phone battery chargers should be made available at agreed-upon charging locations.

Box 3.7

Case example: Using technology in sex worker networks

Some sex worker organizations use mobile phones or the Internet to enable community members to seek and offer support among themselves.

In South Africa, a sex worker community-based organization operates a helpline to disseminate information. Calls to the helpline from a landline phone are free, and mobile phone users can send an SMS text message to receive a call back so that they do not have to pay for a call from their mobile phone. The helpline offers an SMS alert service that sends information to community members who have enrolled for the service. A sex worker can report bad clients (e.g. for non-payment or assault) to the helpline, which will transmit this information via the SMS network.

The New Zealand Prostitutes Collective (NZPC), an organization of sex workers, operates a closed Facebook page that functions like a blog and has a message board for sex workers to post questions, provide support to one another and provide information about services for sex workers.⁴

The Ukrainian sex worker-led organization LEGALIFE runs a website⁵ on which members may post questions about their rights and about LEGALIFE's activities. Responses are written by a local human-rights expert and a consultant on practical psychology affiliated with LEGALIFE. The webpage also features a blog and a forum section for its members, and local and international news. It is managed by a group of sex workers with previous experience in managing web content or who have been trained to do so.

D. Foster leadership opportunities for community outreach workers

Experienced community outreach workers improve the effectiveness of outreach and provide leadership in their community beyond programme services. It is important that programmes adopt an approach from the beginning that allows community outreach workers to grow as leaders. Programmes do this not only by showing respect and appreciation to community outreach workers, but by:

- providing support through training, mentoring, constructive feedback and remuneration
- offering opportunities for them to learn new skills and apply their experience in expanded ways through the programme and in their communities, so that they and other sex workers are empowered.

Training and mentoring of community outreach workers should focus not only on outreach, but also on strengthening their leadership more generally (see also Chapter 1, Section 1.2.6.). Community outreach workers with leadership skills are more likely to use critical thinking and take the initiative to reach greater numbers of sex workers. They may also support the programme in other important ways:

Advocacy: Confident community outreach workers may be able to advocate with the police and sex-work establishment owners to improve interactions with sex workers. Sex workers can be the strongest advocates with establishment owners for correct and consistent condom use and other safer sex practices. Community outreach workers may initially need support in this role from non-sex worker staff of the implementing organization, but staff should be sensitive to the need to reinforce the community outreach worker as a leader for their community, only stepping in when needed.

⁴ NZPC also has a public Facebook page: <https://www.facebook.com/pages/New-Zealand-Prostitutes-CollectiveNZPC-CHCH/194413363949972>.

⁵ <http://legalife.com.ua>.

Programme monitoring: With experience and support, community outreach workers can participate in monitoring the programme and improving its quality. This develops naturally from the approach taken with micro-planning, where community outreach workers assume responsibility for recording, analysing and acting on data about the sex workers to whom they provide services.

Monitoring should not require literacy, and community outreach workers who collect monitoring data should also be provided with tools to analyse them (as with micro-planning) and the authority to act on the analysis. They should also be supported in monitoring aspects of the intervention that the community considers important but which the implementing organization may not monitor for its own purposes, such as trends in the service quality of referral clinics.

Programme management and leadership: Community outreach workers can train and mentor other community outreach workers, and may assume other roles in a programme. As programmes mature, community outreach workers naturally seek advancement as leaders, and jobs once done by implementing organization staff may be done by sex workers who began as community outreach workers. Outreach supervisors/managers may be former sex workers who generally work as full-time staff with a salary commensurate with that of NGO staff in similar positions.

The non-sex worker staff of implementing organizations may have to adjust their roles and expectations when sex workers, whom they may have thought of solely as programme beneficiaries, become their professional peers—and possibly even their supervisors/managers (see Chapter 1, Section 1.2.1 and Chapter 6, Section 6.2.8). Managing such a change requires a commitment from the leadership of the implementing organization. It should be seen as a positive development that helps to sustain HIV prevention in the long term.

3.3 Safe spaces (drop-in centres)

Safe space (drop-in centre)

- A place for sex workers to relax, socialize and hold group activities
- Main venue for interaction between the community and the programme
- Place to help sex workers strengthen social bonds and form a sense of community
- Platform for community mobilization, training and organizing initiatives

From the outset of a programme, “safe spaces” (also known as drop-in centres) should be established to bring community members together. Safe spaces are rooms rented by the programme and furnished simply that provide community members with a comfortable place to relax, rest, get information and interact with each other and with the programme. Safe spaces are multi-functional; they may also serve as:

- a place where community members may discuss programmes with programme managers to improve services
- a venue for psychosocial services and support, based on community demand
- a place to provide information on events and activities relevant to the community (not just programme-related information)

- a distribution point for condoms and lubricant
- a place to strengthen community empowerment by discussing discrimination and stigma against the community and planning a response
- a place for community outreach workers to review their work and plan outreach
- a place for community trainings (of community outreach workers, but also of other sex workers, e.g. in violence response, power analysis).

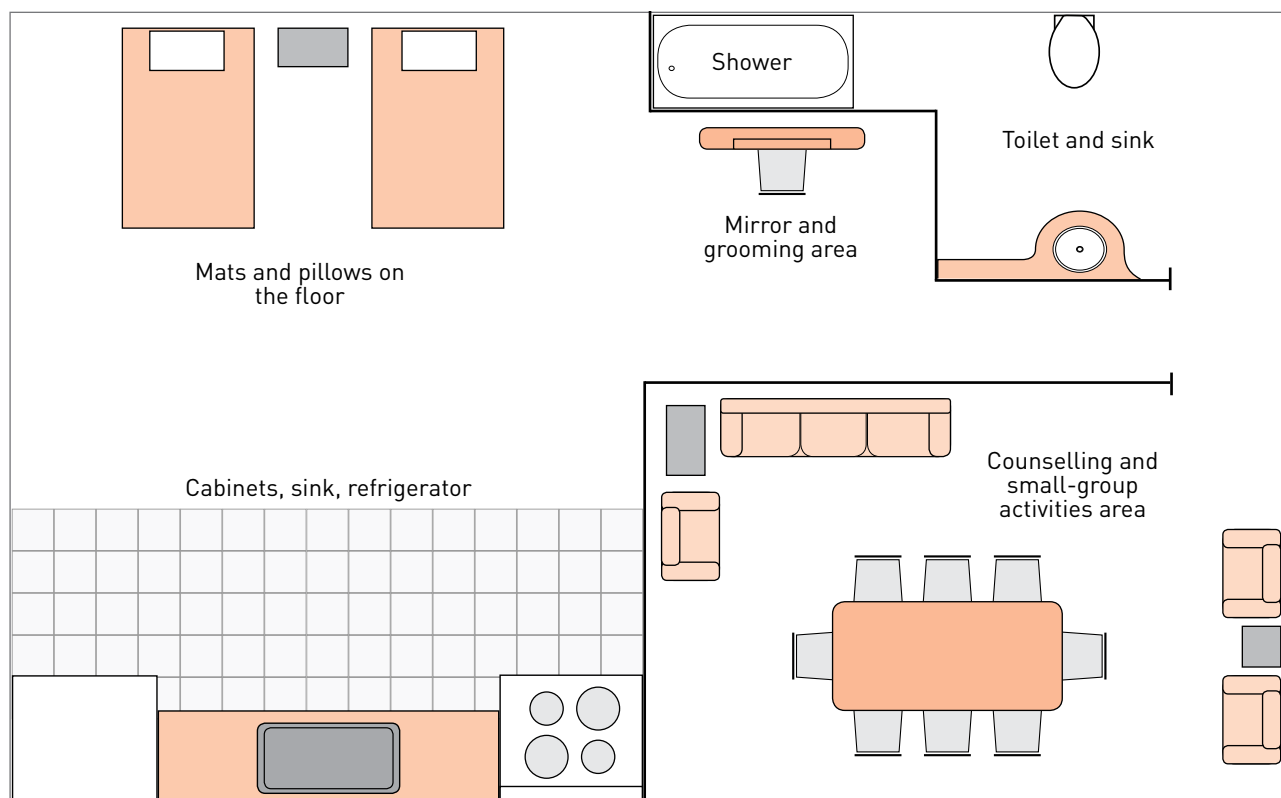
Safe spaces may be located close to programme-operated STI clinics, or even in the same building. There are practical advantages to co-locating safe spaces with clinics, such as the convenience of dealing with just one landlord, and the closer links between community activities and programme services. Nevertheless, care should be taken to ensure that safe spaces remain a distinct community area. It is often important to separate an implementing organization's office from the safe space and ensure that community leaders have clear responsibility for managing activities at the safe space.

3.3.1 Establishing safe spaces

Setting up the space

1. **Sex worker consultation and mapping:** The consultation provides guidance on where to locate the safe space, services to be provided, staffing and service hours. Services should be available when sex workers most need them, i.e. shortly before, during and shortly after their working hours with clients.
2. **Location:** The choice of location should take into consideration not only its accessibility to sex workers but also its visibility to the public and the response from the wider (non-sex worker) community in the vicinity. Care should be taken to ensure that the space is safe from intrusion by outsiders and the police.
3. **Lease agreements and landlords:** Maintaining a fixed location for the safe space is important to prevent disruption of services. The lease drawn up with the landlord should clearly state the duration of the agreement and clarify the hours and nature of use.
4. **Infrastructure and safety:** The safe space should ideally have at least two rooms: one that can be used for one-on-one meetings or counselling, and one for community activities. If possible, there should be a private bathroom with a sink and shower (Figure 3.9). The safe space should be equipped with basic equipment to handle fires and other emergencies.
5. **Designing the space:** The space should be both functional and inviting. Meeting tables and chairs may be kept to one side unless in use; couches or mattresses can make the room comfortable. Walls may be painted or decorated with art made by the community.

Figure 3.9 Example of a safe-space floor plan



Operating the space

- **Management:** The programme should provide resources for the space. To ensure that the community feels ownership, sex workers should have the lead role in decisions about the space and its management.
- **Service promotion:** To ensure sex workers are aware of the safe space and its services, it should be promoted through flyers, SMS messages and community networking.
- **House rules:** These should be formulated by those using the space so that they understand what behaviour is acceptable, e.g. with regard to noise levels (this is also important so as not to disturb any neighbours) as well as drug and alcohol use.
- **Relationships with neighbours:** The safe space managers, including the community, should make plans to manage relationships with neighbours and those outside the sex worker community. Some communities have performed neighbourhood clean-ups to establish a good relationship with their neighbours.
- **Scheduling:** If the programme needs to use the safe space for programme activities that involve a limited number of participants (e.g. outreach planning, training, or interpersonal and group communication activities), these should be scheduled during off-peak hours so that they do not infringe upon access for the broader sex worker community.
- **Programme use:** Growing implementing organizations may want to use the safe space for other programme activities or as offices; efforts should be made to ensure that this does not happen or that such activities are kept to a minimum. The safe space should remain open to members of the community to use informally, even if the programme is using it.

- **Sustainability:** Safe spaces can be made financially sustainable when managed by the community, for example, if the community rents out the space to the programme on a limited basis. Some community groups have developed catering services for events at safe spaces as a form of income generation that is managed directly by the community.


Box 3.8

Safe spaces for everyone

When resources are limited, a single safe space may need to serve a number of groups of sex workers, such as women, men, transgender individuals, younger and older sex workers. Events should be designed to offer specific resources for groups that identify differently. It may be helpful to offer each group an exclusive regular meeting time or times each week. When multiple groups are using the same space, the leadership of the space should be ready to manage possible conflict between groups and ensure that each group has fair access to resources.

3.3.2 Other activities in the safe space

Safe spaces may offer a range of activities and services to suit the specific needs of the communities they are serving. Offering a wide range of services may increase community participation in the safe space and ultimately help make it more sustainable. Examples include:

- classes on beauty tips specific to different groups (female sex workers and transgender sex workers)
- classes in literacy, numeracy, information technology, nutrition and dance
- celebrations of festivals and holidays
- a simple meal or nutritious food to take away
- walk-in general health exam
- showers and laundry facilities
- lockers to store belongings while community members are working
- sleeping areas
- phone-charging stations
- use of the computer and Internet
- remaining open 24 hours a day
- crèches (child care) for children of sex workers.

3.4 Community-led quality improvement

Community committees

- Main mechanism for communities to provide feedback and to shape the quality of programme services
- Regular meetings to review service provision, troubleshoot problems, track changes, build understanding and accountability, and address other community issues

Improving the quality, accessibility and acceptability of programme services requires collecting routine feedback on the community's experience of local services. There are several ways to do this.

3.4.1 Community committees

A community committee is a forum for members of the community to bring important issues, problems and solutions to the attention of the programme on a routine basis. Committees review clinical services, commodity distribution, the functioning of safe spaces and initiatives to address structural barriers. Members of the committees should ideally be elected by the community on a regular basis, e.g. annually. Relevant implementing organization staff may be members of the committee or may be invited to its meetings to discuss issues that arise.

As shown in the management structure for community services depicted in Chapter 6, Figure 6.3, community committees operate primarily at the frontline level, although they may also contribute to oversight of the programme at the municipality/sub-municipality level.

Community committees should meet monthly. A meeting report like the one shown in Figure 3.10 may be used to systematically consider issues and report to the community and programme.

When action is taken by programme staff or community outreach workers themselves, the results should be shared at subsequent meetings to ensure good communication with the community. A record of these discussions and actions should be maintained. The committee can also be a communication channel for the programme to discuss any changes that are being considered, and to share monitoring data with the community.

Because the community committee may at times raise quality issues that programme staff are reluctant to address, it is essential that programme management staff from a higher level be involved than those immediately responsible for the components of the intervention locally. Confidentiality should be respected at all times and senior management should monitor the committee to ensure that the community has the freedom to be critical. An advocate trusted by community outreach workers should act as the programme intermediary; ideally this person should be a community member, although they may be paired with a staff member from the implementing organization who can advocate for changes. There should be a mechanism to communicate problems upwards and beyond local managers if they are perceived to be obstacles to change.

Figure 3.10 Sample community committee report

COMMUNITY COMMITTEE REPORT		
Location: _____		Date: _____
Area	Issue	Proposed resolution
Issues with supply, quality or quantity (condoms/lubricants, test kits, drugs at sites or across sites)	<i>Community reports that some community outreach workers who do outreach in the train station still only provide a maximum of 5 condoms during outreach.</i>	<ol style="list-style-type: none"> 1. Outreach coordinator to work with community outreach workers to provide the number of condoms required by each sex worker and not limit condom distribution. 2. Follow up at train station to ensure change.
Closure or lack of service availability at referral facilities or through outreach	<i>Government Clinic on Central Rd. often will not accept people after 15:00.</i>	<ol style="list-style-type: none"> 1. Write letter to health officer documenting problem. Ask NGO director to sign along with community representative. 2. NGO health officer and community representative should visit Chief Medical Officer to advocate for compliance with agreement on later opening hours signed in May.
Service quality problems, e.g. poor treatment at facilities, discrimination in referral services, unresolved problems at safe spaces	<i>Nurses at Central Rd. doing initial questioning of patients in a public area, not a private room.</i>	<ol style="list-style-type: none"> 1. NGO health officer and community representative should bring this up during visit with Chief Medical Officer to ensure compliance with STI treatment protocol. 2. Follow up with community to determine if clinic is compliant with policy.
Inability of community outreach workers to carry condoms at sites or on the street because of police, etc.	<i>Police harassment of community outreach workers with condoms at bus station.</i>	<ol style="list-style-type: none"> 1. NGO field officer and four community outreach workers to schedule meeting with police to discuss and resolve.
Service overlap by other providers that may be causing confusion	<i>No problems.</i>	N/A
Violence response activities, perpetrators of violence and trends in violence.	<ol style="list-style-type: none"> 1. Report on number of incidents was not given at last community meeting at safe space. 2. Response team members taking survivors to hospital have not been reimbursed for transport costs. 	<ol style="list-style-type: none"> 1. Ensure that community leaders get information from crisis response team members and double-check it with NGO data officer before monthly community meetings. 2. Outreach supervisor to check and ensure that reimbursements are made within one week
Any other issues:		

3.4.2 Other community-led approaches to reinforce quality of clinical services

- Obtain agreement with referral clinics to display patients' rights charters, which are a statement of government policy for all who enter a medical facility.
- Obtain agreement with senior medical personal to post information in clinics on the right to confidentiality.
- Design ways to share information about reliable services in the community, e.g. good doctors to go to for speculum exams, or trustworthy testing and counselling centres and personnel. This information may be posted on a notice board or on a protected Facebook page.
- Schedule regular contact (via visits or letters) with the chief medical officer of a facility to formally report issues and give positive feedback.
- Educate the community on patients' rights and community-based monitoring of services.
- Formally introduce committee members to health-service providers.

3.4.3 Community quality assurance in monitoring and evaluation

Monitoring quality of community service implementation

Programmes are more effective when routine monitoring is designed with local input and there are systems for using data at the community level. Ideally, the programme at the central level should engage those managing multiple sites to determine what information is useful to them to monitor their programmes. (A simple approach is to brainstorm the aspects of the programme that they typically examine during site visits.)

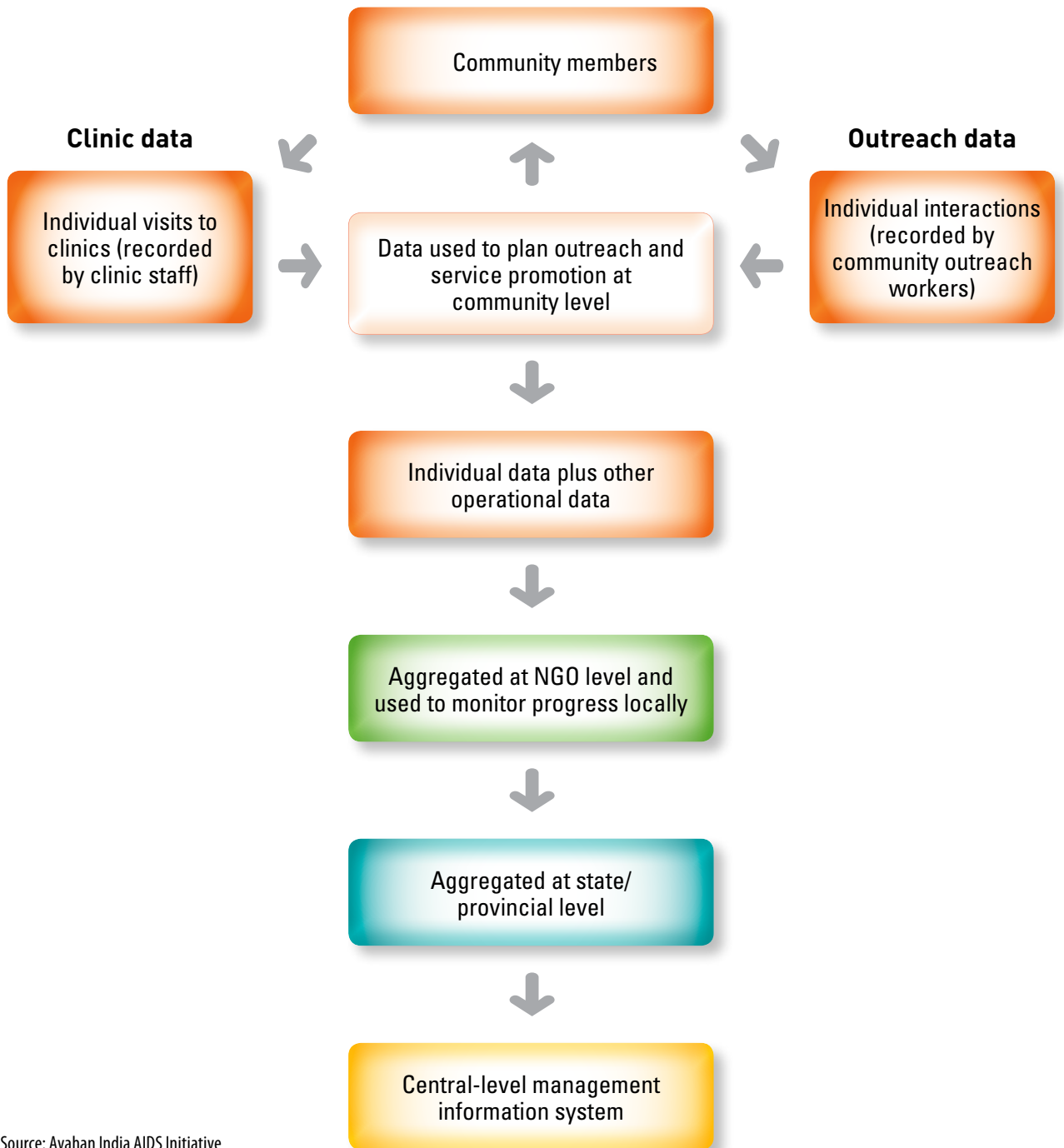
Where interventions are not already community-led, community leaders should be consulted on the kinds of measures that are important to improve the quality of services and outreach.

All programmes need to collect and report data to monitor progress and hold the programme accountable for its objectives. It is important to develop a clear understanding in the community on what data will be collected, how this will happen, and how the data are to be used locally. Data should not simply be "reported up" to a higher level; an approach should be designed that also integrates monitoring for use at the local level. This is important because targets that are set at high levels are easily misinterpreted as being the primary goal of the programme, leading, for example, to focus on the number of people accessing services rather than the quality of those services or sex worker engagement in the programme.

Figure 3.11 shows how programme data may be collected and used at the local level as well as at higher levels of the programme.

It is useful for the local implementing organization and the outreach system (including community outreach workers and supervisors/managers) to regularly review and discuss the monitoring data shown in Table 3.2.

Figure 3.11 Routine monitoring data flow



Source: Avahan India AIDS Initiative

Table 3.2 Community-level monitoring data

Indicator	Definition	Data	Use
Community outreach worker ratio	Proportion of community outreach workers to mapped sex workers	Numerator: total number of community outreach workers Denominator: total number of mapped sex workers	Analyse by local areas and by gender as outreach to urban, rural, male, female and transgender sex workers may require different ratios. Use to monitor whether sufficient community outreach workers are in place and what are the best ratios.
Outreach coverage	Proportion of mapped sex workers reached through one-to-one outreach monthly	Numerator: total number of one-to-one contacts by community outreach workers in a month Denominator: total number of mapped sex workers	Analyse by geographic area to determine whether geographic prioritization of risk and vulnerability is taking place.
Condom distribution through outreach	Mean number of condoms distributed by community outreach workers and staff outreach workers per sex worker monthly	Numerator: total number of condoms distributed by community outreach workers and staff outreach workers in a month Denominator: total number of mapped sex workers	Analyse by geographic area and by community/staff outreach workers. Trends may be helpful to highlight supply problems.
STI and voluntary HTC coverage	Proportion of sex workers who have ever attended: 1. STI clinic 2. HTC clinic	Numerator: number of sex workers who have visited the clinic at least once Denominator: total number of mapped sex workers	This is a crude estimate that gauges basic access and is useful to analyse by gender, local area and different sex work settings, to consider different referral methods, as appropriate. Verification of consultations should be done by checking whether sex workers actually attended, not by counting referral cards handed out. Each type of visit should be recorded and analysed separately.
STI and voluntary HTC demand	Proportion of sex workers receiving: 1. Routine STI check-ups (i.e. quarterly) 2. Routine (six-monthly) HIV testing	Numerator: number of sex workers: 1. Receiving STI consultations during the quarter (or according to current programme standards) 2. Receiving tests in a six-month period (or according to current programme standards) Denominator: number of mapped sex workers	
Positive Health – access to support	Proportion of HIV-positive sex workers with access to Positive Health support	Numerator: number of sex workers reporting a one-to-one or group Positive Health support in a month Denominator: Number of self-reported HIV-positive sex workers	This is another crude data point, especially as it relies on self-reporting of HIV-positive status. It guides programmes on the need for resources for Positive Health when analysed by geographic area.

Monitoring community access to services and community agency

The following indicators have been used in behavioural surveys and qualitative research to gauge sex workers' access to services and their levels of self-efficacy (the belief in one's ability to take actions under specific circumstances) and collective agency (the choice, control and power to act as a group). They have been used as standalone indicators for advocacy purposes, and in indices for academic research, where they can be compared in order to determine predictors and mediators of behaviour and HIV and STI risk, and to show the degree of community empowerment.

The indicators are assessed by questioning sex workers on their levels of confidence and their actions and opinions about different situations, most of which represent potential or actual barriers to safety and health. ("You" in the question refers to the sex worker.)

- **Self-efficacy for condom use:** How confident are you in your ability to use a condom with each client:
 - › even if he gets angry?
 - › even if he offers more money for sex without a condom?
 - › even if you have been using alcohol or drugs?
- **Self-efficacy for STI clinic service use:** How confident are you about going to the clinic for STI services, even if health workers:
 - › know that you are a sex worker?
 - › treat you badly?
 - › don't provide the specific service you need (e.g. no anal exam, no drugs)?
- **Self-efficacy for HTC clinic service use:** How confident are you about going to the clinic for HTC services, even if health workers:
 - › know that you are a sex worker?
 - › treat you badly?
 - › will not keep your visit confidential?
- **Self-efficacy for clinic service use:** How confident are you about going to the clinic for treatment, even if health workers:
 - › know you are a sex worker?
 - › treat you badly?
 - › record your name and address as part of registration?
- **Self-confidence to speak openly:** How confident are you about giving advice to fellow sex workers, or speaking your opinion in front of a large group of people?
- **Collective agency:** Have you negotiated with or stood up to the following individuals in order to help a fellow sex worker:
 - › police?
 - › brothel owner/manager?
 - › gang member?
 - › client?
 - › regular partner?

3 Community-led Services

- **Collective efficacy:** Have you worked together with other sex workers to:
 - › keep each other safe from harm?
 - › increase condom use with clients?
 - › speak up for sex workers' rights?
 - › improve sex workers' lives?
- **Enabling environment:** How fairly do you think sex workers are treated:
 - › at hospitals?
 - › at banks?
 - › at post offices?
 - › in other public places?
 - › by the police?

3.5 Resources and further reading

1. *A Guide to Participatory Planning and Monitoring of HIV Prevention Programs with High-Risk Groups*. Bangalore, India: Karnataka Health Promotion Trust and India Health Action Trust, 2011.
 - a. *Module 1: Introduction and Getting Started*.
http://www.khpt.org/reports%20pdf/Module_1%20Introduction%20and%20Getting%20Started_Final.pdf
 - b. *Module 2: Participatory Planning Tools for FSWs, MSM and Transgenders*.
http://www.khpt.org/reports%20pdf/Module_2%20Participatory%20Planning%20Tools_Final.pdf
 - c. *Module 3: Participatory Monitoring Tools for FSWs, MSM and Transgenders*.
http://www.khpt.org/reports%20pdf/Module_3%20Participatory%20Monitoring%20Tools_Final.pdf
 - d. *Module 4: Individual Tracking Tools for FSWs, MSM and Transgenders*.
http://www.khpt.org/reports%20pdf/Module_4%20Individual%20Tracking%20Tools_Final.pdf
2. *Community Mobilization for Female Sex Workers (Toolkit)*. Bangalore, India: Karnataka Health Promotion Trust, 2009.
 - a. *Module 1: Introduction and Overview*.
<http://www.khpt.org/Pub/Community%20Mobilization/Book%201%20-Introduction%20&%20Overview.pdf>
 - b. *Module 2: Strategic Overview*.
<http://www.khpt.org/Pub/Community%20Mobilization/Book%202%20-%20Strategic%20Approach.pdf>
 - c. *Module 3: Enhancing Self-Esteem*.
<http://www.khpt.org/Pub/Community%20Mobilization/Book%203%20-%20Enhancing%20Self%20Esteem.pdf>
 - d. *Module 4: Facilitation*.
<http://www.khpt.org/Pub/Community%20Mobilization/Book%204%20-%20Facilitation.pdf>
 - e. *Module 5: Responsive Governance*.
<http://www.khpt.org/Pub/Community%20Mobilization/Book%205%20-%20Responsive%20Governance.pdf>
3. *Peer Education: Outreach, Communication & Negotiation. Training Manual*. Brighton, United Kingdom: International HIV/AIDS Alliance, 2005.
http://www.aidsalliance.org/includes/Publication/Peer_education_manual.pdf
4. *Peer Educators' Advanced Training Manual*. New Delhi: FHI 360, 2010.
<http://www.fhi360.org/resource/peer-educators-advanced-training-manual>
5. *Training Manual for Peer Educators of Female Sex Workers in HIV and AIDS Prevention*. Accra: FHI 360, Ghana AIDS Commission, 2011.
<http://www.fhi360.org/resource/social-and-behavior-change-tools-female-sex-workers>
6. *Female Sex Worker Peer Education Toolkit*. Accra: FHI 360, Ghana AIDS Commission, 2011.
http://www.fhi360.org/sites/default/files/media/documents/Toolkit_Peer_Educators.pdf
7. *Micro-Planning in Peer Led Outreach Programs—A Handbook*. New Delhi: Bill & Melinda Gates Foundation, 2013.
[http://docs.gatesfoundation.org/no-search/Documents/Microplanning%20Handbook%20\(Web\).pdf](http://docs.gatesfoundation.org/no-search/Documents/Microplanning%20Handbook%20(Web).pdf)
8. *Network Capacity Analysis: A toolkit for assessing and building capacities for high quality responses to HIV. Workshop facilitation guide*. Brighton, United Kingdom: International HIV/AIDS Alliance, 2008.
http://www.aidsalliance.org/includes/Publication/Network_Capacity_analysis_Workshop_Guide_final.pdf

9. *Network Capacity Analysis: A toolkit for assessing and building capacities for high quality responses to HIV. Rapid Assessment Guide.* Brighton, United Kingdom: International HIV/AIDS Alliance, 2007.
http://www.aidsalliance.org/includes/Publication/Network_capacity_analysis_rapid_web.pdf
10. *Measuring Up—A Guide for Facilitators: HIV-related advocacy evaluation training for civil society organisations.* Brighton, United Kingdom: International HIV/AIDS Alliance, International Council of AIDS Service Organizations, 2010.
<http://www.aidsalliance.org/includes/Publication/Measuring-up-a-guide-for-facilitators.pdf>
11. *Measuring Up—A Guide for Learners: HIV-related advocacy evaluation training for civil society organisations.* Brighton, United Kingdom: International HIV/AIDS Alliance, International Council of AIDS Service Organizations, 2010.
<http://www.aidsalliance.org/includes/Publication/Measuring-up-a-guide-for-learners.pdf>
12. *Work Safe in Sex Work: A European Manual on Good Practices in Work with and for Sex Workers.* Amsterdam: TAMPEP International Foundation, 2009.
<http://www.nswp.org/sites/nswp.org/files/work%20safe%20in%20sex%20work%20tampep.pdf>
13. *Breaking through Barriers: Avahan's scale-up of HIV Prevention among High-risk MSM and Transgenders in India.* New Delhi: Bill & Melinda Gates Foundation, 2010.
<http://www.gatesfoundation.org/avahan/Documents/breaking-thru-barriers.pdf>
14. *"Nothing About Us Without Us." Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative. International Edition.* Toronto, Canada: Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute, 2008.
http://www.aidsalliance.org/includes/Publication/Nothing_About_Us_REPORT_English.pdf
15. *Developing HIV/AIDS Work with Drug Users: A Guide to Participatory Assessment and Response.* Brighton, United Kingdom: International HIV/AIDS Alliance, 2003.
http://www.allianceindia.org/publications/78944-idu0803_idu_guide.pdf
16. *Guide to Participatory Production of Resources for HIV Prevention among Vulnerable Populations.* Brighton, United Kingdom: International HIV/AIDS Alliance, 2005.
http://www.aidsalliance.org/includes/Publication/iec_guide.pdf
17. *Program Review: SMARTgirl, Providing HIV/AIDS Prevention and Care for Entertainment Workers, Reporting Period: October 2008–June 2010.* Phnom Penh: FHI 360, 2010.
<http://www.fhi360.org/resource/program-review-smartgirl-providing-hiv-aids-prevention-and-care-entertainment-workers>
18. *Use of a Community-Based Revolving Fund to Promote Condoms and Water-Based Lubricants among Male and Transgender Sex Workers in Bangkok, Thailand.* Bangkok: FHI 360, 2010.
<http://www.fhi360.org/resource/use-community-based-revolving-fund-promote-condoms-and-water-based-lubricants-among-male-0>
19. *Strategic Behavioral Communication: A User and Technical Manual of Material and Tools.* New Delhi: FHI 360, 2012.
<http://www.fhi360.org/sites/default/files/webpages/sbc-manual/index.html>
20. *At the Top of the Ladder: Community Members Can Truly Lead Programs.* New Delhi: FHI 360, 2011.
<http://www.fhi360.org/resource/top-ladder-community-members-can-truly-lead-programs>
21. *Standard Operating Procedures: Aastha I: An STI/HIV Prevention Program with Sex Workers in Mumbai and Thane, India.* New Delhi: FHI 360, 2010.
<http://www.fhi360.org/resource/standard-operating-procedures-aastha-i-stihiv-prevention-program-sex-workers-mumbai-and>
22. *Standard Operating Procedures: Male Sex Workers Aastha I: An STI/HIV Prevention Program with Sex Workers in Mumbai and Thane, India.* New Delhi: FHI 360, 2010.
<http://www.fhi360.org/resource/standard-operating-procedures-male-sex-workers-aastha-i-stihiv-prevention-program-sex>
23. *CBO Management Committee Training Manual Series: Basic and Advanced.* New Delhi: FHI 360, 2012.
<http://www.fhi360.org/resource/cbo-management-committee-training-manual-series-basic-and-advanced>



4

Condom and Lubricant Programming



What's in this chapter?

