

Research

for Sex Work 2

This is the second issue of the newsletter Research for Sex Work in which people working in the field of STD/HIV/AIDS prevention among sex workers are given the opportunity to share experiences about their work. The first newsletter was about peer education. Many reactions to the items discussed in this publication were sent to us. Many copies were requested. Many people offered to contribute to a next issue and many suggestions for a next issue were given. Most often, the issue of appropriate health services for sex workers was mentioned. Therefore, we put a call for contributions to a special issue on this theme on the HealthDEV e-mail forums at HivNet's website. This resulted in valuable reactions. In addition, some people working in specific projects were requested to contribute to the newsletter. With financial support of UNAIDS and HIVOS and the voluntary contributions of the editors, this issue could be produced. We hope to produce another one next year.

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Research for Sex Work is a newsletter designed for researchers, sex workers, public health workers, local politicians, and others who professionally have to do with HIV/AIDS prevention and/or sex work. It is published by the section Health Care and Culture of the Medical Faculty of the Vrije Universiteit in Amsterdam, the Netherlands. More copies of this publication or the previous one on peer education can be ordered for free by sending your request to the address below. Please state whether you would like to receive this publication and/or the one on peer education.

*Health Care and Culture
Medical Faculty, Vrije Universiteit
Van der Boechorststraat 7
1081 BT Amsterdam
The Netherlands
Ph.: 31-20-4448266
Fax: 31-20-4448394
E-mail: p.brinckman.social@med.vu.nl*

APPROPRIATE HEALTH SERVICES FOR SEX WORKERS

The theme of this second issue of the Research for Sex Work newsletter is 'appropriate health services for sex workers'. Public health specialists and epidemiologists have been publishing about the importance of developing good STD services for sex workers and their clients in order to prevent HIV/AIDS. This suggests that STD services are the most relevant services for sex workers. In some research projects sex workers even seem to be reduced to their sexual organs. By doing that, researchers, project managers and health workers view sex workers basically in a similar way as their clients do: their sexual organs - that can transmit STDs - are considered more important than their personal well-being.

There are a growing number of publications about all kinds of initiatives to establish or

improve STD services for sex workers. Underlying a lot of the research is the view that sex workers are a potential hazard to society and a multiplier in HIV dissemination. Sex workers are often mainly viewed in the context of how their frequent change of sex partners contributes to HIV transmission. This reinforces the patriarchal attitude of protecting men (or 'society') from HIV infection, while in fact the sex workers are far more vulnerable to be infected because of their weak social position.

Stigmatisation

Compared with the massive amount of such one-sided research, relatively little research is done on the conditions of prostitution, the way sex workers think about their work, how they survive, give meaning to their daily activities or how they see themselves and their part-

ners. Little of all the literature produced in the last fifteen years is useful in arriving at a general understanding of prostitution or in a guiding social policy. This may be an illustration of the ambiguous relation between sex workers on the one hand and most health staff and researchers on the other hand. Research on prostitution is often only acceptable as long as it respects the concept that prostitution is a problem and that the researcher should look for solutions of this problem. This view often leads to victimisation or stigmatisation of those working in prostitution. In this issue *Chivariak Khus* describes how most aid organisations in Cambodia view sex workers as vectors of disease. This attitude is detrimental to HIV/AIDS prevention, because for any intervention to stop the spread of HIV among sex workers a relationship of trust is needed between the dif-

ferent stakeholders. Viewing and treating sex workers as transmitters of disease will not be a great help in building confidence.

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STD services at all cost?

The pillars of HIV/AIDS care and prevention programmes for sex workers have become condom promotion, STD prevention, case finding and treatment, supported by health education and health promotion. Many stress that these activities can only take place with the cooperation of the sex workers themselves and that they should be empowered to negotiate better for safe sex. Though limiting the amount of STD and HIV infections is important, we have tried to challenge people to con-

Why would sex workers want to go to sex worker-unfriendly services?

tribute to this newsletter with the questions: STD services for health workers at all cost? How far do we go with developing interventions for sex workers while ignoring the human and social dimensions of sex work? Is it ethical and effective to dissociate the reproductive functions of sex workers from their other health needs? In her contribution to this issue, *Priscilla Alexander* states that there should be no focus on STDs and reproductive health, but on the general well-being of sex workers. Most of the authors in this newsletter emphasise the same.

In many countries in Africa and Asia health services are not accessible to underprivileged women, but also in Europe there often is a need for good services for sex workers. In *Robin Montgomery's* contribution to this

newsletter it is stressed that services for sex workers in Moscow are lacking and in case they do exist they are highly sex worker-unfriendly. Why would sex workers want to go there? *Anna Nowak* from Poland makes the same observation for her country. *Licia Brussa* writes that the same can be said about migrant sex workers in Europe. Local sex workers may have sufficient access to services, but as undocumented migrants prefer to remain invisible, they cannot trust service providers. Brussa therefore recommends free and anonymous services at times and places that are convenient for sex workers.

Would it not be wise to make sure that services are meaningful to the sex workers and that they target their specific problems? These are among others protection from violence and diseases of the reproductive organs. From *Dorothy Nairne's* contribution about a project in Johannesburg, South Africa, we learn that protection from violence is a priority for sex workers and that a safe place is important. From the contribution of *Maurice Bloem* the same can be learned. Sex workers in Dhaka, Bangladesh, are abused by policemen, members of the Mafia and even health care staff. If that is not stopped why would they bother attending a clinic?

As in many countries the majority of sex workers do not see themselves as sex workers it seems wise to have general health posts in areas with a lot of poverty and with high levels of sex work activity. Does this approach work and can such clinics cater for the specific needs of sex workers? *Nzambi Khonde* and *Adrienne Kols* describe a project in Ghana where it appeared to be more effective to make public health clinics more accessible to sex workers, than to establish specific STD clinics for them.

In many countries STD services are poorly developed and a visit to them is regarded as a sign of 'deviant behaviour'. When asked sex workers about the best place for an STD facility, some prefer to have a centre in the area where they are working or even in the brothel where they are active (for convenience rea-

sons), while others prefer to have a centre in a different part of town where nobody knows them and where they can go anonymously. The place and the image of a health facility are important, but it is not easy to satisfy everybody. What are the experiences of different projects with this? From the contribution from *Didericke Rhebergen* et al. about sex work at the streets of Surabaya, Indonesia, it becomes clear how difficult it is to develop services for mobile populations like street sex workers near the places where they work and live. In addition, it can be problematic for many sex workers to visit a facility that has been labelled as a 'place for sex workers', because they prefer to not see themselves as sex workers. In countries where prostitution is not allowed these special facilities might give the police an opportunity to trace sex workers, which of course is another reason to avoid health care services.

Participation

Though many stress that special STD clinics for sex workers are not a good idea, it is essential that health personnel who work with sex workers are aware of specific needs and problems. A drop-in centre where services are available for sex workers can function well in some circumstances. Participation of sex workers in such drop-in centres is highly recommended by some of those contributing to the newsletter. *Smarajit Jana* et al. of the Sonagachi Project in Calcutta state how important participation is. In some projects sex workers have been involved in the health facilities itself. Especially in the intake procedure sex workers may play a role. The advantage is that there is a bigger chance that sex workers feel more at ease in such a health facility. On the other hand their need for privacy is at stake. Another issue is whether sex workers employed by facilities should be paid and how much.

In our research in Indonesia we noticed that most sex workers prefer to go to private doctors. Private doctors have the name to be better because they are more expensive. However, their skills are not specifically geared towards dealing with the specific needs of sex workers.

HealthDEV is an electronic forum that helps people and communities from all over the world exchange information and experiences regarding HIV/AIDS. HealthDEV comprises both regional and topic-specific forums. The first forums were defined by the networks organising the Community Rendez-Vous and Symposia sessions in the 12th World AIDS Conference, Geneva 1998. Themes selected were: networking among people living with HIV or AIDS, sex work, access to treatment and care, community-based research, human rights, immigration and the media. For all these themes, separate e-mail forums were established. Also, regional forums for South East Asia and Africa have been added, as well as INTAIDS (international forum) and the topic-specific forum Gender-AIDS.

All forums are accessible via: <http://www.hivnet.ch/aids98>

There is a need for training private doctors and clinics that treat sex workers regularly in order to improve their attitude and skills. How this can be done we can read in the contribution of *Anneke Gorter*, who describes a Nicaraguan project in which sex workers are handed vouchers for free reproductive health care in a clinic of their own choice, whether private or public.

The overwhelming impression of the contributions to this newsletter is that if meaningful services for sex workers are to be developed, the first thing to do is to base these on respect for sex workers. For them the major reason to visit for example a drop-in centre, may be not the STD services offered, but the opportunity to take a shower, to have a rest or to chat with

colleagues, or the attitude of the personnel. If the creation of a safe, sex worker-friendly facility is not first taken care of, all further initiatives are relatively useless. In practice respect for sex workers is concretised in the opportunity to express their needs and to see these taken seriously, in the attitude of the staff of a health post, in the offering of choices in care, and in research that does not only see them in a one-dimensional way.

Ivan Wolffers
Health Care and Culture
Medical Faculty, Vrije Universiteit
Van der Boechorststraat 7
1081 BT Amsterdam, the Netherlands
Fax: 31-20-4448394
E-mail: p.brinckman.social@med.vu.nl

“THERE AREN'T EVEN ANY WRITTEN MATERIALS IN THE CLINIC TO READ”

AIDS infoshare project activities in Moscow

Anya is 26 and is from the town of Kislovodsk. She came to Moscow six years ago to study. She began to work as a sex worker to finance her studies and realised that it was her vocation. She completed her course but decided to pursue sex work as a career. Anya now runs a brigade from one of the main streets in Moscow. We met her in the 14th STD Clinic where she was being mandatory treated for syphilis. More like a detention centre, this clinic is closed to the public, has bars on the windows and guards positioned at the gates. Anya was furious because this was the second time that she had been infected with syphilis in the past year. The first time she was treated, but the doctors failed to tell her how she might have been infected and how to protect herself against re-infection. “There aren't even any written materials in the clinic to read”, she complained.

It is illegal to live in Moscow without being officially registered and possessing a proper residency permit - even when being a Russian citizen. As the majority of the women involved in Moscow's commercial female sex industry are without proper legal documents (many women being from cities in the Ukraine, Moldova, and Belarus, or from other regions in Russia such as Tomsk, Smolensk or Novosibirsk) they are considered illegal immigrants and thus, are condemned to live on the outskirts of society, barred from many public ser-

vices - even health care. The absence of registration documents also means that it is very difficult to monitor the number of women working in the sex industry. Although official estimations are in existence, in reality, the numbers are much higher. Before August 16 1998, official statistics reported between 13,000 to 30,000 women working in Moscow's sex work business.

Recent data indicates a substantial growth in the number of women; current official statistics estimate that 70,000 women presently

work in Moscow's sex industry. The reasons behind this steady increase are multitudinous and strongly inter-related, whether it be prolonged extreme economic hardship; the continual influx of foreign money, tourists and a large foreign business community; or because of the intensified feminization of poverty which continues to prevail since the initial period of glasnost and political transition of the late 1980s.

High fees or the police

Many factors influence a woman's choice to enter into the complex hierarchy and dangerous nature of sex work. However, such reasons do not influence her ability in being able to access quality, non-discriminatory medical and health care services. In fact, the way in which most women enter into Russia's health care system is either via the police (spontaneous 'round-ups' resulting in involuntary testing for sexually transmitted infections, including HIV and usually resulting in detention), or by paying extremely high medical visitation fees. Needless to say, clinical services are not viewed positively. If a woman is diagnosed with an STD, particularly syphilis or gonorrhoea, she is 'hospitalised' in the 14th STD Clinic until her treatment is complete. This usually entails a two-week period. During their stay, the women are not provided with information as to why they are there.

Despite the testaments of medical professionals, in reality very little information (if any at all) is given about STDs, how they are contracted and how to prevent re-infection. Moreover, the way doctors treat their clients has often been cited by girls as being 'callous' and 'unsympa-



Training sessions for health professionals

As part of a pilot project AIDS infoshare has held separate trainings for health professionals. During the 5-day training for health professionals many of the participants were introduced to the ideas which were being discussed. Topics and themes of discussion included: doctor-patient communications; patient rights to information; sensitization to gender and the complex factors leading to, and involved in sex work; and the differentiation between 'risk groups' and 'risk behaviours'. The trainings have been suspended due to a lack of funding. However, they will soon be reinstated.

