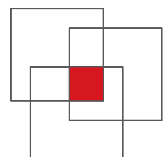




International
Labour
Organization

Leaving No One Behind: Reaching *Key Populations* through workplace action on HIV and AIDS



LEAVING NO ONE BEHIND:
REACHING *KEY POPULATIONS* THROUGH *WORKPLACE* ACTION
ON HIV AND AIDS

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Key populations

The term 'key populations' or 'key population at higher risk of HIV exposure' refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of HIV exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

Reference: UNAIDS Terminology Guidelines 2011

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Leaving No One Behind: Reaching Key Populations through workplace action
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FOREWORD

Globally a significant amount of progress has been made with the HIV and AIDS response. New HIV infections have declined and continue to decline and more people than ever, are receiving life-saving antiretroviral therapy. This progress notwithstanding, the HIV epidemic continues to grow among key populations. Scaling up HIV programmes which provide enhanced access to HIV services for key populations is critical to ending AIDS. No one should be left behind as we build momentum towards ending AIDS.

Based on the need to scale up HIV programmes targeted at key populations, this literature review was commissioned to pull together and create a compilation of evidence-based innovative approaches which used the workplace and/or the workforce as entry points to bring HIV services to key populations. This publication presents a number of innovative case studies which highlight many different ways in which the workplace and/or the workforce can add value to national HIV and AIDS responses by reaching key populations with HIV services. For example, working in partnership with saunas to reach men who have sex with men with HIV services or working in partnership with beauty salons to reach transgender populations with HIV services. This report should challenge our thinking, understanding and perception of what a HIV workplace programme is. It helps us to develop out-of-the-box solutions to some of the problems we face with regards to reaching key populations with HIV services.

This report presents a compilation of common themes which run through many of the different case studies identified. It provides policy makers and programme managers with new ideas that will add value to HIV and AIDS programmes at the national level. It will also equip national HIV workplace focal points with new ideas on ways in which the workplace and/or workforce can complement the national HIV and AIDS response. The report also contains a set of practical actions to guide programme implementation at the country level.

It is the hope of the ILO that this publication will enhance creativity, strengthen programme design and implementation and bring HIV services much closer to key populations. The likelihood of ending AIDS in the post 2015 era is closely linked with our ability to strengthen our programmes with key populations. We must all make progress on this global journey to end AIDS and when we decide to look back, there must be no one left behind.

Alice Ouedraogo

Chief

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Conditions of Work and Equality Department

WORKQUALITY

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ALFEA	Association of Licensed Foreign Recruiting Agencies
APCOM	Asia-Pacific Coalition on Male Sexual Health
BCC	Behaviour Change Communication
BMA	Bangkok Municipal Authority
BRO	Bangkok Rainbow Association
CAT	Community Based Action Teams
C-BED	Community Based Enterprise Development
CEP	Corridor Empowerment Group
CHIPS	Choosing Health in Prisons
COYOTE	Call off Your Old Tired Ethics
DFID	Department for International Development
DIC	Drop In Centres
DLPW	Department of Labour Protection and Welfare
DoL	Division of Labour
EC	Education and Communication
EDA	Exotic Dancers Alliance
EECA	Eastern European and Central Asia
EMPHASIS	Enhancing Mobile Population's Access to HIV/AIDS Services, Information and Support
EU	European Union
EW	Entertainment Worker
FHI	Family Health International
FHI360	Family Health International 360
FYR	Former Yugoslav Republic
GAMC	Gulf Cooperation Council
GFATM	Global Fund for AIDS, TB and Malaria
GMTF	Gay Men's Task Force

HASAB	HIV/AIDS and STD Alliance of Bangladesh
HIV	Human Immunodeficiency Virus
HR	Human Resource
HTT	Hoedspruit Training Trust
ILO	International Labour Organization
IOM	International Organization for Migration
ITF	International Transportation Federation
KACA	Karonga Cargo Association
KPA	Kenya Ports Authority
LGBT	Lesbian, Gay, Bisexual, and Transgender
MARP	Most At Risk Population
M&E	Monitoring and Evaluation
MOPH	Ministry of Public Health
MSM	Men who have Sex with Men
NACO	National AIDS Control Organization
NECTOI	Zimbabwe National Employment Council for the Transport Operating Industry
NGO	Non Governmental Organization
NSA	North Star Alliance
PASAN	Prisoners' HIV/AIDS Support Action Network
PATH	Programme on Appropriate Technology in Health
PEP	Post Exposure Prophylaxis
PEPP	Peer Education at the Pump Project
PLHIV	Person Living with HIV or AIDS
PNG	Papua New Guinea
PPP	<i>Programme de Prévention et de Prise en charge</i>
PWID	People Who Inject Drugs
RAP	Reception Awareness Package
RSA	Rainbow Sky Association
SACCO	Savings and Credit Cooperative
SADC	Southern African Development Community
SFH	Society for Family Health

SHAKTI	Stopping HIV/AIDS through Knowledge and Training Initiative
SIDA	Swedish International Development Agency
SNEG	<i>Syndicate National Des Enterprises Gaies</i>
SLBFE	Sri Lanka Bureau of Foreign Employment
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
SWING	Sex Workers in Group
TAMPEP	Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe Project
TB	Tuberculosis
TBCA	Thailand Business Coalition on HIV/AIDS
ToR	Terms of Reference
TWG	Technical Working Group
UAE	United Arab Emirates
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational and Scientific Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Crime and Drugs
USAID	US Agency for International Development
VCT	Voluntary Counselling and Testing
WBCG	Walvis Bay Corridor Group
YPSA	Young Power in Social Action

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EXECUTIVE SUMMARY

The world has made considerable progress towards the global vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. The annual number of new infections continues to decline and more people than ever are receiving life-saving antiretroviral therapy. Building on the success achieved, the world is poised to end AIDS in the post – 2015 era.

Despite the overall progress made, the epidemic among key populations continues to grow. Key populations such as sex workers, men who have sex with men, transgender populations and people who inject drugs continue to bear a disproportionate brunt of the HIV and AIDS epidemic. For example, according to UNAIDS, people who inject drugs have a prevalence which is 22 times higher than the general population. In low and middle income countries, men who have sex with men and female sex workers are 19 and 13.5 times more likely to have HIV, respectively, than the general population.

Sex workers, men who have sex with men, transgender populations and people who inject drugs face many barriers including criminalization. UNAIDS (2013) reports that, 60 per cent of countries report having laws, regulations or policies which present obstacles to effective HIV prevention, treatment, care and support for key populations. They also experience barriers to HIV treatment, often a result of fears that they will experience discrimination if they seek services in mainstream health settings. This is why sex workers, men who have sex with men, transgender populations and people who inject drugs are often described as *'hard to reach'* populations.

Even though the UNAIDS definition of key populations always includes the populations described above, the definition is flexible enough to accommodate populations that may be key to a country's specific epidemic. In this regard, migrant workers, truckers, ship and dockworkers, health workers, transport workers, the prisons populations, etc may all be considered key populations in different contexts.

This literature review was commissioned to contribute to the body of knowledge on reaching key populations with HIV services. It sought to demonstrate how the workplace and/or the workforce could be creatively used to increase access to HIV services for key populations. It challenges readers to have a paradigm shift in their understanding of what HIV workplace programmes are or should be. Presented in six chapters, the report highlights 42 innovative examples from 28 countries and regions in which the workplace and/or workforce was used as an entry point to reach sex workers, men who have sex with men, transgender populations, people who inject drugs, migrant workers, truckers, ship and dockworkers and the prisons populations with HIV services. Country case studies are presented from Cameroon, Cote d'Ivoire, Kenya, Lesotho, Malawi, Namibia, South Africa, Southern Africa, Zambia and Zimbabwe (*Africa*); Canada, Guyana and USA (*the Americas*); United Arab Emirates (*Arab States*); Bangladesh, Cambodia, China, India, Papua New Guinea, Sri Lanka, Thailand and Vietnam (*Asia and the Pacific*); and Albania, Austria, the European Union, Scotland and the United Kingdom (*Europe and Central Asia*)

In most case studies, formative research, mapping techniques and micro planning tools were used to gain insight into the knowledge, attitudes and behaviours of key populations prior to designing the HIV programmes. A variety of approaches involving the workplace and/or the workforce were used to the key populations with HIV services. For example workplaces such as brothels, hotels, massage parlors, bars, night clubs, restaurants, health facilities, barbers and hairdressing saloons were used to bring HIV services to sex workers and their clients. Men who have sex with men (MSM) were reached through a variety of workplaces such as gay saunas, saunas, gay pubs, clubs and bars. Some of the MSM programmes promoted codes of good practice, which established minimum standards and sought to create a safer environment for all staff and clients to minimize the number of new STI and HIV infections. People who inject drugs were reached through itinerant barbers, hotels, truck stops, karaoke bars, restaurants, sea ports, river ports and ferry crossings and transgender populations were reached through beauty salons run by transgender populations. Other key populations such as migrant workers, mobile workers, garment

industry workers, port workers, fishery workers, transport workers and prisons populations were reached with HIV services in their respective workplaces.

Across all country case studies presented, some common themes were identified and these may contribute towards a successful HIV workplace programmes targeted at key populations. They include the following:

1. Careful initial research to identify the problem, potential solutions, as well as the opportunities that exist locally to ensure that the planned interventions meet the specific needs of key populations. Evidence must lead and underpin the HIV workplace programmes
2. Follow up research was undertaken in many countries to ensure that the approaches and interventions are continuously adapting to change. It is important to acknowledge that universal key populations are sometimes very mobile and transient and hence it is important to make sure that programmes are consistently meeting their needs
3. There is currently some knowledge on *what works* with key populations out there. It is important that programmes use the available information as part of the starting evidence in the design of HIV workplace programmes which meet the needs of key populations
4. The use of various mapping techniques to identify key populations as well as 'workplaces' that may be used as entry points for accessing key populations. It is also important to identify the HIV services needed by the key populations. The identified workplace would only be useful programmatically if it serves as a channel to reach key populations with services.
5. The direct involvement of key populations in the design, implementation, monitoring and evaluation of the programmes is essential. No one understands the needs of key populations more than key populations themselves
6. The involvement and institutional commitment from the management of the identified workplaces is an important element of such

programmes. Whether the programmes focuses at the workplace or is working through the workplace, management commitment and support is crucial to the success of the programme

7. Sensitizing businesses to the fact that such interventions make sense and can contribute towards improving the business. A business case for the interventions is a useful way to secure buy-in and ownership from the business. The wins could be financial, reputational, in terms of quality of service, in terms of customer/client care, etc
8. Peer education has a significant role to play in many of these programmes. Carefully selected, well trained, well equipped and effectively monitored peer education is an essential aspect of reaching key populations through HIV workplace programmes
9. Reaching out to and involving communities through advocacy and direct partnerships is key to ensuring buy-in at the community or local level. The involvement of traditional authorities where possible is important since it enhances buy-in
10. A strong link of the interventions to high-quality, non-judgmental, accessible public health and other services so that key populations can assess a wide range of services as needed
11. A good partnership with law enforcement agencies and the police is essential especially when the programmes focus on reaching universal key populations.
12. Working with and involving the local government authority contributes to local buy-in and sustainability of the programmes.
13. The use of policies and codes of good practice in some entertainment institutions was a helpful and useful way of ensuring that all the women and men workers in those institutions adhered to some minimum standards of protection.
14. Simultaneously addressing the underlying factors that contribute to vulnerability for example focusing on economic empowerment of key populations increases their income levels and makes them less vulnerable to HIV and AIDS.

-
15. In some countries, the use of multi-media and entertainment approaches were instrumental in reducing the high levels of stigma associated with dealing with key populations. Enter-educational approaches are very useful in breaking the ice and reducing the levels of stigma and discrimination
 16. It is important to ensure that programmes include mechanisms for continuous learning, adaptation, monitoring and evaluation. The only way we can truly learn about the effectiveness of a programme is to have a system which allows the programme to track its progress.

The case studies also highlight some common challenges. Across many of these examples, monitoring and evaluation emerges as a weakness. Quite a number of the promising interventions have not been robustly monitored to track results. There is hence an absence of information with regards to the outcome level changes. In some other cases, promising interventions have been cut short or discontinued due to funding challenges.

In conclusion, this global literature review provides a broad overview of how the workplace or the workforce has and can be used to reach key populations. It serves to expand our understanding of the value HIV workplace programmes can bring to national HIV programmes. This study shows that whether the programme is in the formal or informal sector or the private or public sector, it is possible to:

- a) Implement programmes at the workplace to reach the workers (who may be key populations); and
- b) Implement programmes at the workplace to reach the clients of the workplace (who may be key populations).

Going forward, it is clear from the evidence presented that the workplace and the workforce have a key role to play in reaching the hard to reach populations with HIV services. It is hoped that this report will inspire and support policy makers and programme implementers such as representatives from the Ministries of Labour, employers' organizations, workers organi-

zations, national officials working with the National AIDS Programme, Ministry of Health Officials, HIV and AIDS Programme Managers, HIV Programme Practitioners working to reach key populations, NGOs, as well as international development agencies to strengthen national responses to HIV and facilitate the global efforts to end AIDS in the post 2015 era.

BACKGROUND

The International Labour Organizations (ILO) 2010 *Recommendation Concerning HIV/AIDS and the World of Work* (ILO, 2010a) – which provides a framework for action in the workplace context – specifically promotes interventions targeted at key populations.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2011) the term ‘key populations’ or ‘populations at higher risk of Human Immunodeficiency Virus (HIV) exposure’ refers to those most likely to be exposed to HIV or to transmit HIV. In all countries key populations include people living with HIV (PLHIV). In most national epidemic settings, key populations also include men who have sex with men (MSM), transgender persons, people who inject drugs (PWID) as well as sex workers (SW) and their clients. The definition of key populations is not uniform across countries. The Non-Governmental Organization (NGO) Good Practice Guide, which was developed by the International AIDS Alliance, for example (HIV/AIDS Alliance, n.d.) includes prisoners among the list of universal key populations. UNAIDS stresses the importance of ensuring that countries “define the specific populations that are key to their epidemic and response based on the epidemiological and social context” (ibid, p. 18). In practice this means that in many countries mobile and migrant workers, as well as the aforementioned prisoners, are also considered key populations. In other countries key populations may also include: women and girls, men and boys, children and young people, older people, female partners of male prisoners, partners of men who inject drugs, female partners of male migrants and populations in emergency situations.

Regardless of the precise definition, the engagement of key populations is critical to the HIV response. In many regions of the world, HIV epidemics are concentrated among key populations. However, key populations are typically harder to reach than the general population due to a range of structural factors. For MSM, transgender persons, PWID and SW stigma and discrimination (linked to social and cultural factors as well as criminalization)

can be a critical factor that threatens their rights and impedes their access to HIV and Acquired Immune Deficiency Syndrome (AIDS) and Tuberculosis (TB) services. Migrant and mobile populations, by nature of their mobility, type of activity, and often illegal status, can also be difficult to reach. Various kinds of mobility are also linked to heightened risk of exposure, depending on the reason for, and type of, mobility and the extent to which people are outside their social contexts and norms. Prisoners are at exceptional risk of exposure to HIV, TB, sexually transmitted infections (STI) and other diseases because of overcrowding, unsafe conditions, and association with unsafe drug use. For this reason prisoners are also considered key populations in some countries. As a result these key populations are often not adequately reached with HIV services. The definition of key populations is thus country specific. For the purpose of this report the UNAIDS definition of key populations is used.

Within the UNAIDS Division of Labour (DoL), ILO is responsible for scaling up workplace programmes and policies. Experience has shown that workplace structures, workplace policies and programmes can provide access to key populations in many countries. Important in this respect is coordinated action between different actors, and a wide interpretation of what actors and workplaces are part of the ‘world of work’.

The ILO considers the workplace as encompassing “*all sectors of economic activity, including the private and public sectors and the formal and informal economies*” (ILO, 2010a, p. 3). Within the workplace structures, workplace policies, and programmes are important entry points for providing access to key populations in many countries. National non-discriminatory HIV workplace policies provide the broad framework for enterprise or workplace level action, and can be used as a reference and leverage in mobilizing structures as well as individual workers.

The workplace can thus be a formal setting in the traditional sense, such as a formally established institution in the public or private sector. It can also be of a far less formal nature, such as a transit point for truck workers or hair-dressing salon within an informal workplace setting. In this document the

following definitions endorsed by the ILO in the Recommendation concerning HIV and AIDS and the world of work are used: i.e. ‘workplace’ refers to any place in which workers perform their activity; and ‘worker’ refers to any persons working under any form or arrangement (ILO, 2010a, p. 3).

This report is divided into a total of six chapters. Following this background chapter, Chapter 2 provides an overview of the purpose and scope of the report, while Chapter 3 outlines the methodology. The discussion of the findings of the report is divided over two chapters. Chapter 4 discusses examples of workplace-based interventions targeting the four UNAIDS key population groups: SW, MSM, PWID, and transgender persons. Chapter 5 concentrates on selected key populations, which in some settings have been identified as being at risk by nature of the work that they do or where they find themselves. This includes a discussion of workplace-based examples of HIV prevention programmes among migrant workers, truckers, ship and dockworkers, and the prison population. The final chapter – Chapter 6 – highlights a number of lessons from this review.

PURPOSE AND SCOPE

To understand the content of this paper, it is important to understand its purpose.

This study aimed to identify – from published, grey and more informal sources (newspapers etc.) and interviews with key informants, multiple examples of how workplaces, and where relevant workplace programmes, have been used to reach different categories of key populations to increase access to HIV and/or TB services. The study was therefore **not a comprehensive overview of all interventions**, but rather was conducted to provide a snap shot of initiatives – implemented by a variety of actors and in different contexts – that illustrate a range of ways in which the work settings and the workplace has and can be used to reach key populations.

A first function of this document is thus to present information on a selection of HIV programmes, from different epidemic settings, which have used the workplace or workers to increase access to services for key populations. By presenting this variety of experiences, this document hopes to contribute to a broader understanding of what ‘the workplace’ entails and more importantly, to generate ideas around creative ways to reach key populations through the workplace structure. Detailed terms of reference (ToR) outlining the assignment are included in Annex 1.

The report took a broad view on the workplace and on workplace programmes (as per the definitions highlighted in Chapter 1) and policies. It covers examples from different epidemic settings (concentrated, generalized and hyper-endemic settings), from both public and private sectors, as well as from formal and informal economies.

