

SEX WORK & HIV

Asia-Pacific Regional Data Overview



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With the exception of Thailand, adult HIV prevalence in all Asian countries is below 1%, with a regional average between 0.2-0.3%.¹ However, Asia's comparatively low prevalence translates into a substantial portion of the global HIV burden,¹ given that 4.2 billion people (55% of the world's population)² reside in the region. In 2012, there were an estimated 4.9 million people living with AIDS in the Asia Pacific.³ Epidemic trends vary both between and within countries, with emerging epidemics in Indonesia, Pakistan and the Philippines, while new infections are declining in Cambodia, India, Myanmar, Nepal, Papua New Guinea, and Thailand.³ Although the overall HIV prevalence is low, it has risen sharply among key populations at higher risk, including female sex workers and their clients, men who have sex with men and people who inject drugs.

Asia's sex industry is rapidly expanding and changing in some countries, threatening programmatic efforts to control the region's HIV epidemic, although national HIV prevalence rates are declining in large and populous countries like India, Myanmar and Thailand and being kept low in Bangladesh, China and Nepal. Changes in economic conditions, income disparities, the rural-urban differential, disasters and conflicts all influence the size of the sex worker populations and the number of clients.

This Regional Data Overview presents regional data on sex work that is available as it pertains to HIV epidemiology, risk behaviours and vulnerability factors.

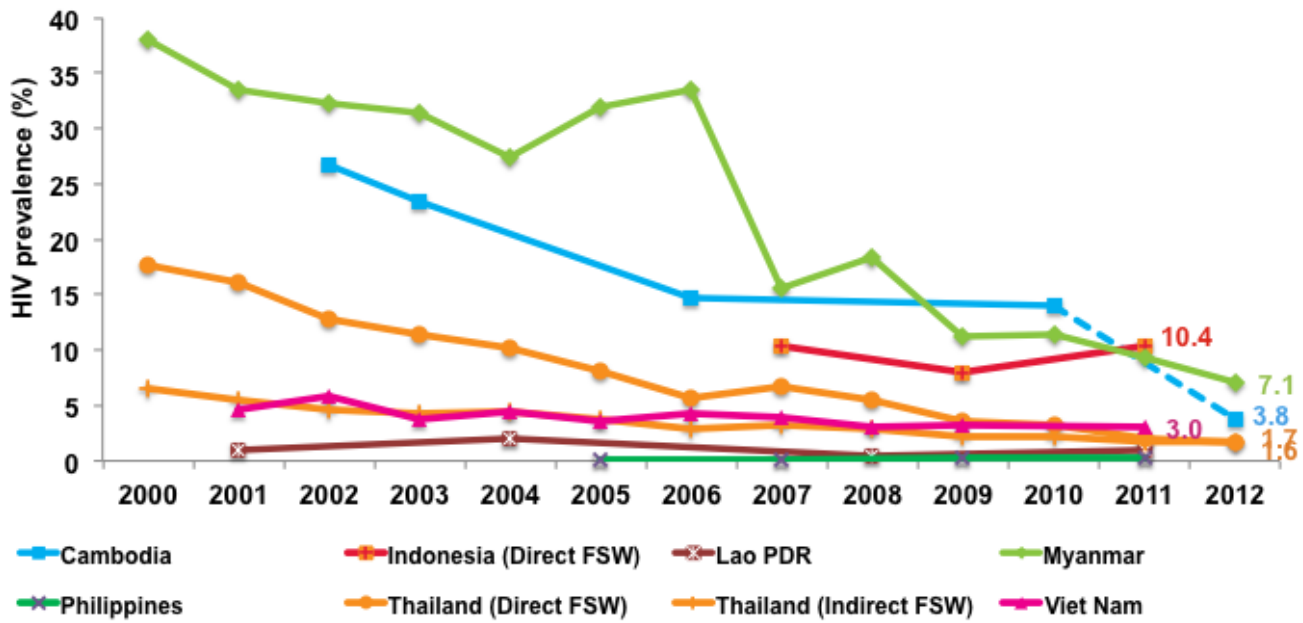
Commercial sex is the primary mode of HIV transmission in many Asian countries: where more people engage in commercial sex than in any other high-risk behaviour.^{4,5} An estimated 0.5%⁶-15%⁷ of men pay for sex across the region. These men are one of the key determinants in both the spread and magnitude of HIV epidemics in the region, since they are the biggest single group that transmits HIV to their intimate partners.⁸

Female sex workers

Sex workers are at a high risk of HIV infection due to risk factors directly associated with sex work, as well as vulnerabilities associated with the circumstances surrounding sex work. HIV prevalence among sex workers is highly variable both between and within countries in Asia and the Pacific.

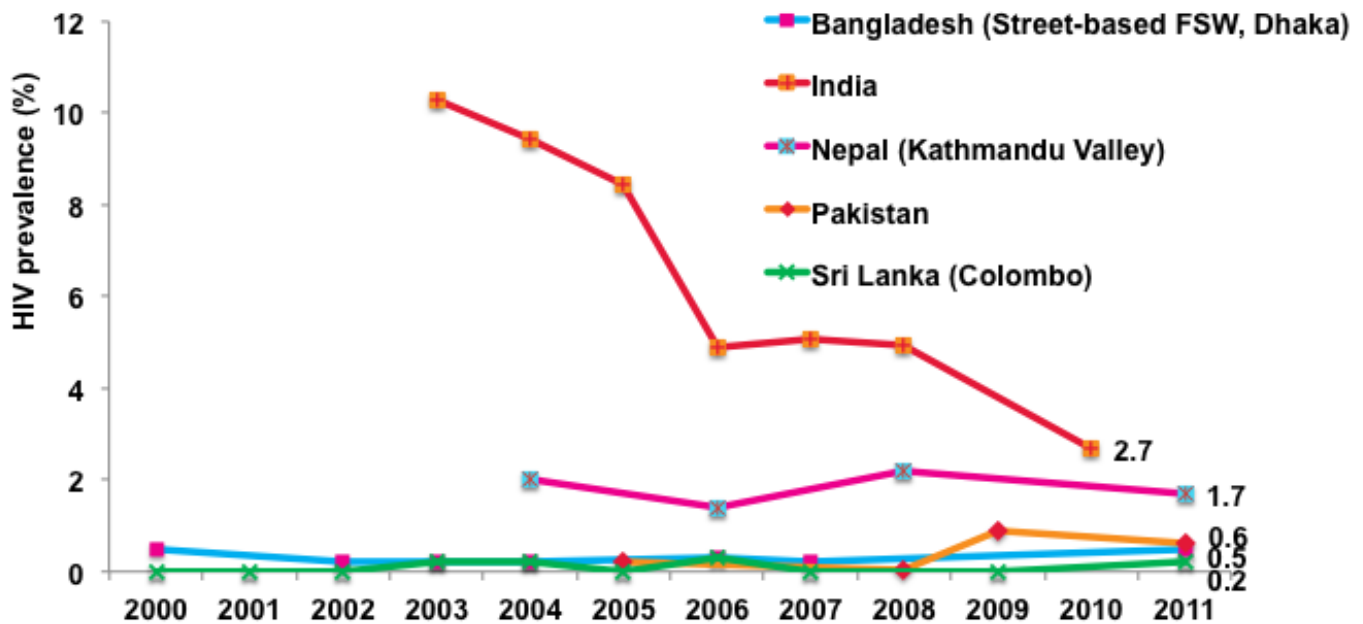
Most recent surveys across the region show that HIV was not detected among female sex workers in Fiji, the Maldives and Mongolia between 2008 and 2012. As shown in Figure 1, prevalence in other countries is as high as 7.1% (Myanmar).