This chapter explains:

- **why condom and lubricant programming is essential** to HIV prevention interventions (Section 4.1)
- **three steps in effective condom and lubricant programming** (Section 4.2):
 - › establishing accessible supplies
 - › multi-level promotion
 - › creating an enabling environment
- **other considerations** for programming (Section 4.2):
 - › programming with male and transgender sex workers
 - › condom negotiation strategies
 - › programming with clients of sex workers
 - › condom social marketing programmes
- **programme management** (Section 4.3).

The chapter also provides a list of **resources and further reading** (Section 4.4).

4.1 Introduction

2012 Recommendations:¹ Evidence-based Recommendation 2

Promote correct and consistent condom use among sex workers and their clients.

The effective supply, distribution and promotion of male and female condoms and lubricants are essential to successful HIV prevention interventions with sex workers. Condoms have been recommended as an HIV prevention method since the mid-1980s and remain the most effective tool for sex workers in preventing HIV transmission. Condom programming therefore occupies a central place in any package of HIV and sexually transmitted infection (STI) prevention, care and treatment services for sex workers. Condom programmes² have been successful in increasing condom use in a variety of sex work settings.

Condom programming involves:

- establishing accessible male and female condom and lubricant supplies for sex workers by:
 - › forecasting and procurement planning
 - › procurement and stock management
 - › distribution
- multi-level promotion of male and female condoms and lubricants
- creating an enabling environment for condom programming.

Condom programming for sex workers is a complex task with multiple steps. It requires a partnership of national government, local governments, local nongovernmental organizations (NGOs) and sex worker-led organizations, among others. The meaningful involvement and leadership of the sex worker community³ are also essential. Respondents to the values and preferences survey⁴ unanimously supported condom promotion and distribution to sex workers, stressing the need to make condoms and lubricants more available (particularly in sex work settings), more affordable and of higher quality.

When condom programming is successful, sex workers are provided with stable, ongoing and adequate supplies of condom and lubricant products that are acceptable to them in material, design and pricing. Sex workers are also provided with information and communication messages to reduce barriers to condom use, as well as the skills to correctly and consistently use condoms. Programmes should also create an enabling environment for condom programming that addresses social and legal barriers to expanded condom and lubricant access and use, such as laws and practices that cause sex workers to fear carrying condoms, poor living and working conditions for some sex workers, and lack of support for condom use in the general population and among male clients of sex workers.

1 *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach.* WHO, UNFPA, UNAIDS, NSWP, 2012.

2 Wherever “condom programmes” or “condom programming” is discussed, this refers to programming for male and female condoms and lubricants. Although this tool uses the generic term “condom” for simplicity, high-quality programmes should include all three of these commodities, as each is important to the prevention of HIV and other STIs. Similarly, when “condoms and lubricants” are referred to, the term “condoms” includes both male and female condoms.

3 In most contexts in this tool, “community” refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to sex workers, “community-led interventions” are interventions led by sex workers, and “community members” are sex workers.

4 A global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations.

4.2 Steps in effective condom programming

Strategic partnerships among all main partners are essential to improve access to, and use of, condoms to prevent or reduce the incidence of unintended pregnancies, STIs and HIV. Partners include sex worker-led organizations, NGOs, the ministry of health or national AIDS programme, department of reproductive health, United Nations agencies, the private sector, social marketing organizations, donor agencies and law enforcement ministries.

At the central management level, the national HIV and AIDS programme, national governments, and national-level civil society organizations have important roles to play in condom and lubricant procurement and supply, national-level condom and lubricant promotion, and creating an enabling environment for condom programming. Local implementing organizations⁵ (including social marketing organizations) and health clinics play essential roles in commodity forecasting, distribution, community-led promotional strategies and advocating for an enabling environment for condom programming at the local level. These roles are outlined in Table 4.1 as well as in Section 4.3, Figure 4.1, where additional information on the various levels of planning and execution of strong partnerships for condom programming is provided.

Table 4.1 Implementation of high-quality condom programming with sex workers

Activity	Role of national HIV and AIDS programme and national implementing organizations	Role of local implementing organizations, local government and health clinics
Establishing accessible male and female condom and lubricant supplies for sex workers	<ul style="list-style-type: none"> • Carry out accurate forecasting of condom and lubricant supply needs. <hr/> <ul style="list-style-type: none"> • Conduct market research to understand sex workers' condom preferences including sizes, colours, flavours, etc. • Define the procurement plan and funding source; ensure sufficient funding is available for needed orders. <hr/> <ul style="list-style-type: none"> • Place condom and lubricant orders on a timely basis, securing an uninterrupted supply of products that: <ol style="list-style-type: none"> 1. Meet World Health Organization (WHO) recommendations 2. Respond to community needs for variety and comfort. 	<ul style="list-style-type: none"> • Conduct forecasting of condom and lubricant needs to inform national forecasts, led by NGOs/community-based organizations (CBOs)/community-led organizations. <hr/> <ul style="list-style-type: none"> • Provide input into market research and procurement planning processes at the national/central level. <hr/> <ul style="list-style-type: none"> • Map the potential distribution outlets in the community for condom and lubricant distribution.⁶ • Assess the size and quality of the distribution outlets (existing and new) to ensure that condoms and lubricants are stored in optimum conditions to avoid deterioration over time.

⁵ An implementing organization is an organization delivering a prevention intervention to sex workers. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes an NGO provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

⁶ See Chapter 3, Section 3.2.2, part A for an example of how to carry out mapping of condom distribution outlets and other outreach services.

Activity	Role of national HIV and AIDS programme and national implementing organizations	Role of local implementing organizations, local government and health clinics
	<ul style="list-style-type: none"> • Consult with sex workers to plan condom distribution points that meet their needs. 	<ul style="list-style-type: none"> • Implement distribution of condoms and lubricants to sex workers and clients, including proper product storage and a complete management information system on condom and lubricant distribution patterns. • Provide free condoms and lubricants through targeted distribution points including clinics, drop-in centres, sex work venues, work places, drinking establishments, transport hubs and rest stops, etc. as well as through community outreach workers.⁷ Sensitize outlet owners and depot holders. • Where partnerships exist, work with the government and health system to distribute condoms and lubricants in high-quality health clinics accessed by sex workers. • Distribute branded social marketing condoms and lubricants through traditional and nontraditional social marketing outlets.
Multi-level promotion of male and female condoms and lubricants	<ul style="list-style-type: none"> • Carry out regular monitoring of central condom and lubricant stocks to ensure timely ordering and avoid stock-outs. • Request feedback on condom product needs and distribution system and make changes accordingly. • Build the capacity of NGOs and community-led networks and organizations of sex workers in community-driven promotional strategies (if needed). • Destigmatize condoms through promotional efforts in the general population, including talk shows and radio programmes, or condom cartoons in popular newspapers. 	<ul style="list-style-type: none"> • Carry out regular monitoring of local condom and lubricant stocks to ensure timely ordering and avoid stock-outs. • Provide regular feedback to national programme on condom and lubricant product needs (i.e. size/scent/colour) and distribution system. • Implement community-driven promotional strategies for condoms and lubricants, such as promotion of condoms through community outreach workers. • Integrate community-driven promotional strategies for condoms and lubricants with other community outreach activities.

⁷ In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”. The terms “community” or “peer” should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.

Activity	Role of national HIV and AIDS programme and national implementing organizations	Role of local implementing organizations, local government and health clinics
	<ul style="list-style-type: none"> • Working with the community, develop tailored behaviour change interventions for correct and consistent condom and lubricant use. • Provide additional commodities and training supplies to local organizations, as needed, including dental dams, gloves, penis models, pelvic models, etc. • Train health-care workers and counsellors to provide condom demonstrations and skills-building information. • Destigmatize condoms through high-level, well-publicized political support for condom use. 	<ul style="list-style-type: none"> • Provide male condom demonstrations and skills-building for correct condom use for anal sex between males, vaginal and anal sex between females and males, and anal sex between transgender persons and males. • Provide education on which available lubricants are condom-compatible and safe. • Provide demonstrations of the female condom using pelvic models. • Build capacity of sex workers to negotiate condom use and sexual risk reduction. • Provide routine reinforcement of condom and lubricant use and negotiation skills, if needed.
Creating an enabling environment for condom programming	<ul style="list-style-type: none"> • Create a universal condom access policy; reject punitive 100% condom use policies. • Revise laws and regulations that penalize possession of condoms. • Stop law enforcement practices of confiscating condoms and using condoms as evidence of sex work. 	<ul style="list-style-type: none"> • Advocate to ensure that condom programming is free of coercion. • Carry out condom and lubricant promotional activities with “gatekeepers”, such as owners of brothels and entertainment establishments. • Collect data on any violence to sex workers and clients related to carrying condoms, and share with policy-makers. • Implement condom promotion and distribution as part of a broader package of health services and activities.

4.2.1 Establishing accessible male and female condom and lubricant supplies for sex workers

An effective supply chain ensures that the right quality product, in the right quantity and in the right condition, is delivered to the right place at the right time, for a reasonable cost. A supply chain typically has the following major components:

- **forecasting** to ensure a reliable supply of condoms and lubricants
- **procurement** of high-quality male and female condoms and lubricants consistent with sex workers' needs and wants
- **quality assurance** at all levels⁸
- **warehousing and storage** of condoms in a way that maintains the integrity of the commodities and their supply chain
- **distribution** to providers and other outlets to serve sex workers' needs
- **logistics management** information system (LMIS) to support informed decision-making and planning

Effective, comprehensive condom programming can only be achieved under the following conditions:

- The process is ideally led and owned by the government in partnership with implementing partners and sex worker organizations, and efforts are coordinated through sound leadership at the national level.
- Government-led efforts are informed by collaboration with condom and lubricant users, including sex workers.
- Demand for condoms and lubricants is created and sustained.
- Adequate supplies of high-quality condoms and lubricants are available and distributed widely.
- Advocacy and capacity-building are carried out to ensure the sustainability of the programme over the long term.

Accurate condom and lubricant supply planning requires forecasting exercises that are based primarily on regular consumption data supplemented with data on service provision, demographic and morbidity data, estimates of population mobility and programme plans. (See Section 4.4 for guidance on contraceptive forecasting, including condoms). National condom programmes should work closely with organizations that serve sex workers to request regular (monthly, bimonthly or quarterly) reports of condom consumption data, defined as the actual quantities of condoms that have been distributed to sex workers within a specified period. Where a functioning LMIS exists, organizations working with sex workers should be incorporated into the LMIS to report condom and lubricant consumption data and changing needs.

Government-led “comprehensive condom programmes” should actively involve sex worker-led organizations and civil-society organizations in condom and lubricant supply forecasting, market segmentation, condom and lubricant distribution and product promotion. In addition, empowering sex worker-led organizations to play an active role in the distribution of condoms and lubricants in sex worker communities is essential to enabling community members to access and use condoms. With direct access to the population being served, sex worker organizations are key distribution points for

⁸ For more information on quality assurance testing as well as proper storage of condoms in warehouses, see the WHO/UNFPA/FHI publication *Male Latex Condom: Specification, Prequalification and Guidelines for Procurement, 2010* listed in Section 4.4.

condoms, providing condoms and lubricants in “safe spaces” (drop-in centres),⁹ through community outreach workers and as part of health services. Sex worker organizations may also want to work with managers and owners of sex work venues to involve them in condom distribution.

Sex workers should be engaged from start to finish in planning, mapping and implementing condom and lubricant distribution points. Table 4.2 provides key questions that implementing organizations should ask in planning for adequate supplies of condoms for sex workers.

Table 4.2 Condom supply planning questions

Questions	Potential answers
From what types of outlets do community members prefer to obtain condoms? (Place strategy)	<ul style="list-style-type: none"> • Sex worker “safe spaces” (drop-in centres) • Community outreach workers • Shops, pharmacies • Medical clinics, doctors, hospitals • Bars, guest houses, hotels, brothels • Workplaces • Truck stops, bus stops
What types of condoms do sex workers prefer? (Price strategy)	<ul style="list-style-type: none"> • Free public-sector condoms • Social marketing condoms • Commercial condoms • Others?
How close are condom outlets to the community? (Accessibility)	<ul style="list-style-type: none"> • Very close (1-5 minute [min.] walk) • Close (10-20 min. walk) • Far (30-45 min. walk) • Very far (1 hour or more)
Do these outlets always have condoms to provide? (Availability)	Male condoms: Yes/No Female condoms: Yes/No Water- or silicone-based lubricants: Yes/No
How many condoms do sex workers and clients have access to weekly? (Current level)	Number of condoms per sex worker: Male condoms: Female condoms: Lubricants:
How many do they need to access? Unmet need (right quantity?)	Number of condoms required per sex worker monthly:
What are the most common problems sex workers report with male condoms (Right quality?)	<ul style="list-style-type: none"> • Breakage • Slippage • Condom has bad smell • Condom is expired • Condom package is damaged • Other
What are the most common problems sex workers experience with female condoms (Right quality?)	<ul style="list-style-type: none"> • Condom has bad smell • Condom is expired • Condom package is damaged • Other
Are condom-compatible lubricants always available at condom distribution points?	Yes/No

⁹ A safe space (drop-in centre) is a place where sex workers may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 3, Section 3.3 for details.

4 Condom and Lubricant Programming

Condom distribution programmes should work with sex workers and clients to understand their preferences for condom products, including condom size, colour, scent and branding preferences. Distributing low-priced social marketing condoms in outlets close to sex work venues, in combination with free distribution of generic condoms through community outreach workers, is often the most effective way to ensure broad-based accessibility of condoms for sex workers and clients.

Wherever condoms are distributed, water- and silicone-based lubricants should also be made available according to the preferences of sex workers. All condom and lubricant products should meet WHO recommendations (see Section 4.4 for information on WHO recommendations for procurement of condom and lubricants). Lubricant distribution should accompany condom distribution, with lubricants made available in tubes, sachets or other packages according to sex workers' preference. Social marketing organizations often package lubricants together with condoms, which can be an effective approach to lubricant distribution.

Box 4.1

Case example: Co-packaging of condoms and lubricant in Laos

In Laos, Population Services International distributed co-packaged condom and lubricant, branded as *Number One Deluxe Plus*. The co-packaged condom and lubricant was distributed by community outreach workers to sex workers, men who have sex with men and transgender individuals in conjunction with an informational brochure that emphasized that condoms and lubricants should be used together to prevent disease transmission and minimize condom breakage.

While lubricant distribution should accompany condom distribution, the primary focus should be on increasing condom use, and therefore product communications should focus on lubricant use in the presence of a condom. There is limited and inconclusive evidence that lubricant use in the absence of a condom may contribute to STI transmission; therefore, programmes should promote lubricants with condoms.

Beyond condoms and lubricants, sex workers often need access to additional protective products. Depending upon the local context and needs, sex workers may need access to dental dams and gloves for specific sexual services, soap and water and/or recommended cleaning products for cleaning sex toys, and other products, as identified by sex workers. Programmes working with sex workers require penis models for condom demonstrations and vaginal models for female condom demonstrations, and should incorporate these and other commodity needs identified above into their procurement planning and product distribution efforts.

4.2.2 Multi-level promotion of male and female condoms and lubricants

A condom promotion strategy for sex workers must be evidence-based. Prior to the development of the strategy, a situation analysis should be carried out, including descriptive data about sex workers, such as where they work and other factors that may help or hinder their ability to use condoms consistently and correctly with all sexual partners. The condom promotion strategy should also be informed by relevant behaviour-change theories and the experiences of behavioural interventions that have increased condom use between sex workers and their clients.

Community-led condom promotion

The condom promotion strategy may be developed in a workshop setting that should be led by, or at the very least include, sex workers who represent relevant sub-groups, including urban and rural, “new entrants” and “experienced”, “indoor”¹⁰ and street-based, and female, male and transgender sex workers. Providing sex workers with a space to engage and lead this process ensures a realistic understanding of their barriers to condom access, preferences for condom acquisition and current condom use with their clients.

The resulting community promotion strategies should apply a holistic approach similar to the approaches to community-led services outlined in Chapter 3. Led by (or in consultation with) sex workers, multiple behaviour change intervention activities and materials (e.g. one-on-one counselling, role plays, flip charts, posters, video testimonies, etc.) may be developed in order to build needed skills and reinforce condom promotion messages. High-quality, community-led activities accompanied by high-quality tools and materials have proven effective in ensuring targeted promotion messaging and building condom-related skills. Behaviour change strategies should be designed to address a variety of personal barriers to condom use, including:

- Knowledge of the health benefits of condoms and where they are available
- Safer sex negotiation abilities¹¹
- Condom skills-building (for both male and female condoms)
- Appropriate use of safe lubricants

Demonstrations of correct male and female condom use by community outreach workers may increase sex workers’ condom use skills and self-efficacy in condom use (i.e. the belief in their ability to use a condom even under challenging circumstances). Approaches should also facilitate sex workers’ ability to build support systems in their community in order to collectively identify ways to encourage consistent condom and lubricant use. Box 4.2 lists strategies for community-led condom promotion; the following page identifies some specific approaches that may be considered.

Box 4.2

Condom promotional/educational strategies with sex workers

- Evidence-based communication messages that create demand for safer sex.
- Condom skills-building for both male and female condoms.
- Information on choosing safe, effective lubricants and avoiding unsafe lubricants.
- Training in safer sex negotiation skills, including how to negotiate condom use and strategies for reducing risk when no condom is available.
- Addressing misconceptions around condom use, such as double condom use and female condom re-use.
- Information on how to protect oneself when providing a broad range of sexual services, such as fulfillment of sexual fantasies, fetish sex¹² and non-penetrative sexual services.
- Specific discussions of the condom and lubricant needs of male-to-male anal sex, male-to-female anal sex, vaginal sex and/or male-to-transgender anal sex.
- Providing risk-reduction education around common reproductive health misconceptions, including douching, washing after sex and preventing unintended pregnancies.

¹⁰ “Indoor” sex workers work in a variety of locations including their homes, brothels, guesthouses, bars, clubs and other sex work venues.

¹¹ See *Making Sex Work Safe* (NSWP, 2011), pp.67–68 for condom negotiation strategies.

¹² Fetish sex is when heightened erotic pleasure is gained from an activity, sensation or item that may differ from what society considers “normal” or traditional in relation to sexual activity.

Condom use with intimate partners

While most condom promotion messages with sex workers focus on condom use with clients and casual partners, in some cases condom promotion programmes identify a need to increase condom use between sex workers and their regular clients and/or their intimate partners. Experienced community outreach workers have developed communication methods to effectively discuss use of condoms with regular partners without intruding on a sex worker's private life. For example, community outreach workers from the Targeted Outreach Program (TOP) in Myanmar use examples from their own regular partnerships to engage in targeted counselling with sex workers around the need to protect oneself in longer-term relationships. In general, discussion of condom use with regular partners needs to be handled discreetly by community outreach workers in order to respect the private lives of sex workers.

Female condoms

The female condom is an important preventive commodity for female sex workers that is frequently neglected in overall condom programming. Promoting the female condom requires the skills to demonstrate its correct use as well as an understanding of its advantages for sex workers:

- It is stronger than the male condom and may be used for anal sex.
- It is useful for female sex workers during menstruation.
- Sex workers can use it when clients cannot maintain an erection.
- It requires less cooperation from the client.

Community outreach workers should be trained to demonstrate correct use of the female condom and should be given female pelvic models to facilitate these demonstrations.

Note: Female condoms should not be re-used; in fact, clients of sex workers often need to be reassured that the female condom is not being re-used in order to feel comfortable using it.

Reducing risk through alternative sexual services

To maintain good health, sex workers need to know not just about condoms and lubricants, but also about the variety of sexual services that can be provided in lieu of penetrative sex. In many cases, sexual services other than penetrative sex may increase the client's satisfaction while reducing the health risks and physical impact for the sex worker. Community outreach workers can help sex workers share their experience and knowledge of sexual services that minimize health risks to the sex worker. Some sex workers provide the low-risk alternative services shown in Box 4.3. Education on risk reduction beyond condom use should be incorporated into all programmes reaching sex workers, including information about the risks associated with non-penetrative sexual services, which can help sex workers decide which services they wish to provide.

Box 4.3

Alternative sexual services to reduce HIV/STI-related risk

Masturbation
Breast sex
Fantasy sex

Thigh sex
Use of sex toys
Voyeurism

Non-penetrative fetish sex
Phone and cybersex

Box 4.4

Case example: Community-led condom promotion in Myanmar

The Targeted Outreach Program (TOP), a programme of Population Services International (PSI) which began in 2003, provides sexual health services for female sex workers and men who have sex with men in Myanmar. TOP's community-based approach engages community members as community outreach workers, field staff and eventually as management.

Sex workers are involved in all aspects of planning, distributing, and promoting condoms. They identify hotspots for condom distribution as well as specific outlets and venues. Community outreach workers provide condoms to sex workers during outreach to complement PSI's social marketing efforts. In addition, TOP builds social support for condom use among sex workers through programming at its 18 safe spaces (drop-in centres).

TOP has been particularly successful in promoting the female condom. Community outreach workers provide one-on-one counselling on female condom use, including demonstrations using a female pelvic model. While TOP has found that proper use of the female condom requires several demonstrations, these skills-building sessions have successfully increased female condom use among female sex workers, and further demand generation activities are planned.

In 2012 TOP distributed more than 1.2 million male condoms and over 110,000 female condoms to sex workers through community-led outreach. PSI also sells socially marketed condoms and lubricants in outlets close to sex work venues. Through a combination of free distribution and socially marketed condoms and lubricants, TOP ensures that sex workers and clients have access to high-quality, affordable, and accessible condoms and lubricants when and where they need them.

Positive indicators of behaviour change and HIV prevalence among sex workers in Myanmar cannot be directly attributed to TOP but are highly correlated with its efforts. Surveys by the government, WHO and PSI estimate that HIV prevalence among female sex workers was 7.1% in 2012, a sharp decrease from 27.5% in 2004 and 18.4% in 2008.

Destigmatizing condoms in the broader social environment

Broad social support for condom use is needed in order for condoms to be used consistently in most commercial sex encounters. Condoms cannot be stigmatized or viewed as only for "risky sex"—it is essential that social values encourage the acceptance of condom use as a "sexual health" tool in both short-term and long-term sexual partnerships. As a result, in addition to working directly with sex workers and their clients, condom promotion programmes should also carry out activities for the general population in order to destigmatize condom use and create overall social support for condom use in all sexual partnerships.

Media campaigns may be used to effectively promote condom use, decrease demand for unprotected sex and change social norms. Campaigns should provide consistent and complementary messaging across mass media, workplaces, health-service providers, and entertainment and sex work venues. Effective condom promotion to clients of sex workers relies on mass media promotion as clients are a highly dispersed group and very much part of the "general population". As a result, they cannot be easily identified for intensive community-based interventions, such as those carried out for sex workers, men who have sex with men, people who use drugs and transgender people.

Ideally, media promotional efforts are delivered through a partnership of organizations, including the national government, relevant NGOs, and private-sector condom companies. Countries such as Cambodia and Thailand, which have achieved significant reductions in heterosexual HIV transmission

4 Condom and Lubricant Programming

in casual and commercial sex, have demonstrated strong leadership from high-level government and social figures acknowledging the existence of risk behaviours and the necessity of condoms. In addition, in Thailand the government supported large-scale marketing campaigns to destigmatize condoms and increase their uptake among both the general population and at-risk populations.

With the ever-increasing reach of the Internet, individuals interested in casual and commercial sex are now often meeting online. The Internet provides a useful venue not only for meeting people, but also for promoting condoms. Condom promotion programmes should expand to online venues, particularly those where commercial and casual sex contacts are made. Online messaging should reinforce and complement condom promotion messages in other mass media and inform individuals about condom outlets. For more information on reaching key populations through electronic media, see WHO's *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach*.

4.2.3 Creating an enabling environment for condom programming

An enabling environment for strong condom programming ensures that:

- policy, legal and regulatory frameworks are supportive of condom programming
- these frameworks are properly enforced
- key organizations and individuals support condom programming and access for sex workers.

Universal condom access should be the focus of condom programming and policies. Sex workers need to have access to condoms and lubricants at all times. The universal condom access promotion and distribution approach rests on governments encouraging the availability of condoms to sex workers, irrespective of national laws pertaining to sex work. Condom promotion and distribution programmes should always be free of coercion. Punitive 100% condom use policies should be avoided as they often require specific actions by sex workers, such as visiting STI clinics, which are then enforced by brothel owners and state agencies, leading to human-rights violations and the restriction of individual freedoms. Instead, governments should encourage establishment owners to operate “safe workplaces” that stock condoms regularly and support sex workers to use condoms with clients. Where condoms are readily available under a universal condom access policy, more coercive regulatory methods—such as requiring condoms during commercial sex or forcing sex workers to undergo testing or to prove condom use—are not necessary.

National governments should ensure that relevant national laws and statutes provide for freedom of condom distribution and personal freedom for individuals to carry condoms. The laws and regulations of some countries still penalize possession of condoms. To enable effective condom distribution programmes and to ensure individual freedoms, these laws should be revised to clearly allow for personal possession of condoms by all individuals. In addition, in countries where law-enforcement officials use condoms as evidence of sex work, governments should take actions to end this practice. Condoms should never be considered to be evidence of sex work, either in official laws or through unofficial law-enforcement practices, and condoms should never be confiscated from sex workers.

Box 4.5

National policies to promote condom use

- Encourage “safe workplaces” and availability of condoms in all sex work venues.
- Revise/remove laws that penalize possession of condoms.
- End the practice of law enforcement officials using condoms as evidence of sex work.
- End practices of law enforcement officials confiscating condoms from sex workers.
- Ensure that current laws/policies incentivize owners of sex work venues to stock condoms.
- Decriminalize or de-penalize sex work in order to reduce fear among sex workers and increase condom use.

Condom distribution programmes should work in partnership with key institutions and individuals to ensure support for condom distribution and promotional activities. Key institutions include national ministries of health, local health departments, local clinic personnel and other relevant members of the health system. Key individuals (“gatekeepers”) include managers of entertainment establishments, nightclubs, brothels, guesthouses and hotels, and others involved in the commercial sex industry. Implementing organizations should work with these individuals to ensure they understand the importance of condom programming and are supportive of it.

Condom programming should never be an isolated activity. In order to be successful, condom promotion and distribution should always be conducted as part of a broader package of health services and activities should be implemented with sex worker leadership and involvement. At the local level, condom programmes should work with sex workers to consider situations where condom use tends to be compromised (e.g. group sex, alcohol and drug use, violence) and to devise solutions that reduce the frequency of those situations or increase condom use in them. Depending upon the local context, either advocacy or programmatic solutions, or both, could address these situations.

Box 4.6

Local strategies for creating an enabling environment for condom programming

- Ensure that condoms are widely available through condom outlets or machines in locations where sex is sold, such as brothels, bars, guesthouses and hotel rooms, and in transport hubs such as train and bus stations, petrol stations, and rest stops on highways.
- Place condoms directly in hotel or guesthouse rooms rather than at lobby desks. This ensures that they are readily available when and where sex occurs and prevents their confiscation by law-enforcement officials.
- Provide proper disposal locations (i.e. garbage cans) in places where sex is sold so that condoms may be disposed of properly and not create visible trash.
- Train local police to promote and protect the human rights of sex workers and HIV/STI prevention knowledge, including the need for condom promotion and distribution.
- Provide community outreach workers with identification cards signed by local police authorities to prevent them from being harassed while they are conducting outreach work.
- Implement workplace-based programmes with clients of sex workers focused on sexual health, including the reduction of demand for unprotected paid sex.

4.2.4 Specific considerations in condom programming

A. Condom programming with male and transgender sex workers

The types of sexual services provided by female, male and transgender sex workers vary, and condom distribution and promotion programmes should take these differences into account and ensure distribution of all commodities relevant to the types of sex provided by male and transgender sex workers. For example, lubricants are particularly important for people practising anal sex, while flavoured condoms may be important for oral sex.

- Promotional/educational programmes working with male sex workers should discuss topics such as condom use when maintaining an erection is difficult, the side-effects of drugs used to treat erectile dysfunction, risk reduction for fetish sex and use of female condoms for anal sex.
- Promotional/educational programmes working with transgender sex workers should provide information on use of female condoms and safer sex after surgery, among other topics.

In all cases, programmes serving male and transgender sex workers should work with these communities to understand their information and commodity needs, and tailor promotion and information accordingly. Both male and transgender sex workers may be highly stigmatized and programmes should provide psychosocial support, as needed. Male and transgender sex workers should be served by community outreach workers of the same gender in order to maximize understanding and the sharing of ideas between the sex workers and the community outreach workers.

B. Condom negotiation strategies

The decision about whether or not to wear a condom—as well as the type of sex to have—usually comes down to a specific negotiation between an individual sex worker and an individual client. In order for condom promotion programmes to be successful, community outreach workers should discuss condom and safer sex negotiation strategies during their meetings with sex workers to enhance their negotiation “toolkits” and skills.

Negotiation tactics that have been identified by sex workers include:

- taking the client’s money prior to the sexual encounter so that clients cannot refuse to pay if a condom is used
- taking the client to a known sex work venue where the rules of the venue require use of a condom
- negotiating with the client to engage in non-penetrative sex
- empowerment of the community; creating a community norm to refuse unprotected sex
- if all else fails, and if it is reasonably safe and feasible to do so, refusing the client if he will not wear a condom.