During the course, obstacles were encountered because many of the participants felt that this training was an 'inapplicable' Western methodology and inappropriate to the Russian context. Many health professionals felt that they did not require further training and information in their field of specialty and they firmly contested to their constant provision of adequate information to their patients. Another obstacle that is frequently met in Russia is the division between the medical and social sectors. This means that medical professionals are most often open to new ideas and techniques when being communicated by a person from the same profession and level of expertise. As none of the trainers/facilitators were from a medical background, this proved to be a barrier from day one. Over time, this difficulty has been repeatedly addressed.

AIDS infoshare project co-ordinators keep in regular contact with the physicians, particularly at the closed 14th STD Clinic. The medical staff has come to know us both on a professional and a more personal level. They receive our numerous printed materials for health professionals and patients and have gradually become more open to our work activities. They have recently shown a positive interest in having us install an information/-brochure stand in their hospital facilities.

thetic' (see box). Since girls can earn up to US\$1000 a night working in strip clubs or bars, the sizeable disparity between their wages and those of their physician (monthly salary of approximately US\$15-40) contribute greatly to doctors' negative attitudes towards sex workers.

AIDS infoshare project activities

In response to this blatant demand for information concerning issues of health and human rights protection, AIDS infoshare has been working directly with Moscow female sex workers over the last three years. An initial needs assessment research¹ entailing in-depth interviews, conversations and surveys, was conducted by two female AIDS infoshare staff members and a male doctor.

The groups of women were limited to four women at a time and the interviews were con-

(expiry date, storage etc.), how to put a condom on, and suggestions were given on ways to persuade clients to use them. As many of the girls recounted, if and when condoms were purchased, they were bought on the basis of the most appealing picture on the cover without paying heed to quality, lubrication or expiry date.

Outreach

Once trust had been gained, the team began to make inquiries about the sex work structure: where the sex workers were from; their age; the degree of contact with officials (including the police); if they had ever had an STD; if they had ever used drugs (if so, which ones); and how much influence did they have over condom use with a client and so on. The women interviewed at the 14th STD Hospital were asked if it was possible for them to introduce the team to their colleagues on the streets and in hotels where they worked. This is essentially how the AIDS infoshare outreach programme began. Twice a week (every Tuesday and Thursday night) the outreach team consisting of AIDS infoshare project co-ordinators, a volunteer venereologist, and dedicated

international volunteers, visit regular sites distributing information, chatting with the girls, and answering their various questions. Based on the needs assessment data gathered, a

If and when condoms were purchased, they were bought on the basis of the most appealing picture on the cover without paying heed to quality, lubrication or expiry date

general information brochure was created in collaboration with a working group consisting of sex workers. Assisting with the design, for-

The way doctors treat their clients has often been cited by girls as being 'callous' and 'unsympathetic'

ducted at the 14th STD Hospital affiliated with the 14th STD Clinic mentioned above. This hospital is, in contrast with the clinic, open to the general public. During the conversations, the girls were provided with information about HIV/AIDS, routes of transmission, STDs, and how STDs facilitate the transmission of HIV. In addition, free condoms were distributed and explicit demonstrations and explanations were given on how to properly care for a condom

AIDS infoshare is a Russian non-governmental organization that was established in 1993 by two Russians and an American. Working in the three principal areas of information, training, and direct services, AIDS infoshare was created to help rebuild Russia's falling system of information distribution and to guard against human rights violations within the Russian health care system. Using one of the largest HIV/AIDS/STDs and Human Rights libraries in Russia, we distribute information, resource materials and AIDS infoshare publications throughout the Russian territory, the Newly Independent States and to countries abroad.

Our trainings focus mainly on two themes: NGO Management (strategic planning, needs assessment methodology, information management, and fund raising); and pre- and post HIV test counselling training seminars for medical professionals.

Our direct services include free legal consultations for people living with HIV/AIDS, their families, friends and caregivers; project activities and outreach work for female sex workers in Moscow; outreach work and condom distributions at various Moscow night-clubs targeting Moscow youth; and helpdesk services providing a source of immediate information, referral numbers, and support consultation.

mat and editing of brochure texts, these women were integral to the success and effectiveness of this endeavour. The final product is the first of its kind in Russia. The brochure entitled, 'Tolka dlya Tebya' (Only for You) looks like a small fashion magazine rather than a brochure on STDs, HIV and AIDS. According to the working group, 'appearances' are extremely important. The overwhelming success of the brochure amongst our target group and health professionals alike have encouraged the creation of four new brochures focusing on the specific topics of: STDs; contraceptives; 'Real Life, Real Questions' - a brochure on HIV/AIDS, Hepatitis B & C, and Drug use; and

'Avoiding Abuse' - a brochure aimed to help improve the safety of women while at work. The success of this brochure series is due to the continual involvement and participation of women within this target group.

Note

The needs assessment research was conducted from March 1997 till August 1998. It has been sponsored by the Dutch Embassy and has been furthered through the AIDS infoshare project 'Women's Health and Human Rights' funded by USAID (United States Agency for International Development) and administered through the International Centre for Research

on Women. Further details and a more detailed account of the needs assessment can be found in the report 'Profile of Sex Workers in Moscow' by Lucy Platt and in a report by project consultant Cheryl Overs from the Network of Sex Work Projects. Please contact the author if you want more information.

Robin Montgomery
Information Co-ordinator AIDS infoshare
PO Box 51, Moscow 105037, Russia
Ph.: 7-095-3837553
Fax: 7-095-3837553
E-mail: infoshare@glas.apc.org

STARTING TO WORK WITH SEX WORKERS IN CAMBODIA: THE NEED FOR CONTEXT

A Case Study: Part 1

A young girl, Sopheap, grows up as one of seven children in a poor rural family. During her youth, Sopheap cannot go to school, because her single mother can't afford to pay the teachers. Everyday, the young girl along with her other family members must struggle to find enough so they can eat that night. Life is difficult and Sopheap's mother is getting old, but Sopheap also has younger siblings. Like most children, she wants to help her family. They gave her life and now she feels that she must do whatever she can to help her family survive. When she is 16 years old, and with the help of her aunt, she decides to migrate to urban Phnom Penh to work. As a sex worker, she is able to send home the much-needed money to buy food and provide some economic security for her impoverished family.

The sex worker situation in Cambodia

The National AIDS Programme estimated that there are now 180,000 people living with HIV/AIDS in Cambodia on a total population of 11.4 million.¹ Thirty years of war and isolation have left Cambodia's infrastructure shattered, with inadequate health and schooling as well as deficient roads, electricity and water; fractured social, family and community networks, including families nearly destroyed and/or uprooted. Cambodia also has the fastest growing STD/HIV/AIDS epidemic in Southeast Asia.

The issue of sex alone is clouded with many social taboos but Cambodian society reserves even more condemnation for sex work and sex workers. Sex work in Cambodia is partly rooted in the endemic vicious cycle of poverty. As the case study above illustrates, sex work in Cambodia can be what the welfare and survival of a whole family unit depends on.

Sex workers in Cambodia are struggling to keep their families in their village of origin fed and to provide them with much needed shelter and clothing. According to an IOM-sponsored qualitative research conducted in Cambodia, "The need to support the family financially has left young women with no other choice, but to leave their village and enter jobs that are not considered to be respectable, like prostitution... There is a saying in Khmer, a son does not feel responsible to take care of his parents, whereas a daughter, even when she works as a prostitute, will still think of her mother."²

A Case Study: Part 2

Sopheap arrives in Phnom Penh with her aunt. She comes to the house of a brothel owner her aunt knows about through contacts in the village. The brothel owner gives her aunt 200 US dollars as an advance and the girl then watches her aunt leave. She helps to do chores around the brothel while the brothel owner tries to find a client wanting a virgin and willing to pay five hundred dollars. Eventually, one day a man arrives and the brothel owner tells her to go with him. She follows him and is taken to a market where he buys her some new clothes. That night he takes her to a hotel and rapes her. After five days, Sopheap goes back to the brothel, where she gets another 150 US dollars, which she then sends home. In addition, her mother tells her that the family needs more money, so Sopheap borrows 200 dollars more from the brothel owner. In return, she has to stay in the brothel and pay off her debts as an indentured servant doing sex work.

The working challenge: the need for context

When asked, "why work with sex workers?" the answer from representatives of most mainstream organisations, both national and international, is that the sex workers are a bridge and/or source of STDs, HIV and AIDS, and that programmes have to be developed to somehow contain sexual diseases from spreading. This kind of paradigm transforms the sex workers from people into vectors of disease, while success is usually measured in how many condoms are distributed.

This mainstream approach is singular and is initiated by a certain segment of society, which is very separate and detached from the sex workers' reality. Simply put, and as illustrated in Cambodia, the sex workers are poor, rural and/or cross-border migrants with limited or no education, while the social workers employed by international as well as national organisations are educated, urban middle class men and women. These differences may lead to insensitivity and indifference. A recent research document examining reintegration of trafficked women in Cambodia quoted a former sex worker's experience with an aid organisation:

"They insulted me and said that I was from a bad family. They said that although I was young, I was romaoh (itchy). They said that I would never correct myself and that I would go back to my old place. I was angry and I left... I went back to Svay Pak [a brothel town outside Phnom Penh]."³ As a consequence, most programmes in Cambodia are not properly

designed and implemented for sex workers; the problem is that programmes do not consider and/or are not interested in the context of sex workers' lives. The programmes are designed starting from the perspective of protecting society and clients, while the sex workers continue to be marginalised and stigmatised.

Participation of sex workers in programme development and implementation is essential to make a real positive change and help ensure programme sensitivity towards the target group(s). Over the past two and a half years, the Coordination of Action Research on AIDS and Mobility (CARAM) programme in Cambodia has been trying to learn and practice participatory action research with sex workers. Although participatory has been a term used for many decades in the field of development, the concept of participation is not well understood by many people working with sex workers. The CARAM programme in Cambodia had to actually redefine our own understanding of how participation was implemented. Previously, the staff only had experiences conducting rapid assessments, which was followed by rapid interventions. However, the CARAM project started with developing relationships with the target group, which took some time and effort. During this time, existing IEC (information, education and communication) materials were distributed along with condoms, followed by casual group discussions that helped the sex workers to gain some degree of trust in the programme. The working relationships lead to a fair amount of trust, which eventu-

The programmes were designed more from the perspective of protecting society and clients

ally allowed the programme to collect the necessary information that was later validated by the sex workers. Along the information gathering process, there was a dual exchange of information. The result was that the participatory action research programme permitted the sex workers to better understand and utilise the messages and services provided by the programme through the close relationships with programme staff. The close relationship was not only a benefit to the sex workers, just as important, it also sensitised the programme staff, who were increasingly able to better contextualize the sex workers' situation and use that deeper understanding to better shape programme interventions.

A Case Study: Part 3

Sopheap does sex work at the brothel without any awareness and knowledge about STDs/HIV. She is too shy and embarrassed to talk about it even though she hears other people talking. She does not understand HIV/AIDS. Besides, her first client did not use a condom, but it did not matter to her because she did not know about condoms, she did not know about her own reproductive organs and sex, and just as important, she did not want to have sex. After three months, the police come to the brothel and arrest every sex worker. They take her for a blood test and find that she is HIV-positive. Sopheap becomes afraid, because she knows other people are afraid too. The brothel owner does not want her anymore, and tells her to leave. She goes into the streets with only her clothes on and less than a dollar in her pocket. She has nowhere to go, no money, and she is hungry. Sopheap does the only thing she can: she sells sex on the streets to find enough money to buy food...

CARAM stands for Coordination of Action Research on AIDS and Mobility. It is an initiative of NGOs involved in migration issues in Asia. These NGOs were concerned about the increased vulnerability of migrants in terms of health in general and STD/HIV/AIDS infection especially. Simultaneously the HIV pandemic has special consequences for the human rights of migrants that have to be addressed.

CARAM is a nonexclusive open network of organisations and individuals. Currently organisations in seven South and Southeast Asian countries have joined CARAM. In each country there is one organisation responsible for the production of information, the development and stimulation of interventions and advocacy work. These NGOs, who are co-ordinating the work of CARAM in their specific countries, form broad national networks of organisations with a focus on migrants and/or AIDS.