Figure 1. HIV prevalence among female sex workers in selected South-East Asian countries, 2000-2012



Source: Prepared by HIV and AIDS Data Hub for Asia and the Pacific based on 1) Integrated Biological and Behavioural Surveys; 2) HIV Sentinel Surveillance Surveys; 3) www.aidsinfoonline.org

Figure 2. HIV prevalence among female sex workers in selected South Asian countries, 2000-2012

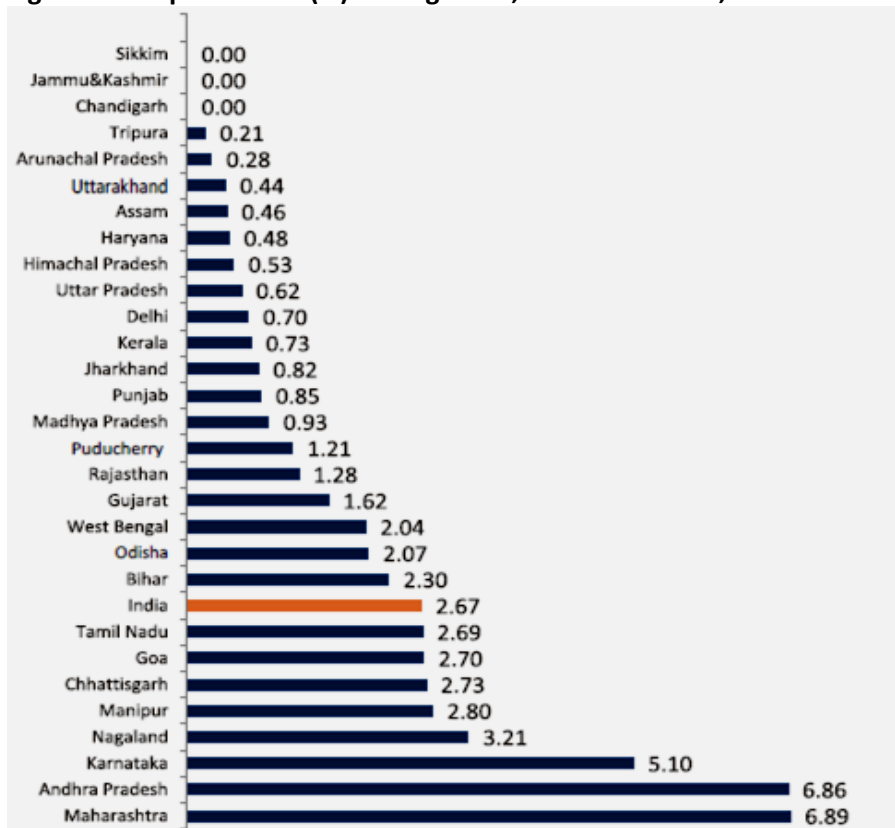


Source: Prepared by HIV and AIDS Data Hub for Asia and the Pacific based on 1) Integrated Biological and Behavioural Surveys; 2) HIV Sentinel Surveillance Surveys; 3) www.aidsinfoonline.org

Within countries, HIV prevalence also varies between different regions or cities. For instance, the estimated 2011 adult HIV prevalence was 0.27% in India, while the nation-wide HIV prevalence among female sex workers was reported as

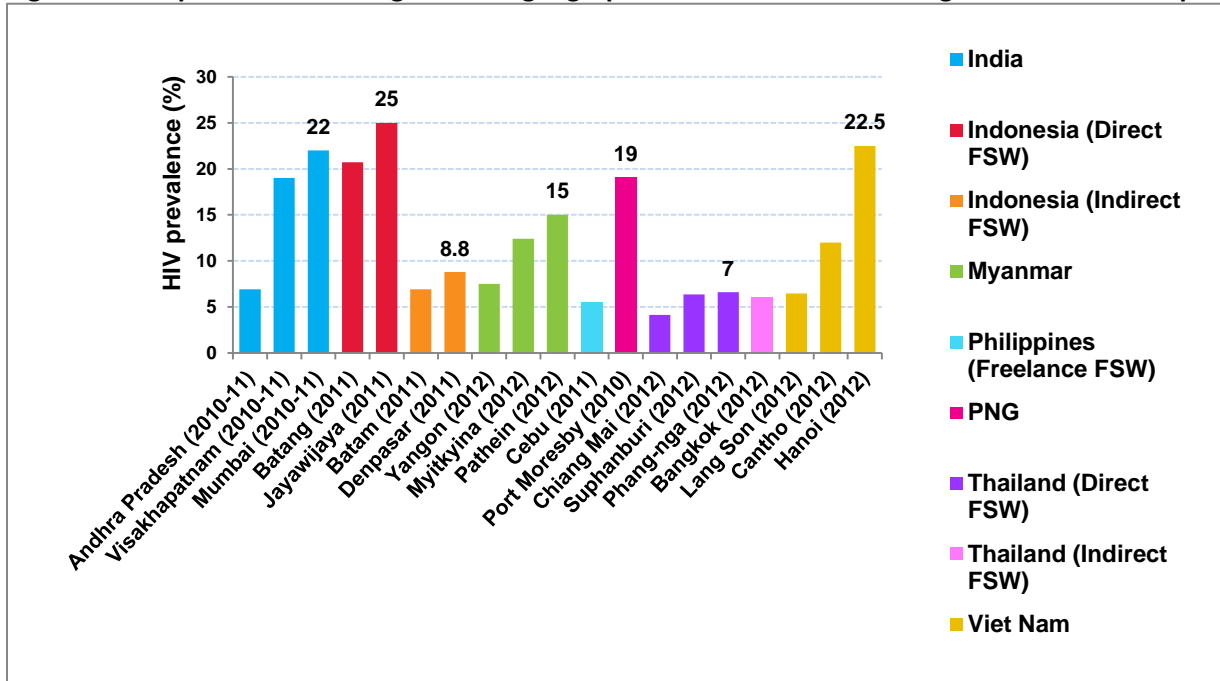
2.67%—reduced from 4.9% in 2008-2009 and differing widely by state. HIV prevalence was below 5% in 27 states and over 5% in three states for this key population (see Fig. 3).^{9,10} In Indonesia, the national HIV prevalence among direct FSWs is 10.4% on average, but there are pockets of higher prevalence, such as 25% in Jayawijaya.¹¹

Figure 3. HIV prevalence (%) among FSWs, India and states, 2010-2011¹²



Source: National AIDS Control Organisation India. HIV Sentinel Surveillance 2010-2011: Technical Brief

Figure 4. HIV prevalence among FSWs in geographical locations that are higher than national prevalence, 2010-2012



Source: Prepared by

HIV and AIDS Data Hub for Asia and the Pacific, based on 1) Integrated Biological and Behavioural Surveys; 2) HIV Sentinel Surveillance Surveys; 3) www.aidsinfoonline.org