Gender dimensions of HIV and AIDS and TB programmes are particularly important, as gender inequalities in many settings facilitate the spread of HIV among key populations. Gender inequalities frequently restrict and control the decisions that key populations make regarding their sexual and

reproductive health choices. Gender differentials, often characterized by violence, are also embedded in social and economic contexts and determine risky behaviours. A particular effort was therefore made to include relevant gender examples.

The primary target group of this report are policy makers and programme implementers at the national level. This includes representatives from the Ministries of Labour, employers' organizations, workers organizations, national officials working with the National AIDS Programme, Ministry of Health Officials, HIV and AIDS Programme Managers, HIV Programme Practitioners working to reach key populations, NGOs, as well as international development agencies.

METHODOLOGY

The main source of information for this report was both published and grey literature. A web search was conducted of on-line reference books, books and eBooks, journals and newspaper articles, reports from the UNAIDS secretariat and co-sponsoring agencies, Government publications, project reports, evaluations and monitoring and evaluation (M&E) reports, and references and bibliographies.

The key word search was used to identify examples of workplace interventions. Key populations (MSM, SW, etc., or their equivalents) were the primary key words. These search terms were used in combination with:

- Terms related to the *nature/purpose of the intervention* (prevention, treatment, services, empowerment, economic empowerment)
- *Workplace settings* (e.g. sex establishment, hotel, hospitality industry, hairdresser, drugstores)

A full list of search terms is provided in Annex 2.

The information collected from the various sources was collated in a database and a selection – for the purpose of presentation and discussion in this report – was made of the most relevant and comprehensive examples for each of the main key population groups.

To be included in the review, an example of a workplace intervention had at a minimum to:

- Identify what the workplace setting was
- Provide information/background on the rationale for using this setting
- Explain how the workplace was used to reach the key population group

Examples that provided information on what changed as a result of the intervention and on factors that made the workplace setting a successful/rel-

evant entry point for reaching particular key population groups were selected with priority – although this information was not always available and is therefore not systematically discussed for all the examples.

Cases that were clearly innovative and provided potentially new insights and approaches were also given priority in the selection process, as were those that provided particular attention to the gender aspects referred to above. The principal researcher (external to ILO) selected the examples in consultation with ILO.

Following the search the draft report was circulated among a group of ILO staff and external informants. Selected key informant interviews were used to prioritize among the examples that were selected and reduce these to a manageable number, to identify additional examples of relevance to the key themes, and to refine the structure of the document, which are reflected in the chapters that follow.

The findings of this study should be seen in the light of the following limitations.

- This report does not constitute a review of all the available literature, and therefore should not be seen as a comprehensive review or even as a representative sample of initiatives.
- The examples discussed in this report did not focus only on case studies with solid evidence of changes as a result of the intervention (although as noted where possible these were included). The discussion of the case studies therefore does not always provide evidence of results and outcomes in all areas.
- The report reflects the relevant gender findings and factors in the discussion of case studies, where information on these aspects existed. However, this assessment is limited by the fact that although policy and planning documentation exists which reflects the importance of a gender dimension in workplace settings (such as is the case in the aforementioned ILO Recommendation on HIV/AIDS and the World of Work (ILO, 2010a), relatively few specific gender examples were found. This is an area that should merit attention in the future.

EXAMPLES OF WORKPLACE INTERVENTIONS

For the purpose of organizing the report, the examples of workplace interventions are divided by key population groups. This next section of the report provides an overview of a selection of interventions related to the four ‘universal’ key populations – sex workers, MSM, PWID, and transgender persons. An overview of interventions with details on the location, objectives, years of implementation, participating partners, and whether the intervention was evaluated or not is provided as a table in Annex 3.

Sex workers are the only category discussed here that are labour-based. The other key population categories are either based on a sexual identity (i.e. MSM and transgender persons) or on behaviours (i.e. PWID). This implies, as highlighted in the previous chapter that workplace based interventions are less likely to specifically target these groups, although risk behaviours may be mentioned as part of intervention efforts.

In some cases the reported workplace interventions targeted more than one key population group – often because of the link between different risk factors and/or behaviours – and could therefore not be neatly categorized under just one heading. Where multiple target groups were part of the intervention this is highlighted in the examples, even if for convenience they are classified under a particular target group.

The next section provides a selection of examples where workplace involvement was either the basis for, or a component of, an HIV/TB prevention effort for sex workers. These examples cover a variety of geographical and epidemic settings and have in common that they included ‘unconventional’ business venues as well as innovative strategies, which use locations where sex work takes place as an entry point. Sex worker categories include women, men, and transgender persons who are involved in sex work.

1.1 SEX WORKERS

Sex work is often associated with higher risk of sexually transmitted infections and violence. The illegality in some countries and stigma of sex work puts women, men and transgender persons who engage in sex work at a high risk of becoming HIV positive. The criminalization of sex work in many countries makes the environment more complex and often contributes to reducing the opportunities to access sex workers with HIV services as they are driven into hiding.

AFRICA

Case Study 1: Cameroon – Fighting HIV among Male and Transgender Sex Workers in Cameroon (Source 59)

Context/where: Cameroon faces a generalized epidemic, with an estimated adult HIV prevalence rate of 4.6 per cent in 2011. Sex work is considered illegal in Cameroon. The legal environment – together with cultural and societal beliefs makes sex workers vulnerable to abuse and violence from clients, pimps, and law enforcement. Male sex workers are doubly marginalized as the law forbids homosexual practice. The risk of danger and abuse, which is high among sex workers, is even greater among transgender sex workers who are often forced into hiding and become even more inaccessible to prevention services.

Workplace link: Acodev uses sex work venues and contacts with owners as an entry points to contact sex workers and their clients, and to garner community support for their efforts. However, the criminalisation of activities has created a very difficult environment to operate. This includes brothels, bars, nightclubs, restaurants, and massage parlours

Aims/activities: In Cameroon Aids Acodev was born out of a demand for HIV services tailored to the needs of male and transgender sex workers. Since 2009, Aids Acodev Cameroon has run an ‘education night patrol’ that visits brothels, bars, nightclubs, restaurants, and massage parlours. Aids Acodev is also active on online dating sites, and conducts talks on HIV

prevention and care in the homes of sex workers. More recently the initiative has targeted Cameroon's religious community, which traditionally has been very closed.

Results/outcomes: The programme provides critical information on condoms, STDs, and other aspects of HIV and AIDS to male and female sex workers. There are no documented outcomes of the intervention.

Lessons: A major objective of Aids Acodev Cameroon is to build coalitions between different sex worker organizations, and to engage broader actors in the community (such as gatekeepers in sex establishments). However the organization has found this to be challenging. It has found that most organizations only work with female sex workers and not with transgender people and that they often adopt moralistic approaches, which make it difficult to engage with the transgender community.

Case Study 2: Cote d'Ivoire – Sex worker education at or near worksites using a peer education approach (Source 60)

Context/where: Côte d'Ivoire, along with several other African countries, saw an early and strong increase in the AIDS epidemic in the late 1980s, with AIDS becoming the leading cause of death of adult males by 1989. In 1990, when HIV prevalence among female sex workers in Abidjan was 69 per cent, a prevention campaign directed to female sex workers – *Programme de Prévention et de Prise en charge (PPP) des MST/SIDA chez les femmes libres et leurs Partenaires* – was set up by the Institute of Public Health, as part of the National AIDS programme.

Workplace link: The workplace link in this example was the inclusion of sex worker workplaces in a comprehensive approach that linked work settings to provision of services and to the community. The worksite of sex workers is a workplace.

Aims/activities: The PPP initially targeted sex work locations in three districts and expanded over the next three years to all ten districts of Abidjan. The intervention mobilized community leaders, provided health education

and peer education by sex workers and former sex workers at or near work-sites, and created a clinic exclusively for sex workers and their stable sex partners.

Results/outcomes: The programme had promising results. Reported condom use with last client increased from 63 per cent in 1991 to 91 per cent in 1997, and the proportion of women who visited any clinic increased from 9 per cent in 1993 to 37 per cent in 1997. Those attending the clinic were more likely to report having used a condom, and those attending for the first time reported dramatic increases in consistent condom use: from 20 per cent in 1992 to 78 per cent in 1998. There were also very clear impacts on the prevalence of STI and HIV between 1992 and 1998 among sex workers in the programme: gonorrhoea prevalence decreased from 33 per cent to 11 per cent and, astonishingly, HIV prevalence decreased from 89 per cent to 32 per cent.

Lessons: Key lessons from this experience include the importance of:

- Combining prevention activities with access to services
- Using monitoring data to ensure that activities are tailored to the recipient population and to their places of work. Results from monitoring showed that the population of female sex workers was constantly changing e.g. the initial population was mainly women from Ghana, but later included far more Ivorian and Nigerian women, and that their locations of work differed.

Case Study 3: Malawi – ILO, Backing young sex worker as entrepreneurs to reduce HIV risk (Source M23)

Context/where: Malawi has a generalized AIDS epidemic with an adult prevalence of 10 per cent in 2011 (down from 14 per cent in 2003). AIDS is the leading cause of death amongst adults in Malawi, and the main cause of the country's low life expectancy. The scale of the epidemic, the lack of data on high-risk groups, and legalization that criminalizes them has worked against the recent impressive government and donor efforts to contain the disease.

With support from ILO the project, implemented from 2010, focuses on providing entrepreneurial training in collaboration with the Karonga Cargo Association (KACA). KACA group represents over 4000 mostly young bicycle taxi riders. These bicycle riders work on the M1 highway border area between northern Malawi and Tanzania. They are key to the transportation of informal workers in the area.

Workplace link: The workplace in this case is the road along which the bicycle riders operate. The existence of KACA as an association provided an entry point for reaching the bicycle riders with entrepreneurship activities and prevention messages. KACA extended its scope by deliberately deciding to include sex worker networks in its organization, and many have become members. This has been instrumental in ensuring relevance of the project, and in increasing the membership of the organization. Taxi riders actively encourage their customers to join and full membership has now reached 7000.

Aims/activities: The work of the bicycle riders puts them at risk because many customers are sex workers or traders who are so poor they often want to pay with sex rather than cash. Female and male bicycle riders are often subject to violence.

With funding from Swedish International Development Cooperation Agency (SIDA), ILO training tools have been used to enhance the business development skills of KACA's members and to strengthen the organizational structure and procedures of KACA.

Results/outcomes: The project has so far trained 54 master trainers who have in turn taught business development skills to 500 others. Anecdotal evidence highlights how KACA members have been able to save money from sex work and start small businesses to supplement their income and reduce their dependency on sex work as a sole source of income.

Lessons: This initiative highlights a number of lessons of relevance to workplace efforts, including the importance of:

- Tackling the underlying factors that lead to risk taking behaviour, in this case by focusing on the economic empowerment of men and women to reduce their vulnerability
- Actively including sex workers in the design and implementation of the approach, to enhance the relevance of the activities, as well as the scope

AMERICAS

Case Study 4: Guyana (Georgetown) – Barbers and hairdressers as information hubs for young people and sex workers (Sources 14a and 14 b)

Context/where: Guyana faces a generalized epidemic. It has one of the highest HIV prevalence rates in the region: 1.6 per cent for pregnant women, and over 25 per cent among sex workers. AIDS is the leading cause of death among the 20-49 age group.

Training for salon workers included ...

- Safe working practices including ensuring the sterility of hair cutting machines, razors, needles for stitching and weaving, manicure and pedicure implements, and tattooing and body piercing equipment.
- Dispensing male and female condoms
- On-site counselling and testing
- Project monitoring

Source: 14 a

Workplace link: the barbers and hairdressing salons are the workplaces through which young people and sex workers are reached with HIV information and services.

Aims/activities: Barbershops and beauty salons were used in a United Nations Population Fund (UNFPA) supported HIV prevention programme, which initiated in 2008, and which targeted sex workers and young people. Shops and salons were chosen based on a mapping of their location in malls, parks, popular attractions, or low-income communities. Owners who opened their doors to the project got added marketing exposure for their small businesses and were provided with incentives. Once the locations were identified, two employees from each shop were sent for training on basic HIV and AIDS education and prevention means. In addition to training participants about sexual and reproductive health and gender issues, the project also used a life skills approach, which focused on issues such as communication, healthy relationships, and leadership.

Results/outcomes: The initiative distributed over 7000 male and 400 female condoms per month. Participants reported that the project resulted in gains in their personal life in relationships with friends, family, and clients. Businesses reported an increase in clientele, partly because of the reputation of the participating salons as being sanitized/safe.

Lessons learnt:

- Adequate training of hairdressers and barbers is critical to the quality of the response
- Good links to non-discriminatory accessible services and service providers need to be established so clients can access these

Case Study 5: USA, San Francisco – Health Project for Female SW at Massage Parlours (Source 75 and 203)

Context/where: In the context of a concentrated epidemic in the USA, women of colour are one of the highest risk groups for new HIV infections (Karon, Fleming, Steketee, and De Cock, 2001). Within this group women working in the sex trade are particularly vulnerable¹.

¹ The 2006 USA Morbidity and Mortality Weekly Report (MMWR) showed that among all racial groups in the U.S.A., Asians and Pacific Islanders (APIs) had the only statistically significant increases in HIV/AIDS diagnosis rates over the four year preceding period.

The Health Project for Asian Women (HPAW) targeted Asian female sex workers at 26 massage parlours in San Francisco, California and was implemented over a four-year period between 2001 and 2004.

Workplace link: The HPAW used the massage parlour (a workplace place with employees) as an entry point to reach both owners, and masseuses, with the objective of promoting health and preventing HIV.

Aims: Two interventions were designed and rolled out, namely:

- A massage Parlour Owner Education Programme.
- A Health Educator Masseuse Counselling Programme.

HPAW staff escorted masseuses to health clinics, handed out safer sex kits and provided translation, referrals and advocacy services. Masseuses participated in a 3-hour counselling session and massage parlour owners received an education session.

Results/outcomes: Masseuses' levels of AIDS knowledge were significantly increased after the intervention as measured through a comparison between pre- and post-test knowledge.

Lessons: Lessons from the project include that:

- Additional time was needed to establish a good relationship with Asian masseuses and managers/owners given the nature of this highly stigmatized and hard-to-reach population. Flexible planning and realistic time frames, as well as specific strategies for reaching these populations are therefore critical.
- Providing services specific to their needs (e.g., escort services for masseuses and information about law and regulations for owners/managers) increased adherence.
- Recruiting culturally sensitive health educators and providing skills training and support to take into account cultural issues increases uptake of services and contributes to the success of these interventions (source 203).

Case Study 6: San Francisco, USA – The Saint James Infirmary and the Occupational Health and Safety Board: Health services run by sex workers (Source M3 and M21)

Context/where: The St. James Infirmary in San Francisco, USA, is a unique example of a workplace that was established as a result of sex workers self-organizing to address the HIV and health needs, and that is used to providing free, confidential health services. The services target sex workers, as well as persons working as nude models, adult actors, and exotic dancers.

Workplace link: The Saint James Infirmary was established as a peer-based clinic, founded and run mostly by people who have worked in the sex industry themselves, and who are thus very familiar with the day-to-day realities of sex work. The workplace of (former) sex workers thus became an entry point for reaching out to other sex workers with prevention and treatment efforts of relevance.

Aims/activities: The St. James Infirmary's philosophy has two aspects that make it unique from other programmes. The Infirmary is based on the premise that one of the biggest obstacles for sex workers in obtaining health care, regardless of their financial situation, is establishing a trusting relationship with their health care provider.

A coalition between the sex worker rights group Call Off Your Old Tired Ethics (COYOTE), the Exotic Dancers Alliance (EDA), and the San Francisco Department of Health founded the clinic in 1992. This partnership has resulted in access to office space, to the City Clinic, and has ensured enhanced legitimacy. The clinic provides services, which include STD and HIV testing, legal referrals, gynaecological and urological care, immunizations, clothing and food donations, acupuncture, massage therapy, and access to a smoking cessation programme².

Research has been used to identify services that can be of particular use for sex workers. For example, the tobacco cessation programme was established after research showed that almost half the sex workers smoked. The clinic

² Instances of sex workers organizing to provide health services are scarce. Other USA based examples include the Adult Industry Medical Health Care Foundation, in Sherman Oaks, California, which was founded by adult movie star Sharon Mitchell in 1998 to address rising HIV infection in the adult movie industry. Danzine, an advocacy group for sex workers in Portland, Oregon, also maintains a thrift store and combines this with a needle exchange programme. But the variety of services and clientele at the St. James Infirmary is unique.

itself has also been used understand what the benefits are of peer provided health services for the health care situation of this target group. This research has shown, for example, that sex workers who access peer provided services have lower rates of HIV than those who use regular medical services.

Results/outcomes: The clinic has extensively provided about 2000 medical services to sex workers per year, conducted between 1500 and 2000 street and venue based outreach contacts, and provided peer education workshops to over 500 sex worker attendees. While the clinic has been used for medical studies, a comprehensive evaluation of the approach does not appear to have been done.

Lessons learned: This example highlights the importance of:

- A deep understanding of the nature of sex work
- The relevance of using (former) sex workers and a peer approach to overcome issues of stigma, distrust and discrimination, which are often faced in reaching out with medical services
- Using research to identify what activities/services might be of greatest relevance to the target group

ASIA AND THE PACIFIC

Case Study 7: Cambodia – the SMARTgirl initiative for Entertainment Workers (Source 74)

Context/where: Epidemiological data over the past twenty years illustrate how Cambodia has transited from a generalized to a concentrated epidemic status (adult HIV prevalence of 3 per cent in 1997 to 0.7 per cent in 2012) with over 90 per cent of PLHIV in need of treatment receiving services. In the earlier period transmission was driven by the mobile poor working population, as well as by prevailing gender norms and inequalities³ and an extensive sex industry. More recently the epidemic is concentrated among Most at Risk Population (MARP) which in the case of Cambodia are: men who are clients of sex workers as well as their spouses; people who inject drugs; male, female, and transgender sex workers, and MSM.

³ A USAID report refers in this context to the Khmer saying, “Men are gold, women are cloth,” to illustrate the lower value which society places on women. The report quotes Amnesty International in saying that “it is widely believed that women can be worn, torn, and stained; men cannot”.

The SMARTgirl initiative was established in Cambodia in 2008 to specifically target Entertainment Workers (EW) as prevalence of HIV was as high as 14 per cent among some groups of EW⁴. It is part of a broader programme – PRASIT – that also targets MSM and clients of EWs, and is led by FHI-360, with funding from USAID. SMARTgirl partners with the private sector (such as Coca-Cola and Smart Mobile)

The initiative was established to respond to findings from research that indicated an urgent need to update and reposition HIV messages. After two decades of prevention efforts were no longer bearing fruits and a anti-trafficking law that was introduced in 2008 had resulted in the shutting down of many brothels with sex workers moving into less easily accessible entertainment areas.