CARAM-Asia Secretariat

Sharuna Verghis

11th Floor, Wisma Yakin

Jalan Masjid India

50100 Kuala Lumpur, Malaysia

Ph: 60-3-2979267

Fax: 60-3-2913681

E-mail: caramasia@hotmail.com

Web page: www.gn.apc.org/caramasia

Working towards a solution

Just as the three-part case study tried to illustrate, the lives of sex workers are complicated and a practical and genuine solution must start by first properly contextualising their situation based on participation. It is necessary start from an assessment of the conditions the sex workers live in. There is a real need to see the sex workers as human beings with their own specific needs, not just as numbers and/or a source or gateway for STDs/HIV/AIDS. Programme success should never be based solely on the number of condoms distributed and/or used because this leads to reinforcing narrow thinking within programme implementation and development.

The challenge for Cambodia, and possibly other countries as well, will be to work using participatory methodologies with the sex workers to help them to learn from each other in order to improve their situation, whether it is through micro-credit, reproductive health, education, and/or human rights. In Cambodia each day many young women enter sex work. They will be exposed to violence, verbal and emotional abuse and STDs/HIV. The actual solutions to the challenges facing sex workers are complicated, but they should start from the process of contextualising their lives. The newly found understanding will not only help programmes to prevent sex workers from contracting STDs/HIV, but will also help them to improve and change their lives through a more sustainable process.

Notes

1 1998 General Population Census sponsored by UNFPA.

2 Trafficking of Cambodian Women and Children to Thailand, an International Organization on Migration (IOM) and Centers for Advanced Studies publication, by Annuska Derks, p.21 1997.

3 Reintegration of Victims of Trafficking in Cambodia, an International Organization on Migration and Centers for Advanced Studies publication, by Annuska Derks, p.12 1998.

Chivariak Khus

Former CARAM Cambodia programme manager

HIV/AIDS INTERVENTIONS FOR STREET-BASED SEX WORKERS IN DHAKA CITY

Going beyond their sexual organs

Sex work in Bangladesh is illegal and most Bangladeshis claim that it is culturally unacceptable. Yet there are an estimated 100,000 sex workers in the country. Sex workers probably are among the social groups that are most looked down upon. In Bengali culture women have a very low status. A woman alone after dark runs the risk of being raped, as some men believe that 'good women' do not go out unaccompanied, and definitely not when it is dark. The newspapers are filled with such news. There are many reports of girls having acid splashed in their faces by potential partners because they refused to marry them. Only a few of such cases are brought to court.

It is easy to understand that sex workers in such a context are virtually without rights and are in a difficult position. Of course they know how to deal with difficult clients and they dare to stand up where other people might remain silent. This is a kind of professional empowerment. In terms of social empowerment however the situation is very different. This becomes obvious when the sex workers have health problems related to their work. Where can they go when they have an STD? Family planning clinics and hospitals may have physicians, but it is better for a sex worker not to tell what her profession is, because the health care staff may abuse her. Begum, one of the sex workers in SHAKTI's street-based sex workers programme tells how she deals with this: "When the doctor asks me: 'How did you get that disease', I will tell him: 'My husband goes to see sex workers and that is how I got it'." When asked

what will happen if the doctor will find out that she is a sex worker, she answers: "He will ask more money, because otherwise he will tell everybody. You have to beg them: 'please don't tell, please don't tell'. What else can you do?"

It is obvious that many sex workers try to avoid physicians and official health care services. Most of them turn to a pharmacy in case they have symptoms of STDs. They explain their problems and buy some drugs. Given the fact that the microorganisms causing the most prevalent STDs have become resistant against most of the cheaper antibiotics, there is little chance that these women will receive appropriate treatment for their STDs.

Drop-in centres

SHAKTI (Stopping HIV/AIDS through Knowledge and Training Initiatives) is a sex workers' project run by CARE International in Bangladesh. The idea behind the programme is to decrease the vulnerability of sex workers by empowerment, education and provision of services. One of the pillars of the programme is peer education to promote condom use.

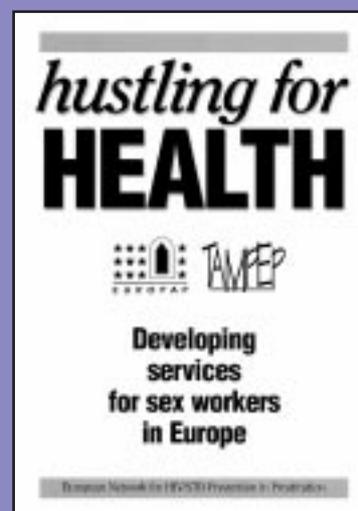
The other important component is to provide appropriate reproductive health facilities. The project has four contact points or drop-in centres at different locations in Dhaka City. Once a week, staff from the NGO Marie Stopes Clinic Society (MSCS) comes to the drop-in centres to provide STD treatment.

Drop-in centres

A drop-in centre is usually in an area of prostitution to ensure easy access for local sex workers, and open at times when sex workers are active, offering a place to talk to project staff and each other, pick up condoms, use the toilet and relax. Drop-ins provide a welcoming environment.

A range of services that can be provided is outlined below, what is feasible for any one project will depend on staff, buildings, and resources:

- Meeting room with coffee and tea (food if possible) where sex workers can relax and talk to each other or staff.
- Counselling room for private discussions between sex workers and staff.
- Condoms and lubricants.
- Emergency phone numbers, especially for emergency accommodation and rape counselling.
- Drugs support, advice and sterile syringes. If drug-dependant sex workers predominate amongst the drop-in users, it would be a good idea to arrange these services on site.
- Toilets - if possible including a shower.
- A drop-in facility could also be the site for a dedicated STD and contraception service and/or general health services, if space and resources are available.



A drop-in centre should be a safe place for sex workers. It should be a place where sex workers can come and talk about their own concerns without encountering hostility from other users (or staff). Sometimes it may be preferable to run separate services for different target groups (e.g. men, transgenders, young people, drug users).

Sex workers may prefer a building that is used by other people; this gives a degree of anonymity, because anyone entering the building is not immediately presumed to be a sex worker. Female sex workers may prefer to have a women-only centre or sessions. A drop-in may be the only place where sex workers can meet and talk about their work openly, in a serious but not in an apologetic way, and this is perhaps the most important reason for having a separate session for sex workers. Their occupation is a common factor, one that stigmatises and isolates, but it also provides the opportunity to meet and develop or express a sense of solidarity and mutual self-respect.

From: Hustling for health. Developing services for sex workers in Europe.
European Network for HIV/STD Prevention in Prostitution
(EUROPAP/TAMPEP) 1998.

One of the contact points is very near the international airport and on Thursdays a physician of MSCS will see the sex workers working near the airport and in the 'richer' residential

Many sex workers try to avoid physicians and official health care services

areas. During a focus group discussion at this contact point, the women told why they like to come there. Their main reason is that the environment is pleasant: they can go to the toilet, take a bath or rest for a while. In addition, the doctor examines them carefully and takes them seriously. She knows that they are sex workers and they do not have to talk about it. Drugs are relatively cheap. Of course, they are a bit shy to enter the contact point when there are people they know around. They may walk an extra round before entering, but once inside they feel at ease at the drop-in centre.

Going beyond their sexual organs

During my work on the SHAKTI project, I have learned how important it is that sex workers are seen by the health care staff as equal human beings and that the contact point provides a safe environment. Health services for sex workers should not only concentrate on STDs, but take into account that these are just one of the many problems they have to face. HIV/AIDS interventions for sex workers should go beyond issuing condoms, they should enable them to negotiate about condom use and provide them with STD treatment. An enabling environment at different levels of society is necessary. Therefore, we should train and sensitize the different stakeholders, like NGO staff, GO staff, donors etc., to create health services for sex workers that go beyond concern for their sexual organs.

Maurice Bloem

Maurice Bloem is a cultural anthropologist who has been working for CARE Bangladesh until recently; first as the Project Co-ordinator of SHAKTI and later as the HIV Programme Technical Advisor. At present, he is an independent consultant.

MIGRANT SEX WORKERS IN EUROPE

Denying rights is an obstacle to proper care

Internationalisation is a key issue influencing the organisation of prostitution, and therefore of health care services. Prostitution can no longer be viewed as a local or national phenomenon but must be treated as an international one involving multicultural groups and international organisations. Therefore, new policies need to take account of changes resulting from internationalisation. Local conditions of migrant sex workers will differ in view of

some countries and discriminatory public health measures against migrant sex workers cannot be tolerated. Evidence shows how regulation is a barrier to migrant sex workers' service use, for fear of being reported as irregular immigrants. This results in extremely limited access to health care services, and to reduced information on safer sex practices and health promotion. This situation increases the risks of infection and transmission of disease.



national laws on prostitution and immigration. Repressive policies interfere with sex workers implementing a strategy of self-protection and autonomy. Policy makers and planners should recognise that the sex industry is an important economic resource for many foreign citizens excluded from the formal economy, and for people who are unable to generate an adequate legitimate income. This does not imply the acceptance of crimes against sex workers, forced prostitution or sexual exploitation.

The acceptance of prostitution and the process of internationalisation are particularly important for effective health care, HIV/STD prevention and harm-minimisation strategies directed at migrant sex workers. Forms of self-organisation and protection, supporting the emergence of a strong collective identity, will safeguard health conditions in this market and offer more effective protection against exploitation.

Reverse effects of immigration legislation

In the fight against organised crime (including woman trafficking and conditions enabling exploitation and dependency), a clear differentiation should be made between political measures against exploiters and policies addressing the rights of migrants themselves, including their decision to enter the European sex work market. We would like to underline once more that registration programmes now in force in

The actual immigration legislation regarding sex workers has very severe consequences for their living and working conditions:

Firstly, their illegal situation leads to:

- *dependency* on pimps, bar/cabaret/club owners, husbands and other people involved in the sex industry, debt bondage
- *exploitation* through underpayment, costs of services offered, long working hours, unprotected and unsafe working conditions
- *isolation* because of cultural differences, language problems, lack of information on social and legal rights
- *mobility*, because their temporary visa has expired or because they are forced and taken by their pimps to another place
- *insecurity and fear*, possibly causing physical and psychological problems (alcohol, drugs)

TAMPEP (Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe/project) is an European project that spans four countries: The Netherlands, Italy, Germany and Austria. It is a model of intervention, reaching a total of 23 different migrant groups of women and transgender people from Eastern Europe, South East Asia, Africa and Latin America. TAMPEP provides migrant sex workers with culturally appropriate HIV and STD education, and resources and materials appropriate to sex work.

and medicine addiction, self-medication, depression, etc.)

- frequent exposure to *dominating and exploiting clients* who force them to accept any offer: low prices, unprotected sex, unsafe working places. This leads to more dependency on protection by pimps and makes sex workers vulnerable to all kinds of other exploiters, including the police.



Secondly, there is a lack of access to health care services for various reasons:

- Because of their illegal status they do not have a valid health insurance, and consequently, they have no access to the health care system and health promotion measures.
- Because of their precarious, insecure and marginalised situation, they have no access to information about their rights to, and possibilities for, getting HIV/AIDS/STD prevention and treatment, even if they are insured. Under those conditions, putting safe sex into practice is not a priority anymore.
- Because of the repressive policy towards migrant sex workers, these people distrust all kinds of authorities, including health care services, which means that they do not make use of those services.
- Because most of the health care services are not prepared to deal with a multicultural population, i.e. they do not make use of cultural mediators¹, migrant sex workers are usually discriminated and misunderstood.

Insufficient health services for uninsured persons

As a logical result of the restrictive laws towards migrant sex workers, the access to basic health care services is insufficient for uninsured women. If they admit they are (migrant) sex workers, they know they will have to deal with discrimination and prejudiced attitudes. High mobility and vulnerability influence their willingness to practice safe sex and cause physical and psychological problems. All these unfavourable circumstances

lead to an increasing number of STD, HIV and TB cases, and unplanned pregnancies.

Many migrant female sex workers have to work seven days a week, 10 to 15 hours a day. As they have incurred large debts to be able to come to Western Europe, there is a strong competition among them. If a client is willing to pay more for sexual contact without a condom, some sex workers might accept this. As an STD prevention, they often take antibiotics, which can be bought at the black market or which are sent from their home countries.

Culture specific services

In order to tackle the above-mentioned problems and keeping in mind that STDs facilitate an HIV infection, we strongly recommend:

- Anonymous STD and HIV/AIDS check-ups and treatment, free of charge.
- General medical care services for uninsured migrant sex workers and if these services are not available, preparation of corrective proposals to national and/or municipal health authorities.
- Support for non-insured migrant sex workers diagnosed with HIV/AIDS.
- The inclusion of cultural mediators in the health care system aimed at migrant sex workers, i.e. as street workers/field workers and as co-workers inside health clinics.
- The creation and development of specific information materials on HIV/AIDS/STD prevention aimed at migrant sex workers while considering the different cultural, health, sexual, ethnic, and linguistic

backgrounds of these sex workers.

