

Asia Pacific Region Thematic Analysis Paper - 1

SEX WORK & HIV

Asia-Pacific Regional Data Overview

AUTHORS

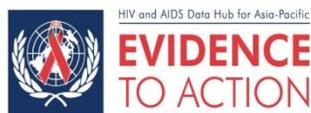
**Dr. Angela Chaudhuri & Miles
Prince**



SWASTI HEALTH RESOURCE CENTRE

SEX WORK & HIV

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With the exception of Thailand, every country in Asia has an adult HIV prevalence of less than 1%, with a regional average between 0.2-0.3%.¹ However, owing to the fact that 4.2 billion people (55% of the world's population)² reside in the region, Asia's comparatively low prevalence translates into a substantial portion of the global HIV burden.¹ 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 people whose behaviour carries a high risk of exposure, including female sex workers (FSWs) and their clients, men who have sex with men (MSM) and people who inject drugs (PWID).

Table 1. Global and Regional HIV Statistics, 2013

HIV and AIDS statistics	Global	Asia Pacific
Adults and children living with HIV	35.3 million (32.2 million-38.8 million)	4.9 million (6.3 million- 3.7 million)
Adults and children newly infected with HIV	2.3 million (1.9 million-2.7 million)	350,000 (550,000-220,000)
Adults and children deaths due to AIDS	1.6 million (1.4 million- 1.9 million)	270,000 (360,000-190,000)

Source: [UNAIDS. \(2013\). Global Report: UNAIDS Report on the Global AIDS Epidemic](#)

Asia's sex industry is rapidly expanding and changing in some countries, threatening programmatic efforts to control the region's HIV epidemic, although the national prevalence has declined in large and populous countries like India, Myanmar, and Thailand and kept low in China, Nepal and Bangladesh. Changes in economic conditions, disparities in income, rural-urban differential, disasters and conflicts all dramatically 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.

HIV & SEX WORK

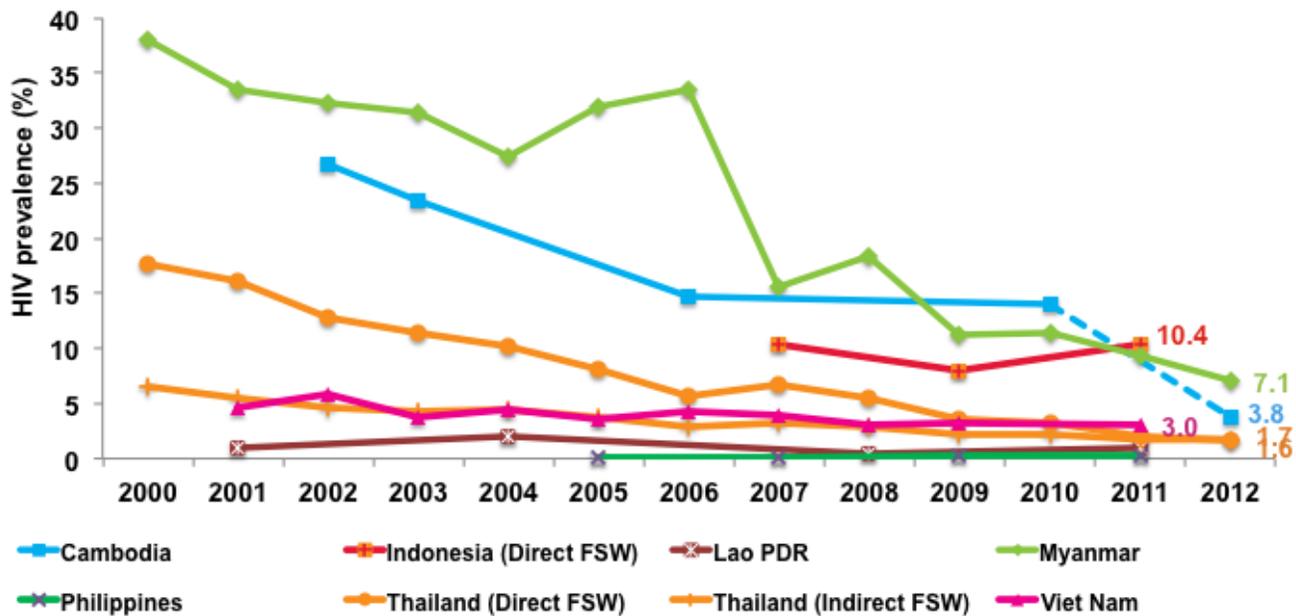
Commercial sex is a primary mode of HIV transmission in many Asian countries where more people engage in commercial sex than in any other high risk behaviour.^{4,5} An estimated 0.5%⁶-15%⁷ of men in the region were clients of sex workers across Asia and the Pacific. These men are key determinants in both the spread and magnitude of HIV epidemics in the region, since they are the biggest single group that transmits HIV to their regular 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 due to vulnerabilities associated with the circumstances surrounding sex work. HIV prevalence among sex workers is highly variable both between and within countries in Asia.