Workplace link: The workplace is used as an avenue for reaching the EW. The strategy includes training volunteer EWs to deliver monthly information sessions on family planning, reproductive health, HIV testing and counselling, and general health and beauty. The sessions take place in entertainment venues where owners have agreed to provide a space. SMARTgirl also supports drop-in centres where monthly group sessions using the same communication tools are held with club members, and where members can get health check-ups, health information, free hairdressing services, and makeup instructions.

What has worked well ...

- Strong monitoring
- Providing both on site (i.e. at the entertainment center) and off site support to EW
- The referral slip strategy which proved to be a useful tracking method for uptake of services

Source: 74.

⁴ A recent study by the National Aids Authority in India on the Cost and Cost-Effectiveness of HIV Prevention and Mitigation Efforts find that targeting EW is the 'best-buy' option among a series of strategies that target high-risk populations (Source: 201).

Aims/activities: The objectives of the SMARTgirl approach were to:

- Implement targeted and branded behaviour change approaches – through peer and outreach education, SMARTgirl clubs, special events, social mobilization, and advocacy – that emphasize risk reduction and promote safer sexual practices.
- Promote and increase access to health information, products, and services among EWs.
- Build the capacity of implementing agencies to plan, implement, manage, and monitor the SMARTgirl programme.
- Build a supportive environment for EW sexual health by mobilizing key stakeholders, including workplace-based groups such as entertainment establishment owners, police, health care providers, and others.

The SMART girl approach included:

- A unique logo and positive role model that promotes an empowered brand identity which the target audience will want to emulate.
- A standard package of STI and HIV prevention interventions, including peer outreach and education, condom provision and promotion, and systematic referral for STI and HIV and other sexual health services.
- A system of tokens with different colours and shapes to distinguish individuals who have been contacted for the first time from people who have had multiple contacts over quarterly periods. This includes referral slips given to individuals and used to track service uptake; when people seek services and produce the referral slip, they may be eligible for lotteries and prizes for the programme.
- Clinical services targeting MARPs.

Results/outcomes: The SMARTgirl programme was implemented in nine provinces in Cambodia and involved 120 outreach workers and peer educators, reaching 34 per cent of all entertainment workers in Cambodia in 2009. A number of output level indicators show that in terms of impact, the initiatives produced:

-
- A dramatic increase in the number of health service referrals.
 - A high increase in the uptake of health referrals by EW.
 - Increased uptake of social marketing of condoms (source: 200).

Case Study 8: Kolkata (India) – Involving brothel owners in the empowerment of sex workers: The Sonagachi Project (Source 34, 71, and 74)

Context/where: India is the second most populated country in the world, after China. HIV prevalence in India is relatively low at 0.3 per cent, and has seen a drop in recent years, but in absolute terms the number of people living with is substantial, making it the third largest HIV positive population after South Africa and Nigeria. Extensive labour migration, low literacy levels, gender disparity as well as PWID and sex work, especially in northeast India and urban areas, have contributed to the spread of HIV.

The Sonagachi Project in the Indian city of Kolkata is one of the often-quoted best practice interventions. The intervention was initiated in 1992 by the All India Institute of Hygiene and Public Health, and has been led by a sex worker-led organization, the Durbar Mahila Samanwaya Committee (or ‘Durbar’) since 1999.

Workplace link: The workplace link is that brothels, brothel owners and other brothel staff are used as an entry point to reach sex workers and their clients. The initiative was thus about working through the brothels and owners to reach SWs.

Aims/activities: By working through brothel owners HIV risk for sex workers steadily reduced through a combination of strategies:

- Brothels served as targeted sites for the projects’ HIV intervention efforts.
- Encouraging madams to take an active role in efforts and to promote healthy regimes.
- Structuring the economic transactions and sexual performances related to sex work, thus standardizing sex-related behaviour.
- Promoting community empowerment among brothel residents.

Results/outcomes: The Sonagachi project benefited more than 65,000 sex workers. The intervention has been successful in that it resulted in a reduction in the number of ‘madams’ and pimps. It has also resulted in many sex workers choosing to move into hotels or sex worker-managed cooperatives. These establishments provide a greater degree of security/safety and independence to sex workers.

The project has evolved over time to include the management, by Sonagachi sex workers, of a co-operative finance scheme. The scheme provides skills training, conducts sustained social marketing of condoms, and makes concerted efforts to reduce the trafficking of girls and women.

In terms of outcomes, the achievements of the Sonagachi programme are well summarized in a recent publication which states that the programme *“achieved markedly increased rates of consistent condom use with clients, and the prevalence of syphilis has been dramatically reduced (Population Council 2002). Trials of the Sonagachi model demonstrated significant condom use increases among female sex workers, compared to a control community receiving standard care of Sexually Transmitted Disease (STD) clinic, condom promotion, and peer education (Basu et al. 2004). The Sonagachi model also significantly: 1) improved HIV and STI risk reduction knowledge; 2) instilled a hopeful future orientation, reflected in a desire for more education or training; 3) improved skills in sexual and workplace negotiations, reflected in increased refusal and condom decision making; 4) built social support by increasing social interactions outside work, social function participation, and helping other sex workers; and 5) addressed environmental barriers of economic vulnerabilities by increasing savings and alternative income. It did not, however, increase members’ ability to take leave or to shift location, nor did it reduce loan-taking”*(from M7, p. 38).

Lessons learnt: Various studies have looked at the lessons learned from Sonagachi. This includes the importance of:

- Working closely with brothel owners.
- Conceiving and implementing strategies for neutralizing brothel owners’ power base and connections in those cases where they show resistance, and in this manner putting pressure onto owners to participate.

- Focusing on behaviour change communication and rights and negotiation skills training in close collaboration with brothel owners.
- Ensuring access to high quality, non-judgmental support from public health services are essential so that sex workers can gain the confidence to utilize such services.
- Working with local government, advocating for sex workers' needs and rights and bringing community issues to the attention of local politicians.

Case Study 9: India – Avahan: SW, MSM and PWID – Example of a combination prevention programme (Source 60, 60b and M20)

Context/where: The Avahan project in India⁵ has worked on interventions with high-risk populations (SW, MSM and PWID) under India's National AIDS Control Organisation (NACO) with funding from the Bill and Melinda Gates Foundation since 2004, in six high prevalence states, including the state of Maharashtra, for which evaluation data is available.

Workplace link: The approach allowed for the programme to establish an approach that specifically used workplace settings to reach out to sex workers. Other critical aspects of the programme were the use of:

- Peer-mediated outreach to address difficulties reported by sex workers, MSM and PWID and promote condom use and regular STI screening.
- Advocacy with police and local government officials through various workplace initiatives, and the establishment of 24-hour crisis-response teams.
- Dedicated health services for sex workers and their regular partners.
- Drop-in centres that also provide welcoming safe spaces, community kitchens, and literacy classes.
- Mobilization and capacity building of community-based organizations implementing prevention programmes.

Aims/activities: The purpose of the programme was to provide focused HIV prevention interventions and services for these three groups. The approach included a research driven component, which conducted participatory mapping and enumeration exercises to estimate the number and typologies of the

⁵ Avahan means "a call to action" in Sanskrit.

target groups and their workplaces, in each geographical area. This included for SW the identification of street-based, brothel- and lodge-based sex work.

Results/outcomes: In terms of results, eighty-five per cent of sex workers (Ramesh et al., 2010) reported being in contact with a peer educator and had visited a project STI clinic by follow-up. Reported condom use at last sex also increased significantly for repeat clients, from 66.1 per cent to 84.1 per cent. Significant declines were observed in prevalence of syphilis (15.8 to 10.8 per cent), chlamydia (8 to 6.2 per cent) and gonorrhoea (7.4 to 3.9 per cent) between two rounds of testing in 2006 and 2009 respectively, although HIV prevalence increased in some areas (likely because of the mobile nature of sex work and the number forced/violent sex acts).

Lessons: After the Avahan Project scaled up services, it produced a guide that supports the implementation of its approach for hard-to-reach populations elsewhere. The premise is that:

- Highly trained individuals in a high-risk group can reach their peers effectively, *and*
- Mapping and micro-planning tools can be used to plan and track service delivery at individual levels and to position individuals as well as small businesses as leaders and managers of service provision.

Case Study 10: Thailand – ILO and the Empower Foundation: Sex Workers Learn Business Skills (Source M1)

Context/where: Thailand has effectively used public policy to prevent the transmission of HIV on a national scale. Early on in the epidemic a countrywide programme to control HIV was put in place. This reduced visits to commercial sex workers by half, increased condom usage, achieved substantial reductions in new HIV infections, and decreased the prevalence of STIs. Today the HIV prevalence is concentrated among people who inject drugs (21.9 per cent in 2010) and female sex workers (1.8 per cent in 2011) and MSM (20 per cent). In Thailand, as in many other contexts, sex workers often have no additional source of income and may have no choice but to accept conditions in their sex work that put them at additional risk of

violence and that may be detrimental to their health. Sex workers are also more vulnerable to HIV – 3 per cent of brothel-based sex workers were living with HIV in 2009 in Thailand and this statistic was over 20 per cent in Bangkok and Chiang Hai.

ILO, in collaboration with Empower Foundation (a sex worker advocacy group), has since 2010 worked towards reducing this economic vulnerability by putting in place a programme that creates access to additional forms of income generation for sex workers in Thailand.

Workplace link: The Community-based Enterprise Development (C-BED) programme uses training in new work opportunities and support to the establishment of small businesses for sex workers as and entry points for addressing HIV and AIDS.

Aims/activities: The C-BED training builds the capacity of entrepreneurs (current and future). The basis of this approach is enhancing the connection between positive labour conditions and positive health outcomes for sex workers which research shows is especially powerful if it uses a community empowerment model, drawing on the community and enhancing community collaboration for example through the establishment of cooperatives.

C-BED conducts training sessions – which typically last for three days – through the use of self-facilitated business skills modules, which rely on activity-based, participant-run, social learning principles. The modules focus on key entrepreneurial topics including: marketing, bookkeeping, productivity, personnel management, costing and quality control. The approach to explaining these principles includes the use of drama, drawing and discussions. The three-day training concludes with participants drawing up a business plan. The modules are designed to be facilitated by literate but uninstructed community members.

Results/outcomes: This initiative has not yet been evaluated and the available resources do not make it possible to highlight lessons learnt. The programme has collected anecdotal evidence of sex workers setting up their own

supplementary income generating activity – such as baking, food delivery, shoe making, and selling of traditional clothes. ILO is currently expanding the programme to Cambodia, Sri Lanka, Thailand, and Vietnam.

Lessons: Lessons learnt from this initiative include the value of:

- Using research to identify specific needs and opportunities, which highlighted the strength of a community based approach
- Recognising and sharing community knowledge and using community members as instructors
- Developing strategies for entrepreneurship that use activity based, participant-run, social learning principles
- Providing access to other work opportunities to reduce the risks associated with sex work

**Case Study 11: Thailand – Service Workers in Group (SWING):
Providing Services to Male and Transgender Sex Workers and expanding
these to include all sex workers (Source M4)**

Context/where: In the course of her work with female sex workers in Bangkok, Thailand, in the 1990s, Ms. Surang Janyam, noticed an increasing number of male and transgender sex workers needing HIV services. To better understand the issues, Ms. Janyam – with a team of like-minded people (mainly former sex workers) – began mapping male sex work hot spots and interviewing male and transgender sex workers to assess their needs. This work was conducted with technical assistance from Family Health International 360 (FHI360).

Workplace link: From a workplace perspective SWING has worked very closely with entertainment venue partners, and has used entertainment venues as access points to reach sex workers with prevention efforts and services. Swing works with a lot of bars and bar owners particularly. The entertainment establishments are the workplaces for sex workers.

Aims/activities: The study highlighted a need for services to diagnose and treat STIs, including HIV. Additionally, non-formal education and English

classes were taught. These services were put in place after initial challenges of stigma and discrimination and limited funding for this particular target group. An important partner for the initiative have been the local communities who have been successfully mobilized to provide the critical donations which made it possible for the local organization – Service Workers in Group (SWING) to set up an office and to initiate and sustain its activities.

Results/outcomes: As the scope of SWINGs work has extended – covering three cities in Thailand – and its organizational capacity improved, the donations from other donors have also increased. Over the years SWING has progressively expanded its services to all sex workers. SWING runs drop-in centres where the medical and other services are provided – among others Voluntary Counselling and Testing (VCT), pap smears, family planning counselling, distribution of condoms and other contraceptive methods, and HIV testing), counselling, skills development as well as club activities such as make-up, sports and cooking. The clinics also operate outreach components whereby SWING volunteers go out into the streets to encourage sex workers to visit the centre. The drop in-centre are also linked its counselling services to further follow-up STIs services.

SWING has expanded from 8 staff in 2004 to 39 full time staff in 2011, 150 volunteers and over 200 peer educators, and operates in Bangkok, Pattaya, and the island of Koh Samai through more than a dozen different projects. In this manner SWING provides services to several thousand sex workers on a yearly basis. As noted in a recent report (Source: M4) *“the lack of rigorous data collection and analysis of interventions are a limitation of this programme. This is not unique to SWING ... there is a greater need for investment of financial and technical resources to ensure high-quality monitoring and evaluation”* (p.66).

Lessons: SWING used research to map the different entertainment venues and establishments where sexual services are available. This was the basis for developing a strategy for approaching the owners of these establishments and for effectively communicating with the sex workers. The mapping highlighted differences in accessibility of locations, often based on whether these were

legal (e.g. karaoke bars) or illegal venues (often involving illegal immigrants), and the need for different approaches, for example to overcome language barriers and to address the mobility that is often associated with illegal work.

Critical lessons from the collaboration with the entertainment venue partners can thus be summarized to include the importance of:

- Engagement with the business community needs to include generating an understanding that healthy workers means better business
- Getting buy-in from the community at large has been critical in also earning the trust of venue owners comes
- Cultivating friendship with venue owners requires being engaged, listening, providing feedback, and building up a reputation across the sector. This was achieved by meeting them often to jointly discuss solutions to problems that concerned them, such as business, HIV prevention and raids.

EUROPE AND CENTRAL ASIA

Case Study 12: Austria, Germany, Italy and the Netherlands – Using peer educators to reach out to female and transgender sex workers (Source M7, M8)

Context/where: In 2012, UNAIDS and WHO estimated that 2.2 million people were living with HIV in the WHO European Region, including 1.3 million in Eastern Europe and Central Asia (EECA) representing and estimated adult prevalence of 0.7 per cent in EECA and 0.2 per cent in western and central Europe.

Workplace link: Prostitution venues (ie. workplaces) were used as entry points to reach sex workers with HIV services. As part of these activities, interviews and discussions are conducted with owners of prostitution venues in order to:

- Determine the possibility of the target population to employ safe sex practices
- Influence behavioural patterns of the target groups, including owners of prostitution venues and other key persons within the milieu, such as: forces of public order, and, at times, the clients

Aims/activities: In Austria, Germany, Italy and the Netherlands, the Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe Project (TAMPEP), implemented since the early 2000's, has sought to work with female and transgender sex workers who have migrated from Africa, Eastern Europe, Latin America and South-east Asia. TAMPEP makes regular use of data collection and mapping as a standard technique to identify where sex work is taking place and to monitor and report on changing trends within the sex industry, the sex venues, and the living and working conditions of sex workers

The TAMPEP approach includes offering seminars and workshops aimed at empowering sex workers and creating an environment that supports safer sex behaviour. The approach includes the use of cultural mediators and peer educators. The latter are continuously trained because of the migratory nature of their activity.

TAMPEP spends a relatively long period (two to three months on the selection, training and following-up of the peer educators. Peer educators receive a small fee while undergoing training, and they participate in course design. The peer educators receive a certificate on completion of the course. The role of the cultural mediators is to conduct follow-up by supporting the peer educators, providing additional information and materials, and facilitating contacts with public health personnel.

Results/outcomes: TAMPEP national teams, consisting of cultural mediators, peer's educators and street operators of different nationalities, contacted more than 30.000 migrant prostitutes.

Lessons: Lessons learned during the programme's first five years highlight the importance of peer education programmes. In implementing these, such programmes should seek to:

- Valuing sex workers' views, knowledge, and life experiences and include them in the development and implementation of interventions
- Conceptualizing sex workers as highly motivated to improve their health and well-being as part of the solution

- Building capacity and leadership among sex workers to facilitate effective participation and community ownership
- Recognising the role of clients and third parties and the environment in HIV transmission
- Continuously adapt to change

Summary: *This section of the report reviewed cases across different settings where workplaces, work, or workers were used as entry points for HIV and TB prevention among SW of differing sexual orientations (including MSM and transgenders).*

The examples highlight a wide range of approaches. Workplaces can be used in the sense of a place where sex work is practiced – and this may be more or less easily identifiable (e.g. a brothel, hotel, or a transportation route) and more or less accessible. These ‘workplaces’ may thus be extremely informal and also be changing in nature which can pose a particular challenge.

A number of common elements emerge from these examples:

- *The importance of a deep understanding of the nature of sex work in the designing of initiatives*
- *Mapping and data collection are important means for getting a good understanding of the situation and opportunities*
- *Peer education and counselling as a key strategy*
- *Recognizing the role of third parties, e.g. managers, owners, etc.*
- *The importance of access to non-discriminatory services in support of HIV and TB prevention and treatment*
- *Advocacy and buy-in from communities to support interventions*

A number of examples also go beyond prevention and treatment to address the underlying causes of vulnerability, e.g. by promoting entrepreneurship and alternative/complementary sources of income.

Finally, while there are examples of results and outcome level assessments, the examples also show that such data is not always systematically collected.

1.2 MEN WHO HAVE SEX WITH MEN (MSM)

MSM are among the populations most seriously affected by the HIV epidemic, across different epidemic contexts. They are often difficult to reach because of issues of stigma, discrimination, and the legal frameworks (criminalization) in countries.

Nonetheless, reaching key populations with effective HIV prevention programmes and services is critically important to curbing and reversing the spread of HIV. This is particularly important because MSM are also often a ‘bridge’ to the general population (Source 60).

This section of the report reviews a number of examples of interventions that sought to bring HIV prevention and support closer to MSM communities using work or workplaces as an entry point. As noted in the introduction to this report, the examples in this area are relatively scarce. The manner in which workplaces are used in the context of HIV prevention is also different. Unlike SW, MSM are not a category of workers. Reaching out to MSM through workplaces therefore involves identifying and using places that are ‘frequented’ by MSM (barber shops, bars, saunas, etc.) as a point of contact.