- The inclusion of social workers inside health care services who are assigned the task of dealing with migrants' problems (like Aliens Laws, residence and work permits, marriage, divorce, asylum, adoption, etc.) and establishing contacts with professionals like lawyers, psychologists, medical specialists, workers in women's shelters, etc.
- The establishment of co-operation between health service functionaries and peer educators/supporters.
- Making services providers more aware of the fact that when working with members of minority groups, they should be very flexible in dealing with them. They should accept that not all activities can take place according to established rules and guidelines.
- Specific offers of health care institutions accompanying the spread of health promotion messages.
- Close co-operation between the various service providers. They should form a network of support services for the target group.
- The establishment of working contacts with local medical personnel originating from the countries of target group members.

Note

¹ Cultural mediation is a basic element of TAMPEP's methodology. Cultural mediators are professional field workers who have the same ethnic and/or cultural backgrounds as the members of the target group.

Licia Brussa

Co-ordinator of TAMPEP in the Netherlands

TAMPEP/Mr A. de Graaf Stichting

Westermarkt 4

1016 DK Amsterdam, the Netherlands

Ph.: 31-20-6247149

Fax: 31-20-6246529

E-mail: tampep@xs4all.nl

Web page: www.xs4all.nl/~mrgraaf/5_ef.htm

Political transformation in Poland *The rise in sex work*

The political transformations that took place in Poland at the turn of the 1980s-1990s let us notice some phenomena that were previously given almost no attention. For example, social minority groups that officially did not exist in a 'normal, healthy and noble' socialist political system, became active. During the socialist era observations on sexual behaviour, especially that of sexual minorities whose manners differed from those generally accepted, were best kept to oneself. Socialism secured work for everybody, declared for family values, and protected human dignity.

That is why it could not consent to sexual 'pathology'. Therefore, a lot of social life phenomena were concealed and controlled. Prostitution was one of these. It was not banned (criminal law forbade only to profit from sex work) but nevertheless, sex work faced numerous informal sanctions - from moral condemnation (almost ostracism) and obligatory medical examinations, to suggested 'co-operation' with the police. Socialist interpretation of social life values, and an extended system of social control caused prostitution to go underground and be almost un-

seen for ordinary people. Sex workers were colloquially called 'whores' and prostitution was identified with pathological behaviours like alcoholism and delinquency, and not with the way of earning a living.

A new way of living

The 1990s not only brought intense political and economical changes, but also social transformation. More social mobility, a new system of values, a new way of living favouring consumption of consumer goods and a trend towards early sexual initiation are responsible for changes in social morality and everyday behaviour of the Polish people. This resulted in changed attitudes to social minorities. The image and practice of sex work changed as well, as a result of:

- The liberalisation of private life: high income of many people affects the increase of demands for sexual services.
- The commercialisation of sex, that becomes a popular 'commodity' (sex shops, pornographic magazines, escort agencies, etc.).
- The disappearance of 'semi-formal' limitations and sanctions from state institutions.
- The changing system of values of the Polish people. Material goods are being thought highly of. Thus, sex work is one of the means to get money for consumer goods.
- The less effective mechanism of social control. The pace of living and the anonymity of life in Poland make engagement in sex work easier.

It is hard to consider the phenomenon of sex work in statistic terms. As a matter of fact, the number of sex workers is only estimated. From the recently published reports it follows that there are about 15,000 Polish women walking the streets and 2,000 coming from other for-

As far as prostitution is concerned there is an ambiguous morality

merly socialist countries in Eastern Europe. The real number may however be much greater. It is extremely difficult to analyse this phenomenon in respect of statistics because it is scarcely possible to penetrate the sex workers' community. Besides, the map of prostitution has been constantly changing. For example, prostitution intensifies in summer/winter re-

sorts, and on the routes leading to Poland's borders. The fact that the borders are open gives sex work an air of internationalism, especially in the western borderland where the 'encounters of nations' take place. Here, women from the former USSR, Bulgaria and Romania offer their services to Poles, Germans or Dutchmen. Here, the demand for sex is much greater than somewhere else in Poland. The borderland became a peculiar sex market, where sex services are sold and bought. Here, sex work is 'exported' to the countries of Western Europe.

Ambiguous morality

The above facts, connected with intensifying sex work and its new categories most certainly contributed to more exposition. Organised forms of sex work such as escort agencies and massage parlours came into existence. Polish customs and morality have been changing: the social attitude towards prostitution has become more tolerant. There is no other explanation for the fact that married women and daughters walk the streets with their husbands' or parents' consent. The existence of prostitution in small towns which takes place in an environment of strong traditions and a social control system in which the Catholic Church plays an important role, cannot be explained otherwise. The studies carried out by Dr Zbigniew Izdebski showed that 80% of contemporary men and 50% of women accept sex work.

These facts, however, do not mean that prostitution in Poland is generally accepted and that the sex sector is booming. As far as prostitution is concerned there is an ambiguous morality. On one hand, the law allows escort agencies to flourish, whilst on the other hand, sex work is condemned and considered in terms of social pathology as an exceptionally immoral phenomenon. The range of reactions to prostitution includes a wide spectrum of opinions, among which the negative ones predominate.

The reasons for such attitudes in recent years are as follows:

- Reinstatement of Christian values as interpreted by the Roman Catholic Church and the increased influence of the Church on public life resulting from political transformation.
- Sex workers, traditionally associated with the underworld and black market, are seen as potential criminals. To profit from somebody else's prostitution is a crime and as such cannot be taxed. The earned money however, must be laundered,

resulting in escalation of criminal behaviour.

- Sex workers and their partners are perceived as a group particularly exposed to HIV infection. This makes them social outcasts linked up with other high-risk groups, such as drug addicts and homosexuals.
- Lack of public tolerance puts sex workers in a handicapped position with respect to social rights.

TADA: Outreach for HIV/STD prevention

At present, sex work in Poland is not banned. All forms of restriction towards sex work, such as health check-up or registration, are given up. Nevertheless, to profit from somebody

The range of reactions to prostitution includes a wide spectrum of opinions, among which the negative ones predominate

else's prostitution still has remained a penal offence, so all sorts of procurement are punished. Nowadays, many HIV prevention programmes are addressed to social minorities who carry the mark of social pathology. These programmes started on the grounds of awareness about the health threat related to risky behaviours, first of all in the communities of drug addicts, homosexuals and persons selling sexual services.

The Programme for the Prevention of HIV/AIDS and other Sexually Transmitted Diseases - TADA - is an example of such a programme. The TADA programme is a non-governmental one and is being realised in six Polish cities. Using street work, we try to reach persons whose behaviour seems risky in the context of the HIV/AIDS problem, e.g., men and women selling sexual services, potential clients and young people subject to various social initiations such as an early sex debut and experimenting with drugs. In our everyday activities we try to offer the following forms of services:

- information about safe sexual behaviour
- organising anonymous medical advice
- creating support groups, and giving information on other institutions for social assistance.

We are aware that our help is inadequate. The need for HIV prevention in Poland is much greater than what we can offer. Nevertheless, we have succeeded to a certain extent. Our work has resulted in less risky behaviour, and less sexual diseases. It also made Polish society as a whole more interested in health dangers brought about by sexual relations. The TADA programme's great strength is a group of professionals trained for realising prevention activities. Popularisation through street work proved a very effective method in getting

through to various social minorities, which is also one of our achievements. Previously, the funding and content-related activities of the programme were supervised by the Ministry of Health and Social Welfare as well as by the United Nations Development Programme. At present, the TADA programme is not financed by any governmental institution. We have been seeking for financial support, but unfortunately our activities are often perceived as supporting prostitution, not as a programme promoting health. As a conse-

quence of this misunderstanding, we have been working voluntarily for eight months.

Anna Nowak
 Co-ordinator of TADA - Polish Programme for the Prevention of HIV/AIDS and other Sexually Transmitted Diseases
 ul. Cyrylla i Melodego 2/6
 71-540 Szczecin, Poland
 Ph./Fax: 48-91-225675

Improved health care for sex workers

A voucher programme for female sex workers in Nicaragua

Female sex workers provide a good illustration of how health care in the developing world has failed to serve the poorest and most needy. This was also the case for the approximately 1,200 female sex workers of Managua, capital of Nicaragua. A special programme was designed in 1995 which would increase the uptake of health services by female sex workers and improve the human and technical quality of the services they receive, whilst keeping consultation costs below those of existing Ministry of Health clinics. This programme started as one of the first trials ever of a voucher system for reproductive health care for female sex workers in a developing country.

The essential idea was to increase the uptake of care by regularly giving female sex workers vouchers entitling them to free care at any one of a variety of private, NGO and public clinics offering reproductive health, contracted in advance by the voucher agency, ICAS.¹

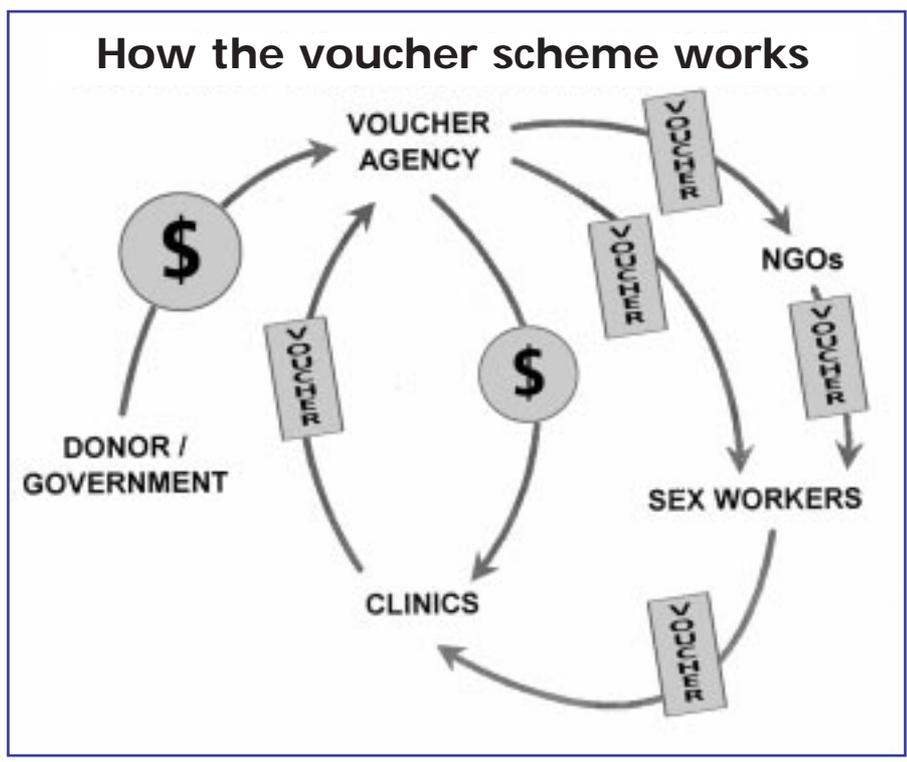
The voucher agency produces the vouchers, some of which it distributes directly to sex workers and some of which it gives to NGO intermediaries who distribute them to the sex workers with whom they maintain close contact. The sex worker takes the voucher to the contracted clinic of her choice where she receives the specified services free of charge. The clinics

return the vouchers to the agency, which reimburses the agreed fee per voucher. The cycle, or voucher round as it will be referred to here, is repeated every three to five months.

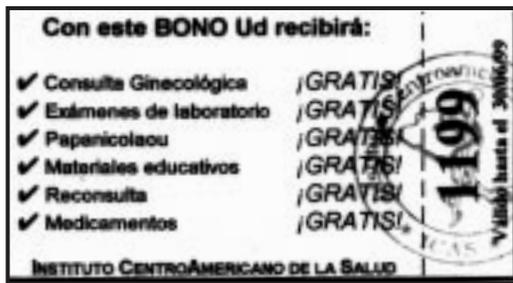
Start and implementation of the programme

●●● *Baseline studies*
 To begin with, several baseline studies were carried out and a survey conducted of the market for reproductive health services. A shortlist of providers was drawn up and these were invited to participate. Baseline assessments of technical quality and cost of services were performed. Female sex workers impersonating patients carried out participant observation of the human quality of health services. Informal, in-depth and semi-structured interviews with sex workers, and structured interviews with a random sample of the general population of female sex workers were conducted to collect data on socio-economic status, health services needs and utilisation, perception of the quality of different health services, sexual practices, knowledge of STDs and prices of sexual services.