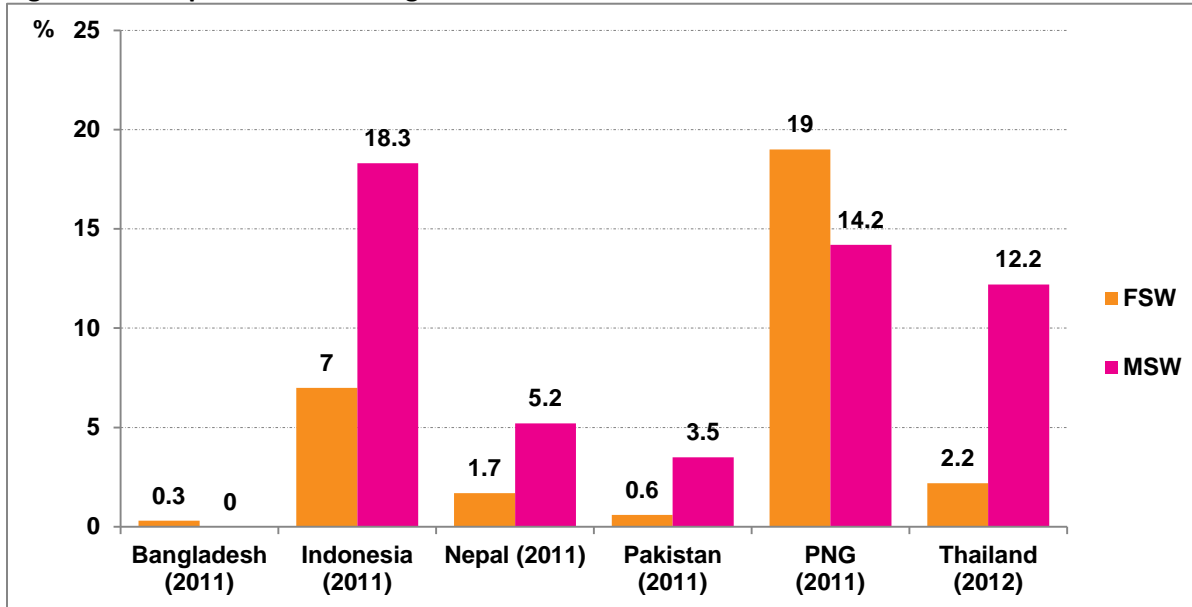
Given the significant variations in prevalence among sex workers within their borders, countries have started to prioritize geographically. For example, India and Nepal have used epidemiological zones to focus resources and programming.

Throughout the region, there has been a shift away from brothel-based sex work towards more indirect forms—taking place in restaurants, tea houses, cafés, hotels, street, homes and vehicles. A major reason for this is that a vast majority of countries in Asia and the Pacific criminalize soliciting.¹³

Male sex workers

HIV prevalence is also high among male sex workers (MSWs), and indeed in several countries in the region, it is more than twice that of the prevalence among FSWs (Fig. 5). For instance, HIV prevalence among Indonesian male sex workers was 18.3% compared to 7% for female sex workers in 2011, and 12.2% compared to 2.2% in Thailand (in 2012).^{11;14}

Figure 5. HIV prevalence among male sex workers versus female sex workers in selected countries, 2011-2012¹⁵



Source: Prepared by HIV and AIDS Data Hub for Asia and the Pacific, based on 1) Integrated Biological and Behavioral Surveys; 2) HIV Sentinel Surveillance Surveys; 3) www.aidsinfoonline.org

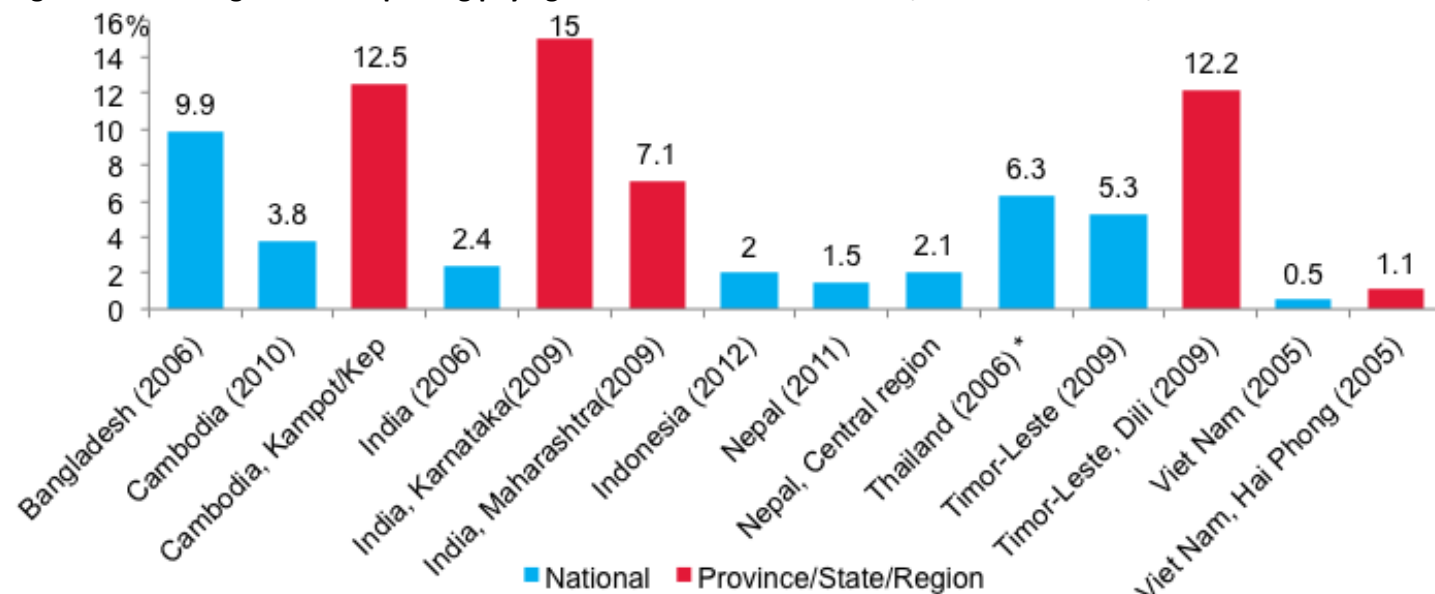
Transsexual/transgender sex workers

Several Asian and Pacific countries have transgender and transsexual communities that are unique and prominent enough to be regarded as separate risk groups from the population of men who have sex with men. A global review of available data found that transgender women are 49 times more likely to be living with HIV than other women, with a pooled HIV prevalence among transgender women of 19%.¹⁶ In South Asia (particularly Bangladesh, India and Pakistan), the term *hijra* is used for transgender people. In South-East Asia (particularly in Indonesia), transgender people are known as the *warias* and, in Malaysia, as *maknyahs*. Available data indicates that only a certain proportion of transsexual and transgender people are sex workers. Regionally, about seven countries have some population size estimates for transgender populations, but only Fiji and Malaysia have estimates of transgender sex workers. Only Fiji, India, Pakistan and Papua New Guinea capture transgender sex workers as part of surveyed populations in HIV seroprevalence surveys. In addition, there is an alarming lack of information and evidence related to HIV incidence in these communities.¹⁷

Clients of sex workers

Men who buy sex from women are the largest population group at risk of contracting HIV in Asia and the Pacific—outnumbering people who inject drugs and men who have sex with men.¹⁸ The Commission on AIDS in Asia estimated that up to 10 million Asian women sell sex to at least 75 million men. Clients of sex workers represent massive populations in the region: 37 million men in China, 30 million men in India and more than three million men in Indonesia.⁴ Client turnover ranges between two clients a day in Sri Lanka and Thailand to almost 10 clients a week in India and Myanmar.¹⁹ Figure 6 shows the percentage of men in selected countries in the region who report having paid for sex in the last 12 months – the highest proportion being among men in Karnataka, India, at 15%.

Figure 6. Percentage of men reporting paying for sex in the last 12 months, selected countries, 2003-2010



Sources: HIV and AIDS Data Hub for Asia and the Pacific, Review in Slides, Men at Higher Risk based on 1. FHI, ICDDR B & USAID. (2006). Assessment of Sexual Behaviour of Men in Bangladesh: A Methodological Experiment; 2.India, NBSS-General Population (2006) and BBS in 6 states (2009) cited in National AIDS Control Organisation India. (2010). UNGASS Country Progress Report: India; 3. Demographic and Health Surveys 5. *Thailand represents age adjusted data from National Sexual Behavior Survey (2006)

Clients of sex workers are often profiled as men who have disposable income and longer periods of time away from home, in social environments where it is acceptable to frequent red light areas or establishments that provide sexual services.²⁰ Furthermore, young single men are more likely to buy sex, although older men may have the financial means to afford multiple partners. Sex workers in southern Viet Nam reported that at least 37% of their clients were businessmen and white-collar workers; in five northern Vietnamese provinces, over half were said to be Government officials. Similar findings were recorded in Indonesia, Lao People’s Democratic Republic and Pakistan.²⁰ But the sectors with the highest numbers of clients of sex workers include fisheries, mining, transport, agriculture and the armed forces.¹⁸ Table 2 shows the range of high-risk occupation groups typically used as proxies for clients of female sex workers together with the percentage of them reporting having paid for sex.

