

A woman with dark hair pulled back, wearing a blue denim vest over a dark top. She is looking directly at the camera with a neutral expression. Her hands are in her pockets. She is wearing small hoop earrings and a bracelet with heart-shaped charms on her left wrist.

# Access to HIV prevention, treatment, care and support for sex workers

Report on the State of the Art

### **About Aids Fonds**

The Aids Fonds is there to support everyone living with or affected by HIV/AIDS. Our mission is 'working towards a world without AIDS'. This means that the Aids Fonds is active both in the Netherlands and abroad.

The main aim of the Aids Fonds is to ensure that everyone has access to prevention, treatment, care and support. Aids Fonds gives special attention to groups that are affected the most, but get the least support. Therefore Aids Fonds has asked Melissa Ditmore to write a state of affairs with regard to Universal Access for sex workers.

### **About the author**

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# Summary

This report presents an overview of HIV prevention, treatment, care and support for sex workers, using case studies and literature to present best practices. The most effective HIV programmes for sex workers are undertaken from a rights based perspective, are grounded in evidence rather than driven by political expedience or moral judgements, work to prevent the abuse of sex workers, recognise the gender and sexual diversity of sex workers, and are culturally appropriate and respect local sex work cultures. Best practices ensure the provision of safe sex materials including male and female condoms and personal lubricant, in an enabling environment. This report offers an overview of the literature about sex work and HIV-prevention, a summary about the state of sex work and HIV prevention on the ground, and recommendations addressing capacity building, strengthening networks, advocacy, and research to scale up the implementation of more effective HIV prevention programmes for sex workers. It provides insight into sex work projects, networks and organizations and their involvement in relevant forums.

The need to scale up HIV/AIDS prevention, treatment and care for sex workers is clear. Universal access to support, treatment, prevention and care for sex workers requires a wide range of services, not limited to health services. Sex workers face many obstacles including stigma and discrimination, addressing immediate needs such as food and shelter, and caring for the children of sex workers.

Interviews with 144 people and site visits in four cities offered insight, goals and strategies for scaling up effective HIV-prevention services for sex workers. Recurring and overlapping themes across geographical areas and types of projects included:

- Self-organisation by sex workers
- Access to health care, education and access to safe sex materials
- Sex workers driving the agenda of organisations
- Promoting safe and good working conditions for sex workers
- Campaigns to realise the human rights of sex workers
- Safe environments for the families of sex workers
- Anti-violence campaigns, and
- Removing sex workers from harm done by police and the military.

These themes should be the focus of interventions and scale-up for sex worker projects. Additional concerns were related to scaling up global advocacy,

particularly with the United Nations, and advocacy to educate people in the US about the effects of specific funding restrictions on PEPFAR and anti-trafficking monies. Advocacy promoting evidence-based, proven-effective programmes relies on data and analysis: This requires both capacity building for sex work projects to collect data ethically and without risk to participants and for targeted action research to document the effects of particular programming to demonstrate successes and problems.

Selling safe sex requires more than safe sex materials. Accurate information about anal intercourse and health is critical for all sex workers of all genders. Information about the correct use of lubricants is necessary because factors that prevent correct use of lubricant contribute to condom failure. In some countries, such as Serbia, lubricants are not on the medical list and cannot be imported.

Campaigns and programmes undertaken are most successful when selected and spearheaded by sex worker participants. All work with sex workers should begin with a participatory and rights-based approach, consulting sex workers and employing sex workers in paid positions at all levels of programming and with input at all stages, from conception to implementation. Establishing the priorities of programmes according to the needs of sex workers requires direct input from sex workers at every level of decision-making. This is the basis of successful projects. Greater inclusion of sex workers in decision-making leads to more people seeking the services offered by projects.

In many places, sex workers would benefit from capacity building to implement and manage projects, to collect data and use this in surveillance, planning programming, and advocacy, and to conduct research and campaigns using this research.

Rights violations including forced testing, police abuse and denial of access to health care and lifesaving medicines have been documented in health, HIV-prevention, research and anti-trafficking programming. Rights abuses must be addressed immediately. When rights abuses occur in HIV/AIDS programming, programming must cease and rights-based methods must be implemented.

Successful advocacy will require support from broader civil society, including organizations and individuals who have not typically supported sex workers. This requires forging new alliances in order to promote sex worker rights beyond access to health services.

## Best practices

Best practices ensure the provision of safe sex materials including male and female condoms and personal lubricant, in an enabling environment. Sex workers of all genders and other sex work venue personnel including managers and staff require information about HIV, STIs, human rights, safe sex and sexual health including anal sex, and health services. The provision of diagnosis, treatment and care for STIs is a critical aspect of HIV-prevention for sex workers. Voluntary and confidential counseling and testing is necessary, alongside treatment and care for HIV/AIDS and secure food supplies, especially for people taking ARVs.

The most effective HIV programmes for sex workers:

- Are undertaken from a rights based perspective
- Are grounded in evidence rather than driven by political expedience or moral judgements
- Work to prevent the abuse of sex workers
- Recognise the gender and sexual diversity of sex workers, and
- Are culturally appropriate and respect local sex work cultures.

Interviewees recommended comprehensive, rights-based HIV/AIDS prevention and care. This means offering information, including information about anal and oral and non-penetrative sex in addition to information about vaginal sex, and access to safe sex commodities including male and female condoms and personal lubricant to sex workers, clients and others involved in the sex industry including brothel managers, other staff and gatekeepers alongside confidential HIV, STI and reproductive health care and treatment. Education and distribution of commodities has been done with great success by peer educators and outreach workers. Education about the use of new technologies will be critical and similar models will need to be adapted as new technologies are developed, such as PrEP, microbicides and vaccines.

It is recognised that 'the most successful initiatives have empowered sex workers.' (UNAIDS, 2008, p.87) and so all work with sex workers should begin with a participatory and rights-based approach, consulting sex workers and employing sex workers in paid positions at all levels of programming and with input at all stages, from conception to implementation. Rights violations including forced testing, police abuse and denial of access to health care and life-saving medicines have been documented in health, HIV-prevention, research and anti-trafficking programming. Rights abuses clearly indicate that programming must be stopped immediately and new methods

investigated. No one wants to be implicated in supporting human rights violations in programming or research.

People affected, including sex workers, 'need to have a more meaningful role in collaborative decision-making, planning, and continued monitoring of progress towards the goal of universal access' to support, treatment, prevention and care (UNAIDS, 2008, p.90).

Programming with sex workers should begin by consulting sex workers and employing sex workers in paid positions at all levels of programming and with input at all stages, from conception to implementation. Rights violations including forced testing, police abuse and denial of access to health care and life-saving medicines have been documented in health, HIV-prevention, research and anti-trafficking programming. Rights abuses clearly indicate that programming must be stopped immediately and new methods investigated. Donors do not want to be implicated in supporting human rights violations in programming or research.

Programming for rights-based HIV prevention and care must include:

- Condom promotion by outreach workers and peer educators and affordable condoms and water-based personal lubricants
- In-depth information about health, sexual health including anal sex, and HIV prevention and transmission
- STI diagnosis and treatment, including monitoring antibiotic resistance
- Support for the self-organizing of sex workers, and
- Access to care and treatment, including medications for HIV/AIDS.

## Recommendations

### Recommendations for direct service programming

It is recommended that input from sex workers be institutionalised within sex work projects in such a way as to prevent tokenism and promote genuine participation in decision-making.

It is imperative to focus on issues that can be addressed effectively. Do not get bound up with large-scale structural issues (feminization of poverty, status of women and girls) at the expense of evidence-based HIV prevention for sex workers.

Training for health workers not to stigmatize or discriminate against sex workers, and not to sexually

harass sex workers is required. Health care service providers who cannot meet these requirements should be reassigned to other work.

One critical facet of HIV prevention for sex workers is the diagnosis and treatment of STIs. However, syndromic management is still more prevalent than diagnosis. Diagnosis is critical because most infections are asymptomatic. Untreated infections in many cases lead to infertility. Diagnosis of STIs is critical to successful treatment with the most effective medications for specific infections. Men, women and transgender sex workers and their clients and non-paying partners are priority populations for STI diagnosis and treatment. Services should be offered in anonymous, noncoercive facilities without intervention by state agents. Indonesia's example demonstrates that STI diagnosis can be successfully undertaken in contexts with limited resources (See the text box 'The Importance of STI Diagnosis: The example of Indonesia' in the main report).

Ensure constant availability of safe sex commodities including condoms and personal lubricant. In-depth education is necessary prior to the introduction of new technologies to market.

Recognition of transgender people, using local language terms, in programming, and include transgender (using local language terms) in record keeping. Do not subsume transgender women as men in programme records.

Project staff should accompany sex workers to clinics in situations with chronic difficulty combating stigma and discrimination against sex workers.

Rights-based sex work programming must not bring sex workers under the control of or be implemented by the police or military.

All programming must be tailored to the local circumstances. What works in one context, venue or town must be adapted to each location rather than replicated. Every programme should be designed and implemented with input and participation of the local community. IEC materials must be dedicated to the locality, not from another place and translated but generated in the area. This may mean adapting existing materials from elsewhere.

### Recommendations for advocacy

Support for sex worker networks at global, regional and local levels is critical to successful advocacy and movement building on the scale achieved by men who have sex with men and HIV+ people. Efforts to

promote the rights of sex workers have also been chronically underfunded. Sex worker networks have typically been unfunded or under-funded. Core support such as funding for offices, infrastructure, communications and management to undertake campaigns is needed.

Advocacy and diplomacy should be used in tandem to advance and ensure the human rights of sex workers, which will in turn enable sex workers to protect themselves and others from HIV and access care. This is imperative in efforts to influence governments.

Strengthening the advocacy messaging of sex workers in the international arena is vital, and there is also a need to do this within the broader civil society. It is recommended that sex worker networks engage with broader civil society activists and advocates in order to promote awareness of the real needs of sex workers. However, these efforts should be smartly targeted and undertaken strategically. Such campaigns will require additional resources to convene and attend meetings, to develop information and messages for audiences unfamiliar with sex work, and to disseminate messages to targeted audiences. Examples of targeted advocacy include the Media Toolkit prepared by the Sex Workers Project in New York, and the efforts of the NSWP to encourage donors to fund evidence-based, rights-based programming for sex workers (Allman, Ditmore and Mollet 2008) and followed by the OSI-sponsored Donor Dialogue on Sex Work and Trafficking held in December 2008 in the US, convened with CREA and NSWP (CREA, NSWP and OSI 2009).

New media and particularly video has proven to be an enormously strong tool for documentation and advocacy. For example, NSWP and APNSW have produced videos that educated many about the effects US funding policies and the effects of the criminalisation of sex work. Each of the campaigns recommended above would be strengthened with video testimony and advocacy. There are many outfits that train others to produce video, in many languages. Small World News works in Arabic, Spanish and English. Witness is well known. Sex Work Awareness in the US has trained sex workers to use simple cameras to produce short videos. This is not a comprehensive list.

It is recommended that the effects of criminalization of sex work, or third parties and clients be documented and evaluated with respect to HIV/AIDS and to the human rights of sex workers. Sex workers' access to comprehensive prevention, treatment and care is adversely affected by criminalisation of any aspects sex work. In many places where the sale of sex itself

is not specifically a criminal act, there are often laws against third parties (managers) and in some places, the purchase of sex (clients). The fact that sex work and/or aspects of business related to sex work are not permitted in many places creates a climate where sex workers are denied labour rights and employment protection. The recognition of sex work as work requires understanding the complexities of the sex industry and its economy. All networks agree that criminalisation of sex work is detrimental to HIV/AIDS prevention, treatment and care. Therefore, regional, national and local campaigns should be supported in as many locations as possible to document the specific ways the criminalisation – or perceived criminalisation – of sex work adversely affects HIV-prevention and this documentation should be used in campaigns to improve public policy and the enforcement of law and policy. Each campaign will necessarily be unique and tailored to the legal environment and policy framework and priorities of local sex workers.

It is difficult to prioritise areas in which such campaigns should be mounted because this is a nearly universal issue. Cambodia's plan to employ police officers to educate sex workers about HIV/AIDS is the first obvious location. South Africa's ongoing debate about prostitution is another opportunity. US funding strategies and the anti-prostitution pledge (APP) have pushed countries to criminalise prostitution.

## Recommendations addressing specific issues and populations

### Recommendations addressing violence

Violence is an issue universally cited by sex workers, and the link between violence and HIV has been well documented.

The most effective anti-violence efforts have addressed violence systematically. Therefore, using the legal system to improve the response to violence against sex workers is recommended, especially for state-level violence. This is best undertaken with a legal programme.

Coordinating reports of violence is recommended, especially when a particular individual or organization has repeatedly committed violence against sex workers.

Coordinated anti-violence campaigns involving the media to draw attention either to specific patterns or systemic abuse by state authorities are recommended.

The use of new technology including mobile phones to document and expose violence against sex workers should be explored and supported.

Transgender people are disproportionately affected by violence even among sex workers. A transgender network is emerging, and should be supported to document violence and advocate for their human rights. These campaigns should include interpersonal and structural violence, such as the erroneous classification of transgender women as men and the use of solitary confinement for transgender women in men's prisons. RedLACTrans should be supported to undertake these efforts in the Americas, including necessary translation to work across languages, for example with the large number of transgender activists and organisations in English-speaking North America. Strong transgender sex worker activists, including female-to-male sex workers, in diverse contexts in Asia and the Pacific are ready and able to undertake such campaigns. PASST in France is the most renowned support organisation with sex workers in Europe. These networks, organisations and individuals should be supported as resources for transgender sex workers in countries and regions with less-well-developed organisations. RedLACTrans, APNSW and ICRSE among others include activists who are experienced with UN organisations and policies. They should be supported to undertake a campaign to encourage the UN, especially UNAIDS, and other global health bodies, to recognise transgender people as they self-identify. This should include the training of other transgender sex work activists to work with them on this campaign.

#### **Recommendations for programming with children**

Advocacy campaigns to promote the rights of the children of sex workers, including access to official documentation including birth certificates and identification cards, are recommended.

Educational programmes for the children of sex workers are recommended.

#### **Recommendations for financial planning and transition or step-out programming**

It is recommended that any efforts to assist sex workers to move to other occupations be part of a comprehensive rights-based programme that respects the self-determination of sex workers, including the decision to do sex work.

Projects to assist career sex workers who are no longer able to earn a liveable wage should be supported. This could include support or training programmes for newcomers to sex work.

Sex workers and their colleagues and clients are untapped resources to combat trafficking in persons. These people should be included in anti-trafficking efforts, not criminalised.

#### **Recommendations for programmes for transgender people**

Require projects to distinguish between transgender people from men who have sex with men. Use the terms that transgender people call themselves locally.

Advocate for international organizations, particularly UNAIDS, and governments to distinguish between men who have sex with men and transgender people, recognising the variety of transgender experiences, including male-to-female and female-to-male transitions.

Include HIV-prevention, care and treatment programming for transgender people, with input and participation by transgender people in ideation and implementation.

All projects, especially those for transgender sex workers, should discuss anal sex and HIV prevention. Sufficient personal lubricant for all interactions should be made available at no cost or affordable for all.

Safe injecting information and material including clean needles of a variety of sizes and information about preventing infection should be offered to transgender sex workers. Drug use is only one reason for injecting. Transgender people may inject hormones and/or silicon. Safety precautions for HIV prevention are similar with all injecting. Silicon injecting, however, presents other issues.

Advocate for humane treatment of transgender people in prison. This means advocating against situations that may encourage violence against transgender people and advocating against solitary confinement.

#### **Recommendations for programmes with men who sell sex**

Programmes should be designed to include men who sell sex in all parts of the world. All projects, but especially those that focus on men, should discuss anal sex and HIV prevention.

Projects that reach out to men who sell sex should make personal lubricant available. Best practices require enough lubricant for all interactions and for lubricant to be free or affordable for all.

Projects should offer or make referrals to services for the intimate partners, including women, of men who sell sex.

#### **Recommendations for programming with migrants**

STI and HIV diagnosis, treatment and care should be provided to all regardless of status in the country in which they seek these services.

Sex workers, colleagues and clients should be partners in efforts to assist migrants and people in coercive situations.

Law enforcement interventions should be avoided.

The use of new technology including mobile phones to assist migrants should be explored and supported.

#### **Recommendations for programmes for sex workers who use drugs**

Harm reduction materials must be made available to sex workers who use drugs. This includes safe injecting kits and information about preventing infection.

#### **Recommendations for programmes for youth**

Programmes for youth should emphasise opportunities, especially education and employment. Some programmes offer specific training and may employ the children of sex workers.

Law enforcement situations should be avoided.

#### **Recommendations for research with and by sex workers**

Sex workers are the experts on their lives and should be included at all stages of research, from ideation and design through realization. Research must include and incorporate input from sex workers at the earliest possible stages, at the onset of design rather than implementation. To come to sex worker communities at the implementation stage is not inclusive and will be perceived as uninclusive at best.

Research should be undertaken with sex workers setting the agenda. Sex workers are keen on research that addresses issues that affect their lives. Where sex workers are included, research has progressed well (see, for examples, Jenkins 2006, UNAIDS 2009, Allman and Ditmore 2009). To present sex workers as uninterested in research reflects poorly on the research being conducted and the skills of the researchers than on sex workers.

Genuine participation in research requires that sex workers be consulted at the planning and design

stages, prior to implementation. In-depth information must be offered in a language that is easily and well understood by the participants. In some cases, capacity building for research literacy will be required.

HIV prevention materials and information must be provided.

Health care including long-term care and treatment for people who seroconvert or suffer side effects must be planned for and provided.

UNAIDS should be encouraged to develop and enforce – with sex worker participation – protocols for good participatory practice.

#### **Recommendations for supporting sex worker networks**

It is recommended that the representation of sex workers in civil society be strengthened by funding networks of sex work projects and sex workers. Priorities include the Global Network of Sex Work Projects. Regional priorities include nascent networks, especially in Africa.

Some networks have limited funding; others, including the Global NSWP, remain underfunded and this has weakened their ability to represent the interests of sex workers. Translation is a critical need for communications across and within networks. Emerging networks have greater needs than more established networks.

In some places, such as Europe, overlapping networks work well together. This is successful in part because the roles and mandates of each network are explicit. In Sub-Saharan Africa, overlapping networks are establishing roles across networks. These roles will determine priorities for support.

Participation in the Global NSWP by projects in the Middle East and North Africa should be supported. This may be facilitated by the creation of an Arabic-language communication network, including a listserv and mobile phone messaging.

RedLACTrans has expressed interest in expanding to be a global network of transgender people (not all of whom are sex workers), and initial efforts to reach out beyond the Americas should be supported. Fund capacity building for and by sex worker networks. In some instances, sex workers have conducted trainings. For example, The Global Network of Sex Work Projects (NSWP) and the Asia Pacific Network of Sex Workers have conducted workshops for members, including human rights

documentation, information on thematic issues such as research ethics and human rights, human rights documentation, and advocacy and activism skills. Sex Work Awareness in the US offers video and media training. SWING is not only a model project for work with male and transgender sex workers, SWING also has experience training other organizations to work with sex workers at all levels of programming, including design, implementation and management. Trainees have included local NGOs, health care providers, and Global Fund recipients from other parts of Asia. These organizations and health care providers report having enjoyed and benefitted from SWING's training. Trainings like these by sex work projects should be continued, supported and replicated.

It is imperative to continue to explore ways to use new media to promote sex workers' rights. For example, sex work networks have found video to be an important advocacy tool. (See, for example, *Taking the Pledge* and *Caught between the Tiger and the Crocodile*) This is one way to include voices from individuals and organisations in places with low literacy rates and who may be unfamiliar or lack resources needed to produce and distribute traditional press releases and reports.

#### Middle East and North Africa

Existing programmes in the Middle East and North Africa include some well-educated sex workers on staff and some effective programmes. However, it is impossible to know the efficacy of most programmes because so little information – in some cases, not even how many people use the services and what services they use – is recorded. A regional workshop is recommended to train programme participants – sex workers – to manage this information, including the use of computers and reporting.

#### Sub-Saharan Africa

The emerging Alliance in Sub-Saharan Africa should be supported as an independent entity from SWEAT and its other members, as recommended in the conference report. The Alliance has members who are strong advocates such as ARASA. However, capacity building for sex workers to monitor and document abuses and mount campaigns is necessary. This new African Alliance should be supported to work across languages, thereby expanding the inclusion of colonial and local languages, with advocates like ARASA and OSI-SA and SWEAT offering technical assistance and capacity building while sex workers themselves determine and execute the agenda of this new and vital Alliance. The smaller francophone network in West and Central Africa offers a model,

with a coordinator who is also a liaison to English-speaking and global networks and organisations, including the NSWP.

#### Latin America

Latin America has separate but strong networks of female sex workers and transgender people. However, the region lacks a non-gender specific network or venue to communicate that includes men and transgender sex workers as well as women. This could be the NSWP's Latin American network.

#### North America

In North America, support is necessary for a campaign to change US policy. In order to be effective, this needs to be undertaken by a coalition or organisations including but not limited to feminist and sex worker organisations, including health activists, advocates and organisations. Such an effort was nearly successful in 2008 but was undermined by specific health organisations. Such efforts must be redoubled in order to ensure success in 2011. In the US political climate, it is imperative that the person or people who lead and inform this campaign has extensive experience as an advocate on policy. Sex workers must be included at all levels but it is clear that capacity building for a campaign of this level is critical because of the particular political context in which targeted messages from sex workers will not be effective without significant support from wider civil society as represented by specific health and feminist activists.

#### Asia and the Pacific

APNSW is quite strong. One of the great capabilities of APNSW is documentation of abuses and support for sex workers and organisations that seek assistance with combating abuses. Andrew Hunter recommended that within the Asia and Pacific region, the new network of sex workers in Myanmar (Burma) is in great need of support.

#### Europe, including post-soviet states

The three overlapping and funded networks within Europe, ICRSE, SWAN and TAMPEP, work well together. Their programming must continue. Sex workers in central and eastern Europe and central Asia (CEECA) would benefit from more capacity building and support for sex workers, especially social support. Some members of SWAN are developing affiliated sex worker organisations but this process needs to be supported to expand and for sex workers themselves to determine the agenda of advocacy and activism in CEECA.

HIV-prevention services designed for sex workers who use drugs are necessary in Eastern Europe and Central Asia.

#### Recommendations for advocacy with large international mechanisms

Global and regional networks need to be supported to participate in key advocacy meetings with global institutions, including but not limited to the UN.

#### US anti-prostitution pledge

It is recommended that a campaign to remove the anti-prostitution pledge (APP) from PEPFAR and a return to evidence-based programming with sex workers be undertaken. This will require participation by people outside the US, travelling to the US to speak with legislators, and a US-based campaign to cultivate legislative support and grassroots support in the home communities of legislators who work toward the repeal of APP.

Advocating for change to US policy on prostitution and trafficking is critical, with efforts within the US in support of legislators who understand the problems associated with APP, and with documentation and the voices of people who have been directly affected by the APP. The US is extremely influential on other states and within the United Nations. For these reasons, strategies should be undertaken to repeal the requirement that partners enact an organisational anti-prostitution policy. The funding made available by laws in which APP features will run out in 2011. At that time, appropriations will begin in the form of new legislation. APP was nearly struck from PEPFAR in 2008. Input from people outside the US is necessary, but these policies can only be challenged with a broad network across the US, led from a political centre, probably Washington, DC or New York City. Concerted advocacy in the form of a media campaign promoting grassroots support in their home communities for key members of the US Congress who support the removal of APP will be necessary to achieve this.

#### Global Fund to Fight AIDS, Tuberculosis and Malaria

It is recommended that country coordinating mechanisms (CCMs) be required to include specific groups that are affected by HIV, including sex workers of all genders. It is also recommended that the GFATM design and implement a non-CCM application process in places where the legal, political or social environment precludes the participation of sex workers.

It is recommended that the GFATM disseminate information in a transparent, accessible and timely manner.

Sex work projects and networks should strive to be included in GFATM processes and monitor the

inclusion of sex workers in Fund programming and the efficacy with which Fund resources reach sex workers. This would require funding for sex work networks.

Mechanisms for the participation of civil society, especially affected populations including sex workers, should be developed for IHP+.