C. Condom programming with clients of sex workers

Clients of sex workers often make the final decision as to whether or not condoms are used, but they are frequently neglected in HIV prevention programmes. Countries that have successfully reduced new infections among sex workers and their clients often took steps to change the attitudes and behaviours of clients rather than focusing solely on the behaviour of sex workers.

As noted earlier, mass media campaigns are an important component of condom programming for clients of sex workers, who are not easily reached by outreach alone. There should also be more

intensive workplace condom promotion programmes to promote condom use in employment sectors with increased mobility and demonstrated higher prevalence of HIV and STIs (i.e. mining, transport, etc.).

Programmes should address normative values and behaviours of men and boys to incorporate respect for the health and human rights of all of their sexual partners, including female, male and transgender sex workers. This includes always using a condom for penetrative sex with a sex worker and never demanding unprotected sex. In addition to promoting condoms to clients of sex workers, programmes should also address common misconceptions around HIV prevention, including the idea that male circumcision or antiretroviral therapy eliminates all risk of transmitting HIV or other STIs.

Effective condom distribution to clients of sex workers relies on a harmonized approach to HIV programming among the health, commercial and judicial sectors. Condoms should be widely promoted and available in the commercial sector, particularly in convenience stores and small-scale vendors near entertainment areas. However, the most important thing is that condoms be available in the locations where commercial sex takes place. When condoms are more or less within arm's reach during a commercial sex act, it is significantly more likely that they will be used. It is therefore absolutely necessary that venues that facilitate sex services, and sex workers themselves, should not be hampered, punished or detained by police or others for possessing condoms.

Box 4.7

Strategies for reducing demand for unprotected sex and increasing condom use with clients of sex workers

- High-level government leadership supporting condom use in all penetrative sex acts.
- Media campaigns to change social norms and destigmatize condom use.
- Workplace programmes for potential clients of sex workers, to change community norms and reduce demand for unprotected paid sex.
- Distribution of condoms and lubricants in locations convenient to clients of sex workers, including convenience stores, workplaces and sex work venues.
- Incorporation of messages regarding the health of sexual partners into health and non-health programmes for men and boys.

D. Condom social marketing programmes with sex workers

Condom social marketing programmes sell lower-priced, subsidized condoms and lubricants to individuals who can afford to pay only some of the total commodity and programme cost of a condom. These programmes seek to increase condom and lubricant affordability, accessibility and availability in the general population while improving the sustainability of condom programming over time. In addition, condom social marketing programmes carry out a variety of branded and generic marketing campaigns that destigmatize condom use overall.

For sex workers and clients, condom social marketing programmes make available a variety of condom and lubricant choices, including condoms of different brands, scents, colours and sizes. Clients of sex workers may prefer certain types of condoms and may purchase socially marketed condoms to fulfil these preferences. Sex workers may also sell socially marketed condoms and lubricants to create an additional income stream.

4 Condom and Lubricant Programming

Despite the many advantages of condom social marketing programmes, they should not be a substitute for the distribution of free condoms and lubricants to sex workers. Condoms and lubricants are essential protective tools for sex workers and should be widely distributed to sex workers as a matter of policy. Condom social marketing programmes should complement and supplement free distribution, improving the choice and desirability of condoms and lubricants and making them more widely available. To coordinate these efforts, programmes can work together at the national level to adopt a total market approach to condom programming, emphasizing segmentation of the marketplace, coordination with the private sector and development of targeted branding strategies for the various marketplace segments.

For more information on a total market approach to condom social marketing, see Abt Associates' *Total Market Initiatives for Reproductive Health* (Section 4.4).

4.3 Condom programme management

4.3.1 Roles and responsibilities in condom programming

Figure 4.1 shows how condom programming is managed through partnerships and coordination among organizations at multiple levels of government and NGOs.

4.3.2 Programme monitoring

Table 4.3 provides monitoring indicators and their data sources that may be used to manage a condom promotion programme.

4.3.3 Evaluation

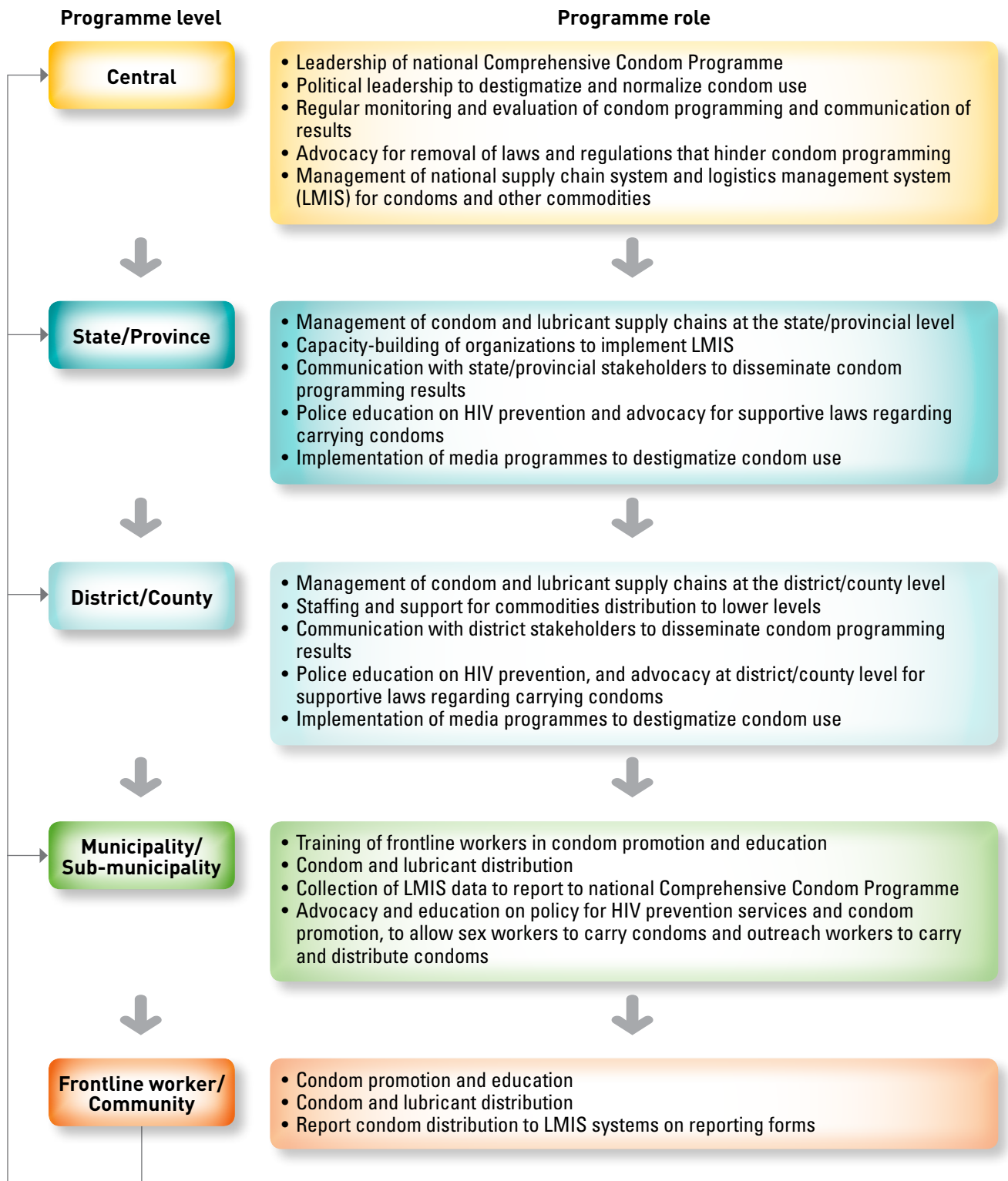
Evaluating the effectiveness of condom promotion and distribution with sex workers supplements regular programme monitoring and provides key data on whether programmes have effectively changed condom use behaviours of sex workers and clients. While a variety of evaluation methodologies and tools may be used, the most common include routine collection of condom distribution and sales data, behavioural surveillance surveys, condom coverage surveys, and process evaluations using routine monitoring data.

Behavioural surveillance surveys are conducted at regular intervals (every 2–4 years) with both sex workers and clients to determine the effect of interventions on health outcomes. These surveys measure changes in self-reported condom use as well as changes in identified motivations and barriers to condom use. Some behavioural surveillance surveys may also incorporate biomarkers that measure HIV and/or STI prevalence.

Condom coverage surveys are generally employed by social marketing programmes. These surveys use lot quality assurance sampling to measure levels of condom coverage and quality of coverage in mapped enumeration areas.

A **process evaluation** using routine monitoring data may be an instructive way to measure progress on condom programme outputs. In particular, condom supply indicators may be measured through routine programme reporting and use of an LMIS. Review of these data at regular intervals helps understand whether condoms are sufficiently available to sex workers.

Figure 4.1 Roles and responsibilities in condom programming



4 Condom and Lubricant Programming

Table 4.3 Condom programming monitoring indicators

Activity	Target	Indicator	Data sources
Establishing accessible male and female condom and lubricant supplies for sex workers	1	Ratio of condoms distributed/ estimated condoms required per month	Micro-planning tools Condom stock registers Enrolment questions on type of sex work and average number of partners Other condom gap assessments
	0	Number of NGOs/service delivery points reporting any condom stock-outs for free distribution in the last month	NGO/service delivery point condom stock registers
	0	Number of NGOs/service delivery points reporting any lubricant stock-outs for free distribution in the last month	NGO/service delivery point lubricant stock registers
	90%	% of enumeration areas where condoms are available for sale within a 10- or 20-minute walk	Social marketing condom coverage survey
	95%	% of sex workers and clients who agree with the statement: "condoms are available when I need them"	Behavioural surveillance surveys
	Multi-level promotion of male and female condoms and lubricants	90%	% of sex workers reporting condom use during last penetrative commercial sex
85%		% of sex workers reporting consistent condom use in commercial sex encounters	Behavioural surveillance surveys
90%		% of clients of sex workers reporting condom use during last commercial sex	Enrolment questions (quasi-baseline) Routine questions in clinic encounter
Increase		% of sex workers reporting identified motivational factors for condom use	Behavioural surveillance surveys
Decrease		% of sex workers reporting identified barriers to condom use	Behavioural surveillance surveys
Creating an enabling environment for condom programming	0	Number of reported incidents of confiscation of condoms	Programme reports
	90%	% of NGOs serving sex workers reporting condom needs into the national condom programme	LMIS records

4.4 Resources and further reading

1. *Total Market Initiatives for Reproductive Health*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates, 2012.
http://www.rhsupplies.org/fileadmin/user_upload/MDA_Documents/Total_Market_Initiatives_for_Reproductive_Health.pdf
2. *Market Segmentation Primer*. PSP-One Project, Abt Associates, 2009.
http://www.rhsupplies.org/fileadmin/user_upload/MDA_Documents/MDAWG_Market_Segmentation_Primer_FINAL_doc.pdf
3. *Contraceptive Forecasting Handbook for Family Planning and HIV/AIDS Prevention Programs*. Arlington, VA: Family Planning Logistics Management (FPLM)/John Snow, Inc., for the U.S. Agency for International Development, 2000.
<http://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=INTL&id=10340&thisSection=Resources>
4. *Market Development Approaches Scoping Report*. London: HLSP, 2006.
http://www.rhsupplies.org/fileadmin/user_upload/MDA_Documents/MDA_Scoping_Report_2006_10.pdf
5. *A Forecasting Guide for New & Underused Methods of Family Planning: What to Do When There Is No Trend Data?* Washington, DC: Institute for Reproductive Health, Georgetown University, John Snow Inc. and Population Services International for the Reproductive Health Supplies Coalition, 2012.
http://www.k4health.org/sites/default/files/A%20Forecasting%20Guide%20for%20New%20and%20Underused%20Methods%201st%20Edition%202012_0.pdf
6. *Female, Male and Transgender Sex workers' Perspective on HIV and STI Prevention and Treatment Services: A Global Sex Worker Consultation*. Edinburgh, United Kingdom: Global Network of Sex Work Projects, 2011.
<http://www.nswp.org/sites/nswp.org/files/NSWP-WHO%20Community%20Consultation%20Report%20archived.pdf>
7. *Making Sex Work Safe*. Edinburgh, United Kingdom: Global Network of Sex Work Projects, 2011.
http://www.nswp.org/sites/nswp.org/files/Making%20Sex%20Work%20Safe_final%20v3.pdf
8. *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach*. Geneva: WHO, UNFPA, UNAIDS, NSWP, 2012.
http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf
9. *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach*. Geneva: World Health Organization, 2011.
http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/
10. *Targeted Interventions under NACP III: Operational Guidelines. Volume I: Core High Risk Groups*. New Delhi: National AIDS Control Organisation, Government of India, 2007.
http://www.iapsmgc.org/userfiles/3TARGETED_INTERVENTION_FOR_HIGH_RISK_GROUP.pdf
11. *Male Latex Condom: Specification, Prequalification and Guidelines for Procurement, 2010*. Geneva: World Health Organization, United Nations Population Fund and Family Health International, 2013.
http://www.unfpa.org/webdav/site/global/shared/procurement/07_resources/malecondoms_specs_procurement_2010.pdf
12. *Use and procurement of additional lubricants for male and female condoms: WHO/UNFPA/FHI360 advisory note*. Geneva: World Health Organization, 2012.
http://apps.who.int/iris/bitstream/10665/76580/1/WHO_RHR_12.33_eng.pdf
13. *Female Condom: Generic Specification, Prequalification and Guidelines for Procurement, 2012*. Geneva: World Health Organization, United Nations Population Fund and FHI 360, 2012.
http://www.unfpa.org/webdav/site/global/shared/procurement/08_QA/Female%20Condom%20Generic%20Specification%20EN.pdf
14. WHO Pre-Qualified Male and Female Condom Suppliers. World Health Organization and United Nations Population Control Fund.
<http://www.who.int/hiv/amds/UNFPACondomSuppliers.pdf>



5

Clinical and Support Services



What's in this chapter?

This chapter discusses how to implement the recommended **package of clinical services** for sex workers. It describes **key principles for designing and delivering services** that are appropriate to the needs of sex workers (Section 5.1).

The services covered in this chapter are:

- voluntary HIV testing and counselling (Section 5.2)
- antiretroviral therapy (Section 5.3)
- treatment for tuberculosis (Section 5.4)
- additional services for sex workers who inject drugs (Section 5.5)
- sexually transmitted infection services (Section 5.6)
- sexual and reproductive health services (Section 5.7)
- mental health (Section 5.8).

The chapter also provides a list of **resources and further reading** (Section 5.9).

5.1 Operational principles for clinical and support services

Providing appropriate, accessible and acceptable clinical and support services for sex workers presents unique challenges because of the stigma and discrimination often faced in clinical settings. However, clinical services can be a focus for community empowerment if sex workers are involved in their design, implementation and monitoring.¹ This also encourages uptake of services by sex workers.

It is essential to build trust between health-care providers and sex workers receiving services. This may be done, in part, by following these overarching principles:

1. **Voluntary and informed consent:** Sex workers have the right to decide on their own treatment and the right to refuse services. Health-care providers should explain all procedures and respect the sex worker's choice if he or she refuses examination or treatment.
2. **Confidentiality:** Confidentiality of patient information, including clinical records and laboratory results, should always be maintained to protect the privacy of sex workers. Sex workers should be allowed to provide identifying information other than their official birth name (identification papers or biometric data should not be required). Continuity of services may be assured by assigning an enrolment number.
3. **Appropriate services:** Clinical services should be effective, of high quality, provided in a timely manner and address the needs of sex workers. Health services should be in line with international standards, current best practices and guidelines.
4. **Accessible services:** Clinical services should be offered at times and places convenient for sex workers. Where possible, services should be integrated or closely linked so that a broad range of health services can be accessed at a single visit (see Section 5.1.2 below).
5. **Acceptable services:** Health-care providers should be discreet, non-judgemental, non-stigmatizing and trained to address the special needs of sex workers.
6. **Affordable services:** Services should be free or affordable, bearing in mind the cost of transport and lost income opportunities for sex workers visiting a service provider.

Figure 5.1 shows how these principles may be put into practice through coordinated activities at each level of a prevention programme for HIV and sexually transmitted infections (STIs).

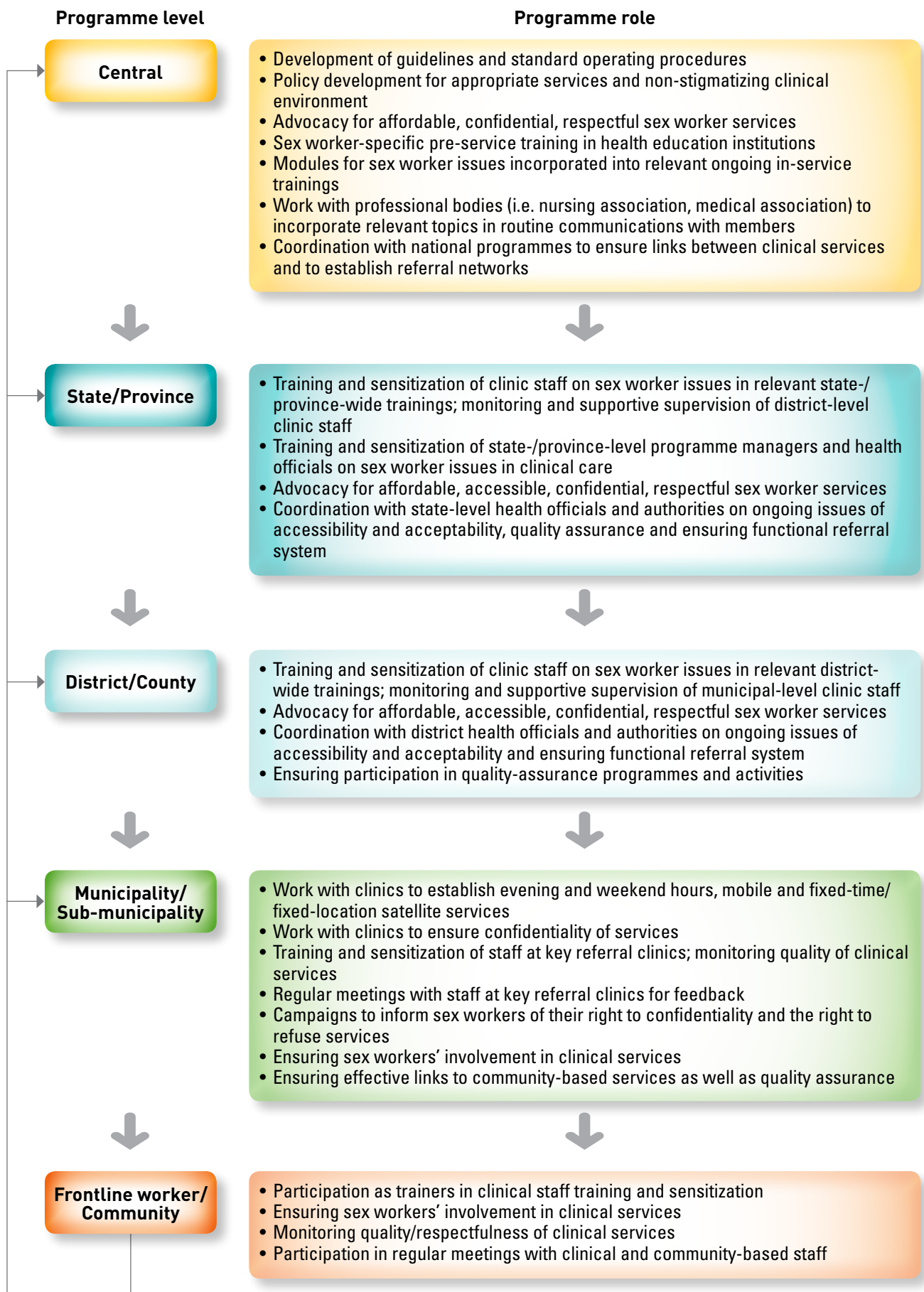
5.1.1 Service delivery and integration

Although different clinical services are divided into separate sections within this chapter, the goal of effective programme planning should be to create delivery models with the fewest barriers for people to access services. Clinical and nonclinical services are often complementary, and coordinating the two may also be appropriate. Approaches to make services more user-friendly include:

- co-locating interventions and cross-training providers
- involving the community in the development, promotion, delivery and monitoring of services
- training non-sex worker staff in a culture and duty of care towards sex workers
- taking steps to ensure that law enforcement activities do not interfere with sex workers' access to services.

¹ In most contexts in this tool, "community" refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to sex workers, "community-led interventions" are interventions led by sex workers, and "community members" are sex workers.

Figure 5.1 Illustrative multi-level approach to acceptable, accessible and respectful clinical services



5.2 Voluntary HIV testing and counselling

5.2.1 Introduction

2012 Recommendations:² Evidence-based Recommendation 5

Offer voluntary HIV testing and counselling to sex workers.

Voluntary HIV testing and counselling (HTC) is an essential entry point to HIV prevention, and to care and life-sustaining treatment for people with HIV. By combining personalized counselling with knowledge of one's HIV status, HTC can motivate behaviours to prevent HIV transmission, and persons living with HIV can access supportive counselling, treatment for opportunistic infections and antiretroviral therapy (ART).

Voluntary HTC services should be part of an integrated programme of HIV prevention, care and treatment, so that sex workers, their partners and their families have access to HTC as frequently as required, at times and locations that are convenient. Counselling and testing services should adhere to the "5 C's" principles described below, and should be delivered respectfully and without coercion, judgement, stigma or discrimination.

Respondents to the values and preferences survey³ stressed that in order for ART to be more widely available to sex workers, more sex workers must know their HIV status. Respondents unanimously expressed disapproval of mandatory or coercive testing.

5.2.2 Types of HIV testing and counselling and delivery

HTC services may be provided in a variety of settings, including:

- mobile community outreach
- health facilities
- safe spaces (drop-in centres)⁴
- bars, clubs and brothels
- homes or households.

Finger-prick blood sample or mouth swab are preferred collection methods. They can be performed by a trained community worker; these methods may also be more acceptable to people who have injected drugs and may have difficulty with venous blood access or have concerns about drug use disclosure.

² *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach.* WHO, UNFPA, UNAIDS, NSWP, 2012.

³ A global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations.

⁴ A safe space or drop-in centre is a place where sex workers may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 3, Section 3.3, for details.

Box 5.1

Case example: Comprehensive care with and for sex workers in Kenya

Comprehensive services with and for sex workers have been provided in Kenya for a number of years. Prevention education and condom distribution are provided in “hot spots” by outreach workers, most of whom are trained sex workers. HTC is provided in clinics as well as at outreach sites. All persons found to be HIV-positive are referred to a nearby clinic, although sex workers may choose alternate locations if they prefer, and they move from site to site as they choose. Clinics are open in the evenings and on Saturdays and offer comprehensive care including pre-ART care, prevention and treatment of opportunistic infections, support groups and long-term ART. Additional services, such as diagnosis and treatment of other STIs and cervical cancer screening are also available. These projects, located in all the major cities of Kenya, have advisory committees that include sex workers and advocates, and operate with the support of the Ministry of Health. As of June 2013, over 40,000 sex workers and family members had received services through these comprehensive programmes throughout the country.

5.2.3 Essential activities for voluntary HTC services for sex workers**A. Preparation**

Appropriate preparation for delivering HTC services includes building community awareness and demand, training providers, selecting locations and times to deliver services, and procuring supplies.

Community awareness and building demand for voluntary HTC

- Community members should be informed about the benefits of knowing one’s HIV status and about the availability of treatment if they are infected with HIV. Even with awareness-raising activities for the general public or key populations, sex workers may not know about services that are respectful of sex workers or provided by trained and qualified sex workers.
- As part of awareness-raising campaigns, sex workers should be informed of their right to confidentiality and consent and their right to refuse HIV testing if they choose.

Training providers and community outreach workers

- Training in HTC should follow national and international standards (see Section 5.9).
- Training for counsellors who will provide HTC to sex workers should include additional training on:
 - the duty to be respectful and non-judgemental
 - the specific needs of sex workers
 - the absolute requirement to maintain confidentiality, not only about HIV results, but also about any other information provided during the counselling session, including the sex worker’s engagement in sex work.

Location and timing of services

- Both the location and the timing of voluntary HTC services should be responsive to the needs and requests of sex workers. In some settings, this might mean providing services during evening hours or weekends, such as “moonlight HTC”, which has been provided in a number of countries.
- Community settings may be more attractive than health-care institutions.

Procuring essential supplies

- Procurement of supplies to conduct HIV testing is usually done by the agency or organization providing the services.
- A programme serving sex workers that wishes to provide voluntary HTC on-site should work with local health authorities to obtain training and authorization to provide HTC, as well as the needed supplies.
- It may be helpful to obtain handouts or other informational material about the importance of HIV testing to distribute to sex workers.

Management

Refer to Chapter 6. For information specific to the management of voluntary HTC services, please refer to the WHO *Handbook for improving HIV testing and counselling services*.⁵

B. HTC service delivery

Pre-test information

- The pre-test session should focus on basic HIV information and information about the HIV testing process, and ensure that testing is voluntary.
- A risk assessment may be used to develop a risk reduction plan that is specific to the situation of the client. However, it is not necessary to investigate the sex worker's behaviours, number of partners, injecting drug use and other information unless the client volunteers this information.

Post-test counselling

This counselling is provided when the test results are ready to be given to the client.

- Information about what is needed in the post-test counselling session may be found in the WHO publication *Delivering HIV test results and messages for re-testing and counselling in adults*.
- Sex workers who are found to have HIV infection should be offered immediate referral for long-term care and treatment at a clinic or hospital whose staff are respectful of sex workers. They should also receive counselling about how to avoid transmitting HIV to others.
- All people, including sex workers, who are found to be HIV-negative should be provided with risk-reduction information specific to their individual risks, given access to condoms and lubricant, and counselled on strategies to negotiate safer sex. (See also Chapter 4.)
- Mental health issues, such as anxiety and depression, should be assessed if the counsellor has been trained in these areas. Referral to a clinician with training in mental health may be helpful. (See also Section 5.8.)

Repeat testing

- Sex workers who test HIV-negative should be advised to return for repeat testing after four weeks. They should also seek re-testing at least annually. See *Delivering HIV test results and messages for re-testing and counselling in adults* for more detailed information on repeat testing for sex workers and others at high risk for HIV infection.
- Some programmes serving sex workers and others at high risk offer those who test negative repeat HTC at regular intervals. This repeat testing may be done every three months or whenever a sex worker requests it, and should be offered at least annually as recommended by WHO for persons at higher risk. Repeat HIV testing should also be offered whenever there is a new STI diagnosis.

⁵ Details on this and other WHO publications mentioned in this chapter may be found in Section 5.9.

Self-testing

Reports suggest that HIV rapid tests are being sold and used for self-testing in an increasing number of countries, and sex workers and their clients may be using HIV tests for self-testing. Guidance on self-testing will be issued by WHO by 2014. Key issues relating to self-testing among sex workers are:

- There are potential benefits and risks of self-testing. One benefit may be to make HIV testing acceptable to people who currently avoid HIV testing in facilities. People who could benefit from regular retesting may find self-testing more convenient than returning to a facility frequently. The risks of self-testing include operator error or mistakes, misinterpretation of results, and lack of confirmation of HIV-positive results. Lack of counselling may result in depression and lack of access to treatment among those who test HIV-positive.
- It is an abuse of HIV testing in any form—including self tests—for employers, brothel owners or clients to force a sex worker to be tested. Coercing a person to use a self-test does not constitute voluntary testing.
- Any person who tests HIV-positive on the basis of a self-test should be informed of the need for confirmatory testing at an HTC site, health facility or laboratory.
- All persons using self-tests, including sex workers, should be counselled that a negative test result is not a reason to stop using condoms, because persons recently exposed to HIV may have a negative result on self-testing but be infectious.

Partner and family testing

Voluntary testing of regular partners, spouses and family members is available in many settings. When a sex worker tests HIV-positive, it is often helpful to offer voluntary counselling and testing to members of the family or household. Sex workers living with HIV should be supported to disclose their results to trusted family members, and voluntary HTC should be available to their partners, children and other family members.

C. Follow-up

Prevention services

- All persons, including sex workers, regardless of HIV status, should be informed about prevention services, including condoms and lubricants (see Chapter 4).
- Male sex workers who have female sex partners should be informed about the protective effects of male circumcision and referred to voluntary medical male circumcision services. Potential side-effects and the waiting period prior to resuming sexual activity should be carefully explained. The protective effect of male circumcision for men who have sex with men remains unclear. (See resources in Section 5.9.)

Connection to care and supportive services

Every person who tests HIV-positive should be offered care, support and treatment that is respectful and acceptable. Programmes serving sex workers, especially when providing voluntary HTC, should take responsibility to ensure that those who are HIV-positive are empowered to:

- enroll in care at a site that is acceptable to them and respectful of them
- participate in community-led support groups
- return for all follow-up visits.

Programmes serving sex workers should take extra efforts to support links to care, such as identifying a trusted peer (or community outreach worker)⁶ to accompany HIV-positive sex workers to care, support and treatment services. However, this should only be done with the sex worker's consent.

5.2.4 Quality assurance of services

In the design and development of voluntary HTC services, special attention should be paid to establishing effective and acceptable links to services, quality assurance of testing and appropriate testing strategies to confirm positive test results in line with national guidelines. See Section 5.9 for tools for quality assurance testing.

5.2.5 Voluntary HTC performed by community outreach workers and lay counsellors

Voluntary HTC may be more acceptable to sex workers when the testing and counselling are performed by a trusted peer, i.e. another sex worker. Adequate training, ongoing performance support and monitoring are essential for all staff performing HIV testing at the community level, including health workers, programme staff and community outreach workers. Community outreach workers are an effective part of the voluntary HTC workforce. Community outreach workers who provide HTC should receive certified training in line with national HTC guidelines. Opportunities for professional development and promotion to supervisory, management and leadership roles should always be available for community outreach workers.

Box 5.2

Case example: Outreach to provide HIV testing and counselling in Ghana

Pro-Link, an NGO, provides HIV prevention services to sex workers in five regions of Ghana. One project site in a low-income area of the capital, Accra, serves a catchment area of approximately 90,000 residents. Outreach activities have identified at least 50 locations and brothels in the community, with an estimated 5,000 sex workers. Pro-Link has trained 54 community outreach workers, sponsors community support groups and savings clubs, and has operated a drop-in centre since 2008, staffed by outreach workers and a nurse who provides STI screening and treatment, voluntary HTC, and follow-up care for those living with HIV.

Miriama, a sex worker who has been trained in on-site HIV rapid testing, counselling and follow-up care, provides HTC outreach services at locations where women work, including on the rooftop of a brothel. When a sex worker tests HIV-positive, Miriama makes sure that the sex worker goes to a nearby clinic for confirmatory testing and enrolment in care and treatment, if needed. Miriama manages to create private spaces even where there are no walls, ensures confidentiality even with the brothel owner downstairs, and expresses an accepting and loving approach to the sex workers she serves, many of whom are very young.

⁶ In this tool, "community outreach worker" is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called "staff outreach workers" or also simply "outreach workers"). Community outreach workers may also be known by other terms, including "peer educators", "peer outreach workers" or simply "outreach workers". The terms "community" or "peer" should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.

5.3 Antiretroviral therapy

5.3.1 Introduction

2012 Recommendations: Evidence-based Recommendation 6

Use the 2013 WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* for sex workers living with HIV.