Table 2. Males in high-risk occupational groups who reported commercial sex in last year, selected countries and cities, 2004-2012	Group	Percentage (%)	Year
Afghanistan	Long-distance truckers (ever)	29	2012
Bhutan	Military Personnel	0.1	2006
Cambodia	Moto-taxi drivers	34	2010
Fiji	Uniformed personnel	11	2008
	STI clinic attendees	7	2008
	Tertiary students	9	2008
India	Truck drivers	2.6	2011

Indonesia	Seafarers, dock workers, truck drivers and moto-taxi drivers	23	2011
Lao PDR (Champassak)	Electricity workers	41	2008
Lao PDR (Luang Prabang)		63	
Lao PDR (Savannakhet)		52	
Lao PDR (Vientiane)		50	
Maldives	Sea farers	6	2008
	Resort workers	4	
	Construction workers	2	
Mongolia	Male STI clinic attendees	9.3	2007
	Mobile men	12.9	
Nepal	Truckers	48.2	2009
Pakistan (Balochistan)	Mine workers	8	2011
Sri Lanka	Military personnel	11	2008
Timor-Leste	Uniformed personnel	34	

Source: HIV and AIDS Data Hub for Asia and the Pacific, Review in Slides, Men at Higher Risk. www.aidsdatahub.org

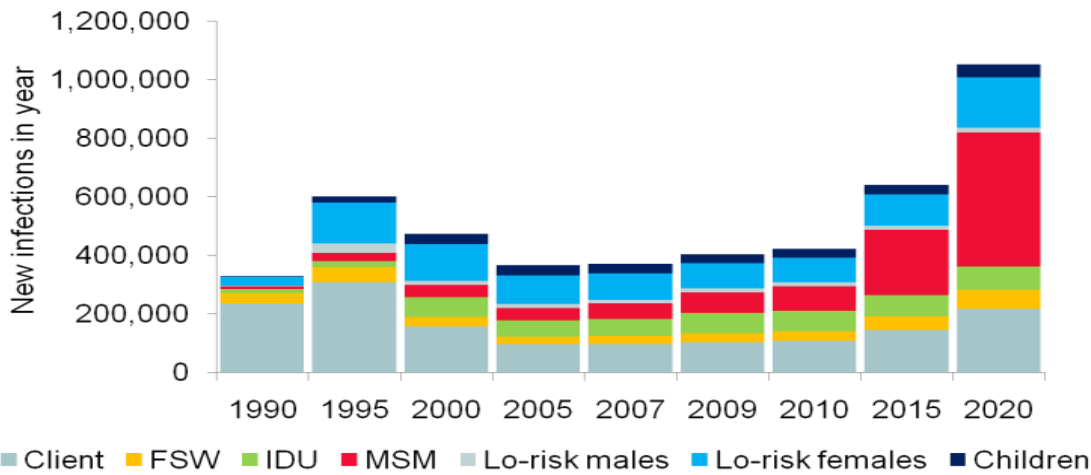
HIV prevalence among clients of sex workers is often captured in HIV surveillance among males whose occupations are known to frequent sex workers. Each country has its own — common clients of sex workers (such as truckers in India, seafarers in the Philippines, Sri Lanka, Thailand, etc.). HIV prevalence is also quite wide-ranging: the prevalence among truck drivers in India is between 1.9 and 6.8%,²¹ while it is 1.1% in Thailand among seafarers.²² Even in groups of clients where HIV is low or has not yet been detected, clients remain vulnerable given their risk-taking behaviours in commercial sex.

Risk behaviours

Condom use

Condom use is directly associated with accessibility (price and availability) and clients' preferences. While female sex workers reported a regional median of 80% condom use at last sex with clients, usage rates among male sex workers are half this number,³ which indicates lack of focused condom programming among male sex workers. Countries where female sex workers report high levels of consistent condoms use (for example Cambodia and Thailand) have turned their epidemics around.³ Throughout the region, women are increasingly being infected by heterosexual contact via their regular male partners who themselves engage in high-risk behaviours, including drug use and paid sex. Male clients of female sex workers are an important bridge population between key populations at higher risk and the general population. While it is projected that the proportion of new infections will rise among female sex workers in the coming years, the number of clients of female sex workers and low-risk females (including spouses and intimate partners of clients of sex workers and injecting drug users) will be the groups accounting for the most number of new HIV infections in 2020, after men who have sex with men (Fig. 7).²³

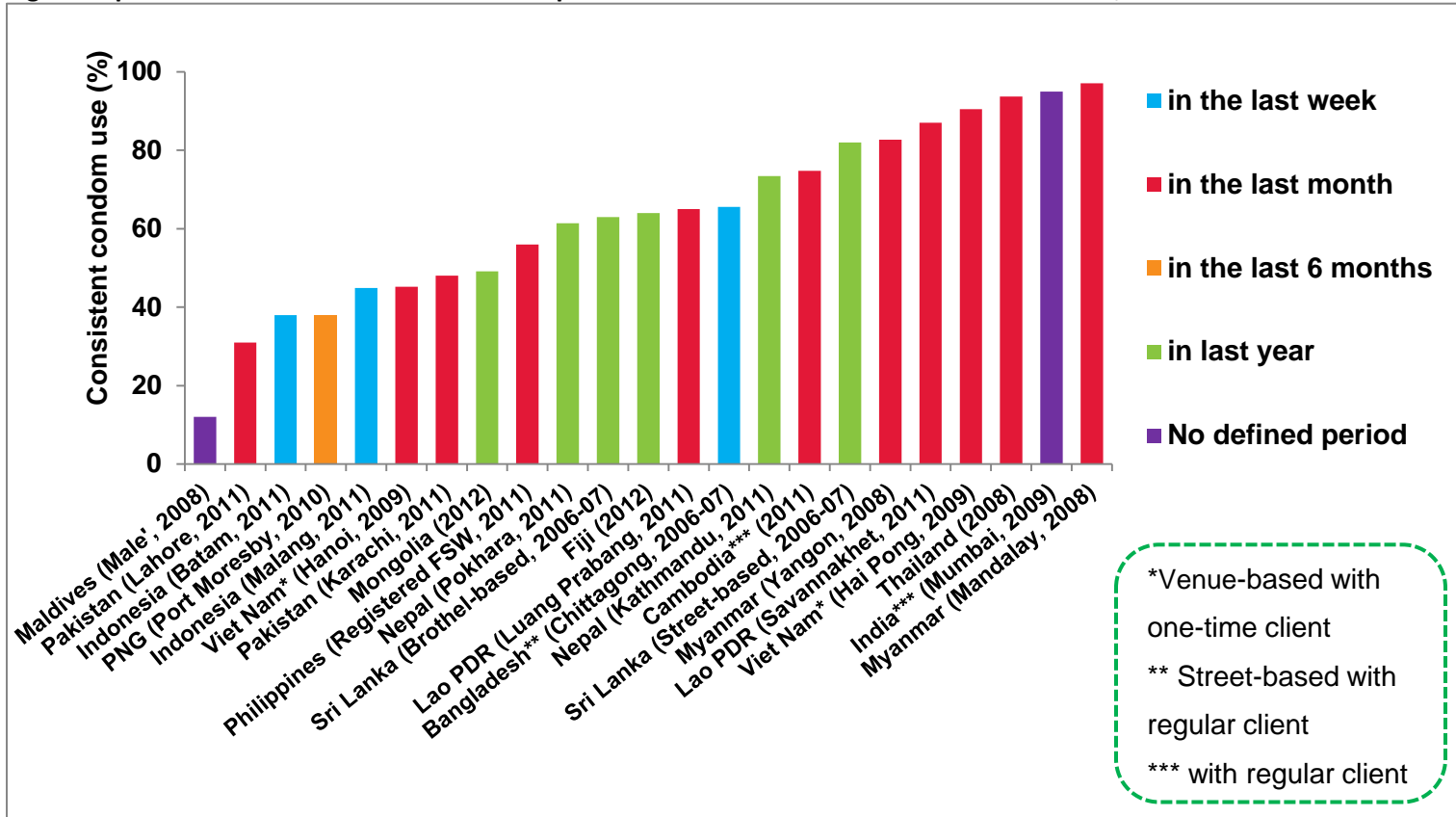
Figure 7. Projected incidence distribution among population groups, 1990-2020



Source: HIV and AIDS Data Hub for Asia and the Pacific, Review in Slides. Key affected populations. Based on P.Rao presentation in ICAAP, Bali, August 2009.