#### United Nations

In May of 2009, representatives of the Global Working Group on HIV and Sex Work Policy, established by the NSWP, met with Michel Sidibé and other representatives of UNAIDS and its Cosponsors and agreed that UNAIDS would ensure the meaningful participation of sex workers and would work closely with the NSWP in the future, indicating that global and regional sex work networks will be actively involved in the interpretation and implementation of the Guidance Note on HIV/AIDS and Sex Work. Sidibé also gave a commitment that UNAIDS would call for governments to remove punitive laws, which criminalise sex work. It is recommended that efforts be made to influence UNAIDS to re-evaluate the placement of sex work within its partner organisations.

It is recommended that the PCB and other bodies and organisations seek clarification from UNAIDS about the implementation of the Guidance Note, especially with regard to the reduction of HIV in sex work settings and to be concrete in terms of how the guidance note will inform UN and country level programming. For example, will it just be disseminated or are there trainings and TA planned; will there be indicators developed in terms of measuring the countries' response on addressing sex work issues, and how will this inform the country AIDS plans.

Campaigns to expand access to life-saving medicines could, for example, attempt to enforce the use of compulsory licenses enabled by the TRIPS agreement to enable greater production and availability of life-saving medicines.

Advocate for surveillance and public health programming to reflect the reality of transgender people, including expanding gender conceptualization beyond male and female to include transgender people, according to local manifestations. If the UN lead by example, it would be easy to require UN-sponsored programmes to include transgender people as transgender rather than male in their monitoring and further enable more sophisticated understanding of the AIDS pandemic and other STIs and health issues as they pertain to a significant and vulnerable population.

# 1. Definition and Scope of the Problem

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More than 33 million people are living with HIV. The epidemic is spreading at a faster rate than the provision of services. Therefore the scale up of effective prevention is very much needed. Effective prevention aims at the people who are most at risk. Among these people are sex workers.

Sex workers have multiple sexual partners. 'An environment in which people have multiple sex partners is especially conducive to the spread of the virus. Protecting sex workers from HIV infection benefits them and also has a large potential HIV prevention benefit for the general population. HIV prevention programs with sex workers are highly cost-effective. Evidence shows that keeping HIV levels low among sex workers slows HIV epidemics. In countries with low and concentrated epidemics, strategies should focus on building the knowledge base and capacity of sex workers.' (UNAIDS, no date, 'Sex workers and clients'.)

The involvement of key populations is often not put into practice because of the criminalization of the behaviour that distinguishes the particular groups. Because of this for instance sex workers are often not involved in the development and planning of prevention efforts targeting sex workers. This is also the case with planning by the CCMs for grants of the Global Fund (Fried and Kowalski-Morton, 2008). The Aids Fonds works in accordance with the GIPA principle (Greater Involvement of People Living with HIV/AIDS).

Civil society groups working on HIV and sex work is very diverse. This report spells out next steps and what is needed to support community mobilization on sex work and HIV/AIDS.

## 1.1 Who do we mean by sex workers?

According to the UNAIDS terminology guidelines of 2008 commercial sex work means 'the sale of sexual services'. Sex workers can be women, men and transgender people. Sex work is in principle consensual sex. However, in some circumstances it can be difficult to distinguish between sexual violence, human trafficking and sex work. This is for instance the case with juveniles who may – according to the UNAIDS guidelines of 2008 – be called prostitutes. For HIV prevention, all sex workers are relevant and should therefore be taken into consideration. However, different kinds of solutions are appropriate for different kinds of sex workers.

## 1.2 What do we already know?

### 1.2.1 What do we know about effective programmes? (Greenall, 2007)

For effective HIV prevention among sex workers, correct use of condoms, and lubricant (if available) at each sexual act should be promoted, and availability of affordable quality male and female condoms should be ensured. Furthermore, sex workers must have access to comprehensive health care services with an emphasis on quality sexually transmitted infection (STI) diagnosis and treatment. Availability of HIV counseling and testing and AIDS care, including antiretroviral therapy is essential (UNAIDS, no date, 'Sex workers and clients').

Programmes that use a rights based approach have been shown to be more effective. For instance mandatory health testing has created a false sense of security and has made sex workers and clients less careful. Not even legalisation, but decriminalization is a focus is a lot of effective programmes, because especially the oppressive behaviour of law enforcers has a negative effect on HIV prevention. Not only law enforcers but also health care personnel find it very difficult to respect sex workers as human beings, so efforts must also be targeted at them.

The risk of infection is highest where sex workers are most powerless and therefore unable to negotiate or insist on the use of condoms by their clients, or to resist violent and coercive sex. Therefore both social and structural efforts to reduce violence in sex work settings are needed (UNAIDS, no date, 'Sex workers and clients'). Programmes that are focused on the empowerment of sex workers can therefore be very effective.

There is a strong link between the risk of HIV transmission and violence – which often occurs in sex work settings. Not only violence itself but also the fear

of getting hurt makes that people are more vulnerable to contracting HIV. Effective programmes deal with violence in a systematic way (Greenall, 2008).

Step-out or transition programmes can be effective when the human rights of the targeted people are respected and when focused on sex workers who want to step out or focused on the reasons why sex workers want to do sex work (American Jewish World Service, 2006, quoted in Dorf, 2006, p.18). Identifying cases of human trafficking instead of confusing human trafficking with sex work is an important aspect of effective and well-targeted HIV prevention. Human rights violations have occurred in situations where these principles were not implemented. For example, in Cambodia, sex workers were imprisoned and no services were offered, but this was called an anti-trafficking measure. (*Caught Between the Tiger and the Crocodile*, 2008).

Comprehensive health services for sex workers in a non-judgemental setting do not lead to more sex workers, but may lead to greater visibility of sex workers.

### 1.2.2 Networks and organizations

Important networks and organizations of sex workers that are internationally active include the Asia-Pacific Network of Sex Workers, Empower, the Global Network of Sex Work Projects, the International Committee on the Rights of Sex Workers in Europe (ICRSE), the International Union of Sex Workers, Prostitutes of New York (PONY), the Scarlet Alliance, Sisonke, Service Workers In-Group (SWING), Srikandi Sejati, TAMPEP, Women's Network for Unity, and WONETHA.

Organisations that work on human rights, sex work and HIV include: the African Sex Work Alliance, the AIDS and Rights Alliance for Southern Africa, the Canadian HIV/AIDS Legal Network, Center for Advocacy on Stigma and Marginalization (CASAM), Cordaid, HIVOS, the International Council of AIDS Service Organizations, the International HIV/AIDS Alliance, Open Society Institute, Oxfam Novib, Sex Worker Rights Advocacy Network (SWAN), Sex Worker Education and Advocacy Taskforce (SWEAT), Stella, the Seven Sisters, and Taiz-Plus. Within UNAIDS, UNFPA holds the portfolio on sex workers and HIV.<sup>1</sup>

### 1.2.3 Involvement of sex workers

The empowerment and involvement of sex workers in HIV programmes has proven to be very effective (Crago, 2008). However, the criminalization of sex work is a serious barrier to the involvement of sex workers (Commission on AIDS in Asia, 2007).

Governments typically address sex workers as lawbreakers, rather than critical stakeholders that must be involved. The US is one of the most striking examples of a government that does not wish to deal with sex workers: The anti-prostitution pledge even forbids other governments to do so (*Taking the Pledge*, 2007).

### 1.2.4 Objective information

Criminalization and discrimination make it difficult to gather accurate information about sex work. Good information is of great importance for advocacy. Around the world, an obstacle to resourcing HIV-related programming for sex workers is a lack of epidemiological information about HIV among sex workers. The International HIV/AIDS Alliance quotes the Report of the UN Secretary General on the lack of demographic information about HIV among sex workers and transgender people in Latin America and the Caribbean (International HIV/AIDS Alliance, 2009, p.20).

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In many countries there is limited willingness or capacity to focus on the legal, social, economic and cultural issues that drive the epidemic. Groups known to be most at risk of infection – such as sex workers, injecting drug users and men who have sex with men – rarely receive targeted services, resulting in ineffective responses. Overt and covert stigmatization and discrimination against these groups is a significant factor impeding data collection and targeted funding and programming.

– Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: Focus on Progress over the Past 12 Months, Report of the UN Secretary-General, May 2007

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This lack of information not only makes it difficult to push for effective programmes, but also gives space to assumptions that are based more on prejudices than on knowledge. Sex work is for instance often confused with human trafficking and sex workers with victims of human trafficking. For effective HIV programming it is important to differentiate between sex work and trafficking, and to approach sex workers and trafficked persons with services tailored to their distinct needs.

<sup>1</sup> For an oversight of organizations that give funding to sex work projects, please check 'Sex Worker Health and Rights: where is the funding?', Open Society Institute, June 2006. [www.soros.org/initiatives/health/focus/sharp/articles\\_publications/publications/where\\_20060719](http://www.soros.org/initiatives/health/focus/sharp/articles_publications/publications/where_20060719)

The report also makes recommendations for funders. One of the recommendations is to support capacity-building (Long-term funding partnerships, with multiyear grants and technical assistance provided to sex workers organizations, will make the greatest improvements in sex worker health and rights work.

## 2. Methods

### 2.1 Literature, 14

### 2.2 Interviews and site visits, 14

#### 2.1 Literature

The literature on sex work documents that sex workers are among the people at greatest risk of contracting HIV when the virus appears in a given community, and therefore require a range of prevention commodities and services as well as care and treatment. However, many countries do not collect epidemiological data about sex work and in no country are all sex workers included in epidemiological data. Some regions are underrepresented in the literature. A disproportionate number of articles focus on street-based sex workers because of their visibility, despite street-based sex workers being a minority. The majority of papers do not address the developing world, especially places with high prevalence of HIV and STIs. Therefore, while there is a great deal of literature, not all of this information is useful for planning work with sex workers in specific environments where HIV-prevention is critical. Furthermore, a great deal of potential information is lost because sex workers are almost uniformly and exclusively examined as sex workers rather than in relation to other facets of their lives, including decision-making, migration, and economics (Agust'n, 2005).

This review focuses on the recent peer-reviewed journals, and supplements this body of information with videos, NGO reports, and news articles in order to be as current as possible. Journal articles were selected by searching for 'prostitut#', sex work, HIV, and AIDS in the databases PubMed, PLOSONline and others. In some cases, more information was sought about particular programmes and key informants offered additional papers. Information from the global south was prioritised for inclusion.

#### 2.2 Interviews and site visits

Sex work projects in four urban centres were visited and 144 people consulted in person and by telephone, Skype and email for this report, including sex workers, NGO personnel, representatives of international organizations, scholars and researchers. Each site visit offered a case study of a particular phenomenon.

Many programmes were considered for site visits, and it was not possible to visit every region, or even every continent. Sites were chosen based on rates of HIV and AIDS, particular programming, critical issues including drug resistance and whether information was

available from the literature. In February 2009, South Africa, Egypt, Thailand and Indonesia were visited. Johannesburg, South Africa was chosen in order to see sex work programming in a general epidemic, with visits to Wits University, their Reproductive Health and HIV Research Unit (RHRU) and meeting with the steering committee of Johannesburg Sisonke, the South African network of sex workers. Marieke Ridder of STI AIDS Netherlands recommended the inclusion of Cairo, Egypt, for the possibility of interviewing UNAIDS staff for the Middle East and North Africa and to highlight the innovative legal assistance offered to sex workers. Furthermore, other active projects in the region were better represented in the literature. I took advantage of changing flights in Bangkok, Thailand to visit SWING, which had just completed a participatory research project with sex workers. Jakarta, Indonesia was chosen in order to observe firsthand the effects of drug resistance and the response of the government and public health programmes, in a city with programmes targeting male, female and transgender sex workers and with two clinics renowned for their services. It was especially valuable to see these clinics after they had changed programming in response to the escalation of STIs and HIV that were related to antibiotic resistant strains of STIs. Meetings in the Netherlands prior to site visits clarified report priorities.

Sex workers and project staff were asked about local situations and programming and their recommendations and priorities for programming, advocacy and other concerns. Project staff in Algeria, Congo, Ivory Coast, Mali, Morocco, Tunisia, and Thailand were interviewed remotely, and asked about their experiences, specific issues for their work, and their recommendations for HIV/AIDS prevention, care and treatment with sex workers. Additionally, people with expertise on specific issues such as research or particular programming or networks were interviewed about their areas of expertise and their recommendations. The list of people consulted is in the appendix.

## 3. Fact-finding and Examples

### 3.1 An Overview of the HIV/AIDS Pandemic and Sex Work, 15

#### 3.1.1 Regional overview and specific populations, 15

#### 3.1 An Overview of the HIV/AIDS Pandemic and Sex Work

Few places have useful estimates of the numbers of sex workers (Vandepitte et al., 2006). Fewer still have epidemiological information about rates of STIs and HIV among sex workers. Many, if not most, nations do not collect data about HIV prevalence among sex workers and this makes it difficult to know whether sex workers are disproportionately affected by HIV/AIDS. The 2008 Report on the Global AIDS Epidemic states that, 'Institutionalized discrimination is also reflected in acts of omission, such as when the level of HIV resources directed towards the needs of men who have sex with men, injecting drug users, or sex workers is not commensurate with local epidemiology or when HIV surveillance fails to track such groups.' (UNAIDS, 2008, p.77)

It is well understood that places where the epidemic is new, sex workers are typically one of the first populations to be affected. However, the good news is that sex workers have generally been receptive to HIV-prevention efforts in their workplaces, especially where interventions are based on rights and evidence.

#### 3.1.1 Regional overview and specific populations

##### East and Southeast Asia

Monitoring the AIDS Pandemic found that sex workers in Vietnam who inject drugs have 49% HIV prevalence, while there is a smaller concentrated epidemic at 8% of sex workers who do not use drugs (2005). Indonesia has very fast-growing numbers of infections, including higher rates among sex workers. In 2005, the Chinese Ministry of Health estimated that 20% of people living with HIV/AIDS in China were sex workers and their clients. Longde Wang (2007) describes the subepidemic among Chinese sex workers: From 2003-2006, 'among 36 sentinel sites of sex workers, the proportion reporting HIV increased from 33.3 to 44.4% and infection rates of up to 17%, indicating diffusion both geographically and in frequency.' Wang adds that it is estimated that sex workers account for one-fifth of all cases of HIV

in China. Since then, China has mounted a response to HIV/AIDS that now includes sex workers in the planning and implementation.<sup>2</sup> HIV epidemics among sex workers in Cambodia and Thailand are well documented and HIV remains a problem. Injecting drug users who sell sex have very high rates of HIV in Vietnam, while sex workers who do not use drugs have lower prevalence at 8%. In 2007, PlusNews reported that HIV prevalence among sex workers in Laos was 2%, but that sex workers had high rates of STIs, a precursor for HIV infection. Indonesia has the fastest growing epidemic in Southeast Asia, spurred on by antibiotic resistance and low rates of condom use.

##### Sub-Saharan Africa

High HIV prevalence has been reported among sex workers in West Africa. Senegal has reported HIV prevalence of 20% among sex workers, and Mali has reported rates of 35% among sex workers (UNAIDS, 2008, p.43). One person interviewed from a programme in West Africa said that many of her colleagues are dying, and that everyone knows what disease is killing so many sex workers, but that 'people do not utilise the medical services available because they experience stigma and discrimination.'

In generalized epidemics, as seen across Southern Africa, sex work is less of a factor in HIV transmission because of the high rates of HIV among the general public. However, in generalized epidemics, sex workers will be more frequently exposed due to the number of partners they have. Therefore, it is imperative for sex workers to have HIV-prevention, treatment and care even as competition for resources increases in a generalized epidemic.

##### Middle East and North Africa

UNAIDS personnel in Cairo said that emerging epidemics across the Middle East and North Africa have been documented at antenatal clinics, leading to speculation that sex workers are more affected and that immediate action is necessary to avert faster regional growth of the epidemic. The 2006 BSS in Egypt (Ministry of Health and Population) found 0.8% prevalence among sex workers. STI rates were higher and there was a lack of knowledge about STIs. UNAIDS reported significant overlap between sex workers and injecting drug users (IDUs) in Algeria, Egypt, Lebanon and Syria (UNAIDS, 2008, p.60). Therefore, increasing the use of condoms and clean needles is critical.

##### The Caribbean

There is very little epidemiological data about HIV and sex work in the Caribbean. UNAIDS reports that HIV prevalence of 9% was reported among sex workers

in Jamaica and 31% in Guyana (2008, p.55). It also appears that prevalence is declining in the Dominican Republic and that more sex workers are using condoms more consistently (Kerrigan et al, 2006).

#### Central America

In Central America, El Salvador (16% prevalence among street-based sex workers) and Guatemala (15% prevalence among street-based sex workers) (AVERT) and Honduras (10% prevalence among sex workers) are experiencing concentrated epidemics among sex workers. However, the Ministry of Health in Honduras reported steep declines in HIV among sex workers after concerted efforts were made to promote to condoms (UNAIDS, 2008, p.56).

#### South America

Bautista et al found relatively lower rates of HIV among sex workers in South America, especially in Bolivia and Ecuador and Peru. This may be linked to relatively lower rates of HIV/AIDS in general in South America and to the history of sex workers organising along a labour rights model. Montano et al (2005) documented rates of HIV up to 6.3% among brothel-based sex workers in South America, much lower than those among men who have sex with men.

#### South Asia

Concentrated epidemics among sex workers have been documented in many parts of South Asia. In India's high-prevalence states, HIV prevalence among sex workers is quite high, at 24% in Mysore (Ramesh 2008) and 41% among transgender sex workers in Mumbai (Shinde, 2009). In places where sex workers are organised, rates are lower. The best example of this is the Durbar Mahila Samanwaya Committee, which uses a comprehensive approach to collectively address problems beyond HIV that may affect vulnerability to HIV. In Kolkata, HIV prevalence among sex workers is under 10%. Pakistan and Bangladesh are low-prevalence countries in which sex workers are at risk and where HIV prevention efforts with sex workers need to be increased. Sex workers in Bangladesh suffered a setback in HIV prevention when funding for the two largest programmes was lost (see *Taking the Pledge*, 2007). In May 2009, Plus News reported that Pakistan's Ministry of Health said that Pakistan now has a concentrated epidemic among injecting drug users. There is overlap with sex workers, and sex workers are usually affected when HIV rates increase among drug users. Nepali women who have returned to Nepal after being trafficked to India to sell sex have very high rates of HIV. This context requires specific HIV prevention, care and treatment programming, tailored to situations involving coercion and minors.

#### Eastern Europe and Central Asia

High rates of STIs have been diagnosed among sex workers in Eastern Europe and Central Asia, which is a precursor to growth of HIV. In Eastern Europe, this is linked with drug use, especially in the Ukraine and the Russian Federation (UNAIDS Best Practices Collection 2006).

#### The Pacific

In the Pacific, Papua New Guinea has a hot epidemic. There is little data from Pacific Islands, but movement-building among sex workers is growing in the region, and may lead to better information. This emerging national network receives capacity building training from Australia's Scarlet Alliance.

#### Injecting Drug Users

Concentrated epidemics have been documented among drug using sex workers in Vietnam and some former soviet states. This overlap is not limited to the developing world: High rates of HIV have been documented among sex workers who use drugs in Ireland (National Advisory Committee on Drugs, 2009). There is overlap between IDUs and sex workers, most notably in China, India, Pakistan, the Russian Federation and Vietnam (UNAIDS, 2008, pp.50,53).

#### Transgender People

Concentrated epidemics have been documented among transgender people (International HIV/AIDS Alliance, 2008), many of whom sell sex because there are limited occupational opportunities afforded transgender people.

Broader and more intense coverage is needed for sex workers in general, and in specific in Central America, Indonesia, the Pacific, South Asia, West Africa, and among transgender sex workers and among sex workers who use drugs. A recent study found that 39% of sex workers surveyed in Goa, India, were familiar with HIV-prevention methods and that 31% have no knowledge of HIV/AIDS. In this study, knowledge and access to free STI services were associated with lower likelihood of being HIV+ (Shamanesh, Cowan, Wayal, Copas, Patel & Mabey, 2009). Clearly, scaling up coverage now is critical for HIV prevention among sex workers.

The lack of data about HIV and sex work, and the fact that most sex workers surveyed are female, means that there is not enough information to be confident that we 'know the epidemic' well enough to plan adequately for HIV programming with sex workers. Better surveillance and care and treatment is necessary to determine other epidemic hotspots.

There are valid obstacles to surveillance. Sex workers have good reasons to avoid and even object to enumeration. For example, Red Cross data about sex workers was given to religious police in Nigeria (BBC, 2008). Sex workers' fears that local authorities could use estimated numbers of sex workers as targets for arrest, and, in the case of non-nationals, deportation, are well founded. However, the lack of useful numbers can be problematic for planning programming, in terms of how many people may make use of particular services, numbers of condoms to make available to distribute, and the number of staff needed, for example, to handle appointments. These estimates are made much easier with the assistance and participation of local sex workers who are familiar with the local sex industry and perhaps even the numbers of people working in different types of venues. Guest et al (2007, p.3) estimate that there are between 200,000 and 300,000 sex workers in Thailand. They used earlier surveys and the authors' familiarity with sex work venues to come to this. They were so well informed because of the involvement of sex work projects and sex workers themselves.<sup>3</sup> This is another example of how the importance of including sex workers in all levels of programming is critical to the success of HIV-prevention with and for sex workers. The level of trust necessary to ensure successful programming is not possible in an environment in which sensitive information could be shared with law enforcement and other people whom sex workers routinely try to avoid.

Sex workers urgently need better HIV-prevention and treatment programmes and commodities. Scale-up of prevention is critical to stemming the AIDS pandemic. HIV prevention programmes in most countries are estimated to reach no more than 20 percent of sex workers, despite the fact that sex workers are disproportionately affected by HIV in most places (Global HIV Prevention Working Group, 2007, p.2; UNAIDS, 2008, p.32). Sex workers in some places offer a bellwether, as sex workers may experience changing rates of HIV and STIs before the general public, further demonstrating that work with sex workers should be a priority in HIV/AIDS programming. The Global HIV Prevention Working Group estimates that half of new infections estimated could be averted if only HIV prevention efforts were brought to scale, meaning 'sufficient coverage, intensity, and duration to have optimal public health impact' (2007, p.1). UNICEF, WHO, and UNAIDS (2007) estimate that condoms are worn for only 9% of risky sex acts. There is a lot of work to be done. Scaling up HIV prevention and treatment with sex workers *now* is critical.

Scaling-up HIV prevention will require reaching many more sex workers. The Global HIV Prevention Working Group estimates that no country reaches more than 20% of sex workers (2007, p.2), but what does reaching sex workers mean? Coverage is not one single encounter but repeated, ongoing contact and delivery of services including safe sex skills like condom use and techniques, and/or safe sex materials including male and female condoms and water-based personal lubricant. Coverage is indicated by regular repetition of contacts and the intensity of services and materials offered and delivered. Scaling up means reaching many more sex workers much more intensely.

<sup>2</sup> Personal correspondence with Andrew Hunter, May 2009.

<sup>3</sup> Surang Janyam and Tee of SWING, personal communication, February 2009.

# General issues

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Myriad issues touch upon sex work: epidemiology, medicine, human rights, violence, HIV, STIs, economics, gender issues, drug use, discrimination and trafficking in persons are a few of the most obvious. Many of these topics overlap rather than fan out into neat categories. Furthermore, a great deal of potential information is lost because sex workers are almost uniformly and exclusively examined as sex workers rather than in relation to other facets of their lives, including decision-making, migration, and economics (Agust'n, 2005). This section addresses the topics of human rights; best practices for HIV prevention; access to prevention materials, treatment and care; strengthening civil society structures,

barriers to effective sex work programming within large financial structures, and suggestions for working with UNAIDS.

Interviews and site visits offered goals and strategies for scaling up effective HIV-prevention services for sex workers. Recurring and overlapping themes across geographical areas and types of projects included self-organisation by sex workers, access to health care, education and access to safe sex materials, sex workers driving the agenda of organisations, promoting safe and good working conditions for sex workers, campaigns to realise the human rights of sex workers, safe environments for the families of sex workers, anti-violence campaigns, and removing sex workers from harm done by police and the military. These themes should be the focus of interventions and scale-up for sex worker projects. Additional concerns were related to scaling up global advocacy, particularly at the United Nations, and advocacy to educate people in the US about the effects of specific funding restrictions on PEPFAR and anti-trafficking monies. Advocacy promoting evidence-based, proven-effective programmes relies on data and analysis: This requires both capacity building for sex work projects to collect data ethically and without risk to participants and for targeted action research to document the effects of particular programming to demonstrate successes and problems.