The increased availability of and access to ART has significantly decreased HIV-related illness as well as deaths due to HIV. Recent advances in HIV treatment, and the success of community advocacy for increased availability of affordable drugs, have resulted in substantial improvements in the quality of life of people living with HIV throughout the world. Although access in resource-limited settings is usually not as comprehensive as in industrialized countries, free or subsidized ART services are now widely available in many countries with high HIV prevalence.

The treatment principles and recommendations for antiretroviral drug (ARV) use by sex workers are the same ones applicable for all people with HIV infection. All sex workers with HIV and/or tuberculosis (TB) should have access to ART and to anti-TB drugs and services. In addition to the clinical benefit to the HIV-positive sex worker, providing ART has the potential to prevent HIV transmission by reducing viral load.

Sex workers may face greater challenges than the general population in accessing HIV care and treatment services and, once started on ART, to retention in care and adherence to treatment. This is often because of stigma and discrimination in health-care settings and the inflexibility and inconvenience of service provision. Other barriers to successful ART provision for sex workers include mobility, criminalization of sex work and uncertain immigration or legal status, which may prevent them from accessing free ART in settings where only country nationals are entitled to free medical care.

However, providing ART to sex workers is feasible and is as effective as in the general population. Programmes providing outreach or services to sex workers should ensure that sex workers know where to go for treatment and are supported in their access to ART and TB medications.

Respondents to the values and preferences survey⁷ supported the use of the same ART protocols as for other adults with HIV. The need for universally accessible treatment was emphasized, including access to treatment for migrants and those without legal documents.

⁷ A global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations.

5.3.2 Essential definitions and prerequisites of ART services

The 2013 WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infections* outline recommendations on when to start ART and what to use.

- ART should be initiated in all HIV-positive individuals with CD4 count ≤ 500 cells/mm³ regardless of WHO clinical stage.
- As a priority, ART should be initiated in HIV-positive individuals with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and HIV-positive individuals with CD4 count ≤ 350 cells/mm³.
- ART should be offered to all HIV-positive individuals, regardless of WHO clinical stage or CD4 cell count, in the following situations:
 - › individuals co-infected with HIV and active TB disease
 - › individuals co-infected with HIV and hepatitis B virus (HBV) with evidence of severe chronic liver disease
 - › pregnant and breastfeeding women with HIV
 - › HIV-positive partners in serodiscordant couples, to reduce the risk of HIV transmission to uninfected partners
 - › all HIV-positive children under 5 years old.

The guidelines also recommend:

- use of simplified, less toxic and more convenient antiretroviral regimens for first- and second-line treatment, preferably as fixed-dose combinations
- integration of ART in TB, antenatal and maternal and child health services, and in settings providing opioid substitution therapy (OST)
- decentralization of ART services. ART should be provided in peripheral health facilities, initiated by nurses and with maintenance support from community health workers
- the “Three I’s” for HIV/TB (intensified TB case-finding, isoniazid preventive therapy [IPT] and TB infection control), as outlined in the *WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders*.

5.3.3 Specific considerations for sex workers on ART

The principles for ART use, including when to start and what to use, are the same for all people with HIV. Therefore the clinical management of HIV-positive sex workers should not differ from that of other populations, and there are no special requirements.

Sex workers in many countries report that they experience stigma, discrimination and a lack of respect when attending health-care facilities used by the general public. However, experience in some high HIV-burden countries, including Cambodia, Côte d’Ivoire, Kenya, Thailand and Zambia shows that ART services designed specifically for sex workers increase treatment uptake and adherence.

Box 5.3

Understanding and addressing concerns about ART

Like many people, sex workers may have fears and concerns about ART, and outreach and support programmes should understand and address fears or misconceptions about the possible adverse effects of ARVs.

As ART is now recommended for people earlier in their infection, those with HIV who are asymptomatic require careful counselling to understand why it is beneficial to initiate ART before feeling unwell or having symptoms. The benefit of adhering to prescribed treatment and maintaining a suppressed viral load of HIV to support good health and prevent treatment failure, as well as the benefit of ART in reducing the risk of HIV transmission, should be fully discussed. This may happen over several sessions, if necessary, checking whether the sex worker understands the issues and answering any questions.

Knowledge of the current community understanding of ART issues is imperative so that programmes, clinicians, counsellors and outreach workers may address any concerns with accurate and appropriate information.

Sex worker-specific ART services

There are several key clinical service delivery elements specific to sex workers that may make access to ART easier, more acceptable and more effective, and support adherence to ART and retention in care:

- flexible clinic hours (weekends, evenings)
- clinical services at sites located near places of work
- “no appointment needed” and drop-in services available
- “emergency” drug pickups available when running out of ARVs
- family-centred services for sex workers with children
- patient-held records for sex workers who may seek ART at different sites
- respectful and non-judgemental staff attitudes.

Additional considerations when providing ART for sex workers may include:

- Drug treatment services available in the same or nearby location.
- Potential co-morbidities, such as cervical cancer, other STIs, HBV and hepatitis C (HCV).
- Addressing social vulnerabilities, including injecting drug use, other substance use, and violence that may affect access to treatment, adherence and retention, and lack of continuity of care and treatment interruptions (due to imprisonment, migration).
- All programmes referring sex workers to clinical sites providing ART should ensure that these services adhere to international standards of care outlined in this tool as well as address other key support, care and social services.
- Contraception and antenatal care services (including prevention of mother-to-child transmission for HIV-positive pregnant women) should also be available, and links to services supported, where needed.
- In order to meet the needs of mobile sex workers, health providers should also be flexible in interpreting national guidelines on the quantities of drugs to dispense at one time.
- The range of clinical support services for sex workers should be tailored to address the specific needs of male, female and transgender sex workers.

- Migrant sex workers and sex workers without documentation may experience significant barriers to accessing ART services. Programmes serving sex workers should be as flexible as possible to achieve the goal of universal access to care and treatment.

Integrated or “one-stop-shop” services may be one of the best ways of providing a fully comprehensive range of HIV and related health services. This may be possible in some settings where a number of services are available, such as voluntary HTC, clinical services including ART and treatment of HIV-related infections, contraception, antenatal services, cervical screening, legal advice, condoms, vaccinations, STI and viral hepatitis screening.

Community support for ART

Additional community elements that could be provided in parallel with formal clinical services to improve ART and health care for sex workers include:

- **trained community outreach workers** to accompany sex workers to clinics to receive ART. This should be provided only if the sex worker wants it. Community outreach workers should be trained to understand and respect the confidentiality of the sex worker receiving treatment.
- **community support and empowerment groups** for HIV-positive sex workers.
- **community committees** to monitor service delivery, and feedback loops to ensure appropriate, accessible and high-quality treatment
- **community safe spaces (drop-in centres).**

Box 5.4

Case example: Managing care and treatment for male sex workers in Kenya

Health Options for Young Men on HIV, AIDS and STIs (HOYMAS—www.hoymas.org) started in 2009 as a support group for male sex workers in Nairobi, Kenya. It now provides services for more than 1,200 male sex workers, more than half of whom are living with HIV. HOYMAS is owned, led and designed by the community. It provides a comprehensive range of HIV and health services in a safe space, with a nurse on site to help with daily issues of prevention, care and treatment. Services include:

- **A place to rest** for people on ART
- **Medicine storage**—men who do not have a safe place to store their ARVs may keep them at the centre and collect them when needed
- **Nutritional support** for those with HIV, and in particular to help those taking ARVs
- **Peer support** (“my brother’s keeper” programme)
- **Home visits** to sick members
- **Referrals** for other services, e.g. legal and post-violence support
- **Distribution outlet** for condoms and lubricants and information and education communication materials

HOYMAS also networks with government-managed health services to sensitize health workers to the clinical needs of men who have sex with men and male sex workers. HOYMAS’ community outreach workers liaise between the centre and five district hospitals and provide training to health workers on men who have sex with men and HIV issues.

Treatment literacy

Treatment of AIDS and other conditions, such as hepatitis, is continually changing, and it is important for sex workers to be up-to-date with recent developments so they can be fully informed and involved in their treatment. Sex worker-led treatment literacy programmes help sex workers stay informed about and understand issues relating to their treatment.

Box 5.5

Case example: Sex worker treatment literacy in Asia

The Asia Pacific Network of Sex Workers (APNSW) integrates sex worker-specific issues into the Treatment Literacy and Advocacy training conducted by the International Treatment Preparedness Coalition and Asia Catalyst. There is a dual focus on treatment literacy and advocacy. The real-life impact of side-effects of ARVs is examined and the reluctance of sex workers to start ART is discussed. The sessions explore how best to integrate adherence into the sex workers' working environment, e.g. for those who work in bars or work irregular hours.

The sex worker-specific workshops aim to form better relationships across at-risk populations, i.e. between sex worker groups and other groups. APNSW also takes a high profile in treatment activism, especially around threats to access to generic medicines.

Pre-exposure prophylaxis

The 2012 Recommendations do not include guidance on the use of pre-exposure prophylaxis (PrEP) for sex workers. Separate guidance, issued in 2012 by WHO, on PrEP for HIV-serodiscordant couples, men and transgender women who have sex with men at high risk of HIV, encourages countries that wish to introduce PrEP for these particular groups to consider doing so through demonstration projects to ascertain its acceptability and how best to deliver it safely and effectively. It is recognized that adherence to PrEP is key to its effectiveness as a prevention strategy and that it may offer an additional HIV prevention option for some people who choose to use it.

5.4 Tuberculosis and sex workers

The 2012 Recommendations do not include a specific recommendation on TB. Diagnosis, prevention and treatment of TB in sex workers should follow national and international guidelines for treatment of TB in adults. The current global policy and guidelines on HIV-associated TB, at the time of printing, are:

- *WHO Policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders* (2012)
- *WHO Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings* (2011)

People living with HIV are around 30 times more likely to develop TB than those who are HIV-negative, and they are at increased risk of dying from TB. People who use drugs and people with a history of incarceration are also at increased risk of developing TB, regardless of HIV status. While there are limited data on the association between TB and sex work, sex workers living with HIV, sex workers who inject drugs, and sex workers exposed to poor, cramped working and living conditions, including brothels or prisons, are at increased risk of developing TB, including multidrug-resistant TB.

The 2012 WHO TB/HIV policy recommends a 12-point package of interventions known as the collaborative TB/HIV activities. The aim of the package is to: establish and strengthen mechanisms for delivering integrated TB and HIV services; reduce the burden of TB among those living with HIV, which includes intensified case-finding, IPT and infection control (also known as the “Three I’s for HIV/TB”); and reduce the burden of HIV in TB patients. It recommends that all people living with HIV, including sex workers, should be screened regularly for the following four symptoms: current cough, fever, weight loss and night sweats. If they do not report any one of the four symptoms, active TB may be reasonably excluded and they should be offered IPT for at least six months. Those reporting one or more symptoms should be evaluated for TB and other conditions. If TB is suspected, WHO-approved molecular tests, such as Xpert MTB/RIF (a rapid automated test that looks for resistance to RIF), are recommended as the primary diagnostic test for TB in anyone living with HIV or at risk of drug-resistant TB.

Early ART significantly reduces the risk of mortality from HIV-associated TB. Given that TB is one of the most common AIDS-defining illnesses, WHO recommends that all TB patients, including sex workers, be offered HTC as a priority if their HIV status is not already known. If an individual is found to be living with both TB and HIV, WHO recommends that they should be started on ART as soon as possible, irrespective of CD4 count.

Programmes or community outreach services for sex workers are ideally placed to carry out TB screening and to support sex workers throughout the cycle of care, from TB prevention through diagnosis and treatment. They also play a vital role in training sex workers to recognise TB symptoms and understand TB transmission, as well as the importance of infection control and cough etiquette to reduce TB transmission. In addition, they can help sex workers identify nearby health facilities for diagnosis and initiation of treatment of active or latent TB, as necessary.

Ideally, the co-treatment of TB and HIV, as well as other co-morbidities such as drug dependence, should be made available at the same time and place. TB clinic staff should be trained on the need for respectful approaches to sex workers. Similar to ART, adherence is crucial for persons receiving TB treatment and prophylaxis, and health workers, counsellors, and community members serving sex workers should provide encouragement to sex workers receiving treatment for active or latent TB to ensure adherence.

Box 5.6

Case example: HIV and undiagnosed TB

Many people living with HIV also have TB and need careful diagnosis, including for extra-pulmonary TB. Daisy, a sex worker advocate in Uganda, was on ART for more than eight years but still had severe spinal pain. In her own words, “I’d lost hope, and almost wanted to commit suicide, the pain was so bad.” Clinicians first told her that she had back pain because of her sex work, and then that her pain was psychosomatic, and referred her to a psychiatrist. Neither the psychiatrist nor physiotherapy helped.

Finally, after suffering with severe pain for more than two years, additional diagnostics were done and it was found that Daisy had TB of the spine. Because her TB was untreated for so long, her spine is damaged and could collapse, causing paralysis. She is now on TB drugs and wears a corset to prevent further spinal damage.

5.5 Additional services for sex workers who inject drugs

5.5.1 Introduction

2012 Recommendations: Evidence-based Recommendation 7

Use current WHO recommendations on harm reduction for sex workers who inject drugs.

In some regions of the world there is a substantial overlap between communities of people who inject drugs and sex workers. HIV transmission through injecting drug use accounts for 10% of the world's new infections, and in some countries is the primary route of transmission. The prevalence of HIV among sex workers who inject drugs tends to be significantly higher than among those who do not inject. This vulnerability may be greater in females who inject drugs due to gender inequalities and injecting practices. Therefore, when considering HIV prevention among sex workers, attention should be paid to ensuring that those sex workers who inject any kind of drugs have access to the services they need to keep themselves safe from the danger of acquiring or transmitting HIV, viral hepatitis and other bloodborne infections.

Sex workers who inject drugs, including those who are HIV-positive, should have full access to a comprehensive package of integrated HIV prevention, support, treatment and care services, as well as access to support and voluntary treatment for drug dependence should they want it.

The *WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users—2012 revision* sets out nine key interventions that have proven efficacy in reducing HIV transmission among people who inject drugs. Seven of these interventions are already covered in other parts of this tool, and only the remaining two are exclusive to injecting behaviour: **opioid substitution therapy** (OST) and **needle and syringe programmes** (NSPs). These two interventions specifically reduce transmission among people who inject drugs and should be prioritized in a comprehensive HIV prevention package for sex workers who inject drugs. Only about half of the countries that report injecting drug use have also implemented OST and/or NSP. In countries where these services do not exist it is essential to support advocacy activities and community-led outreach services.

5.5.2 Opioid substitution therapy

There is overwhelming evidence gathered over 30 years that methadone substitution therapy is highly efficient, cost-effective and safe and has many collateral benefits in terms of stabilizing and improving the quality of life of people who are dependent on opioids. Some countries have started using buprenorphine with similar results. While OST is designed to treat opioid dependence, it has proven highly effective in preventing transmission of HIV and other bloodborne viruses through the sharing of injecting equipment, and in supporting adherence to the treatment of HIV and other health problems.

OST may be delivered in a wide range of settings and has been shown to be most effective when:

- dosage is adequate and individualized, based on the expressed needs of the user
- access to treatment is fast, easy and local, without overburdening bureaucracy

- take-home doses are available so that users do not have to attend the service daily
- the service is mobile and can be transferred to another location, should the user require it
- the service is integrated with a range of other support and care services, including NSPs.

OST and NSPs should not be treated as mutually exclusive, and accessing NSPs while enrolled in an OST programme should never be used as evidence by service providers that a person is no longer suitable for the OST programme.

5.5.3 Needle and syringe programmes

NSPs are cheap, easy to establish and have proven to be highly effective in reducing HIV transmission among people who inject drugs without increasing injecting behaviour. NSPs are best delivered at the community level and are an important point of first contact with people who inject drugs who are reluctant to use other services for fear of discrimination or abuse. The most effective NSPs:

- are community-led, with community members trained to deliver the service, including first aid
- are located close to where people who use drugs are
- are mobile and adaptable to the changing patterns of the drug-using scene
- offer a range of needle and syringe sizes (including those with low dead space between needle and syringe) and other essential injecting equipment, without any restrictions on the number of needles
- offer a range of other support and care services, such as legal aid, nutrition, family and housing advice, as well as health maintenance, like vein care and abscess avoidance and care
- offer overdose prevention, either by ensuring all staff are trained in overdose revival techniques or by providing naloxone to people who inject drugs and their families and community members..

5.5.4 Other considerations

Up to 90% of people who inject drugs in some countries are infected with HCV. NSPs should also provide other injecting equipment, such as cookers, swabs and bleach in order to prevent HCV. There is evidence that providing low dead space syringes (LDSS—which are designed to reduce the amount of blood remaining in the syringe after completely pushing down the plunger) reduces the risk of HIV and HCV transmission. NSPs should therefore provide LDSS in addition to other syringes appropriate for local needs.

Because injecting drug use is criminalized in many countries, and NSPs are generally highly visible, it is essential for those considering the establishment of such services to engage at a very early stage with the police and the wider community in order to gain their support.

Injecting equipment may also be shared by other communities, such as transgender women, who may use it for breast augmentation or hormonal therapy. It is essential to ensure that these people have access to the range of services they require to keep themselves safe.

It is also important that any service in contact with people who inject offer HBV vaccination (see Section 5.6.2, part D).

5.6 STI services

5.6.1 Introduction

2012 Recommendations: Evidence-based Recommendation 3

Offer periodic screening for asymptomatic STIs to female sex workers.

Screening and treatment of sex workers for STIs is important to prevent the acquisition and transmission of infections and to reduce reproductive health complications, such as pelvic inflammatory diseases, infertility and congenital infections.

Provision of basic HIV and STI clinical services is an essential component of a comprehensive package of services for sex workers and should be a priority in sex worker interventions. All sex workers should have access to acceptable, effective and high-quality STI services. These should be human rights-based, confidential, accessed voluntarily and without coercion, and provided after informed consent. Well-trained and non-judgemental health-care providers build trust and confidence among sex workers, who should be involved in service provision and not be seen as passive recipients of services.

An STI services package consists of case management for both symptomatic and asymptomatic STIs. Comprehensive STI case management also includes the promotion and provision of condom use, support for compliance with treatment, risk reduction counselling and partner management. Once established and scaled up, services may be expanded in scope to meet the broader health needs of sex workers.

Respondents to the values and preferences survey⁸ expressed unanimous support for periodic voluntary screening for STIs.

5.6.2 STI services for sex workers

Regular screening for asymptomatic infections among sex workers using laboratory tests is cost-effective given the high rates of STIs, and can reduce STI prevalence over time. It is therefore essential to invest in STI screening. Where laboratory diagnosis is available, laboratories should be staffed by qualified personnel with adequate training to perform technically demanding procedures, with quality assurance systems in place.

Absence of laboratory tests should not be a barrier to screening sex workers for STIs. A regular STI check-up is an opportunity to reinforce prevention and address other health needs. The check-up may consist of probing for symptoms of STIs and checking for signs of cervical and ano-rectal infections, including speculum and proctoscopic examination.

Provision of effective services to sex workers with STI symptoms should be a priority for STI services. Symptomatic STI patients may be aware they are infected and are more likely to seek care. In resource-poor settings where reliable STI testing is not feasible, WHO has recommended a syndromic approach (locally adapted) to manage symptomatic infections.

⁸ A global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations.

STI services/interventions should be designed, organized and implemented at scale. Achieving high coverage, ensuring quality services and linking or integrating to HIV, sexual and reproductive health (SRH) and other services requires systematic, standardized approaches. A phased approach to scaling up services, moving from externally led services to community-led ones, is illustrated in Figure 5.2.

A. Designing STI services

Assess current STI services

When mapping sex worker communities before establishing an intervention (see Chapter 6, Section 6.2.6, part A), data on the quality of STI services, current use of services, their acceptability and accessibility should also be collected. This information may be used to determine the demand for STI services and develop a plan to improve existing services or establish new ones.

Define essential STI service package and other services for sex workers

STI services for sex workers should meet basic standards of quantity and quality. The national programme should lead the development of STI guidelines and operational standards and define the essential STI and other service package in consultation with technical experts, implementers and sex workers. These guidelines and standards will be the basis for implementation, training, supervision and monitoring.

The basic STI service package includes:

- syndromic case management for patients with symptoms
- screening and treatment of asymptomatic STIs:
 - › syphilis screening
 - › gonorrhoea and chlamydia screening
 - › routine STI check-ups
 - › referrals to voluntary HTC.

It is important that the STI service package be linked or integrated with HIV, SRH and primary care, when appropriate and feasible.

Since sex workers have a higher risk of STIs and their risk factors differ from those of the general population, STI management flowcharts specific to sex workers should be developed. Examples of these guidelines and standards are the Avahan India AIDS Initiative's *Clinic Operational Guidelines and Standards* and the Government of Kenya's *National Guidelines for HIV/STI Programs for Sex Workers*.

Organize STI services

A functioning management structure is important to implement and scale up STI and SRH services efficiently. It is important to specify roles and responsibilities at the different levels of the clinical services structure (see Figure 5.3). Communication and coordination mechanisms should be identified, and technical support and supervision at the different levels of care clearly articulated.

Figure 5.2 Scale-up of STI services for/with sex workers

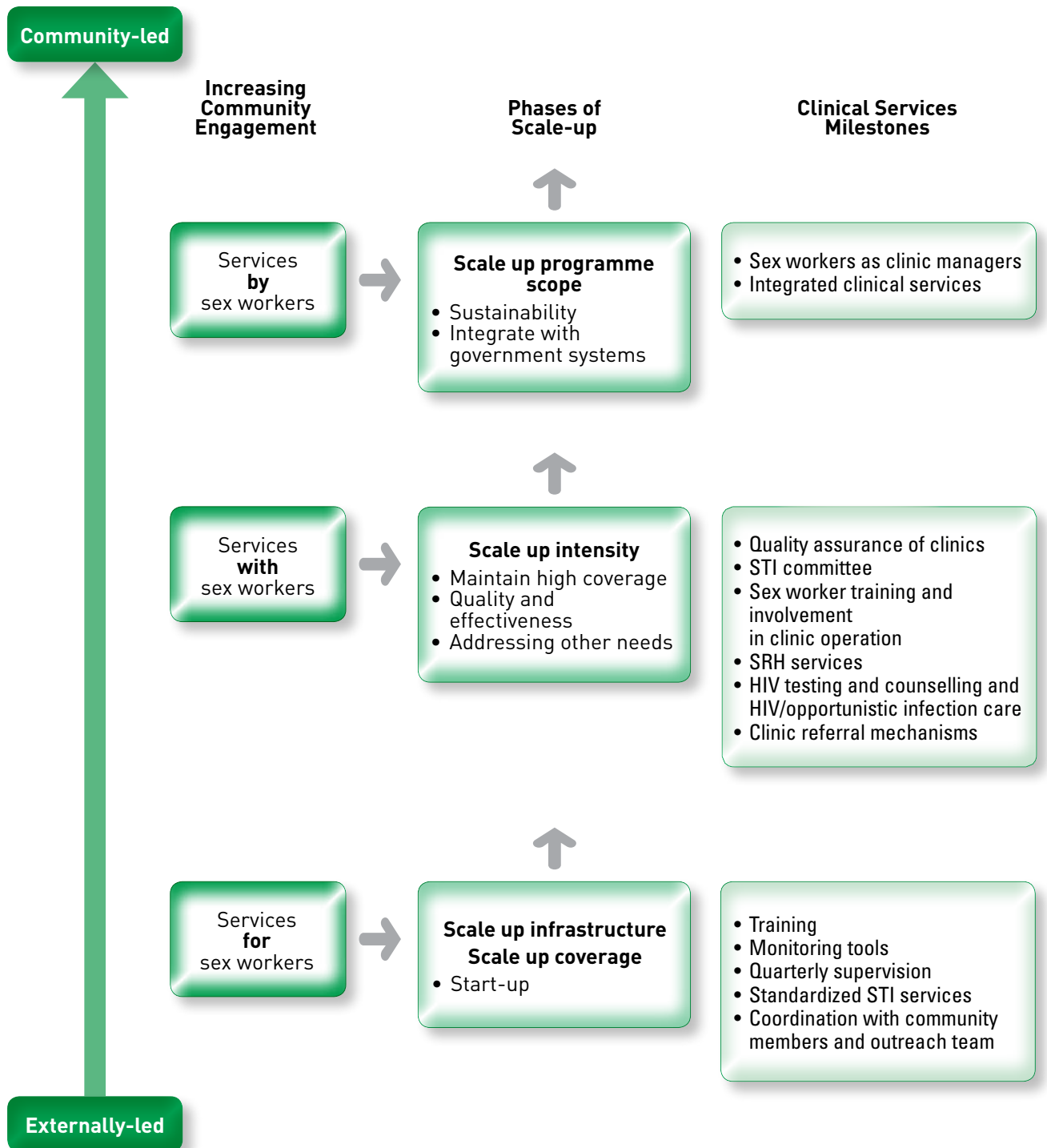
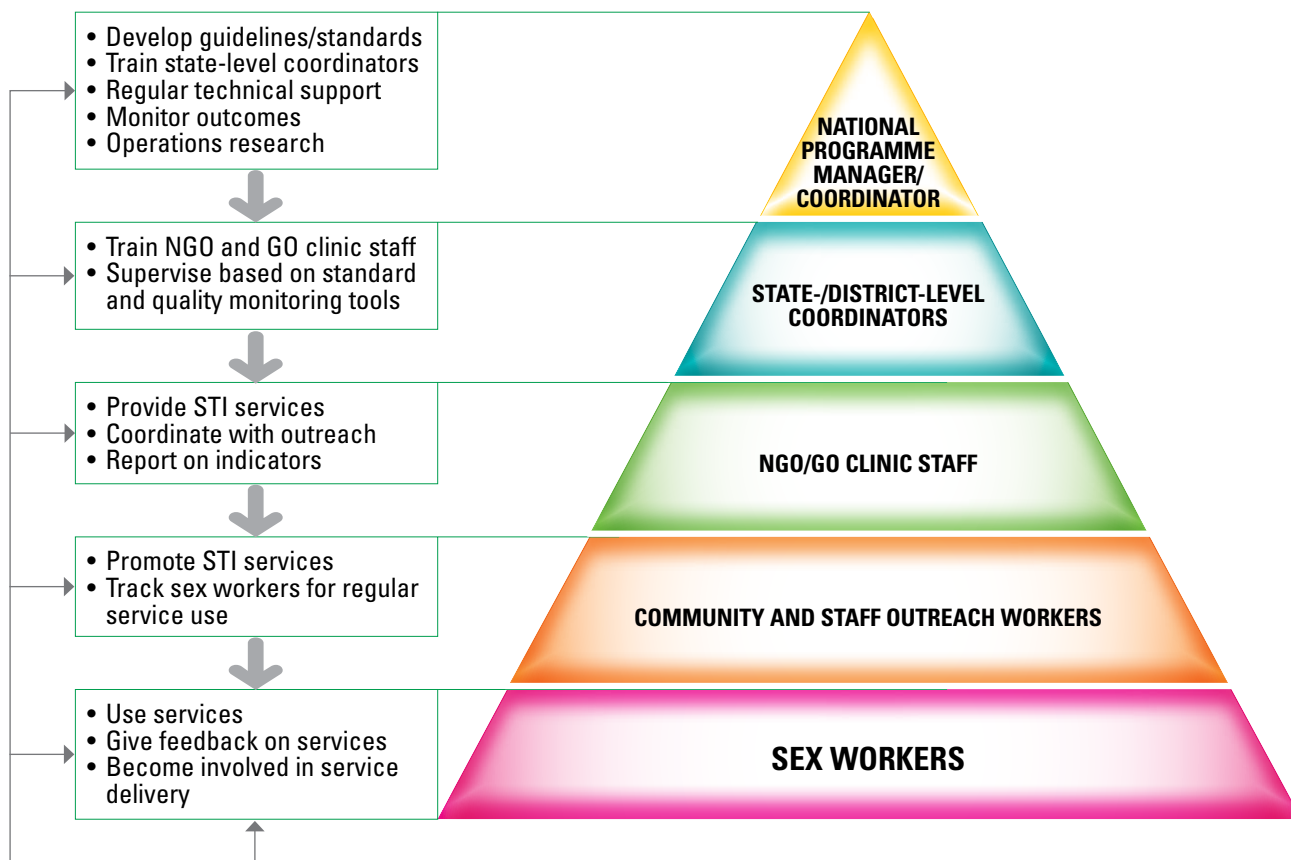


Figure 5.3 Roles and responsibilities for STI services



B. Implementing and managing STI services

Set up STI services

Establish STI services that are accessible and acceptable for sex workers based on available resources and capacity. STI services should be respectful and non-judgemental, and should address sex workers’ particular needs.

In establishing clinical services, consider the factors listed in Table 5.1 to balance access with cost.

Establish STI health care-seeking behaviour as a community norm

It is essential that sex workers be aware of the symptoms of STIs and be encouraged to seek care promptly, and to seek regular STI screening. Linking STI services to outreach and community services helps achieve this.

Coordination with sex worker-led outreach is essential to promote STI services and support clinic follow-up. At the same time, provision of STI services reinforces condom promotion and education by community outreach workers. Clinic staff should develop strong communication with community outreach workers. Improving communication and referrals increases the overall prevention effect.