Condom use is the most effective strategy to prevent HIV transmission among sex workers. While the earlier programmes focused on condom use alone, the more recent strategies emphasize consistent condom use. Countries seeing a declining epidemic show consistent condom use among clients (such as India, Myanmar and Thailand; see Fig 8). Unfortunately, critical data like this are not reported uniformly, nor regularly available across countries. Where data are available, there is evidence that sex workers' consistent condom use is extremely varied between their clients and their intimate partners. Possible reasons for these variations may be availability of quality condoms, seeing condom use as unnecessary with an intimate partner or a lack of power to determine condom use. For example, in 2007, Mongolian sex workers' consistent condom use with clients was 41%, whereas sex with regular partners was 27%.²⁴ Even more striking variances are seen in Cambodia, India and Viet Nam. Cambodian sex workers' consistent condom use with clients was high in 2010 (81-84% in last 3 months), but with "sweethearts" was only 39-48% (in last 3 months).²⁵ In Hanoi, 72% of street-based sex workers reported consistent condom use with first time clients and 56% with regular clients, in contrast to only 18% with non-commercial partners (2005-6).²⁶ Similarly, sex workers in India reporting consistent condom use with clients in the last month was 73% compared to 37% with non-commercial partners (2006).²⁷ These differences highlight the risk of HIV for both sex workers and their partners.

Fig 8. Proportion of female sex workers who reported consistent condom use with their clients, 2008-2012.

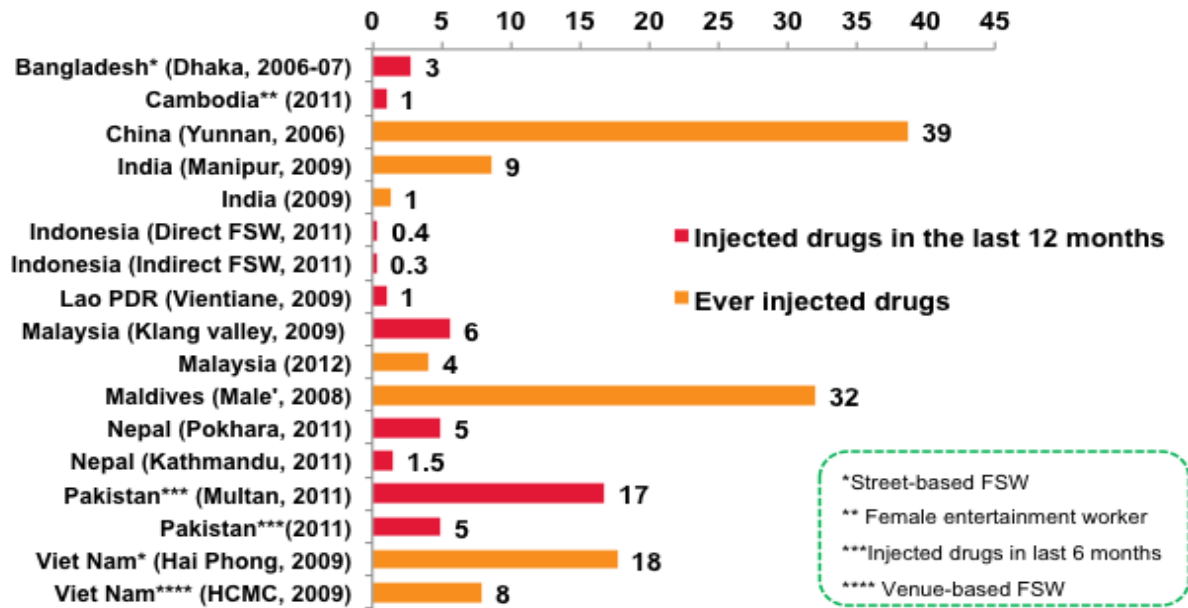


Source: HIV and AIDS Data Hub for Asia and the Pacific, Review in Slides, Female Sex workers based on 1) Integrated Biological and Behavioral Surveys; 2) Behavioral Surveillance Surveys

Overlapping risk behaviours between sex workers and people who inject drugs

In Asia and the Pacific, there is often considerable overlap between the populations of sex workers and injecting drug users and this, coupled with the popularity of methamphetamine and other amphetamine-type stimulants, has been linked to the spread of HIV.¹ Available data show that not only do drug users buy and sell sex, but also significant numbers of sex workers inject drugs. Figure 9 shows the proportion of female sex workers who report ever having injected drugs and those injected in the last 12 months.

Figure 9. Proportion of female sex workers who reported ever injected drugs and injected in the last 12 months, 2006-2012



Source: HIV and AIDS Data Hub for Asia and the Pacific, Review in Slides, Female Sex workers based on 1) Integrated Biological and Behavioural Surveys; 2) Behavioural Surveillance Surveys

Individuals who simultaneously fall into two categories of key populations (people who inject drugs and sex workers) are therefore particularly vulnerable to HIV infection. Potential factors that link substance abuse and sex work include homelessness, unstable family life, socio-economic deprivation, disrupted schooling and confidence and self-esteem issues. While the impact of drugs on sexual behaviour may vary depending on the drug, length of use and other factors, transmission of HIV and other sexually transmitted infections may be facilitated either directly through the injecting behaviour or through the loss of inhibition and judgment resulting in unsafe sexual practices.²⁸