●●● *Mapping of the sex worker population*
 The distribution of the female sex worker population was mapped through 'snowball'-interviewing at the sites. Fieldworkers identified a total of 121 sites by asking informants at each site for the names of other sites. It took about six months to visit all sites. At only 76 out of 121 possible sites, prostitution was actually taking place. The prices for different sexual services at each site were ascertained, as was the number of women working at them. This gave a final estimate of about 1,200 female



sex workers in Managua, which is close to the number of vouchers that has actually been distributed each round. Over time, sites change



and it is therefore necessary to keep the map up-to-date. A stratification of the sites based on the prices charged has proven to be useful for data analysis and for targeting the women in greatest need.

● ● ● *Contracting the service providers*

In 1996 no laboratory in Managua was performing chlamydia tests and only a few were testing for gonorrhoea. The best laboratories were invited to tender their services and the cheapest of these was contracted to conduct the tests, including a cheap chlamydia test in the first three rounds. Each of the clinics

Female sex workers impersonating patients carried out observation of the human quality of health services

approached was asked to tender a price for a gynaecological consultation (treatment would be provided separately by ICAS). In the first round eight contracts were signed, which stipulated not only the reimbursement value of each voucher but also required the staff to follow a set protocol and to receive training. After each round a decision whether or not to

Services offered

The voucher entitles the bearer to choose from a number of clinics where she can obtain free of charge: a full gynaecological consultation; laboratory tests for gonorrhoea, syphilis, trichomoniasis, candidiasis, gardnerella; diagnosis through physical examination of condylomata acuminata, phthirus pubis, scabies, herpes simplex, chancroid, lymphogranuloma venereum and granuloma inguinale; a cervical cancer test; health education; counselling on contraception; condoms; lubricants and treatment when the diagnostic tests proved positive. Since the fourth round 1 gram of azithromycin (single-dose) is offered in stead of chlamydia testing, since reliable chlamydia testing seemed impossible.

renew contracts is made, based on an assessment of the quality of care provided.

● ● ● *Feedback from sex workers and clinics*

From the beginning, female sex workers have been heavily involved in the design of the programme, especially with respect to clinic preferences, opening hours, optimum period between rounds, services offered, and type of condoms and lubricants offered. Also, the design of the vouchers and the booklet with information on clinics were pretested. As mentioned earlier several methods are used, always with emphasis on determining preferences, objections, problems experienced and complaints. In each round 10% of voucher users is interviewed about their experience with the clinic they visited (this also functions as a quality control of the clinics). Feedback from clinics is obtained during workshops held before each round and through interviewing receptionists, nurses, doctors and directors. To carry out these functions ICAS employs a small team comprised of a medically trained programme co-ordinator, a sociologist (part-time), a consultant gynaecologist (part-time), a statistician and a number of fieldworkers for voucher distribution and interviewing on an ad hoc basis.

Problems encountered

● ● ● *Technical and human quality*

The 'human quality' of most clinics was much better than expected. However, observations carried out for the project by female sex workers demonstrated that the 'gatekeepers' - receptionists and nurses - lacked sensitivity. They received training and sensitisation in how to serve sex workers, which greatly improved their attitude towards them. Technical quality (all doctors had to pass an exam) was much lower than expected. A set protocol was necessary as well as training.

● ● ● *Services offered*

Owing to a lack of funds when the fourth round was due to start, a limited package of services was offered with no tests and no follow-up consultation. The services consisted of a gynaecological consultation, azithromycin treatment for all and health education. Only

gonorrhoea testing was performed, since this is used as a tracer condition for all STDs. Voucher redemption on this occasion was low (28%). Fieldwork revealed that female sex workers considered the lack of testing as the most important reason. For them testing is important to ascertain their health status and to see how successfully they are preventing STDs, but also to be able to demonstrate an

Sex workers commented that for them one of the highest benefits was to be able to visit health services used by 'normal' women without being discriminated against

absence of infection to their clients. The fifth round offered testing again along with universal azithromycin treatment and redemption increased to 44%.

● ● ● *Follow-up consultation*

Over time, the proportion of women attending their follow-up consultation has dropped from 89% in the first round to 76% in the sixth round. This decline might be partially explained by the change in policy halfway through the programme to give all female sex workers azithromycin on their first visit. This medicine cures both chlamydia and gonorrhoea. In the coming rounds, doctors will encourage the sex workers to return in order to receive additional treatment if necessary and clinics will receive a financial incentive for each female sex worker returning.

Results and reception of the programme

● ● ● *Epidemiology*

Approximately 1,000 to 1,200 vouchers were distributed in each of the six rounds from 1996 to early 1999. The prevalence of STDs (9.2% in 1999) is lower than it was at the beginning but not by a great deal, perhaps due to the high turnover of female sex workers in Managua. However, the incidence rate in women using vouchers more than once has dropped by 65% since the beginning of the programme, from

279 per 1000 person-years in the second round till 99 per 1000 in the sixth round.

Analysis showed that female sex workers who tested positive for an STD have a subsequent incidence of STDs four times higher than sex workers who were negative on their first visit. A more intensive follow-up for all female sex workers with gonorrhoea and/or syphilis is therefore needed and since the sixth round these women receive an extra voucher between rounds. Also, as proposed by sex workers themselves, they now receive vouchers for their partners and/or regular clients as well.

●●● Reception by sex workers

In all contacts with female sex workers they commented that for them one of the highest benefits was to be able to visit health services used by 'normal' women without being discriminated against. Furthermore they could choose where to go; personnel of clinics really cared to treat them well; waiting times were short; the embarrassment of explaining to the doctor that they were sex workers was avoided since the voucher already indicated this and doctors knew what they were doing. When asked why they had chosen a certain clinic, especially short distance and friendliness were mentioned. When asked how the programme could be improved, they suggested less time between rounds, education of other female sex workers at their working sites who were not using their vouchers, and testing for HIV/AIDS.

Reasons given by female sex workers who had received a voucher for not using them, were that they had lost it, that they were too ashamed to visit a clinic or that they had domestic troubles preventing them to come. Other rea-

The Instituto Centroamericano de la Salud (Central American Health Institute - ICAS) is a Central American non-profit organisation without political or religious affiliations; it is dedicated exclusively to the health improvement of the population of Central America. ICAS operates as an international collaboration of accomplished health professionals, scientists and consultants. It provides the health sector with highly qualified technical assistance, innovative research and development projects, and special training programmes in areas often neglected by other agencies. ICAS has offices in five Central American countries: Costa Rica, Nicaragua, Guatemala, El Salvador and Honduras.

sons stated were that they did not have time, that they had been imprisoned or forgot about the voucher until it had expired. Also, some mentioned they did not have a need to visit a doctor, that they check their health situation at another place, buy their medicines from a pharmacy when needed, or just do not like to visit clinics.

●●● Reception by clinics

Interviews with the clinics' directors revealed that for most of them the economic benefits of the project were limited. The main advantage perceived by the clinics was the improvement in the technical quality of their services and lessons learnt were systematically applied to all of the clients. Doctors found that they have become more perceptive to the problems of sex workers (for them, a new type of client) and, in some cases, young glue-sniffing girls (mainly street children). They also found that serving these women has been challenging and professionally enriching. After the first round, the

interest from providers to participate in the scheme increased greatly as they realised not only that the scheme was a legitimate and reliable source of income, but also that the female sex workers would not dress in a manner that put off their other clients. An additional benefit mentioned by the service providers was that being contracted by an agency with the prestige of ICAS confers a certain status upon the clinic, especially for the smaller ones which are glad to be 'in the same league' as the larger clinics.

●●● Reception by NGO's

The work done by ICAS in identifying, targeting and reaching female sex workers has helped the NGOs that were recruited for voucher distribution to expand their own outreach programmes and in doing so they have learnt how to better approach this difficult-to-reach group of women.

Note

1 The voucher agency is the Central American Health Institute (ICAS), an NGO conducting health research, which received technical support from the Liverpool School of Tropical Medicine. The voucher programme was funded by the British government and at present is being supported by the Elton John AIDS Foundation.

Anna Gorter, Peter Sandiford, Zoyla Segura and Caridad Villabella
 Instituto Centroamericano de la Salud (ICAS)
 Apartado Postal 2234
 Managua, Nicaragua
 Ph.: 505-270-0891, Fax: 505-277-0178
 E-mail: agorter@ibw.com.ni
 Web page: www.icas.net



HEALTH CARE FOR SEX WORKERS SHOULD GO BEYOND STD CARE

Almost all discussions of health and sex work focus on sexually transmitted diseases, until recently almost exclusively in terms of the risk of sex workers infecting others. Only in the last few years have discussants occasionally talked in terms of how to help sex workers protect themselves from STDs. This change in view does not go far enough: health care for sex workers should be more than concern for their reproductive system.

The call for papers to which this article is a response is entitled 'STD services for sex workers at all cost?', as though that was the only important issue. The author asks whether STD services should be designed specifically for sex workers, whether they should be located within sex work districts or establishments, or outside of them, and whether syndromic treatment directed by algorithms and/or mass treatment with antibiotics is the best way to address the issue of sex work and STDs. The author is concerned about how to get sex workers to present themselves to STD services often enough (to protect the proverbial client and the general population, perhaps, because it is too late to protect the sex worker). Unfortunately, the answer to all of these questions is really 'no', because the issue is not STDs, it is health. That is, health care for sex workers must consider the entire spectrum of the occupational safety and health context of prostitution and related sex work, not just what happens to the sexual and reproductive system.

There is little published data on the general health and/or occupational health hazards of sex workers, although many have looked at

the epidemiology of HIV and/or STDs among sex workers, and a few writers have looked at mental health issues, violence, and occupational safety and health in relation to HIV/AIDS prevention. Only a small number have looked at broader occupational safety and health issues.¹ In the absence of formal research, the sources of primary information about sex workers' health concerns include conversations and anecdotes, rarely published, and published memoirs, interviews, and sex workers' rights anthologies. However, it is important to understand that health, per se, is not a major topic of discussion among sex workers. Rather, it is the effect of the laws and policies that segregate them from the rest of society and the need to change the legal and social context within which sex work takes place. Nonetheless, it is possible to identify some health issues that do concern sex workers.

Health issues

Perhaps the most important issue is violence and the threat of violence, which is encouraged by the illegality of sex work in most countries and the resistance of law enforcement agencies in all countries to take seriously sex workers' reports of being raped, or to

seriously investigate murder when the victim is a sex worker. It is essential to not underestimate the impact of police on sex workers' lives. Even in countries where prostitution, per se, is not illegal, prostitutes and other sex workers are often arrested under laws dealing with vagrancy, loitering, public health, and public order, and no matter where prostitutes work, they tell stories of police raids.

The emphasis must be on primary care, nutrition, and physical safety, and only then on how to prevent STDs

A second major issue is emotional stress and depression, associated with managing stigma and living with the fear of violence and arrest, which in turn affect the use of drugs and alcohol to manage stress. Both of those health hazards would be significantly reduced by the decriminalisation of all aspects of sex work and the development of occupational safety and health (OSHA) regulations governing the working conditions in managed sex work (e.g., brothels, strip clubs, massage parlours, nightclubs, tea houses, etc.) The enforcement of laws against sexual assault, kidnapping, extortion, and similar offences, is necessary to deal with cases of coercion and violence.

Other health hazards, such as repetitive stress injuries (e.g., to the wrist and shoulder from hand stimulation of the client, jaw pain from performing fellatio), bladder and kidney infections, and sexually transmitted diseases can be prevented with OSHA regulations², proper training, and the use of barriers for wet sex (i.e., sex involving contact between mucous membranes and bodily fluids). However, an almost invisible health hazard has to do with the reluctance of sex workers to inform health care providers of their work, for fear of being treated with contempt.