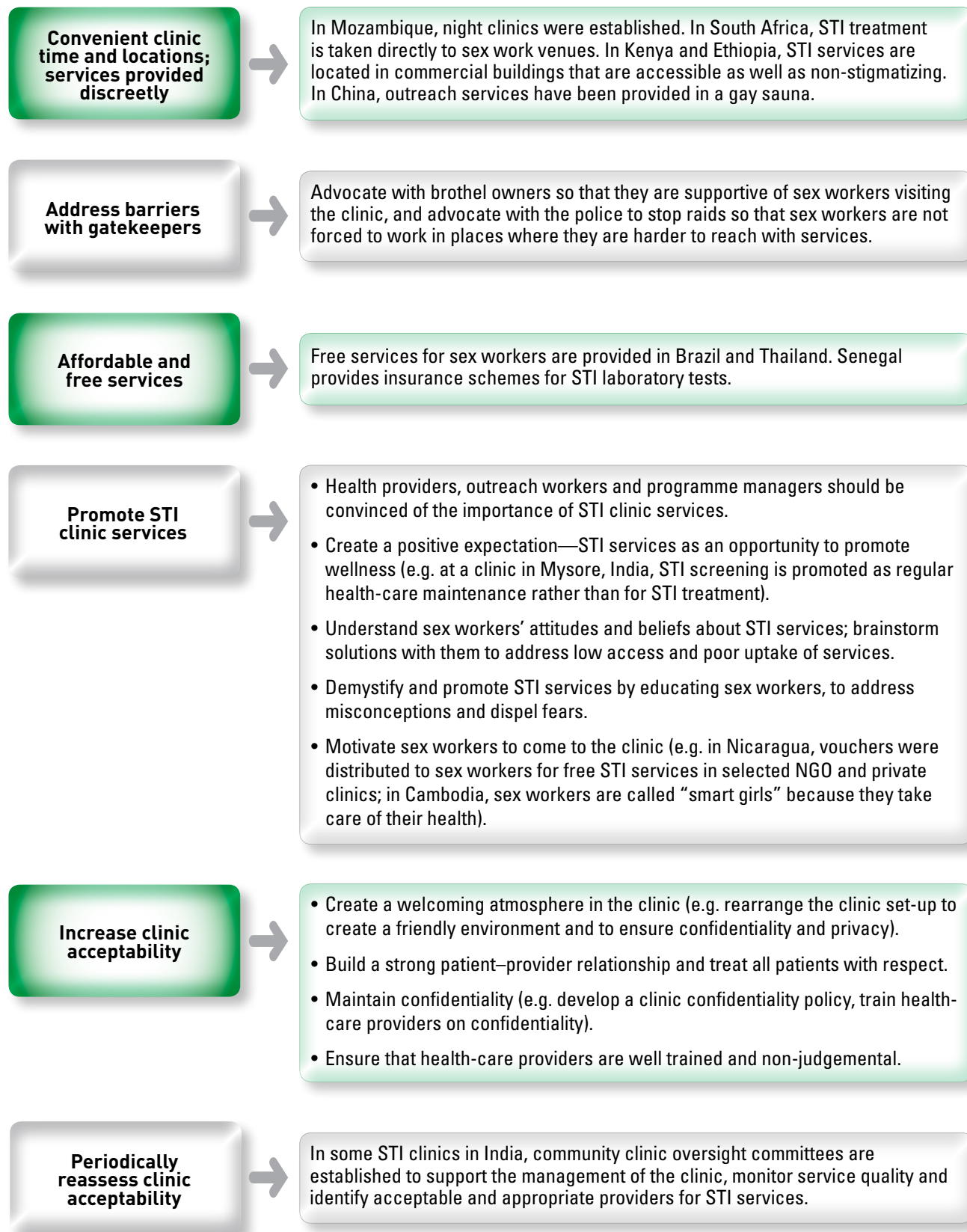
Table 5.1 Clinical service models

Type of clinic	Description	Advantages	Disadvantages
Stand-alone (often NGO-run)	<ul style="list-style-type: none"> • Full-time services in fixed location; ideal where there is a high concentration of sex workers (e.g. red-light district) and a large number of sex workers (> 500) • Dedicated staff required 	<ul style="list-style-type: none"> • Technically efficient • Comprehensive services may be provided; mix of clinical and educational interventions is possible • Flexible to address needs of sex workers • Possibility of linking to safe space (drop-in centre) • Involvement of sex workers is possible 	<ul style="list-style-type: none"> • May be costly if few sex workers access the clinic • Possibility of stigma associated with clinic • May be difficult to sustain
Outreach clinics (often NGO-run)	<ul style="list-style-type: none"> • Satellite clinics (fixed location), mobile vans, health camps • Part-time clinics • Operate at fixed time in fixed locations • Ideal for reaching hard-to-reach sex workers and for providing services to smaller numbers of sex workers • Dedicated staff required 	<ul style="list-style-type: none"> • May reach hard-to-reach sex workers • Acceptable and accessible • Cost-effective if accessing hard-to-reach sex workers 	<ul style="list-style-type: none"> • Provision of comprehensive services for sex workers may not be possible • Quality of services may be variable
Preferred service providers (private)	<ul style="list-style-type: none"> • Services provided by trained private providers identified by sex workers. (It is essential that private practitioners be trained to provide effective STI services to sex workers based on national guidelines.) 	<ul style="list-style-type: none"> • Acceptable to sex workers • May be cost-effective for a small number of sex workers • Sustainable 	<ul style="list-style-type: none"> • Comprehensive services may not be provided (e.g. educational and counselling services) • Quality monitoring and reporting may not be possible
Government-owned clinics	<ul style="list-style-type: none"> • Government clinics, either stand-alone STI clinics or integrated with other services e.g. SRH, HIV, primary care 	<ul style="list-style-type: none"> • Sustainable • Provision of technically efficient services if staff are well trained and facilities are available 	<ul style="list-style-type: none"> • May not be acceptable and accessible to sex workers; strong links with NGO- and community-led outreach services are needed

Address structural barriers to accessibility and acceptability of services

Consider the activities depicted in Figure 5.4.

Figure 5.4 How programmes improve accessibility and acceptability of STI clinic services



Involve sex workers and community outreach workers in clinic operations

Sex workers are capable of engaging at many levels of STI clinic operations, including management. Involvement of sex workers increases the sense of ownership and makes the clinic more acceptable and sustainable. STI services should promote meaningful participation of sex workers. Clinics should formalize sex worker involvement by specifying how sex workers may be involved in developing, managing and monitoring services.

Professional development should be an integral part of community empowerment, allowing sex workers to learn and be mentored to provide clinical services. Sex workers involved in the clinic operations should be trained to undertake their tasks, should maintain confidentiality and should be remunerated for their work.

Box 5.7

Case example: Community involvement in clinic operations in Uganda and India

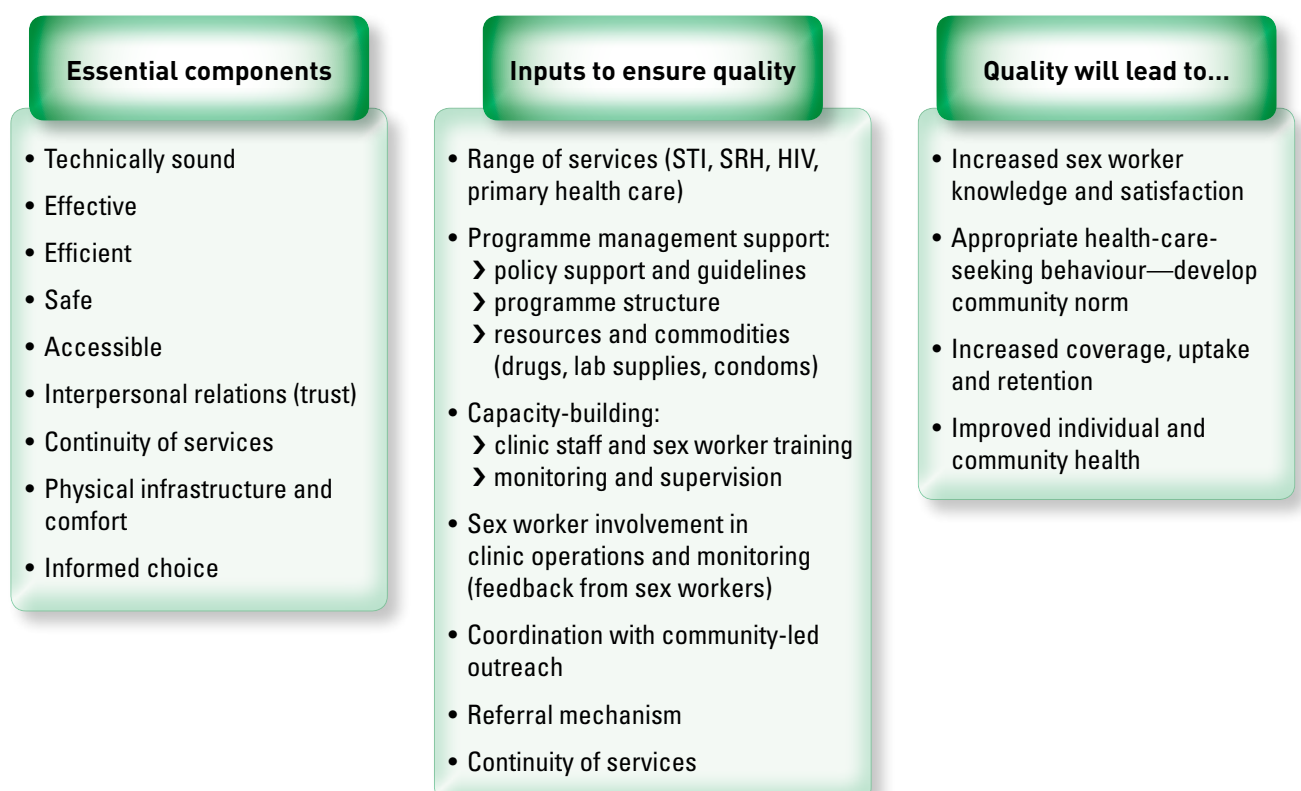
In Uganda, sex workers supported government clinics in taking steps to make the services more acceptable to community members, and became involved in clinic operations.

In Mysore, India, sex workers have undergone formal training in nursing. Twelve sex workers who have completed their degree are now employed as nurses at the clinic.

Provide an appropriate and high-quality STI service package

Providing high-quality services encourages STI patients to seek care regularly. Figure 5.5 shows the factors that ensure quality in STI services.

Figure 5.5 Ensuring high-quality STI services



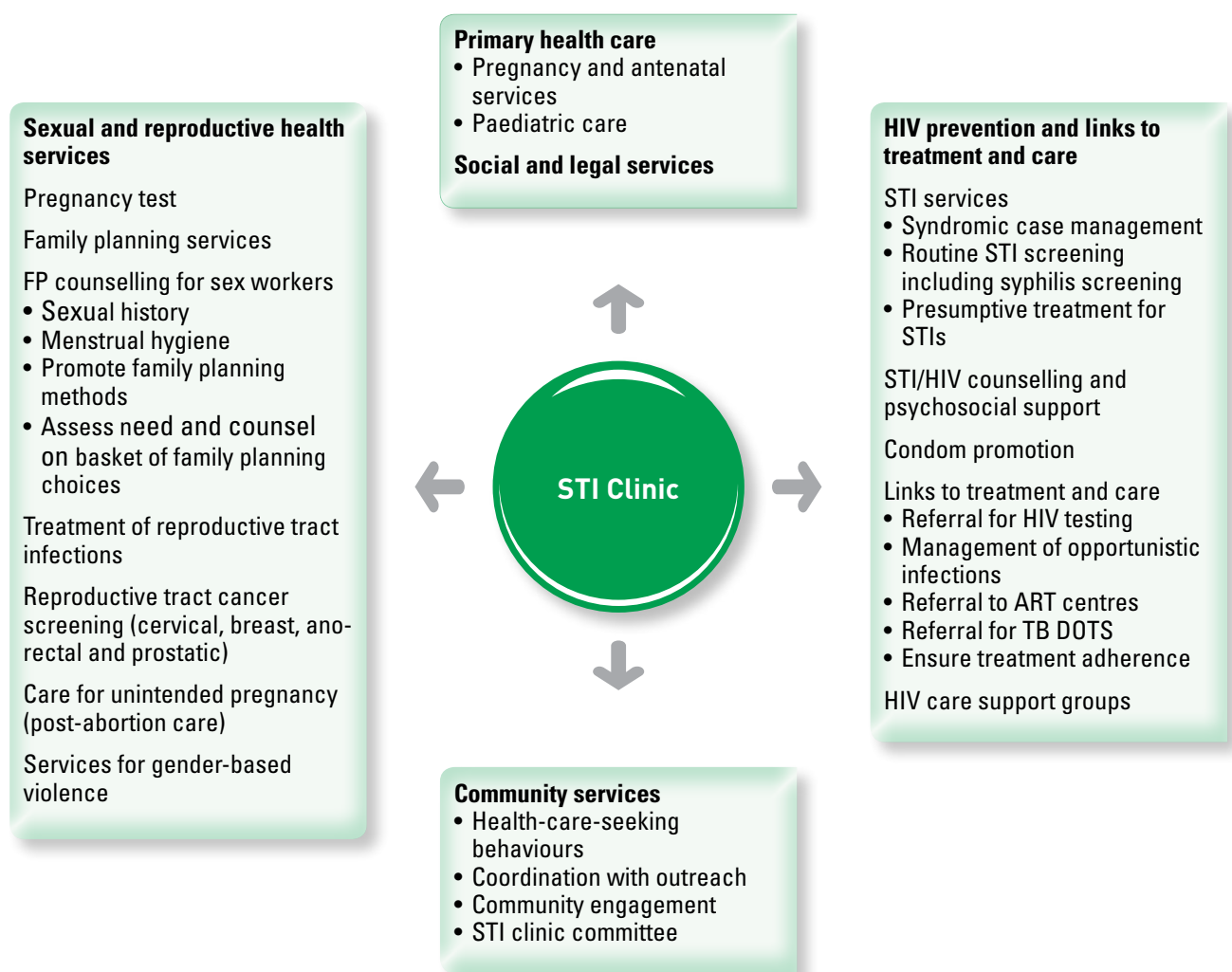
Link and integrate services

The majority of programmes providing services to sex workers focus on HIV and other STIs. However, sex workers and their families have the same needs for primary health care as anyone else. Sex workers may also experience problems associated with alcohol and drug use.

Programmes should work to provide a full range of health and social services. These should be accessible on site or by referral, without fear of discrimination. Services may be added incrementally based on sex workers' priorities, the feasibility of providing services, and alternative solutions. HIV, SRH, HBV immunization, TB, and drug and alcohol dependency treatment are discussed in other sections of this tool.

Sex workers whose HIV, SRH and other health issues cannot be met or managed appropriately by the programme's services should be referred to other facilities. Referral networks should be established depending on anticipated needs (see Figure 5.6). Clinics should compile a referral list of recommended providers, including names, addresses, telephone numbers and operating hours. Whenever necessary (e.g. due to perceived barriers to accessing services), accompanied referral should be considered.

Figure 5.6 STI referral network



Box 5.8

Addressing the needs of male and transgender sex workers

Male and transgender sex workers need gender-specific interventions and services. Some male sex workers are heterosexual or bisexual while others identify as gay (homosexual). WHO guidelines for the *Prevention and treatment of HIV and other sexually transmitted infections STIs among men who have sex with men and transgender people* (2011) recommend the following:

- Men who have sex with men and transgender people with symptomatic STIs should seek and be offered syndromic management and treatment (in line with existing WHO guidance).
- Offer periodic testing for asymptomatic urethral and rectal *N. gonorrhoeae* and *C. trachomatis* infections, using nucleic acid amplification test (NAAT) rather than culture.
- Offer periodic serological testing for asymptomatic syphilis infection.
- Men who have sex with men and transgender people should be included in catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage (in line with existing WHO guidance).

It is essential to involve male and transgender sex workers in designing, implementing and monitoring STI services. In any setting, clinic standards should be adapted to ensure that gender-specific and appropriate services are provided. The model of service delivery depends on the specific context and on inputs from the male and transgender sex workers. In some settings, services for female sex workers may be adapted to provide services for male and transgender sex workers (e.g. offering services at specified times so that female, male and transgender sex workers may be seen separately at the same clinic). In some settings, clinics for men who have sex with men have provided services for male and transgender sex workers; in others, dedicated services for the sex workers have been established.

C. Periodic presumptive treatment**2012 Recommendations: Evidence-based Recommendation 4**

Offer sex workers, in settings with high prevalence and limited clinical services, periodic presumptive treatment (PPT) for asymptomatic STIs.

The 2012 Recommendations state that:

1. PPT should be implemented only as a short-term measure in settings where STI prevalence is high, e.g. >15% prevalence of *N. gonorrhoeae* and/or *C. trachomatis* infection.
2. PPT for gonorrhoea and chlamydial infection should always be free, voluntary and confidential, and include counselling and informed consent.
3. PPT for gonorrhoea and chlamydial infection should only be offered as part of comprehensive sexual health services (including community empowerment, condom programming, STI screening, STI treatment and care) and while HIV/STI services are being further developed.
4. There should be ongoing monitoring of the possible benefits and harm that sex workers could experience from being offered PPT.

Related operational considerations include:

- the use of single-dose combination antibiotics for high cure rates
- enhanced condom promotion, including ensuring quality and accessibility to reduce rates of re-infection
- enhanced sex worker-led outreach to increase knowledge, coverage and use of services
- enhanced support for safer working conditions to increase opportunities for condom negotiation
- use of PPT as an emergency response only with these other components to reinforce STI control and HIV prevention with sex workers and their clients
- phasing out of PPT as soon as possible, e.g. after six months, even if prevalence has not declined, as other measures should by then be in place to maintain control.

The values and preferences survey concluded that the potential risks of PPT to sex workers outweigh the potential benefits. Sex workers reported harmful consequences from the introduction and use of PPT, and ongoing monitoring of the possible harm that sex workers could experience from PPT was requested. There was unanimous agreement from the values and preferences survey, and from participants at the related validation meeting, that PPT should only be offered when sex workers have access to all relevant information, including about side-effects, and only when uptake is voluntary and not imposed as part of a coercive or mandatory public-health effort.

D. Viral hepatitis

2012 Recommendations: Evidence-based Recommendation 8

Include sex workers as targets of catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage.

HBV is transmitted between people by contact with the blood or other body fluids of an infected person. Sexual contact and injecting drug use also transmit the virus. Risky sexual practices and sex work are associated with HBV infection in different regions of the world. Fortunately, highly effective vaccines against the virus are available. WHO recommends three doses of the vaccine for complete immunization and protection against potential HBV infection. WHO has also published *Guidance on prevention of viral hepatitis B and C among people who inject drugs*.

Like HBV, HCV is transmitted through contact with the blood or other body fluids of an infected person. Most HCV infections occur through the use of contaminated injection equipment among persons who inject drugs or in medical settings. HCV can also be transmitted by sexual contact, and the group at greatest risk is HIV-infected men who have sex with men. There is no vaccine to prevent HCV infection, but it can be cured with treatment. WHO is developing guidance for HCV treatment, and has published *Guidance on prevention of viral hepatitis B and C among people who inject drugs*.

5.7 Addressing the sexual and reproductive health needs of sex workers

5.7.1 Introduction

Sex workers of all genders have SRH needs and the same reproductive health rights. SRH needs are often overlooked; it is important to expand clinical services beyond STIs and HIV to address them. Making SRH services available on-site or by referral allows for sex workers' broader needs to be attended to and increases their confidence and participation in the programme. The following SRH services should be considered:

- family planning and contraceptive counselling
- safe pregnancy
- abortion and post-abortion care
- reproductive tract cancer screening (e.g. cervical, ano-rectal and prostatic cancers)
- counselling on hormone use and referral to other gender enhancement practices for transgender sex workers.

Box 5.9

Case example: Government provision of SRH services to sex workers

Diagonal Interventions to Fast Forward Enhanced Reproductive Health (DIFFER), an initiative in India, Kenya, Mozambique and South Africa funded by the European Commission, is exploring a "diagonal" strategy, incorporating health-systems strengthening (a horizontal approach) with more targeted outreach to sex workers (a vertical approach) to define STI and broader SRH services. Models for delivery of services to meet the needs of sex workers and women include:

- government SRH services with special hours or spaces for sex worker services
- government SRH services with outreach and mobile or satellite sex worker services
- better coordination and two-way referral between services for sex workers run by community-based organizations or NGOs and government SRH services.

Box 5.10

Hormonal therapy for transgender sex workers

There is currently no consensus on the safest and most effective dosing regimens for hormonal therapy for gender transition. Several centres have developed guidance on the use of hormones. Transgender people use hormonal therapy for its feminizing (estrogen) or masculinizing (testosterone) effects. This is usually done through advice from their friends or from information on the Internet. High doses are usually administered, and these have potentially serious side-effects. High doses of estrogen may result in an increased risk of thromboembolism and other outcomes such as liver dysfunction, breast cancer, coronary artery disease, cerebrovascular disease and headaches.

A qualified practitioner should be consulted when considering hormonal therapy, and people on hormonal therapy need access to medical monitoring.

5.7.2 Family planning and contraceptive counselling

The basic steps in effective family planning and contraceptive counselling for sex workers are:

- Provide counselling to determine the sex worker's pregnancy intention.
- Discuss available methods of contraception, including dual protection.
- Determine medical eligibility for the desired family planning method.
- Provide or prescribe the family planning method.
- Promote and provide condoms.

Sex workers may use condoms less consistently with regular partners than with their clients. Many sex workers therefore need dual method protection against pregnancy as well as against STIs and HIV. This may be achieved by using a highly effective contraceptive method for pregnancy prevention, and the male or female condom for STI and HIV prevention.

The following information should be provided so that sex workers may make an informed, voluntary choice of contraceptive methods:

- relative effectiveness of each method
- correct use of the method
- how it works
- common side-effects
- health risks and benefits
- signs and symptoms that would necessitate a return to the clinic
- return to fertility after discontinuing the contraceptive method.

Emergency contraception

Emergency contraception may be provided to a woman who has had unprotected vaginal sex, is not currently using a contraceptive method and is not pregnant. It should be provided as soon as possible after unprotected sex, ideally within 72 hours, with a limit of 120 hours. (Effectiveness is reduced beyond 72 hours.) Emergency contraception should be accessible to sex workers and the frequency of its use should be monitored.

Note: Since emergency contraception is not completely effective in preventing pregnancy and might not be efficient if used frequently, it is important to encourage sex workers to use a long-term family planning method.

Safe pregnancy

If a sex worker plans to become pregnant, she should be provided with information about safe pregnancy, including regular antenatal care, HIV and STI prevention and testing, appropriate nutrition and safe delivery.

Abortion and post-abortion care

Where abortion is legal, links to safe abortion services should be established. Where it is illegal, sex workers should be informed about the risks of informal abortion methods. Sex workers should have access to appropriate post-abortion care to reduce related morbidity and mortality, and care for post-abortion complications should be provided. Sex workers should be counselled on family planning to prevent future unwanted pregnancies.

5.7.3 Cervical cancer screening

Human papilloma virus (HPV) is an STI that can cause cervical cancer. Cervical cancer screening promotes early detection of precancerous and cancerous cervical lesions and prevents serious morbidity and mortality. Information and services for cervical cancer screening and treatment should be provided to sex workers.

It is recommended that cervical screening be performed for every woman aged 30–49 at least once in her lifetime. Screening may be done through visual inspection with acetic acid (vinegar), conventional Pap smear or HPV testing. Pre-cancerous and cancerous lesions should be treated immediately.

Women who are HIV-positive should be screened for cervical cancer regardless of age. Priority should be given to maximizing coverage of the risk age group and to ensuring complete follow-up of women with abnormal screening test results.

5.7.4 Screening for other cancers

Screening for breast cancer, ano-rectal and prostate cancer should be part of routine care, and links to treatment services should be provided.

5.7.5 Clinical care for survivors of sexual assault

Where possible, clinical care for survivors of sexual assault should be linked with community-led responses to violence (see Chapter 2, Section 2.2.6).

- Offer first-line support to survivors of sexual assault by any perpetrator.
- Take a complete history to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe, including genitalia).
- Offer emergency contraception to women presenting within five days of sexual assault, and ideally as soon as possible after the assault to maximize effectiveness.
- Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making with the survivor to determine whether HIV PEP is appropriate.
- Survivors of sexual assault should be offered prophylaxis for:
 - chlamydia
 - gonorrhoea
 - trichomonas
 - syphilis, depending on the prevalence.

The choice of drug and regimens should follow national guidelines.

- Hepatitis B vaccination without hepatitis B immunoglobulin should be offered as per national guidelines.
- Psychological support and care should be offered, including coping strategies for dealing with severe stress.

Interventions up to three months post-trauma

- Continue to offer support and care.
- If the survivor has mental health problems, provide evidence-based mental health services that are accessible, available and follow the WHO *mhGAP Intervention Guide*.

Intervention from three months post-trauma

- Assess for mental health problems and manage according to *mhGAP*.
- If survivor has post-traumatic stress disorder, arrange for appropriate therapy.

5.8 Mental health

Mental well-being makes up an integral part of any individual's capacity to lead a fulfilling life. Mental health and overall well-being are influenced not only by individual attributes, but also by the social circumstances in which people find themselves and the environment in which they live. Sex workers may be particularly vulnerable to mental health problems, because of poverty, criminalization, marginalization, discrimination or violence.

Poor mental health may be a barrier to seeking testing or treatment for HIV, and to continuing in care for those who are HIV-positive. Programmes should monitor for and address the obstacles to mental health created by HIV service providers who are unskilled in recognizing mental health problems or who actively stigmatize sex workers with such problems.

The WHO *mhGAP Intervention Guide* provides guidance in evidence-based interventions to identify and manage a number of priority conditions, including depression, psychosis, bipolar disorders, alcohol-use disorders, drug-use disorders, self-harm, suicidal ideation and other emotional or medically unexplained conditions.

5.9 Resources and further reading

WHO guidance relevant to voluntary HIV testing and counselling

WHO has issued guidance on HIV testing services since 1988, soon after the first tests were developed. The most recent guidance documents are:

1. *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infections: recommendations for a public health approach*. Geneva: World Health Organization, 2013.
<http://www.who.int/hiv/pub/guidelines/arv2013/en/>
2. *Handbook for improving HIV testing and counselling services*. Geneva: World Health Organization, 2010.
<http://www.who.int/hiv/pub/vct/9789241500463/en/index.html>
3. *Service delivery approaches to HIV testing and counselling (HTC): a strategic policy framework*. Geneva: World Health Organization, 2012.
http://www.who.int/hiv/pub/vct/htc_framework/en/
4. *Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: recommendations for a public health approach*. Geneva: World Health Organization, 2012.
<http://www.who.int/hiv/pub/guidelines/9789241501972/en/>
5. *Delivering HIV test results and messages for re-testing and counselling in adults*. Geneva: World Health Organization, 2010.
http://www.who.int/hiv/pub/vct/hiv_re_testing/en/
6. *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva: World Health Organization, 2007.
<http://www.who.int/hiv/pub/vct/pitc2007/en/>
7. *Handbook for improving HIV testing and counselling services: field-test version*. Geneva: World Health Organization, 2010.
<http://www.who.int/hiv/pub/vct/9789241500463/en/>

8. *HIV Rapid Test Training Package*. Geneva: World Health Organization [no date].
http://www.who.int/diagnostics_laboratory/documents/guidance/hivrtraining_overview/en/index.html
9. *Laboratory Quality Management System Training Toolkit*. Geneva: World Health Organization, 2011.
http://www.who.int/lhr/training/laboratory_quality/en/index.html

WHO guidance relevant to pre-exposure prophylaxis

1. *Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects*. Geneva: World Health Organization, 2012.
http://www.who.int/hiv/pub/guidance_prep/en/

WHO guidance relevant to tuberculosis

1. *WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders*. Geneva: World Health Organization, 2012.
http://www.who.int/tb/publications/2012/tb_hiv_policy_9789241503006/en/index.html
2. *Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings*. Geneva: World Health Organization, 2011.
<http://www.who.int/hiv/pub/tb/9789241500708/en/>
3. *Rapid implementation of the Xpert MTB/RIF diagnostic test: technical and operational "How-to"; practical considerations*. Geneva: World Health Organization, 2011.
http://whqlibdoc.who.int/publications/2011/9789241501569_eng.pdf
4. *Global tuberculosis report 2013*. Geneva: World Health Organization, 2013. In press.

WHO guidance relevant to injecting drug use

1. *WHO/UNODC/UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision*. Geneva: World Health Organization, 2013.
http://www.who.int/hiv/pub/idu/targets_universal_access/en/index.html
2. *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Geneva: World Health Organization, 2009.
<http://www.who.int/hiv/pub/idu/opioid/en/index.html>
3. *Guide to starting and managing needle and syringe programmes*. Geneva: World Health organization, 2007.
<http://www.who.int/hiv/pub/idu/needleprogram/en/index.html>
4. *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): manual for use in primary care*. Geneva: World Health Organization, 2010.
http://www.who.int/substance_abuse/activities/assist/en/
5. *The ASSIST-linked brief intervention for hazardous and harmful substance use: manual for use in primary care*. Geneva: World Health Organization, 2010.
http://whqlibdoc.who.int/publications/2010/9789241599399_eng.pdf

Guidance relevant to male medical circumcision

1. *UN resources on male circumcision for HIV prevention*. Geneva: World Health Organization and Joint United Nations Programme on HIV/AIDS, 2010.
http://www.who.int/hiv/pub/malecircumcision/mc_un_inventory/en/index.html

Guidance relevant to sexually transmitted infections

1. *Guidelines for the management of sexually transmitted infections*. Geneva: World Health Organization, 2003.
<http://www.who.int/reproductivehealth/publications/rtis/9241546263/en/index.html>
2. *Expert consultation and review of the latest evidence to update guidance for the management of sexually transmitted infections: meeting report*. Geneva: World Health Organization, 2011.
http://www.who.int/reproductivehealth/publications/rtis/rhr_11_37/en/index.html

5 Clinical and Support Services

3. *Sexually transmitted and other reproductive tract infections: a guide to essential practice*. Geneva: World Health Organization, 2005.
<http://www.who.int/reproductivehealth/publications/rtis/9241592656/en/index.html>
4. *The use of rapid syphilis tests*. Geneva: World Health Organization/Special programme for Research and Training in Tropical Diseases (TDR), 2006.
http://www.who.int/reproductivehealth/publications/rtis/TDR_SDI_06_1/en/index.html
5. *Prevention and treatment of HIV and other sexually transmitted infections among men who have sex with men and transgender people: recommendations for a public health approach 2011*. Geneva: World Health Organization, 2011.
http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/index.html
6. *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*. Geneva: World Health Organization, 2013.
<http://www.who.int/hiv/pub/guidelines/arv2013/en/>
7. *A strategic approach to strengthening control of reproductive tract and sexually transmitted infections: use of the programme guidance tool*. Geneva: World Health Organization, 2009.
<http://www.who.int/reproductivehealth/publications/rtis/9789241598569/en/index.html>
8. *Clinic Operational Guidelines & Standards: Comprehensive STI Services for Sex Workers in Avahan-Supported Clinics in India*. New Delhi: Family Health International [no date].
<https://www.indiahiv.org/Documents/Avahan%20COGS.pdf>
9. *National Guidelines for HIV/STI Programs for Sex Workers*. Government of Kenya, Ministry of Public Health and Sanitation, 2010.
<http://nascop.or.ke/library/Marps/Sex%20Worker%20Guidelines.pdf>
10. Position paper on hepatitis B. World Health Organization *Weekly Epidemiological Record*, 2009, 84:405–420.
<http://www.who.int/wer/2009/wer8440.pdf>
11. *Guidance on prevention of viral hepatitis B and C among people who inject drugs*. Geneva: World Health Organization, 2012.
<http://www.who.int/hiv/pub/guidelines/hepatitis/en/index.html>

Sexual and reproductive health

1. *Family Planning: A Global Handbook for Providers (2011 update)*. Baltimore, MD and Geneva: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs and World Health Organization, 2011.
http://www.who.int/reproductivehealth/publications/family_planning/9780978856304/en/index.html
2. *Safe abortion: technical and policy guidance for health systems—Second edition*. Geneva: World Health Organization, 2012.
http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/index.html
3. *WHO guidance note: comprehensive cervical cancer prevention and control – a healthier future for girls and women*. Geneva: World Health Organization, 2013.
<http://www.who.int/reproductivehealth/publications/cancers/9789241505147/en/index.html>
4. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva: World Health Organization, 2013.
<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

Mental health

1. *Risks to mental health: an overview of vulnerabilities and risk factors. Background paper by WHO secretariat for the development of a comprehensive mental health action plan*. Geneva: World Health Organization, 2012.
http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf
2. *mHGAIP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva: World Health Organization, 2010.
http://www.who.int/mental_health/evidence/mhGAP_intervention_guide/en/

Operational tools

1. *Clinic Operational Guidelines and Standards: Comprehensive STI Services for Sex Workers in Avahan-Supported Clinics in India*. Family Health International, 2006.
<https://www.indiahiv.org/SitePages/PublicationType.aspx/2>
2. *Avahan Common Minimum Programme for HIV Prevention in India*. New Delhi: Bill & Melinda Gates Foundation, 2010.
<http://www.gatesfoundation.org/avahan/Documents/cmp-monograph.pdf>
3. *STI Clinic Supervisory Handbook: Comprehensive STI services for Sex Workers in Avahan-Supported Clinics in India*. New Delhi: Family Health International (FHI360), 2007.
http://aidsdatahub.org/dmdocuments/STI_Clinic_Supervisory_Handbook.pdf.pdf

Other resources

1. *Building Partnerships on HIV and Sex Work: Report and Recommendations from the First Asia and the Pacific Regional Consultation on HIV and Sex Work*. Bangkok: Asia Pacific Network of Sex Workers, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, 2011.
<http://asiapacific.unfpa.org/public/pid/7491>
2. *Female, Male and Transgender Sex Workers' Perspectives on HIV & STI Prevention and Treatment Services: A Global Sex Worker Consultation*. Edinburgh: Global Network of Sex Work Projects, 2011.
<http://www.nswp.org/sites/nswp.org/files/NSWP-WHO%20Community%20Consultation%20Report%20archived.pdf>

Further reading

1. Mogasale V, Wi T, Das A, et al. Quality assurance and quality improvement using supportive supervision in a large-scale STI intervention with sex workers, men who have sex with men/transgenders and injecting-drug users in India. *Sexually Transmitted Infections*, 2010; 86:i83–i88.
2. Chersich M, Luchters S, Ntaganira I, et al. Priority interventions to reduce HIV transmission in sex work settings in sub-Saharan Africa and delivery of these services. *Journal of the International AIDS Society*, 2013; 16:17980.
3. Denison JA, O'Reilly KR, Schmid GP, et al. HIV voluntary counselling and testing and behavioral risk reduction in developing countries: a meta-analysis, 1990–2005. *AIDS and Behavior*, 2008; 12(3):363–373.
4. Getahun H, Baddeley A, Raviglione M. Managing tuberculosis in people who use and inject illicit drugs. *Bulletin of the World Health Organization*, 2013; 91:154–156.
<http://www.who.int/bulletin/volumes/91/2/13-117267/en/index.html>



6

Programme
Management and
Organizational
Capacity-
building



What's in this chapter?