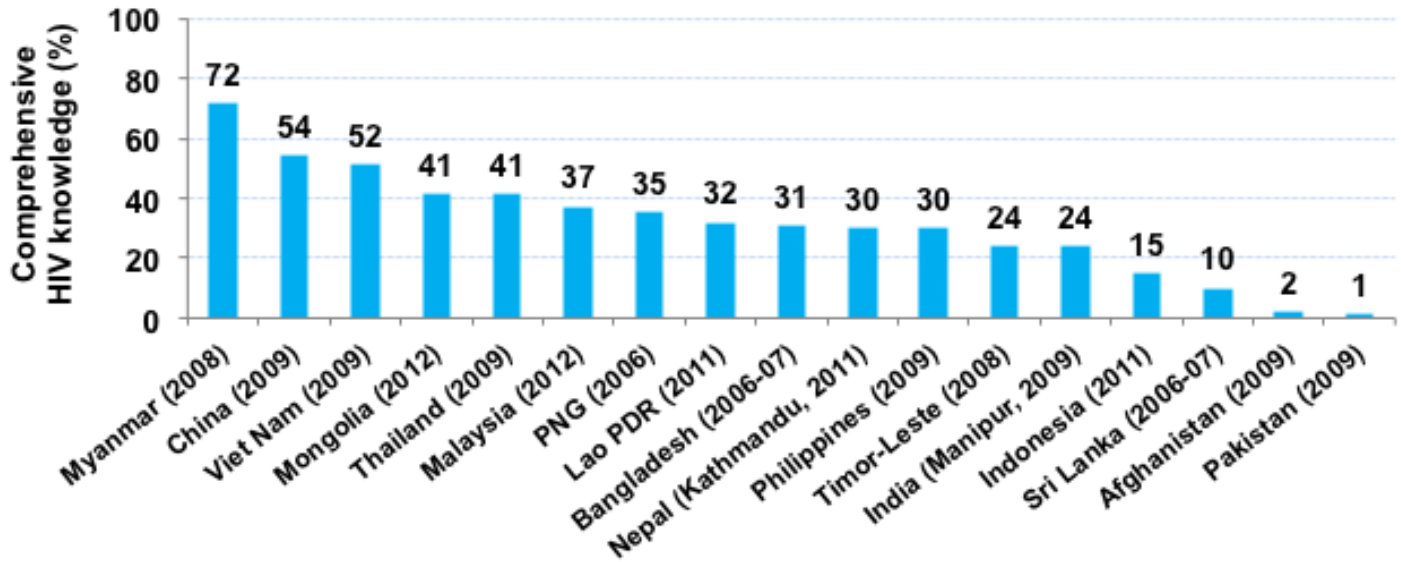
Vulnerability factors

Knowledge and awareness of HIV transmission

Comprehensive knowledge about HIV—the ability to both correctly identify ways of avoiding sexual transmission of HIV and to reject misconceptions about HIV transmission—varies widely across the region (see Figs below). In general, sex workers and their clients continue to lack adequate information about how to protect themselves and others from HIV infection. To assess this knowledge, sex workers who are surveyed are asked:

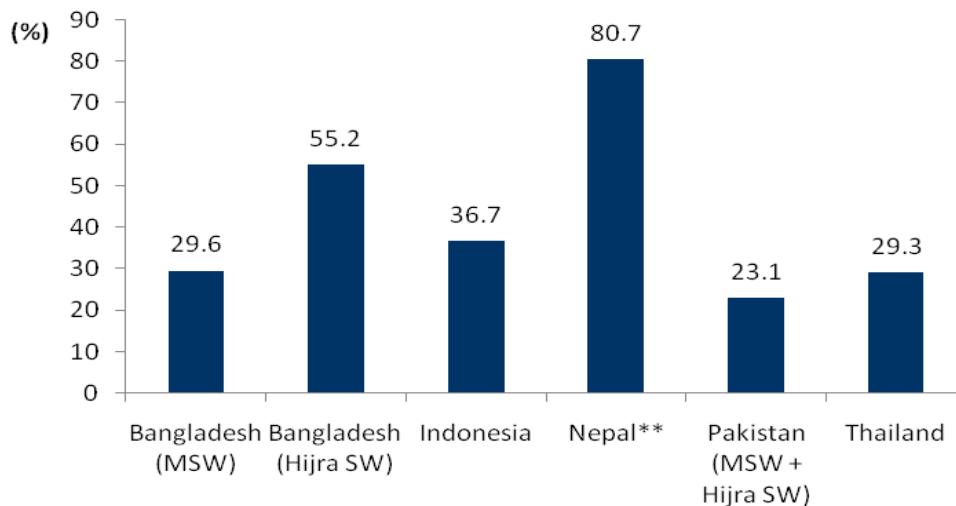
- 1) Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?
- 2) Can using condoms reduce the risk of HIV transmission?
- 3) Can a healthy-looking person have HIV?
- 4) Can a person get HIV from mosquito bites?
- 5) Can a person get HIV by sharing a meal with someone who is infected?

Figure 10. Percentage of sex worker populations with comprehensive knowledge of HIV, selected countries
a) Female sex workers, 2006-2012



Source: HIV and AIDS Data Hub for Asia and the Pacific, Review in Slides, Female Sex workers based on 1) Integrated Biological and Behavioral Surveys; 2) Behavioral Surveillance Surveys 3) UNAIDS. (2010). Global Report: UNAIDS Report on the Global AIDS Epidemic.

10 b) Male sex workers and *hijra* sex workers, 2009*



*or most recent data

**Kathmandu

Sources: ^{32;33;29;34;134}

Of the countries capturing this data via behavioural surveillance, most show that less than half of female, male and *hijra* sex workers have comprehensive knowledge. Among female sex workers, comprehensive knowledge is as low as 1.1% in Pakistan and 2% in Afghanistan, whereas it is as high as 71.5% in Myanmar.^{29;30;31} Awareness of HIV transmission and

prevention methods appears to be higher among male and *hijra* sex workers as compared to female sex workers. This is the case, for example, in Indonesia, Nepal and Pakistan.

Comprehensive knowledge is also low among clients of sex workers. Among those countries in the region capturing this data, knowledge was highest (57%) among clients in Lao People’s Democratic Republic but was below 50% in Bangladesh, Fiji, Indonesia, Mongolia and Papua New Guinea.³⁵

Legal and policy-related environments

Criminalization of sex work increases sex workers’ vulnerability by reducing their access to social benefits and rights, including health care. This in turn affects their personal identity, their self-esteem and their ability to make well-informed decisions about their lives.³⁶ In addition, criminalization leads to a complete lack of social protection, exposing sex workers to violation and non-protection of rights by law enforcement officials. All countries in this region are reported to criminalize soliciting except New Zealand and Timor-Leste; soliciting is not illegal (generally not prohibited but exceptions apply) in Indonesia and Papua New Guinea. Sex work in private is criminalized in 18 countries across the region—Afghanistan, Bhutan, Maldives, and Pakistan in South Asia; all East Asian countries; Lao PDR, Myanmar, Philippines, Thailand and Viet Nam in South-East Asia; and Marshall Islands, Micronesia, Palau and Papua New Guinea in the Pacific.²³ The constitutions of Bangladesh and Pakistan include provisions that require the state to prevent or not promote prostitution. Afghanistan, the Maldives and Pakistan incorporate *sharia* principles into criminal law, which can result in corporal punishment for sex outside of marriage. Pakistan and Afghanistan have stiff punitive laws and very strict police enforcement.³⁷

Table 3. Legality of adult sex work in Asia ³⁷ Country	Law
Afghanistan	Charged with adultery under Art. 427 of the 1976 Penal Code (long-term imprisonment); Hanafi principles of Sharia law
Bangladesh	Suppression of Immoral Traffic Act (1933) prohibits soliciting in public and brothel keeping; Oppression of Women and Children (Special Enactment) Act (1995) prohibits hiring women for sex work
Bhutan	Penal Code 2004; clients and female sex workers, brothel and soliciting
India	The Immoral Traffic Prevention Act provides offences for brothel-keeping (section 3), living on earnings of sex work (section 4), procuring, inducing or detaining for sex work (section 5 & 6), sex work in areas near public places and notified areas (section 7) and soliciting (section 8)
Indonesia	Neither sex work, nor soliciting nor running a brothel are illegal, The Penal Code prohibits facilitation of acts of obscenity by others as a livelihood (Art. 296), trading in women (Art. 297), vagrancy (Art. 505) and living on a female sex worker’s earnings (Art. 506)
Lao PDR	Illegal to engage in sex work or assist a person in sex work (Penal Code, Art. 122); adultery is also illegal (Penal Code, Art. 117)
Malaysia	Penal Code does not criminalize the act of sex work in private, state-level sharia law operates to criminalize Muslim citizens who engage in sex work
Maldives	<i>Sharia</i> and Penal Code 88
Pakistan	Adultery (not specific to sex work) offence of Zina Ordinance (1979)
Sri Lanka	Vagrants Ordinance prohibits soliciting
China	Law on Penalties for Administration of Public Security (fine or imprisonment); brothels are