Sex workers' health care

Health care for sex workers must consider the entire body, not simply the sexual and reproductive systems. In addition, health care providers who work with sex workers must accept them without moral judgements, must consider their sexual labour as work, not pathology, and must recognise the importance of and the right to safe working conditions. They must recognise the legitimacy of sex workers' relationships, and not assume that spouses and

clinics are not likely to be well attended. It may be that the best location is one in which the clinic will be less noticeable to police, for example as a clinic in a hospital or other facility that has lots of doctors' offices and/or social service agencies. On the other hand, a sex workers' community centre, which provides legal services, child care, self-defence classes, a credit union, collective bargaining, and other support services might be the best place to house a clinic.

implementation, and evaluation of the programme. But not in a token manner. Form a managing board more than half of the members of which are sex workers, whether they call themselves prostitutes, dealers, working women, ladies of the evening, hustlers, drag queens, hospitality workers, entertainers, dancers, strippers, or people who have fun with foreigners. Hire sex workers on the same economic basis as other workers (i.e., not just for stipends or for the profits realised from social



lovers are stereotypically violent 'pimps' (anyone who receives an income from sex workers is defined by law as a pimp).

Obviously, it is at least theoretically easier to provide good health care and other services for sex workers in wealthy, industrialised countries than in poor countries struggling with structural adjustment and other financial crises. However, it is a mistake to think that because there is not much money, it is better to focus on the health problem framed by outsiders - sexually transmitted diseases - because it will only perpetuate the stigma and shame that has caused such programmes to fail in the past. The emphasis must be on primary care, nutrition, and physical safety, and only then on how to prevent STDs.

Recommendations

The question of location and hours of operation must always be decided on the basis of local conditions. Any clinic that is based in one location in a city where sex workers work in various locations will pose problems of transportation and convenience. For example, since sex workers' working hours tend to be afternoons, evenings, and late at night, morning

Even a poor clinic can arrange for experienced sex workers to run classes for newer workers on how to prevent violence, how to use your body in such a way as to minimise the risk of muscular aches and pains, how to establish control in a sex work transaction, how to negotiate with clients and with bosses, etc. Sex workers often have extensive counselling skills, developed in their work with clients, which can be easily transferred to the health care setting. Hire retiring sex workers to staff the support services part of a clinic, which both provides them with training to make the transition to formal sector employment and enables the clinic to provide the support services. If a city has a university, graduate students in social work, economic development, and law, can intern with the clinic, providing the services that support good health, as well as training sex workers to provide those services. Establish alliances with the Peace Corps, from the United States, and similar programmes from other donor countries, to provide community development workers who can teach important skills to sex workers.

Ultimately, the only way to ensure that health care is provided in a way that is acceptable to sex workers is to involve them in the design,

marketing of condoms). Not only can they be trained as medical assistants and counsellors; they often have managerial and organising skills that are invaluable in any workplace.

Notes

1 For a list of the articles and books relevant to this paper, please contact the author by mail or e-mail.

2 To date, only one country, Australia, has developed OSHA regulations.

Priscilla Alexander

Priscilla Alexander has been a sex workers' rights activist since she met Margo St. James in 1976. Along the way, she has written numerous position papers, resolutions, and articles on sex work, and was co-editor of the book Sex Work: Writings by Women in the Sex Industry, from which the term 'sex work' comes.

*North American Task Force on Prostitution
2785 Broadway, Apt. 4L
New York, NY 10025-2834
United States of America
E-mail: prisalex@interport.net*

Integrating services within existing Ministry of Health institutions

The experience of Ghana

In 1996, the Ghana component of the West Africa Project to Combat AIDS (WAPTCA - see box) launched an STD/AIDS intervention programme targeting sex workers in the Ghanaese capital, Accra and in Tema, a sea port located at 30 km from Accra. To assure the programme's sustainability, WAPTCA personnel worked with local health authorities to offer services to sex workers through the Ministry of Health's service delivery system. We recruited Ministry of Health nurses and trained them in health education and communication, STD management, and working



with vulnerable groups. The MOH nurses are fully seconded to the project, which motivates them with monthly incentives in addition to their government salary.

A baseline study identified two different categories of sex workers in Ghana: older, home-based workers known as 'seaters' and younger, mobile workers known as 'roamers'. Because roamers, operating in hotels, night-clubs, and on the streets, are difficult to reach, the programme initially directed its efforts to seaters. The first step was to identify and build a relationship with the leaders and gatekeepers of the sex

workers' community, including landlords, 'queen mothers' or women leaders, hotel owners, and pimps. After explaining the purpose and potential benefits of the programme to the landlords and queen mothers, they, in turn, sensitised and mobilised the sex workers. Once the seaters became involved in the intervention, they introduced project personnel to the roamers' community.

Peer education

The programme combines outreach and clinic-based services. Community health nurses visit seaters at home to educate them about health issues, teach them negotiation skills, distribute IEC materials, and to promote and sell condoms. They also encourage sex workers to attend the clinics for medical care and STD screening. To reach roamers, the project turned to peer educators. Sex workers and their leaders helped to select potential peer educators, who then received two days of training in reproductive physiology, knowledge of STDs, project interventions, and interpersonal communications. Peer educators receive about US\$50 a month for their work and continue to receive training on the job.

Clinical care

The programme also runs clinics at general government primary health care facilities where sex workers can seek treatment for general ailments as well as STDs. Drugs are sold to them at cost. The syndromic approach is used to manage STDs, and complicated cases are referred to a specialist. During their clinic visits, patients also are shown slides and counselled on STDs and encouraged to buy condoms.

To encourage sex workers to come to the clinic for active screening, outreach workers schedule visits at their convenience and offer free treatment for any medical problems discovered. Screening begins with a health talk explaining its benefits and the procedures involved. Health workers then record each woman's sexual and medical history, perform a general and gynaecological examination, and collect a variety of sam-

The West Africa Project to Combat AIDS (WAPTCA) is funded by the Canadian International Development Agency (CIDA). It is co-ordinated and managed by the Centre de Coopération Internationale en Santé et Développement (CCISD, Université Laval), which is the implementing agency. The project is located in seven countries: Senegal, Mali, Guinea, Burkina Faso, Ivory Coast, Benin and Ghana. To implement the project, CCISD is working with three partner organisations. The Centre de Recherche Clinique du Centre Universitaire de Santé de l'Estrie (CRC-CUSE, Université de Sherbrooke, Canada) has the mandate of assisting in the implementation of the Ghanaese component. The goal of the project is to minimise the transmission of HIV/AIDS and STDs in West Africa. Its purpose is to help control HIV and STDs through primary health networks that will give priority to high-risk groups and will become self-financing over time. From the onset, the Ghanaese component gave priority to the institution of a sex worker-oriented intervention programme that provides services from existing government health institutions.

ples. Women who test positive for STDs are summoned for treatment. Following this initial screening, sex workers are asked to return quarterly for follow-up screening, during which no samples are taken.

Testing, costs, and prevention

Few sex workers in Ghana want to know their HIV status, and HIV testing is not made compulsory despite its high prevalence among sex workers (75% of seaters and 25% of roamers have tested positive for HIV). Roamers are currently less affected probably because they are younger and have a shorter sex work life. Women who do want to know their HIV status are counselled beforehand as well as afterwards.

In order to recover costs and become sustainable, the project sells condoms to sex workers instead of distributing them for free. Before launching the condom distribution effort, staff asked sex workers which types of condoms they used and preferred. The project stocks two brands of well-known latex condoms, so that the sex workers have a choice, and sells them at cost.

The programme also organises IEC activities for young people and other groups, and it engages in advocacy with local police officials, explaining how they can contribute to AIDS prevention in vulnerable groups.

Evaluation

WAPTCA's many achievements in Ghana include:

- Building a strong relationship with the community of sex workers and their leadership.
- Attracting an increasing number of sex workers to the clinics for both screening and treatment: clinic attendance rose from 1,695 in 1997 to 2,561 in 1998.
- Obtaining the co-operation of the sex workers, so that they introduce new sex workers to the clinic, bring in colleagues with symptoms of AIDS, and bring their regular partners for STD services.
- Encouraging condom use among sex workers: condom sales rose from 300,000 in 1997 to 367,000 in 1998, and sex workers have begun to eject clients who refuse to use condoms.

Impressed by results in Accra, the MOH asked WAPTCA to launch the same programme in Kumasi, the second largest city in Ghana. This initiative was started in December 1998 and has been received enthusiastically by local sex workers. As of the end of April 1999, 200 sex workers in Kumasi were seen at a first active



screening visit. There are now plans to extend the intervention to other areas as well.

Lessons learned from this experience include:

- Integrating services for sex workers within existing MOH institutions, staffed by MOH personnel, maximises the likelihood of success and of sustainability.
- Charging for condoms and for treatment visits contributes to sustainability, but free drugs and treatment are an important and effective incentive for sex workers to come for screening.
- Sex workers will collaborate with an STD intervention provided that the health team takes the initiative to go where they live and work, treats them with respect and dignity, and offers affordable services and drugs.
- Peer educators are more effective in reaching roamers than health staff.
- A national policy legalising prostitution, banning police harassment, and funding health screening for sex workers is needed.
- HIV/AIDS interventions targeting sex workers are probably one of the most cost-effective measures in public health.

Difficulties encountered during the implementation of the project are:

- High mobility of roamers and their lack of social organisation.
- Adolescent roamers are highly vulnerable.

They are unable to negotiate with men for safer sex.

- Sex work is illegal in Ghana. Police harassment in sex workers' communities drives sex workers into hiding, thus discouraging them from seeking care.
- More and more sex workers are developing AIDS and therefore need more care.
- Several women would like to stop sex work. They expect the project to assist them financially to start a new business.

Nzambi Khonde and Adrienne Kols

Nzambi Khonde/Comfort Asamoah-Adu
 CIDA-AIDS Project
 PO Box 710, Achimota-Accra, Ghana
 Ph.: 233-21-241452
 Fax: 233-21-233340
 E-mail: nkxhonde@gh.com
 casamoahadu@hotmail.com

Adrienne Kols
 Consultant to the Program for Appropriate
 Technology in Health (PATH)
 11101 Falls Road
 Lutherville, Maryland 21093 USA
 Ph.: 1-410-825-2022
 Fax: 1-603-754-3139
 E-mail: ajkols@aol.com

This WAPTCA project profile has been originally prepared for the Reproductive Health Outlook website (www.rho.org). It can be found at the page 'Program examples' in the Gender and Sexual Health section. The RHO website provides regularly updated information about a wide variety of reproductive health issues, including reproductive tract infections, HIV/AIDS, cervical cancer, infertility, and family planning. It examines reproductive health services for sex workers within the context of broader gender issues. The website includes topic summaries, annotated bibliographies, links to the best resources online, and programme profiles. RHO is maintained by PATH (the Program for Appropriate Technology in Health) and is especially designed for policy makers, programme managers, and health care providers working in low resource settings.

A HOTEL-BASED STD PROGRAMME IN A VIOLENT NEIGHBOURHOOD IN JOHANNESBURG

“Please, help me cleanse my womb”

For the past year, team members of Women at Risk, a RHRU study looking at conditions of work and the lives of sex workers in Hillbrow have been conducting research in hotels, flats, clinics and other sites typically frequented by sex workers who work and reside in the Hillbrow area of Johannesburg, South Africa. As the project co-ordinator of the team, I can attest to the fact that not a focus group discussion, a day of administering questionnaires or just a meet and greet session with sex workers was completed without someone asking, “please, please, please, can you help me cleanse my womb?”

Following their requests I always asked them to describe what exactly was happening with their bodies that they thought necessitated ‘womb cleansing’. Clearly and concisely sex workers in Hillbrow described symptoms ranging from abnormal discharges, vaginal sores and excessive bleeding to difficulty conceiving. This implies several things, including the well-known reality that sex workers operating in the Hillbrow area have a high prevalence of

The site: Hillbrow, Johannesburg

Located just outside of central Johannesburg, Hillbrow is an area considered as extremely dangerous both day and night and is an ideal setting for the transmission of STDs. Residents are transient since Hillbrow serves as a cross-roads to obtain road transportation to areas throughout South Africa and it is a port of entry for immigrants coming into Johannesburg. As a result, residents of Hillbrow hail



sexually transmitted diseases (a prevalence that is significantly higher than the general population). Furthermore, they recognise that such illnesses are not only bad for business but also undermine their overall quality of life.

Consequently, there is a dire need for effective interventions targeted and designed for sex workers to treat and prevent STDs.

from all over Africa in search of employment opportunities. With a current unemployment rate of 40% in Gauteng Province where Hillbrow is located, men and women rarely secure employment within the formal sector. This densely populated residential area of flats and hotels has a growing population of women who are entering into and working in the sex industry; many of these women come

from poorer, rural areas in South Africa. Hillbrow's sex industry is highly visible throughout this area, which is notorious for its abundance of night-clubs, hotels (which function as quasi brothels), hard liquor, illicit drugs and, of course, availability of sexual services. About 80% of sex workers in Hillbrow operate from hotels, as opposed to escort agencies, massage parlours or the streets.