## 4.1 Human rights

Sex workers' human rights have been violated in a variety of ways including violence but also by making sex workers invisible and not recognizing their input into issues that affect them, leading to situations in which sex workers' concerns are sacrificed for propriety. Rights-based programming counters the two great pitfalls of programming with sex workers: not admitting that sex workers' have agency and denying sex workers of their agency. Meena Seshu wrote to the UNAIDS Global Reference Group on HIV/AIDS and Human Rights that,

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The inability to accept that the movement for prostitutes' rights can be informed by the women-in-prostitution and sex-workers themselves is as much a part of denial of human rights as discrimination of mainstream women on the basis of caste, class, race or religion. There is an immediate need to unravel and reach out and listen to the women in the communities. (Seshu, 2003, p.4)

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### 4.1.1 Criminalisation of sex work and law enforcement approaches to sex work

The criminalisation of sex work has created environments in which sex work is hidden and HIV

prevention has been adversely affected. The 2008 Report on the Global AIDS Epidemic states, 'where the activities of some groups are criminalized (e.g. men who have sex with men, drug users, or sex workers) the law and its enforcement can become a major barrier to access and uptake of HIV prevention, treatment, care, and support.' (UNAIDS, 2008, p.77) Indeed, sex workers around the world cite the state and its agents as the prime violators of their human rights, especially in the form of violence (Qiu, 2002; Tucker, 2005; Fick, 2006b; Jenkins, Cambodian Prostitutes Union, & Women's Network for Unity, 2006). Programming and legal systems that bring sex workers into contact with law enforcement exposes sex workers to abuse, bribery and human rights violations. Sex workers are not the only people subject to harassment; outreach workers and HIV-prevention programme personnel are also vulnerable (Human Rights Watch, 2002).

Police interfere with HIV-prevention efforts directly, by harassing or arresting peer educators and outreach workers and confiscating condoms for use as evidence, and indirectly, because people hiding from the police are harder to reach. Other examples of law enforcement approaches to sex work being detrimental to HIV-prevention include the use of condoms as evidence against sex workers, sex businesses and clients. Condoms have been used as evidence in cases involving sex work establishments in the United Kingdom and the US in the past two years. Sex workers from South Africa, the US, the UK and Asia described the use of condoms as justification for abuse or arrest by police officers. The most urgent and effective structural interventions for sex workers may be those that address sex workers' interactions with the police (Biradavolu et al., 2009; Sarankov et al., 2005; UNAIDS Best Practice Collection, 2006; WHO Tool-kit for Sex Workers, 2004).

Large-scale public health programming in which armed, uniformed personnel are involved in implementation are susceptible to police abuses. Abuses are exacerbated in situations in which HIV testing of sex workers is mandated by these programmes and implemented by the police and military (Network of Sex Work Projects, 2002). For example, the 100% Condom Use Programmes (100%CUP) in Thailand (Loff et al., 2003) and Cambodia have been linked to abuses (Lowe, 2003). Furthermore, in addition to human rights violations, 100%CUP has not led to high rates of condom use in Fiji, Indonesia, Papua New Guinea and Vietnam and it appears that condom use in Laos is declining (WHO, 2006). Considering the potential for abuses, the criticism of Cambodia's intention to train police to educate sex workers about HIV is not

surprising. Sou Sotheavy, director of the Men's and Women's Network for Development, highlighted the 'contradiction between the Anti-human Trafficking Law [which indiscriminately imprisoned sex workers] and the policies to protect people from being infected' with HIV/AIDS. Sou added, 'Sex workers will still be scared when the police enforce this law.' (Kuon and Shay, 2009)

The Report of the Commission on AIDS in Asia calls for the decriminalization of sex work, and counsels governments and other actors to, 'Avoid programmes that accentuate AIDS-related stigma and can be counterproductive. Such programmes may include "crack-downs" on red-light areas and arrest of sex workers.' Realistic efforts to include affected populations such as sex workers are critical to combat the spread of HIV – in fact, sex workers are generally leaders in sexual health when their human rights are respected. The report further promotes the needs of marginalized populations including drug users for efficacious and ethical solutions, such as harm reduction methodologies, to address the HIV epidemic (2008, p.17). Legal situations in which sex work is criminalized (Gruskin et al., 2007; Tucker et al., 2005; Zhang, Fujie, Haberera, Yu Wang, Yan Zhao, Ye Ma, et al., 2007) or treated as if it were a criminal activity despite the law (Jayasree, 2002; Morgan Thomas quoted in UNAIDS, UNFPA & the Government of Brazil, 2006, p.11) create situations in which sex workers are not able to effectively enforce their human rights<sup>4</sup> or protect themselves from HIV. For example, Bangladesh, China, Vietnam and other countries have rehabilitation centres or remand homes in which sex workers are forced to stay after arrest, and in which severe human rights abuses including forced medical testing including HIV testing occurs (Qiu, 2002; Tucker, 2005; *Taking the Pledge*, 2007, *Caught between the Tiger and the Crocodile*, 2008).

High levels of violence against sex workers are promoted by the fact that police rarely take reports from sex workers, and that police violence includes extortion of sex (Ditmore, 2009; Fick, 2006a; Gruskin et al., 2006; Jayasree, 2002; Jenkins, Cambodian Prostitutes Union & Women's Network for Unity, 2006; Kinnell, 2008; Pettifor et al., 2000; Reynaga, 2008; Stadler & Delany, 2006; Thukral & Ditmore, 2003; Thukral, Ditmore & Murphy, 2005). This violence is not only a problem in itself but is further compounded by the well-documented escalating relationship between HIV and violence.

The effects of laws criminalizing the *purchase* of sexual services have been evaluated in a small number of Western countries including Canada and Sweden.

Effects reported include displacement, typically to isolated, less safe locations, subsequently increasing vulnerability to violence and exploitation (Scoular & McDonald, 2004; Van Brunschot, 2003). None offer information about HIV, but it is clear that safe sex is compromised when sex workers and their clients become more clandestine in efforts to hide from the police and local would-be vigilantes (Hanenberg & Rojanapithayakorn, 1998; Van Brunschot, 2003; Kinnell, 2008).

Many people contacted and all sex workers contacted referred to detrimental effects of a law enforcement approach to sex work. While there is not a consensus on legalization versus decriminalisation among sex workers there is universal support among sex workers for opposing the criminalisation of sex work. Meena Seshu wrote of her work with SANGRAM, a social support organization for sex workers in Maharashtra State, India, 'Increase in criminalisation is proportional to the increase in brutality, violence, abuse, debt-bondage, deception, coercion, and slavery-like practice within prostitution.' (2003, p.7)

Ruth Morgan Thomas said, 'Criminalization has an immense impact on our ability to provide effective and accessible HIV prevention services. That's why the Asia Committee advocates decriminalization.' The effects of criminalization on sex workers and their colleagues and clients is felt around the world. Morgan Thomas offered examples from her work as the manager of SCOT-PEP in Scotland. SCOT-PEP services were offered anonymously, and for the past ten years, SCOT-PEP collected information that enabled them to identify repeat contacts of their services. This information revealed that while the numbers of sex workers accessing SCOT-PEP's services were constant, sex workers are a mobile population, moving in and out of sex work, so that there was approximately 50% turnover each year in a natural process not involving 'rescue'. This implies that half of Edinburgh's sex workers move on and that they are replaced with newcomers. However, as law enforcement against street-based sex workers became more oppressive in Scotland, including the closure of a managed area on World AIDS Day 2001 and the criminalisation of street-based sex workers clients in 2007, the rate of transition declined to as low as 27%. At the same time levels of violence reported by street-based sex workers increased by more than ten-fold.

Sex workers' access to comprehensive prevention, treatment and care is adversely affected by criminalisation of any aspects sex work. In many places where the sale of sex itself is not specifically a

criminal act, there are often laws against third parties (managers) and in some places, the purchase of sex (clients). The fact that sex work and/or aspects of business related to sex work are not permitted in many places creates a climate where sex workers are denied labour rights and employment protection. The recognition of sex work as work requires understanding the complexities of the sex industry and its economy. Ruth Morgan Thomas said, 'Some sex workers do not want to take on all the responsibilities of running their own business. It is an accepted practice that third parties profit from other peoples' labour in all other work sectors. While coercion should never be accepted or permitted, granting sex workers the same rights as other workers requires the acceptance of third parties. Sex work should not be subject to legal exceptionalism.'

Di Tommaso et al (2009) find that trafficked sex workers in more secluded circumstances measure low on their scale of well being, measured using levels of abuse experienced, freedom of movement and access to health care (p.155). They link this to the criminalization of sex work and the corresponding increase in clandestine venues and work. Di Tommaso et al found a significant correlation in the case of trafficked persons and the ways they left their situations. Those who were involved in police actions ('rescues') had significantly lower well-being than those who left their situations on their own or with the assistance of a friend or colleague (self-reported, in their terminology) (p.156).

#### **Recommendations**

It is recommended that the effects of criminalisation of sex work, or third parties and clients be documented and evaluated with respect to HIV/AIDS and to the human rights of sex workers.

#### **4.1.2 Examples of sex workers setting project agendas**

Sex worker organising is a key part of the most successful sex work projects. Durbar Mahila Samanwaya Committee (DMSC) in Kolkata is the most renowned example. Meena Seshu wrote of her work with VAMP 'One of the most valuable lessons learned during the course of our work has been to listen to the women, and respect their wisdom earned from a life of resistance.' (2003, p.1) Interviews highlighted the success of programmes in which sex workers determine the agenda and priorities of sex work projects. The involvement of sex workers at all levels is recommended to facilitate this. ALCIS in the Democratic Republic of the Congo, Clinique de Confiance in Ivory Coast and DANAYA SO in Mali offer excellent demonstrations and advice for other

projects to emulate or adapt. Sex worker organisations in Australia (Scarlet Alliance 2000) and New Zealand (Occupational Safety and Health Service of the New Zealand Department of Labour 2004) have drafted occupational health and safety standards, which could also be adapted.

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The sex workers organise the association. The members of the 5 operational teams, the 5 local committees, the national coordination and the national committee organise a yearly planning workshop; [and long-term planning] and local quarterly planning. Except for the quarterly planning they are assisted by a consultant. The sex workers execute and monitor all activities: a theatre group, animators and coordinators and the members of the committees. – Sylvia Mollet, DANAYA SO

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'The needs of sex workers' are integrated in our work plan. We work closely with communities, workers and with an association of sex workers who are HIV positive. Sex workers participated in all workshops for evaluation and monitoring of our programme.' – Dr. Anoma Camille, Clinique de Confiance

'ALCIS projects start off directly from the real needs felt and expressed by the sex workers and the interventions of ALCIS for the beneficiaries are in cohesion with their needs. Our planning is participative.' – ALCIS

'ALCIS has adopted the strategy of peer education consisting in the training of a group of sex workers who have a mission to promote a change of behaviour in the sex workers. The trained sex workers as peer educators animate sessions and educational discussion groups oriented towards other sex workers.' – ALCIS

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At ALCIS, the sex workers are associated in decision-making and with this they influence the orientation of our strategies and intervention politics. ... ALCIS coordination has integrated 10 delegated sex workers of the solidarity committees with whom ALCIS is collaborating. They occupy different posts of responsibility and among them there are 7 social assistants, one taking care of the supervision of the 10 solidarity committees, one is taking care of finances and one of the services for the HIV-positive sex workers.... They occupy posts of responsibility, allowing them even to reach out to other stakeholders. – ALCIS

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These messages are being received: Dr. Adel Zeddami in Algeria described scaling up using rights-based comprehensive programming, driven by the demands

of organised sex workers. 'It can be informal, especially with clandestine populations like sex workers. Reinforce the network with a national strategy with outputs at all levels, with implications for other sectors beyond health.' The network of sex workers is meant to lead to multi-sectoral partnerships with NGOs in tandem health care providers, and eventually to influence the Ministry of Health.

#### **Recommendations**

It is recommended that input from sex workers be institutionalised within sex work projects in such a way as to prevent tokenism and promote genuine participation in decision-making.

#### **4.1.3 Family issues**

The children of sex workers face difficulties in places where both parents' names or the father's name is necessary to obtain an identification card, to register for school, to obtain health care, and other bureaucratic functions.

The first priority reported by sex workers with DANAYA SO in Mali was taking care of their children. More than 80% of the women have several children not recognized by their fathers, complicating their access to services and schools.

Sex workers in Egypt reported difficulty with obtaining identification cards, which they need to secure birth certificates for their children, many of whom are not recognized by their fathers. Identification cards are necessary for work, housing, and registering children for school.

Representatives of GEMA, the sex workers project in Pela-Pela in Indonesia, reported being concerned about the education of the children of sex workers. This concern is shared by sex workers elsewhere: a number of projects in India seek to send the children of sex workers to school. Children of sex workers also face stigma and discrimination even at school. Seshu describes discrimination from teachers, students, and hostility from public as some of the reasons the children of sex workers often leave school (2003, p.6).

Additional obstacles to education for the children of sex workers include the lack of recognition by fathers of children and the difficulties this creates in obtaining birth certificates in some places. Birth certificates are required for school registration in many places. Furthermore, not being recognised by parents and the lack of documentation contribute to stigmatization beyond school.

## Recommendations

- Advocacy campaigns to promote the rights of the children of sex workers, including access to official documentation including birth certificates and identification cards, are recommended.
- Educational programmes for the children of sex workers are recommended.

### 4.1.4 Violence

Violence is an issue universally cited by sex workers, and the link between violence and HIV has been well documented.

#### Violence and Harassment by State Agents

Sex workers everywhere face the risk of violence, particularly from the police and military. Police problems were reported nearly everywhere, including primarily violence and extortion of sex and money. This is one reason why sex workers are reluctant to report violence to the police. This contributes to the lack of retribution when sex workers are attacked, promoting further violence against sex workers.

ALCIS, in Congo, reported that the gravest danger sex workers face is 'The physical and sexual violence of men in uniform.'

In Algeria, state-level advocacy was recommended in order 'to prevent arrests of peer educators or vulnerable populations for their existence. Perhaps we cannot change the enforcement but it should be dependent on actions, not a person's status, without HIV status for example as evidence of having broken the law.'

In Morocco, 'Pimps are rare. The real pimps are the police. The women have solidarity but it's very difficult to stand against the police.'

A member of Sisonke in Johannesburg said of the police, 'They force us to give money, or they take sex.' A sex worker in South Africa described one example, saying, 'A transgender sex worker was stripped by soldiers who threw stones at her. A journalist helped her, saying, "I'm going to expose you for doing this".'

In Egypt, problems with the police are especially difficult for men who sell sex. Sexual activities between men are criminalized, and so is sex work, using the same law. For sex workers and men who have sex with men, being HIV+ is seen as proof of guilt. There have been two high-profile instances of arrests of twelve and ten men respectively. Those who are HIV positive have been detained with their positive status being used as evidence of wrongdoing in the form of same-sex sexual activity.

In Lebanon, the morals police were reported to be the most problematic, especially for sex workers who also use drugs.

Similar examples were echoed nearly everywhere and are prominent in the literature.

Zi Teng in Hong Kong has pioneered the use of mobile phones, specifically camera phones and software that enables the immediate upload of photos to the Internet and sharing photos among lists of message recipients to document and share information about violence by state agents.

#### Violence from Others

Sarkar et al found that HIV among sex workers was correlated with having experienced violence (2008, p.228). Witwatersrand University's Reproductive Health and Rights Unit offers health services to sex workers in inner city Johannesburg, where many migrants have come from neighbouring nations and further away. Lauren Jankelowitz, of RHRU in Johannesburg said, 'Migrant women have all had some kind of sexual assault.'

Beauty, with Johannesburg Sisonke, explained that sex workers are not the only targets of violence: 'Clients also get killed, sometimes in robberies.'

Zi Teng in Hong Kong has pioneered the use of mobile phones, specifically camera phones and software that enables the immediate upload of photos to the Internet and sharing photos among lists of message recipients to combat violence from people posing as clients.

## Recommendations

- The most effective anti-violence efforts have addressed violence systematically. Therefore, using the legal system to improve the response to violence against sex workers is recommended, especially for state-level violence. This is best undertaken with a legal programme.
- Coordinating reports of violence is recommended, especially when a particular individual or organisation has repeatedly committed violence against sex workers.
- Coordinated anti-violence campaigns involving the media to draw attention either to specific patterns or systemic abuse by state authorities are recommended.
- The use of new technology including mobile phones to document and expose violence against sex workers should be explored and supported.

### 4.1.5 Economic development and transition or step-out programmes

Sex work is foremost an income-generating activity. The ILO report *The Sex Sector* estimates that sex workers support between five and eight other people and create similar numbers of ancillary employment in salons, service positions such as laundry and food preparation and cleaners. The ILO reported that sex workers supported families and that sex work itself comprised approximately 65% of work in the sex sector, with the remaining third being ancillary positions such as cleaners, cooks and security personnel. Sex workers in many places including Thailand (Guest et al., 2007, p.71; ILO, 1998, p.10) and Cambodia report supporting extended families (Ditmore, 2006). Despite this, development typically posits sex work as a problem to be solved rather than as an income-generating activity. This is in part because of the association of sex work with poverty, rather than economic activity. The perception of sex work as a problem – instead of the way sex workers see their work, as a source of income – has led to a number of programmes that aim to move sex workers into other work. Some of these programmes are microfinance programmes and anti-trafficking efforts. The most successful programmes focus on the self-determination of participants and supporting the desires of sex workers rather than pushing sex workers into other work. Microfinance, income generating programmes, anti-trafficking efforts and transition programmes are discussed below.

Poverty is not the only indicator for sex work and sex work is not always a way out of poverty. Many sex workers are indeed impoverished (Thukral, Ditmore & Murphy 2005; Ditmore, 2006; Leggett, 1999) and some are unable to generate an income adequate to their needs, especially in cases in which extended families are being supported by one sex worker (Ditmore, 2006). Others are unable to manage money, even when they can generate a significant income, because immediate expenses paid day-to-day, as in a hotel, are more expensive than other living arrangements that may require a capital investment to acquire, even if they are less costly in the long run (Leggett, 1999; Stadler & Delany, 2006). Men cite the same reasons for entering sex work as women (Longde Wang, 2007, p.55; Zhang, Li, Hu, Liu, & Shi, 2000; Zhang, Li Xiufang, Shi Tongxin, Cao Ningxiao, & Hu Tiezhong, 2001).

The literature shows that while many people expect anti-poverty initiatives to reduce sex work, this is not always or even typically the case. For example, sex work or transactional sex is often undertaken to accumulate capital for an investment in another

business or in farmland or for accessories of modern life (Gysels et al., 2002; Leclerc-Madlala, 2004; Lee, 2004). Karandikar (2007) and Agust'n (2006) demonstrate that income generated by sex work is linked to development in the form of remittances and individual income. The ILO estimated that the sex industry provides between 2 and 14 percent of gross domestic product in four countries surveyed (1998, p.7) demonstrate that the sex industry simply dwarfs development money. Sex work puts money directly into people's hands, while development money is not distributed this way.

It is very common for sex workers to enter the industry in order to support others, most often family members. Some older sex workers benefit from this kind of support. As they grow older their children, usually daughters, become the breadwinners. Other older workers, however, are more isolated. They may have no children, and they may be shunned by the very family that they have worked to support. In such cases, they often remain in the industry in a different role. Some keep houses where other sex workers rent rooms, while others generate income by hiring other sex workers to work for them.

The characteristics of such situations vary considerably. Some may indeed include coercion and even trafficking, but many are simply practical rather than exploitative. Unfortunately, local authorities often target all those providing rooms or employing others as traffickers, without taking into account the actual circumstances and the specific arrangements made between the different parties (Gupte et al, 2008; VAMP and SANGRAM, 2008).

Such indiscriminate actions are not a useful or appropriate response. Their effect is to increase hardship for all those involved, while placing them in more precarious situations where they are at greater risk of violence, exploitation and disease, and where they have less access to programmes aiming to help them. The proper response is to promote good working conditions in sex work and to combat coercion and trafficking through community- and rights-based approaches. Programmes targeted at sex workers who are unable to make a living, as well as programmes that offer alternatives for people who do not wish to do sex work, are key elements of such approaches.

Employment structures in many parts of the developing world include paying for introductions and borrowing money to be repaid with future work. This may look like trafficking to people outside these communities, but paying for an introduction or borrowing against future labour is not itself trafficking. This is a factor of general employment conditions

in places where jobs are scarce. Cases in which a debt against future labour is unpayable because of extortionate interest rates and escalating costs are examples of debt bondage. Extortionate interest rates on loans to sex workers, made outside banking institutions but by established neighbourhood moneylenders who charged very high rates of interest, were one reason for the foundation and success of DMSC's Usha Cooperative.

#### Microfinance and Financial Empowerment Programmes

Microcredit may put money directly into the hands of aid recipients, and so has been touted as a way to promote economic empowerment in the form of investment in business and farmland. Microcredit programmes seeking to promote exit of women (and only women) from sex work have not been successful in Ghana (although STI prevention programming including peer education was successful) (Shrestha et al., 2002). A Kenyan study reported over one-third of women participating in a microcredit scheme leaving sex work, but no comparison was made with non-participants in the microcredit scheme, preventing comparison. Furthermore, this programme and others rely on high-pressure and even coercive measures to collect repayment (McCormick & Munguti, 2003).

The sole example of a truly effective financial empowerment programme with sex workers is the Usha Cooperative, which is part of the famed Durbar Mahila Samanwaya Committee (DMSC) in Kolkata. DMSC is justly renowned for its human rights-based programming with sex workers. The aim of the DMSC project described in Gayen (2006) is the prevention of minors doing sex work and prevention of forced sex work. The Usha Cooperative is a credit union run by sex workers, in which community members deposit their earnings in the financial cooperative, rather than accumulating savings in the form of cash and jewelry, because other financial institutions did not accept sex workers as clients. This has changed the lives of the people who used to hold their savings in their rooms, because a life's savings could be lost in a robbery, 'rescue' or arrest (Ditmore, 2007a). The cooperative has also changed the power dynamics within the community. Prior to the establishment of the cooperative, women saved their money in cash and valuables, which they asked others to keep for them, a service for which they paid informally and without clear reckoning. DMSC-TAAH (2005) describes the surprise of one participant when she received her entire balance without any such withholding or fee. The cooperative encouraged participation and strong savings with daily visits by a collector who accepted deposits. These collectors offered advice about saving, but also promoted condom use and encouraged

participants to take advantage of health services. Usha also makes loans to participants, most of which are used to repay moneylenders who charge high rates of interest. Usha Cooperative reports that women invest their accumulated savings in ways that were more difficult if not impossible before, including investing in education of their children and on health care. Another aspect of greater economic stability in the form of savings is that sex workers are more able to encourage and enforce condom use because those who have savings are simply not as financially desperate as people without savings (DMSC-TAAH 2005).

#### Anti-trafficking Programming

Some projects that have been intended to combat 'trafficking in persons', a term used to describe coercive situations and debt bondage in all sectors, have focused exclusively on sex work, with the intention of moving women out of sex work and into other occupations. Some of these programmes work on the premise that all sex work is coerced, which is not supported by information from sex workers (Ditmore, 2009; *Caught Between the Tiger and the Crocodile*, 2008;). However, very few anti-trafficking programmes offer job training, and fewer still offer job training that leads to a living wage. Some anti-trafficking NGOs conduct raids on brothels, in which the women rounded up may be arrested and typically lose the savings and assets that they have stored in their workplaces. Some say that there are minors, people under 18 years of age, working in the brothels. Agencies that believe they are 'rescuing' children must not remove the children of sex workers from their parents and must not remove adults from their workplaces. Raids by outsiders have had extremely detrimental effects including the separation of children from their families, adolescents dropping out of school and severe health repercussions (Gupte et al., 2007; VAMP Collective & SANGRAM, 2008). Rehabilitation centres are experienced by youth and sex workers not as places to learn skills and grow but as prisons (*Caught Between the Tiger and the Crocodile*, 2008; Ditmore, 2007b). Hazera Bagum, of Durjoy Nari Shongho in Bangladesh, spent two years in a remand home and when asked about it says, 'I never want to be rescued again' (Ditmore, 2007b). Additionally, raids may lead to the deportation of migrant sex workers, many of whom will return to sex work, and travel again to do so.