	illegal under criminal law
Mongolia	The Law on Combating Licentiousness (Prostitution and Pornography) prohibits sex work, soliciting and brothels
Cambodia	The Law on the Suppression of Human Trafficking and Sexual Exploitation (2008) makes it an offence for a person to willingly solicit another in public for the purpose of prostituting him or herself (Art. 24); procurement of prostitution (Art. 26); management of an establishment of prostitution (Art. 30); and provision of premises for prostitution (Art. 32). Art. 298 of the Criminal Code also punishes soliciting
Myanmar	The Suppression of Prostitution Act 1949 prohibits sex work, brothels and soliciting
Philippines	The Revised Penal Code provides offences for prostitution as a form of vagrancy (Art. 202), and for engaging in the business of prostitution, profiting by prostitution or enlisting the services of another person for the purpose of prostitution (Art. 341). The Anti-Trafficking in Persons Act of 2003 makes it an offence to maintain or hire a person to engage in prostitution.
Thailand	The Prostitution Prevention and Suppression Act (1996) penalizes soliciting in public (Art. 5), pimping, advertising, procuring sex workers (even with their consent) (Art. 9) and managing sex work businesses (Art. 11).
Timor-Leste	The 2009 Penal Code provides offences for sexual exploitation of a third party (a person who makes a livelihood from, promotes, facilitates or, by any other means, contributes toward engaging another person in prostitution) (Art. 174)
Viet Nam	Considered a “social evil” under administrative law. The 2000 Penal Code makes harbouring prostitutes illegal (one to seven years imprisonment). “Enticing or procuring” prostitutes can result in six months to five years imprisonment.

Regardless of the legal environment, police and local authorities have been known to take punitive or restrictive actions against sex workers, which can result in the violation of their rights to voluntary and confidential HIV testing, available health services and safe sex-related information and education. Fear of police crackdowns and arrest may lead to increase sex workers’ mobility, thereby expanding sexual networks and discouraging sex workers from turning to the health system for HIV and sexually transmitted infections testing and treatment.³⁷ Conflicting policies, lack of coordination between Government bodies and weak law enforcement commonly hamper HIV programme implementation and the promotion of human rights.³⁶

Prevailing attitudes towards sex workers negatively impact their health-seeking behaviour for sexually transmitted infections. In many countries, police sometimes target the carrying or distribution of condoms as evidence of sex work, thus discouraging safe sex.³⁷ Sex workers in Bangladesh,³⁶ Hong Kong,³⁸ India³⁹ and Macau⁴⁰ report widespread sexual assault by the police officers and other authorities.

Punitive laws against sex workers affect their self-esteem, identity, legal rights, social entitlements including identity and citizenship rights and protection, increase their vulnerability to exploitation, limit their access to health care, education and other livelihood options (such as banking facilities), all of which further increases their vulnerabilities.

Violence in sex work

Violence against sex workers perpetrated by police or military personnel contributes to HIV vulnerability and is reported in numerous countries. Incidents involving sexual assaults perpetrated by police or military have been reported in Bangladesh, Cambodia, China, Fiji, India, Kiribati, Myanmar, Nepal, Papua New Guinea and Sri Lanka. Sex workers are

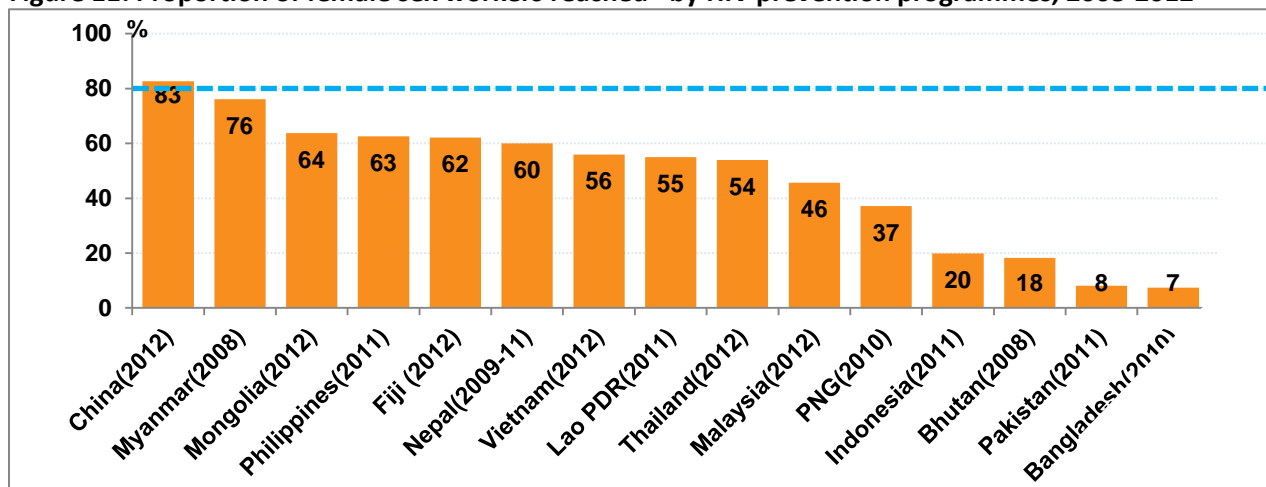
often targeted for harassment and violence because they are considered immoral and deserving of punishment. Criminalization legitimizes violence and discrimination against sex workers (particularly from law enforcement authorities and health workers).³⁷ Violence from partners, clients and other sex workers has also been noted in several countries.⁴¹

Responses

Coverage of intervention programmes

Many countries have shown that it is possible to scale up prevention interventions to a level of 80% coverage and show an impact. Mobilization and engagement with key populations is credited with having boosted programmes and services outreach and contributed to falling infection rates.¹ As a result, HIV prevalence among female sex workers has declined in Cambodia, India, Myanmar and Thailand, and is sustained at a low level in China, Nepal and the Philippines.

Figure 11: Proportion of female sex workers reached* by HIV prevention programmes, 2008-2012



* Know where to receive an HIV test and were given condoms in the last 12 months

Source: HIV and AIDS Data Hub for Asia and the Pacific, Review in Slides, Female Sex workers based on 1) Integrated Biological and Behavioral Surveys; 2) Behavioural Surveillance Surveys; 3) www.aidsinfoonline.org

The data from each country are by no means comparable, however this figure does show how countries have been able to cover hard-to-reach populations like female sex workers through prevention programmes.

Examples of successful initiatives

1. The 100% condom use programme

In 1991, Thailand responded to a rapidly-growing HIV epidemic by implementing the first 100% condom use programme (pioneered in the Ratchaburi province in 1989). All sex workers in brothels were required to use condoms with clients.⁴² Instead of trying to eliminate commercial sex, safe sex was promoted through large-scale condom distribution, discouraging men from visiting sex workers, promoting women's rights and broadcasting HIV prevention messages, as well as open debates on HIV and sexual issues. The programme is an example of a dual approach involving individual behavioural change as well as socio-structural and organizational change. This was achieved through a nationwide partnership of the public and private health sectors, including nongovernmental organizations and advocacy groups. The primary responsibility for enforcing condom use was on the establishments, which would be closed down if they did not

comply. The programme helped to empower sex workers to negotiate condom use with their clients. As a result, reported condom use rose in Thailand from 14% in 1989 to over 90% in 1994.⁴² It was also credited with reducing HIV prevalence among female sex workers in Thailand from 33% in 1994 to 5% in 2007, with an estimated 200 000 new cases averted between 1993 and 2000. This initial success was attributed to the fact that clients had no option but to use condoms when paying for sex. However, in recent years, with funding for HIV prevention falling by two-thirds and public concern dwindling, HIV has become widespread among other key populations such as men who have sex with men and people who inject drugs. Condom use has also declined, particularly among the non-brothel working sex workers who were largely neglected by the 100% condom use programme.⁴²

Although the 100% condom programme in Thailand increased condom use and lowered sexual transmission of infections (including HIV) among sex workers and clients, substantial avenues for infection remain. Condom use remained low (32 to 75%) among sex workers and non-commercial or intimate partners.⁴² Average condom use between sex workers and all partners was only about 60%, despite sex workers being given boxes of condoms every time they attended medical check-ups. In addition to this, most sex workers who were part of the 100% condom programme worked in direct sex establishments such as brothels—transient sex workers and those who worked at other locations did not record the same levels of condom use. Clients reported 88% condom use at direct sites with their regular sex workers, but 81% at indirect sites with regular sex workers. Similarly, clients reported only 40% consistent condom use with intimate partners and about two thirds with non-commercial partners.⁴² While sex workers had access to treatment for sexually transmitted infections, empowerment in the form of education and condom negotiation skills were less common in the 100% condom programme.