AMERICAS

Case Study 13: Seattle, USA – “Black men get a trim and a frank discussion” (Source 12)

Context/where: The Down Low Barbershop Programme was initiated in Seattle, the USA in the early 2000s with support from the Department of Public Health. At the time in the USA about half of all new HIV infections were among African-Americans. While the prevention effort targeted black men within these communities in general, the problem was severest among those who have sex with other men.

Workplace link: In this example a specific workplace (barber shops) was used to reach a key population group as clients of services.

Aims/activities: In this programme African American barbers were enlisted to contribute to HIV prevention efforts. The strategy of the programme was to capitalize on the relationship that trusting often exists between barbers and their clients.

As part of the programme, barbers received an eight-hour training, focusing on HIV prevention, basic counselling and links to referral services. The barbers reported using the training to develop their own favourite techniques for getting their clients to talk about HIV and AIDS. They would inquire after their clients' love lives and then ask questions such as: "Are you protecting yourself? Do you know what AIDS is? Do you know that it is growing fastest in the African-American community?"

In addition to "in shop chat" of this kind, the Down Low programme also organized safe-sex workshops for clients after hours. The workshops included handing out condoms as well as print materials. They provided an opportunity for participants to ask questions and included hands on activities. Barbers in turn trained selected clients as outreach persons to extend the web of persons involved in these prevention and support activities.

Results/outcomes: Workshops attracted large numbers of customers and were filled to capacity (barber shops are often full). Participants reported being attracted to participate by a curiosity and concern. They also received a \$20 gift voucher towards a haircut and a \$30 money order to spend as they please. Shop owners were paid \$250 to host the workshops.

Lessons: No formal documentation on lessons learnt was identified for this example. However, this example shows how places that are frequented by key population groups can be used to reach these populations. It also highlights how such interventions can have incentives for business owners, both financially as well as from the perspective of making them more comfortable in offering a quality service.

ASIA AND THE PACIFIC

Case Study 14: Thailand, Bangkok – ILO – Reducing HIV vulnerabilities of MSM who have sex with men in saunas (Source 64)

Context/where: In Thailand, MSM remain one of the most vulnerable populations for HIV infection. Epidemiological research forecasts that up to two thirds of new infections between 2011 and 2015 will be among MSM, and that this will account for a third of all new infections in Bangkok.

Workplace link: Focusing on saunas (ie. workplaces) provides an entry point for effectively reaching at-risk MSM through an existing workforce which could be trained to promote peer education and support, and to maintain and promote HIV prevention and management standards in the workplace.

Aims/activities: This initiative – which was rolled out in 2012 – identified saunas, and workers in saunas, as one of the most important and effective points for targeting at-risk behaviours among MSM in Bangkok. Non-transactional sexual behaviours frequently take place at these venues. The ILO, in partnership with owners and managers of Bangkok sauna venues, and two local peer-based organizations -Bangkok Rainbow Organization (BRO) and Rainbow Sky Association (RSAT), led the project. Other intervening organizations included the Bangkok Municipal Authority (BMA), the Ministries of Public Health (MOPH), the Department of Labour Protection and Welfare (DLPW), the Asia-Pacific Coalition on Male Sexual Health (APCOM), the United Nations Development Programme Thailand (UNDP), the United Nations Educational, Scientific, and Cultural Organization (UNESCO), and UNAIDS.

The initiative was designed to support Bangkok sauna owners and managers through local peer-based organizations to develop an enterprise-based model for HIV prevention and management in saunas workplace. Key strategies included:

- Development of a positive policy environment for HIV work at saunas

- HIV/AIDS education and training for staff of saunas to protect themselves and reach out to MSM customers in the workplace
- Identifying and putting in place new infrastructure and distribution of condoms and lubricant within saunas to ensure easy access

Results/outcomes: The initiative is still on going and has not yet been evaluated. However preliminary information provides support for the following results. As of July 2013 the initiative has contributed to:

- Assessing and improving knowledge and understanding of HIV prevention and management needs in the Bangkok sauna industry
- Capacity building of local peer-based organizations to support workplace programmes in saunas
- Establishment of new ‘infrastructure’ for distributing condoms and water-based lubricants, which is in compliance with international standards for sauna venues
- Development of a training package on HIV prevention and management for Bangkok sauna staff. The packages focuses on individual protection, strategies for reaching out to customers, and on upholding minimum standards in the workplace
- Drafting of guidelines and a workplace policy tool that establishes minimum HIV prevention and management standards for the Thai sauna industry
- Provision of technical support to Government to support the drafting of a licensing model for the sauna industry which includes HIV prevention measures/standards

The intervention is being implemented as a pilot. New partnerships for prevention have been identified and a network of sauna enterprises mobilized through consultation with operators of 19 venues (out of the total 31 enterprises operating in Bangkok). Sixteen sauna venues have adopted the staff-training package.

EUROPE AND CENTRAL ASIA

Case Study 15: European Union (EU) – The Everywhere Project, Encouraging responsible business owners to adopt Codes of Good Practice (Sources 65 and 67a, b, c, and d)

Context/where: Another recent workplace intervention concerns an initiative by a consortium of 17 partners working in public health/health promotion from eight European countries (Italy, France, Poland, Cyprus, Slovenia, Hungary, Spain and the United Kingdom). The Everywhere project was a two-year pilot project co-funded by the EC between 2008 and 2010 under the Public Health Programme. Comprising 17 partners from eight European countries, it included public health organizations, academic institutions, NGOs active in HIV issues, and organizations that unite gay business owners.

Workplace link: As part of the initiative businesses including gay dating websites, hotels, travel agents and sex venues were approached in the eight countries.

Aims/activities: The Everywhere Project aimed to develop and validate an innovative and culturally adapted European model of HIV prevention targeting MSM for use in cities across Europe. Its objective is to encourage businesses to become more socially responsible in the prevention of HIV, through a network of social mediators. Social mediators are sexual health experts specialized in working directly with ‘gay’ businesses to facilitate the achievement of the Minimum or Premium Everywhere Seal of Approval, which the programme awards. Each country has at least one full time social mediator. Social mediators were responsible for using outreach methods to reach businesses and initiate dialogues, build relationships and bring about agreements concerning specific HIV-prevention activities for each establishment.

Specific aims of the Everywhere Project are to:

- Join forces with businesses from environments associated with MSM tourism and entertainment in Europe (sex venues, hotels, travel agencies, and

gay dating websites) to put information and preventive materials in clients hands in settings where sex between men is practiced

- Create and train a network of social mediators to identify, access, and achieve the commitment of business sector in the prevention of HIV in MSM
- Define action protocols for business owners (whose clientele are mainly MSM), the adoption of which will certify the business as being socially responsible venues in the response to HIV

Results/outcomes: A number of businesses were awarded the Everywhere Seal of Approval for their efforts in HIV/AIDS prevention. Developed by *Syndicate National Des Entreprises Gaies* (SNEG) in France in collaboration with project partners, the seal represents a visible recognition of quality and allows MSM to identify those businesses that are socially responsible in HIV prevention wherever they travel in Europe.

The principles which these businesses adhere to include ensuring:

- Condom and lubricant provision
- Information availability
- Staff knowledge about Everywhere
- A safer environment
- Welcoming of outreach workers
- Regular knowledge updates for staff
- Commitment to anti-discrimination

The Everywhere Model was implemented through a pilot in 140 establishments and subsequently scaled up to more establishments. During a five-month pilot action, 83 'gay' businesses were certified with the Everywhere Seal of Approval. By the end of the action, SM distributed a total of 30,000 leaflets (16,000 for MSM; 14,000 for businesses), 5,000 branded bookmarks and 71,812 condoms and lubricant sachets in designed Everywhere wallets through 'gay' business. All materials were translated into

eight languages and were distributed strategically by partners as either direct health-promotion materials or as marketing and profile- raising tools.

Lessons: The implementation of this pilot highlighted the following:

- Gay businesses can be important settings through which to ‘reach’ MSM and deliver public health and health promotion interventions
- Gay businesses are willing to commit to HIV-prevention activities targeting MSM and non-monetary incentives can be an effective way of doing so
- It is possible to develop standards in prevention that can be applied in varied cultural, social and political locations
- Adopting this approach will, however, have to take into account that the number of gay businesses may vary considerably by location depending on social, cultural and legal factors.

Case Study 16 – Scotland – Gay Men’s Task Force (GMTF) – Bar-based, peer-led community-level sexual health promotion (Source M5 and M9)

Context/where: In Scotland in the 1990’s sex between men was the primary route of HIV transmission.

Workplace link: Bars, as workplaces, were used as a contact point with the MSM community.

Aims/activities: To address the growing HIV epidemic among men, a number of community level agencies in Glasgow decided to combine their preventive efforts to form the Gay Men’s Task Force (GMTF). The aim of this intervention was to change sexual health amongst MSM by encouraging them to reduce their sexual risk behaviour for HIV infection and increase their use of health services

It involved education in bars, MSM specific medical services, and a free-phone hotline. A system of peer-led sexual health promotion in five exclusively gay bars in Glasgow was put in place. The peer educators were

recruited from many sources, including the commercial gay scene and existing voluntary HIV-related organizations.

Peer educators received two days of training, including communication skills, role-play in approaching men and specified message delivery. They were also provided with on-going support throughout the intervention. When approaching the MSM the peer educators wore distinctive uniforms (t-shirts, jackets, and bags) and distributed sexual health promotion materials within the bars. They engaged in focused interactions with men in relation to a variety of sexual health issues (e.g. hepatitis B, HIV testing, HIV risk). The MSM specific health services were provided in both hospital and gay community settings. A free phone hotline provided details of local sexual health services.

Results/outcomes: The intervention had a direct impact on Glasgow's homosexual men and was found to have reached over one third of such men in the city. Importantly the intervention reached men of all ages and social classes. Subsequent research showed that men reached through the intervention were more likely to have higher levels of HIV testing, of hepatitis B vaccination, and to use of sexual health services. These men were also more likely to have used the MSM specific sexual health service. Peer education, as a form of health outreach, was found to be an effective intervention tool in terms of the uptake of sexual health services, but is less effective in achieving actual sexual behaviour change among MSM.

Lessons: Research showed that the peer education had a 'dose effect' such that those MSM who had more than one contact with a peer educator were more even more likely to proceed with HIV testing, to reduce unsafe sex, and to contact the hotline and the medical services.

Case Study 17: United Kingdom (UK), London – Venue based interventions for MSM (Source 62)

Context/where: In UK just under 100.000 people were living with HIV in 2012. Around one in five (22 per cent) were undiagnosed and unaware of

their infection. A total of 6360 people were newly diagnosed with HIV in 2012. A particular concern is the continual increase in UK-acquired infections in MSM and in heterosexuals. Infections acquired abroad continue to decrease.

Workplace link: As in the previous example workplaces (ie. gay pubs, clubs and bars) were used to reach out to the specific key population group which uses these services.

Aims/activities: This activity, which was conducted in the mid 2000's, targeted homosexually active men living in London, particularly sub-groups identified as being at a greater risk of infection i.e. those who had tested HIV sero-positive, who had more than ten sexual partners per year, and those aged 25 years and under. Outreach to MSM was put in place for a total of 29 gay pubs, clubs and bars, by two associations. The purpose of the intervention was to:

- Increase men's desire not to be involved in HIV exposure
- Strengthen negotiation skills
- Enhance knowledge about HIV and HIV testing
- Increase awareness of potential for HIV exposure in their own behaviour
- Strengthen knowledge and referral possibilities to HIV and sexual health services

The programme was based on empowerment and ecological models of health promotion addressing biological, psychological and social 'unmet needs' with the aim of enabling men to reduce their vulnerability to HIV infection.

The outreach component for managers focused on the above as well as on providing a safe environment for clients. A team (mostly consisting of gay men) was put in place to conduct outreach activities targeting the venue managers and the persons frequenting the venues. Interviews were carried out with venue managers initially to enhance understanding of the context and to work on initial motivation.

In addition to the prior research to identify venues and motivate/liaise with managers, the work also included: achieving targets for number of visits; staffing a stand displaying leaflets; engaging in conversations with men at the stand and around the venue; providing information, advice and referral; and distributing leaflets, condoms and lubricant to men and ensuring that these were available at the venues.

Results/outcomes: Follow up research showed that gay men generally found outreach acceptable and useful, and professionals were not regarded negatively. Impact on knowledge was commonly reported; impacts on negotiation skills and reflection on personal behaviour were more common among men experiencing longer contacts.

Lessons: The conclusion was that professional HIV prevention outreach in gay venues in large cities is a feasible and acceptable intervention with significant potential impacts. The inclusion of venue managers and workers should be an essential part of the approach. Outreach workers need to be well briefed and trained to maximize impact.

Case Study 18: United Kingdom (UK) – Promoting Codes of Good Practice for Saunas, Bars and Clubs (Source 66)

Context/where: In another effort to address the rising number of HIV infections among MSM in the UK, the Terrence Higgins Trust in 2008 launched a Code of Good Practice for saunas and other entertainment areas such as bars and clubs under the title of ‘Play Zone’.

Workplace link: By participating in the scheme it is assumed that owners, promoters and managers of workplaces that are frequented by MSM give a clear message that they recognize the importance of providing a safe, clean environment for customers and staff. Venues that meet the standards set out in the code receive Play Zone branding and certificates which they can display. This makes identification of such safe places easier for customers. Participating establishments also partner with similar venues throughout the country on improving sexual health.

Aims/activities: The main aim of the Code was to create a safer environment for all users of sauna venues, as well as for staff and to raise awareness around sexual health and minimize the number of new STI and HIV infections.

The Code established minimum standards for sauna environment in terms of lighting, cleaning, provision of sexual health information and staff training. It also put an important accent on strategies for ensuring adequate access to condoms and lubricants. Venues in London and Brighton were invited to voluntarily participate in a pilot phase of the Code, which is being scaled up since 2013.

As part of the strategy owners sign up to a Code pledge. The pledge demonstrates a commitment by the establishment to promoting the sexual health of their customers and the wider gay community. Dissemination of the Code was promoted through the development of a manual for sauna staff. The manual provides information and includes links to important additional resources, contact numbers, and services. Free training is also available for venue staff on HIV, sexual health, Post Exposure Prophylaxis (PEP), drug and alcohol awareness and first aid.

Results/outcomes: Evidence on the acceptability of this initiative to both venue owners and gay men remains to be further collected as the initiative expands. This would provide an idea of the degree of compliance of saunas and other venues with these requirements/agreements. It would also provide insight into the extent to which the Code of Practice has contributed to safer behaviours, as measured for example by condom use, new infections, etc.

Lessons:

- The project has shown that getting into the community is not just a good way to reach those who might slip through the system of sexual health clinics, it also finds new leaders.
- New leaders open the door to new partnerships and innovative ways to reach even more people.

Summary: *The workplace focus in these examples from different settings is on using places that are frequented by MSM as entry points/points of contact for prevention and for accessing services.*

As in the SW examples, using peer education, linking with services, and mapping are important techniques.

- *These examples also raise some additional strategies of particular relevance/importance:*
- *Linking to business owners/managers, and the different degrees to which owners/managers can be involved and engaged*
- *Innovative practices for encouraging safe standards such as codes of conduct and seal of approval*
- *The potential importance of incentives for business, caring for workers, including by drawing attention to social responsibility*
- *Ensuring strong technical support and inputs to third parties, including government entities, for example in drafting legislation and establishing standards*

The examples also highlight that workplace approaches in the broad sense may be easier to implement in some countries than others depending on the legal environment and cultural and social barriers.

1.3 PEOPLE WHO INJECT DRUGS (PWID)

Very few examples of workplace-based programmes specifically targeted to the key population of PWID were identified in this study. However PWID behaviour was a focus of some of the above examples given the close association between PWID and other risk behaviours such as sex between men and sex work.

ASIA AND THE PACIFIC

Case Study 19: India – Itinerant barbers reach out to PWID and other persons at risk (Source 3)

Context/where: In India the focus was on ‘itinerant barbers’ who move from place to place to provide their services in locations that are convenient to customers.

Workplace link: The intervention used ‘workers’ in informal workplaces as an entry point to reaching PWID and SW.

Aims/activities: This programme, which was rolled out in 2004-2005, specifically targeted men who engage with sex workers or who are PWID (or both) and did so through a mapping of high-risk areas. The programme recognized that in many crowded cities men are often alone in search of work, having few friends, and no family, and that in this context, barbers (who are visited weekly or more) may be one of the few regular points of contact. The programme thus trained barbers in sterilization techniques, as well as in promoting condom use, recognizing the symptoms of HIV/AIDS and techniques/approaches for discussing the disease with customers. Barbers who suspected a client might be at risk were provided with information that allowed them to refer the client to a nearby HIV/AIDS facility. The programme was developed by the Switzerland-based aid organization Association Francois-Xavier Bagnoud. India’s National AIDS Control Organization provided the condoms and educational materials at no cost.

Results/outcomes: The initiative trained over 10,000 barbers in India. No other information on results and outcomes was identified.

Lessons: While systematic lesson learning was not identified for this initiative the available information does point to the importance of carefully mapping and identifying opportunities for relaying information and for persuading key populations to access services.

Case Study 20: Vietnam – Using Barbers, Shoeshine Boys, Motorcycle Taxi Drivers and Workplace advocates in HIV prevention and in promoting access to treatment (Source 5 and 8)

Context/where: In Vietnam, which has a concentrated epidemic, unsafe sexual and injecting drug use (in particular needle sharing), together with inconsistent condom use was identified in the early 2000's as a major factor in the spread of the HIV.

Workplace link: Various types of informal workers were used in this example to reach out to difficult to reach key population groups. Unconventional workplaces where PWID and SW are found, were also included in the approach.

Aims/activities: In order to design an intervention to address this, and in an initiative implemented by The Provincial Health Department, The Provincial AIDS Standing Bureau, and FHI (with funding from USAID) formative research was used to gain insight into the knowledge, behaviour and attitudes of PWID, SW and their clients, and to gain a better understanding of the social and cultural environment.

The information collected in this manner led to the decision to engage a variety of somewhat unlikely 'health leaders' in the approach to addressing HIV and AIDS, namely barbers, shoeshine boys, motorcycle taxi drivers and workplace advocates from the workplaces concerned. The rationale for this was that members of these groups were identified as being potentially important peer educators and *"in a position to speak to and influence large numbers of people (predominantly men)"* (source: 8). Their role as influencers was identified as being in particular related to *"convincing men to be more responsible in sexual health matters in their roles as citizens, fathers, husbands, friends, and employees."*

The peer educators were provided with training and a variety of specific print materials (leaflets, magazines, comic books, etc.) were developed to assist in disseminating messages. Motorcycle drivers were identified as a particularly

important peer education group given that their work takes them close to many of the hot spots for commercial sex or drug use such hotels, truck stops, karaoke bars, restaurants, major highways and intersections, factories and commercial areas, sea ports, river ports and ferry crossing.