Campbell (2000, p.479) described the former, neglecting the fact that sex workers exercise agency at work and outside work, saying that, 'the interviews suggest that the tendency to speak of women's 'powerlessness' (as is the case in many studies of African women in the context of the HIV epidemic) is unduly simplistic and fails to take account of the range

of coping strategies and social support networks that women have constructed to deal with their day to day life challenges. These strategies and networks could serve as potentially strong resources for community-based sexual health promotion programmes.' This could easily have been said of anti-trafficking programmes that seek to rescue women, a perspective often held by people who perceive sex workers as powerless and without agency. Sex workers, clients and trafficked persons are untapped resources for anti-trafficking programming.

Direct service programmes that address trafficking and have documented their assistance to significant numbers of people include Europe's TAMPEP network, Durbar Mahila Samanwaya Committee (DMSC) in Kolkata, India, and the Sex Workers Project in New York, USA. Each of these projects uses a rights-based model to assist people to leave coercive situations, including trafficking, and to assist both people who want to leave sex work and who want to stay in sex work. Efforts to distinguish genuine coercion are complicated by everyone's desire for social acceptability: A founder of the Durbar Mahila Samanwaya Committee, Dr. Smarajit Jana, described his experience arriving in the red light areas of Kolkata, when every sex worker told him that she was there under duress. When he had spent more time there, everyone's stories changed and he understood that everyone knew what they were getting into. He asked why they told him otherwise, and they said that they did not want him to think that they were 'bad' women (Ditmore, 2007a, p.180). People from all over the Indian subcontinent travel to work in Kolkata's 13 red light areas.

Durbar Mahila Samanwaya Committee (DMSC) of Kolkata has been successful at removing children from the red light areas. This was undertaken as part of their anti-trafficking work, with self-regulatory boards that investigate the arrivals of newcomers to the red light areas in order to ensure that no one is present under duress and that no minors are employed. It is important to keep in mind that this was undertaken as part of a rights-based programme to prevent police harassment and abuse, committed under the pretext of removing minors from the brothels (Ditmore, 2007a).

#### Income Generation and Transition Programming

A critical point of the income generation and transition projects described here is that sex workers are not required or encouraged to stop doing sex work.

Some programmes offer training and resources for sex workers to develop an additional source of income to supplement their earnings in sex work. This was explained by representatives of the Durbar Mahila

Samanwaya Committee of Kolkata, India, as a way to relieve economic desperation. If a person is sure of having a small amount of other income, he or she is better able to decline risky situations, such as those that may involve multiple clients, undesirable activities (as deemed by the worker in question) or that may become violent. For some sex workers, peer education functions this way, offering a guaranteed income that is not a liveable wage but lessens economic pressure.

Earnings potential for sex workers decreases over time (Bernstein, 2001; Ditmore, 2006; Escoffier, 2006; Gangoli, 2001). This has implications for programming, in that sex workers who have had longer careers may benefit greatly from alternative employment programmes. Older sex workers typically have fewer clients than younger sex workers. As they age, their role in the sex industry may change. Programmes that provide employment alternatives outside the sex industry for those who can no longer earn a living in sex work could be very valuable.

SCOT-PEP offers an example of a project that emphasised what sex workers want over prioritising step-out programming. Ruth Morgan Thomas, SCOT-PEP manager, said 'SCOT-PEP ran a project to assist sex workers to develop personal plans beyond sex work. There were no attempts to persuade sex workers that they should leave sex work or that sex work was harmful, nor was participation in this programme a requirement to receive other services from SCOT-PEP. For the two and a half years it ran, 10% of sex workers [who used SCOT-PEP's services] chose to access this support. Eighty percent of them moved on from the Edinburgh sex industry by the end of the project. The reason for its success is that it emphasised self-determination.'

#### Recommendations

- It is recommended that any efforts to assist sex workers to move to other occupations be part of a comprehensive rights-based programme that respects the self-determination of sex workers, including the decision to do sex work.
- Projects to assist career sex workers who are no longer able to earn a liveable wage should be supported. This could include support or training programmes for newcomers to sex work.
- Sex workers and their colleagues and clients are untapped resources to combat trafficking in persons. These people should be included in anti-trafficking efforts, not criminalised.

#### 4.2 Best practices

Best practices ensure the provision of safe sex materials including male and female condoms and personal lubricant, in an enabling environment. Sex

workers of all genders and other sex work venue personnel including managers and staff require information about HIV, STIs, human rights, safe sex and sexual health including anal sex, and health services. The provision of diagnosis, treatment and care for STIs is a critical aspect of HIV-prevention for sex workers. Voluntary and confidential counseling and testing is necessary, alongside treatment and care for HIV/AIDS and secure food supplies, especially for people taking ARVs.

The most effective HIV programmes for sex workers:

- Are undertaken from a rights based perspective
- Are grounded in evidence rather than driven by political expedience or moral judgements
- Work to prevent the abuse of sex workers
- Recognise the gender and sexual diversity of sex workers, and
- Are culturally appropriate and respect local sex work cultures.

Interviewees recommended comprehensive, rights-based HIV/AIDS prevention and care. This means offering information, including information about anal and oral and non-penetrative sex, and access to safe sex commodities including male and female condoms and personal lubricant to sex workers, clients and others involved in the sex industry including brothel managers, other staff and gatekeepers alongside confidential HIV, STI and reproductive health care and treatment. Education and distribution of commodities has been done with great success by peer educators and outreach workers. Education about the use of new technologies will be critical and similar models will need to be adapted as new technologies are developed, such as PrEP, microbicides and vaccines.

Prerequisites for sex workers to be able to sell safe sex are good working conditions in safe workplaces, free of abuse and violence. Good personal situations, free from stigmatisation and discrimination, with safe places to live and raise children are also necessary. Sex workers' self-determination and autonomy at work and outside work is supported with information about human rights: sex workers are better able to exercise their human rights when they are informed about their rights and the mechanisms available to enforce them.

It is recognised that 'the most successful initiatives have empowered sex workers.' (UNAIDS, 2008, p.87) and so all work with sex workers should begin with a participatory and rights-based approach, consulting sex workers and employing sex workers in paid positions at all levels of programming and with input at all stages, from conception to implementation. Rights violations including forced testing, police abuse and denial of

access to health care and life-saving medicines have been documented in health, HIV-prevention, research and anti-trafficking programming. Rights abuses clearly indicate that programming must be stopped immediately and new methods investigated.

People affected, including sex workers, 'need to have a more meaningful role in collaborative decision-making, planning, and continued monitoring of progress towards the goal of universal access' to support, treatment, prevention and care (UNAIDS, 2008, p.90).

The most successful projects are long-term and may begin within an implementing agency but are eventually community-based and run. Meena Seshu wrote, 'Short project oriented interventions with a targeted approach cannot hope to achieve a sustained response to the epidemic. In situations wherein access to treatment services to the general population is itself difficult and sporadic, a service for vulnerable groups is an almost impossible dream.' (Seshu, 2003, p.9) Programmes that blame sex workers, view them as bridge populations rather than people who are themselves vulnerable to HIV/AIDS, or view sex workers as a means to reach specific men, 'is proving to be an alienating process that will continue to blame marginalised communities rather than empower them to combat HIV. In such a situation it is inevitable that the control and implementation of such programs will always remain with the implementing agencies rather than owned by the communities' (Seshu, 2003, p.9).

#### 4.2.1 What works?

##### Safe sex commodities, behaviour change and negotiating skills

Male and female condoms remain the only proven-effective method to prevent sexual transmission of HIV. Therefore, consistent condom use by sex workers is critical to the protection of their health and wellbeing. (New technologies will be discussed below.) Easy, affordable access to condoms for all people engaged in commercial sex as either buyers or sellers can dramatically raise condom use. However, many sex workers do not have access to condoms: 'across 39 countries, an average of 60% of sex workers reported having access to condoms and HIV testing. Regional variations include 41% in South and South-East Asia, 72.8% in Latin America and the Caribbean, 69% in Eastern Europe and Central Asia (seven countries), and 69.7% in sub-Saharan Africa (UNGASS Indicator 9).' (UNAIDS, 2008, p.113) 'Reported rates of condom use with the last client are generally quite high, although there are exceptions; in Lebanon, only about one third of sex workers said they used a condom with their last client.' (UNAIDS, 2008, p.113)

Education alone does not lead to behaviour change, in this case, consistent use of condoms. The advantages of using multiple methods including peer outreach, information and education campaigns, organizing and support groups, to promote behaviour at the level of the individual and the group is clear (Valdiserri et al., 2003). Campbell (2000, 481) describes the mechanism behind behaviour change well: 'People are far more likely to change their behaviour if they see that liked and trusted individuals are changing theirs.' This is the rationale behind peer education and outreach programming (See also Richters et al., 2008). In Africa, peer-based HIV-prevention programmes for sex workers have proven to be highly effective in changing sexual behaviours and reducing the rate of new HIV' (UNAIDS, 2008, p.113).

Sex workers in most places and situations quickly adopt condom use once programming is implemented. This is not only the case with sex workers, but also clients (Rosen et al., 2003) and other intimate partners. Condom use can be enforced only by the people directly involved: the sex worker and client (CASAM, 2008, 16). But few programmes place equal emphasis on prevention for clients of sex workers. This plays a role in the fact that consistent condom use with all clients and some non-paying partners has not been achieved at high enough levels. For example, Keming et al (2007) reports that female sex workers in five sites across China were amenable to HIV-prevention messages and technology but that consistent behaviour change was not achieved during the study period, and that sex workers were less likely to use condoms with non-paying partners (pp.S96, S98). This is a common phenomenon around the world: these may be the partners with whom sex workers would like to have children.

Sarkar et al include information about condom negotiations, that such negotiating is more successful in the bed than at the time of setting a price (p.227). However, negotiating skills are not part of training offered by local organisations. Only 4% of the 580 sex workers interviewed reported any such training from NGOs (Sarkar et al, 2008, p.227). This is a missed opportunity.

Affordability and availability are prerequisites of condom use. It is easier to forego condom use when the condom itself represents a significant portion of the fee for sex, up to 40% in some circumstances (Longo & Overs, 1997; Overs, 2008). Condom use is affected by other financial factors: it was reported that sex workers may be offered significantly more money for sex without a condom (or, conversely, significantly less money for protected sex) (Rao et

al., 2003). Free or inexpensive condoms and water-based personal lubricant are crucial for HIV prevention programming with sex workers. For example, placing free condoms in hotel rooms or handing them to couples upon registering for the room increased condom use in professional sex (Egger et al., 2000). Social marketing of condoms can reduce costs and in places where social marketing is profitable, it can support peer education programmes.

A recent study found that people new to sex work were more likely to contract HIV than experienced sex workers (Sopheab, 2008). This demonstrates the importance of reaching out to novice sex workers. Familiarity with condom use and HIV prevention techniques has other benefits: such familiarity was linked with willingness to be tested as well as lower HIV prevalence among sex workers in Andhra Pradesh, India (Dandona et al., 2005a). This was also linked with longer duration in the business, while unwillingness to be tested correlated with non-condom use with clients. Sex workers who lived in brothels, which implies in communities of sex workers, were more likely to use condoms on a regular basis than sex workers who did not work in brothels in Andhra Pradesh (Dandona et al., 2005b). The brothels offer communities of people who may be informed of the benefits of condom use and who form a social group, effectively functioning as a peer-group that promotes regular use of condoms.

Brothels also offer large markets for condoms. Sex work projects including Kolkata's Durbar Mahila Samanwaya Committee (DMSC) and Bangladesh's Durjoy Nari Shangho support some of their programming with sales of condoms (Jenkins, 2000; Jenkins & Rahman 2002).

Diagnosis and treatment of sexually transmitted infections (STIs), when combined with elevation of condom use, has been demonstrated to contribute to a decrease in HIV infection (Fonck et al., 2000; Kaul et al., 2004; Steen et al., 2004). Periodic presumptive treatment (PPT) with wide-spectrum antibiotics has been seen to be effective in at least one situation but these results have *not* been replicated in other situations (Steen et al., 2000; Steen & Dallabetta, 2003; Williams et al., 2003). In addition, PPT may contribute to growing resistance to antibiotics and thereby increase risk in situations where people believe they have been effectively treated. PPT is *not* recommended. Viruses (which do not respond to antibiotic treatment) such as herpes remain an issue and can lead to ulcers that increase vulnerability to HIV infection (Weiss, 2004).

A rights-based approach to sex work is often repeated as a prerequisite for successful long-term work with sex workers. However, it is less well understood what this means in programming. Centre for Advocacy on Stigma and Marginalization (CASAM) (2008, p.8) elaborated rights-based programming thusly: 'These principles include: express linkage to rights, accountability, empowerment, participation, non-discrimination and attention to vulnerable groups. HIV/AIDS programs targeting sex workers should have at their core a commitment to sex worker leadership in program design and implementation; formation of collective identity and action among sex workers; and the elimination of stigma and discrimination related to sex work.'

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#### **The importance of STI diagnosis: The example of Indonesia**

Many places use syndromic management of sexually transmitted infections (STIs), in which symptoms are diagnosed and treatment prescribed on the basis of symptoms. This is not adequate for anyone and is still less acceptable for sex workers, who are more sexually active than others. The majority of STIs are asymptomatic, and therefore cannot be addressed by syndromic management. Untreated STIs can cause infertility and be transmitted to sex partners. For this reason, routine health care for sex workers should include STI testing, diagnosis and treatment. Indonesia experienced epidemic rates of antibiotic resistant strains of STIs, in part due to overuse of over-the-counter remedies including antibiotics. Subsequently, STI and HIV rates tripled. This led the nation to implement a model programme, in which diagnostic equipment is in clinics serving sex workers, including mobile clinics in which the doctors and practitioners go to the brothels. Sex worker outreach workers also refer others to the mobile clinics and standard clinics. Diagnosis is made the same day and medicines are provided immediately.

The Jelia Clinic and PKBI Clinic both offer testing, diagnosis and treatment to sex workers of all genders and their clients, as well as other services including general health care and, in the case of PKBI, childbirth. Diagnostic equipment is on-site. Mobile clinics go to the sex workers during hours when they cannot leave work and offer same-day diagnoses and offer treatment.

Indonesia has demonstrated that diagnosis and treatment of STIs is possible in an environment with limited resources.

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Sex workers in many contexts may have few occupational opportunities, low levels of education and literacy, and may be marginalized by wider civil

society as well as police, health care personnel and other people with whom they may have regular contact. Violence, police abuse, children's needs, homelessness and issues of drug dependency are some of the myriad issues that may take precedence over HIV prevention. Durbar Mahila Samanwaya Committee (DMSC) of Kolkata, India, is renowned for addressing these issues *in addition to* HIV prevention. DMSC programming includes clinics, ARV treatment, social marketing of condoms, a credit cooperative (more about which below) and an anti-trafficking project (more about which below). Each of these facets of DMSC programming has been instituted and implemented by sex workers and community members, and this has contributed immeasurably to their success (Basu et al., 2004). This is genuinely participatory and rights-based work.

Rights-based programming with sex work has been and remains severely underfunded (Dorf, 2006) despite the fact it is now known that rights-based programming is critical for HIV prevention, especially with marginalized populations such as sex workers. (UNAIDS & the Office of the High Commissioner for Human Rights, 2006) Sex workers have typically been approached as a target population – one *to* which something is done rather than done *with* – by projects and programmes. Sex workers and their allies have documented a change in direction *away* from rights-based programming in the recently released UNAIDS Guidance Note on HIV Prevention and Sex Work (UNAIDS, 2009).

#### **4.2.2 Considerations for best practices with specific sub-populations**

Few places have useful estimates of the numbers of sex workers (Vandepitte et al., 2006) and there is less information about specific groups of sex workers, such as transgender people and men who sell sex than about women who sell sex. On one hand, this is not surprising because existing programmes typically work with female sex workers. However, all sex workers of all genders require HIV treatment and prevention services and commodities. Rights-based programming encompassing the wide variety of sex workers in a diverse range of contexts is critical to the effective scale-up of HIV prevention and treatment programmes.

#### **Consequences of Misclassification: A Transgender Epidemic**

Best practices include all sex workers and emphasise efforts for the most vulnerable. This requires recognising transgender people. Classification has rendered some groups less visible than they merit. The recognitions of only two genders in UNAIDS data and in most country

data obscures the rates of HIV and the needs of transgender people. The categorization of transgender women as MSM (men who have sex with men) hides an epidemic among transgender women (Kim et al., 2008; International HIV/AIDS Alliance 2008).

Transgender people have fewer occupational opportunities and options than other people (Jenkins, Pramoj na Ayutthaya & Hunter, 2006). This leads to many transgender people working in sectors without the benefit of occupational safety and often without recognition as work, including many transgender women doing sex work. Many transgender people (people born with the male or female genitalia but who identify differently, including as neither male nor female) do sex work, because stigma and discrimination against transgender people render other options for work rare for transgender people. It is imperative to acknowledge the diversity of transgender people: programmes tailored for the needs of transgender women may offer nothing for transgender men. The term transgender refers to a wide variety of experiences of people who do not fit in the male-female gender binary.

In many places, transgender sex workers are a subculture within sex work communities. However, cultural roles in mainstream society seem to be shrinking, even in cultures in which at least one 'third gender' has been recognized. One example is the *hijras* of India; other examples come from American and Pacific indigenous cultures. Transgender people should be recognized and accommodated in planning sex worker HIV-prevention programmes and interventions. One aspect of planning is recognizing transgender people in classification and conceptualization. Local manifestations of transgender culture and sex work by transgender people will vary around the world, but the need to recognize transgender people as a distinct population is constant.

Most organizations, including the UN and most governments, include transgender people in their surveillance and record-keeping only under their 'birth' gender, rather than acknowledging the variety of gender and roles distinct from genitalia. The consequences of this misclassification range from the epidemiological to immediate danger. Regarding public health, counting transgender sex workers among men who have sex with men masks the level of HIV infection among transgender people in a number of countries. Data analysed by the International HIV/AIDS Alliance exposes HIV prevalence rates among transgender people at 42% in India, 35% in Argentina, 28% in the United States, with rates over

50% among Latina and Asian transgender people in California, 25% in El Salvador, 9% in Cambodia and 22% in Indonesia. All of these rates were higher than those found among men who have sex with men. The lack of attention to transgender people leads to services catering to men who have sex with men rather than targeting transgender people, a manifestation of structural discrimination that could be eliminated by paying appropriate attention to the needs of transgender people, including transgender sex workers. Recognizing a transgender person's lived, rather than birth or genital, gender, is beneficial for their health in that services can be tailored to the specific health needs of transgender people (Nemoto et al., 2008; Riascos et al., 2008). These needs can include clinical and medical treatment, such as hormone therapy, as well as social and structural needs including recognition at the institutional level.

Transgender sex workers play strong roles within many HIV-prevention programmes, and their input is critical for tailoring services to their needs (Arrue et al., 2008; Kim et al., 2008).

Some transgender people may inject hormones or free-floating silicone implants (International HIV/AIDS Alliance, 2008). They require safe injecting material and information about safe injecting, including the prevention of infection.

Transgender women classified as men are typically held in men's prisons and jails if arrested, detained, or imprisoned. Violence and sexual assault, including rape, are concerns for all sex workers, but when assault occurs in police custody, there is almost no chance of recourse without significant and stalwart support from community and organizations. Transgender women suffer disproportionate rates of assault and harassment in most contexts due to stigma and discrimination, but even more so when they are housed in men's prisons and jails. Transgender people are sometimes held in isolation, ostensibly to protect them from violence. However, the mental health problems associated with isolation present another form of violence. In places where sex workers are subject to arrest or police harassment, conditions of detention are an even greater concern. Identity cards that recognize the lived gender of transgender people can be useful to mitigate these dangers (Riasco et al., 2008).

#### **Recommendations**

- Require projects to distinguish between transgender people from men who have sex with men. Use the terms that transgender people call themselves locally.

- Advocate for international organizations, particularly UNAIDS, and governments to distinguish between men who have sex with men and transgender people, recognising the variety of transgender experiences, including male-to-female and female-to-male transitions.
- Include HIV-prevention, care and treatment programming for transgender people, with input and participation by transgender people in ideation and implementation.
- All projects, especially those for transgender sex workers, should discuss anal sex and HIV prevention. Sufficient personal lubricant for all interactions should be made available at no cost or affordable for all.
- Safe injecting information and material including clean needles of a variety of sizes and information about preventing infection should be offered to transgender sex workers.
- Advocate for humane treatment of transgender people in prison. This means advocating against situations that may encourage violence against transgender people and advocating against solitary confinement.

#### Men Who Sell Sex

Best practices in HIV-prevention, treatment and care include sex workers of all genders, including men who have sex with men. Men who have sex with men (MSM), and male sex workers are underrepresented in the literature about selling sex. In many places in Africa, MSM are marginalized, but MSM are present everywhere. Men who sell sex are also present, and primarily find male clients. People planning programming with hidden populations should take heart: one study reported that, 'Despite high community stigma and legal concerns, trust was established with a core group of MSM sex workers, who currently benefit from regular HIV counselling and testing, STD screening, and provision of comprehensive care at a research STD-clinic.' (Geibel et al., 2007, p.1351).

Men who sell sex in many parts of the developing world typically marry women (Guodong Mi et al., 2007). Guodong et al (2007) wrote 'Furthermore, the pressure to marry and have a family is high in a developing country like China, usually making marriage with women inevitable for most MSW [male sex workers]. This could be said of many places. They go on, 'Between 70 and 80% of urban, well-educated MSW will be or were married, while this proportion might be close to 90% in rural areas' (Zhang B. C., Li Xiufang, Shi Tongxin, Cao Ningxiao & Hu Tiezhong cited in Guodong Mi et al., 2007).

China has made significant efforts to offer HIV-prevention services for sex workers and includes male

and female sex workers. However, Detels et al reports that men who have sex with men are not well studied and require more safe sex commodities than are available (2007).

#### Recommendations

- Programmes should be designed to include men who sell sex in all parts of the world. All projects, but especially those that focus on men, should discuss anal sex and HIV prevention.
- Projects that reach out to men who sell sex should make personal lubricant available. Best practices require enough lubricant for all interactions and for lubricant to be free or affordable for all.
- Projects should offer or make referrals to services for the intimate partners, including women, of men who sell sex.

#### Migrants

There is significant migration within nations, from rural areas to towns and cities, and across borders of developing nations, for example from Indonesia to Malaysia and from Burma to Thailand. The numbers that relocate to developed countries are smaller than the numbers that move to neighbouring countries that are richer than their states of origin but still classified as developing nations. (Martin & Zurcher, 2008, p.14) Migrants may end up in jobs that are deemed undesirable or dirty, including sex work. Some migrants who sell sex know exactly what they will do and the conditions of their employment. Others find that they have been misled or lied to.

Migrants also require tailored programming. Many migrants come from poor areas and may not know about HIV or have been exposed to outreach and prevention programmes. For example, Detels et al reports that HIV prevention materials such as condoms are not available throughout China, a country with massive migration and a large sex industry, and that this is compounded by a concentration of HIV in rural and resource-deprived areas (2007). When people imagine migrants in sex work, the image they picture is typically women from poor areas moving to richer areas. Men do the same, although male migrants are underrepresented in the literature about sex work. Na Hea et al (2007) offer a typology of male migrants in Shanghai, with 'moneyboys', mostly from rural areas, with little information about HIV (p.S74). Other male migrants were more likely to come to Shanghai with job offers, and to have lived in Shanghai for more time (p.S75). Moneyboys in Shanghai appear to be at greater risk of contracting HIV than other migrants. This may be related to both their lack of support before they arrive and their lack of knowledge about HIV.

Transgender people may relocate to large cities or other places where there may be a community of other transgender people. Others choose to move to places where surgery, medical and other services geared toward transgender people are available.