This chapter has two distinct parts:

Part I: Management systems for a programme serving multiple sex work locations within a country and multiple sex work sites within urban locations. This part addresses:

- **how management systems support** effective HIV and STI prevention programmes with sex workers (Section 6.1)
- **how to design, organize and implement a programme at scale**, including:
 - › establishing programme standards, data monitoring systems and an evaluation plan (Sections 6.2.1–6.2.3)
 - › setting up management structures (Section 6.2.4)
 - › implementing the programme in stages (Sections 6.2.5–6.2.7)
 - › ensuring sex worker participation in programme implementation (Section 6.2.8)
 - › developing staff capacity (Sections 6.3–6.4).

Part II: Elements of organizational capacity-building for local sex worker organizations to expand services or areas served. This part addresses:

- **how to build the capacity of sex worker organizations** (Sections 6.5–6.7)

The chapter also provides a list of **resources and further reading** (Section 6.8).

Part I: Programme Management

6.1 Introduction

This chapter explains how to establish a management system for an HIV and STI prevention and care programme serving multiple sex work locations within a country and multiple sex work sites within urban locations, with the goal of covering a high proportion of sex workers with at least minimal services. Such a programme requires centralized management and, depending on the size of the country, additional layers of management to support local implementing organizations.¹

Comprehensive HIV/STI prevention and care interventions with sex worker communities² are complex and have many aspects that must be addressed simultaneously. For example, they require regular outreach to sex workers and their clients, usually in settings with significant social, cultural, religious and legal barriers. Sex workers' needs may vary depending on their gender (female, male or transgender), as well as the settings in which they work (indoors,³ outdoors or arranged via the Internet or by mobile phone).

Many implementing organizations have little experience working with sex workers, while sex worker organizations may have limited organizational capacity to implement and scale up programmes themselves. Linking with existing clinical services often requires building the capacity of providers to deliver services to sex workers in a non-stigmatizing way. Establishing services outside the government or private sectors requires effort to build management infrastructure and processes. Finally, funding often comes from multiple sources, with different reporting requirements for government and other funders.

Management systems address all of these issues by:

- defining roles and responsibilities, providing oversight, managing relationships with external partners, doing advocacy and coordinating with other programmes
- planning and administering the activities of multiple interventions at various levels in the overall programme
- supporting the operational activities that support the work, including data reporting systems, commodity procurement, quality monitoring and improvement, support and supervision, training, etc.
- implementing financial procedures and controls.

This chapter is not a comprehensive strategic planning or management guide. Resources for essential aspects of strategic planning and programme management that are not unique to sex worker programmes are listed in Section 6.8. The chapter focuses on management approaches and systems that address the unique needs of sex worker programmes and have been used in successful programmes with a high degree of coverage. These unique aspects include:

1 An implementing organization is an organization delivering a prevention intervention to sex workers. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes a nongovernmental organization provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

2 In most contexts in this tool, "community" or "communities" refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, "outreach to the community" means outreach to sex workers, "community-led interventions" are interventions led by sex workers, and "community members" are sex workers.

3 "Indoor" sex workers work in a variety of locations including but not limited to their homes, brothels, guesthouses, bars, clubs and other sex work venues.

Coverage: High coverage of sex worker populations is essential to achieve impact at a population level, and coverage should be monitored at all levels—municipal, district, state/province and central. Planning for and calculating coverage requires an estimate of the total sex worker population (the denominator). For a country-wide view, the national AIDS control programme or a central management agency obtains or coordinates this coverage information, in partnership with all implementing organizations (see Section 6.2.6, Box 6.4). Programmes that achieve high coverage of sex workers and wide geographic scope (“scaled programmes”) require close partnerships between government, donors and implementing organizations.

Mobility and migration: Sex workers are often highly mobile, moving within a city, country or across state or national borders to follow fluctuating demand (e.g. due to festivals or temporary infrastructure or agricultural work). Interventions should be flexible to meet the varying demand for outreach and commodities, and to serve sex workers who may not speak the local language.

Sex worker leadership: Sex workers are best able to locate and communicate with their peers and to identify problems and issues in the community. An overarching goal of the programme should be to build the capacity of sex workers to take on this role. The programme design should also incorporate meaningful positions for sex workers in management and monitoring of the programme to make it more effective and sustainable (see Section 6.2.8 and Chapter 1, Section 1.2.6 and Chapter 3, Section 3.2).

Addressing structural constraints: To be as effective as possible, HIV interventions should not only focus on individual behaviour change but also address the broader factors that contribute to sex workers’ vulnerability, such as criminalization and other legal issues, stigma, discrimination, poverty, housing instability, violence, harassment and limited access to health, social and financial services. Interventions at various levels to address some of these structural constraints are highlighted in Chapters 1, 2 and 5.

Strict confidentiality and protection of data: Designing and managing a programme with sex workers requires information on the location of sex work sites, the size of the community and, ideally, a unique identifier that may be used across the programme to assess coverage and avoid double counting, particularly where there are multiple implementing organizations. Data that identify locations or individuals must be handled with strict confidentiality and protected from access by individuals, groups or organizations that might cause harm to the sex workers.

Flexibility and continuous programme learning: The sex work environment changes rapidly because of economic fluctuations, legal/social issues and new technologies, such as mobile phones and the Internet. Given this evolving context and the relative inexperience of most organizations in programming for sex workers, it is important to develop systems to quickly adjust the programme when necessary, and to disseminate lessons and innovations across it.

6.2 Planning and implementing an HIV/STI programme with sex workers

Creating a scaled programme requires collaboration among partners at different levels:

- the central level (for example, the national AIDS control programme or a central institution, if the programme is countrywide; a regional or state government/organization, if the programme is a sub-national one)
- an intermediate level (this could be an NGO or other partner at the level of a state, district or municipality)
- the local level (implementing organizations).

The elements of a scaled programme are outlined in Table 6.1 and described in detail below. In each case, the highest-level agency or institution takes the lead in planning each element, in collaboration with the agencies or organizations at the other levels. Although this chapter is written primarily from the viewpoint of central-level planning, there are multiple roles and responsibilities for each level of the programme in management, supervision and monitoring, as shown in Figure 6.3 (Section 6.2.4) and Figure 6.6 (Section 6.2.7). Many of the elements described for a scaled programme are relevant for a programme of any size.

Table 6.1 Elements of a scaled HIV/STI programme with sex workers

Designing a scaled programme for sex workers	<ul style="list-style-type: none"> • Define programme and standards (Section 6.2.1) • Establish a data monitoring system for management (Section 6.2.2) • Plan the programme evaluation (Section 6.2.3)
Organizing a scaled programme for sex workers	<ul style="list-style-type: none"> • Define the management structure (Section 6.2.4)
Implementing a scaled programme for sex workers	<ul style="list-style-type: none"> • Prioritize (Section 6.2.5) • Implement in a staged manner (Section 6.2.6) • Establish a supervision system (Section 6.2.7) • Progressively ensure full sex worker participation (Section 6.2.8)

Designing a scaled programme for sex workers

6.2.1 Define programme and standards

It is very important to clearly articulate and understand the programme logic model, the specific interventions of the programme and the expected standards of implementation. Being able to articulate and understand them will:

- give clarity across the programme on the intervention elements and programme packages
- establish a basis for the design of the monitoring system (e.g. defining the process, input, output, outcome and impact indicators)
- make it possible to assess programme quality.

A logic model illustrates the programme's interventions as well as how these are expected to lead to the desired impact. It identifies the technical skills and human resources required, as well as

commodities and supplies, training and, depending on the size of the intervention, the budget. These elements are periodically adjusted based on new data and improved as lessons and local innovations are shown to be successful.

Many countries have strategic plans and implementation guides in which a logic model is implicit. However, defining a more explicit logic model helps clarify monitoring and evaluation. (Examples of country guidelines, strategic plans and standard operating procedures are listed in Section 6.8.)

Figure 6.1 is a programme logic model for a multi-component intervention with sex workers. The sequencing of expected changes is important to the programme evaluation design discussed in Section 6.2.3.

This logic model does not, however, articulate the standards expected during implementation. Technical and management standards for each aspect of the intervention are defined by the programme, ideally in collaboration with implementing organizations and consistent with the values and preferences of the community. For example:

- **Technical**

- › What is the target ratio of community outreach workers⁴ to community members?
- › How often is a community outreach worker expected to meet sex workers?
- › What is the content of the outreach session?
- › How often is voluntary HIV testing offered?
- › What drugs will be used to treat STIs?
- › How many condoms and lubricant packages should be distributed?

- **Management**

- › Supervision frequency by programme level and technical area, including frequency of meetings between community outreach workers and their supervisor/manager
- › Definitions of reporting indicators
- › Frequency of reporting monitoring data

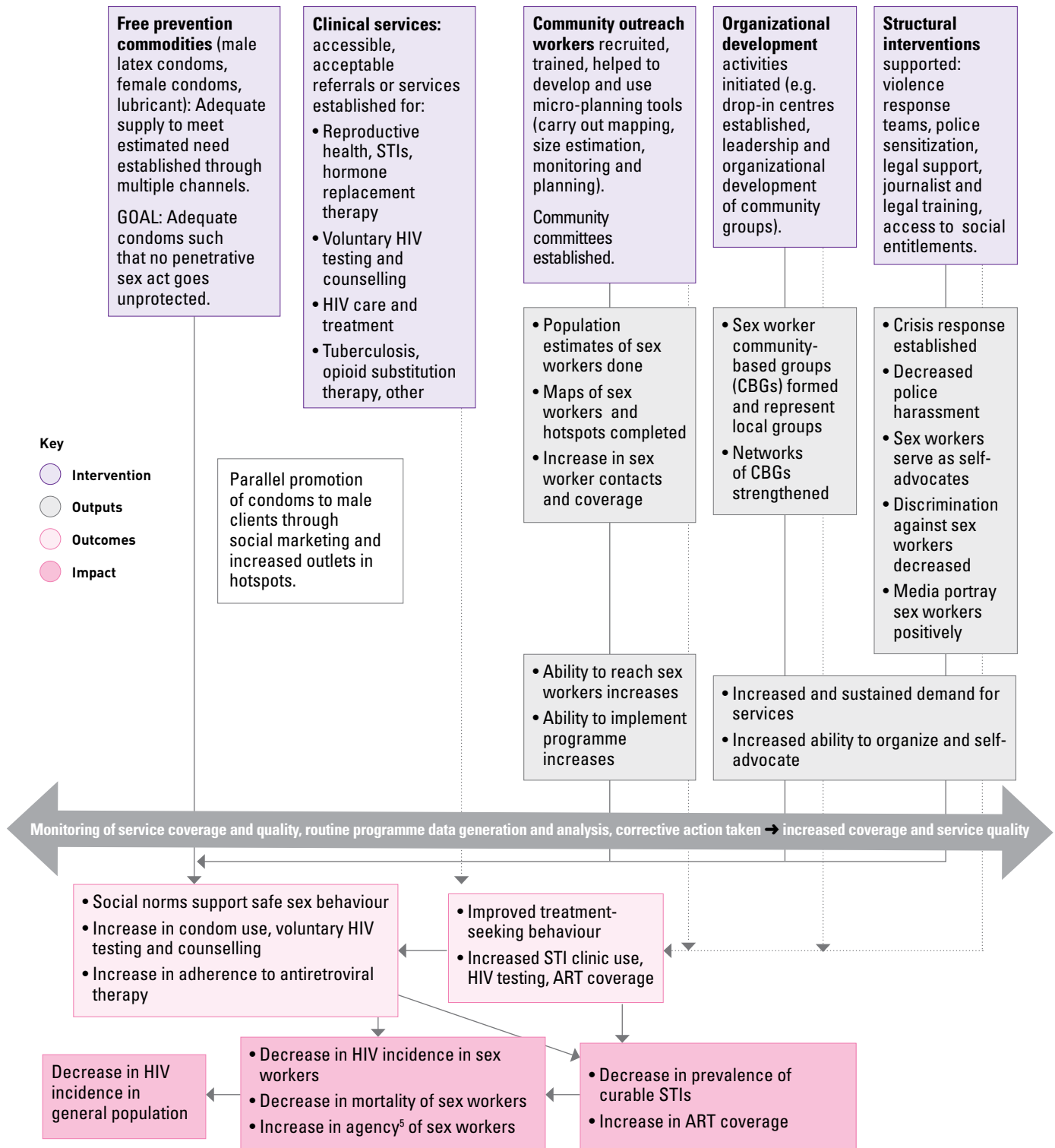
The other chapters in this tool provide some recommendations for standards specific to sex work interventions (see for example Chapter 3, Section 3.4). Clinical service standards are defined by each country as part of its national guidelines or, if not available, by WHO regional or global guidelines. STI management guidelines often need to be developed or modified for sex worker populations, given the higher prevalence of STIs among sex workers in most countries, and to address diagnosis and management issues of rectal STIs, which are often not covered in national guidelines. Standards for outreach, organizational development and structural interventions are generally not readily available and should be developed or adapted to the specific setting.

⁴ In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff may be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”. The terms “community” or “peer” should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.

6 Programme Management and Organizational Capacity-building

Figure 6.1 Programme logic model for a multi-component programme with sex workers

Target services: Based on mapping and size estimation in each district, focusing on highest density, highest risk first. Implement multi-component intervention package for sex workers.



Source: Avahan India AIDS Initiative

⁵ Agency in this context (and in other parts of this chapter where the word clearly does not mean “organization”) refers to the choice, control and power that a sex worker has to act for her/himself.

Box 6.1

Case example: Establishing a national quality standard for sex worker interventions in Côte d'Ivoire

In Côte d'Ivoire, community-based and clinic-based HIV prevention activities for female sex workers began in 1991, with the establishment of a dedicated clinic in the capital city. Based on the success of this programme, multiple international and national partners supported national scale-up of the model from 1996. In order to standardize and ensure high-quality services for sex workers, the National Programme for HIV Prevention among Highly Vulnerable Populations and its partners developed a "Minimum Package of Prevention and Care Activities for Sex Workers" in 2007. Quality standards for each of these activities were developed during a two-year process involving all partners. A technical working group drafted a set of standards, which fell into three categories:

1. Input (health infrastructure, staff, etc.)
2. Process (clinical guidelines, procedures, algorithms)
3. Output (patient satisfaction, coverage of target population).

A consistent format was used for each standard: a statement of the standard; criteria describing the elements required to meet the standard; and indicators for measuring the criteria. A validation workshop with 50 participants was held, resulting in a finalized and endorsed national guide with quality standards in 2009. They were then implemented across the country with on-site training of implementing agencies, ongoing coaching, deployment of tools for measuring standards and quality audits.

6.2.2 Establish a data monitoring system for management

A routine data collection system is needed that aggregates and consolidates information so that dashboard⁶ indicators may be monitored, and to enable "drilling down", i.e. the ability to look at detailed reports from lower levels. Central (national) management should be able to see data from the level of states/provinces and districts, while state/province managers and implementing organizations should be able to drill down to reports from frontline workers. This allows managers to identify areas or implementing sites whose performance is significantly different than others' (for example, low condom and lubricant distribution, or low coverage of the estimated sex worker population) and that may need additional management attention for improvement.

A well-designed monitoring system:

- allows reported indicators to be developed from data that are routinely collected and that are useful for programme and management decisions at the level where they are collected. Data that are not useful and used at the level of collection will not be prioritized and will often not be of high quality. Note that at each level of implementation and management, additional data may be collected that are not reported upwards but are used instead to improve services.
- captures the sex worker's interactions with community outreach workers or clinical services (e.g. formal contact with a community outreach worker, attended a clinic, was referred for a service, etc.) with minimal error (limited transfer and cross-posting of data)
- has clear indicator definitions and ongoing control of data quality
- aggregates data upwards but retains drill-down capability.

⁶ Dashboard indicators are the most important programme monitoring indicators, aggregated to a national level. They provide an overview of how well the programme is functioning (rather like the gauges on the dashboard of a car inform the driver how well the engine is running).

Box 6.2

Case example: Using routine monitoring data and qualitative interviews to improve services in India

Distribution of free condoms to sex workers through routine outreach was an essential component of the Avahan AIDS Initiative in India. An examination of routine monitoring data from condom distribution in early 2005, about one year after the programme had started, revealed that across about 120 NGOs, as many as 50% of the approximately 700,000 free condoms being distributed monthly were being given out by outreach workers who were not sex workers.

This raised questions about whether those most in need were receiving condoms and why community outreach workers, who were in more frequent contact with community members, were not charged with the primary responsibility for distributing the condoms. Discussions with the implementing NGOs, non-sex worker outreach workers, and community outreach workers revealed that some NGO staff lacked confidence that the community outreach workers knew how to adjust supplies to the individual needs of sex workers, when to reorder, and that they would actually distribute the condoms.

In response, the implementing NGOs at the state and local levels launched skills-building sessions to increase community outreach workers' capacity to carry out these tasks. They also developed tools to record and monitor condom outreach, and trained non-sex worker outreach workers to coach and mentor community outreach workers rather than manage them closely. After these changes, sex worker participation in service delivery, including condom distribution, increased markedly: one year later, 2.5 million free condoms were being distributed each month.

For sex worker programmes, there are eight main data sources necessary to design, monitor and manage the programme (labelled A–H in Table 6.2). These are discussed on the following three pages. Table 6.3, which follows this section, is an example of a programme indicator table that may be used at higher levels in management to monitor progress towards the goal of scale-up.

Table 6.2 Main data sources for design, monitoring and management of HIV/STI programmes with sex workers

A	Special data-collection exercises
B	Programme data not routinely collected during direct contact between sex workers and programme services
C	Programme data from routine direct contact between sex workers and programme services
D	Administrative data related to services including drugs, consumables and referrals
E	Qualitative assessments
F	Quality monitoring
G	Expenditure data
H	Other outside data

Data sources for programme design, monitoring and management

A. Special data-collection exercises

Mapping of sex workers and population size estimates are examples of special data-collection exercises. They are necessary to start a programme, for budget and programme planning and for deciding how many services to place, and where (see Section 6.2.6, part A). Size estimates are also essential to estimating levels of coverage, using data on sex workers' contact with fixed-site or outreach services. Site-based size estimates, rather than country- or province-based estimates, are crucial to developing a programme, as they help implementing organizations develop site-based intervention plans. Mathematical size estimate exercises may be used to validate these programme estimates. The size estimates are updated periodically, and remapping may be done if social, political or economic forces lead to significant changes in the sex worker population.

Note: Maps and other data containing information about sex workers (e.g. location, type of sex work practised) should be considered confidential and stored securely at a central location, such as a safe space (drop-in centre).⁷ Programme planners and implementing organizations should guard against the possibility of maps being obtained by law enforcement authorities or other groups who might use them to locate and close sites or otherwise cause harm to sex workers. If these confidential materials are disclosed, it is likely that the programme will lose the trust of the community.

Spot polling-booth surveys are another special data-collection exercise, used to assess reported condom use with clients and regular partners, needle sharing, or access to HIV services for monitoring progress.

B. Programme data not routinely collected during direct contact between sex workers and programme services

Monitoring of infrastructure (e.g. number of safe spaces, number of clinics) **and personnel** (e.g. number of people hired, trained and retrained by position, quality of training). These data are important to monitor service provision over the predetermined geographic area, and human resources. Monitoring the planned and unplanned turnover of community outreach workers is necessary to plan trainings for new recruits as well as progressive capacity-building activities.

Data from enrolment of sex workers as they become affiliated with the programme: Upon enrolment in the programme, the sex worker is assigned a unique identification code (which must maintain the sex worker's anonymity). Useful data to collect at enrolment include:

- Variables that describe the demographics of the sex worker: age, gender, type of sex work practised (street-based, indoor, etc.), length of time in sex work.
- Variables that capture "baseline" behaviour: reported condom use at last penetrative commercial sex; estimate of partner numbers per week; whether voluntarily tested for HIV in the last year, etc.

These data are useful to estimate sex workers' expected condom/lubricant needs (based on the type of sex work and average number of partners for penetrative sex) and give some gauge of risk in the population for prioritization of services. The data may be triangulated with other data for programme evaluation.

⁷ A safe space or drop-in centre is a place where sex workers may gather to relax, meet other community members, and hold social events, meetings or training. See Chapter 3, Section 3.3, for details.

C. Programme data from routine direct contact between sex workers and programme services

Data on contacts by sex workers with outreach workers, outreach services and clinical services are key to monitoring programme coverage. Ideally, this information should be collected at the point of contact and aggregated upward to the NGO, district, state and central levels, with minimal transcription to minimize errors. Depending on the community outreach workers' level of education, pictorial tools may be used. In this case, the role of the community outreach worker's supervisor/manager is to capture this information anonymously in a format that can be made electronic (e.g. number of new and repeat contacts, number of condoms distributed, number of referrals, etc.).

In addition to data associated with routine outreach activities, some data the programme may want to monitor are generated more irregularly, such as data on incidents of violence or access to entitlements. Because these events are not routine and usually require an additional form to be submitted, they are more difficult to track. It is recommended that sites submit reports routinely even if there are no events to report, in order to understand whether low numbers reflect reality or represent a failure to report the information.

Tracking mechanisms. Sex workers may be highly mobile, moving from one area to another within a country or even migrating across borders. This makes it difficult to monitor the total number of sex workers receiving services, because as they move into areas serviced by a different team or implementing organization they may be counted as a "new" sex worker to the programme. One way to address this is to ask sex workers who appear new to the programme whether they have received services before and from where; another is to provide some sort of anonymous, non-stigmatizing ID card that indicates that the sex worker has received services from the programme. A local NGO or service unit might record new contacts, new-to-area contacts and previous contacts as a way to distinguish this while capturing the degree of mobility.

Biometric markers, such as electronically recorded fingerprints, have sometimes been proposed as a way to identify programme participants. The expense associated with installing electronic data collection devices at all service points and establishing and maintaining a centralized database makes this unfeasible for most programmes. However, even where the cost is not an issue, the use of biometric data is considered an infringement of sex workers' rights, because of the potential for the abuse of the identifying data by law enforcement authorities or other groups. Therefore the use of biometric data is not recommended in programmes with sex workers.

D. Administrative data related to services, including drugs, consumables and referrals

Drugs and consumable supplies are managed with appropriate stock management policies and procedures. The importance of these administrative data is to: ensure consistent, uninterrupted supply of drugs, consumables and commodities; monitor consumption/distribution as a marker of coverage (e.g. condoms distributed compared to the estimated gap); and corroborate clinic reporting (e.g. STI drugs and syndromes reported).

Referral outcomes (i.e. whether a sex worker referred to a service attended the service, not the clinical outcome) should be assessed through an established communication channel with the referral service. (Clinical outcomes, such as the result of an HIV test or undetectable viral load, are important outcomes to monitor, but collecting this type of data is not the responsibility of sex worker interventions.)

E. Qualitative assessments

Regular qualitative assessments with community members can determine whether communication is being understood and whether there are unaddressed needs that could be met by the programme. They may also be used to further investigate and understand answers on quantitative surveys.

Box 6.3

Case example: Using qualitative information and other sources of data to inform programming in Ghana

In Ghana, two recent qualitative studies have described a trend of younger men who have sex with men also engaging in commercial sex with older men in order to receive material support, including clothing, rent and food. In 2012, FHI 360/SHARPER (the Strengthening HIV and AIDS Response Partnership with Evidence-based Results project, funded by USAID Ghana) identified a hidden sub-population of male sex workers working at brothels or via a network on the Internet. Discussions with these sex workers revealed that only a small proportion had been reached through traditional community-led interventions for men who have sex with men. SHARPER developed relationships with three of the seven identified sex work networks and in early 2013 began implementing outreach prevention education and HIV testing and counselling events. Just under 50% of those reached now know their HIV status, and HIV-infected male sex workers have been referred to HIV care and treatment services.

F. Quality monitoring

The standard-setting process outlined in Section 6.2.1 is the foundation of quality monitoring, as services are assessed against specified standards (quality assurance). Assessments may be done externally through quality audits or using participatory approaches. Taking action to solve any identified deficiencies (quality improvement) is an important step to maximizing service quality.

G. Expenditure data

These data are important to monitor the project's financial status and ensure that payments to implementing organizations are punctual, to keep the programme running. In addition, if coded in a standardized manner across all of the implementing organizations, the data may enable the programme to estimate the cost per beneficiary for each of the implementing organizations and to reveal any that may need additional management scrutiny.

H. Other outside data

Data from other sources outside the programme, such as government surveillance, academic research, or surveys done by other institutions, may be useful to inform progress or highlight necessary adjustments in the programme.

Table 6.3 Illustrative monitoring indicators for multi-component sex worker intervention

These are illustrative indicators; additional ones may be appropriate for each intervention area. Programme planners should consult the WHO *Technical guide for countries to programme, monitor and set targets for HIV prevention, treatment and care for sex workers and men who have sex with men and transgender people* (under development by WHO) and other guidance in countries. Priority considerations are: useful indicators for implementation that may also be aggregated upwards; and consistency in definitions across all implementing partners in the country in order to get an overall picture of progress.

Component	Indicator	Data sources
Establishing and maintaining programme infrastructure		
Presence in geographic area	% of districts/counties with contracts signed to establish services	Programme data/reports Planning documents based on mapping and size estimates
	% of towns/locations with comprehensive services established	Programme data/reports Planning documents based on mapping and size estimates
Services in geographic area	% of project offices established	Programme data/reports Planning documents based on mapping and size estimates
	% of safe spaces (drop-in centres)/community centres established/open	Programme data/reports Planning documents based on mapping and size estimates
	% of interventions with established links to reproductive health services	Programme data/reports Site assessment reports
	% of interventions with established links to voluntary HTC services	Programme data/reports Site assessment reports
	% of interventions with established links to HIV care and treatment services	Programme data/reports Site assessment reports
Project staff hired and trained	% of district/county director/coordinators	Programme reports Planning documents
	% of outreach supervisors/managers (target is 1 per 5–7 community outreach workers)	Programme reports Population size estimates
	% of technical staff at district/county level (target is to have enough to visit all sites at least monthly for supportive supervision/data review—usually 1 covers 3–5 sites). Illustrative technical areas: monitoring for management, clinical services (reproductive health, voluntary HTC, antiretroviral therapy [ART] care), structural interventions/advocacy, outreach, management/financial.	Programme reports Planning documents

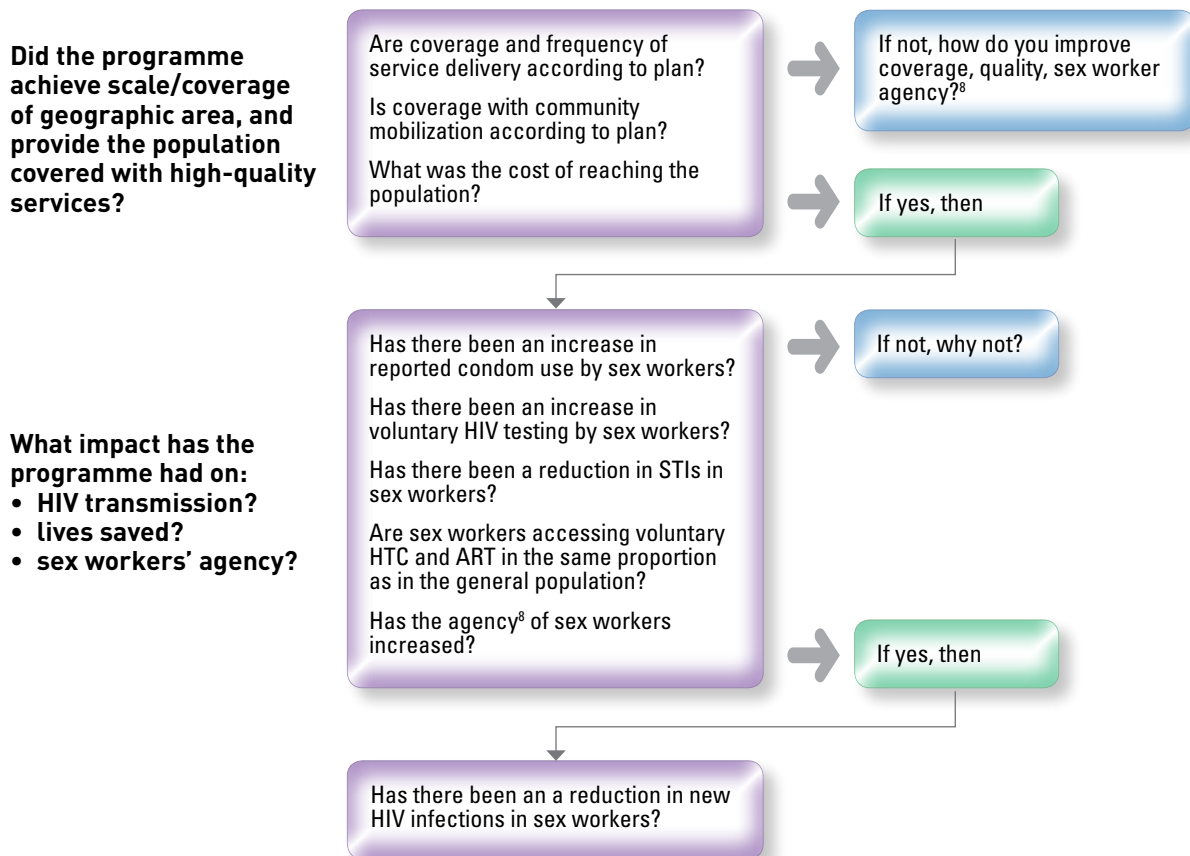
Component	Indicator	Data sources
	% of finance and administration staff	Programme reports Planning documents
	% of community outreach workers (target is ~1 per 50 sex workers at a site)	Programme reports Population size estimates
Staff turnover	Number of community outreach workers who discontinued working in the last month	Programme reports
Staff training	Number of community outreach workers trained during the last month	Programme reports
	Number of outreach supervisors/managers trained during the last month	Programme reports
	Number of technical staff trained during the last month	Programme reports
Behavioural interventions		
Intensity of engagement with sex workers	% of individual sex workers reached monthly with prevention package (as defined by the programme; see Section 6.2.1) (Calculated by dividing total number of individual sex workers contacted by community outreach workers in a month by the total number of sex workers targeted)	Micro-planning tools Periodic denominator estimates
Condoms and lubricants		
Adequacy of condom distribution and supply	Ratio of condoms distributed to estimated condoms required per month	Micro-planning tools Condom stock registers Enrolment questions on kind of sex work practised and average number of partners Other condom gap assessments
	Number of NGOs/GOs/CBOs reporting any condom stock-outs for free distribution in the last month	NGO/GO/CBO condom stock registers
	Number of NGOs/GOs/CBOs reporting any lubricant stock-outs for free distribution in the last month	NGO/GO/CBO stock registers
Behaviour change	% of sex workers reporting condom use during last commercial sex	Enrolment questions (quasi-baseline) Routine question in clinic encounter Small programme polling-booth survey
	% of sex workers reporting condom use during last sex with regular partner	Enrolment questions (quasi-baseline) Routine question in clinic encounter Small programme polling-booth survey

Component	Indicator	Data sources
Clinical services		
Reproductive health/STI service use	% individual sex workers referred for STI services monthly	Referral forms Periodic denominator estimates
	% individual sex workers accessing STI services monthly	Clinic forms Periodic denominator estimates
STI syndromes	% individual sex workers with STI syndrome who visit clinic quarterly	Clinic forms
HIV testing and counselling	% of sex workers referred to voluntary HTC services monthly	Referral forms Periodic denominator estimates
HIV care and treatment	% of sex workers newly diagnosed with HIV referred to care services monthly	Programme forms
	% of sex workers eligible for ART who are started on ART monthly	Programme forms
	% of sex workers started on ART who remain in care and are adherent to regimens at one year	Clinic forms
Structural interventions/Community mobilization		
Rights violations	Number of reported incidents of violence against individual sex workers	Violence report forms
	% of reports of violence responded to within [designated time period] by crisis response system	Crisis response forms
Stigma	Number of reported incidents of stigma in clinical services	Stigma report forms
Social entitlements	Number of sex workers accessing ration cards/voting cards/ID/bank accounts, etc.	Report forms
Community mobilization	% of community group members who are sex workers but not community outreach workers	Report forms

6.2.3 Plan the programme evaluation

An evaluation plan should assess the programme’s fidelity to its original design (i.e. was it implemented to the scale and with the elements defined in the programme logic model?) as well as to its intended impact. An illustrative high-level evaluation framework is depicted in Figure 6.2. See Section 6.8 for a list of guidance documents for designing evaluation programmes for sex workers.