The Avahan project

India's Avahan project provides funding and support to targeted HIV prevention programmes in the six Indian states with the highest HIV prevalence (Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Manipur and Nagaland) and along the nation's major trucking routes (long-distance truckers account for 10-12% of clients) to serve more than 220 000 female sex workers, 5 million clients and partners, 80 000 men who have sex with men and 18 000 people who inject drugs.⁴³

Community groups were formed and trained in media handling, self-help groups, advocacy and legal literacy to start shaping local advocacy activities and leading activities such as the violence response systems and negotiations with local power structures. Different communities were addressed and catered for by specific programmes and clinics. With the support of the "Common Minimum Programme", each centre was given the flexibility to customize implementation to meet local needs. Within two years, 83% of the key populations mentioned above had been contacted by a peer outreach worker at least once. Multiple data sources reported increased condom use in commercial sex, which was reflected in the national BSS in 2001 and 2006. The percentage of individuals from key populations who attend a clinic for sexually transmitted infections increased from 25% in August 2005 to 90% in December 2006; similarly, condom distribution went from 1.3 to 4.6 million.⁴⁴

Due to sex work being often illegal, advocacy is required to create an enabling environment for sex work interventions. Local advocacy support should be gained from establishment owners, pimps and local police in order to support intervention services.

A number of large-scale programmes (such as Sonagachi in Kolkata, India, the Avahan project in India's six highest HIV-prevalence states, the Shakti project in Dhaka) promote sex workers' rights, run literacy and vocational programmes and provide micro-loans, thereby empowering sex workers.⁴⁵ Savings and credit schemes have also helped reduce dependency on sex work. Most of the successful HIV prevention programmes include outreach activities by sex workers,

involving peer educators and the provision of condoms, as well as management and treatment of sexually transmitted infections.

The Pragati project, funded through the Bill and Melinda Gates Foundation and launched in India in 2005, follows an empowerment-based approach to HIV-prevention among sex workers. The programme is implemented through a partnership between Swasti, Swathi Mahila Sangha and the Karnataka Health Promotion Trust and is driven by local stakeholders. Since 2005, Pragati (which means “progress”) has reached out to more than 16 000 sex workers in the city of Bangalore primarily in high transit areas such as bus and railway stations and busy markets. The project focuses on involving sex workers and other community members to develop programming to improve access to health care and create a supportive environment for safe sex practices.⁴⁶

The Pragati project provides a wide range of services and programming including:

- sexually transmitted infection- and HIV-related health prevention and treatment services;
- a micro-finance lending programme;
- a community-led violence response programme staffed by women who can respond 24 hours a day, seven days a week to acts of violence and harassment throughout Bangalore; and
- treatment for women who abuse alcohol.

By using a community-based empowerment approach, Pragati has had success among a severely marginalized subpopulation in Bangalore and in other Indian urban areas.

VAMP (Veshya Anyay Mukti Parishad) Plus, part of the 5000-member strong VAMP sex worker collective in seven districts in Western Maharashtra and North Karnataka (India), focuses on the following areas to improve the lives of its members and their children:

- facilitating access to HIV testing, counselling and treatment services through awareness, education, outreach and accompanied referral;
- creating a community care and safety net that helps sex workers living with HIV seek and receive treatment, care and support and address problems related to health and well-being including nutrition, shelter and safety; and
- creating a safe space for sex workers living with HIV to discuss their rights, as well as legal and social issues affecting them and their families and develop collective action to assert and claim their rights.⁴⁷

A female sex worker involved with VAMP Plus stated: “Before, [sex workers] were treated like animals. We were not even allowed in the hospital to receive any kind of medical check-up. Now we are treated like anyone else. We are accommodated in the same rooms as other patients. Hospitals and doctors are more respectful and sensitive to our needs.”⁴³ Due to sex workers’ legal status in India and other countries in the region, they have had to rely on one another, rather than the Government, to provide a community care network. The VAMP Plus programme is a good example of the successful treatment, testing and care schemes that are possible when sex workers are organized and empowered.

The Avahan programme (see above) attributes a large portion of its success to peer educators, who can provide information on trends within their communities and the nature of intervention needed. Their activities include sharing prevention information with their colleagues, distributing condoms, needles and syringes where appropriate, making referrals to clinics and other services and gathering information on individual risk profiles such as vulnerability to violence and access to services. The process of peer training, supervision and problem-solving empowers community members and creates a foundation for the eventual handover of management of the programme itself. It creates leaders who can advocate wider community rights. The programme created a platform for issues such as stigma associated with HIV and

marginalized groups, violence inflicted by police or clients and denial or non-availability of essential entitlements such as ration cards.⁴³

The EMPOWER programme, a sex worker activist project, works with migrant workers (particularly from Myanmar) and produced Thailand's first HIV educational materials.⁴⁸ EMPOWER runs its own bar, "Can Do", which is collectively owned and run by sex workers, with a sex worker-designed security system, condom distribution and trained safe sex counsellors. EMPOWER University offers primary and high school qualifications, computer skills and safer sex counselling skills, as well as leadership, media, research and public speaking. However, EMPOWER does not receive HIV funding from the United States Government, as that would require the foundation to oppose prostitution under the United States' Anti-Prostitution Pledge.⁴⁸

KEY MESSAGES

- Refined and localized data and strategic information is needed. Many countries resource and implement interventions according to a national aggregate. Subnational data will help in geographical prioritization and will have more impact.
- Nuancing programme strategies for key populations is critical. Many countries have achieved scale, but not impact, indicating the need for quality enhancements. Most countries have one national strategy for all female sex workers regardless of their sub-type (such as urban or rural, home-based, street-based or brothel-based). Vulnerabilities and risk behaviours are different depending on the sub-types, so having a nuanced approach would greatly enhance the quality of programming and have far-reaching impact.
- Communities, in particular key populations, need to be at the center of driving the HIV response. Investments in community systems strengthening are therefore critical, particularly in the areas of service delivery, monitoring systems, mobilization and advocacy.
- Testing, prevention, treatment and care services need to be responsive to the needs and experiences of the beneficiaries in safe and non-judgmental settings. Therefore, expanding current services to broader sexual reproductive health and rights (beyond just HIV) is very important. Community testing and treatment continuum (prevention of loss to follow up) through community interventions must be explored.
- Community-led interventions show compelling results in contacting hard-to-reach key populations and facilitating access to services. There is a growing regional momentum towards strengthening community institutions for sustained impact, including community-based HIV testing and counselling for key populations integrating sexual and reproductive health and HIV services, and preventing and addressing violence.
- As HIV programmes mature and increasingly focus on the challenges of long-term prevention, treatment, care and support, national responses need to be considered within the broader health and development contexts. The sustainability and effectiveness of HIV programmes can be greatly enhanced by creating and strengthening linkages within the health system, between health and community systems, and with other non-health programmes.
- To sustain positive health outcomes among sex workers, it is necessary for a country to remove punitive laws that enhance vulnerabilities. In addition, particular key populations like sex workers must have access to social protection, education, employment and enterprise development facilities to empower them and address their vulnerabilities.

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