Rights-based programming for migrants requires information and services to be made available to people of all genders who are in places without legal sanction and who may engage in sex work without legal permission or in places in which sex work is criminalised. For example, in some places, it is difficult for migrants to access STI diagnosis and treatment, a critical aspect of HIV prevention for sex workers. It may be still more difficult for migrants to access care and treatment for HIV. Beyrer and Masenior point out that 'Lack of legal status is perhaps the largest barrier preventing sex workers from receiving many important services and social benefits such as free and anonymous medical treatment, a steady job (outside of sex work), protection from the police, lodging, and psychological assistance. This is not a function of the legality of prostitution (sex work is not illegal in the Russian Federation), but of not having legal residency' (2007).

Those who have the least control over their situations, particularly those in 'trafficking' situations, are the most likely to experience violence, rendering them further vulnerable to violence. Twenty percent of sex workers interviewed by Sarkar et al self-reported having been trafficked, which was associated with experiencing violence and should itself be considered violence. These women were more likely to be HIV+ than those who did not self-report having been trafficked (Sarkar et al, 2008)

People who move to an area in which they do not speak the local language have specific vulnerabilities. For this reason, efforts to reach out to migrants who sell sex typically provide resources in a variety of languages. TAMPEP is an organisation that reaches out to migrants who sell sex in Europe, and so their website includes all of their brochures in approximately 20 languages. However, migration expert Laura Agust'n points out that those who are reached by most outreach efforts are aware of HIV transmission and prevention. Distributing condoms is welcome but efforts must be made to reach less visible migrants, such as those in clubs and brothels, who may be in ethnic or linguistic enclaves or working among people from a variety of backgrounds and experiences. It is critical to recognise that situations involving force and coercion exist in sex work. It is also critical to recognise that not all sex workers are in such situations and that not all migrant sex workers are

in such situations. The conflation of prostitution with trafficking creates additional problems for sex workers, and prevents sex workers and their clients from assisting sex workers in coercive situations. It has been documented that sex workers and their colleagues and clients are able to assist people in coercive situations (Ditmore 2009, Di Tommaso 2009, Ditmore 2007, Save the Children 2008). Furthermore, Ditmore (2009) and Di Tommaso (2009) document that it may be less traumatic for a person in a coercive situation to leave with assistance from trusted acquaintances than when law enforcement interventions such as raids are undertaken. Raids are traumatic for those involved have traumatic effects for those directly involved and many people beyond those involved, including caregivers and social workers (Ditmore 2009, VAMP 2008). Agust'n highlights the uses of new technology to assist migrants in situations in which they have little control.

#### Recommendations

- STI and HIV diagnosis, treatment and care should be provided to all regardless of status in the country in which they seek these services.
- Sex workers, colleagues and clients should be partners in efforts to assist migrants and people in coercive situations.
- Law enforcement interventions should be avoided.
- The use of new technology including mobile phones to assist migrants should be explored and supported.

#### Substance Use and Sex Work

Programmes are needed that incorporate best practices for sex workers who inject or otherwise use drugs, including in developing countries. Some sex workers are substance-dependent and others may work in order to maintain substance use. These groups need special services, but almost no sex work programmes cater specifically to the needs of drug-injecting or drug-using sex workers. Injecting with contaminated equipment is the most direct mode of HIV transmission. Furthermore, there is a body of evidence that sex workers are more susceptible to violence when they are intoxicated (Guest et al., 2007, p.72; Jenkins, Cambodian Prostitutes Union & Women's Network for Unity, 2006). Sarkar et al found that condom use was impaired by the consumption of alcohol (2008, p.227). Detels et al report that there are few drug dependency treatment programmes in China (2007, p.1). At this time, injecting is the main route of transmission in former soviet republics, affecting sex workers who inject or are the partners of injectors. Luo & Cofrancesco (2006) cite that approximately half of female drug injectors in former soviet republics sell sex and that men who inject drugs may be a bridge

population to wives, sex workers and other partners. People who use drugs and who sell sex may be discriminated against for either or both activities. Sex workers have been known to discriminate against others who use drugs. Harm reduction professionals have discriminated against sex workers who seek their services, and against transgender people. People who smoke methamphetamines or cocaine or its derivatives may develop burns in the mouth. This can be a route for the transmission of HIV during oral sex and therefore precautions such as covered oral sex should be emphasised.

### Recommendations

- Harm reduction materials must be made available to sex workers who use drugs. This includes safe injecting kits and information about preventing infection. Service providers should not discriminate against people they do not expect to need their services, such as transgender people seeking to exchange needles.
- Prescribing or making referrals to organisations that prescribe substitution therapies, when desired.

### Youth

No one is in favour of children selling sex. However, while there are street children and homeless children, some will sell sex. Save the Children (2008) describes the fact that some people under 18 who sell sex are not coerced but choose to sell sex from within a very limited range of choices. Those who are in coercive situations and those who are not need HIV prevention information and materials, and they need assistance.

It has been documented that younger women are more vulnerable to HIV than women who have reached physical maturity for physiological reasons. It is clear that younger sex workers – those most likely to be new to the profession – are at greater risk of contracting HIV than those who have long standing in the profession. Sarkar et al found that HIV was correlated with youth (under 20 years of age) (2008, p.224) and experiencing violence (2008, p.228). Therefore, they need information and safe sex materials.

Save the Children included information about migrants, including buys and girls under 18, selling sex. They described situations of coercion and situations of opportunity, in which an older local man befriended them and in many cases helped them to leave abusive family situations or necessary paperwork in their adopted countries (2008, pp.44- 46,67-68). These situations are not exclusive to migrants. Many youth may be offered money for sex or encouraged to sell sex. Some may see selling sex as a way to be independent. However, relationships that depend

upon a young person selling sex can be cause for concern. Information and resources that promote self-determination should be offered to youth.

Youth have limited opportunities for employment or income generation. Many people who began selling sex when they were young would not recommend sex work to others, even though they may have no regrets about sex work. Sex work is more difficult than they may realize. Furthermore, those who sell sex are stigmatized at school, at the offices of social services that purport to help them, and often at home.

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*The children see this every day, and not just with social workers, but also with teachers, sometimes even the parents put the blame on their children... whenever anyone gets to know that a child is a trafficking victim, they regard him/her with reproach, blaming him/her for what happened.' (Save the Children, 2008, p.85).*

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Durbar Mahila Samanwaya Committee (DMSC) of Kolkata has been successful at removing children from the red light areas, with self-regulatory boards that investigate the arrivals of newcomers to the red light areas in order to ensure that no minors are employed, as discussed above. These efforts were undertaken as part of a rights-based programme to prevent police harassment and abuse, committed under the pretext of removing minors from the brothels (Ditmore, 2007a). Agencies that believe they are 'rescuing' children must not remove the children of sex workers from their parents and must not remove adults from their workplaces.

Children of sex workers may experience stigma and discrimination and limited life and job opportunities. In some places, stigma and discrimination can prevent children's attending school. This is especially the case in situations in which the parent's occupation is well known and cannot be hidden. Many people pursue the same occupations as their parents, and children of sex workers are no different in this respect. However, most parents, including sex workers, would like their children to have a wider range of opportunities than they had. Educational opportunities and job placement programmes for the children of sex workers may expand life opportunities.

### Recommendations

- Programmes for youth should emphasise opportunities, especially education and employment. Some programmes offer specific training and may employ the children of sex workers.
- Law enforcement situations should be avoided.

### 4.2.3 Ethics in research and new prevention methods

Sex workers expressed interest in research but also reservations about participation, discrimination, adverse effects and the need to understand more than some researchers were willing to offer (Allman and Ditmore, 2009). Participatory research in which sex workers are full partners in the conception, design, implementation and dissemination of research are the best method (UNAIDS, 2007; Allman & Ditmore, 2009) and sex work projects can be key partners in this process (Overs, 2008, p.36). Indeed, McGrory, Irvin and Heise describe the immediate inclusion of community members and stakeholders at all stages of development and conceptions and implementation of clinical research as a *requirement* (2009, p.45). However, for sex workers to be genuine partners requires a significant change, in that stakeholders including people who might be recruited to participate in trials be consulted and involved before implementation. Forbes and Mudaliar write 'Conducting an HIV prevention trial with minimal or late-stage civil society input is no longer acceptable – nor is it generally regarded as a wise or efficient approach. The three examples above (the Good Participatory Practice Guidelines, the Botswana experience, and the VOICE trial's inclusive approach to protocol drafting) mark the leading edge of change and illustrate that substantial evolution in the field is occurring' (Forbes and Mudaliar, 2009, p.29).

The greatest risk in clinical trials is that participants will believe that the item being tried *is* an effective preventative measure and will stop taking precautions against HIV like using condoms. Clinical trials of potential preventatives for HIV involving sex workers have been stopped after sex worker-led demonstrations against unethical practices (Kao Tha et al., 2004., Loff et al., 2005; Forbes and Mudaliar, 2009; McGrory, Irvin & Heise, 2009). This lead to a willingness on the part of researchers to work with possible trial participants and affected communities, some of which demanded long-term health care for those who contract HIV during the duration of the trial. However, later trials incorporating effective safe sex promotion, counselling and distribution of condoms were inadequate as trials specifically because they were model programmes for safe sex: too few people contracted HIV during the study to be able to determine the effectiveness of the new technology being tried (Peterson et al., 2006).

Forbes and Mudaliar use the example of the treatment of sex workers during the aborted tenofovir trial in Cambodia, and report that one of the foreign researchers interviewed said that some of the

local researchers and staff involved devalued and disregarded the input from sex workers (2009, p.21). This is a concrete example of stigma and discrimination against sex workers in a research context. Stigma and discrimination against sex workers are not exceptional and in most places are the norm. Forbes and Mudaliar state 'The involvement at any level of staff or decision-makers who cannot respect the trial participants and potential participants is insupportable, as are actions that deny – or can be seen to deny – their agency' (2009, p.30). This is echoed by McGrory, Irvin and Heise, who wrote that researchers 'need to think about human, social, and political issues actively and strategically at every step of the conceptualization, design, conduct, and follow through of trials. This is especially true in resource-constrained countries where economic disparities and complex colonial histories are involved, and even more so when issues involving sex and gender are central' (2009, p.6). Indeed, McGrory et al report that a health advocate was hired as part of the tenofovir trial in Cameroon when women, many of whom engaged in sex work, experienced difficulty accessing services from the clinic to which the trial had referred them (2009, p.19).

One issue in clinical research is how people who seroconvert during a trial will access treatment and care after a trial, and how side effects will be treated should they arise. UNAIDS issued guidance clarifying that trial participants should receive treatment and care post-trials, but that this should be undertaken by a range of actors including governments, researchers and sponsors (UNAIDS, 2007). Difficulties accessing services as documented by McGrory et al (2009) and the stigmatization and discrimination among research staff documented by Forbes and Mudaliar (2009) give insight into the amount of education and training that will be required for sex workers to receive healthcare and access to treatment as part of clinical trials, as well as in general.

McGrory et al (2009) and Forbes and Mudaliar (2009) refer to the development of guidelines for 'Good Participatory Practice' (GPP) sponsored by UNAIDS and undertaken by the AIDS Vaccine Advocacy Coalition (AVAC) in consultation with a range of stakeholders. However, the only inclusion of marginalized communities were among drug users and sex workers, both of whom expressed the sentiment that the guidance as it stands is a beginning but not adequate for genuine participation.<sup>5</sup> It is expected that this process will lead to future steps and not be seen as the conclusion of this process. McGrory et al

echo this sentiment, stating that 'Efforts to determine whether these guidelines can be made normative for HIV prevention trials should continue' (2009, p.45).

### Participatory Research

Thailand's Service Workers In-Group Foundation (SWING) offers a case example of good participatory practice in research, disproving the assertions made after the closure of specific PrEP trials that sex workers are uncooperative with research. Although this example focuses on social research, clinical research can and should emulate this level of cooperation and respect with participants.

During the 2004 International AIDS Conference in Bangkok, Empower Foundation, an organisation of female sex workers in Thailand, distributed a flier about the questions asked by researchers being the same for twenty years.<sup>6</sup> These elementary and intrusive questions (Empower's examples included, 'Where are you from? How old are you? Do you have children? How much do you charge?') demonstrated that none of this research was driven by the interests of sex workers.

Sex workers support and undertake research that addresses their lives and needs. SWING recently completed a study about the life and health of female sex workers with the Institute for Population and Social Research of Mahidol University (Guest et al., 2007). This was a truly participatory project, with sex workers involved at every stage. Sex workers set the agenda for the research, designed the study, implemented the study and helped analyse the data collected. SWING's Surang Janyam is a co-author of the final report. Their experiences with this project were so positive that they have now undertaken a research project on their own, in which male and transgender sex workers use diaries to record sexual activities, consulting with some of the people who developed the participatory study. SWING's contributions have been recognised: Surang Janyam is a 2009 recipient of the Human Rights Defenders Award from the National Human rights Committee of Thailand.

Many sex worker groups participate in research but this is best when sex workers set the research agenda (e.g. Jenkins, Cambodian Prostitutes Union & Women's Network for Unity, 2006). The Paulo Longo Research Initiative was set up to conduct research that will contribute to the literature on sex work, specifically focusing on issues of import to sex workers. Kate Hawkins, with PLRI affiliate the Institute for Development Studies, said, 'Meaningful involvement of sex workers in the research process should be a central guiding tenet of ethical research on sex work –

not an optional extra. It is critical to open channels for sex workers to access resources to conduct their own studies and identify their own research priorities. The lack of financing for sex work research replicates the lack of access that sex workers experience in terms of other sources of HIV funding. PLRI recognises this and aims to redress the exclusion of sex workers in research. PLRI believe that good quality evidence on sex work should inform HIV policy development and implementation.'

Themes identified by PLRI for research on HIV with respect to sex work include access to health care and treatment, epidemiology, violence, genuine and meaningful participation and needs assessment.

### Microbicides, Vaccines and Pre-exposure Prophylaxis

No chemical or biological preventive for HIV is currently approved for use. However, research and development and trials of microbicides, vaccines and pre-exposure prophylaxis (PrEP) are underway and some of these products may make it to the market within the next five years. Many issues arise with the roll-out of new preventive technology, including education, partial effectiveness, safety for high-volume use, forced use, and condom migration and risk compensation (Overs, 2008).

### Circumcision

Circumcision of the penis has been found to reduce vulnerability of heterosexual men to HIV as well as herpes simplex virus 2 (HSV-2) and human papilloma virus (HPV) but not vulnerability to syphilis (Tobian et al., 2009; Golden & Wasserheit, 2009). It is not yet known whether these effects are consistent among men who have sex with men or in populations that engage in anal sex with some regularity. Condom use is necessary regardless of whether a man has been circumcised. Concerns include the medical expertise needed to perform circumcision, time necessary to heal thoroughly before engaging in sexual activity (unhealed wounds are more vulnerable and may facilitate transmission of infections), and condom migration and risk compensation. If men involved in commercial sex as sellers or buyers see circumcision as protection from HIV and STIs and use condoms less frequently, any benefit of circumcision will be lost.

### Recommendations

- Sex workers are the experts on their lives and should be included at all stages of research, from ideation and design through realization. Research must include and incorporate input from sex workers at the earliest possible stages, at the onset of design

- rather than implementation. To come to sex worker communities at the implementation stage is not inclusive and will be perceived as uninclusive at best.
- Research should be undertaken with sex workers setting the agenda. Sex workers are keen on research that addresses issues that affect their lives. Where sex workers are included, research has progressed well. To present sex workers as uninterested in research reflects poorly on the research being conducted and the skills of the researchers than on sex workers.
- Genuine participation in research requires that sex workers be consulted at the planning and design stages, prior to implementation. In-depth information must be offered in a language that is easily and well understood by the participants. In some cases, capacity building for research literacy will be required.
- HIV prevention materials and information must be provided.
- Health care including long-term care and treatment for people who seroconvert or suffer side effects must be planned for and provided.
- UNAIDS should be encouraged to develop and enforce – with sex worker participation – protocols for good participatory practice.

### 4.3 Access to HIV prevention, treatment and care

Universal access to support, treatment, prevention and care requires the provision of a wide range of services.

Interviewees recommended comprehensive, rights-based HIV/AIDS prevention and care. This means offering information about and access to safe sex commodities including male and female condoms and personal lubricant for sex workers, clients and others involved in the sex industry including brothel managers, other staff and gatekeepers alongside confidential HIV, STI and reproductive health care and treatment.

Education and distribution of commodities has been done with great success by peer educators and outreach workers. However, in some places, condom stock-outs have occurred, and delivery chains have sometimes broken down. These events are dangerous for sex workers: it is possible to have enough condoms and for the logistics to work. This is imperative for sex workers to sell safe sex.

Water-based lubricants are unavailable or rarely available in some places. They are expensive in many places and the cost is often prohibitive for sex workers. Appropriate lubricants are critical for sex workers of all genders.

Education about the use of new technologies will be critical and similar models will need to be adapted as new technologies are developed, such as PrEP, microbicides and vaccines.

Sex workers routinely described experiencing stigmatization and discrimination in health care settings. In some cases, this extended to violence, including the rape of sex workers<sup>7</sup> and victims of violence by health care workers,<sup>7</sup> or forced sex with health care personnel from whom sex workers have sought care and treatment (Seshu 2003, p.5). One interview with a project in West Africa said that while HIV testing and services are available, in reality, 'sex workers don't have access to AIDS testing because they feel discriminated against' and so they do not use these services.

Sex workers need access to sexual and reproductive health care. Sex workers expressed concern about the provision of healthcare beyond sexual and reproductive health.

The health needs, including general health and sexual and reproductive health, of children, partners, families and communities of sex workers are often overlooked.

Access to life-saving medicines for TB and HIV/AIDS were also cited. In a number of places, resistance to first-line drugs for HIV/AIDS has been documented. UNAIDS staff reported that there have been cases of resistance to first-line drugs in the Middle East and North Africa, therefore it is imperative for the TRIPS agreements to be enforced in order make compulsory licensing available for second-line medications as well as first-line medicines.

In places where sex workers feel and face stigma from healthcare professionals, let alone assault and harassment, sex workers reported that special training for medical professionals is necessary. However, some sex workers, particularly in the Middle East and North Africa, reported staying away from sex-worker-specific clinics for fear of being identified as sex workers. In Southern Africa, sex workers described experiencing harassment and discrimination in clinics for the general population. In all of these situations, sensitivity to the level of general stigma requires that sex workers be welcome and comfortable at clinics no matter who they target.

### Recommendations

- Ensure constant availability of safe sex commodities including condoms and personal lubricant.
- Training for health service providers who work with sex workers is necessary in all settings.

- Project staff should accompany sex workers to clinics in situations with chronic difficulty combating stigma and discrimination against sex workers.
- In-depth education is necessary prior to the introduction of new technologies to market.

#### 4.4 Strengthening the Civil Society structures

Efforts to promote the rights of sex workers have also been chronically underfunded. Sex worker networks have typically been unfunded or underfunded. Despite this, sex workers have made a number of successful campaigns due to dedicated volunteers. The lack of funding has greatly contributed to the continuing issues faced by sex workers, including lack of recognition, lack of representation (Dorf, 2006). The efforts of a team of volunteer advocates have relied on miniscule budgets or even self-funded advocacy on sex work for over a decade (Doezema, 2005). Considering these factors, sex workers and their advocates have had great impact with very few resources.

Sex workers have routinely been treated as targets of health and HIV prevention campaigns rather than active participants with vested interests in protecting their health and preventing HIV. This exclusion stems from social mores in which sex work occurs but is not discussed, is frowned upon or even in which sex workers are viewed as punishable because of their work. This stigmatization has caused rights-based programming to be terribly underfunded. It is well known that health programmes have great effect when affected populations participate and plan programming and implementation. This is a clear prerequisite for understanding the actual activities that need to be addressed and the situations that contribute to vulnerability and risk-taking. However, in most cases, local sex workers are the last people to be consulted (if at all) and have the least input into programming. This is backwards.

The people in the best position to enforce such equitable conditions and treatment are sex workers themselves, especially sex workers who have organized networks to promote their interests. Numerous networks of sex workers exist, and more are emerging. However, none have resources comparable to those of other social movements, such as networks of men who have sex with men, and some networks have negligible or even no resources at all beyond their own earnings. And yet sex workers are critical partners in the fight against HIV/AIDS, and in most of the world, sex workers are disproportionately affected by HIV. Thierry Schaffauser of the International Committee for the Rights of Sex Workers in Europe advises everyone who wants to work with

sex workers to 'consult sex workers about the issues concerning them and not religious or feminist or any group who think they know the truth on sex work. We are the real experts on our lives.'

Sex workers describe the benefits of networks, from simply knowing that others are committed to the same struggle to sharing information to learn about successful and less successful measures undertaken elsewhere, and, most importantly, offering and receiving support from individuals and organisations. One person interviewed from the African francophone network reported that people are more willing to share information with those they know, and so networks need to be built upon face-to-face meetings in addition to using information technology. Properly resourced networks of sex workers, sex work projects and advocates would have great impact, on the lives of sex workers and many others including the family members of sex workers, their partners including paying clients and lovers, the families of their partners, and the wider population. Additionally, the concerns of sex workers are not frequently addressed by other networks and organizations, for whom sex workers may be a minority or invisible membership. Sex workers can rely on some support from specific networks addressing human rights and combating violence, but only sex worker networks are specifically dedicated to advocating for the rights of sex workers. Sex workers are affected by many issues and while concerns sometimes overlap, it is clear that only sex worker networks can properly address these issues. What follows is a description of international networks of sex workers.

##### 4.4.1 Global and regional networks

###### The Global Network of Sex Work Projects

The Global Network of Sex Work Projects (NSWP)<sup>8</sup> is the sole global network advocating for the rights of sex workers. NSWP was founded in 1992 to promote the health and human rights of sex workers, and functioned as a loose, unincorporated and unfunded network for over a decade. Membership is engaged but has been notably volatile, which has adversely affected the network. Additionally, NSWP functions in a hostile environment. Most organisations, including many that work with sex workers, do not seek or value input from sex workers, and there are well organised and resourced structures dedicated to limiting to the movements, rights and actions of sex workers.

NSWP does not have full-time, paid staff. Therefore, the majority of work for the network, including all responses to events and crises has been done on a volunteer basis, with some project-based funding.

NSWP board member Ruth Morgan Thomas said, 'It has become apparent that we need financial support for infrastructure and human resources. All of the NSWP volunteer committee and Board are all incredibly busy implementing their own local, national and regional activities – and all the networking we are doing, sharing experiences, learning from bad experiences, campaigning, this is all carried out as volunteers in addition to our programmes. To expect this to continue without staff is entirely unrealistic. We need a secretariat with a coordinator, policy and information officer and good administration and finance management support and we need to ensure multi-lingual communication. We need to free up the volunteers from the bureaucracy and paperwork so that they can devote their time to advocacy for sex workers rights, campaigning and community-based research.'

The NSWP is in the process of raising core funding to employ staff. An external consultant conducted an organizational review and the NSWP is in the process of restructuring based on her report. The formal structure is as a network of networks, with five regional networks. The regions are Africa, Asia and the Pacific, Europe, Latin America, and North America. Translation within and across regions is a great need, with great expenses. Networks in Africa and North America are exciting emerging networks, with needs specific to this nascent stage. Networks in Asia and Latin America are the most organized and the strongest. Europe is quickly catching up.

Recent campaigns include redrafting the UNAIDS guidance note and promoting rights-based programmes that foster good working conditions in sex work, including a coordinated campaign during the 2008 International AIDS Conference. UNAIDS has released its revised guidance, but this new document retains an abolitionist perspective rather than promoting workers' rights and human rights for sex workers. Global Working Group of the NSWP, convened to address the 2007 draft guidance, continues to strategize and respond to UNAIDS.

NSWP produced guidelines for donors and implementing agencies working with sex workers (2008) with input from sex workers and projects around the world. These guidelines were distributed to the Technical Review Panel (TRP) for the eighth round of applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

NSWP produces the journal *Research for Sex Work*, the sole journal offering its unique mix of articles from sex workers, researchers and projects. The tenth

issue was distributed during the International AIDS Conference in Mexico City. The eleventh was distributed in July and August 2009.

NSWP is a partner of the new Paulo Longo Research Initiative (PLRI), which is dedicated to increasing and improving the body of evidence about sex work by producing methodologically sound, ethical, participatory action research. PLRI activities will be arranged around five themes: human rights and law, health, gender and sexuality, mobility and migration, and economics and development. It is a new collaboration between sex workers and researchers, who are not mutually exclusive. Other partners are the Centre for Advocacy on Stigmatization and Marginalization, the Institute for Development Studies and Monash University.