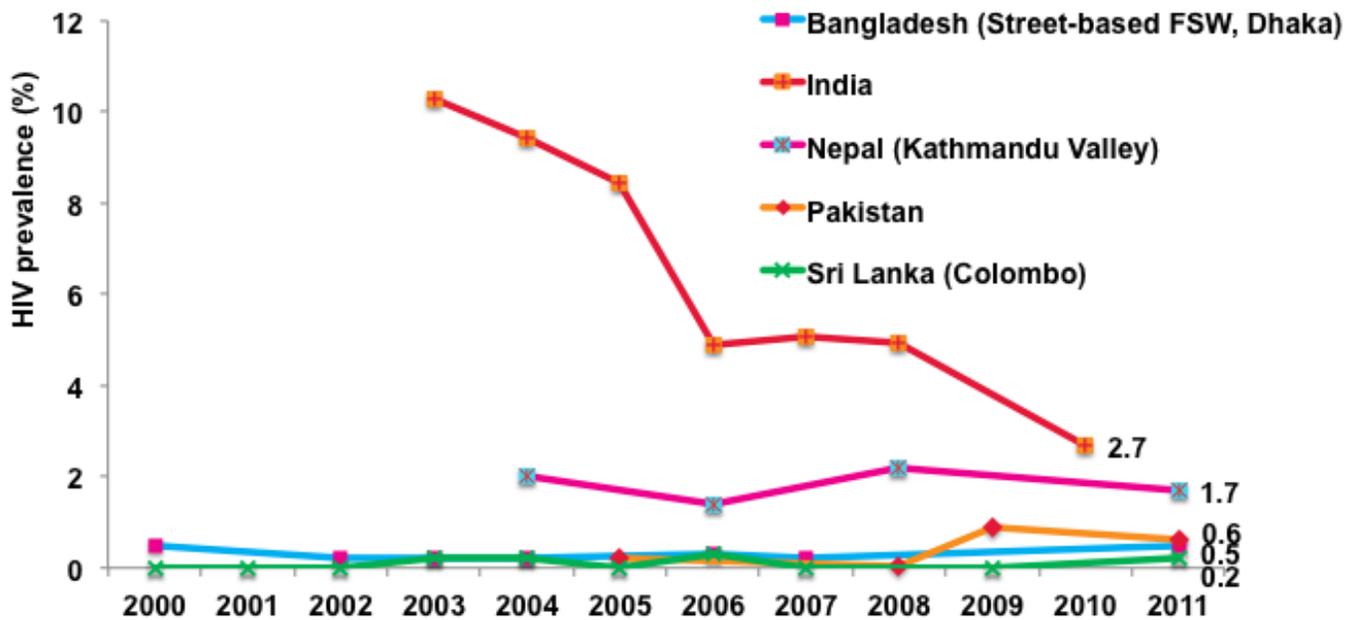
Most recent surveys across the region show that HIV was not detected among FSWs sampled in Fiji, Maldives, and Mongolia between 2008 to 2012. As shown in Figure 1, prevalence among other countries is as high as 7.1% in Myanmar.

Figure 1. HIV prevalence among female sex workers in selected ASEAN 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

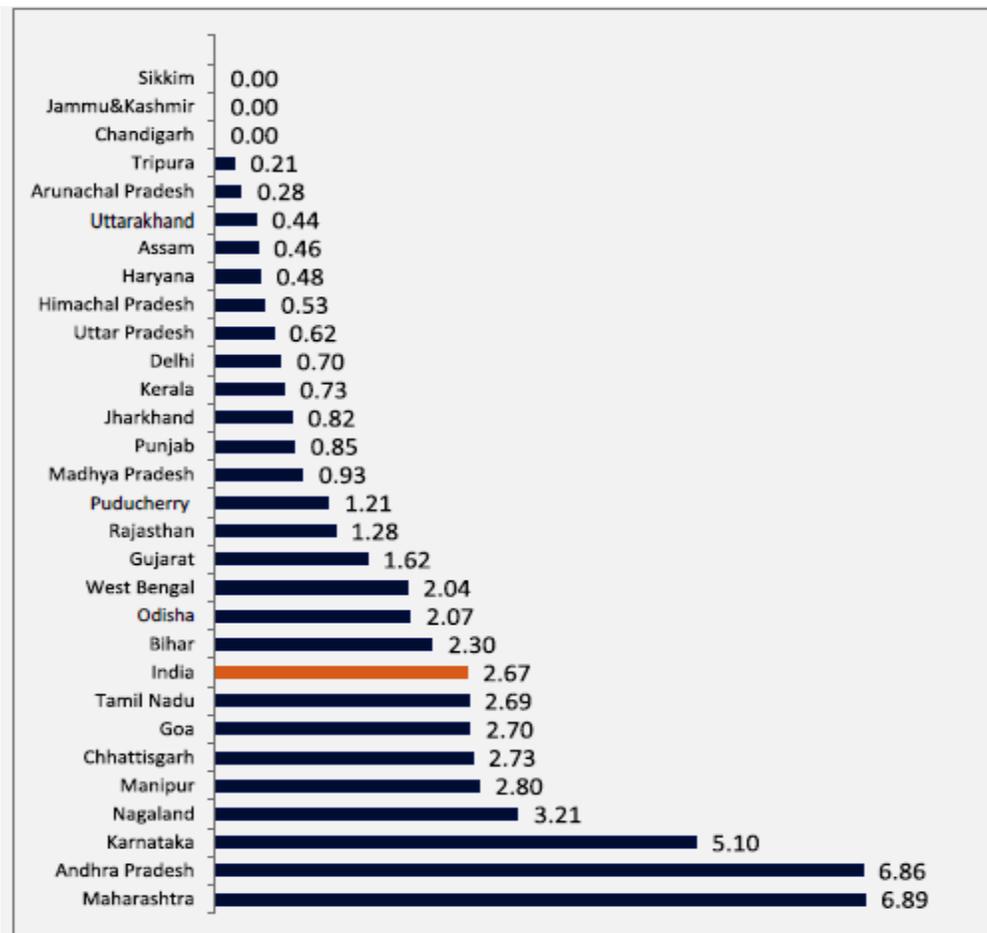
Figure 2. HIV prevalence among female sex workers in selected South Asian countries, 2000-2012



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 there are also variations of HIV prevalence between different regions or cities. For instance, in India estimated 2011 adult HIV prevalence was 0.27%, while nationwide HIV prevalence among FSWs was reported as 2.67%, reduced from 4.9% in 2008-2009 and ranging widely by state. Twenty-seven states had HIV prevalence below 5%, while 3 states had HIV prevalence above 5% among this group (see Fig. 3).^{9;10} Similarly in Indonesia, though the national average of HIV prevalence among direct FSWs is 10.4%, there are pockets with higher prevalence rate, such as 25% in Jayawijaya.¹¹