Results/outcomes: The intervention produced encouraging results. Within six months, 135 workplace peer educators were trained and initiated outreach activities. The peer educators reached almost 18,800 employees at eight factories. In the community, 290 motorbike peer educators worked with over 62,857 customers, 92 barbers reached 67,825 customers, and 20 shoeshine boys reached 10,766 customers. Because of its success the intervention was subsequently scaled up to other major cities in Vietnam.

The project included a strong monitoring component that assessed progress against base-line self-report data. This data showed encouraging results. Condom usage increased in the targeted areas and that attitudes towards unsafe behaviours had changed. The project also contributed to raising the self-esteem of barbers and motorcycle peer educators, in particular because it had enhanced public respect for their jobs and a recognition that their work was making a difference to people in the community.

Lessons:

- A key success factor of the campaign was the building of positive images of male personal responsibility in addressing HIV.
- The focus on dispelling images of sex work and injection drug use as a “social evil” as this facilitated and enhanced the effectiveness of the contact with drug users and commercial sex workers.

Summary: *In the area of PWID very few relevant and sufficiently well documented examples related to the 'workplace' were identified, highlighting the limitations of a 'workplace' approach for populations who are not accessible by nature of their 'employment' (as is the case of MSM, PWID, and transsexuals).*

This is also complicated by the 'underground' nature of much of PWID. Key informants contacted through this study noted that this may be a key factor in making it difficult to identify good examples that have a relation to 'workplace' or 'workers'. In this words of one informant: "this may be an area where good things may be happening, but on a relatively small scale, and which are not being recorded/picked up".

Nonetheless the few examples highlight:

- *The importance of bridge populations in reaching difficult to reach key populations such as PWID (e.g. itinerant barbers), and that these may be 'bridge workers' and therefore be reached by virtue of their professional activity*
- *The mobile nature of the 'workforce' that is in contact with PWID*
- *The importance of addressing social conceptions of sex work and of specific key population groups*

1.4 TRANSGENDER PERSONS

Lesbian, Gay, Bisexual, and Transgender (LGBT) people face sexual orientation discrimination, stigmatization, and marginalization in society and in the workplace. "These challenges often limit economic opportunities, affect mental health, and may place members of this population at an increased risk for HIV infection. Factors including needle sharing and substance abuse, high-risk sexual behaviours, commercial sex work, health care access, lack of knowledge regarding HIV transmission, violence, stigma and discrimination, and mental health issues are identified in the literature as risk factors for the acquisition of HIV infection by members of this population" (De Santis, 2009). For transgender sex workers, the risk of danger and abuse is often greater. Transgender sex workers are usually forced to live in hiding.

These groups have tended to be under-researched, although this has changed somewhat in recent years. As a result, the needs of transgender persons are often not specifically or sufficiently used to inform the design of HIV approaches. The absence of specific approaches, made it particularly difficult for this study also to identify specific examples of workplace related initiatives.

ASIA AND THE PACIFIC

Case Study 21: India, Delhi – Transgender Beauty Parlour (Source M22)

Context/where: The Pahal Foundation, an Indian NGO, which works on community awareness about HIV and AIDS, identified access to transgender people as a particular constraint. Transgender persons are often hidden within society, and are subject to stigma and trauma which makes them particularly difficult to reach, and often excluded from economic opportunities.

Workplace link: The workplace link is the beauty parlour which is in itself a workplace. This example highlights how establishing work opportunities for transgender persons can contribute to creating economic opportunities and to improving the integration of traditionally marginalized transgender persons into the community.

Aims/activities: To break this trend the NGO decided to experiment with establishing a beauty parlour only for transgender persons which was set up in 2009. Initially conceived as a pilot, the Queer Beauty Parlour has been a very big success.

The Beauty Parlour was established exclusively for transgender people in and around the capital. The Parlour is not only dedicated to transgender people but is also run by them. Uniquely the suggestion to establish the beauty parlour came from the local community, which identified the trauma and exclusion faced by transgender populations as an issue and also highlighted the need for economic opportunities for the community.

The beauty parlour is a unique centre that provides transgender persons with beauty solutions having their own free space, and has been successfully integrated within the community. Pasted on the wall are stories about the worldwide gay and lesbian movement. The shop itself provides beauty products as well as access to condoms, lubricants and HIV/AIDS information.

Results/outcomes: The Beauty Parlour has between 8 and 10 clients per day and a fully booked agenda. The success of the beauty parlour has led the lead beautician – a transgender person who was the first to join – to introduce training for other beauticians who will be assisted in setting up businesses in other parts of the community.

Lessons: An important lesson from this experience is the involvement of the community in the identification of solutions.

Summary: Few examples were identified also in this area.

Lessons of relevance include:

- The importance of involving key populations in design and implementation (also relevant for the other key population groups)
- The use of advocacy to draw attention to issues, to create visibility and acceptability
- The importance of self-organization among members of key population groups

The role that Government action can play in securing institutional buy in

The next part of this report – Chapter 5 – will deal with a number of key population groups (such as migrants, garment workers, prisoners, etc.) that are specific to certain contexts and thus vary by setting. These key populations will not occur in all settings, but are relatively frequent.

EXAMPLES OF WORKPLACE INTERVENTIONS FOR OTHER KEY POPULATIONS, WHICH VARY BY SETTING

2.1 MIGRANTS AND THEIR FAMILIES

The recent period in history has seen important technological advancements, which in turn have brought about socioeconomic development and accumulation of wealth. Transportation systems and movements of people between places have contributed to this. While these developments have brought opportunities, they have also been a contributing factor to the spread of HIV and AIDS. *“Particularly in marginalized areas, transport milieu are highly conducive to risk-laden behavioural patterns and are thus transformed into transmission settings and vectors of disease* (Apostolopoulos, n.d., in Source 45). The following examples illustrate how different groups of migrants and their families have been affected in the process and highlight where and to what extent workplace responses have been part of this.

AFRICA

Case Study 22: Southern Africa – ILO, Reaching cross-border workers in transport corridors in Southern Africa (source 25)

Context/where: In many parts of the world the focus has also been on mobile workers in an initiative that started in 2007 with support from SIDA.

Workplace link: The initiative has used formal government workplaces and workers in these locations as contact points and advocates for services for a highly mobile population. The workplace has also been used to reach less formal workplaces and workers, such as vendors along railways lines.

Aims/activities: The ILO transport corridor initiative has focussed on HIV prevention for mobile transportation workers who cross borders for temporary work between the neighbouring countries of Malawi, Mozambique, South Africa and Zimbabwe. As an innovative approach to creating an enabling environment for HIV prevention – and in the same manner as was the

case for the aforementioned initiative in Sri Lanka – the ILO trained employees of cross-border institutions such as customs agencies and other regulatory bodies, as well as from over seventy transportation companies in implementing HIV and AIDS programmes. Peer educators were also trained and have played a key role. Condoms are regularly distributed across the corridors. At the Ressano-Garcia border, between South Africa and Mozambique, the intervention went beyond traditional prevention approaches, reaching out to informal communities operating along the railways who play an important role in linking with migrant workers as they pass through. The initiative has included the signing of an agreement between ASSOTSI (an informal sector association) and customs authorities to ensure that informal workers are not excluded from access to HIV services at the borders.

Results/outcomes: Over 42,000 transport workers, including long-distance truck drivers, have been reached at hotspots along key cross-border routes.

Lessons: The liaison work with small and informal traders and communities that interact with transport workers was enormously important in understanding and addressing a number of the key underlying factors of vulnerability like difficult economic conditions and gender inequalities. In each country the approach has been able to take into account local conditions and opportunities. In Zimbabwe, for example, the success in mobilizing leaders from small businesses and informal sector associations is significant. This resulted in the establishment of a Savings and Credit Cooperative (SACCO) at one of the key border post in the country. The cooperative extends short-term loans to its members to allow them to find their feet and to give them a better chance at integration.

Case Study 23: South Africa – Sensitizing farm owners, supervisors and workers on the gender dynamics and how these affect the spread of HIV and AIDS (Source 78 and 28)

Context/where: South Africa faces a generalized epidemic and has the highest absolute number of people living with HIV – 5.6 million, globally. Many factors play a role in the high HIV rates, including poverty; inequality and

social instability; high levels of STIs; the low status of women and sexual violence; high mobility (particularly migrant labour); limited and uneven access to quality medical care; and a history of poor leadership in the response to the epidemic.

Innovative aspects of the farm work ...

- Painting of murals on premises
- Drafting of farm level and community action plans
- Establishment of Community Action Teams
- Involvement and training of multiple stakeholder groups
- Strong focus on gender socialization and gender concerns

Source 78

Workplace link: Farms – as the workplace for farm workers and supervisors – were the main entry point for the initiative.

Aims/activities: In partnership with the Hoedspruit Training Trust (HTT), the International Organization for Migration (IOM) set up the Commercial Farm workers HIV Prevention and Care project in mid-2005. Operating on 18 commercial farms in the Hoedspruit area, the project implemented a holistic approach to tackling HIV through four interlinked components:

- In the workplace
- Care and support
- Behaviour change communication
- Addressing gender issues

The purpose of the intervention was to create awareness amongst farm workers, specifically amongst men and farm supervisors on the gender dynamics that

exacerbate the HIV and AIDS epidemic, and to develop skills to mitigate its impact. Activities included advocacy among a variety of stakeholders including: farm supervisors, the local chief of police, education authorities, the sexual offences stakeholders' forum, the local media, priests and other religious leaders, the Municipal Manager and the Mayor. Video and print materials, including the painting of murals in prominent places, were used to make the case. Various targeted workshops and training activities were also a key component, and produced work and action plans at farm and community level to address gender issues as a key outcome. Workshops typically included the following content:

- Gender socialization: exploring gender roles, gender norms, gender value clarifications and gender and power
- Sex and sexuality: exploring sexuality, sensuality and pleasure, HIV/AIDS risk and violence
- Sex and reproductive health: exploring sexual rights and responsibility, sex in marriage and long-term relationships and attitudes towards rape and sexual violence

Community Action Teams (CATs) were formally established to implement the work plans. Teams/support groups met on a regular basis and also had a monitoring/evaluation function.

Results/outcomes: Through the intervention farms developed HIV and AIDS workplace policies. The project evaluation established important changes in terms of attitudes and commitment of key stakeholder groups. Farm supervisors showed commitment and real actions targeted at:

- Respect for women and care for children
- Assisting in educating people about the use of condoms
- Campaigning against HIV/AIDS, rape and domestic violence
- Developing care groups to look after the welfare of farm workers and disseminate
- Information
- Conduct advocacy activities with other farms and other stakeholder groups

The evaluation also showed that advocacy activities produced positive changes in areas such as housing, ARV treatment, VCT services and recreation facilities

Lessons: The initiative was able to make inroads into beginning to change the commitment of farm supervisors towards gender issues. However, for a lasting impact these initiatives would need to be complemented by efforts to also strengthen mechanisms for dealing directly with gender based violence at a community level.

ARAB STATES

Case Study 24: United Arab Emirates (UAE) – Establishment of a Department of Human Rights by the Dubai Policy Department (Source 51)

Context/where: The HIV situation in UAE can be characterized as low-prevalence. The majority of HIV cases are found in the emirates of Abu Dhabi and Dubai, reflecting the larger populations in those two cities, as well as higher levels of risky behaviours, as both cities appear to be more exposed to high-risk phenomena associated with HIV, including migration, sex work, and trafficking of women. Sex work does exist in UAE, but it is poorly documented, illegal and criminalized by law, and it takes place in a hidden environment. Overall, there is very little information available on sex work in UAE, but data from Dubai police have highlighted the link between sex work and human trafficking. UAE's vibrant economy, open borders and tourism drive the demand for sex work. Reportedly, the large majority of sex workers are foreign women, especially catering for the needs of foreign men, including expatriates living in UAE. The illegal character, social rejection, and the possible relation to organized crime make it extremely challenging to reach these women with HIV-prevention programmes.

Workplace link: This example illustrates how an existing workplace which comes into regular contact with a key population group can be more effectively used to address the needs of this group.

Aims/activities: As part of a broader range of activities, and to address this particular aspect of HIV prevention, a General Department of Human

Rights was established by the Dubai Police in 2006. This was initially a short-term intervention, but has since become part of the institutional/organizational structure of the police force and has strengthened protection of women who are victims of human trafficking.

Results/outcomes: Since its establishment the Department has reported approximately 50 cases of sex-work-related human trafficking per year. It has also been instrumental in distributing Information, Education and Communication (IEC) materials in various locations, including at HIV-testing centres for expatriates in their local languages. The police department has also been instrumental in linking persons in need to key services, for example related to HIV testing, and drug treatment.

Lessons: This experience with regard to the protection of the human rights of vulnerable populations is a potentially powerful model for the development and implementation of similar programmes for HIV prevention among most-at-risk populations.

ASIA AND THE PACIFIC

Case Study 25: Bangladesh – Obtaining broker's assistance to reach cross border mobile population (Source 52, M12 and M15)

Context/where: HIV adult prevalence in Bangladesh stands at less than 0.1 per cent in the general population. Although HIV prevalence was below 1 per cent in most groups of female and male sex workers, prevalence in casual sex workers in some geographical areas (e.g. border towns in the northwest part of Bangladesh) is higher. Large proportions of MSM and male sex workers, report STI symptoms, as well as multiple sex partners (including women), group sex (often associated with violence and without condoms), and very low condom use with all types of partners. Cross-border movement into India – which has become a necessity for the economic survival of people living in bordering areas of Bangladesh – contributes to the risk factors.

Workplace link: Brokers (as a specific category of workers) were used as the approach to reach cross border populations. This highlights how a less

conventional workplace/workplace actor can play a role in HIV prevention and access to services.

Aims/activities: EMPHASIS (Enhancing Mobile Population's Access to HIV & AIDS Services, Information and Support) is a 5 years (2009-2014) sub-regional initiative by CARE India, Bangladesh and Nepal funded by BIG Lottery Group of United Kingdom. The programme has three major components, one of which focuses on reaching migrants in transit areas⁶.

Outreach staff was entrusted with building a relationship with the brokers and with using them as entry points. The brokers were active participants in this process, for example in the selection of locations for contact. Preferential stopover points were identified and the outreach activity – through contact with the broker – managed to successfully reach both migrants and families, without posing a danger or putting the group at risk of harassment, which could have been the case if a law enforcement agency had been used to the same effect.

Capacity building of the health service providers to increase service access for the cross border mobile population was a second important ingredient, in order to ensure that the referral provided by brokers would be effective.

Results/outcome: The programme reached over 300,000 at source, transit and destination. Over 13,500 individuals including Peer Educators and health- service providers were trained in service provision on HIV/AIDS, life skills, technical skills, gender sensitization, health system strengthening and vulnerabilities of migrant population. Data on outcomes is still being collected.

Lessons:

- Engaging with private sector actors such as hoteliers and transport unions, spouse groups, District AIDS Coordination Committees, and district level migrant networks is an effective approach towards having a comprehensive response to HIV and AIDS and cross border migration at source.

⁶ The other two components are self help groups for wives of immigrants to reduce stigma and discrimination related to HIV and cross border mobility, and capacity building of the health service providers to increase service access for the cross border mobile population.

- The project – which initially focused on HIV interventions gradually evolved into a comprehensive programmatic approach to migration allowing it to address factors that impact on social and economic vulnerability including access to education for migrants’ children, initiatives towards safe remittances, domestic violence and harassment at work place, equal wages for labour migrants, and rescue and repatriation.

Case Study 26: China – ILO, the Hometown Fellow Campaign – Innovative HIV prevention strategies for young migrants (Source 25 and M13)

Context/where: Although overall prevalence of HIV is relatively low in China (UNAIDS reported a 0.1 per cent prevalence in 2008), there are pockets of high infection among specific populations and in some localities. This programme sought to address some of these pockets of high infection, in particular those related to young migrants.

Workplace link: The involvement of large construction companies was critical to the combination of workplace based activities and peer outreach. Links with other workplaces, such as entertainment areas, train stations, etc., were also important in implementing the multi-pronged communication and behaviour change strategy.

Aims/activities: In China, the ILO “Hometown Fellow” campaign focussed on providing HIV prevention messages to migrant workers. The initiative, initiated by ILO, is being implemented in partnership with the Ministry of Labour, employer and worker bodies, the State Council AIDS Working Committee Organization and 19 large-scale enterprises in construction, mining and transport sectors in China’s provinces most affected by HIV.

Formative research at the start of the programme highlighted that there are strong social bonds among migrants who have a common provincial origin, and that this bond is potentially influential on attitudes and behaviour. The programme therefore focussed on delivering messages through the voices of migrants. A second aspect of the programme was to work through enterprise

structures with peer educators in the workplace, dormitories and nearby entertainment areas. Group training in enterprises as well as targeted messages delivered through company owned television and radio channels was put in place to reinforce the peer education messages.

With the help of Mega Info Media, which runs the national railways station television network, a short film was screened in 2009 along inter-provincial transport routes in 850 major train stations and 500 cities in labour-sending and receiving areas. The film sought to engage young people by presenting a main character that they could identify with. A popular Chinese movie star who was once a construction worker himself, who could identify with the role, and be seen as a legitimate spokesperson by the target audience, played the character.

As part of the initiative there has also been a focus on young female migrants to ensure that they have knowledge of their basic employment and reproductive health rights. The 'Know Your Rights Campaign' was launched in 2011 with a target of 300,000 workers in the Guangdong province. It includes workplace programmes on reproductive health and HIV and AIDS. To work towards sustainability, HIV prevention is being integrated into technical curricula of vocational schools so that young people receive vital information and resources as part of their training.

Results/outcomes: The ILO "Hometown Fellow" campaign reached approximately 40 million workers during their journey between their homes and construction sites. In addition, over 2,000 teachers were been trained in delivering participatory training to prospective young migrant workers.

Lessons: Specific lessons learned for this initiative was not identified, nor was an evaluation report available. However the descriptive information on the project highlights the importance of baseline research to understand what influences behaviour, and to design appropriate strategies for reaching potentially complex and very mobile target groups.