###### The Middle East and North Africa: An underrepresented region

A patchwork of sex work projects exists throughout the Middle East and North Africa (MENA), most funded and founded by UNAIDS and some by the International HIV/AIDS Alliance. There is no regional network and there is little participation in international networks by sex workers from the Middle East and North Africa. Sex workers from MENA are underrepresented in literature, at meetings and conferences, and in advocacy. However, there are enough interested projects and people in the region for an Arabic-language listserv and network to be useful.

Most sex workers are poor and do not have consistent access to computers, but a significant proportion have high levels of education. This means that networks would need to communicate with mobile phones and in some cases verbal communication including face-to-face conversation in addition to using listservs and Internet forums. In some places, sex worker self-organizing would face the same issues of capacity building and lack of infrastructure as in other parts of Africa.

These programmes are not well known outside the region, in part because there is little literature about them. Many programmes involve sex workers as peer educators, but very little effectiveness can be measured because few of these projects (under five) keep or analyze information about the numbers of contacts they make through outreach and the services sought at associated clinics and referrals made. Dr. Adel Zeddani explained that 'The indicators should be kept and record keeping improved, including numbers of clinic attendees, services accessed, and epidemiologic data based on the STI and HIV testing and treatment. ... Introduce better record keeping and better assessment of the changing needs of [sex

workers]. ... Follow up on referrals and services to see what is accepted and what is under-utilized and why.' A programme to train sex workers to manage the data, including monitoring and evaluation, with frequent periodic reports, would increase the efficacy of projects. This would not only involve the community at the level of management but also make it possible to link efficacy to implementation, which is not currently happening within the majority of programmes in MENA. This would reinforce outreach and support for outreach workers and peer educators.

Scaling up HIV prevention is necessary now, as low prevalence countries in MENA are seeing an increase in antenatal HIV in MTCT clinics, particularly in Egypt and Saudi Arabia. There have also been six or seven reported cases of resistance to first-line ARVs, indicating the need for access to second and third line medicines.

Most programmes are in the capital cities. The next places to establish outreach and peer education projects promoting behaviour change among sex workers are port cities and tourist centres. Scaling up in MENA could start with six countries and a sub-regional training. The desired output would be good standards for sex work programming at the national level, and this should include alignment with monitoring and evaluation at the national level and a flow of information that would be national-level advocacy.

There are significant obstacles to promoting sex workers to higher positions, the greatest being stigma and discrimination by those above them. Sex workers have demonstrated significant capacity and ability in outreach, the design and implementation of interventions, and managing projects. However, most reach a plateau beyond which it is difficult to ascend regardless of ability. For example, one woman who has risen from being a peer educator to a higher position was passed over for a scholarship to study epidemiology abroad; her history as a sex worker was known to the decision-making committee. She said, 'We know why I didn't go abroad to study, it's because I'm a whore.'

### Sub-Saharan Africa

Sex workers in sub-Saharan Africa face great obstacles to organizing. Capacity building and technical support are most in need. Infrastructure is lacking, and communications rely on mobile phones and on neighbours who will allow the phone to be used while the person being called is sought. Networking in these conditions is difficult and resource-intensive. However, many people are dedicated, so much so that there are overlapping emerging networks.

In Southern Africa, numerous networks are emerging simultaneously. There is a French-language African Network that is small but active. This francophone network shares information about conference, policies and research in addition to bilateral communication, including facilitating contact with the global NSWP and other networks in order to share information that they would not otherwise get. Overlapping emerging efforts to organize and network sex workers in English-speaking Africa include Sisonke, the South African national network, AIDS and Rights Alliance of Southern Africa (ARASA), and an OSI-sponsored regional network across Southern Africa (excepting South Africa). SWEAT, the Sex Worker Education and Advocacy Taskforce, organized a regional meeting with representatives from nine countries in February 2009.

Sisonke is a national network of sex workers in South Africa, which is strongest in Johannesburg where they have office space and have enjoyed institutional support and capacity building from other organizations delivering direct services. This is a strong model for supporting emerging networks and is cost effective. OSI-South Africa supports a network of sex work projects in Southern Africa, but they do not currently work in South Africa. South Africa is the economic powerhouse of the region, but there is great need for support for sex workers. This network is also connected with OSI partners in East Africa. SWEAT, in Capetown, recently organized a meeting of sex work projects from across Africa (but primarily from Southern Africa), with significant support from Johannesburg Sisonke. This was a great achievement for an unfunded network of sex workers and a project that has previously focused on South Africa. ARASA focuses on legal projects and advocacy efforts, and works with some sex work projects. Each of these networks overlap and each is new.

Only Sisonke is sex-worker led. However, OSI-South Africa has offered enormous capacity building in a region with great obstacles to sex worker organizing. For example, many sex workers are contacted by phone only, and frequently using the phone of another person or business. This requires cooperation and patience not only on the part of those trying to communicate but also by the people who facilitate such contact.

These networks must establish how they will work together, on which issues, and how to advocate on the same and on different issues, preferably in tandem. This division of labour will determine the best ways to support these networks and the specific issues they address.

Translation is an issue, especially for work in rural areas where sex workers may not speak colonial languages, and language choices are often political.

At the landmark conference held in February 2009, the desire for a regional network was expressed, especially to work with international organisations and the UN in order to enforce the human rights of sex workers. It was clear that many sex workers are unaware of their rights, and that others take advantage of this lack of awareness and the fact that sex work is criminalized in many places. Peer education should also address human rights education. Attention to migrants' issues including concrete ways to share information were also discussed, in addition to perennial issues like police violence. A regional hotline for migrant sex workers was suggested.

### Asia and the Pacific

The Asia-Pacific Network of Sex Workers (APNSW) is the largest, most diverse, organized and active network of sex workers. APNSW's has built up real grassroots sex worker leadership capacity, including speakers of over 12 languages, from such adverse contexts as within Myanmar. Leaders work as a group to support each other. Members hail from diverse regions from Central Asia to Pacific Islands. Translation is a great need, although most network discussions are held in English. Some APNSW member organizations, such as Durbar Mahila Samanwaya Committee (DMSC) and Women's Network for Unity (WNU) have thousands or even tens of thousands of members, and are well organized. Others, such as a group in Myanmar, work in situations that may require them to be less overt. This Burmese group is particularly in need of support. Pacific islands are also in need of support for sex work projects. AusAID and the Global Fund offer some support, but this does not extend to most islands.

APNSW and member organisation WNU received the HIV and Rights Award from the Canadian HIV/AIDS Legal Network and Human Rights Watch during the International AIDS Conference in 2008. APNSW was recognised for its work leading the response to the UNAIDS Guidance Note. WNU was recognised for their work documenting and exposing violence and abuse in Cambodia when sex work had been criminalized there under pressure from the US (*Caught Between the Tiger and the Crocodile*, 2008). Anti-trafficking efforts that harm sex workers have been an enormous issue throughout the region. VAMP and SANGRAM, sex worker rights organisations in Sangli, India, have reported that US-based Christian fundamentalist organisations have targeted their community for raids, and that these raids have led to assault and sexual assault, children dropping out of

school, and medical problems (Gupte, 2008; VAMP & SANGRAM, 2008). Not all news about anti-trafficking issues is bad: The National Network of Sex Workers in India recently defeated a revision of the Indian Trafficking Prevention Act that would have created problems for sex workers in non-coercive situations. Other recent campaigns include opposing law enforcement involvement in large-scale public health programmes, such as the 100% Condom Use Programmes (100%CUP), because of documented abuses, and efforts to promote strong ethics in research involving sex workers after documented abuses and misinformation. Following the APNSW campaign, China has revised its implementation of 100%CUP and now includes sex worker participation in their national AIDS campaign.

### Europe

Three funded European networks overlap and work together: the Sex Worker Rights Advocacy Network (SWAN) in Central and Eastern Europe and Central Asia, supported by OSI, TAMPEP, which uses a rights-based perspective to assist migrants in Europe and sex workers in coercive situations, and the International Committee for the Rights of Sex Workers in Europe (ICRSE). TAMPEP is a network of 26 organisations in 25 European countries<sup>9</sup>, targeting female and transgender sex workers from in and outside the European Union. TAMPEP's website includes information about legal frameworks, TAMPEP's research, and services available. The services4sexworkers section of TAMPEP's website ([www.services4sexworkers.eu](http://www.services4sexworkers.eu)) has been especially highly praised for its usefulness in post-soviet countries. TAMPEP is conducting a mapping project and assessing the effects of the legal frameworks in use in Europe. TAMPEP is also producing a manual on good practices, for which the criteria are direct involvement of sex workers, evaluation, and transferability and adaptability to other contexts.

ICRSE is sex worker-led and vibrant, with an informative and multi-lingual website used to share information within and external to ICRSE. SWAN has a coordinator who produces a newsletter with support from OSI. Most of these organisations were founded as harm-reduction projects, and some are involved in sex worker rights groups. The most vibrant are HOPP in Macedonia, with STAR, an incubating sex workers group, and Taiz-Plus in Kyrgyzstan. Sex worker groups in Ukraine and some other countries have spun off from the original harm reduction projects within the SWAN network. SWAN offers media training to combat stigma and discrimination, and to prepare sex

workers to interact directly with journalists. SWAN will release a report about police violence this summer. Documentation is a strong focus.

In 2005, ICRSE convened an international meeting with global participation. The meeting was a landmark event and a Manifesto and a Declaration of the Rights of Sex Workers in Europe were produced. Thierry Schaffauser, of the Advisory Group of the ICRSE, said, 'since that conference that I am much more involved in the European network of sex workers activists. I think it gave me a lot of energy to see how things could be possible in some countries and so achievable everywhere.' Schaffauser echoes the Declaration, saying that it is imperative to 'ensure equal rights in terms of health, labour, safety, migration, parenthood, pension, jobseeker allowances, like any other worker and citizen.'

Many European nations have outreach programmes dedicated to sex workers, but sex workers seem to be facing a more conservative environment in Europe, with legal changes affecting sex workers in ways that limit who can work where. For example, non-EU citizens are excluded from most legal sex work venues. Workers who are not European nationals are welcome within these networks. One aspect of this conservative environment has been the use of anti-trafficking efforts to restrain the sex industry and sex workers. For example, in 2008, a document entitled 'On prostitution and its health consequences on women in Member States' was submitted to the European Parliament FEMM committee. ICRSE, TAMPEP and SWAN submitted a collaborative statement of protest and the document was not adopted. In fact, the report was defeated 26 votes to 3 with 2 abstentions. 'The arguments that were submitted by sex worker and other organisations were very helpful and enabled FEMM committee members to make an informed decision' (ICRSE, 2008, p.4).

### Latin America

Latin America features a network of female sex workers and a transgender network not limited to sex workers.

There is a strong network of female sex workers in Latin America, which grew out of the labour rights movement and takes a strong stance that prostitution should be acknowledged and regarded as a form of work. This network is supported by the International HIV/AIDS Alliance. This network is strongest in South America. Country delegations from Argentina, Brazil and Mexico to UNGASS meetings have included sex worker leaders from the Latin American Network.

RedLACTrans is a network of transgender people in Latin America, many of whom sell sex. RedLACTrans has strong membership from the Spanish-speaking Caribbean and Central and South America. RedLACTrans has some funding and members actively participate in international meetings addressing HIV/AIDS. The coordinator is a Spanish-speaking Dominican woman living in New York. RedLACTrans has had strong and active representation at UN meetings on HIV/AIDS, especially UNGASS, and has coordinated participation of transgender people in research including both medical and social research. RedLACTrans coordinated two focus groups about research ethics with marginalized populations for the AVAC research into Good Participatory Practice with sex workers.

Male sex workers are currently left out of these networks and there is no network of male sex workers. Organizations of and for male sex workers are welcome within NSWP but are not part of a network of sex workers within the region.

These networks typically communicate in Spanish, and only Brazilian sex work projects and sex workers are well-represented from areas where Spanish is not the dominant language. Translation for Dutch, English and indigenous languages may lead to greater participation from these areas.

### North America

Canada and the United States are rich countries with poor funding for sex workers. There are few funded programmes for sex workers in either nation. Funded programmes are more active than projects without funding, but there is a large volunteer ethic that has led to the creation of innovative media and activism by sex workers.

A grassroots movement of sex workers, usually called Sex Worker Outreach Projects (SWOP) has emerged in the US, but is strongest in urban centres. Groups that pre-date SWOP have other names. To generalize, all function as support groups, and with specific actors in the east focusing on national and international politics while the west is more culturally-oriented with some attention to state law in California. Desiree Alliance is a network of these groups. Desiree Alliance has held three national meetings, each of which brought together more than 250 sex workers and advocates from around the country to brainstorm and collaborate on new community-developed solutions. Desiree Alliance is part of a widespread grassroots resistance movement to conservative local policies throughout the US and to the oppressive policies of the Federal Administration. Desiree

Alliance began by reaching out to organizations with similar constituencies or intersecting concerns, and spearheaded a campaign in 2005 that successfully encouraged the National Organization for Women (NOW) to reject a proposed policy that would have required that organization to publicly denounce sex workers. The next meeting is planned for 2010.

US and Canadian sex workers are active within the NSWP. There is less participation from the English and French speaking Caribbean, in part due to a lack of resources and infrastructure. Some projects in the Caribbean participate on NSWP listservs but these are typically represented by staff rather than sex workers. Sex workers in Canada stated in 2006 that they did not want to create a national network.

Most programming with sex workers focuses on health and HIV prevention. The Saint James Infirmary, Maggie's, Young Women's Empowerment Project, Stella and HIPS are examples of organizations run by sex workers or people with experience in the underground economy (which often involves sexual transactions). Stella, in Montreal, works with Medecins du Monde to offer health services including STI examinations to female, transvestite and transgender sex workers, regardless of immigration status. HIPS, in Washington, DC, has a van that they take to street scenes in order to distribute condoms, harm reduction materials, food and to offer counselling.

Unique programmes in the US include Sex Work Awareness (SWA)<sup>10</sup> and the Sex Workers Project at the Urban Justice Center. The mission of SWA is to educate people about the realities of sex work by promoting sex-worker created media and information (including research). The Sex Workers Project offers legal and social services for sex workers and trafficked persons. SWP receives no federal anti-trafficking money, in part due to the anti-prostitution pledge.

### Recommendations

- It is recommended that the representation of sex workers in civil society be strengthened by funding networks of sex work projects and sex workers. Priorities include the Global Network of Sex Work Projects. Regional priorities include nascent networks, especially in Africa. Core support such as funding for offices, infrastructure, communications and management to undertake campaigns is needed.
- Some networks have limited funding; others, including the Global NSWP, remain underfunded and this has weakened their ability to represent the interests of sex workers. Translation is a critical need

for communications across and within networks. Emerging networks have greater needs than more established networks.

- In some places, such as Europe, overlapping networks work well together. This is successful in part because the roles and mandates of each network are explicit. In Sub-Saharan Africa, overlapping networks are establishing roles across networks. These roles will determine priorities for support.
- Participation in the Global NSWP by projects in the Middle East and North Africa Red should be supported. This may be facilitated by the creation of an Arabic-language communication network, including a listserv and mobile phone messaging.
- RedLACTrans has expressed interest in expanding to be a global network of transgender people (not all of whom are sex workers), and initial efforts to reach out beyond the Americas should be supported.
- Fund capacity building for and by sex worker networks. In some instances, sex workers have conducted trainings. For example, The Global Network of Sex Work Projects (NSWP) and the Asia Pacific Network of Sex Workers have conducted workshops for members, including human rights documentation, information on thematic issues such as research ethics and human rights, human rights documentation, and advocacy and activism skills. Sex Work Awareness in the US offers video and media training. SWING is not only a model project for work with male and transgender sex workers, SWING also has experience training other organizations to work with sex workers at all levels of programming, including design, implementation and management. Trainees have included local NGOs, health care providers, and Global Fund recipients from other parts of Asia. These organizations and health care providers report having enjoyed and benefitted from SWING's training. Trainings like these by sex work projects should be continued, supported and replicated.
- Global and regional networks need to be supported to participate in key advocacy meetings with global institutions, including but not limited to the UN.
- It is imperative to continue to explore ways to use new media to promote sex workers' rights. For example, sex work networks have found video to be an important advocacy tool. (See, for example, *Taking the Pledge* and *Caught between the Tiger and the Crocodile*) This is one way to include voices from individuals and organisations in places with low literacy rates and who may be unfamiliar or lack resources needed to produce and distribute traditional press releases and reports. Mobile phones are useful for sharing information among groups, with text messaging and new software,

such as Twitter and Twitpics, that enable users to communicate between mobile phones and the Internet. This is helpful for sharing information, for example, about violent incidents (such as pictures of assailants) and health information and service availability.

#### 4.5 Barriers to effective sex work programming within large finance mechanisms

Two of the largest funding initiatives for HIV/AIDS programming are the United States' President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). These mechanisms support some programmes with sex workers, however, both have specific barriers to effective programming with sex workers.

##### 4.5.1 PEPFAR

The United States provides funding for HIV programming, including funds for care and treatment, via the President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR focuses on specific countries with severe epidemics but aid is not limited to these nations. Since December 2002, the US government has imposed restrictions upon anti-trafficking and HIV/AIDS funding including PEPFAR (Ditmore, 2008). Secretary of State Colin Powell sent a cable to USAID country offices, partners and grantees, December 22, 2002, saying, 'Organizations advocating prostitution as an employment choice or which advocate or support the legalization of prostitution are not appropriate partners for USAID anti-trafficking grants and contracts.' (on file with the author) Later legislation required partner organisations to have an explicit policy opposing prostitution (US Global AIDS Act 2003). This restriction, referred to as the 'anti-prostitution pledge' (APP), has led to a decrease in services for sex workers despite the urgent need to scale up HIV-prevention services. For example, the effects of these restrictions have included the denial of services to male, female and transgender sex workers in a variety of venues and the closing of some services dedicated to sex workers (*Taking the Pledge*, 2007). Stigma and discrimination against sex workers increased in health care settings after the imposition of this requirement. For example, sex workers in Cambodia reported experiencing greater stigmatization, even in a research situation in which sex workers were sought (Forbes and Mudaliar, 2009, p.16). Bendavid and Bhattacharya (2009) reported that the US President's Emergency Plan for AIDS Relief (PEPFAR) has prevented deaths by increasing availability of treatment and care but has not prevented HIV infection; this is an indictment of the policy that has directly contributed to a decrease in sex workers' access to HIV-prevention programmes. There is a non-

discrimination clause that specifies that no one may be denied care or services because of APP, but this is enforced irregularly.

Enforcement of these restrictions is inconsistent but the restrictions are not pro forma. There is a lack of clarity about what the pledge means in the field. For this reason, some organisations restrict their programming to interventions that are not geared toward sex workers or even by excluding sex workers (*Taking the Pledge*, 2007). There has been confusion over which organisations are required to comply, and so more organisations than were required to do so and even nations and UN agencies were asked to sign the policy. For example, Migrants Assistance Programme in Thailand was a subgrantee and not required to sign, but was asked to do so anyway (*Taking the Pledge*, 2007) by the direct grantee because of a lack of clarity over whom should be asked to sign.

Brazil rejected US\$40 million because of this restriction, highlighting both Brazilian sovereignty and the role that sex workers play in HIV prevention. Some organisations have rejected this restricted funding. Two US-based lawsuits have been filed to challenge the pledge. Some organisations have responded by changing the language used in programming, obscuring which interventions reach sex workers by using less specific terms, such as, for example, 'vulnerable women'. This contributes to difficulties evaluating HIV-programming for sex workers, because involvement with sex workers is obscured in response to being discouraged, despite sex workers being disproportionately affected by HIV in many places. Some recipients of US funds have worked to include sex workers in their programming with effective, evidence-based and rights-based programming. In many cases, these are significant grants within which small amounts have been dedicated to working with sex workers (for whom even small amounts are significant) in ways that are constructive. However, fear of losing funding has meant that people consulted with such projects have asked not to be identified and for their projects to be obscured in this report. The reasonable fear of losing funding and thereby being forced to stop operations contributes to a lack of documentation of strong rights-based programming and interventions for sex workers, further obscuring the efficacy of some programmes.

It remains to be seen how the new US administration will implement PEPFAR. However, the emphasis on evidence may bode well for improving programming with sex workers. APP was nearly struck from PEPFAR in 2008. Efforts to remove APP from PEPFAR will resume in the lead-up to the expiration of PEPFAR in 2011.

#### Recommendations

It is recommended that a campaign to remove APP from PEPFAR and a return to evidence-based programming with sex workers be undertaken. This will require participation by people outside the US, travelling to the US to speak with legislators, and a US-based campaign to cultivate legislative support and grassroots support in the home communities of legislators who work toward the repeal of APP.

##### 4.5.2 Global fund to fight aids, tuberculosis and malaria

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was founded to address the HIV/AIDS pandemic in developing countries with emphasis on key populations, including sex workers. The fund gives money directly to countries and has enabled many countries to scale-up their responses to the HIV/AIDS pandemic. GFATM has a Technical Review Panel (TRP) and Country Coordinating Mechanisms (CCMs). Countries submit a short proposal, some of which include sex work. Each nation determines its own strategy and implementation, including whether and how to address sex work.

The TRP is composed of acknowledged experts in HIV prevention, treatment and care. The TRP assesses eligible proposals on their technical merit, feasibility and sustainability. However, proposals are typically short and do not include detailed information about implementation of programming. It appears that proposals will be evaluated by the International Health Partnership (IHP+) in the future. IHP+ is composed of large international agencies and government representatives. There may be less opportunity for civil society to participate and offer expert input.

CCMs were meant to decentralize grant making and turn over grants to local ownership. One of the core principles of the Global Fund is for need and demand to drive its work. Therefore, sex workers should be involved. However, CCMs in many places reflect moral and ideological concerns with sex work. Dr. Joanne Csete of the Mailman School of Public Health explained that 'There is good evidence that at times CCMs in many countries have not been welcoming to sex worker organizations. The same is true of drug user organizations. In places where sex work is criminalized, CCMs have a lot of leeway to exclude sex worker representatives. I think that is a shame because the CCMs are strategically important for the inclusion of marginalized people in programming and policy making.'

Karyn Kaplan, Director of Policy and Development for the Thai AIDS Treatment Action Group, said,

'In Thailand, there is one PWA on the CCM and that person speaks no English. Many of the documents go around in English, so they are totally excluded. Unless we get better representation on the CCM's and greater capacity building about preparing proposals and what the situation in the country, you won't get proposals that meet the needs of the most vulnerable and excluded groups in that country.'

The International HIV/AIDS Alliance writes, 'It has been challenging for key populations to feel adequately represented within country-coordinating mechanisms. This is particularly true of sex workers and transgenders who often feel unrepresented in places like Peru when the one seat for 'vulnerable populations' is occupied by a gay man.'<sup>11</sup> (International HIV/AIDS Alliance 2009, p.6) Susana Fried and Shannon Kowalski-Morton, analysed 65 CCMs for an Open Society Institute publication (2009). They point out that the criminalisation of sex work may preclude any participation in the CCM and that not participating further obscures the epidemic among sex workers (2009, p.4-5). Criminalisation is only the most obvious way that sex workers can be excluded from CCMs. In fact, the Global Fund itself has learned that CCMs do not focus on marginalized groups (Wilkinson et al 2006). Criminalised activity and status, alongside the clandestine nature of many stigmatized or criminalised activities, present an obstacle to seeking money from the state in the form of risk of arrest or scrutinization and the inherent conflict involved.

Countries design their own programmes; some fund rights-based and evidence-based programming with sex workers, but many countries are less focused on sex workers or fund less effective efforts. The International Treatment Preparedness Coalition report on CCMs documents that governments dominate the CCMs and do not accept all input from participants, some of whom are too intimidated to counter government voices (2008). It appears that some of the most critical populations, such as transgender people, an overwhelming majority of whom do sex work because they have few other occupational options, are neglected by GFATM programming (International HIV/AIDS Alliance 2009). GFATM has not been evaluated with regard to distribution of spending among key populations or effectiveness of programming with sex workers. However, the International HIV/AIDS Alliance has evaluated the spending with regard to key populations for 15 of 35 GFATM grants made in Latin America and the Caribbean. (International HIV/AIDS Alliance 2009) and found that 'Organisations of sex workers or people living with HIV only received direct funding in 2 of the 15 grants' (p.10).