‘Sex worker-friendly’ services: the Esselen Street Clinic

To complement the established sex sector, there are a number of available health services and clinics in Hillbrow. Of particular significance is the Esselen Street Clinic which specialises in STD treatment, offers family planning services, provides pre and post test counselling for HIV testing and has an outreach programme which has been geared specifically to meet the needs of sex workers who operate from Hillbrow's establishments. It should be noted that the outreach service is understaffed and although fulfilling the needs of street- and hotel-based sex workers, they primarily focus on condom distribution and HIV/AIDS awareness with little emphasis on treatment of STDs.

According to the Women at Risk study, generally speaking and compared to other services offered in and around the area, Esselen Street is considered by its staff and some sex workers to be ‘sex worker-friendly’. In fact, in an average month, this clinic manages to service 8,000 clients, some of whom presumably have some contact with the sex industry on some level either as clients, employees of hotels or sex workers themselves. All the same, the actual percentage of sex workers who utilise the clinic is unknown.

Despite the tremendous amount of traffic seen in the Esselen Street Clinic, coupled with other private and public services available in the Hillbrow area including outreach activities, many of these women still are unable to negotiate condom use with their clients and personal partners. As a result, it is estimated that the HIV rate amongst sex workers in Hillbrow is above 50%, with high rates of other STDs as well: gonorrhoea 30%, chlamydia 10% and syphilis 28% (RHRU microbicide trial 1998). Obviously, these alarming rates of STDs, especially HIV, among sex workers in Hillbrow is a cause for great concern. To reduce these rates, treatment and prevention are necessary.

Despite the massive clientele at the Esselen Street Clinic, there must be other factors preventing Hillbrow-based sex workers from

accessing available STD services, suggesting yet another need for innovative and creative interventions aimed at sex workers. Also, it is in order to briefly discuss barriers impeding sex workers attendance at the Esselen Street Clinic.

Barriers impeding access to services

Although some sex workers may characterise the Esselen Street Clinic as 'sex worker-friendly', that sentiment may not be shared by all and there are barriers preventing sex workers' access to care. As in other public clinics, being a client of the Esselen Street Clinic is time consuming since this clinic operates strictly on a drop-in basis. Also, privacy and confidentiality may remain an issue for some women who may be afraid of being identified as a sex worker because of the symptoms they present. Some sex workers may have preconceived notions that they will feel intimidated and stigmatised by poor attitudes of health care providers.

Preliminary results from the Women at Risk Study suggest that a number of hotels in Hillbrow strongly discourage the women who reside and conduct business in the confines of the hotel, to venture outside. In addition, several respondents from the study stated that they did not want to leave the hotel because former clients may have been stalking or pursuing them with malintentions. Key informants also mentioned that a small segment of sex workers generated additional income by taking money from their sleeping or drunken clients.

Although anecdotal, this would surely be a reason to prevent someone from leaving the hotel where the security guards could provide some sort of protection from an angry client. In these cases, sex workers are stuck in the hotel, lacking much needed health care services, but protecting themselves from a violent encounter. Such notions along with the high

The Reproductive Health Research Unit is a joint project of the Department of Obstetrics and Gynaecology, Baragwanath Hospital and the University of the Witwatersrand, and the Greater Metropolitan Council. The Research Unit is based at the Chris Hani Baragwanath Hospital in Soweto, Johannesburg, South Africa. Its objectives are among others to develop alternative models for reproductive health service delivery; to undertake reproductive health research; to develop technical expertise; and to develop appropriate training in health for health personnel.

prevalence of STDs among sex workers led to the development of the hotel-based STD initiative.

Hotel-based STD initiative

Removing logistical impediments to accessing STD treatment was the major thrust behind Hillbrow's most recent intervention for sex workers. The Reproductive Health Research Unit (RHRU), in collaboration with the Ministry

Sex workers were delighted at the thought of being able to receive treatment without leaving the hotel

of Health, plans to provide sex workers with STD treatment in their hotels. Of course, such a bold intervention needs the buy-in of several key role players including hotel management/owners, hotel employees such as security guards, who often play the role of gatekeepers to sex workers, and the sex workers themselves.

It is important to note that in South Africa sex work is a criminal offence. Although in 1997 the debate on the decriminalisation of sex work was going on, the discussion on sex work was largely quelled by the preparations for the 1999 elections then coming up. Since sex work is illegal in South Africa, most hotel owners and managers maintain a hands off policy in their establishments, merely renting rooms to women who in turn work independently.

All the same, out of some 20 hotels in the larger Hillbrow area, about 15 have traditionally been open to the Esselen Street Outreach team distributing condoms and promoting safer sex while hotel managers provide private rooms for workshops. Likewise, hotel managers have been remarkably receptive to participating in the Women at Risk Study by encouraging the women who 'stay' in their hotels to lend their time to researchers.

Based upon the reception of the outreach team and more recently of the researchers, several hotel managers have also declared their willingness to grant the use of their premises for STD treatment and prevention activities. As with sex workers, hotel managers are sometimes aware that a hotel having a reputa-

tion of transmitting STDs can destroy business. Correspondingly, sex workers have asserted their needs for such services and were delighted at the thought of being able to receive treatment without leaving the hotel.

By obtaining a room in the hotel, the care team could visit each participating hotel and treat curable STDs. Ideally a care team would consist of a medical doctor, several nurses, a health educator and a traditional healer. In South Africa a number of belief systems are firmly grounded in causative explanations for illnesses, including STDs. When I talked to sex workers describing symptoms of STDs and expressing a need for 'womb cleansing', the first response when I queried what they believed caused the problem was fellow sex workers bewitching them. Such problems cannot be addressed by medical doctors and nurses, who lack the perspective and knowledge of a traditional healer who would add a holistic approach within the scope of the South African context.

This initiative would take a comprehensive approach, also including the other pillars of HIV/AIDS prevention, namely condom promotion and HIV education and awareness efforts. After taking care of a number of concerns about implementing a peer education programme, like identification, selection and compensation of peers etcetera, the condom promotion and education component could be partially executed by health and peer educators. In addition, a number of checks and balances must be in place even prior to launching this initiative. As we have noted before,

Ideally a care team would consist of a medical doctor, several nurses, a health educator and a traditional healer

Hillbrow is a high-crime area where security is a major consideration for endeavours. Without incorporating a security strategy, the care team could be prey for criminals lurking throughout the streets of Hillbrow along with those inside hotels who familiarise themselves with the schedule to attempt to steal medication and

materials. Safety of the care team must be a top priority. The care team must not only be well skilled in regards to STDs, but also hold a non-judgmental attitude toward sex work. These are just a few concerns being discussed at the moment.

Room for growth

Such a programme has enormous possibilities including the generation of income by providing STD services to clients and hotel employees for a nominal fee. In case peer educators are compensated for their time, funds generated from paid services could not only be used for stipends, but eventually to sustain the costs of care team members and necessary supplies. As mentioned earlier, the Ministry of Health at both the national and provincial levels have expressed interest in this intervention, showing

the feasibility of absorbing costs once donor funding is exhausted.

These very efforts could even result in sex workers coming together in the name of STD prevention and subsequently organising themselves or establishing self-help groups, which both are sustainable. It is a marvellous thought that, in part, the impetus of this intervention was fuelled by sex workers expressing their needs to have their 'wombs cleansed'.

Dorothy E. Nairne
Project Co-ordinator
Reproductive Health Research Unit (RHRU)
Baragwanath Hospital
PO Bertsham, Johannesburg 2013, South Africa
Ph.: 27-11-9331231
Fax: 27-11-9331227
E-mail: getcrunk@iafrica.com

ment of the wider community (children) in free sex" (Republika, July 16 1998).

Furthermore, the heterogeneity of sex workers is often overlooked. In the discourse on HIV/AIDS, sex workers are frequently assumed to be a homogeneous group, defined by some common characteristics. However, there is a wide variety of forms and aspects of sex work. In Surabaya, the second city of Indonesia, a distinction can be made between high class sex workers operating through agencies, middle class sex workers working in registered brothels in different parts of the city, and finally, lower class sex workers working on the streets. In addition, there are many part-time sex workers, varying from housewives and students who pick up a client occasionally in e.g. a shopping mall to women who get in contact with their potential clients during their work as low-paid hairdressers or waitresses. In addition, there are approximately 500 transsexuals and transvestites working in Surabaya, who can also be divided into lower, upper and middle class. Interventions aimed at sex workers that fail to recognise the differences between sex workers are inappropriate. Therefore, more knowledge and understanding of the specific groups is needed.

For practical reasons the majority of such studies focus on brothel-based sex workers. In research of sex work, a bias towards brothel-based sex work can be detected. A bulk of studies have focused on sex workers working in brothels, whereas only a limited amount of studies have been performed among street sex workers.

Some reflections on street sex workers and STD/HIV/AIDS services in Surabaya, Indonesia

Since the start of the AIDS epidemic, a lot of world-wide research has been addressed to sex workers and STDs/HIV/AIDS. However, most studies are designed to protect the general public from contracting HIV/AIDS and other STDs. It has been stated that HIV/AIDS discourses mainly portray sex workers as the infectors of the general population, as the vectors of

HIV/AIDS. Also in Indonesian society, this attitude is prevalent. This is illustrated by the following quote extracted from *Republika*, an Indonesian newspaper: "Sex workers are regarded as a potential infector of society: The invasion of the 'night flowers' is considered to be very worrying, especially for the spread of dirty diseases and furthermore, the involve-



Obviously, it is hard to avoid the three pitfalls mentioned above: 1) treating sex workers as the vectors of disease, 2) neglecting their heterogeneity and 3) being biased towards brothel-based sex workers.

Unintended bias

From May till October 1998 a study on female street sex work has been conducted among the sex workers working at Jalan Diponegoro, one of the main streets in Surabaya. An STD/HIV/AIDS services project run by Yayasan Hotline Surya Service (YHSS), an NGO focusing on empowerment of sex workers and on providing STD/HIV services for sex workers in Surabaya, was analysed.

Considering the first two points, YHSS succeeds to avoid the pitfalls that have been detected in the literature on sex workers. The focus of this

Special services for transgender sex workers

Transgender sex workers - operated or not operated transsexuals and transvestites - are a special group for HIV/AIDS prevention because of their sexual practices: reciprocal sodomy and fellatio with mostly heterosexual partners. Transsexuals who have undergone sex change furthermore have an increased risk of HIV infection because after male to female surgery '(neo) vaginal' sex usually is difficult, which increases the risk of condom rupture. Health workers therefore recommend water-based gels to be used in addition to condoms. Some transsexuals buy hormones or/and silicones on the black market without consulting a doctor. Sharing syringes with other transsexuals increases the risk of an HIV or hepatitis infection and generally adds to potential dangers in using these feminising products without proper medical supervision.

P.A.S.T.T., Prévention Action Santé Travail pour les Transgenders, is one of the few NGOs in Europe especially targeting transgender sex workers. The foundations were laid in 1992 but the programme took off in 1994 using a camping van equipped as a mobile drop-in centre, which toured two districts in Paris in the evening. P.A.S.T.T. became an NGO in 1997. Nowadays, besides the mobile van, a daytime drop-in centre is open to the transgender public five days a week. The most important objectives of P.A.S.T.T. are to decrease the risk of HIV infection between transgender sex workers and their sexual partners and to improve their health and living conditions. Currently, P.A.S.T.T. has eight programmes: 1) Reception and Orientation Program, 2) Prevention Program, 3) Accommodation Program, 4) Lawyer Assistance Program, 5) Social Assistance Program, 6) Prison Program, 7) Employment Assistance Program and 8) Artistic Program.

In 1993, prior to the intervention, the police estimated the number of transsexuals and transvestites in Paris to be 600. According to a research done soon after the mobile van started its tours, 52% of the transgenders interviewed take hormonal feminising treatment, 42% are transvestites and only 4% have undergone feminising surgery. In 1998 P.A.S.T.T. contacted 750 transgenders (transsexuals and transvestites) in the prostitution field.

P.A.S.T.T.

94 rue La Fayette

75010 Paris

France

Ph.:33-1-53241540

Fax:33-1-53241538

E-mail: pastt@club-internet.fr

Web page: www.intersocial.org/~pastt



NGO is on the sex workers themselves. The aim of the services is to protect the women from STDs, and not to protect the larger community from the women. Furthermore, the heterogeneity of sex workers is taken into account. The sex workers are seen as individuals, and not as a homogeneous group.