Case Study 27: Sri Lanka – ILO, HIV doesn't stop at borders – a human rights approach to protect migrant and cross-border workers (Source 25)

Context/where: Each year, a substantial number of Sri Lankan workers seek temporary employment outside of the country, in particular in the Gulf States. Prior to departure they are required to go through various official channels, such as Sri Lanka Bureau of Foreign Employment (SLBFE), the national Association of Licensed Foreign Recruiting Agencies (ALFEA), and will likely visit one of the 13 medical centres approved by the Gulf Cooperation Council (GAMC) as part of the pre-departure procedure.

Workplace link: This approach has used compulsory services (ie. workplaces) that immigrant workers have to link up to as a means for providing critical information and access to HIV and health services.

Aims/activities: Knowledge of this process led to the design of a programme in 2010 that has focused on Sri Lankan migrant workers in order to provide them with critical information and supplies to reduce their risk. The programme has had a strong focus on the specific needs of women given that they are at a higher risk of exploitation during the migration process and once they are in the country of destination.

The focus of the prevention programme – which has received support from ILO – has thus been on the various compulsory “stops” which potential migrants need to make at these offices before leaving the country to work overseas, as well as other contact points upon arrival in the country of destination.

Results/outcomes: The strategy has successfully reached some 1,500 migrant workers with information on how they can best ensure they are protected against HIV and reduce HIV vulnerabilities during the migration process.

Lessons: The following lessons stand out from this experience:

- Recruiting agents, government officials and members of CBOs who have been trained in HIV prevention and outreach have been key to the strategy. This ensures that together with the regular formalities, migrant workers

and their families receive potentially lifesaving information and resources on the prevention of HIV and AIDS and related diseases

- Gender sensitive pre-departure HIV and reproductive health training has been a particularly salient component of this approach, and has successfully highlighted the specific risks to women

Case Study 28: Thailand – Migrant workers, their dependents and related entertainment workers in coastal provinces and along the border with Myanmar (Sources 26a and 26 b)

Context/where: Migrant workers from border countries (Cambodia, Laos and Myanmar) are a major source of labour for Thailand. These migrants are entitled to health insurance if they are documented. However, most migrants are not, and thus face barriers in accessing health care and other services, including HIV prevention services. Migrants are also vulnerable to HIV because they are far from home, often ignorant of the risks, and use the services of sex workers. At all project sites there was a special focus on sex workers and EW.

Workplace link: The workplace link is the focus on migrant workplaces in various sectors (fisheries, construction, etc.) as a contact point for reaching migrants through health assistants.

Aims/activities: The PHAMIT programme – initiated in 2003 – sought to reduce the number of new HIV infections among migrant workers in Thailand and in the sub-region (Thailand, Cambodia and Myanmar). The PHAMIT programme focused on nineteen coastal provinces in Thailand and three non-coastal provinces along the border with Myanmar. In the coastal provinces, most beneficiaries were migrants working in fishing and seafood processing, while those working in other jobs such as factories, construction, and agriculture were the main beneficiaries in non-coastal provinces.

The programme was implemented through a partnership between eight NGOs and the MOPH and received funding from the Global Fund to Fight AIDS, TB and Malaria (GFATM). Key objectives of the programme were to:

- Increase condom use and reproductive health practices among migrant workers and related populations
- Make the health system favourable for migrant workers to receive health prevention and treatment services
- Improve the psychosocial environment for migrant workers and their dependents
- Advocate for policies that support migrants' right to health care and treatment

The project employed a number of strategies. This included working with existing NGOs to enhance service delivery and to strengthen advocacy, efforts with Government Departments to put in place 'migrant friendly services', and a focus on migrant communities through the innovative concept of 'migrant health assistants'. The latter were registered migrants living in Thailand, designated, recruited and trained to support migrants in accessing public health services.

Results/outcomes: The programme reached over 460,000 target beneficiaries with HIV prevention information and messages. Comparison with baseline data showed that:

- Condom use during sex with casual partners increased from 40 to nearly 90 per cent among programme beneficiaries
- The number of migrant women receiving antenatal care services increased by up to 20 per cent in target areas
- Nearly 2000 HIV-positive migrants received home-based care and treatment for opportunistic infections

The overall impact has been magnified by strategic advocacy aimed at various government agencies. The Thai government is increasingly recognizing migrant workers' rights and access to health services as demonstrated by the inclusion of migrant workers as a target population in the 2007-2011 National AIDS Strategic Plan, and by making subsidized ARV treatment available to a number of HIV- positive migrant workers in Thailand.

Lessons: At the programme evaluation stage, a number of factors clearly emerged as having contributed to the success of the programme. The most salient of these include:

- The strong relevance of the intervention to an urgent and felt need among affected communities
- Strong liaison work with hospitals and government departments which ensured that gaps in referral and access to health care and HIV prevention services for migrant workers became less important
- Strong and concerted effort to mobilize as many partners as possible in the response, including government departments, local governments and employers, NGOs

2.2 GARMENT INDUSTRY

AFRICA

Case Study 29: Lesotho – Garment Industry, vulnerable women and wives of migrant workers (Source 16 and 18, and M21)

Context/where: Lesotho – a small landlocked country in Southern Africa – has one of the highest adult HIV prevalence rates in the world, which stood at 23.3 per cent in 2011. According to the most recent UNGASS report (2012) major drivers of the epidemic are: a) multiple concurrent sexual partnerships (which are partially a reflection of mobility of populations); b) poor access to health services, and inadequate levels of HIV-testing; c) inadequate frequency of condom use across all sexually active population groups; d) social and cultural practices; e) high rates of alcohol use; f) low demand for male circumcision; and g) high rates of poverty and inequality.

Workplace link: The programme used garment factories as entry points for reaching garment workers and their families. A deliberate strategy of sensitization of factory managers was included to ensure institutional commitment to the response.

Aims/activities: The Apparel Lesotho Alliance to Fight AIDS (ALAFA) was set up in 2006 as an innovative HIV prevention and treatment programme targeting the largest industrial sector in the country. A large majority of workers in the small foreign owned clothing factories is female, and 40 per cent tested positive for HIV. Many of the textile workers have male partners working in South African mines – a significant risk factor in their exposure/vulnerability to the disease.

ALAFA put in place targeted peer education programmes for female workers, male workers, and workers 25 years old and younger at the workplace level. These programmes were designed based on research to respond to the target groups' social role and characteristics. With men, the group discussions centred around what it means to be a responsible male: recognizing and avoiding high-risk sex, regularly testing for HIV and keeping your family safe. The programme for young people emphasized developing male-female communication skills and HIV risk avoidance, including reducing sexual activity or delaying sexual debut. The women's component integrated gender dynamics, communication in relationships, factors that contribute to HIV transmission, and the problems faced by HIV-discordant couples. All three programmes have a component on multiple concurrent partnerships. The programmes also included regular access to condoms and HIV testing by all workers and their families. Multi-day training sessions for factory managers were part of the approach. Sessions were conducted in both the local Sesotho language and Mandarin Chinese (which is the language spoken by the Chinese managers).

The programme has also included a focus on expanding access to treatment through collaboration with the Lesotho Network of AIDS Service Organizations to strengthen rural clinics. A medical tracking scheme ensures that appropriate action can be taken when patients are missing visits. Lesotho has one of the most elevated rates of TB and a growing aspect of ALAFA's treatment programme has been attention to TB.

Results/outcomes: About 100 Lesotho-born workers and Chinese managers received HIV training in 2011. These trainings have enhanced corporate understanding of the local HIV situation and have brought about improved

and more explicit company support of ALAFA's worker programmes including in financial terms.

As of October 2011, ALAFA clinics had treated 443 workers for TB of which 397 were currently receiving HIV drugs. Medical records for TB and HIV are tracked together, and the medical visits themselves are coordinated to reduce absenteeism. The result has been a high TB cure rate.

ASIA AND THE PACIFIC

Case Study 30: Chittagong (Bangladesh) – Garment Industry, women and female sex workers (Sources 17a, 17b, 17c, 17d, 17e)

Context/where: Bangladesh has a concentrated epidemic, with HIV prevalence at less than 0.1 per cent in the general population. In 2011, the HIV prevalence among PWID, female and male sex workers, MSM and Hijras⁷ was 0.7 per cent. However, prevalence in casual sex workers in some geographical areas (e.g. border towns in the northwest part of Bangladesh, and transit areas) was substantially higher and could lead to the spread of HIV.

Workplace link: The approach for the garment workers included specific strategies related to the physical workplace as an entry point for interventions.

Lessons from the Chittagong example on what works ...

- Needs assessment of the specific target groups
- Planning for and including refresher courses for master trainers
- Using adherence by some workplaces to convince others to join
- Generating visibility for the initiative
- Mapping of health care facilities for STI, SRH management and general health of garment factory workers within and local to the factories

(Source: 17a).

⁷ A Hijra is usually considered a member of, "the third gender", neither man nor woman. Most are physically male or intersex, but some are physically female

Aims/activities: Between 2008 and 2012, Young Power in Social Action (PYPSA) delivered a combination of prevention programmes targeting women working in the garment industry some of whom engage in sex work or exchange sexual favours to supplement income. These projects – which were implemented with support from the HIV/AIDS and STD Alliance in Bangladesh (HASAB), Family Health International (FHI) and donors such as the GFATM, Save the Children, and Access Health International – sought to increase knowledge, to promote the use of condoms, and encourage the uptake of health services.

Factory managers as well as staff were involved in lunchtime peer discussions on health issues in general, and on HIV and AIDS in particular. The sessions focused on disseminating information, on encouraging workers to pose questions and also on ensuring that workers seek contact with the medical team, which was put in place to conduct weekly visits to the factory to treat workers.

A referral network was also part of the approach, and involved most of the big hospitals of the city allowing the programme to cater for different needs. The programme involved various factories and included the development and endorsement of a workplace policy on HIV and AIDS at each factory, as well as national advocacy activities.

A life skills-based peer educator approach for changing health care behaviour was employed. This involved recruiting peer educators among garment workers and female sex workers. Peer educators were provided with training to encourage positive health seeking behaviour and education on the prevention of HIV/AIDS in their respective groups. The programme also included a mobile medical team, which conducted weekly visits to rural areas, as well as a drop-in centre for female sex workers where the latter could spend time, access services as well as engage in rest and recreation. In addition outreach activities took place in residential communities using a variety of media such as theatre, music and video. Since, most sex workers are illiterate pictorial training materials such as flip charts and leaflets were used.

Results/outcomes: Over 2000 sex workers had been reached by the YPSA network in 2011 (17d), as well as 16000 plus garment workers (17e). There appears to have been limited follow up of outcomes, although reports mention good adherence to the prevention sessions and a modest increase in uptake of health services (17e).

Lessons:

- The use of interactive media, such as video and life skills education enhances engagement of workers
- The development of separate strategies for sub groups within an overall key population can be critical to success. Research can provide valuable information for designing such strategies
- Managers of garment factories can be engaged in prevention activities provided that the economic and social benefits are clear, and that facilities exist for referring staff to health and other services
- To ensure continued implementation of prevention services, refresher training for master trainers and peer educators is important

2.3 PORTS, FISHERY AND TRANSPORTATION SECTOR WORKERS

Ports, fishery and transportation sectors are particularly vulnerable to HIV due to a multitude of factors including the movement of populations, the long period which people in this area of work spend away from home, the lack of good access to HIV services and the opportunities for purchasing sex and drugs in many of these locations.

Truckers are at an increased risk of engaging in behaviours that expose them to STIs, including HIV, due to loneliness, isolation, and long waits at truck inspection sites. High-risk behaviours include unprotected sex with partners outside of marriage; engaging in anal sex; sexual relations with sex workers; substance abuse and misuse, including people who inject drugs; and gambling. The combination of substance abuse (truckers sometimes use alcohol, prescription drugs, and marijuana to relax or sleep and cocaine and/or meth-

amphetamine to stay awake on long hauls) and high-risk sexual behaviour creates an optimal environment for STI/HIV transmission for these workers. Close to 6 per cent of truckers are women, a portion of whom may travel as part of husband and wife truck driving teams.

AFRICA

Case Study 31: Kenya – Using peer education in an HIV/AIDS management programme for the Kenya Ports Authority (Source 41, Source M14)

Context/where: Kenya has one of the most widespread epidemics in the world, which has, however, seen a decline in recent years. Currently adult prevalence stands at 6.2 per cent (2009) and is higher among women than men. Studies have shown a high HIV prevalence amongst sex workers, PWID, MSM, truck drivers and cross-border mobile populations.

Workplace link: the Kenya Ports Authority is the workplace around which this HIV and AIDS programme was developed and implemented.

Aims/activities: The peer education Kenya Ports Authority (KPA) HIV/AIDS programme was implemented jointly with FHI starting in 2000. The objective of the programme was to extend HIV prevention and treatment to port workers. As a first step findings from research were shared with senior management and union leaders to sensitize and motivate them and to build a supportive environment for the HIV/AIDS programme and to discuss current and potential impacts of AIDS on KPA's operations.

The dialogue with senior management resulted in a revision of the structure for HIV prevention being put in place. The port was divided into six logical subunits, each treated as a discrete entity with specific focal persons and peer educators recruited. The focal person's role was to serve as a link between each section's prevention efforts and the senior management of the company and to work closely with peer educators. One workplace peer educator was recruited for every 50 employees. Each peer educator was put in charge of organizing at least one group participatory outreach meeting every week. Role-playing, picture cards, short dramas and games were used

to convey messages at these group meetings. Additionally, each peer educator informally discussed AIDS with at least ten employees monthly. In addition, peer educators also promoted awareness offsite, identified symptoms and the need for prompt care, and referral of individuals for treatment. Outreach activities were closely linked to intensive condom distribution, which occurs during peer-led educational activities. In one year, the peer educators distributed more than 65,000 condoms, which were placed in strategic places such as restrooms. The prevention programme received an annual budget from the KPA, reflecting the importance which senior management accorded to this work following the advocacy efforts. The budget allocation enabled the KPA to go beyond the workplace, into the community, and to conduct peer-led educational activities in residential areas.

Results/outcomes: Findings from research indicate that the HIV/AIDS peer education programme increased respondents HIV/AIDS knowledge levels and that participants have acquired positive attitudes towards HIV/AIDS. The programme also reduced stigma associated with a diagnosis of HIV/AIDS. Attendance at PE events and uptake in VCT increased significantly. Over time a reduction in the percentage of the workforce that testing positive was noted, as well as in the number of HIV related deaths.

Lessons:

- Working through workplaces makes it relatively easy to establish peer education programmes because communities are well defined with organizational structures, hierarchies and policies. This makes it possible to target people with common demographic characteristics
- Advocacy and buy in of senior management is critical, in particular because the resources are needed to ensure sustainability of interventions

Case Study 32: Kenya – Addressing stigma and secrecy around HIV/AIDS among transport workers (Source 44)

Context/where: To address prevailing prominent stigma and secrecy around HIV and AIDS which has been a barrier to HIV testing and to accessing treatment, this initiative launched a multi-month storytelling

programme in 2009 involving Kenyan transport workers, AIDS clinicians, and union members. The approach was to get the different stakeholder groups engaged in listening to and telling stories about HIV and its impact on their lives.

Workplace link: Unions of transport workers provided access to scale up HIV services to women and men workers.

Aims/activities: The International Transport Workers' Federation (ITF) recruited a consultancy firm to support the mainstreaming of HIV/AIDS awareness, to build knowledge, increase access to treatment, and decrease secrecy and discrimination by strengthening the collective voice of transport workers.

The Behaviour Change Communication (BCC) programme was designed to empower transport workers, who have great vulnerability to HIV, to speak out openly about the disease and be ready to take action on their own behalf, consciously altering structures of inequality, subordination, and isolation.

The strategy that was put in place by the consultancy company was to conduct an assessment of the cultural, social, and political context of HIV infection and to provide a follow-up strategy to guide the continued use of the 'Narativ' Listening and Storytelling Method. The story telling was recorded on video to be used for advocacy and training purposes, and to raise awareness.

Results/outcomes: HIV-positive transport workers in Kenya built upon their training and formed a network that brings together a diverse group of union members who are committed to sharing and listening to each other's stories and spreading the awareness of HIV/AIDS in their communities. Anecdotal evidence indicated that the storytelling had encouraged stigma reduction and voluntary disclosure.

Lessons: Innovative means of recording experience can be a powerful way of engaging workers in prevention and breaking silence around HIV.

Case Study 33: Namibia – The Walvis Bay Corridor Group (WBCG) Wellness Service, promoting wellness centers and moonlight testing for truckers (Source 47 and 38)

Context/where: Namibia's epidemic is generalized. Its current rate of HIV prevalence stands at over 18 per cent. However, the number of people who are newly infected with HIV has seen a decline in recent years. A similar downward trend has been observed in AIDS related deaths.

Workplace link: The WBCG service was introduced and expanded as part of a company policy and service. The integration in the company policy and practices was critical to the roll out of these services.

Aims/activities: In 2010, the Walvis Bay Corridor Group (WBCG) established and launched two wellness service centres in Walvis Bay and Katima Mulilo in Namibia in 2005. These wellness centres provide peer education, HIV counselling and testing, STI screening and treatment for transport workers and the communities with which they directly interact. The wellness centres are located at sites, such as truck stops, cross border sites, docks and depots where there are a significant number of transport workers. They provide a free, informal and anonymous environment in which transport workers can get information and have their health concerns attended to. Key partners in the initiative include the Namibian Ministry of Health and Social Services, the Namibian Ministry of Works and Transport, development partners such as GIZ, SIDA, the Corridor Empowerment Project (CEP), the Society for Family Health (SFH), the United States Agency for International Development (USAID), the US Embassy Public Affairs Division, Southern Africa Development Community (SADC) and North Star Alliance (NSA).

To further improve the wellness services to the transport community, particularly to address the challenges experienced in reaching long distance truck drivers due to the nature of their work, the Wellness Service has been expanded to include a component of mobile wellness. Key to reaching the transportation workers has been use of “moonlight” testing.

Moonlight testing involves visiting the hot spots and truck stops with a mobile wellness clinic, within Windhoek, Namibia, between 17h00 and 23h00 on the 'moonlight' hours three times a week. The moonlight interventions include SBC communication and HIV counselling and testing for long distance truck drivers and commercial sex workers. While this intervention remains to be evaluated preliminary information highlights high uptake numbers as well as perceived relevance of the services offered.

Results/outcomes: The WBCG Wellness Service conducted HIV prevention programmes and wellness-screening services for over 4000 transport workers between 2011 and 2012 and reached 18 transport companies in Namibia, at their respective workplaces. The programme reported estimated HIV positivity rate of around 15 per cent in 2012 for transport workers which is slightly lower than the national positivity rate of 18.2 per cent as per the 2012 sentinel survey results, and encouraging given the higher risks of transportation workers.