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Across all the grants analysed for the purpose of this report over US\$170 million has been granted to its sub-recipients. Only 4.6% of the total has reached key population organisations in the form of sub-recipient grants. Not surprisingly, organisations of people living with HIV have received the largest amount, at just over 50%, and men who have sex with men groups have received 27.6%. Women living with HIV/AIDS and sex workers have been able to access resources far less at 16.3% and 6.1% respectively. What is most striking in reviewing this data is that organisations of transgenders have not been sub-recipients of funds in any of the 15 grants and yet prevalence studies in some parts of the region suggest rates up to 45% among this population group. (International HIV/AIDS Alliance, 2009, p.5, emphasis in the original)

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This means that of the US\$170 million, only US\$477,000 – less than one-half of a million dollars – was allocated to programming with sex workers. It was found that El Salvador and Haiti allocated an additional US\$ 4 million (2.5% of the total) to organisations of sex workers and men who have sex with men (p.10).

The Alliance report links participation in the CCM with access to GFATM resources. 'Key populations are strongly present in the country-coordinating mechanisms (CCMs) in Ecuador, Bolivia and to some extent in El Salvador and Peru. This coincides with the country grants that have allocated the highest proportion to key population organisations among those analysed for this report, which implies that there is a direct correlation between participation in CCMs and resource allocation to respective population groups' (p.5). The Alliance report later says, 'sex workers and transgenders interviewed believed that weak strategic capacity of their organisations was an issue, but only to the extent that they lacked the knowledge and experience in using decision-making spaces (such as CCMs) to their advantage' (p.17). Fried and Kowalski-Morton found that in countries where sex workers' organisations and projects had strong links to the CCMs and to the implementing organisations, they were able to access GFATM resources, sometimes as sub-grantees (p.6).

Both the Alliance report (2009) and the Fried and Kowalski-Morton article (2008) describe the difficulty members of key populations including sex workers and transgender people to access information from the CCMs. Even though transgender people and sex workers were identified as the targets of the funding, their organisations were excluded from CCM processes numerous countries. This exclusion will likely be exacerbated by the move from CCMs to IHP+ unless member governments insist on the inclusion and representation of members of key populations including sex workers within IHP+.

Central Asia and Eastern Europe further demonstrate that participation within the CCM leads to funding reaching sex work projects. Fried and Kowalski-Morton write that 'In Eastern Europe and Central Asia, for example, funding from the Global Fund has been used to introduce and expand services for sex workers in every country where HIV grants are being implemented' (2008, p.4). Fried and Kowalski-Morton go on to document similar obstacles to participation by sex workers, men who have sex with men and LGBT individuals as the Alliance documented in Latin America. In addition, even when sex workers are able to participate, their input is not always used or acknowledged.

Fried and Kowalski-Morton cite a GFATM survey which found that only 31% of CCMs have a 'documented and transparent process for ensuring the input of a broad range of stakeholders, including non-CCM members, in proposal development procedures' (2008, p.6). They also remind us that the fund recognises the inherent problems for those who engage in activities that are criminalised to access fund resources via their governments, and so a mechanism to apply to the fund directly has been implemented. However, the International HIV/AIDS Alliance report about accessibility of fund resources reiterates concerns voiced above by Ruth Morgan Thomas:

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Sex workers and transgenders interviewed for this report identified the need for technical support in proposal development. However, rather than requesting their own capacity built in this area, they highlighted the contribution and role that can be played by having a skilled staff member within their organisation. Claudia Baudracco explained that many donors who provide resources to incipient key populations organisations only fund activities and do not contribute to operational costs. This does not allow for additional staff to be hired and it means that many key populations groups rely almost wholly on volunteers.

Claudia believes that donors need to recognise that organisations led by key populations also need technical and administrative staff skilled in fundraising and managing the day-to-day operations (accounting, reporting etc); including such staff within a community organisation increases their opportunities for institutional strengthening. Neither Claudia nor Elena Reynaga detracted from their communities' own capacity needs. However they felt that as activists, they are best placed reaching out to their community and advocating for their communities needs, rather than working on the mechanics of a proposal. Nonetheless, both were clear that the content and

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vision of the proposal needs to come from members of the key population. Technical staff members would be there to translate their ideas and strategies into a donor-friendly format (2009: 21).

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#### Recommendations

- It is recommended that CCMs be required to include specific groups that are affected by HIV, including sex workers of all genders. It is also recommended that the GFATM design and implement a non-CCM application process in places where the legal, political or social environment precludes the participation of sex workers. Community Systems Strengthening (CSS) may be an avenue for the GFATM to support community-based organisations, including sex work projects.
- It is recommended that the GFATM disseminate information in a transparent, accessible and timely manner.
- Sex work projects and networks should strive to be included in GFATM processes and monitor the inclusion of sex workers in Fund programming and the efficacy with which Fund resources reach sex workers. This would require funding for sex work networks, perhaps through CSS.
- Mechanisms for the participation of civil society, especially affected populations including sex workers, should be developed for IHP+. Advocacy should also be undertaken at the national level to ensure that sex workers are included in the process regardless of the status of sex work in country.

#### 4.6 Suggestions for the UN

UNAIDS has followed the abolitionist stance of the United States. An unfortunate moralistic perspective promoting the abolition of sex work has taken hold, as demonstrated in the recent UNAIDS Guidance Note on HIV/AIDS and Sex Work (2009).

The 2007 draft UNAIDS Guidance Note on HIV/AIDS and Sex Work was protested by the NSWP-convened Global Working Group on Sex Work and HIV for its emphasis on reducing sex work rather than reducing HIV transmission within sex work (Seshu et al., 2008). The next version, released in March 2009 (UNAIDS) maintains this abolitionist perspective but couches it in the language of human rights – dangerously obscuring the human rights of the sex workers it purports to assist in preventing HIV—even as it contradicts UN Guidance on Human Rights, which states, 'with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work.' Sex workers and advocates emphasized that the ability to

enforce condom use is directly related to good working conditions in sex work in a global consultation held in Rio de Janeiro, Brazil, in 2006 (UNAIDS, UNFPA & the Government of Brazil 2006) and in the response of the Global Working Group to the draft Guidance released in 2007 (APNSW, ICRSE, & NSWP, 2007). Reynaga (2008) points out that the sex in sex work is not the problem, but rather that professional sex without condoms is the problem with regard to HIV prevention by and for sex workers.

The UNAIDS 2007 draft Guidance Note on HIV/AIDS and Sex Work, and the revised Guidance Note released in 2009, both prepared by UNFPA, ignore input from sex workers as documented in its own report of the global consultation held in 2006. (UNAIDS, UNFPA and the Government of Brazil 2006) The Guidance Note emphasised a reduction of sex work rather than a reduction of the transmission of HIV in sex work settings. For this reason, NSWP convened a Global Working Group on Sex Work and HIV Policy, which drafted a document emphasising the reduction of HIV transmission in sex work. This was submitted to UNAIDS in September 2007. The UNAIDS PCB and the Human Rights Reference Group recommended that the GWG's guidance be adopted. Efforts to communicate with UNFPA and UNAIDS by activists and advocates including the NSWP's Global Working Group on Sex Work and HIV, Open Society Institute, and the Canadian HIV/AIDS Legal Network have received only cursory acknowledgement without addressing the substantive issues raised.

In early 2009, UNAIDS released a new Guidance Note that retains the original emphasis on the reduction of sex work, including reduction of demand for sex work. NSWP board member and manager of SCOT-PEP Ruth Morgan Thomas said, 'The emphasis and ambiguity around demand reduction and exiting in the UN Guidance Note will potentially lead to moral and ideological rather than evidence-based programming, which would divert very limited resources for sex work programming to areas with no evidence for meaningful impact in relation to universal access to HIV prevention, treatment and care services for sex workers.' Therefore, it is imperative to examine the ambiguities within the UNAIDS Guidance Note on HIV and Sex Work and that actions be taken to ensure that UN guidance is not implemented in such a way as to promote demand reduction and/or the criminalization of the clients of sex workers or exiting as primary HIV prevention tools. UNAIDS implementation of its guidance is important because UNAIDS has influence at the country level over the implementation of GFATM and other resources.

UNFPA scheduled and invited attendees to a regional meeting in the Asia-Pacific region to launch the UNAIDS Guidance Note for May 2009, prior to a meeting between the Global Working Group on Sex Work and HIV Policy and UNAIDS Director Michel Sidibé. The Asia-Pacific meeting organised by UNFPA to roll out the Guidance Note in that region, prior to a meeting between GWG/NSWP and Michel Sidibé to discuss concerns about the Guidance Note and the potential role of NSWP in its implementation at global, regional and country level was further evidence that UNFPA had no *real* commitment to working with the global or regional sex work networks.

Sex work was put under the purview of UNFPA because it was the sole UN agency not receiving US funding. This has changed with the new US administration and US funding to UNFPA has been restored. The breach of trust described above is a considerable. It is suggested that UNDP and UNESCO be considered. WHO has in the past exhibited significant expertise on sex work and HIV but a medicalized approach to sex work is less desirable than a rights-based approach to sex work. The strongest example of this medicalized approach is WHO's promotion of 100% Condom Use Programmes implemented by law enforcement in Cambodia, Mongolia and other locations. Everyone is in favour of condom promotion, but programme implementation involving or increasing police control over sex workers has been fraught with rights violations. UNODC is not suggested because sex work is not a crime in most of the world and for UNODC to accept the remit of sex work would further conflate trafficking with prostitution.

In May of 2009, representatives of the Global Working Group on HIV and Sex Work Policy, established by the NSWP, met with Michel Sidibé and other representatives of UNAIDS and its Cosponsors and agreed that UNAIDS would ensure the meaningful participation of sex workers and would work closely with the NSWP in the future, indicating that global and regional sex work networks will be actively involved in the interpretation and implementation of the Guidance Note on HIV/AIDS and Sex Work. Sidibé also gave a commitment that UNAIDS would call for governments to remove punitive laws, which criminalise sex work.

#### Recommendations

- It is recommended that efforts be made to influence UNAIDS to re-evaluate the placement of sex work within its partner organisations.

- It is recommended that the PCB and other bodies and organisations seek clarification from UNAIDS about the implementation of the Guidance Note, especially with regard to the reduction of HIV in sex work settings and to be concrete in terms of how the guidance note will inform UN and country level programming. For example, will it just be disseminated or are there trainings and TA planned; will there be indicators developed in terms of measuring the countries' response on addressing sex work issues, and how will this inform the country AIDS plans.
- It is recommended that the agreement that global and regional sex work networks including be directly involved in the interpretation and implementation of the guidance note be enforced.

#### 4.7 Engagement with broader civil society

Strengthening the advocacy messaging of sex-workers in the international arena is vital, and there is also a need to do this within the broader civil society. Sex work networks should seek support from trade unions, NGOs, LBGTIQ community, feminist organisations, faith-based organisations and more. These organisations are typically unaware of the real needs of the sex worker community, and frequently voice the wrong messages about sex work. Broader civil society and sex work networks could engage in more meaningful ways in their work that would promote sex worker rights beyond access to health services. A continuing problem is the fact that an emotional position against sex work, often equated with 'sex trafficking', overshadows any recommendation to evaluate one's own policy and actions. This can be combated by strategic and targeted campaigns to build alliances with influential organisations and individuals to promote information about the reality of sex workers' lives and the actual issues they face, including violence, abuse and discrimination.

A strong example of such an effort is the Media Toolkit prepared by the Sex Workers Project in New York, which includes resources for activists and journalists alongside briefing papers. Another example has been NSWP efforts to encourage donors to fund evidence-based, rights-based programming for sex workers, first with guidance for donors encouraging the funding of best practices recommended during an online global consultation with sex workers from around the world (Allman, Ditmore and Mollet 2008) and followed by the OSI-sponsored Donor Dialogue on Sex Work and Trafficking held in December 2008 in the US, convened with CREA and NSWP (CREA, NSWP and OSI 2009).

#### Recommendations

It is recommended that sex worker networks engage with broader civil society activists and advocates in order to promote awareness of the real needs of sex workers. However, these efforts should be smartly targeted and undertaken strategically. Such campaigns will require additional resources to convene and attend meetings, to develop information and messages for audiences unfamiliar with sex work, and to disseminate messages to targeted audiences.

#### 4.8 Country and region specific issues

##### 4.8.1 Access to STI Diagnosis and Drug Resistance in Indonesia

Indonesia demonstrates the need for and value of affordable health care including STI diagnosis and effective treatment. Jakarta, Indonesia has projects that reach out to male, female and transgender sex workers. These projects promote condom use and have connections to good public health clinics. However, not all of the clinics are free, and clinics used syndromic management, meaning that only symptoms were treated. One problem with this approach is that most STIs are asymptomatic and therefore most STIs remained untreated. Another is that the antibiotics prescribed may not have been the best choice for the infection exhibited: STIs are best treated upon diagnosis to distinguish which STIs are present and what treatment is best. Indonesia experienced an epidemic of STIs directly due to antibiotic resistance that rendered treatment for STIs ineffective. Between the time the antibiotic resistance was recognized and addressed, STI and HIV rates had tripled.

Actions taken in response to the rise in STIs and HIV include providing on-site STI diagnosis at clinics in 'hot spots' in and near nightclubs and areas known for sex work. Clinics that formerly offered only syndromic management of STIs now offer onsite diagnosis and treatment, including some mobile clinics that go to brothels. The equipment necessary is small and fit into existing offices without expansion. Trained lab technicians are employed at these sites. Indonesia demonstrated that a country with limited resources can offer timely STI diagnosis and treatment in a sensitive environment to sex workers. Partners described below refer or bring people to clinics and mobile clinics to people who need them.

The MSM programme It's My Life Club has targets for outreach workers to meet new contacts and to have repeat contacts – a possible model for other projects seeking to document and expand coverage. This programme has outreach workers specifically for men who sell sex. The men who participate with It's My Life

Club frankly described the difficulties of using condoms consistently, saying 'With a client, it is usually easy. But when I am with my lover or some really hot guy, I forget about the condom. I am only thinking of him.'

GEMA is an organisation that reaches out to sex workers, clients and gatekeepers, who are primarily security people, in Pela-Pela, the most famous brothel area of Jakarta. GEMA distributes condoms and lubricant and has a relationship with a mobile clinic. But their influence needs to grow in order to promote condom use effectively: only 2% of the female sex workers use condoms consistently. One woman said, 'I am insulted when the clients want to use condoms. We have to trust each other.' Another replied, 'She has to learn to use condoms.' Some of the obstacles are the very inexpensive quack medicines available, many of which include diluted antibiotics. These are less expensive than the mobile clinic that visits the brothel. The implications of this are discussed below.

Srikandi Sejati is a programme for transgender people. Voluntary counselling and testing for HIV is offered. There is a drop-in centre and a hospice for the terminally ill. Memorials to project members who have died of HIV are a reminder of the reasons to protect one's self. Transgender people, many of whom are sex workers, have the highest rates of condom use in Indonesia because strong leadership promotes consistent condom use, but even this rate is only 30%

##### Antibiotic Resistance and the Cost of Health Care

In many places, antibiotics and other medicines are widely available and inexpensive. These conditions contribute to the overuse of antibiotics, and in turn, antibiotic resistant strains of many bacteria, including those bacteria responsible for STIs. In many places, some sex workers and other people take antibiotics or other drugs which they believe will protect them from STIs and HIV when they intend to or have had unprotected sex. Such practices have not been proven to prevent STIs or HIV and contributes to antibiotic resistance.

Where health care services are not free, they compete with other providers, including pharmacists, 'wise women', and traditional healers as well as quacks and charlatans. Each of these typically cost less than visiting a proper clinic or surgery and may involve less waiting and less travel. Travel adds significantly to time and cost for many people who might otherwise go to an established clinic. These are all factors in where sex workers will choose to seek services. This means that clinic services should be geographically convenient and operate at times that are convenient for sex workers, at prices that are lower than local alternatives.

Each of these alternative service providers may offer treatments including diluted antibiotics and other concoctions, many of which may offer no more than a placebo effect and contribute to the development of resistant strains of STIs.

In 2004, clinics run by an international NGO in Indonesia found that despite treating STIs, HIV incidence did not decline. It was later discovered that chlamydia, gonorrhoea and syphilis strains prevalent in Indonesia were resistant to the antibiotics available, including Ciprofloxacin. The Indonesian government required proof, meaning a study, and then testing to approve the use and distribution of azithromycin in Indonesia in 2008.<sup>12</sup> Azithromycin has proven effective for now, but the overuse and misuse of antibiotics means that resistance is a perennial concern to be combated with education, behaviour change and continuous development of new antibiotics. Nor is Indonesia an extreme example: it is easy to buy antibiotics over the counter even in places where antibiotics are legally available only with a doctor's prescription. Overuse of antibiotics, especially people who are not able to access subsidized national healthcare systems and who use the services of pharmacies or charlatans because they are more economical than paying for a doctor, is not unique to Indonesia but has been documented among sex workers in Thailand (Guest et al., 2007, p.75) and the general populations of many places. Resistant strains of infectious agents are a global issue.

#### 4.8.2 Sisonke: An Emerging Network Selforganising in South Africa

Sisonke is the South Africa's emerging national network of sex workers. The network is run entirely by volunteers and currently operates without organisational support or a budget. The most active group is in Johannesburg, the largest city in the region. Lauren Jankelowitz of the Reproductive Health and HIV Research Unit (RHRU) of the University of Witwatersrand in Johannesburg explained that the rate of HIV in the general population of South Africa is estimated to be between 12 and 25%, and that approximately 20% of the general population of South Africa is HIV+. Sex workers who use RHRU's clinic services have higher rates of HIV, between 50 and 60%. Many Sisonke members in Johannesburg use the services of RHRU, and a number of Sisonke members have become employed as peer educators with RHRU, facilitating communication with Sisonke members and with partner organisations. This has contributed to the high level of activity and success of Johannesburg Sisonke. Other chapters do not have similar resources and therefore are not yet at this

stage. Johannesburg Sisonke's priorities include legal advocacy, which means hiring an attorney, and starting a savings scheme that would include a funeral plan for their members. The need for the savings scheme and funeral plan is directly related to rates of HIV and endemic violence in South Africa.

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The uses and benefits of data collection and analysis by projects Despite its strong service record, Shehab Institute, like many organizations, has made little progress developing an evidential database. Some community-based organisations are content to carry on with their work without such evidence to support them. Sex workers are often more compelled by self-organizing than data collection, but these are not mutually exclusive. Some organisations may wish to develop such a body of data but not have the capacity to do so without taking valuable staff time from other work.

Others programmes set up by large international organisations may even be required to record such data, but have either not made the commitment or do not understand the link between programming and evidence of efficacy (and, eventually, funding).

Capacity building may be useful and/or necessary in these instances.

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Sisonke has the capacity and strategy to accomplish these tasks and are now in the process of seeking funding for printing, translation and organisational costs. Johannesburg Sisonke is poised to lead the only sex-worker lead network in the region and is very interested in future organising across borders. Migrants are a significant portion of South Africa's population, and this is reflected in Sisonke's membership, contributing to the interest in regional networks.

Sisonke co-organised a regional meeting of sex workers with the Sex Work Education and Advocacy Taskforce SWEAT. Johannesburg Sisonke was mostly involved as the hosts of the meeting. Representatives from all participating nations agreed on the need for advocacy and campaigning against police violence and harassment and on the need for global advocacy to promote sex workers rights in order for sex workers to realise the full potential of their human rights. All agreed on the need to educate health care workers and train them not to stigmatise or discriminate against sex workers.

Six hundred people visit RHRU's clinic for sex workers each month for STI testing and treatment, but only 40 people per month seek HIV testing. Even the peer educators themselves are hesitant to be tested, because of the stigma of HIV, the fear of discrimination and lack of understanding about treatment options and availability. ARV treatment has not reached the great need in South Africa, and therefore few people have seen successful ARV treatment. RHRU expects that as more people become aware of effective ARV treatment, they will come for HIV testing and treatment. This will require much greater numbers of peer educators, outreach workers and health care personnel. Johannesburg Sisonke could easily expand peer education programmes within the brothels and other areas as part of scaling up HIV-prevention efforts.

#### 4.8.3 Adaptability and an Innovative Legal Programme for Sex Workers in Egypt

Shehab Institute in Cairo offers sexual and reproductive health services and legal services to female sex workers. The director said, 'This is the first legal programme for sex workers in the Middle East.' The programme was started in Nasr City, far from the city centre, but has a very busy drop-in centre (DIC) near one of the major transit stations of Cairo's public transit system. The overwhelming majority of requests are for legal services, covering a wide variety of issues including situations of blackmail, arrest, obtaining identification and other documents including birth certificates for the children of sex workers, extortion and debt, housing and more. Problems with the police include violence, theft, extortion of sex, and that sex workers cannot report crimes against them to the police. HIV is a growing problem. The 2006 BSS in Egypt (Ministry of Health and Population) found 0.8% prevalence among sex workers. STI rates were higher and there was a lack of knowledge about STIs. Sex workers overlap with IDUs in Egypt. The time is now to scale up if there is any hope of averting a concentrated epidemic. Therefore, increasing the use of condoms and clean needles is critical.

Female sex workers face difficulty when they carry condoms, which the police consider evidence of wrongdoing. It is easier for men to carry condoms, but police enforcement is an obstacle to HIV prevention work with sex workers of all genders. An outreach worker with Shehab Institute said, 'It's not easy to start with condoms. First we make contact. Our repeat contacts ask for condoms and then tell us about their lives.' 'Men ask for condoms, and we do the workshop in the café, the workshop on how to use condoms.' Clients have no problems with the police in Egypt, 'The client is always absent in the raids. It's the woman

who has incited debauchery.' Raids on discos are the most common, and the unmarried women are afraid to carry condoms. Men do not have this problem.

Shehab Institute is entering a point of transition and considering how to move forward. They are assessing the use of the original DIC in Nasr City and concentrating resources at the more accessible city-centre DIC. Shehab Institute is evaluating the reasons for the great demand for legal services in order to increase the effectiveness of their advocacy and considering possible reasons why medical services are underutilized and how to increase the demand for these services. Issues include the interactions between medical and outreach personnel with sex workers, which may be affected by stigma and harassment.

Shehab Institute is adapting its programming to accommodate demand and improve services. This process is critical to all programmes because sex work exists in a precarious political, legal and social position. Where contexts lead to sudden and unplanned for change, projects should have the ability to be flexible and adaptable in their response. It is also imperative to evaluate the performance and attitudes of project staff, and to train staff, to combat stigma and discrimination. Personnel who promote stigma or discriminate against sex workers must be removed from the project to prevent their jeopardizing the success of the project.

<sup>4</sup> Personal correspondence with Karen Malone, February 2009, about ongoing research by the AIDS Rights Alliance of Southern Africa (ARASA) about sexual health and rights in Southern Africa.

<sup>5</sup> Disclosure: The author was involved in the consultation with sex workers, with Dan Allman of the University of Toronto. See Allman and Ditmore, 2009.

<sup>6</sup> On file with the author.

<sup>7</sup> Interview with RHRU personnel, February 2009.

<sup>8</sup> Disclosure: The author is a member of the board of NSWP.

<sup>9</sup> Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Italy, Latvia, Lithuania, Luxemburg, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Switzerland, and United Kingdom.

<sup>10</sup> Disclosure: The author is affiliated with SWA.

<sup>11</sup> International HIV/AIDS Alliance, Report on access to Global Fund resources by HIV/AIDS Key Populations in Latin America and the Caribbean. April 2009. Page 6.

<sup>12</sup> Conversations with Vidia Darmawi and Elizabeth Pisani, January and February 2009. Author has FHI clinic data on file.

## 5. Conclusions

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The need to scale up HIV/AIDS prevention, treatment and care for sex workers is clear. 'Protecting sex workers from HIV infection benefits them and also has a large potential HIV prevention benefit for the general population. HIV prevention programmes with sex workers are highly cost-effective. Evidence shows that keeping HIV levels low among sex workers slows HIV epidemics' (UNAIDS, no date, 'Sex workers and clients'). Universal access to support, treatment, prevention and care for sex workers requires a wide range of services, not limited to health services. Campaigns and programmes undertaken are most successful when chosen by sex worker participants.