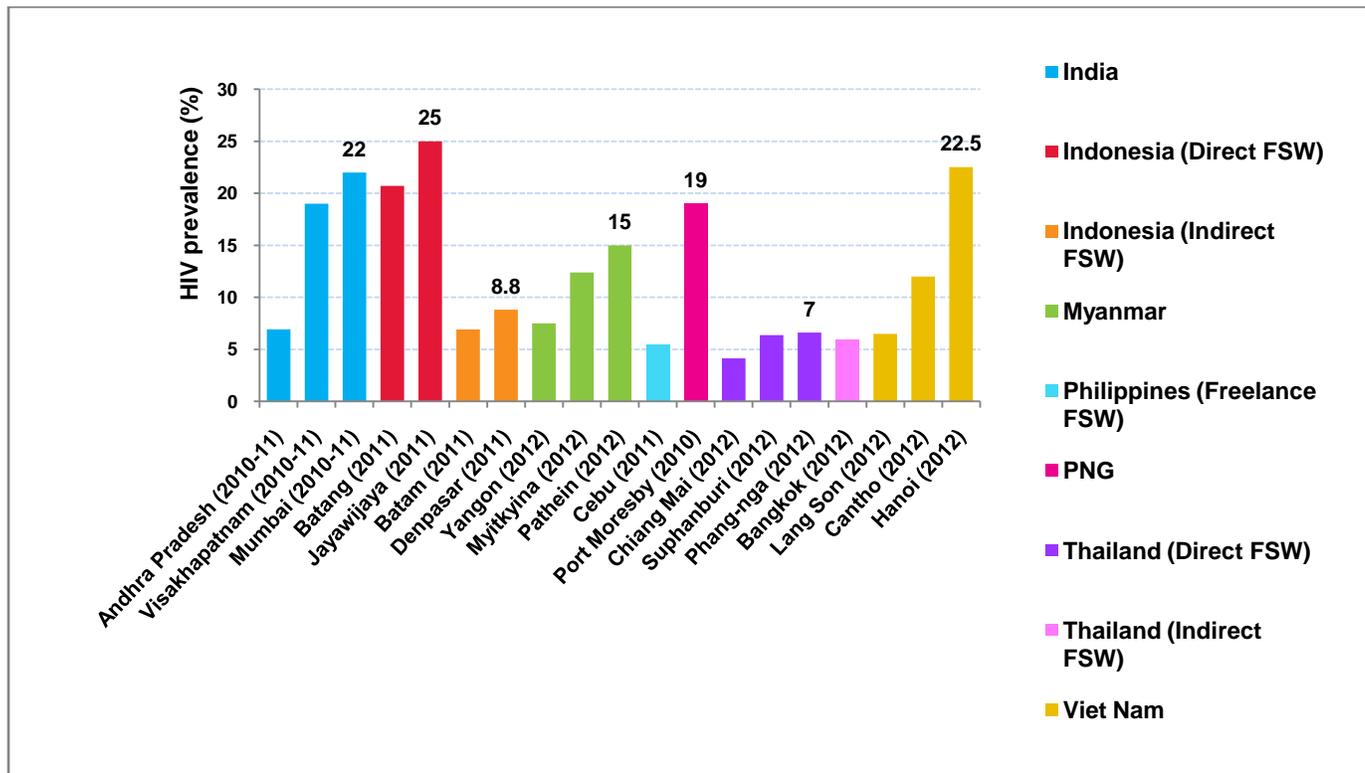
Figure 3. HIV prevalence (%) among FSWs, India and states, 2010-2011¹²



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

Other countries having surveillance systems that are robust enough to capture sub national variations include Myanmar, Thailand and Vietnam.

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

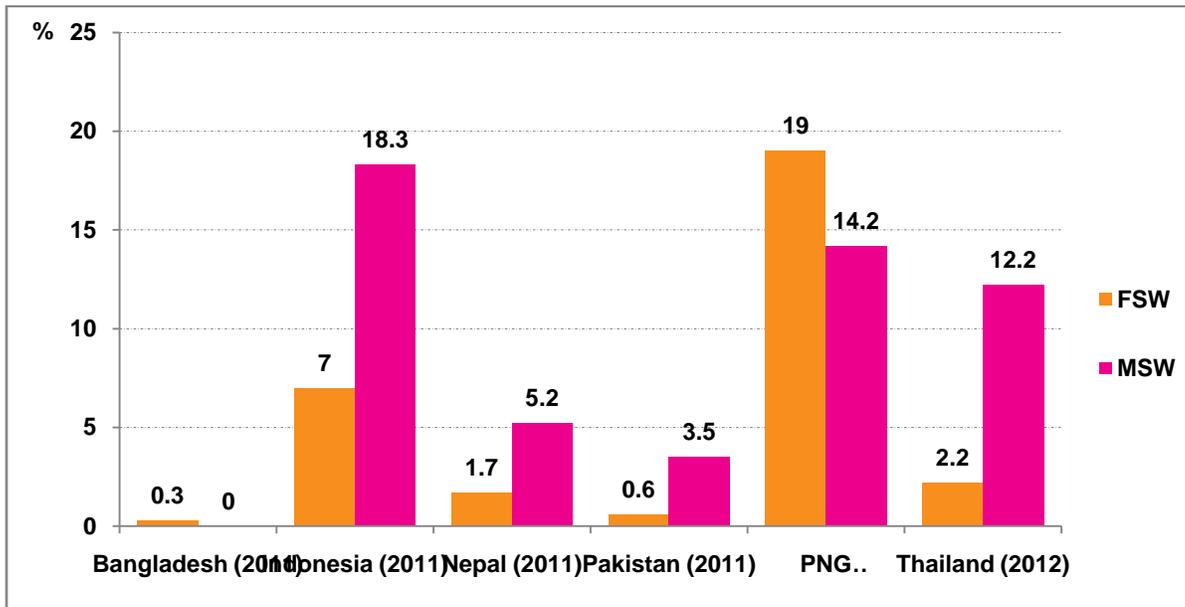
Given the high amount of variations in prevalence among sex workers seen within the countries, countries have started to prioritise geographically. India and Nepal are examples of countries that have used epidemiological zones to focus resources and programming.

Throughout the region, sex work has been shifting away from being brothel-based and towards more indirect forms, taking place in restaurants, tea houses, cafes, hotels, street, homes and vehicles. A large part of the reason for this is that vast majority of countries in Asia and the Pacific criminalized 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 MSWs versus FSWs is 18.3% vs. 7% in Indonesia (in 2011), and 2.2% vs. 12.2% in Thailand (in 2012).^{11,14}

Figure 5. HIV prevalence among male sex workers vs. 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