Lessons: The WBCG employed a mixed model approach which provides stronger evidence of impact and also provides room for more efficient, effective and sustainable health services within the transport sector, tailored to the characteristics of the workforce.

Case Study 34: Zimbabwe – Truckers and Sex Workers (Source 43)

Context/where: Zimbabwe has high rates of HIV infection and prevalence (14.7 per cent adult prevalence in 2012). Truck drivers operating on the overland routes through Zimbabwe have been a source of the disease.

Workplace link: This programme was implemented by a transportation organization, through its companies, and thus had a strong workplace focus, in spite of the mobile nature of the workforce. In addition, it used a large number of workplaces, which interacted with the truckers as entry points for contact (e.g. shops, bars, etc.).

Aims/activities: The Zimbabwe National Employment Council for the Transport Operating Industry (NECTOI)⁸ began an AIDS education programme in 1992 targeting transport workers. A major input into the programme was a base-line study which showed that drivers had poor AIDS awareness and many misconceptions about condom use. The study also identified a particular type of truck driver, *“who was sexually very active on the road – some could not imagine going more than a day or two without sex – who regularly had sex with prostitutes and belittled drivers who did not”* (Source 43, p. 132).

The programme developed a peer-based outreach programme for long-distance truck drivers and their assistants, along three major highways in Zimbabwe. The objective of the programme was to reduce STIs, to encourage condom use (especially in commercial sex) and to emphasize the dangers of unprotected sex and large numbers of sexual partners.

Peer educators recruited and trained in the programme included sex workers, as well as petrol station workers, hotel workers, bar workers, police and others who had contact with truck drivers. Twenty-one project sites along the three largest transportation routes were put in place. Messages were conveyed through a combination of peer interaction as well as song and drama. The approach also included working with local authorities, including Ministry of Health units (to overcome traditional hostility of STI clinic workers towards sex workers), AIDS service organizations, and local government and community leaders such as shop, bar and hotel owners and traditional chiefs. A weekly radio programme for truck workers helped disseminate regular messages.

Results/outcomes: About 500 peer educators were trained in 1995-1997, almost all project sites had drama groups of local teenagers. AIDS awareness and condom use rose dramatically from 1992 to 1995. Most measures of risk behaviour showed smaller changes in the period from 1995 onward but still followed a generally positive trend.

⁸ NECTOI is a non-profit-making statutory body consisting equally of industry and labour representatives and funded by the Transport and General Workers Union, the Transport Operators Association and the Zimbabwe Rural Transport Organisation. The transport industry is estimated to employ 80, 000 – 100,000 people in Zimbabwe, mostly in about 2, 500 registered transport companies.

ASIA AND THE PACIFIC

Case Study 35: Bangladesh – Focusing on Rickshaw pullers, transport workers, truckers and their helpers, port, dock and ferry workers as bridge populations (Source 33)

Context/where: In 1995, CARE Bangladesh initiated an HIV/AIDS intervention programme called Stopping HIV/AIDS through Knowledge and Training Initiatives (SHAKTI), which was funded by the United Kingdom's Department for International Development (DFID), to improve HIV and AIDS programming in Bangladesh.

Aims/activities: This initiative focused on working with bridge populations, including rickshaw pullers and truckers, dock workers, laborers, and ferry workers, to scale up HIV prevention and treatment. Baseline information showed that over half the persons in this group had had sex with sex workers in the six months preceding the survey. Of those who had sex only 11 per cent had used a condom. The SHAKTI project had four major working strategies. These were to:

- Raise awareness
- Have repeated contact of high quality with sex workers
- Provide the means of behaviour change (condoms and STD treatment)
- Create an enabling environment

The initiative prioritized the development of partnerships with transportation unions, especially trucker unions. Outreach workers conducted regular peer HIV education activities as well as partner tracking for transportation workers who tested positive for HIV and other STIs. Drop-In Centres (DIC) were established for STI syndromic management, and outreach workers systematically referred transportation workers and partners to these services as necessary.

Workplace link: Unions of transporters were the first point of contact for the initiative and provided a means for putting in place the various activities.

Results/outcomes: By 2004, the transport-worker intervention was selling up to 400,000 condoms per month across the country through its outreach worker system. Comparison to base line data showed:

- An increase in knowledge measures e.g. knowledge of the value of condoms rose from 36 per cent to 87 per cent
- Self-reported intent to use condoms rose
- Self-reported consistent condom use rose from about 14 per cent to 28 per cent

Lessons: The initiative was rolled out over a number of years. The following lessons were retained from this experience:

- Power relations between target group members need to be well understood for an effective peer education design
- There is value in monitoring truckers and helpers separately because of the very different nature of their socio-economic conditions. Truckers have a steady income. They also have a hierarchical relationship with the helpers. Different approaches are needed to address these different characteristics
- From a programmatic perspective, it is important that interventions recognize the differences that exist in the networking systems of different kinds of transport workers. These differences reflect themselves in different risks. As a result it is important that peer related activities tailor to these specificities. For example, the programme found that rickshaw pullers are more mobile and make small amounts of money and tend to engage with local sex workers, whereas dock workers have more resources and have frequent interactions with foreigners
- Establishing mechanisms within intervention design for continuous learning is critical to programme effectiveness
- Working with unions can provide important leverage but unions often lacked organizational and technical capacity. Programmes can be more effective if they include mechanisms for providing support that will strengthen unions

- Access to health services through DIC was an important part of the intervention, however these were not sustainable because they were set up as separate units with project funding and ended when the intervention ended
- When working with or through partners, provision should be made well in advance for providing technical and organizational assistance to ensure partners develop sufficient capacity to continue the programme once funding subsidies end
- Unions offer an ideal environment for HIV-prevention activities. Building the capacity of the union leadership to carry out HIV-prevention activities under the union umbrella is important as is the buy in of senior management

Case Study 36: Papua New Guinea (PNG) – Targeting truckers, dockworkers, police and other high risk groups – The TRANSEX Project (Source 57 and 58 and 33)

Context/where: An early example (dating from the 1990's) addressing various workplaces comes from Papua New Guinea where an innovative programme sought to respond to the alarming increase in HIV, in particular among sex workers and clients of sex workers. Papua New Guinea has an adult prevalence rate of 0.7 per cent, but among sex workers the HIV prevalence rate was estimated at 19 per cent in 2011 (Source 58).

Workplace link: Across the different workplaces (shipping firms, police, security firms), workplace policy workshops were held which contributed to institutionalizing the approach. Initial resistance from some workplaces – especially the trucking firms and selected large security firms – was overcome by a deliberate approach to increase the visibility of the prevention efforts. Workshops were televised and newspapers involved in disseminating information. This helped give greater credibility to the approach and to encourage cooperation from the resistant companies.

Aims/activities: The programme – which was implemented as part of a larger sexual health project conducted by the PNG Department of Health with funding from AUSAID – identified and targeted major sex worker cli-

ent groups (mostly truckers, dock workers, members of the police force and other uniformed persons). It also sought to address the perceived needs of sex workers, who were not in a position to negotiate safe sex.

Factors that were identified as having contributed to the success of the intervention:

- Extensive qualitative research on the real contexts of risk-taking in vulnerable groups
- Use of findings from research to develop materials and peer education modules tailored to the specific life situations of target groups
- Providing options, i.e. female as well as male condoms, and introducing lubricant for sex workers
- Including approaches in training to diminish moralistic and judgmental attitudes among
- Developing meaningful relationships with target groups
- Using workplace policy workshops
- Including care and counseling for HIV-positive sex workers in the approach
- Involving the media to encourage other companies to be part of the initiative

The initial approach was to attempt to approach truckers while they were working. Outreach workers were recruited to talk to truck drivers and to provide them with basic information as well as condoms. However, this strategy proved difficult with truck drivers not always responding receptively and difficulties of access and security for the outreach workers. After further research the programme decided to train dispatchers to provide condoms and information. In this process, individual truckers started to come forward and – initially without direct involvement of their companies – showed interest in becoming involved as peer educators.

Over time a number of trucking firms became engaged, resulting in formal workplace training sessions being organized in rest stops established along

the road for company drivers. These rest stops made it easier for outreach workers and peer educators to access the drivers and provided a secure setting where outreach workers could engage with multiple truck drivers if appropriate.

A second major target group for this initiative were sailors and dockworkers. For these groups contact was made through shipping companies, unions and workers' associations/cooperatives. Sailors and dockworkers proved to be very accessible to the project. Shipping companies, unions and workers' associations were very cooperative, providing the room for outreach workers to enter the wharf, board ships, and interview men.

A more sensitive and difficult area of work targeted for improved condom use was the police and the armed forces. The initial research work had highlighted major issues with respect to rape and harassment by police of sex workers. A particularly difficult area of work involved addressing the sensitive topic of line-ups with the police⁹. The programme decided to directly but privately confront the Police Commissioner, given that addressing this area would require an approach that involved the full hierarchy of the police force. The strategy also included outreach to other stakeholder groups pressuring for change, including policewomen as well as policemen's wives, who were informed about the practice and the risk that it involved for them.

Results/outcomes: As a result of the programme, and after an 18 months period participation in line-ups reduced from 10 per cent of the men at baseline reporting being involved in a line-up during the previous week, to four per cent nine months later. Total condom use with casual and commercial sex partners increased from 49 to 70 per cent. The frequency of gang rape was halved, from 10 per cent to five per cent. Among sex workers, total condom use increased from 20 to 43 per cent. Follow-up also established that policewomen became actively involved in protecting sex workers. In a number of cases, sex workers were able to report and ensure prosecution of policemen who had raped them.

Lessons: The success of the Transex project, is due to several factors.

⁹ This is the term used for coercive group sex in Papua New Guinea (Source, 57).

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- Extensive qualitative research on the real contexts of risk-taking in vulnerable groups can be critical to the development of materials and peer education modules tailored to specific life situations
 - Training to diminish moralistic and judgmental attitudes is important, requires time and effort and supports the development of meaningful relationships with target groups
 - Sex workers can become a major part of the solution, despite their illegal status.
 - Workplace policy workshops are highly useful but must be well prepared and implemented by knowledgeable technical staff

Case Study 37: Thailand – Peer Education at the Pump Project (PEPP), a collaboration between the Business Coalition on HIV/AIDS (TBCA) and Shell (Source 55)

Context/where: In 1992 the Shell Company Thailand established a comprehensive, non-discriminatory HIV/AIDS policy as part of a much wider occupational health policy approach. The company recognized at an early stage the potential impact that HIV could have on the workplace, workers, and by consequence on the operations of the company.

Workplace link: For the Shell Company of Thailand the programme has strong perceived benefits. The workplace HIV/AIDS education is considered a key instrument to improving and safeguarding staff morale and productivity.

Aims/activities: In 1997, the Shell Company of Thailand entered into partnership with the Thailand Business Coalition on HIV/AIDS (TBCA) and the United Nations Children's Fund (UNICEF), to undertake the Peer Education at the Pump Project (PEPP) at its petrol stations.

This project aimed at providing HIV/AIDS education to fuel-attendants at 75 Shell petrol stations in Bangkok and Chiang Mai. The majority of attendants were young and are considered as a high-risk group given their frequent interaction with truck drivers and other transportation workers, their mobility and their poor income. A percentage of pump attendants

supplement their resources with sex work or use the services of sex workers who are located around the pump stations.

The approach included selecting pump attendants to act as peer educators. Most of the peer educators were head pump attendants and cashiers – deliberately selected to ensure greater sustainability, as turnover rates are lower among this group. The PEPP training curriculum was designed by the Programme on Appropriate Technology in Health (PATH), providing information on family planning, STIs, HIV/AIDS education and prevention and drug abuse.

Peer educators were given information, education and communication materials to facilitate their role in trying to change the misconceptions and ignorance amongst the attendants. In order to maintain the momentum and interest, the peer educators were asked to complete a personal action plan. The TBCA facilitated competitions and exhibitions at the Shell pumps along with regional meetings for peer-educators.

Results/outcomes: The PEPP programme has been successful enough to encourage other oil companies to replicate it at their petrol stations.

Lessons:

- Workplace HIV/AIDS education can play an important role in improving and safeguarding staff morale and productivity, whereas inaction could have serious consequences for businesses
- The potential exists for the benefits of training attendants reaching a much wider audience, as petrol stations can be focus points for commercial sex workers accessing their clients, particularly truckers who can be significant vectors of HIV/AIDS.

2.4 PRISON POPULATIONS

HIV prevalence among prisoners in many countries is significantly higher than that of the general population. Many prisoners contract their

infection outside the institutions before imprisonment. However, the risk of being infected in prison is considerable – particularly through sharing of needles and unprotected sex. Outbreaks of HIV infection in prison systems are testimony to how rapidly HIV will spread in an environment of this kind unless action is taken. HIV/AIDS, STIs, HCV, and TB are thus a significant health threat to prisoners, prison staff and their families. They also constitute a burden for prison and public health authorities and governments. Nonetheless, health challenges, responses to HIV/TB/Hepatitis C and other infectious diseases have largely been inadequate or have not been provided at all in prison settings (UNODC, 2010).

However, there is some evidence that educational activities in prisons can make a difference (source: 49). The next section highlights some examples of prison-based initiatives.

AFRICA

Case Study 38: Inmate peer educators are essential to prison-based HIV testing and TB screening in Zambia (Source 29)

Context/where: Like many of its neighbouring countries Zambia faces a generalized epidemic with an adult HIV prevalence of 17 per cent. High HIV and TB rates, poor health services, overcrowding and lack of human and financial resources are common in prisons of sub-Saharan African countries, including Zambia.

Workplace link: the prison is a workplace for the prison officers and security guards. Using this workplace as a basis, it is possible to engage prisoners to scale up HIV programmes

Aims/activities: Severe staff shortages and the need for inmate buy-in led to recruitment and training of inmates to assist in the implementation of prison-based HIV testing and TB screening. The initiative was put in place by the Zambia Prisons Service (ZPS) and the Zambian Centre for Infectious Disease Research, in 2010 and 2011.

Eligible peers were chosen by prison officers, and received five days of training to complete symptom assessments, refer inmates for TB/HIV screening, collect sputum, to assist with enrolment into National HIV and TB treatment programmes, and provide educational outreach and counselling. A key aspect of the programme was the recruitment/mobilization/mentoring of inmate drama members (existing drama groups in prisons) to convey health messages through acting, music, and dance.

Results/outcomes: The programme successfully trained a total of 74 peer educators and 57 drama members and between November 2010 and September 2011, peers led 6,436 inmates (average of 32 inmates screened per day), through HIV testing and TB screening.

Lessons: A challenge to the programme was the request by prisoners who worked as peer educators for incentives, concerns over TB exposure, and difficulty maintaining adequate numbers of peers because of inmate release and transfer. Solutions included: promotions of prisoners within inmate hierarchies, provision of N95 respirators, and additional training to maintain peer numbers and establish peer-to-peer mentorship. In order to achieve this close link with the prison staff was essential and contributed to the initial success of this programme.

AMERICAS

Case Study 39: Canada – Prisoners' HIV/AIDS Support Action Network (PASAN) (Source 69, 79 and M25)

Context/where: Gay men and other men who have sex with men continued to be the population most affected by HIV and AIDS, accounting for an estimated 48% of all HIV infections. Estimates of HIV prevalence in Canadian federal and provincial prisons range from two to eight per cent, or at least ten times the reported prevalence in the population.

Workplace link: The workplace in this case is both a place of stay and work for prisoners, but also a place of work for prisons guards and others who are in regular contact with prisoners.

Aims/activities: PASAN was established in 1991 as a grassroots response to the problem of HIV and AIDS in prisons. The objectives of the PASAN initiative are to decrease behaviours that put people at risk for HIV and hepatitis C infection, enhance access to HIV, hepatitis C and STI prevention materials, and promote sexual health. In addition, the programme content addresses social and economic factors related to discrimination, poverty, race, sexual orientation, culture, gender, language skills, age, physical or mental ability and HIV sero-positivity.

The initiative actively involves former prisoners as board members, and as outreach and activism staff. The support of the prison administration and staff is important, and PASAN has conducted educational workshops and consultations with prison staff to ensure support to its programme.

PASAN operates the only national AIDS Hotline specifically for prisoners, as well as individual support counselling, advocacy, pre-release planning and referrals for prisoners and youth in custody living with HIV/AIDS, primarily in the Ontario region institutions. PASAN has also published numerous resources, including the first study ever done on women and HIV/AIDS in prison (Source 80), and a quarterly newsletter, Cell Count, distributed to prisoners, institutions, and agencies across the country.

Results/outcomes: The results of the overall PASAN approach were formally evaluated in 2002. At the outcome level the report found an increase in the HIV prevalence in prisons. Some significant, positive developments are highlighted (including the introduction of innovative education approaches). However, challenges have persisted including: insufficiently strong government leadership; inconsistent/poor coordination between partners; insufficient/breaks in supplies such as condoms, access to testing, etc.; as well as reluctance by authorities in embracing a harm reduction approach. The non-mandatory nature of the education programme was also highlighted.

Lessons: This example underscores difficulties related to this particular working environment, the coordination between actors, and the need for

strong policy support for initiatives. It also shows that evidence of what works may not always be politically palatable.

Case Study 40: Canada – Choosing Health in Prisons (CHIPS) (Source 81)

Aims/activities: Choosing Health in Prisons (CHIPS) is a voluntary programme offered by CSC. Every prisoner entering a federal prison in Canada is eligible to be in the programme. Prison health care at Stony Mountain in Canada has made the CHIPS programme a priority at intake. The programme is run every two weeks by a designated facilitator and takes a full five days to complete, during which time prisoners receive their regular pay. This constitutes an important motivational incentive for participation.

Ninety-four per cent of the prison population goes through the programme. For prisoners who are not able to attend CHIPS (because they cannot mix with the population), they are given a Reception Awareness Package (RAP) in segregation and told that they can ask questions at any time.

The programme covers information on HIV/AIDS, HCV, STIs, harm reduction and other health-related concerns. The approach ensures that differences within and between groups are recognized and that content is appropriately adjusted. Facilitators use a variety of learning tools (audio, visual, verbal, kinaesthetic and writing) in addition to playing games and showing videos to keep the group engaged in the learning process. Some of the content focuses on the prison environment, and peers (i.e., other prisoners) come in to talk about how to stay “safe” in the prison environment.

Workplace link: Prison staff and structures are actively involved in providing the services to prison population.