Programmes, organisations and networks that empower sex workers to protect themselves and advocate on their own behalf are the most successful. Programmes that treat sex workers as bridge populations rather than people deserving of the same treatment and respect as others will not succeed. Establishing the priorities of programmes according to the needs of sex workers requires direct input from sex workers at every level of decision-making. This is the basis of successful projects. Greater inclusion of sex workers in decision-making leads to more people seeking the services offered by projects.

Organisations of sex workers need funding for capacity building to implement and manage projects, to collect data and use this in surveillance, for planning programming, and advocacy, and to conduct research and campaigns using this research.

Stigma and discrimination are obstacles to scaling up HIV-related services for sex workers. However, research commissioned by Aids Fonds found that people who were HIV+ attributed many poor interactions with others to stigma and discrimination against people who are HIV+. However, some of these interactions were not likely based upon stigma

but the wide variety of reasons that contribute to poor interactions with others, including bad moods, misunderstandings and more (Aids Fonds 2007). European activists have coined the term 'putophobia' for stigmatising and discriminating against sex workers. While putophobia is widespread, sex workers may sometimes similarly attribute interactions that were unpleasant for other reasons to putophobia, just as HIV+ people in the Netherlands attributed many more adverse situations to discrimination than were actually rooted in discrimination against HIV+ people. The best way to combat putophobia, stigma and discrimination is to promote the human rights of sex workers and to remind civil society that sex workers are productive members of society, rather than adjacent to civil society.

The health sector is one in which putophobia is well known, and must be combated with programmes to accompany sex workers to places where they have experienced discrimination, and programming to enable sex workers to promote safe sex. Sex workers are the best educators of their clients and some of the people in the best position to assist others to leave sex work. Sex workers are part of the solution and must be full partners and stakeholders in all programming with sex workers.

Diagnosis and treatment of sexually transmitted infections is a critical part of HIV prevention for sex workers.

Programming for sex workers, particularly direct services, should incorporate best practices described above. Recommendations for direct services, including campaigns that have been identified during site visits and interviews, follow.

Specific groups of sex workers including youth, migrants, men who sell sex, and transgender sex workers, and sex workers who use drugs have specific needs which must be met. Recommendations for specific populations are described below.

Sex worker networks include strong advocates but have historically lacked resources. Recommendations for supporting sex worker networks are presented below.

Pressing issues include advocacy with large international mechanisms such as the Global Fund, UNAIDS and US funding policy. Recommendations for advocacy with these institutions are presented below.

### 5.1 Recommendations

#### 5.1.1 Recommendations for direct service programming

- It is recommended that input from sex workers be institutionalised within sex work projects in such a way as to prevent tokenism and promote genuine participation in decision-making.
- It is imperative to focus on issues that can be addressed effectively. Do not get bound up with large-scale structural issues (feminization of poverty, status of women and girls) at the expense of evidence-based HIV prevention for sex workers.
- Training for health workers not to stigmatize or discriminate against sex workers, and not to sexually harass sex workers is required. Health care service providers who cannot meet these requirements should be reassigned to other work.
- One critical facet of HIV prevention for sex workers is the diagnosis and treatment of STIs. However, syndromic management is still more prevalent than diagnosis. Diagnosis is critical because most infections are asymptomatic. Untreated infections in many cases lead to infertility. Diagnosis of STIs is critical to successful treatment with the most effective medications for specific infections. Men, women and transgender sex workers and their clients and non-paying partners are priority populations for STI diagnosis and treatment. Services should be offered in anonymous, non-coercive facilities without intervention by state agents. Indonesia's example demonstrates that STI diagnosis can be successfully undertaken in contexts with limited resources.
- Ensure constant availability of safe sex commodities including condoms and personal lubricant. In-depth education is necessary prior to the introduction of new technologies to market.
- Recognition of transgender people, using local language terms, in programming, and include transgender (using local language terms) in record keeping. Do not subsume transgender women as men in programme records.
- Project staff should accompany sex workers to clinics in situations with chronic difficulty combating stigma and discrimination against sex workers.
- Rights-based sex work programming must not bring sex workers under the control of or be implemented by the police or military.
- All programming must be tailored to the local circumstances. What works in one context, venue or town must be adapted to each location rather than replicated. Every programme should be designed and implemented with input and participation of the local community. IEC materials must be dedicated

to the locality, not from another place and translated but generated in the area. This may mean adapting existing materials from elsewhere.

#### 5.1.2 Recommendations for advocacy

- Support for sex worker networks at global, regional and local levels is critical to successful advocacy and movement building on the scale achieved by men who have sex with men and HIV+ people.
- Advocacy and diplomacy should be used in tandem to advance and ensure the human rights of sex workers, which will in turn enable sex workers to protect themselves and others from HIV and access care. This is imperative in efforts to influence governments.
- New media and particularly video has proven to be an enormously strong tool for documentation and advocacy. For example, NSWP and APNSW have produced videos that educated many about the effects US funding policies and the effects of the criminalisation of sex work. Each of the campaigns recommended above would be strengthened with video testimony and advocacy. There are many outfits that train others to produce video, in many languages. Small World News works in Arabic, Spanish and English. Witness is well known. Sex Work Awareness in the US has trained sex workers to use simple cameras to produce short videos. This is not a comprehensive list.
- It is recommended that the effects of criminalisation of sex work, or third parties and clients be documented and evaluated with respect to HIV/AIDS and to the human rights of sex workers. Sex workers' access to comprehensive prevention, treatment and care is adversely affected by criminalisation of any aspects sex work. In many places where the sale of sex itself is not specifically a criminal act, there are often laws against third parties (managers) and in some places, the purchase of sex (clients). The fact that sex work and/or aspects of business related to sex work are not permitted in many places creates a climate where sex workers are denied labour rights and employment protection. The recognition of sex work as work requires understanding the complexities of the sex industry and its economy. All networks agree that criminalisation of sex work is detrimental to HIV/AIDS prevention, treatment and care. Therefore, regional, national and local campaigns should be supported in as many locations as possible to document the specific ways the criminalisation – or perceived criminalisation – of sex work adversely affects HIV-prevention and this documentation should be used in campaigns to improve public policy and the enforcement of law

and policy. Each campaign will necessarily be unique and tailored to the legal environment and policy framework and priorities of local sex workers.

- It is difficult to prioritise areas in which such campaigns should be mounted because this is a nearly universal issue. Cambodia's plan to employ police officers to educate sex workers about HIV/AIDS is the first obvious location. South Africa's ongoing debate about prostitution is another opportunity. US funding strategies and the anti-prostitution pledge (APP) have pushed countries to criminalise prostitution.

### 5.1.3 Recommendations addressing specific issues and populations

#### Recommendations addressing violence

- Violence is an issue universally cited by sex workers, and the link between violence and HIV has been well documented.
- The most effective anti-violence efforts have addressed violence systematically. Therefore, using the legal system to improve the response to violence against sex workers is recommended, especially for state-level violence. This is best undertaken with a legal programme.
- Coordinating reports of violence is recommended, especially when a particular individual or organisation has repeatedly committed violence against sex workers.
- Coordinated anti-violence campaigns involving the media to draw attention either to specific patterns or systemic abuse by state authorities are recommended.
- The use of new technology including mobile phones to document and expose violence against sex workers should be explored and supported.
- Transgender people are disproportionately affected by violence even among sex workers. A transgender network is emerging, and should be supported to document violence and advocate for their human rights. These campaigns should include interpersonal and structural violence, such as the erroneous classification of transgender women as men and the use of solitary confinement for transgender women in men's prisons. RedLACTrans should be supported to undertake these efforts in the Americas, including necessary translation to work across languages, for example with the large number of transgender activists and organisations in English-speaking North America. Strong transgender sex worker activists, including female-to-male sex workers, in diverse contexts in Asia and the Pacific are ready and able to undertake such campaigns. PASST in France is the most renowned support organisation with

transgender sex workers in Europe. These networks, organisations and individuals should be supported as resources for transgender sex workers in countries and regions with less-well-developed organisations. RedLACTrans, APNSW and ICRSE among others include activists who are experienced with UN organisations and policies. They should be supported to undertake a campaign to encourage the UN, especially UNAIDS, and other global health bodies, to recognise transgender people as they self-identify. This should include the training of other transgender sex work activists to work with them on this campaign.

#### Recommendations for programming with children

- Advocacy campaigns to promote the rights of the children of sex workers, including access to official documentation including birth certificates and identification cards, are recommended.
- Educational programmes for the children of sex workers are recommended.

#### Recommendations for financial planning and transition or step-out programming

- It is recommended that any efforts to assist sex workers to move to other occupations be part of a comprehensive rights-based programme that respects the self-determination of sex workers, including the decision to do sex work.
- Projects to assist career sex workers who are no longer able to earn a liveable wage should be supported. This could include support or training programmes for newcomers to sex work.
- Sex workers and their colleagues and clients are untapped resources to combat trafficking in persons. These people should be included in anti-trafficking efforts, not criminalised.

#### Recommendations for programmes for transgender people

- Require projects to distinguish between transgender people from men who have sex with men. Use the terms that transgender people call themselves locally.
- Advocate for international organizations, particularly UNAIDS, and governments to distinguish between men who have sex with men and transgender people, recognising the variety of transgender experiences, including male-to-female and female-to-male transitions.
- Include HIV-prevention, care and treatment programming for transgender people, with input and participation by transgender people in ideation and implementation.

- All projects, especially those for transgender sex workers, should discuss anal sex and HIV prevention. Sufficient personal lubricant for all interactions should be made available at no cost or affordable for all.
- Safe injecting information and material including clean needles of a variety of sizes and information about preventing infection should be offered to transgender sex workers.
- Advocate for humane treatment of transgender people in prison. This means advocating against situations that may encourage violence against transgender people and advocating against solitary confinement.

#### Recommendations for programmes with men who sell sex

- Programmes should be designed to include men who sell sex in all parts of the world. All projects, but especially those that focus on men, should discuss anal sex and HIV prevention.
- Projects that reach out to men who sell sex should make personal lubricant available. Best practices require enough lubricant for all interactions and for lubricant to be free or affordable for all.
- Projects should offer or make referrals to services for the intimate partners, including women, of men who sell sex.

#### Recommendations for programming with migrants

- STI and HIV diagnosis, treatment and care should be provided to all regardless of status in the country in which they seek these services.
- Sex workers, colleagues and clients should be partners in efforts to assist migrants and people in coercive situations.
- Law enforcement interventions should be avoided.
- The use of new technology including mobile phones to assist migrants should be explored and supported.

#### Recommendations for programmes for sex workers who use drugs

- Harm reduction materials must be made available to sex workers who use drugs. This includes safe injecting kits and information about preventing infection.

#### Recommendations for programmes for youth

- Programmes for youth should emphasise opportunities, especially education and employment. Some young people engage in paid sexual activities, but this is not desirable. Some successful programmes offer specific training and may employ the children of sex workers.
- Law enforcement situations should be avoided.

#### Recommendations for research with and by sex workers

- Sex workers are the experts on their lives and should be included at all stages of research, from ideation and design through realization. Research must include and incorporate input from sex workers at the earliest possible stages, at the onset of design rather than implementation. To come to sex worker communities at the implementation stage is not inclusive and will be perceived as uninclusive at best.
- Research should be undertaken with sex workers setting the agenda. Sex workers are keen on research that addresses issues that affect their lives. Where sex workers are included, research has progressed well. To present sex workers as uninterested in research reflects poorly on the research being conducted and the skills of the researchers than on sex workers.
- Genuine participation in research requires that sex workers be consulted at the planning and design stages, prior to implementation. In-depth information must be offered in a language that is easily and well understood by the participants. In some cases, capacity building for research literacy will be required.
- HIV prevention materials and information must be provided.
- Health care including long-term care and treatment for people who seroconvert or suffer side effects must be planned for and provided.
- UNAIDS should be encouraged to develop and enforce – with sex worker participation – protocols for good participatory practice.

#### 5.1.4 Recommendations for supporting sex worker networks

- It is recommended that the representation of sex workers in civil society be strengthened by funding networks of sex work projects and sex workers. Priorities include the Global Network of Sex Work Projects. Regional priorities include nascent networks, especially in Africa.
- Some networks have limited funding; others, including the Global NSWP, remain underfunded and this has weakened their ability to represent the interests of sex workers. Translation is a critical need for communications across and within networks. Emerging networks have greater needs than more established networks.
- In some places, such as Europe, overlapping networks work well together. This is successful in part because the roles and mandates of each network are explicit. In Sub-Saharan Africa, overlapping networks are establishing roles across networks. These roles will determine priorities for support.

- Participation in the Global NSWP by projects in the Middle East and North Africa Red should be supported. This may be facilitated by the creation of an Arabic-language communication network, including a listserv and mobile phone messaging.
- RedLACTrans has expressed interest in expanding to be a global network of transgender people (not all of whom are sex workers), and initial efforts to reach out beyond the Americas should be supported.
- Fund capacity building for and by sex worker networks. In some instances, sex workers have conducted trainings. For example, The Global Network of Sex Work Projects (NSWP) and the Asia Pacific Network of Sex Workers have conducted workshops for members, including human rights documentation, information on thematic issues such as research ethics and human rights, human rights documentation, and advocacy and activism skills. Sex Work Awareness in the US offers video and media training. SWING is not only a model project for work with male and transgender sex workers, SWING also has experience training other organizations to work with sex workers at all levels of programming, including design, implementation and management. Trainees have included local NGOs, health care providers, and Global Fund recipients from other parts of Asia. These organizations and health care providers report having enjoyed and benefitted from SWING's training. Trainings like these by sex work projects should be continued, supported and replicated.
- It is imperative to continue to explore ways to use new media to promote sex workers' rights. For example, sex work networks have found video to be an important advocacy tool. (See, for example, *Taking the Pledge* and *Caught between the Tiger and the Crocodile*) This is one way to include voices from individuals and organisations in places with low literacy rates and who may be unfamiliar or lack resources needed to produce and distribute traditional press releases and reports.

#### Middle East and North Africa

Existing programmes in the Middle East and North Africa include some well-educated sex workers on staff and some effective programmes. However, it is impossible to know the efficacy of most programmes because so little information – in some cases, not even how many people use the services and what services they use – is recorded. A regional workshop is recommended to train programme participants – sex workers – to manage this information, including the use of computers and reporting.

#### Sub-Saharan Africa

The emerging Alliance in Sub-Saharan Africa should be supported as an independent entity from SWEAT and its other members, as recommended in the conference report. The Alliance has members who are strong advocates such as ARASA. However, capacity building for sex workers to monitor and document abuses and mount campaigns is necessary. This new African Alliance should be supported to work across languages, thereby expanding the inclusion of colonial and local languages, with advocates like ARASA and OSI-SA and SWEAT offering technical assistance and capacity building while sex workers themselves determine and execute the agenda of this new and vital Alliance. The smaller francophone network in West and Central Africa offers a model, with a coordinator who is also a liaison to English-speaking and global networks and organisations, including the NSWP.

#### Latin America

Latin America has separate but strong networks of female sex workers and transgender people. However, the region lacks a non-gender specific network or venue to communicate that includes men and transgender sex workers as well as women. This could be the NSWP's Latin American network.

#### North America

In North America, support is necessary for a campaign to change US policy. In order to be effective, this needs to be undertaken by a coalition or organisations including but not limited to feminist and sex worker organisations, including health activists, advocates and organisations. Such an effort was nearly successful in 2008 but was undermined by specific health organisations. Such efforts must be redoubled in order to ensure success in 2011. In the US political climate, it is imperative that the person or people who lead and inform this campaign has extensive experience as an advocate on policy. Sex workers must be included at all levels but it is clear that capacity building for a campaign of this level is critical because of the particular political context in which targeted messages from sex workers will not be effective without significant support from wider civil society as represented by specific health and feminist activists.

#### Asia and the Pacific

APNSW is quite strong. One of the great capabilities of APNSW is documentation of abuses and support for sex workers and organisations that seek assistance with combating abuses. Andrew Hunter recommended

that within the Asia and Pacific region, the new network of sex workers in Myanmar (Burma) is in great need of support.

#### Europe, including post-soviet states

The three overlapping and funded networks within Europe, ICRSE, SWAN and TAMPEP, work well together. Their programming must continue. Sex workers in central and eastern Europe and central Asia (CEECA) would benefit from more capacity building and support for sex workers, especially social support. Some members of SWAN are developing affiliated sex worker organisations but this process needs to be supported to expand and for sex workers themselves to determine the agenda of advocacy and activism in CEECA.

HIV-prevention services designed for sex workers who use drugs are necessary in Eastern Europe and Central Asia.

#### 5.1.5 Recommendations for advocacy with large international mechanisms

Global and regional networks need to be supported to participate in key advocacy meetings with global institutions, including but not limited to the UN.

#### US anti-prostitution pledge

It is recommended that a campaign to remove APP from PEPFAR and a return to evidence-based programming with sex workers be undertaken. This will require participation by people outside the US, travelling to the US to speak with legislators, and a US-based campaign to cultivate legislative support and grassroots support in the home communities of legislators who work toward the repeal of APP.

Advocating for change to US policy on prostitution and trafficking is critical, with efforts within the US in support of legislators who understand the problems associated with APP, and with documentation and the voices of people who have been directly affected by the APP. The US is extremely influential on other states and within the United Nations. For these reasons, strategies should be undertaken to repeal the requirement that partners enact an organisational anti-prostitution policy. The funding made available by laws in which APP features will run out in 2011. At that time, appropriations will begin in the form of new legislation. APP was nearly struck from PEPFAR in 2008. Input from people outside the US is necessary, but these policies can only be challenged with a broad network across the US, led from a political centre, probably Washington, DC or New York City. Concerted advocacy in the form of a media campaign promoting

grassroots support in their home communities for key members of the US Congress who support the removal of APP will be necessary to achieve this.

#### Global Fund to Fight AIDS, Tuberculosis and Malaria

It is recommended that CCMs be required to include specific groups that are affected by HIV, including sex workers of all genders. It is also recommended that the GFATM design and implement a non-CCM application process in places where the legal, political or social environment precludes the participation of sex workers. Community Systems Strengthening (CSS) funding may be an avenue for supporting sex workers, especially if the proposal guidelines clarify what are community systems strengthening activities, particularly including marginalized populations such as sex workers.

It is recommended that the GFATM disseminate information in a transparent, accessible and timely manner.

Sex work projects and networks should strive to be included in GFATM processes and monitor the inclusion of sex workers in Fund programming and the efficacy with which Fund resources reach sex workers. This would require funding for sex work networks.

Mechanisms for the participation of civil society, especially affected populations including sex workers, should be developed for IHP+.

#### United Nations

It is recommended that efforts be made to influence UNAIDS to re-evaluate the placement of sex work within its partner organisations.

It is recommended that global and regional sex work networks be actively involved in the interpretation and implementation of the Guidance Note on HIV/AIDS and Sex Work.

It is recommended that the PCB and other bodies and organisations seek clarification from UNAIDS about the implementation of the Guidance Note, especially with regard to the reduction of HIV in sex work settings and to be concrete in terms of how the guidance note will inform UN and country level programming. For example, will it just be disseminated or are there trainings and TA planned; will there be indicators developed in terms of measuring the countries' response on addressing sex work issues, and how will this inform the country AIDS plans. Campaigns to expand access to life-saving medicines could, for example, attempt to enforce the use of

compulsory licenses enabled by the TRIPS agreement to enable greater production and availability of life-saving medicines.

Advocate for surveillance and public health programming to reflect the reality of transgender people, including expanding gender conceptualization beyond male and female to include transgender people, according to local manifestations. If the UN lead by example, it would be easy to require UN-sponsored programmes to include transgender people as transgender rather than male in their monitoring and further enable more sophisticated understanding of the AIDS pandemic and other STIs and health issues as they pertain to a significant and vulnerable population.

## 6. Appendix: People consulted

### 6.1 Netherlands, 57

### 6.2 South Africa, 57

### 6.3 Egypt, 57

### 6.4 Thailand, 57

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### 6.6 Others, 57

#### 6.1 Netherlands

- Marieke Ridder, SOA AIDS Netherlands
- Marcel van Soest, World AIDS Campaign
- Georgina Caswell, GNP+
- Marjan Wijers, independent expert on trafficking in persons

#### 6.2 South Africa

- Jillian Gardner, Steve Biko Centre for Bioethics, Witwatersrand University
- Marlene Richter, Witwatersrand University Medical School
- Lauren Jankelowitz, Reproductive Health and HIV Research Unit (RHRU)
- Vicci Tallis, Open Society Institute South Africa
- Valda Lucas, Sex Worker Education and Advocacy Taskforce (SWEAT)
- Siponge, Sisonke
- Beauty, Sisonke
- Joyce Mahke, RHRU
- Motsamai Petros, RHRU
- Laura, Sisonke
- Ten women of various nationalities and places of origin in three brothels in Johannesburg
- Dianne Massawe, SWEAT

#### 6.3 Egypt

- Amal El Kharouaoui, consultant
- Iris Semini, UNAIDS
- Wessam ElBeih, UNAIDS Egypt
- Amal UNFPA
- Reda Shakry, Shehab Institute Project Manager
- Laila Baza, Shehab Institute, Sex Workers Project Coordinator
- Kholud Hassan, outreach worker, Shehab Institute
- Cecilia Joeseef, outreach worker, Shehab Institute
- Hany Mostafa, outreach worker, Shehab Institute
- Bahaa Ahmed, outreach worker, Shehab Institute

#### 6.4 Thailand

- Andrew Hunter
- Surang Janyam, SWING
- Tee, SWING
- Amornsuk, SWING
- Liz Cameron, Empower Chiang Mai and Empower Phuket

#### 6.5 Indonesia

- Vidia Darmawi, Consultant
- Ines Angela, Srikand Sejati
- Ryan, MSM group
- Franky, GEMA
- Dédé Oétomo,
- Dr. I. M. Wiry, Jelia Clinic MD
- Dr. Mira Sumaaya, Jelia Clinic Director
- 2 sex worker peer educators
- 4 client peer educators
- 50 women in Pela Pela brothel
- 5 brothel security men, Pela Pela
- 3 MSW peer educators
- 1 MSM peer educator
- Dr Maya, PKBI
- Director, PKBI
- Dr Stanleysius Bondan, PKBI
- Leni Sugiharto, Srikandi Sejati
- Yola, Srikandi Sejati peer educator
- Reza, Srikandi Sejati peer educator
- Nancy Iskandar, VCT counselor, Srikandi Sejati and PKBI
- Windy, VCT counselor, Srikandi Sejati and PKBI

#### 6.6 Others

- Jayne Arnott, UK
- Sam Avrett, consultant, US
- Eduard Saunders, Kilifi, Kenya
- Sylvia Mollet, DANAYA SO, Bamako, Mali
- Dr. Camille Anoma, Clinique de Confiance, Abidjan, Ivory Coast
- ALCIS, Congo
- Milouda, Association de lutte contre le sida (ALCS), Morocco
- Adel Zeddami, Algeria
- Myriam Benmamou, UNAIDS Focal Point, Tunisia
- Amina, Morocco
- Nadia El Bilal, SIDC, Lebanon
- Alex Solange, Fenway Community Health Institute, Boston, US
- Ruth Morgan Thomas, manager of SCOT-PEP, Scotland, UK, and NSWP board member
- Heather Doyle, Director, Sexual Health and Rights Project, Open Society Institute
- Gulnara Kurmanova, Taiz-Plus, Kyrgyzstan
- Joanne Csete, Assistant Professor of Population and Family Health, Mailman School of Public Health, US

- Shannon Kowalski-Morton, Program Officer, GFATM, Open Society Institute, US
- Laura Agust'n, consultant on migration, especially within and from Latin America and Europe, and author of Sex at the Margins
- Kate Hawkins, Institute for Development Studies and the Paulo Longo Research Initiative
- Karyn Kaplan, Director of Policy and Development, Thai AIDS Treatment Action Group
- Jennifer Clamen, sex work activist and member of the Coalition for the Rights of Sex Workers, Montreal, Canada
- Thierry Schaffhauser, Advisory Group, International Committee for the Rights of Sex Workers in Europe
- Licia Brussa, TAMPEP
- Susan Lopez-Embury, Desiree Alliance
- And those who chose to remain anonymous.

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