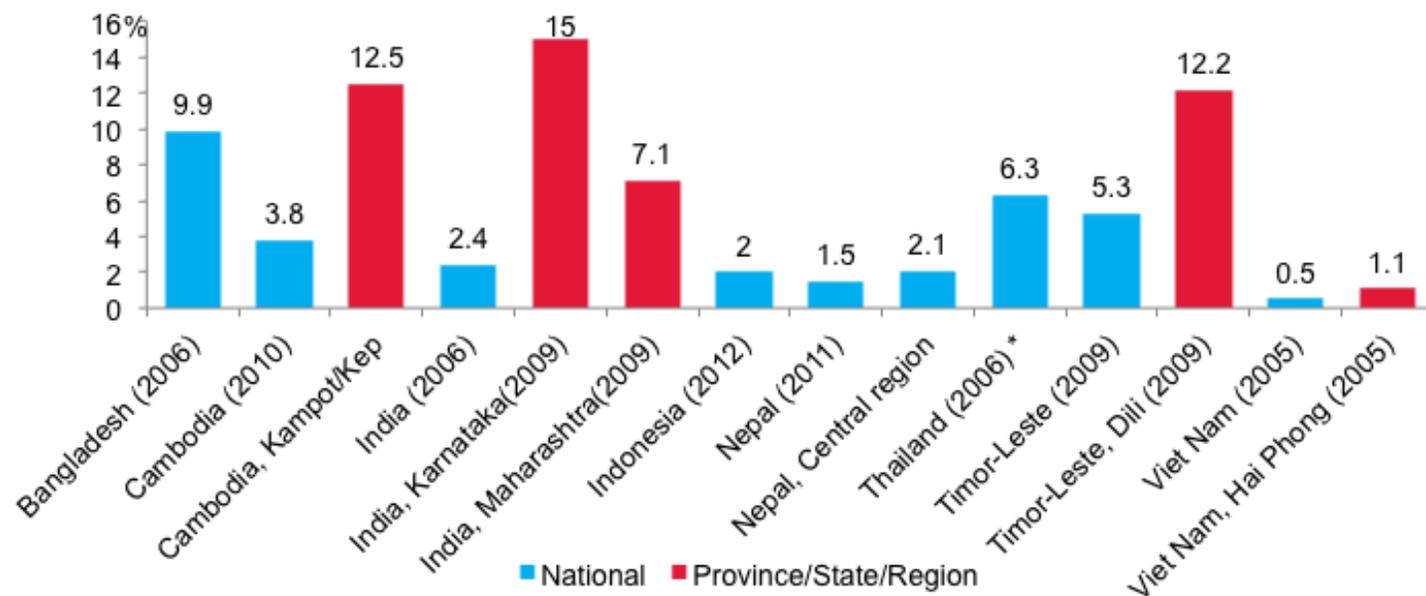
Several Asian countries have transgender and transsexual communities that are unique and prominent enough to be regarded as separate risk groups from the MSM population. A global review of available data found that transgender women are 49 times more likely to be living with HIV than women overall, with a pooled HIV prevalence among transgender women of 19%.¹⁶ In South Asia (particularly Pakistan, India and Bangladesh), the terminology *hijra* is used for transgender people, and in South East Asia (particularly in Indonesia) transgender are known as the *warias* and as *maknyahs* in Malaysia. However, only a proportion of transsexuals and transgenders are sex workers. Among the few countries capturing surveillance data on transgender sex worker populations, HIV prevalence ranges from 1% in Bangladesh and 30.8% in Jakarta, Indonesia. It must be noted that the figure for Jakarta includes all TG, however 81% sold sex in the last year according to the 2011 IBBS. In this region about seven countries have some population size estimates for transgender populations of which only Fiji and Malaysia have estimates of TG sex workers, and it is only Fiji, India, Pakistan and Papua New Guinea that capture TG sex workers as part of surveyed populations in HIV seroprevalence surveys. 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, outnumbering people who inject drugs (PWIDs) and MSM in Asia and the Pacific.¹⁸ The Commission on AIDS in Asia estimated that up to 10 million Asian women sell sex to at least 75 million men. Examples of the magnitude of the population sizes of clients of sex workers in the region include 37 million men in China, 30 million men in India and more than three million men in Indonesia.⁴ Client turnover ranges between 2 clients a day in Thailand and Sri Lanka to almost 10 clients a week in India

and Myanmar.¹⁹ Figure 6 shows the percentage of men in selected countries in the region reporting paying 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 Organization 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 mostly men who have jobs providing them with 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, unmarried men are more likely to buy sex although older men have the financial means to afford multiple partners. In Southern Vietnam, sex workers reported that at least 37% of their clients were businessmen and white-collar workers, while over half in five northern provinces were said to be government officials. Similar findings were recorded in Indonesia, Lao PDR and Pakistan.²⁰ Still, the most vulnerable sectors with high numbers of clients of sex workers in the region 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 FSWs together with the percentage of them reporting having had commercial sex.

Table 2. Males in high-risk occupational groups (proxy for clients of FSW) who reported commercial sex in last year, selected countries and cities, 2004-2012

Location	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 clients	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 (LuangPrabang)		63	
Lao PDR (Savannakhet)		52	
Lao PDR (Vientiane)		50	
Maldives	Sea farers	6	2008
	Resort workers	4	
	Construction workers	2	
Mongolia	Male STI clients	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 these males in occupations known to frequent sex workers. Each country has its own key bridge populations or common clients of sex workers (e.g. Truckers in India, seafarers in Sri Lanka, Philippines, Thailand, etc.). The HIV prevalence is also quite wide ranging; for example, the prevalence among truck drivers in India is at 1.9-6.8%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, these clients remain vulnerable given their risk-taking behaviours in commercial sex.

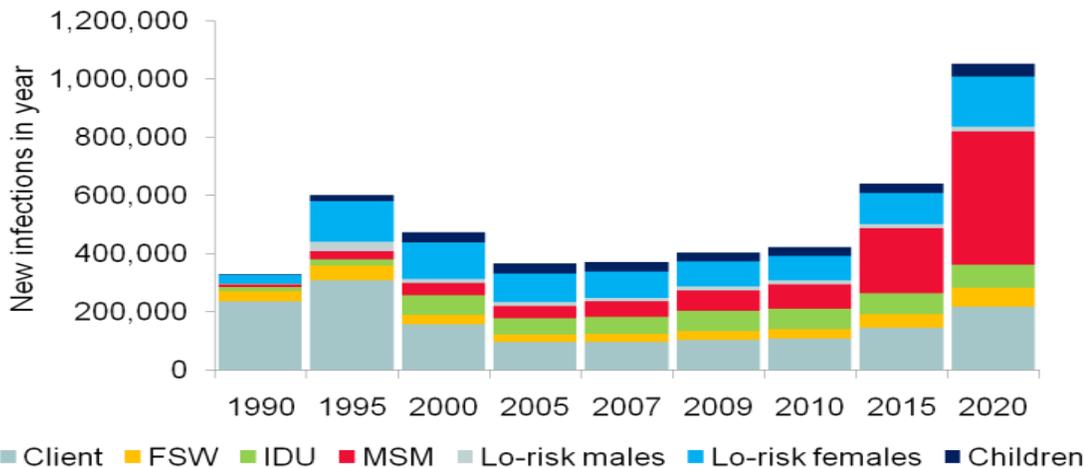
RISK BEHAVIOURS

Condom use

Condom use is directly associated with accessibility (price and availability) and clients' preferences. While female sex workers reported a median of 80% condom use at last sex with clients, usage rates among male sex workers are half this number.³ This indicates lack of focussed 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 visiting FSWs. Male clients of FSW 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 FSWs in coming years, the number of clients of FSWs 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 MSM (Fig. 7).²³