Figure 6.2 Evaluation framework for a multi-component HIV/STI programme with sex workers



Some key issues to consider when designing the evaluation are:

- **Clarity on evaluation goal:** Since data analysis and dissemination are nearly always under-budgeted, it is best practice to define and budget for monitoring and evaluation activities at the start of the programme. It is recommended that 5–10% of the total project budget be allocated to monitoring and evaluation.

Clarity is required on what is being measured, for whom and with how much “certainty” in the inference. These levels of certainty have been defined as adequacy, plausibility and probability:

- › **Adequacy evaluations** assess how well the interventions met the programme logic model and whether the expected change occurred.
- › **Plausibility evaluations** collect data to increase the level of confidence that changes observed were due to the programme, usually by choosing a control group. In the case of sex worker programmes, this is likely to be an historical control group obtained with baseline data collection.

8 Agency in this context (and in other parts of this chapter where the word clearly does not mean “organization”) refers to the choice, control and power that a sex worker has to act for her/himself.

› **Probability evaluations** involve randomization and are not necessary or feasible for most programme evaluations.

Most sex worker evaluations fall somewhere between adequacy and plausibility. It should be noted that good monitoring data are essential, first to demonstrate that the programme was implemented as planned, and second as a signal to managers and funders that the programme is on track.

- **Data triangulation:** True baseline surveys (i.e. before interventions are started) in sex work communities are difficult. Programmes need to build trust with the community before one asks intimate questions or takes biologic specimens. Building trust usually entails providing services, and baseline behaviour related to condom use may change quickly. It is therefore important to try and collect additional information on “baseline” condom use through enrolment questionnaires, or use condom distribution data to triangulate with survey data (see Section 6.2.2).
- **Validation of programme data:** Surveys used for evaluation should also be used to validate the other programme data, where possible. In particular, surveys may be used to:
 - › estimate programme coverage and validate the monitoring estimates
 - › do size estimates using more mathematically based approaches
 - › assess the level of reported violence
 - › assess the level of individual and community agency.
- **Dissemination plan:** Dissemination plans should involve activities at all levels—from central to local levels—including to the sex workers themselves. Dissemination creates ownership of the results to help improve programmes.

Organizing a scaled programme for sex workers

6.2.4 Define the management structure

A clear structure for implementation and well-defined roles and responsibilities are essential for smooth programme management. These include the roles and responsibilities at each level of implementation, both in the programme and outside (government, media, medical services, etc.). At the national/central level, the government or central management agency:

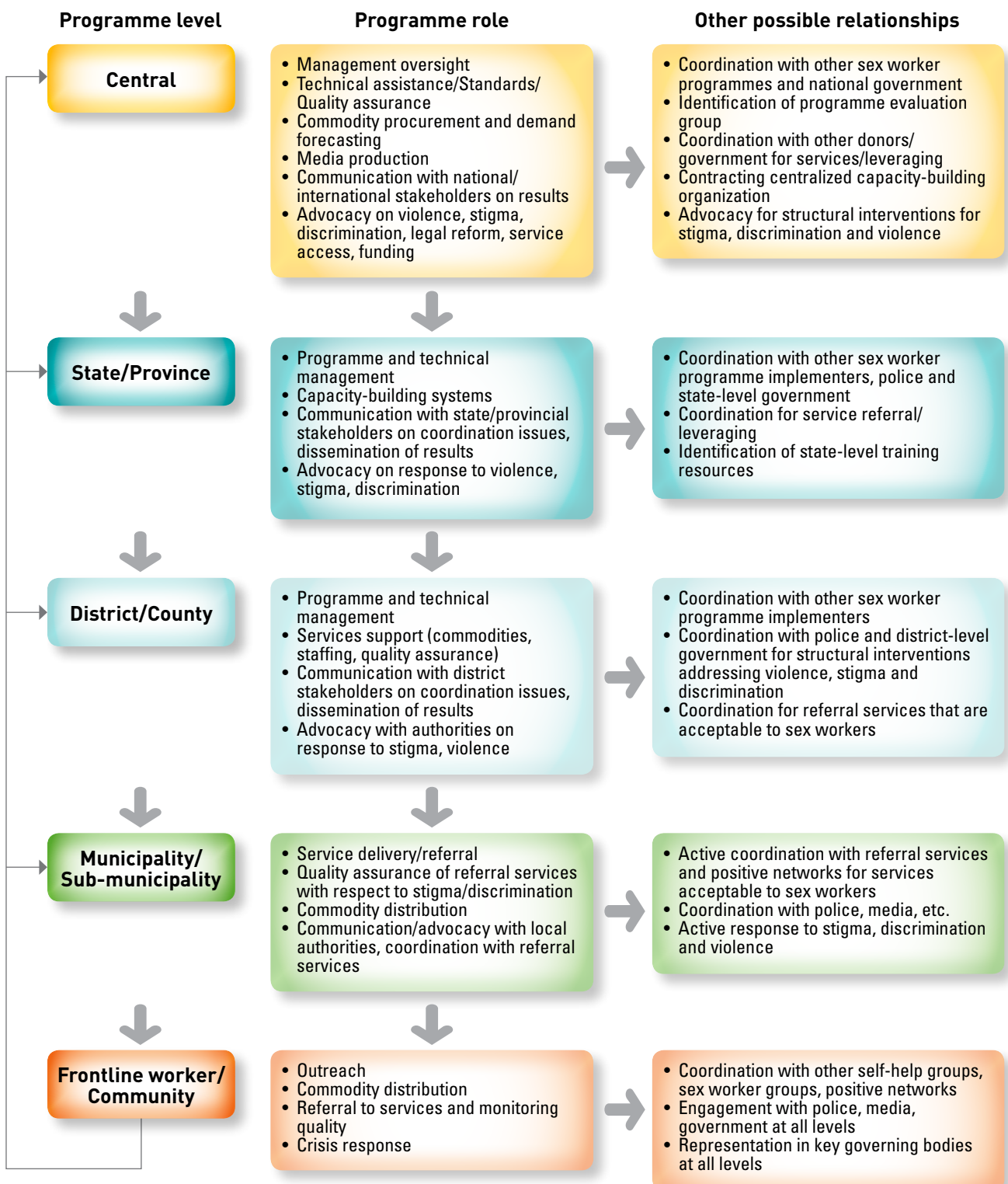
- sets programming standards
- monitors dashboard indicators from all implementing organizations in the country
- ensures that programmes are implemented in prioritized areas and sub-populations of sex workers
- has a centralized view of the monitoring data
- ensures a country-wide evaluation plan.

If government or a designated central management agency is not setting standards or requiring centralized indicator reporting, implementing organizations should work together to standardize a minimum package and centralize indicator collection in consultation with the government.

Figure 6.3 illustrates a management structure of a national programme, showing the oversight and reporting relationships with the programme as well as the external relationships managed at the various levels. Key management roles are:

- **setting milestones** coupled with field oversight for both quality and progress; regular review of progress against targets to adjust strategies and tactics; and use of programme experience and data to make mid-course corrections.
- **establishing an organizational culture** that aims to:
 - empower sex workers to manage the programme
 - empower staff at all levels to use local monitoring data to improve the programme.

Figure 6.3 Illustrative management structure for a national HIV prevention and care programme with sex workers (programme roles are not exhaustive)



Implementing a scaled programme for sex workers

6.2.5 Prioritize

Financial resources are usually insufficient to cover all sex workers in the entire country with the same package of services; as a result, programmes must prioritize both interventions and locations. This may be accomplished by varying the way in which technical components are delivered and by prioritizing those areas where the largest number of sex workers and those at highest risk may be reached. The following are considerations for prioritization:

Where to establish services

- **Locations with the largest number of sex workers in a geographic area:** This allows a few implementing organizations with the attendant management costs to reach a large proportion of sex workers. Large numbers of sex workers are usually found in urban areas or in places where there are large numbers of men without their families (extraction industries, construction projects, truck stops, migrant farm labour, etc.).
- **Locations with sex workers at higher risk of infection:** Higher risk is determined by factors such as the number of paying partners, type of sex (anal sex is higher risk) and the agency and experience of sex workers, e.g. brothel-based sex workers may be at higher risk than street-based sex workers because of their decreased agency and higher number of clients; newer sex workers may be at higher risk because they have less experience in negotiating condom use and avoiding or mitigating violent situations.

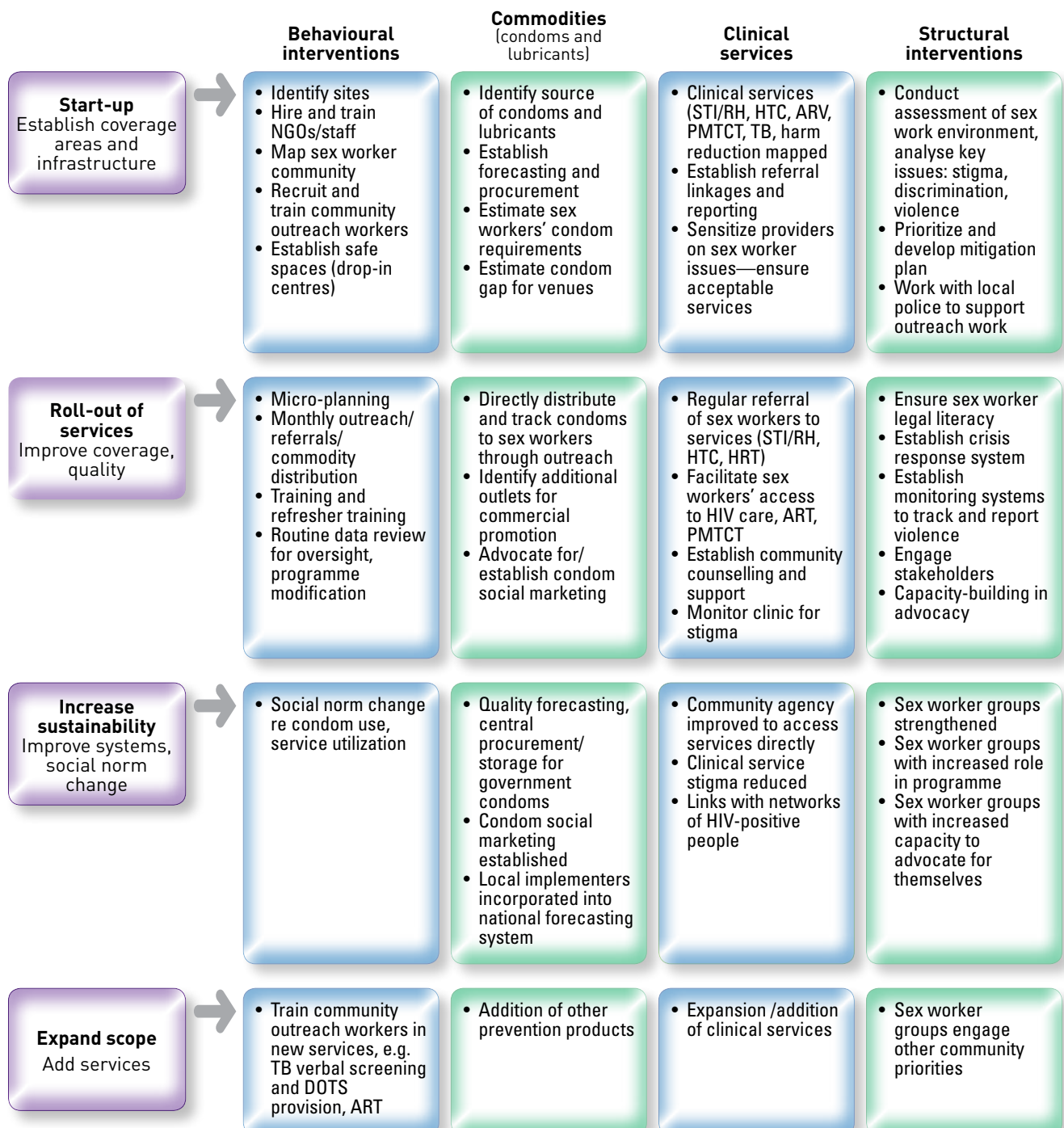
What services to provide: At a minimum, they should include:

- **Harm reduction commodities** including adequate availability of condoms and lubricant, and needles and syringes. These are essential for sex workers to protect themselves. In many settings, supplies are completely inadequate to the need. See Chapter 4 and Chapter 5, Section 5.5 for full details.
- **Community empowerment activities** to increase service reach and effectiveness and sex worker agency. As Chapter 3 explains in detail, community mobilization activities are increasingly being shown to be cost-effective and should be considered part of an essential package and not just “nice to have”.
- **Referrals** to accessible and acceptable clinical services for reproductive health, STIs, hormone replacement therapy, HIV testing, antiretroviral therapy (ART), tuberculosis (TB), hepatitis B vaccine and management, and opioid substitution therapy (see Chapter 5 for more details). High-quality referral services are sometimes more difficult to establish than project-owned services. Referral services often require behaviour change on the part of the providers to ensure that they are non-discriminatory, non-stigmatizing and confidential; and on the part of sex workers, who may have experienced abuse or discrimination from service providers on earlier occasions. Sometimes it is necessary to work with administrative bodies to change clinic hours to make them more accessible to sex workers. Moreover, training of staff is often necessary to familiarize them with sex worker-specific clinical protocols. Some programmes use voucher schemes to increase access to clinical services from private providers. In the long run, however, effective referrals to respectful, accessible services may be more sustainable than programme-run clinical services if the level of use by the community is high.
- **Addressing key structural barriers** such as violence and police interference with service delivery. These are determined by the local context (see Chapter 2 for more details).

6.2.6 Implement in a staged manner

Implementing and executing the programme in clear stages helps achieve wide geographic coverage. First, the programme is rolled out nearly simultaneously across the target geographic areas (as opposed to a pilot-and-replicate approach) by creating a physical infrastructure in these areas. This is followed by a focus on implementing services and constant quality improvement. Finally, as the interventions mature, the focus of implementation shifts to making interventions and services more sustainable. Additional services may be layered on over time. Figure 6.4 summarizes the staged implementation of a programme.

Figure 6.4 Stages of implementing a multi-component programme with sex workers

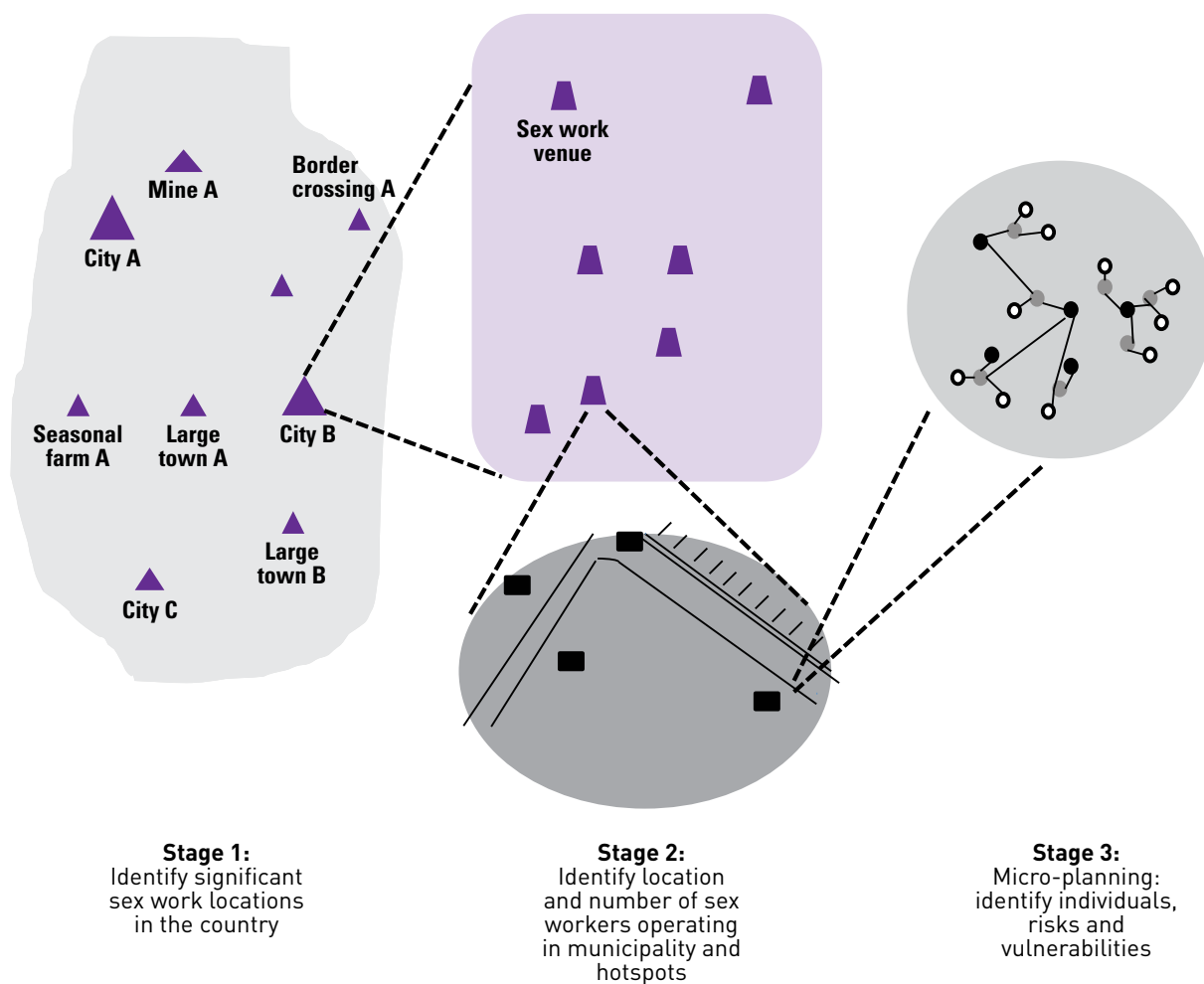


A. From start-up to establishing infrastructure across the target geographic area

Mapping and size estimates: Key steps in starting a programme include knowing where to establish services and contracting with implementing organizations.

- At the central planning level, reliable information about the size of a sex worker community in a given geographic area forms the basis for locating services, funding, setting performance targets, allocating programme resources and assessing coverage.
- At the implementation level, programmers have multiple purposes for mapping and size estimation information, including:
 - › estimating the size of the community in a given area to determine personnel needs
 - › defining locations of sex workers for locating interventions
 - › obtaining information on risk behaviours, risk perceptions and barriers to inform the initial intervention design. See Box 6.4 and Figure 6.5 for more details on approaches to determining where to start services.

Figure 6.5 Stages in determining where to establish services for sex workers



Source: Adapted from *A Systematic Approach to the Design and Scale-up of Targeted Interventions for HIV Prevention among Urban Sex Workers* (Karnataka Health Promotion Trust, Karnataka, India, 2012).

Box 6.4

Mapping, size estimation and micro-planning

Mapping and size estimation is a multi-stage process, focusing increasingly on local levels to refine the information and make it more accurate. (See also Figure 6.5.) Mapping should always be done discreetly so as not to draw undue attention to the activity.

First stage: “Where in the country does a significant amount of sex work occur?” To determine where services should be established, a central-level planner must first understand where sex workers are located. This information may be obtained by interviewing police in urban areas, health providers, and representatives of industries that attract a large number of male workers (extraction, construction, seasonal agriculture, etc.). An approximate number of sex workers should be obtained for each identified area in order to focus interventions initially on the locations with the largest number.

Second stage: “How many sex workers are operating in this municipality/area, and where?” Once the general geographic area is known, more detailed mapping and size estimation may be done. This exercise can be an adaptation of the PLACE method (Priorities for Local AIDS Control Efforts—see Section 6.8) or Participatory Site Assessments, depending on the level of sex worker involvement in the mapping and size estimation process.

- **First phase:** Local key informants (police, taxi drivers, NGO workers, truckers) are interviewed to identify where sex workers meet clients. Sex workers who are willing to assist may also be recruited to help list sites where sex work is solicited.
- **Second phase:** Locations identified by multiple informants or described as having large numbers of sex workers are investigated further. Detailed information is sought from sex workers on the number of sex workers by time of day, specific places where sex workers gather and additional areas near the location where other sex workers may be found. (The purpose of asking for additional locations is to find any unknown sites not identified by key informants in the first phase.)
 - › Depending on the relationship with the broader sex work community in the areas, the findings may be validated by presenting and discussing them with the community.
 - › Maps showing local landmarks and sex work locations may be prepared, either on paper or using electronic equipment, such as global positioning systems (GPS) or geographic information systems (GIS). (This information should be kept strictly confidential because of the potential for serious harm should authorities gain access to and misuse it.)

The programme uses this information in close consultation with the community to decide where service points, such as safe spaces (drop-in centres) and clinics, should be located. Other clinics may be listed and mapped to establish referral relationships. The programme design is further refined and informed by sex workers who describe the locations, hours, habits and other information that will determine when, where and how services are set up.

Third stage: “Who are the sex workers and what is their risk and vulnerability?” In this stage, social network maps are used to identify precisely who may be reached by individual community outreach workers, and to further inform local planning, while including sex worker’s values and preferences. Full details can be found in Chapter 3, Section 3.2.2 part A.

Box 6.5

Case example: Programmatic mapping and key population size estimation in Kenya

Since 2006, several small-scale size estimation studies have been done to understand the size and distribution of sex worker populations in Kenya. In 2012, a large-scale geographic mapping exercise was conducted by Kenya's National AIDS & STI Control Programme (NASCOP), with support from the World Bank, to provide accurate information on the size, locations and characteristics of populations of sex workers, men who have sex with men and people who inject drugs in key urban and semi-urban areas. The goal was to improve the scale, quality and impact of HIV prevention programmes among these populations.

A total of 51 urban centres were mapped, representing 70% of towns with a general population of 5,000 or more in each province. These data, and data from other studies conducted since 2006, were then compiled to finalize the 2013 national estimates for populations of sex workers, men who have sex with men and people who inject drugs. NASCOP estimates that there are 133,700 female sex workers in Kenya. It is the first time that the government has developed national, provincial and city estimates. They serve as baseline data for NASCOP to analyse gaps in funding and programming and develop a scale-up plan to reach female sex workers (along with other groups at risk) as part of the upcoming national strategic plan.

Allocating responsibilities among implementing units/NGOs: In assigning implementing units or NGOs to begin services, it is important to carve out distinct catchment areas for coverage responsibility. As far as possible, overlaps in geographic areas should be avoided. This should be balanced against the size of the sex worker communities assigned to each implementing organization. If the target population is too small, it will make the intervention too costly per sex worker reached; if it is too large, it may exceed the organization's management capabilities.

Hiring and training staff: A multi-component HIV intervention for sex workers requires team members with a variety of skills. The composition of a team depends on the services provided, how the services are delivered, the size of the sex worker community, and the geographic area being covered. Table 6.4 provides an example of an implementation team at a municipality/sub-municipality level.

The team includes both non-sex worker staff and community members. Non-sex worker staff should be sensitive to the context of sex work and the discrimination, violence and other problems sex workers face. They should also be able to discuss such topics as sex and service delivery needs in a non-judgemental manner. Although staff are hired for a specific role in the programme and will have a job description, they need to be flexible to adapt to new situations on the ground and incorporate new approaches. Given the overarching goal of sex worker progression and community empowerment, staff should be prepared to learn from the sex workers as well as serve as mentors to the process. Chapter 3, Box 3.3 describes the characteristics of successful community outreach workers.

Capacity-building of human resources is an important aspect of any programme but is particularly important in programmes with sex workers where the intent is to progressively increase their involvement in the programme. A full discussion of organizational capacity-building is in Part II of this chapter.

Table 6.4 Illustrative composition of an implementation team at the municipal/sub-municipal level for ~1,000 sex workers

Position (number of staff)	General responsibility	Comments
Coordination and administrative personnel		
Programme coordinator (1)	Responsible for the overall implementation of the project.	
Data officer (1)	Aggregate the data, generate the reports and monitor data quality.	
Accountant (1)	Maintain accounts and pay local expenses of the programme.	
Medical personnel		
<i>The number and type of medical personnel needed are based on the biomedical component(s) of the programme.</i>		
Physician (1)	Provide clinical services offered by the programme.	If clinical services to the community are entirely referral-based, this position is not necessary.
Nurse (1)	Provide/support clinical services offered by the programme.	If clinical services to the community are entirely referral-based, this position is not necessary.
Clinic support staff (1)	Greet patients, maintain reception area.	
Outreach personnel		
Counsellor (1)	Identify and manage mental health issues, such as depression and anxiety. Provide additional support for behaviour-change processes	Even if clinical services are not offered by the programme, a counsellor may provide additional counselling to sex workers on issues related to referral clinical services.
Outreach supervisors/managers (~5)	Supervise community outreach workers on a weekly basis. Ensure that sex worker outreach information is recorded and incorporated into routine monitoring systems.	
Community outreach workers (~20)	Routine outreach to sex workers, provision of commodities, referrals, follow-up and structural interventions. Support behaviour-change process. Support sex workers in responding to stigma, discrimination and violence.	Assumption is that one community outreach worker works 5 days a week, 4 hours per day and can meet 2 or 3 sex workers in a day. Will need time for routine meetings with outreach supervisors/managers and monthly implementing organization meeting. Number may be adjusted if sex workers are in close proximity (e.g. brothels) or are dispersed.
Office support staff (1)	Support routine office processes.	

B. From rolling out services to improving coverage and quality

During this stage of implementation the focus is on ensuring coverage of the community with services and improving quality. This roll-out stage is a continuous process in which management at all levels reviews progress against targets and adjusts strategies and tactics, as necessary. Mid-course corrections are made based on new data, new approaches or environmental or structural changes that affect programming. The intensity and the quality of coverage increases as staff become more skilled in their positions. It is during this phase that flexibility and continuous programme learning are extremely valuable. A strong monitoring system with regular reviews is essential to the successful roll-out of services. It also signals to funders and the government whether programming is being implemented successfully.

C. Aiming toward systems improvement, social norm change and increased sustainability

The overall aim of programme implementation is to provide services to reduce HIV and STI transmission and to treat HIV and other related infections, while empowering sex workers to participate and progressively build their capacity to implement the programme, and addressing structural barriers through advocacy and policy change. This makes the programme more effective and potentially more sustainable. The ideal characteristics of such a programme include the following:

- Sex workers lead in implementing outreach, distributing condoms and lubricant and facilitating effective clinical referrals.
- Sex workers have enough individual and collective agency to address problems themselves with the police, the health system, the government and other sex workers.
- Sex workers have positions at local, district and national level on planning bodies for service delivery and violence response.
- Social norm change among sex workers and clients makes condom use routine.
- Sex workers are able to access health services without stigma and discrimination at the same frequency as the general population.
- Prevention commodity supplies are adequate, through both social marketing and strengthened country procurement and distribution mechanisms, and sex worker programmes are part of a commodity tracking system.

Programme implementation in this stage is a matter of strengthening systems, addressing structural barriers and empowering communities while simultaneously providing and measuring services. Some of the earlier intensive programme activities may be reduced as social norms regarding condom use and clinical service use change.

D. From expanding scope to adding services

Once the infrastructure, community engagement and coverage have been established and the programme is functioning well, it is relatively straightforward to add services.

6.2.7 Establish a supervision system

Regularly scheduled supervision meetings help create a “data use culture” that enables corrective action and continuous improvement at all levels, as well as independent problem-solving. Periodic meetings should be scheduled to review data at every level, from community outreach workers to NGO staff, to the state/provincial level, to central management. Visits by the supervision staff to the field also provide qualitative information on implementation to help interpret data and find solutions. As an example, a supervision and programme review system used by a large project in India is

Box 6.6

Case example: Expanding scope and layering on tuberculosis screening services in India

TB is prevalent in India and is a common opportunistic infection among HIV-infected individuals. In 2007, after comprehensive HIV prevention services had been scaled up over a period of three years, the Avahan India AIDS Initiative, in partnership with the country's national TB programme, conducted intensified case-finding of sex workers through verbal screening for TB symptoms during routine outreach by community outreach workers and regular clinic visits. Sex workers with symptoms suggesting TB were accompanied to the TB diagnostic centre and, if necessary, to a DOTS (directly observed treatment – short course) treatment centre. In order to train community outreach workers to do this, low-literate tools were developed, including visual aids, such as flash cards, posters and a video. The TB verbal screening activity was easily incorporated into the community outreach workers' tracking tools, helping to ensure routine implementation during outreach.