However, because of the high turnover, their mobility and the constraints of outreach work, it appears to be more difficult to develop STD services for street sex workers. This difficulty is also faced in YHSS's programme. The STD clinic is located in a brothel area and is partly run by female sex workers from the surrounding brothels. The study among the street sex workers from Jalan Diponegoro revealed that most street sex workers feel uneasy about the place of these STD services. Most sex workers experienced that the distance between the clinic in Bangun Sari and their residential areas is too big. Sari, a 30-years old sex worker, who was involved in STD/HIV/AIDS programmes of YHSS as a peer educator, stated:

"I don't want to go there. It is too far! They forget the women from Jalan Diponegoro. They say, we have to go to that clinic in Bangun Sari, but I don't want. Why did they build that clinic in that brothel area? It is to please the women from the brothels."

Boundaries and competition

These feelings are fuelled by a sense of competition between street sex workers and brothel-based sex workers. The study revealed that sex workers greatly mark the boundaries between in-group and out-group sex workers. Street sex workers stress the fact that they are different from brothel-based sex workers. Hence the street sex workers see the absence of an STD clinic especially for them as a neglectance of their needs compared to the out-group sex workers, brothel-based sex workers. Brussa and Mongard also noticed this sense of competition in the first issue of *Research for Sex Work*.¹ Projects addressing sex workers should be aware of the influence of this sense of competition.

To conclude these reflections on STD services, we can state the following. First, some flaws in theory on STD services and sex workers can be detected. Sex workers are often seen as the vectors of disease, their heterogeneity is not taken into account, and a bias towards brothel-based sex work can be noted. Considering a practical implementation of these theoretical approaches, an STD services project run by Yayasan Hotline Surya Service in Surabaya was briefly analysed. It seemed that this particular project succeeded in avoiding a 'sex-worker-as-vector' approach. Furthermore, it acknowledged the heterogeneity of the sex workers. However, even in this well organised and sensitive project, a bias towards brothel-based sex

workers could not be prevented. Given the difficulties to organise facilities for street sex workers we need innovative approaches and extra inputs in order not to create more divisions between sex workers than there are already. Currently, YHSS is planning to experiment with other approaches especially designed for street sex workers, like mobile clinic units.

Note

1 Licia Brussa & Hanka Mongard. Some problems concerning peer education. Research for Sex Work, June 1998.

Didericke Rhebergen, Didik Yudho, Esthi Susanti Hudiono and Julius R. Siyaranamual

*Didericke Rhebergen
Faculty of Medicine
Section Health Care and Culture
Vrije Universiteit Amsterdam, the Netherlands
E-mail: p.brinckman.social@med.vu.nl*

*Didik Yudho
Esthi Susanti Hudiono
Julius R. Siyaranamual
Yayasan Hotline Surya Service
Jalan Rungkut Asri Utara RL/1 F-18
Surabaya, Indonesia
E-mail: did@indo.net.id*

CREATING AN ENABLING ENVIRONMENT

Lessons learnt from the Sonagachi Project, India

At national and international meetings on HIV/AIDS, we are often asked what it is that makes the Sonagachi Project work? Our usual one-line rejoinder is, "responding to the targeted community's needs". The simplicity of our answer tends to disappoint the inquirer who expects us to present a complicated, intricate model. We try to be helpful and go on to explain that "an intervention becomes effective only if it creates an enabling environment for members of the target community to act on their own behalf and in their own interests". This produces further baffled queries. In this article, we will spell out what we mean by creating an 'enabling environment' with illustrations from our seven years' experience of implementing the Sonagachi Project.

The Sonagachi Project¹ started in 1992, primarily as an operational research project to assess the prevalence of STDs and HIV among sex workers in the red light districts in and around Sonagachi in Calcutta, India. The research involved a three-month community-based cross-sectional survey, looking into issues of social demography of the locality, mapping the practice of sexual behaviour among sex workers, their clients and partners, and estimating the prevalence of STDs and HIV among them.

Following the survey, an intervention programme was started in the area with the objective of controlling the spread of STDs and

HIV among sex workers and their partners and clients. The intervention programme started with three principal components: providing health services including STD treatment from a central clinic in the area; dissemination of IEC messages regarding prevention of STD/HIV transmission; and promotion of condom use. For implementing the outreach components, a group of sex workers from the locality were employed as peer educators.

Right from the beginning we adopted a very flexible approach so that we could adapt the programme to the changing circumstances and needs articulated by the community we worked with. In this way we could remodel it when necessary, as our perceptions were enriched by our growing experience of working with the sex workers' community.²

Guiding principles of the Sonagachi Model

Creating an enabling environment is a process in which an appropriate social milieu is prepared for implementing a targeted intervention programme. As land has to be ploughed before sowing seeds, the context within which a programme is to be implemented has to be similarly conditioned for effective intervention. In doing so in the Sonagachi Project, we followed some basic guiding principles that shaped our approach. They were:

1 From the very beginning there was no attempt to 'rescue' or 'rehabilitate' sex work-

ers. That is, they were accepted for what they were. Moreover their capabilities as human beings and workers were recognised and respected. In fact, the basic approach of the Sonagachi Project can be summed up as the three 'R's: Respect, Reliance and Recognition.

***Whatever be the objective
of the programme, it has to
build on what the target
community perceives as
their immediate needs***

That is to *respect* sex work and persons engaged in sex work, to *rely* on them to run the programme and to *recognise* their professional and human rights.

2 In the Sonagachi Project sex workers were not treated as passive 'beneficiaries' without any choice or agency but as *change agents*.

3 In the early stages of the Sonagachi Project, peer educators, well supported by the programme management, recognised that in

order to realise even the very basic programme objectives of controlling transmission of HIV and STDs, it was crucial to view sex workers in their totality. *They should be regarded as complete persons with a range of emotional and material needs and not merely in terms of their sexual behaviour.* This holds true for sex workers but also applies to other target communities marginalised either because of their social

Sex workers' needs and interests were given prime importance in designing and carrying out any activity

exclusion per se or as a result of their vulnerability to HIV. The crucial first step in implementing any intervention programme for members of any marginalised population is to understand and address the range of issues that determine the quality of their lives and to locate these issues in the more general environment they are part of.

4 In the Sonagachi Project sex workers' needs and interests were given prime importance in designing and carrying out any activity. The effectiveness and sustainability of any intervention programme depends on how far the community for whom the programme is implemented accepts it as beneficial to them. Thus, whatever the objective of the programme may be, it has to take into account and build on what the targeted community perceives as their immediate and urgent needs.

5 The Sonagachi Project strongly emphasised the genuine representation and active participation of the sex workers at every level of the programme. Sex workers were given a central status within the programme right from the beginning. The leadership tried to imbue a genuine spirit of partnership between the project team and the community of sex workers they worked with. The real and dynamic involvement of members of the target community to effectuate the changes the programme should bring as opposed to the traditional approach of treating them as passive recipients of beneficence is crucial for ensuring effectiveness and sustainability of any programme.

Principal components

The guiding principles were translated into practice through three principal activity components:

1 Working with the community

■ ■ ■ The principles

- Safe spaces, both within the project and outside, have to be created for the members of the marginal community where they can confidently articulate their needs and aspirations.
- A marginal, socially excluded and discursively invisible community has to be made visible.
- Steps have to be taken to facilitate self-actualisation of the members of the community.

■ ■ ■ What we did in the Sonagachi Project

- A relationship of trust was developed between the programme management and the sex workers' community through involving them in all aspects of planning and implementation of programme components.
- Activities that directly addressed the needs articulated by sex workers were undertaken, even if they were not necessarily planned as part of the original proposed programme. Activities like literacy training and legal literacy training for sex workers were taken up. Immunisation and other support services for sex workers' children were also undertaken, like out-of-school education, sports, painting, cultural training etc.
- Their contribution to the programme and their role as members of the labour force were highlighted at local, national and international forums, thereby making them more and more visible as legitimate citizens, to inculcate a sense of pride and worthiness in them as sex workers.
- Steps were taken against all forms of discriminatory practices against sex workers, within the sex trade (like police harassment, violence, oppression by madams etc.) and outside it (exclusion of their children from mainstream education, social stigma against sex workers etc.).
- Any activity (e.g., on-the-job training and special capacity building sessions for sex workers) undertaken by the intervention programme proved to increase the capacity of sex workers. This also increased their self-esteem and empowered them socially, economically (by helping them to form their own credit society and social marketing agency), and politically (by facilitating the sex

workers to combine and assert their rights and to help the formation of an exclusive platform of sex workers).

2 Working with the controllers of the sex trade

■ ■ ■ The principle

The hostility and the potential threat posed by controllers of the sex trade has to be neutralised through dialogue, negotiation and manoeuvring, so that the controllers do not impede the activities of the intervention programme.

■ ■ ■ What we did at the Sonagachi Project

- Prostitution was accepted as a valid profession and no attempt was made at discouraging sex workers to practice prostitution and or at rescuing or rehabilitating them. This reassured the other stakeholders in the sex trade that we outsiders were not going to disrupt their business.
- A thorough understanding of the sex trade, including the particularities of each red light area was developed to map the relation of power and conflicts in interests between different groups of stakeholders in the sex industry. Based on this understanding, specific strategies of manoeuvring were evolved and followed to win friends and neutralise enemies within the sex trade.

Steps were taken against all forms of discriminatory practices

- Special activities were targeted at different sections of the controllers of the sex trade. These included madams, pimps, *babus* or regular clients of sex workers, to orient them regarding risk of transmission of STDs and HIV and also about the larger programme objectives to encourage them to work with us rather than pose obstacles for us.

3 Advocacy to influence policy

■ ■ ■ The principle

Appropriate advocacy and lobbying needs to be carried out at the policy levels, locally and globally, so that the legitimacy of the intervention programme is widely accepted.

■ ■ ■ *What we did at the Sonagachi Project*

We carried out extensive and on-going advocacy campaigns and individual lobbying with policy makers and opinion builders at all levels to persuade them of the legitimacy of our approach and to convince them that sex workers are entitled to equal rights concerning health and life. We targeted the local opinion makers, the local (elected) representatives of people, ministers, political party officials, human rights and other democratic fronts, women's groups, trade unions, bureaucrats, intellectuals, other NGOs, and bilateral and multilateral donor agencies, international HIV-related networks and others. Consequently, the Sonagachi Project gained public recognition and wide acceptance, which in turn gave us the necessary manoeuvring room to carry out the more radical options. Moreover, this gave us enough credibility as a programme to question and challenge some of the fundamental structural constraints that keep sex workers excluded from policy considerations and social participation, thereby rendering them more vulnerable to physical and social ill-being.

Breaking through the barriers

Sex workers are vulnerable to HIV transmission not just because of their sex lives, but because they are not in a position to take decisions to protect their health and their life. They are powerless to act on such decisions, even if they would take them. Therefore, orthodox behaviour change communication designed to influence individual sexual behaviour is not adequate for enabling sex workers to adopt safe sexual practices. Sex workers are handicapped because they are socially excluded by the combination of their class, gender and sexuality, and by the moral stigmatisation caused by their profession. Developments in history frames and determines their social exclusion; they are ostracised because of their occupation and their sexuality. Structural social rules exclude them materially and their stigmatisation adds to their material deprivation. Given these conditions sex workers as a group will have to be enabled to break through the structural barriers that keep them excluded from access to resources as well as participation in society before any individual sex worker can be really empowered to protect herself.

Notes

1 The STD HIV Intervention Programme (SHIP) popularly known as the Sonagachi Project has been able to control STD and HIV transmission among sex workers and their sexual partners since its inception in 1992. The data from the latest evaluative survey done in 1999 are as follows:

VDRL positivity (1:8 and above) has changed from 25.4 in 1992 to 11.5. Genital ulcer has reduced from 6.22 in 1992 to 0.99. HIV prevalence has remained stable within 5% during 1995 to 1998, which is remarkably low for this community. Condom use has increased from 2.7 in 1992 to 80.5% in 1998.

2 In the context of the Sonagachi Project this community refers to sex workers, that is anyone who has ever practiced sex work as a profession and identifies herself/himself or is identified as a sex worker; their children; and their *babus* or regular clients.

Smarajit Jana, Nandinee Bandyopadhyay, Amitrajit Saha, Mrinal Kanti Dutta
STD HIV Intervention Programme (SHIP)
E-mail: ship@cal.vsnl.net.in

C O L O F O N

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