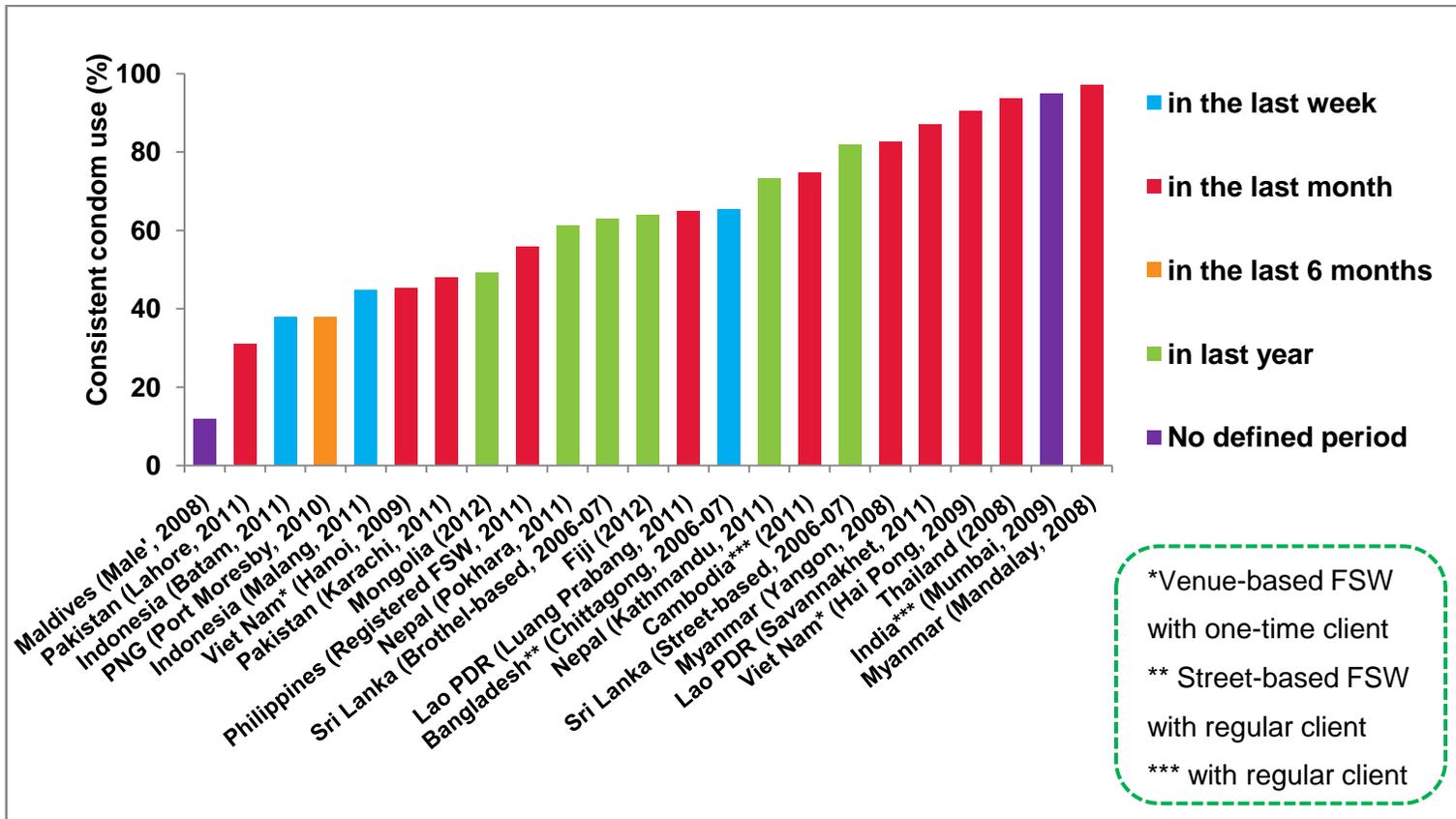
Figure 7. Projected incidence distribution among population groups, 1990-2020



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 programs focussed on condom use alone, the more recent strategies have focussed on consistent condom use. The countries showing a declining epidemic show consistent condom use among clients(e.g., Thailand, India, Myanmar) (see Fig 8). Unfortunately, critical data like this is not reported uniformly and regularly available across countries. Where data is available, there is evidence that sex workers'consistent condom use is extremely varied between their clientsand their intimate partners. A few possible factors leading to this variance could be availability of quality condoms, seeing condom use as unnecessary with an intimate partner, or a lack of power to determine condom use in the relationship.Take as an example Mongolia in 2007. Consistent condom use with clients was 41%, whereas sex with regular partners was 27%.²⁴Even more striking variances are seen in Cambodia, Viet Nam, and India. In Cambodia, where sex workers' consistent condom use with clients was high in 2010 (81-84% in last 3 months), consistent condom use with "sweethearts" was only 39-48% (in last 3 months).²⁵In Ha Noi, Vietnam,72% of street-based sex workers reportedconsistent condom 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).²⁷These differences highlight the risk of HIV for both sex workers and their partners.