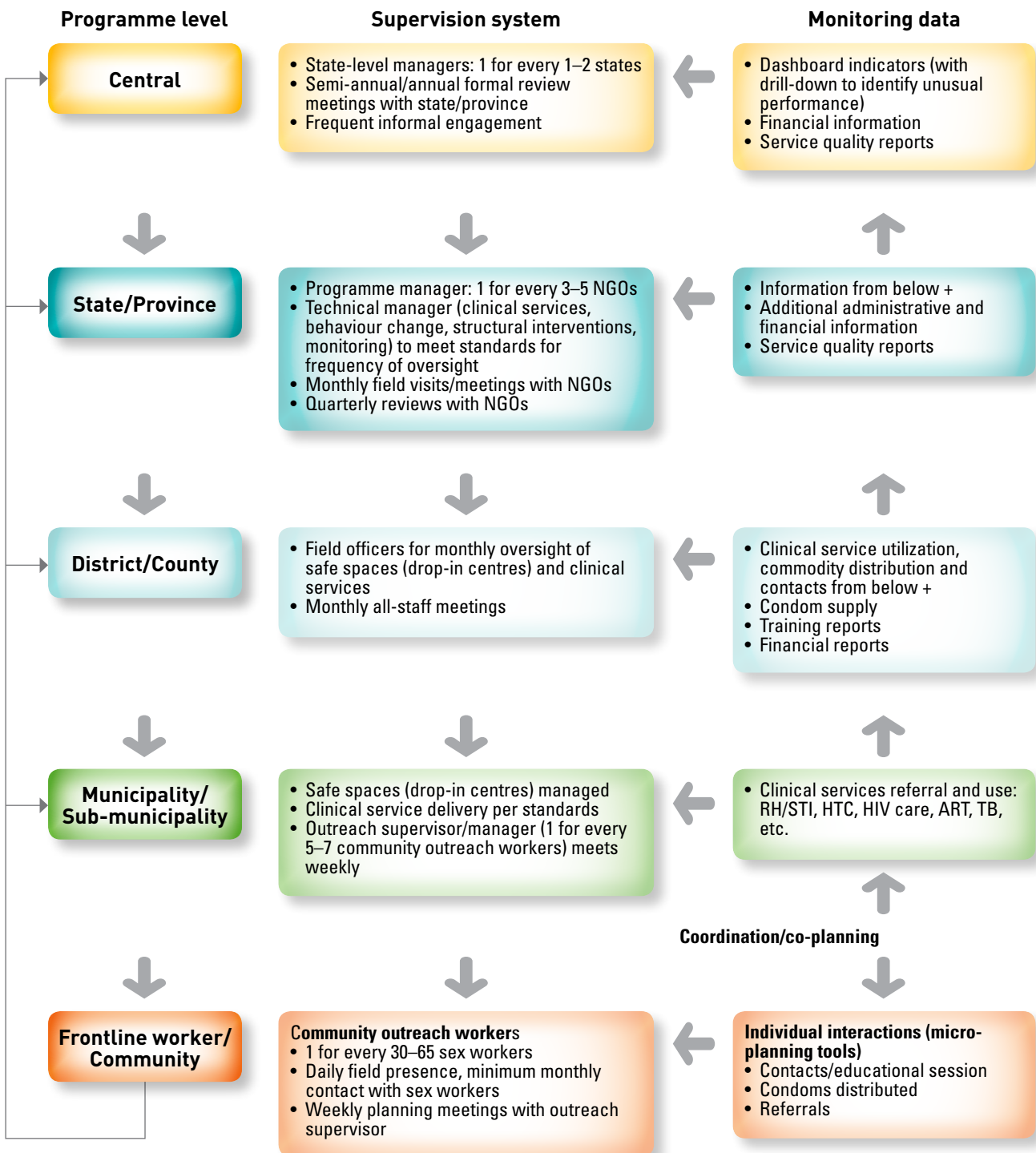
Over a period of three years, from April 2008 to March 2011, more than 18,000 individuals were identified as TB suspects from an estimated denominator of 300,000 and were referred to a TB diagnostic centre. Of these, 17% were diagnosed with TB.

depicted in Figure 6.6, along with the level of data that was used as part of the review. It should be noted that community committee meetings and regular supervision meetings between community outreach workers and their supervisors/managers are two ways in which qualitative as well as quantitative data about the programme may be gathered. This is an important part of the community empowerment process described in Chapter 1.

Further functions of supportive supervision include:

- motivating and training staff
- sharing guidelines
- monitoring and evaluating staff performance
- managing day-to-day challenges
- facilitating organizational support.

Figure 6.6 Supervision and monitoring system for a national HIV prevention and care programme with sex workers



6.2.8 Progressively ensure full sex worker participation

Sex worker programmes should be designed in such a way as to move from doing programmes *for* sex workers to doing them *with* sex workers, and ultimately to programmes done *by* sex workers. To accomplish this:

- Leadership by management at all levels should maintain a focus on the community empowerment component of the intervention just as much as the more technical components. This prioritization should be repeatedly articulated and given ongoing support.
- Capacity-building and mentoring of sex workers are necessary to provide them the tools, support and skills to increasingly deliver services, which results in better services and potentially increases the sustainability of the programmes (see Section 6.7 below, as well as Chapter 1, Section 1.2.2 and Chapter 3, Section 3.2).
- Human resource policies that define terms of reference for positions held by sex workers and clear advancement criteria are essential (see also Chapter 3, Section 3.2.2, part D).
- Management should explicitly address staff expectations and the processes of transferring responsibility from non-sex worker NGO staff to sex workers (see Chapter 1, Section 1.2.1).

6.3 Capacity-building/programme learning

In most settings, there is limited experience in sex worker interventions. Consequently, the capacity-building system also needs to recognize that not all implementing organizations have the same experience and background in sex worker programming. It is equally true for non-sex worker and sex worker staff that lack of experience does not mean lack of ability. Capacity of the non-sex worker and sex worker staff may be built through regular classroom training, field exposure, supervision/mentoring and interactive problem-solving sessions. Ideally, the training materials should be adapted or developed centrally to maintain quality of training and consistency with the minimum standards specified by the programme, and be based on an assessment of the capacity-building needs. Pre- and post-assessments are useful to monitor the quality of the trainings.

Box 6.7

Case example: Organizational and technical assessment of state government agencies and civil society organizations for HIV prevention services in Nigeria

Between October 2012 and April 2013 Nigeria's Strengthening HIV Prevention Services (SHiPS) project for most-at-risk populations undertook an organizational and technical assessment of State Agencies for the Control of HIV/AIDS (SACAs) and civil society organizations (CSOs) across selected states, to identify gaps to be addressed by capacity-building prior to scaling up HIV prevention services.

Two national tools were used to give a uniform and objective assessment: the National Harmonized Organizational and Capacity Assessment Tool (NHOCAT) for the SACAs, and the Partnership Assessment and Development Framework tool (PADEF) for the CSOs. A total of 11 SACAs and 62 CSOs were assessed. The empirical parameters in the PADEF were used to shortlist 37 CSOs as potential implementing partners for the scale-up; of these, 20 are currently engaged as implementing partners. Gaps in capacity identified in the NHOCAT and PADEF assessments were used to guide the development of a structured systems-strengthening programme for the SACAs in the SHiPS project states and the CSOs implementing the SHiPS project, with clear timelines and expected outcomes.

Sustained engagement through training, mentoring and coaching of SACAs, along with effective supportive supervision of the implementing CSOs, is gradually enhancing the ability of the CSOs to implement HIV programmes, and of the SACAs to coordinate them.

Non-sex worker staff: Training goals for non-sex worker programme staff include:

- acquainting the staff with the specifics of the project (e.g. intervention, reporting forms)
- building technical skills in new areas (e.g. examining for anal and oral STIs, counselling issues related to sex work)
- orienting staff to the issues of sex work and the overall goal of transferring skills and responsibilities to the sex worker community. This may require a change in staff members' attitudes toward sex workers (sexuality, morality of sex work, etc.).

Some approaches to capture programme lessons include:

- routine visits for programme managers to learn about local innovations and transfer lessons to other sites
- regularly scheduled programme reviews with several implementing organizations together; they may also be used for cross-sharing
- cross-site meetings of technical officers to share approaches
- formal revision of programme approaches, minimum standards, standard operating procedures and reporting forms.

Sex worker staff: The programme goal is to increasingly involve sex workers in the management of the programme and to capacitate them to address some of the environmental and structural constraints that inhibit preventive behaviour. Training objectives are to strengthen the capacity of the sex workers to do outreach, increasingly manage all aspects of outreach and to move into other staff positions in the programme, including management. This can be phased as basic and advanced training. More details can be found in Chapter 3, Section 3.2.2 part B.

Although non-sex worker staff and sex worker staff may differ in their types and levels of experience, wherever possible training should take place jointly so that all participants can learn from one another and bridge the gaps in their knowledge and skills in a collaborative manner.

6.4 Staff development

Several good practices have been articulated to ensure that staffing is optimal and that staff are motivated and satisfied by their work. These practices include:

- clear job descriptions and roles and responsibilities for all positions in the programme, including sex worker positions
- clear reporting lines showing to whom each person is accountable
- team-building and a culture of mentoring
- clear criteria for performance reviews
- clear policies on leave, travel reimbursement, and remuneration for work, including equitable policies for sex workers. Ideally, these should be uniform across a country
- opportunities for training for different positions in the organization, such as outreach supervisor, clinic assistant, nursing, counselling, social work, office manager.

Part II: Building the Capacity of Sex Worker Organizations

6.5 Introduction

Organizational capacity-building is a comprehensive approach to strengthening an organization's ability to plan, manage and finance itself so that it can implement its own vision and strategy, rather than only responding to the vision of donors. In the context of HIV prevention and more broadly, this approach is of particular importance to sex worker-led organizations, whether they are already established or come into being as a result of HIV prevention programming.

The development community has a long history of capacity-building.⁹ Early efforts generally aimed to help organizations manage the funds from a specific donor, or implement donor-supported technical programmes. Today, the approach to organizational capacity-building is to strengthen the organization as a whole, even where there is still a focus on improving the ability to implement a specific project. (In fact, capacity-building in the context of project implementation is generally more effective than organizational capacity-building in isolation, as it allows for practical application of the theoretical learning.)

Like other organizations, sex worker organizations face varying challenges to becoming stronger and more sustainable and benefit from different approaches. An established organization may have a better understanding of its community's needs and be better able to lead the process of capacity-building, whereas a recently formed organization may need more guidance. But certain principles apply to capacity-building in general. Support should be:

- **Comprehensive:** Acknowledging all the capacity-building needs of an organization allows for a more systematic approach and the opportunity to address all the essential needs.
- **Contextualized and customized:** The support should address the cultural, political and social settings and should also address the specific needs of the organization being strengthened.
- **Locally owned:** Those supporting capacity-building may understand the processes and can help identify needs. But if the organization is not making its own decisions, capacity-building efforts will not be as successful.
- **Readiness-based:** The type, level and amount of capacity-building should be based on the organization's ability to absorb and use what is being given.
- **Inward/outward-oriented:** While it is essential for an organization to ensure the health of its staff and internal structures, it is also important to remember that any organization is part of a larger community and needs to understand opportunities for partnership and the potential benefits from external links.
- **Sustainability-based:** Capacity-building should strengthen an organization's ability to maintain a resource base so that it may continue to function well.
- **Learning-focused:** An organization that does not continue to learn about its functions, beneficiaries, community, technical areas, etc. will become stagnant and cease to be relevant.

⁹ Although the term capacity-building is used here, "capacity development", "organizational development" or a number of other terms would serve equally well.

Box 6.8

The role of community empowerment in capacity-building

The role of capacity-building is to institutionalize support for sex workers and to further empower these groups to lead their own responses. This is important in two respects:

- Because many sex worker populations are migratory and those responsible for the interventions may not remain with the organization in the long term, creating an organizational structure provides consistency over time and processes to ensure that key people are replaced if they leave.
- Although community empowerment supported by others may involve communities making their own decisions, such organizations are still led by outsiders. Organizations led by sex workers are not beholden to external forces and will, therefore, be empowering by definition.

Note that not all sex worker groups will (or should) become independent organizations. It is up to each community of sex workers to define its own way forward. This may entail the development of a CBO or NGO, but some organizations may find it easier and more appropriate to continue to work through other organizations.

6.6 Forming a registered organization

Chapter 1, Section 1.2.3 describes some of the ways sex worker organizations or collectives may be formed. Such organizations are likely at first to be informal groupings that then create structures and processes in order to carry out a community-led agenda more effectively.

Depending on the organization's type, size and goals, as well as the country in which it is forming, it may decide to become a legally registered entity. The process to do this varies from country to country. It is important that the organization have a clear understanding of its expectations with respect to size, geographic reach, types of activities, etc. Mission and vision statements and a strategy statement or strategic plan help an organization to define these elements.

Most countries have NGO coordinating bodies that offer advice or guidance through the process of forming a formal organization. Networks of AIDS service organizations include the Asia Pacific Council of AIDS Service Organizations (APCASO) and the African Council of AIDS Service Organizations (AfriCASO). In individual countries, networks that cover all sectors, for example the Botswana Council of Non-Governmental Organizations (BOCONGO) and the Namibia NGO Forum (NANGOF), can also provide information.¹⁰ Sex worker-led organizations in neighbouring countries or regional networks of sex worker-led organizations can also often provide advice and support on dealing with registration and overcoming the barriers that face sex workers registering their own organizations.

The necessary registration materials must be obtained from the relevant government office. Precise requirements for documentation are set out by the government. Examples of the types of documentation required are:

- one of the following: memorandum of association, by-laws, constitution, charter, etc.
- report of annual activities

¹⁰ APCASO: www.apcaso.org
AfriCASO: www.africaso.net
BOCONGO: www.bocongo.org.bw
NANGOF: www.nangoftrust.org.na/

- financial reports/audit reports
- organizational resources
- organizational chart/staffing plan (and human resources manual, if available)
- board of directors and rules and regulations governing the board (board endorsement of registration is also needed)
- letters of support from key partners.

Some of these documents may not be available for organizations just starting up and may need to be developed. If the organization finds the requirements too complex or difficult to meet, it may be possible to register as a member of a network. This may be an appropriate intermediate step for a nascent organization on its way to registration, giving it the protection and support of the network as it grows and develops the materials needed for individual registration. The Global Network of Sex Work Projects (NSWP) does not require sex worker-led groups to be legally registered before applying for network membership and can provide links to other members who can provide support in building organizational capacity.¹¹

6.7 Organizational capacity-building

Capacity-building for sex worker organizations presents specific challenges:

- The stigma and issues around the legality of sex work.
- Sex worker organizations, if staffed exclusively by sex workers, may initially lack the full range of technical skills needed to function optimally.
- Staff members who continue to engage in sex work for economic or other reasons may not have enough time to prioritize their work for the organization.
- The mobility of sex workers may make it difficult to retain staff and maintain consistency within the organization.

To deal with missing skills, some organizations outsource certain functions, such as financial management, to businesses that provide this service. One way to mitigate the loss of staff is to have more people involved in organizational activities, so that there is a larger number with institutional memory. This is especially important for mentoring leadership to facilitate smooth transitions.

Organizations can also build their capacities in certain areas. A best practice is for an organization to undergo a capacity assessment. There are many tools for this, including self-assessments, although a good facilitated assessment helps an organization bring out issues it might not identify itself. The assessment provides the organization with a capacity-building plan to address the identified areas for improvement. Chapter 1, Section 1.2.6 describes issues of leadership and financial management, while Sections 6.2.2. and 6.2.3 above describe data monitoring and programme evaluation. Other areas that are also generally explored in an assessment and that are the most important for organizations to build capacity are discussed here.

¹¹ www.nswp.org

6.7.1 Governance

Good governance means the responsible management of an organization's strategic vision and resources. Transparency, accountability, effective management and rule of law are essential components of good governance and of an organization's ability to meet its mandate. Organizational assessments help organizations ensure the following, which are considered best practices in governance:

- clear vision and mission to drive the organization
- organizational structure that aligns with mission
- strong and active governing body (board) that helps guide and advocate
- participatory selection process for governing body and leadership
- defined processes for decision-making that engage and inform the membership
- community involvement in committees to oversee programmes.

It is important for an organization to have a clear vision. There are often many internal and external pressures on an organization to address issues that may not be within its real area of concern, and the vision allows it to stay focused on what it has identified as its core mission.

A board gives strategic direction, provides support in legal affairs, accounting, etc. and protects the organization. In the case of sex worker organizations, a board may include members with the connections and influence to advocate to reduce the stigmatization that sex workers face. A board may also help with fundraising. The size of a board is less important than the commitment of its members; they should be chosen based on their demonstrated commitment to the organization's cause and to helping to establish and grow the organization.

6.7.2 Project management

An organization's agenda is accomplished through concrete activities, often developed as programmes and projects. An organization is on the right track if it:

- develops and follows realistic workplans and budgets that are in line with its vision and mission
- defines technical interventions that are in line with local and international best practices
- ensures that its programmes and projects are responsive to the needs of its members.

Well-managed, technically sound projects and programmes not only ensure that organizational objectives are achieved, but also instil confidence in donors and key stakeholders about the competence of the organization.

6.7.3 Resource mobilization

Organizations should always be engaged in resource mobilization to fund efforts on a long-term basis. It is important that the organization be strategic and look beyond the short term, especially if it is currently benefitting from a grant that will end after several years. While there is no guarantee that an organization will be able to raise money, there are best practices that may help an organization do so. Important issues to consider with respect to resource mobilization include:

- Is the resource mobilization strategy in line with the organization's vision and mission?
- Can resources be raised from members of the organization, i.e. through a small monthly or annual

membership fee? This increases a sense of ownership, but the sum should not be so high as to exclude sex workers from joining.

- Are there government schemes that may be able to fund specific activities or programmes?

6.7.4 Networking

Developing a strong, successful sex worker organization is as much about relationships as it is about systems. Networking involves donors, communities, government at both national and local levels, service providers and NGO networks. Some of the functions of networking are ensuring human rights, securing comprehensive services for beneficiaries and developing relationships with donors (see Box 6.9 and also Chapter 1, Section 1.2.8).

Two areas of networking that are especially important for sex worker organizations are engagement with the state, e.g. politicians, police, health and social entitlement programmes; and engagement with non-state organizations and institutions.

Engagement with the state

- This is particularly important to enable sex worker programmes to advocate for access to health services, freedom from discrimination and harassment, protection from and redress for violence, and securing rights and entitlements as citizens.
- A partner organization working with the sex worker organization on capacity-building may have the connections to place members of community-led groups on committees that oversee health programmes, or provide access to politicians and other officials.
- Capacity-building may help sex workers unfamiliar with the structure of formal meetings, or the protocol for dealing with officials, learn how to participate and engage effectively.

Box 6.9

Case example: Direct engagement by the community with the government in India

In India in 2010, representatives of sex worker collectives and community groups representing the transgender community, men who have sex with men and people who inject drugs were invited to give presentations to a consultation meeting of the country's Planning Commission, which formulates the Government of India's five-year plans. Their access to this high-level government body through its Civil Society Window Initiative was facilitated by the Centre for Advocacy Research, a nongovernmental organization that was working with the community groups on advocacy issues.

The representatives, who came from seven Indian states, talked about the challenges they faced in accessing government schemes and social entitlements, and presented recommendations for improved access to services including health, pensions, education and livelihood options. The following year these recommendations were incorporated in the Planning Commission's Approach Paper to the 12th Five Year Plan. The paper called for targeted programmes for communities that suffer discrimination because of their social and cultural identity, including sex workers and lesbian, gay, bisexual and transgender individuals.

The testimony of the community groups to the Planning Commission helped boost their credibility with the government as advocates and opened doors for them to engage in policy dialogue with government agencies responsible for women's and children's development, rural livelihoods and legal services. Following state-level consultations, government departments were poised in September 2013 to issue new regulations facilitating access to social benefits for sex workers, men who have sex with men and transgendered persons.

Engagement with non-state organizations and institutions

This includes:

- other CBOs/NGOs or community-led organizations of sex workers
- religious and other community groups
- media
- other CBOs/NGOs working on related areas (social entitlements, rights, violence, health, etc.).

Capacity-building helps sex worker organizations analyse the significance of socially powerful groups or institutions, such as religious groups and the media, and learn how to engage and influence them. Examples include changing a church's focus from condemning sex work to respect for people with HIV, or encouraging newspapers to report positively and accurately about sex workers' efforts to reduce HIV infection.

Box 6.10

Case example: Sex worker networks

Once sex worker collectives form, they can integrate with regional, national and global sex worker networks. For example, Karnataka Health Promotion Trust in India uses a "federal" model of governance in which local sex worker collectives form sub-district, district and state committees to increase the negotiating power of sex worker collectives at multiple levels. The Asia Pacific Network of Sex Workers connects sex worker projects from across the entire region. The Global Network of Sex Work Projects has representation from sex worker organizations across the world.

6.8 Resources and further reading

Strategic planning and programme management

1. *Planning guide for the health sector response to HIV/AIDS*. Geneva: World Health Organization, 2011. http://whqlibdoc.who.int/publications/2011/9789241502535_eng.pdf
2. *Planning and Managing for HIV/AIDS Results: A Handbook*. Washington, DC: Global AIDS Monitoring and Evaluation Team (GAMET), World Bank Global HIV/AIDS Program, 2007. http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/Results_Handbook_31Oct2007.pdf
3. *Guide to the strategic planning process for a national response to HIV/AIDS*. Geneva: United Nations Joint Programme on HIV/AIDS, 1998. http://data.unaids.org/publications/IRC-pub05/jc441-stratplan-intro_en.pdf
4. *Practical guidance for scaling up health service innovations*. Geneva: World Health Organization and ExpandNet, 2009. http://www.expandnet.net/PDFs/WHO_ExpandNet_Practical_Guide_published.pdf
5. *Nine steps for developing a scaling-up strategy*. Geneva: World Health Organization and ExpandNet, 2010. http://whqlibdoc.who.int/publications/2010/9789241500319_eng.pdf
6. *A Commodity Management Planning Guide for the Scale-Up of HIV Counseling and Testing Services*. Arlington, VA: Management Sciences for Health, 2008. http://www.msh.org/sites/msh.org/files/HIV-Testing-Commodity-Guide-VCT_final.pdf
7. *Management and Organizational Sustainability Tool (MOST): A Guide for Users and Facilitators, Second edition*. Cambridge, MA: Management Sciences for Health, 2004. <http://www.msh.org/resources/management-and-organizational-sustainability-tool-most>

8. *National Guidelines for Implementation of HIV Prevention Programs for Female Sex Workers in Nigeria*. National AIDS Control Agency, Government of Nigeria, 2013.
http://naca.gov.ng/index2.php?option=com_docman&task=doc_view&gid=152&Itemid=268

Defining programme logic model, implementation components and standards

1. *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach*. Geneva: WHO, UNFPA, UNAIDS, NSWP, 2012.
http://apps.who.int/iris/bitstream/10665/77745/1/9789241504744_eng.pdf
2. *A Systematic Approach to the Design and Scale-up of Targeted Interventions for HIV Prevention among Urban Female Sex Workers*. Bangalore, India: Karnataka Health Promotion Trust, University of Manitoba, World Bank, 2012.
<http://www.khpt.org/reports%20pdf/A%20Systematic%20Approach%20to%20the%20Design%20and%20Scale-Up%20of%20Targeted%20Interventions%20for%20HIV%20Prevention,%20full%20version.pdf>
3. *UNAIDS guidance note on HIV and sex work*. Geneva: Joint United Nations Programme on HIV/AIDS, 2012.
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2009/JC2306_UNAIDS-guidance-note-HIV-sex-work_en.pdf
4. *Guidelines on estimating the size of populations most at risk to HIV*. Geneva: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 2010.
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/2011_estimating_populations_en.pdf
5. *PLACE—Priorities for Local AIDS Control Efforts: A Manual for Implementing the PLACE Method*. Chapel Hill, NC: MEASURE Evaluation, 2005.
<http://www.cpc.unc.edu/measure/publications/ms-05-13>
6. *Clinic Operational Guidelines & Standards: Comprehensive STI Services for Sex workers in Avahan-Supported Clinics in India*. New Delhi: Family Health International [no date].
<https://www.indiahiv.org/Documents/Avahan%20COGS.pdf>
7. *Using Logic Models to Bring Together Planning, Evaluation, and Action: Logic Model Development Guide*. Battle Creek, MI: W.K. Kellogg Foundation, 2004.
<http://www.wkkf.org/knowledge-center/resources/2006/02/wk-kellogg-foundation-logic-model-development-guide.aspx>

Routine programme monitoring system

1. *Technical Guide for Countries to Programme, Monitor and Set Targets for HIV Prevention, Treatment and Care for Sex Workers, Men who Have Sex with Men and Transgender People*. Geneva: World Health Organization, 2013. In press.
http://www.who.int/hiv/pub/guidelines/targets_key_populations/
2. *Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People. Volume 1: National and Sub-National Levels*. Chapel Hill, NC: MEASURE Evaluation, 2013.
<http://www.cpc.unc.edu/measure/publications/ms-11-49a>
3. *Toolkit for monitoring and evaluation of interventions for sex workers*. World Health Organization South-East Asia and Western Pacific Regions, 2009.
http://www.aidsdatahub.org/dmdocuments/ToolKit_M_E_SW.pdf
4. *National AIDS Programmes: A Guide to Monitoring and Evaluation*. Geneva: Joint United Nations Programme on HIV/AIDS, 2000.
https://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub05/jc427-mon_ev_full_en.pdf
5. *A Guide to Monitoring and Evaluation of Capacity-Building Interventions in the Health Sector in Developing Countries. MEASURE Evaluation Manual Series, No.7*. Chapel Hill, NC: Carolina Population Center, University of North Carolina at Chapel Hill, 2003.
http://www.aidstar-two.org/Tools-Database.cfm?action=detail&id=86&language_id=
6. *Monitoring and Evaluation Systems Strengthening Tool*. Developed by the Global Fund, PEPFAR, USAID, and others. Published through the USAID Measure Evaluation Project, 2007.
<http://www.cpc.unc.edu/measure/publications/ms-07-18>

6 Programme Management and Organizational Capacity-building

Supervision system

1. *STI Clinic Supervisory Handbook, Comprehensive STI services for Sex Workers in Avahan-Supported Clinics in India*. New Delhi: Family Health International [no date].
http://www.aidsdatahub.org/dmdocuments/STI_Clinic_Supervisory_Handbook.pdf.pdf
2. *Making Supervision Supportive and Sustainable: New Approaches to Old Problems*. Washington, DC: Maximizing Access and Quality Initiative, 2002.
<http://www.k4health.org/sites/default/files/maqpaperonsupervision.pdf>
3. *Supportive Supervision to Improve Integrated Primary Health Care*. Cambridge, MA: Management Sciences for Health, 2006.
<http://www1.msh.org/Documents/OccasionalPapers/upload/Supportive-Supervision-to-Improve-Primary-Health-Care.pdf>
4. *Supportive Supervision to Improve Integrated Primary Health Care*. Cambridge, MA: Management Sciences for Health, 2010.
<http://www1.msh.org/Documents/OccasionalPapers/upload/Supportive-Supervision-to-Improve-Primary-Health-Care.pdf>

Evaluation

1. *Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People*. Measure Evaluation, North Carolina, 2013.
 - a. *Volume I: National and Sub-National Levels*.
<http://www.cpc.unc.edu/measure/publications/ms-11-49a>
 - b. *Volume II: Service Delivery Providers*. In press.
2. *Behavioral Surveillance Surveys: Guidelines for Repeated Behavioral Surveys in Populations at Risk of HIV*. Arlington, VA: Family Health International, 2000.
http://www.who.int/hiv/strategic/en/bss_fhi2000.pdf
3. *Guidelines on surveillance among populations most at risk for HIV*. Geneva: UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, 2011.
http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2011/20110518_Surveillance_among_most_at_risk.pdf

Organizational capacity-building

1. *Community Mobilization of Female Sex Workers. Module 2: A Strategic Approach to Empower Female Sex Workers in Karnataka*. Bangalore, India: Karnataka Health Promotion Trust, 2008.
http://www.khpt.org/Community_Mobilization.pdf
2. *Managers Who Lead: A Handbook for Improving Health Services*. Cambridge, MA: Management Sciences for Health, 2005.
<http://www.msh.org/sites/msh.org/files/mwl-2008-edition.pdf>
3. *Health Systems in Action: An eHandbook for Leaders and Managers*. Cambridge, MA: Management Sciences for Health, 2010.
<http://www.msh.org/resources/health-systems-in-action-an-e-handbook-for-leaders-and-managers>
4. *Systematic Organizational Capacity Building: Tackling Planning and Implementation Challenges*. Cambridge, MA: Management Sciences for Health, 2011.
www.aidstar-two.org/upload/AS2_Tech-Brief3.pdf
5. *Organizational Capacity Building Framework: A Foundation for Stronger, More Sustainable HIV/AIDS Programs, Organizations & Networks*. Cambridge, MA: Management Sciences for Health, 2011.
www.aidstar-two.org/upload/AS2_TechnicalBrief-2_4-Jan-2011.pdf
6. *Challenges Encountered in Capacity Building: A Review of Literature and Selected Tools*. Cambridge, MA: Management Sciences for Health, 2010.
www.aidstar-two.org/Focus-Areas/upload/AS2_TechnicalBrief_1.pdf

Further reading

1. Blanchard JF, Bhattacharjee P, Kumaran S, et al. Concepts and strategies for scaling up focused prevention for sex workers in India. *Sexually Transmitted Infections*, 2008; 84:ii9–ii23.
http://sti.bmj.com/cgi/content/abstract/84/Suppl_2/ii19
2. Chandrashekar S, Guinness L, Kumaranayake L, et al. The effects of scale on the costs of targeted HIV prevention interventions among female and male sex workers, men who have sex with men, and transgenders in India. *Sexually Transmitted Infections*, 2010; 86:i89–i94.
http://sti.bmj.com/content/86/Suppl_1/i89.full.pdf
3. Chandrashekar S, Vassall A, Reddy B, et al. The costs of HIV prevention for different target populations in Mumbai, Thane and Bangalore. *BMC Public Health*, 2011; 11(Suppl 6):S7.
<http://www.biomedcentral.com/content/pdf/1471-2458-11-S6-S7.pdf>
4. Chandrasekaran P, Dallabetta G, Loo V, et al. Evaluation design for large-scale HIV prevention programs: the case of Avahan, the India AIDS Initiative. *AIDS*, 2008; 22(Suppl 5):S1–S15.
<http://www.aidsonline.com/pt/re/aids/abstract.00002030-200812005-00001.htm>
5. Kerrigan D, Wirtz, A, Baral S, et al. *The Global HIV Epidemics among Sex Workers*. Washington, DC: World Bank, 2013.
<http://www.worldbank.org/content/dam/Worldbank/document/GlobalHIVEpidemicsAmongSexWorkers.pdf>
6. Schwartländer B, Stover J, Hallett T, et al. Towards an improved investment approach for an effective response to HIV/AIDS. *The Lancet*, 2011; 377:2031–2041.
<http://www.sciencedirect.com/science/article/pii/S0140673611607022>
7. Semini I, Batona G, Lafrance C, et al. Implementing for results: program analysis of the HIV/STI interventions for sex workers in Benin. *AIDS Care*, 2013; 25(Suppl 1):S30–S39.
<http://www.tandfonline.com/doi/pdf/10.1080/09540121.2013.784392>
8. Shahmanesh M, Patel V, Mabey D, et al. Effectiveness of interventions for the prevention of HIV and other sexually transmitted infections in female sex workers in resource poor setting: a systematic review. *Tropical Medicine and International Health*, 2008; 13:659–679.
<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-3156.2008.02040.x/pdf>
9. Verma R, Shekhar A, Khobragade S, et al. Scale-up and coverage of Avahan: a large-scale HIV-prevention program among female sex workers and men who have sex with men in four Indian states. *Sexually Transmitted Infections*, 2010; 86:i76–i82.
http://sti.bmj.com/content/86/Suppl_1/i76.full.pdf



Notes

A series of horizontal dotted lines for writing notes.



For more information, contact:

World Health Organization
20, avenue Appia
CH-1211 Geneva 27
Switzerland

ISBN 978 92 4 150618 2