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

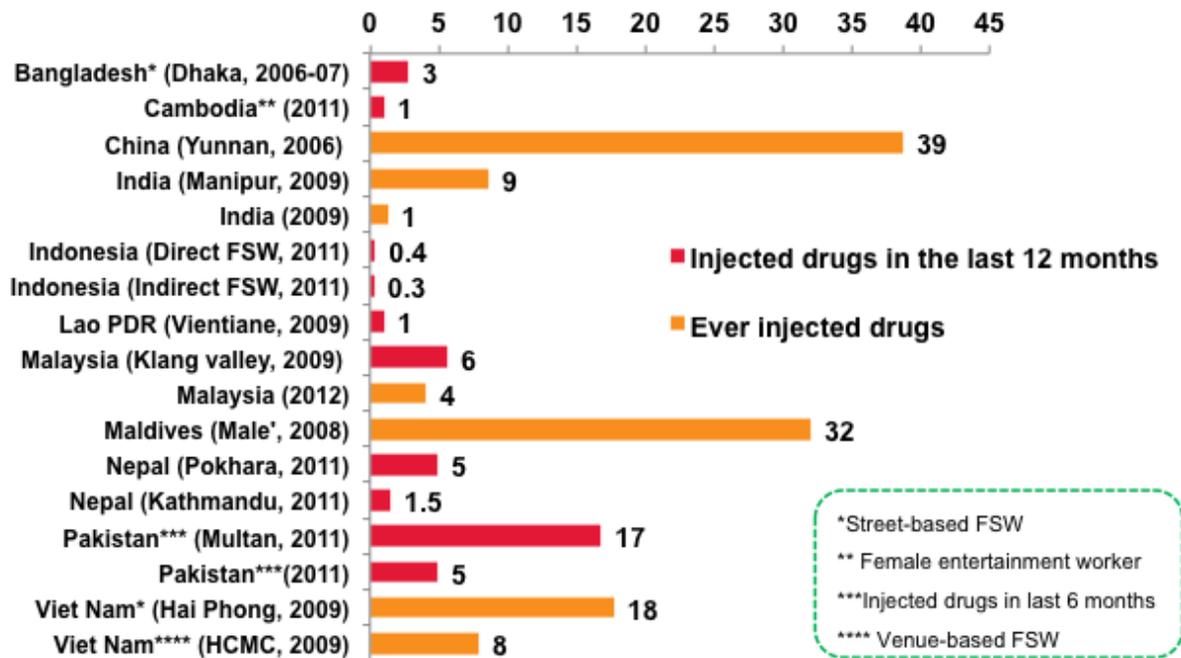


Source: HIV and AIDS Data Hub for Asia and the Pacific, Review in Slides, Female Sex workers based on 1) Integrated Biological and Behavioral Surveys; 2) Behavioral Surveillance Surveys

Overlapping risk behaviours between sex workers and injecting drug users

In Asia 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 epidemics.¹ Available data shows that – not only do PWID buy and sell sex – but also that significant numbers of sex workers also inject drugs. Figure 9 shows the proportion of FSWs who report ever having injected drugs and those injected in the last 12 months.

Figure 9. Proportion of FSW 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

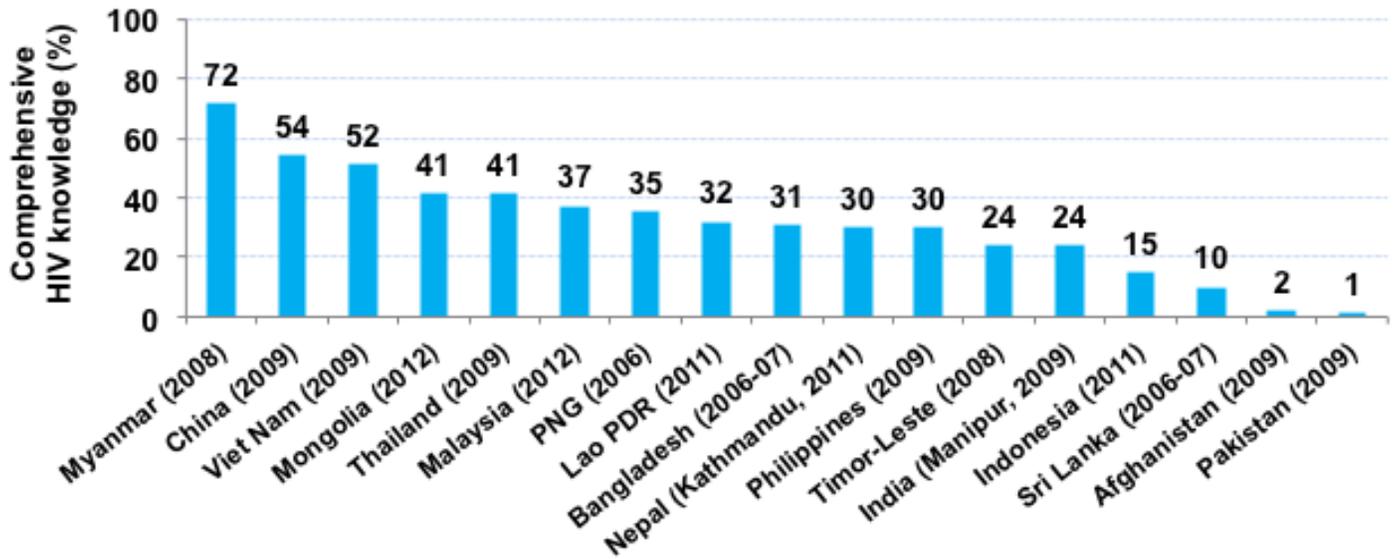
Individuals who fall into both categories of key populations at higher risk – PWID and FSWs – are therefore particularly vulnerable to HIV infection. Among potential factors that link substance abuse and sex work include homelessness, unstable family lives, socio-economic deprivation, disrupted schooling, and confidence and esteem issues. While the impact of drugs on sexual behaviour may vary by drug, length of use and other factors, HIV and STI transmission 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

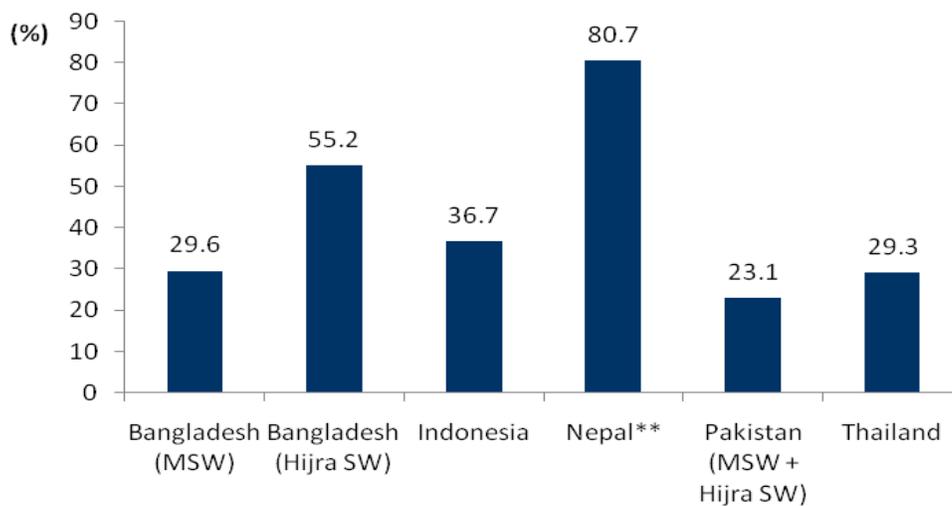
Comprehensive knowledge about HIV – that is, the ability to both correctly identify ways of preventing the sexual transmission of HIV and to reject major misconceptions about HIV transmission – varies widely across the region (Figs below). In general, sex workers and their clients continue to lack adequate information about how to protect themselves and others from HIV infection. In order to assess this knowledge, sex workers who are surveyed are asked the following five questions: (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 50% of female, male and *hijra* sex workers have comprehensive knowledge. Among FSWs, comprehensive knowledge is as low as 1.1% and 2% in Pakistan and Afghanistan, respectively – whereas it reaches as high as 71.5% in Myanmar.^{29;30;31} Knowledge of HIV transmission and prevention methods appears to be better among male and *hijra* SWs as compared to female SWs. 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 among clients in Lao PDR at 57%, while less than 50% of clients in Bangladesh, Fiji, Indonesia, Mongolia and the PNG had this knowledge.³⁵ This data point has not been accurately collected across all the countries and updated.

Legal and policy-related environments

Criminalization of sex workers increases their vulnerability by reducing their access to social benefits and rights including health care. This in turn affects the sex workers' personal identity, self-esteem and in turn harms self-interest and their ability to make well-informed decisions about their lives including health care.³⁶ In addition, criminalisation leads to a complete and utter lack of social protection, particularly exposing them to violation and non-protection of rights by law enforcement officials. In this region, it is reported to criminalize soliciting in all countries except Timor Leste and New Zealand and soliciting is not illegal (generally not prohibited but exceptions apply) in Indonesia and Papua New Guinea. Whereas sex work in private is criminalized in 18 countries: 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 Pakistan and Bangladesh 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 practices.³⁷

Table 3. Legality of Adult sex work in Asia³⁷

Country	Law
Afghanistan	Charged with adultery under Article 427 of the Penal Code 1976 (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 of women for sex work
Bhutan	Penal Code 2004; clients and FSW, 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 (Article 296), trading in women (Article 297), vagrancy (Article 505) and living on the earnings of a female sex worker (Article 506)
Lao PDR	Illegal to engage in sex work, or assist a person in sex work. Penal Code Art 122 Adultery is

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	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	The 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 provides offences for a person to willingly solicit another in public for the purpose of prostituting himself or herself (Article 24); procurement of prostitution (Article 26); management of an establishment of prostitution (Article 30); provision of premises for prostitution (Article 32). Article 298 of the Criminal Code also punishes soliciting
Myanmar	The Suppression of Prostitution Act 1949- sex work, keeping brothels and soliciting
Philippines	The Revised Penal Code provides offences for prostitution as a form of vagrancy (Article 202), and for engaging in the business of prostitution, profiting by prostitution or enlisting the services of another person for the purpose of prostitution (Article 341). The Anti-Trafficking in Persons Act of 2003 provides an offence to maintain or hire a person to engage in prostitution.
Thailand	The Prostitution Prevention and Suppression Act (1996) provides offences for soliciting in public (Article 5), pimping, advertising, procuring sex workers (even with their consent) (Article 9) and managing sex work businesses (Article 11).
Timor Leste	The Penal Code 2009 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) (Article 174)
Viet Nam	Considered a 'social evil' under administrative law. Penal Code 2000 makes harbouring prostitutes illegal with sentencing between 1-7 years imprisonment. 'Enticing or procuring' prostitutes can result in 6 months to 5 years imprisonment.

Despite whatever type of legal environment that exists, police and local authorities have been known to take punitive or more restrictive actions against sex workers which can result in the violation of their rights to voluntary and confidential medical testing, available health services and safe sex-related information and education. Fear of police crackdowns and arrest may lead to increased mobility of sex workers, thereby expanding sexual networks and discouraging sex workers from turning to the healthcare system for testing and treatment of HIV and other STIs.³⁷ Conflicting policies, lack of coordination amongst government bodies and weak enforcement of laws are common barriers that hamper HIV intervention programme implementation and 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 the availability and use of condoms.³⁷ Sex workers from 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 home, healthcare, education and other livelihoods options (banking facilities)- all of which enhances their vulnerabilities even further.

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 by police or military have been reported from 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 care providers).³⁷

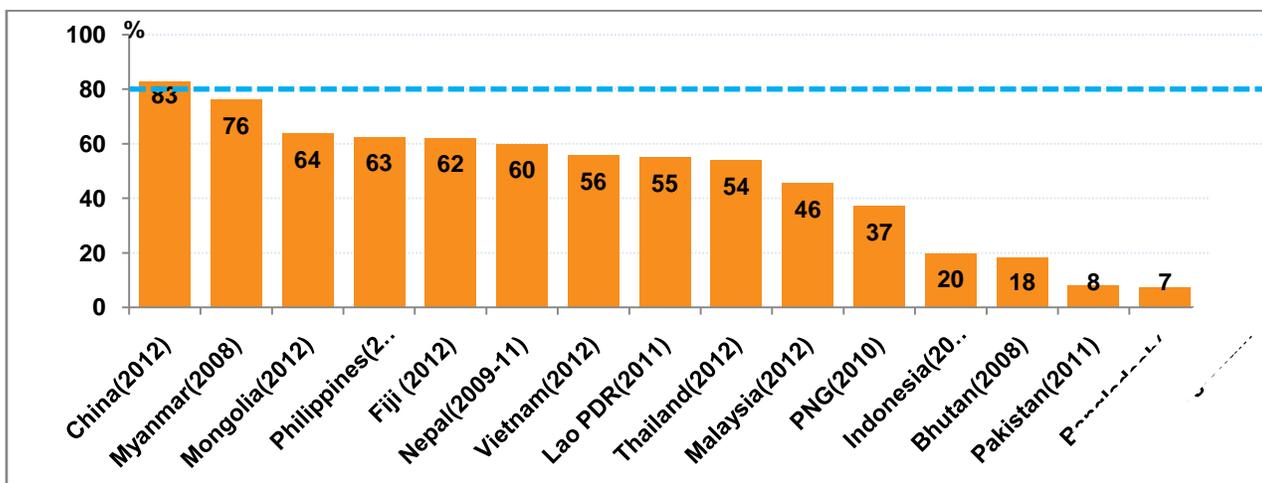
Violence from partners, clients and other sex workers have also been noted in many instances hence fuelling the need for crisis response as evidenced from interventions in several countries.⁴¹

RESPONSES

Coverage of intervention programmes

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

Figure 11: Proportion of FSW reached* with HIV prevention programmes, 2008-2012



* Know where to go to receive an HIV test and had been 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) Behavioral Surveillance Surveys; 3) www.aidsinfoonline.org

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

Examples of Successful Initiatives

The 100% Condom Use Programme

In 1991, Thailand in response to a rapidly growing HIV epidemic, implemented the first 100% Condom Use Programme (pioneered in the Ratchaburi province in 1989), in which all sex workers in sex establishments 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 anti-HIV messages and open debates on HIV and sexual issues. The programme represents an example of a dual approach involving the individual behavioural change as well as socio-structural and organisational change. This is achieved through a nationwide partnership of the public and private health sectors, including AIDS service organisations, non-governmental organisations, and advocacy groups. The primary responsibility of enforcing condom use was on the establishments, which would be closed down if they were non-compliant. The programme helped to empower sex workers to negotiate aggressively with clients to use condoms. 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 FSWs 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 of the 100% condom use initiative was attributed to the fact that clients had no option but to agree to condom use during transactional sex. However, in recent years, as funding for HIV prevention has fallen by two-thirds and public concern has dwindled, the virus has become widespread among other high risk groups such as MSMs and PWID, and condom use has declined particularly among the non-brothel working sex workers who were largely neglected by the 100% condom use programme.⁴²

Although the 100% condom policy in Thailand improved condom use and lowered transmission of STIs and HIV between sex workers and clients, substantial avenues for infection remained. With non-commercial and intimate partners, condom use remained low, between 32–75%.⁴² The net result was that the 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 were from direct sex establishments such as brothels, hence transient sex workers and those who worked at other locations did not record the same level 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 STIs, empowerment in the form of education and condom negotiation skills were less common in the 100% condom programme.

The Avahan Project, India

The Avahan programme in India 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 (as long distance truckers accounted for 10 – 12% of FSW clients) to serve more than 220,000 FSW, 5 million clients and partners, 80,000 MSM and 18,000 PWID.⁴³

Community groups were formed and trained in areas such as 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 high-risk communities were addressed and catered for with specific

programmes, clinics and treatment methods. With the support of the “Common Minimum Program”, as it is called, each centre is given the flexibility to customise implementation based on local needs. At the end of two years, 83% of the enumerated high-risk population 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 high-risk group individuals to attend an STI clinic increased from 25% in August 2005 to 90% in December 2006, and condom distribution for the same went from 1.3 million to 4.6 million.⁴⁴

Due to the often-illegal nature of sex work, 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 – for example, Sonagachi in Kolkata, India, the Avahan project in India’s six highest HIV-prevalence states, the Shakti project in Dhaka, Bangladesh – promote sex workers’ rights, run literacy and vocational programmes, and provide micro loans, thereby increasing sex worker empowerment.⁴⁵ Savings and credit schemes have also helped reduce dependency on sex work. Most of the successful prevention programs include outreach activities by SWs, involving peer educators and the provision of condoms, as well as management and treatment of STIs.

The Pragati project (meaning ‘Progress’), 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 program is implemented through a partnership between Swasti, SwathiMahilaSangha and the Karnakata Health Promotion Trust and is dedicated to a process driven by local stakeholders. Since 2005, Pragati has reached out to more than 16,000 sex workers in the city of Bangalore primarily in high transit areas such as bus stations, railway stations and in busy markets. The project focuses on involving sex workers and other community members to develop programming to improve access to healthcare and create a supportive environment for safe sex practices.⁴⁶

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

- HIV- and STI-related health prevention and treatment services
- A micro-finance lending program
- A community-led violence response program staffed by women who respond to 24 hours a day, seven days a week to acts of violence and harassment throughout Bangalore
- Treatment for women who abuse alcohol

By using a community-based empowerment approach Pragati has had success among a severely marginalized sub-population in Bangalore and in urban areas in India, generally.

VAMP (VeshyaAnyayMuktiParishad) Plus, part of the VAMP sex worker collective which has 5,000 members from seven districts in Western Maharashtra and North Karnataka (India), focuses on the following three areas to improve the lives of sex workers and their children:

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

One FSW involved with VAMP Plus states: “Before, we [sex workers] were treated like animals. We were not even allowed in the hospital to receive any kind of medical check-up. Now we are treated like anyone else. We are accommodated in the same rooms as other patients. Hospitals and doctors are more respectful and sensitive to our needs.”⁴³ Due to the legal status of sex workers in India and other countries in the region, sex workers 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 successes in treatment, testing and care that are possible when sex workers are organized and empowered.

The Avahan programme, noted above, attributes a large portion of its success to peer educators, who are informers regarding 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 members of the communities and creates a foundation for the eventual handover of management of the programme itself. It creates leaders who can go on to advocate for wider rights of their communities. The program created a platform for issues such as stigma associated with HIV and marginalised groups, violence inflicted by police or clients, and denial or non-availability of essential entitlements such as ration cards.⁴³

The EMPOWER program, a sex worker activist project, works with many migrant workers, particularly from Myanmar, and produced Thailand’s first HIV educational materials.⁴⁸ EMPOWER runs its own bar, “Can Do”, collectively owned and run by sex workers, with a sex worker-designed security system, condom distribution, and workers who are trained as 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 US government as that would require the foundation to oppose prostitution under the U.S. Anti-Prostitution Pledge.⁴⁸

KEY MESSAGES

- Refined and localized data and strategic information is needed. Even today many countries resource and implement interventions according to the national aggregate. Localized data will help in geographical prioritization that will result in impact.
- Nuancing program strategies for key affected sub-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 FSWs regardless of their sub type like urban or rural, home based, street based or brothel based. Since the vulnerabilities and risk behaviors are different among the sub-types having nuanced program 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 HIV response, and play a pivotal role. Therefore, investments in community systems strengthening are 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, than just HIV is very important. Community testing and treatment continuum (prevention of loss to follow up) through community interventions is critical to explore.

- Community-led interventions show compelling results in contacting hard-to-reach key populations and facilitating access to services. There is a growing regional momentum and action towards strengthening community institutions for sustained impact, including in the area of community-based HIV testing and counselling for key populations integrating sexual and reproductive health and HIV services, and preventing and addressing violence.
- As HIV programs 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 programs can be greatly enhanced by creating and strengthening linkages within the health system, between health and community systems, and with other non-health programs.
- To sustain positive health outcomes among sex workers it is necessary for a country to examine its policy environment and remove punitive laws that enhance vulnerabilities. In addition particular key populations like sex workers must have access to social protection like entitlements, education, employment and enterprise development facilities to empower and address their vulnerabilities.

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