Results/outcomes: The programme has resulted in an increase in HIV and HCV testing. As a result of the CHIPS programme, about 85 per cent of the prison population has sought testing for HIV/AIDS, and there is an equally high rate of immunization for hepatitis A and B.

Lessons:

- Peer education has been an important aspect of the process. This has allowed new prisoners coming into the prison system have a better understanding of the risk involved in particular activities.
- Buy-in from prison staff was critical to making the programme successful. Liaising and mobilizing other prison staff has ensured that the programme is part of the regular prison planning and monitoring systems. As a result the staff persons responsible for prisoner intake view the programme as a priority, which contributes to the programme's high completion rate.

ASIA AND THE PACIFIC

Case Study 41: Bangladesh – Prison prevention programme (Source 52)

Aims/activities: In 2010 the United Nations Office on Crime and Drugs (UNODC) also initiated an HIV prevention programme in prison settings in Bangladesh. It is implemented through a partnership with NGOs and government in six prisons respectively Dhaka and Rajshahi. The basis for the programme was a situational assessment that was conducted in twelve prisons, of which six were retained for the initial activities. Major programme activities include:

- Advocacy and sensitization
- Training of health workers working under prison and health authorities on HIV/AIDS/ STIS, and TB
- Identification and training of peer educators and peer volunteers among the prison inmates
- HIV/AIDS and STI education to prison inmates through peer educators and volunteers using different IEC specific to prison
- STI and TB treatment
- Provision of ART to HIV positive people

The programme envisages the principle “Prison Health is Public Health” as prisoners and prison staffs are in continuous contact with community – prisoners come from community and most go back to the community. It

will integrate lessons learnt from previous support to prison programmes, which had included:

- Using innovative techniques such as getting prisoners to script their own plays and present them within the prison community (enhancing the relevance to prisoners own lives and communities)
- Quiz competitions organized by the jailor and the site officer
- Interactive sessions were held on health issues related to drugs, HIV/AIDS and STIs, which encourage exchanges of views between inmates, prison staff and external NGO staff providing support

Workplace link: the prison is a workplace for the prison officers and security guards. The approach was to use the prisons as an entry point to increase access to HIV services for key populations

Results/outcomes: Preliminary findings suggest that the educational programmes have played an important role in reducing fears about HIV and its transmission among staff members and inmates and that it has contributed to uptake of testing by both groups.

Lessons: Accurate and adequate information for staff and inmates can affect institutional policies in ways that can alter prisoners' lives profoundly.

EUROPE AND CENTRAL ASIA

Case Study 42: Albania, Serbia and the Former Yugoslav Republic (FYR) Macedonia, Encouraging authorities to contain the HIV/TB/Hepatitis C epidemics (Source 70)

Context/where: The rates of HIV, TB and hepatitis C and B infections among prisoners in most countries of the world are significantly higher than those in the general population.

Workplace link: the prison is a workplace for the prison officers and security guards. Using this workplace as a basis, it is possible to scale up HIV programmes to prison inmates.

Aims/activities: In this context the UNODC introduced a project in 2011 focus on “Ensuring relevant authorities act to contain the HIV/TB/Hepatitis C epidemics among drug users and in prison settings in Albania, Serbia and the FYR of Macedonia”.

The project aimed at increasing access to comprehensive HIV/AIDS, hepatitis C and TB prevention and care services for injecting drug users and in prisons in Albania, Serbia and the FYR of Macedonia. Together with representatives of Ministry of Justice and civil society organizations, the initiative conducted policy assessments for comprehensive HIV prevention and treatment services for drug users and prison settings in the three countries. Results of the assessments were shared with key stakeholders and resulted in the establishment in each country of national Technical Working Groups (TWG). These groups include representatives from prison health staff, prison administration, judicial authorities, national health services and NGOs. The TWG in cooperation with Ministries of Health and Ministries of Justice planned specific prison based interventions for prevention, diagnosis and treatment of HIV/HCV in prisons. Training for prisons has included best practice approaches in HIV/TB/HBC prevention in prison institutions. As this is a relatively new initiative it remains to be evaluated.

LESSONS AND ISSUES FOR REFLECTION

This report presents a total of 42 case studies where the workplace or the workforce was used as an entry point to provide HIV services to key populations in different epidemic settings.

Key populations

The first part of the presentation of case studies focuses on reaching sex workers, men who have sex with men, transgender populations and injecting drug users with HIV services through workplace structures or workers working in those identified structures. In virtually all contexts, these key populations have a higher HIV prevalence than the general population. Key populations are *hard to reach* populations. Many structural and programmatic barriers make it difficult to increase access to HIV services for these key populations. Issues such as stigma, discrimination and criminalization make it difficult to bring HIV services close to these populations. The case studies identified innovative approaches of bringing HIV services to these *hard to reach* populations. For example, massage parlours, brothels, hotels, saunas, gay clubs, motels, itinerant barbers, restaurants and beauty salons were identified and used as workplaces through which, access to sex workers, men who have sex with men, transgender populations and injecting drug users was made possible. Through these workplaces and locations, HIV information and services was made available to the key populations. The decision to adopt this approach was informed by research and the generation of evidence around the behaviours of key populations. In many countries, the workers in these identified workplaces were trained and equipped to reach out to their clients who were in most cases, key populations. For example sauna workers in Thailand provided HIV services to men who have sex with men and in India, itinerant barbers and the workers in transgender beauty salons were used to reach sex workers and transgender populations respectively. In some case studies, the workers were themselves key populations hence the approach was to use key populations to reach key populations. The country case study examples

presented in this report are important because they serve as a guide to policy makers and programme implementers on creative ways in which the potential of the workplace can be fully harnessed to support national efforts to combat HIV and AIDS. A paradigm shift in the conceptualization of what constitutes HIV workplace programmes is essential to optimize the use of the workplace.

Key populations

This section deals with key populations who vary from context to context but nonetheless are disproportionately affected by the HIV epidemic within their respective countries. These populations include migrant workers, transport workers, farm workers, mobile populations, garment workers, port and fishery workers, truckers, mine workers, etc. These populations are relatively easier to reach when compared to the key populations discussed earlier. In many countries, these populations are reached with HIV services in their workplaces which may be in the public or private sectors or the formal or informal economy. The HIV workplace programmes which bring services to context specific key populations can be described as programmes which use interventions at the workplace to reach the women and men workers whiles, the HIV workplace programmes which bring HIV services to universal key populations can be described as programmes designed to reach the clients of the workers and hence these are programmes which pass through the workplace. There are many programmes which adopt both approaches and hence in practice there isn't always a clear distinction but a conceptual understanding of the difference is critical for programme design.

Across the case studies presented, some common themes were identified that might contribute towards a successful HIV workplace programme and these are presented subsequently:

- Careful initial research to identify the problem, potential solutions, as well as the opportunities that exist locally to ensure that the planned interventions meet the specific needs of key populations is needed. Evidence must lead and underpin the HIV workplace programmes

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- Follow up research was undertaken in many countries to ensure that the approaches and interventions are continuously adapting to change. It is important to acknowledge that universal key populations are often very mobile and transient and hence it is important to make sure that programmes are consistently meeting their needs
 - There is currently some knowledge on *what works* with key populations out there. It is important that programmes use the available information as part of the evidence in the design of HIV workplace programmes which meet the needs of key populations
 - The use of various mapping techniques to identify key populations as well as ‘workplaces’ that may be used as entry points for accessing key populations. It is also important to identify the HIV services needed by the key populations. The identified workplace would only be useful programmatically if it serves as a channel to reach key populations with services.
 - The direct involvement of key populations in the design, implementation, monitoring and evaluation of the programmes is essential. No one understands the needs of key populations more than key populations themselves
 - The involvement and institutional commitment from the management of the identified workplaces is an important element of such programmes. Whether the programmes focuses at the workplace or is working through the workplace, management commitment and support is crucial to the success of the programme
 - Sensitizing businesses to the fact that such interventions make sense and can contribute towards improving the business. A business case for the interventions is a useful way to secure buy-in and ownership from the business. The wins could be financial, reputational, in terms of quality of service, in terms of customer/client care, etc
 - Peer education has a significant role to play in many of these programmes. Carefully selected, well trained, well equipped and effectively monitored peer education is an essential aspect of reaching key populations through HIV workplace programmes
 - Reaching out to and involving communities through advocacy and direct partnerships is key to ensuring buy-in at the community or local level.

The involvement of traditional authorities where possible is important since it enhances buy-in

- A strong link of the interventions to high-quality, non-judgmental, accessible public health and other services so that key populations can access a wide range of services as needed
- A good partnership with law enforcement agencies and the police is essential especially when the programmes focus on reaching universal key populations.
- Working with and involving the local government authority contributes to local buy-in and sustainability of the programmes.
- The use of policies and codes of good practice in some entertainment institutions was a helpful and useful way of ensuring that all the women and men workers in those institutions adhered to some minimum standards of protection.
- Simultaneously addressing the underlying factors that contribute to vulnerability for example focusing on economic empowerment increases income levels and makes them less vulnerable to HIV and AIDS.
- In some countries, the use of multi-media and entertainment approaches were instrumental in reducing the high levels of stigma associated with dealing with key populations. Enter-educational approaches are very useful in breaking the ice and reducing the levels of stigma and discrimination
- It is important to ensure that programmes include mechanisms for continuous learning, adaptation, monitoring and evaluation. The only way we can truly learn about the effectiveness of a programme is to have a system which allows the programme to track its progress.

The case studies also highlight some common challenges. Across many of these examples, monitoring and evaluation emerges as a weakness. Quite a number of the promising interventions have not been robustly monitored to track results. There is hence an absence of information with regards to the outcome level changes. In some other cases, promising interventions have been cut short or discontinued due to funding challenges. Stigma and discrimination is also a major challenge to many of these programmes, espe-

cially those focusing on universal key populations. The lessons learned from this report can be condensed into a number of summarized working strategies for policy makers and practitioners.

- These include the following:
- Understanding the problem
- Raising awareness on the extent of the problem
- Creating an enabling environment including by providing (access) to means for behaviour change
- Ensuring broad and meaningful involvement of all actors – respecting their concerns and identifying incentives
- Establishing mechanisms for listening, learning and adaptation
- Ensuring access to sound technical and organizational assistance for key partners
- Monitoring and evaluation of programmes

BIBLIOGRAPHY/REFERENCES

Avahan. (2009). From Hills to Valleys: Avahan's HIV Prevention Programme among Injecting Drug Users in Northeast India. New Delhi: Bill & Melinda Gates Foundation, 2009.

Avert (2013). Case study: The Tamil Nadu Transgender Welfare Board. Avert. Accessed on-line on the 15th of September 2013 at: <http://www.avert.org/transgender-hiv.htm> (Source 77)

Bao, V. et al. (2003). Expanding Workplace HIV/AIDS Prevention Activities for a Highly Mobile Population: Construction Workers in Ho Chi Minh. Horizons. Accessed on-line on the 15th of September 2013: <http://www.popcouncil.org/pdfs/horizons/vtn-mcnstrwrkrssum.pdf> (Source 29)

Bonell, C., Strange, V., Allen, E., & E. Barnett-Page. (2006). HIV prevention outreach in commercial gay venues in large cities: evaluation findings from London. Health Education Research Theory & Practice, Vol.21 (4) 2006, pp. 452–464 (Source 62)

Brussa, L. (Ed.). (1997). TAMPEP, October 1996-September 1997: Final Report. TAMPEP. (Source M8)

Canadian HIV/AIDS Legal Network. Past recipients of the Canadian HIV/AIDS Award. Accessed on-line on the 15th of September 2013 at: http://www.aidslaw.ca/EN/about_us/what_we_do/past_recipients.htm (Source 69)

CARE and Emphasis Regional Secretariat. (2013). Enhancing Mobile Populations' Access to HIV and AIDS Services, Information and Support. Lalitpur, Nepal. (Source M12)

Center for AIDS Prevention Studies (CAPS). (2005). Research Portfolio. University of California San Francisco, California. (Source 203)

Chaprakani, V. (2012). The Case of The Tamil Nadu Transgender Welfare Board: Insights for Developing Practical Models of Social Protection Programmes for Transgender People in India – Policy Brief. UNDP. (Source M10)

CHMI Vietnam (2011). HIV/AIDS prevention for men. Accessed on-line on the 15th of September 2013 at: <http://healthmarketinnovations.org/programme/hivaids-prevention-men> (Source 5)

Chu, S. (2009). “Do the Right Thing”: An evidence-based response to addiction and mental health in federal prisons. Brief to the House of Commons Standing

Committee on Public Safety and National Security regarding its study Federal Corrections: Mental Health and Addiction. Canadian HIV/AIDS Legal Network. Ottawa, Canada (Source 79)

Cohan, D., Lutnick, A., Davidson, P., Cloniger, C., Herlyn, A., Breyer, J., Cobaugh, C., Wilson, D. and J. Klausner. (2006). Sex worker health: San Francisco style. *Sexually Transmitted Infections* Vol. 82(5): pp. 418–422 (source M3).

Daley, K. (2000). *The Business Coalition Response to HIV/AIDS: Impact and Lessons Learned*. UNAIDS. Geneva, Switzerland (Source 55)

Derroy, J. (2013). *Storytelling to Combat HIV/AIDS Stigma amongst Transport Workers*. The Communication Initiative. Accessed on-line on the 15th of September 2013 at: http://www.comminit.com/health_rights_media/content/storytelling-combat-hiv-aids-stigma-amongst-transport-workers (Source 44)

De Xaxàs, M., O'Reilly, K., Evans, C., Higgins, D., Gillies, P. & S. Jana. (2008) Meeting community needs for HIV prevention and more: Intersectoral action for health in the Sonagachi red-light area of Kolkata. The Durbar Mahila Samanwaya Committee (DMSC) Theory & Action for Health (TAAH) Research Team (74)

Dias, G. & J. Betteridge. (2007). *Hard Time: HIV and Hepatitis C Prevention Programmeming for Prisoners in Canada*. Canadian HIV/AIDS Legal Network, Prisoners' HIV/AIDS Support Action Network (PASAN). Toronto, Canada (Source 81)

Draft FCB. (2010). *Barbers, Shoeshine Boys, Comic Books and Condoms*. Accessed on-line on the 15th of September 2013 at: <http://draftfcb.co.nz/category/draftfcb-catalyst/page/5/> (Source 8)

Dunn, K. and A. Mondal. (2010). *Report on the Review of the Decent Country Work Programmeme: Bangladesh 2006-2006*. ILO Regional Pacific Office. Bangkok, Thailand. (Source 17 f)

Eurasian Harm Reduction Network. (2012). *Project: Ensuring relevant authorities act to contain the HIV/TB/Hepatitis C epidemics among drug users and in prison settings in Albania, Serbia and the FYR of Macedonia*. UNDOC. (Source 70)

Gilden, D. (2009). *Case Studies for Global Health – Building Relationships, Sharing Knowledge – 2nd Edition 2012*. Case Studies for Global Health. Accessed on-line on the 15th of September 2013 at: <http://www.casestudiesforglobalhealth.org/post.cfm/lesotho-factory-based-aids-group-adjusts-to-changing-realities-update> (Source 16)

Ghose T, Swendeman DT, George SM . (2011). The role of brothels in reducing HIV risk in Sonagachi, India. *Qual Health Res.* Vol 21(5): pp. 587-600 (Source 71).

Government of Bangladesh. (2012). Country Progress Report: Bangladesh Country Progress Report. Dhaka, Bangladesh (Source 52)

Government of Lesotho. (2012). Lesotho – Global AIDS Response Country Progress Report – January 2010 to December 2011. Ministry of Health and Social Welfare of Lesotho (Source M21)

Government of Papua New Guinea. (2012). Global AIDS Report 2012: Country Progress Report, Papua New Guinea, Reporting Period. January 2010 – December 2011. Government of Papua New Guinea. Port Moresby, Papua New Guinea. (Source 58)

Government of the United Arab Emirates. (2012). United Arab Emirates – Global AIDS Response Progress Report 2012. Government of the United Arab Emirates. (Source 51)

HIV/AIDS Alliance (n.d.). NGO Code of Code Practice – Self Assessment Checklist: Key Populations. HIV/AIDS Alliance, Brighton, UK. (Source M6)

Homan, R. & F. Oluoch. (2010). Cost-Benefit Evaluation of the Kenya Ports Authority HIV Prevention, Education and AIDS Care Activities. FHI. (Source M14)

ILO (2013). Reducing HIV Vulnerabilities of Men Who Have Sex with Men in Saunas (Bangkok, Thailand). Accessed on-line on the 15 September 2013 at: http://www.ilo.org/asia/whatwedo/projects/WCMS_190020/lang--en/index.htm (Source 64)

ILO (n.d.). Reaching out to sex workers and their clients. Accessed on-line on the 10th of March 2014 at: http://www.ilo.org/wcmsp5/groups/public/@ed_protect/@protrav/@ilo_aids/documents/genericdocument/wcms_185717.pdf (Source M 23)

IOM. (2005). HIV/AIDS and Populations Mobility – Overview of the IOM Global HIV/AIDS Programme 2006. IOM. Geneva. Switzerland (Source 28)

Jenkins, C. (2000). Female sex worker HIV prevention projects: Lessons learnt from Papua New Guinea, India and Bangladesh. UNAIDS. Geneva, Switzerland (Source 33)

Jenkins, C. (1997). Final Report to UNAIDS: Police and Sex Workers in Papua New Guinea. Papua New Guinea Institute of Medical Research. Goroka, Papua New Guinea (Source 57)

Kaiser Family Health (2006). Associated Press Examines Indian HIV Prevention Programme That Trains Barbers to Promote Prevention Among Clients. Accessed online on the 15th of September 2013 at: <http://www.thebody.com/content/art7575.html> (Source 3)

Kitala, J. (2011). A study on the impact of HIV/AIDS peer education programme on the management of HIV and Aids at the Kenya Ports Authority (KPA). Assignment submitted in partial fulfilment of the requirement for the degree of Master of Philosophy (HIV/AIDS Management) at Stellenbosch University. Africa Centre for HIV/AIDS Management Faculty of Economic and Management Sciences, Stellenbosch University. Stellenbosch, South Africa. (Source 41)

Knight, V. (Ed.) (2006). Transport Workers at Risk to HIV – Documenting our Experience 2000-2004. Care Bangladesh (Source M15)

Lines, R. (2002). Action on HIV/AIDS in Prisons – Too Little, Too Late: A Report Card. Canadian HIV/AIDS Legal Network (Source M25)

McMillan, L., (2013). Sex work and HIV/STI prevention in the Pacific region, including analysis of the needs of, and lessons learnt from, programmes in four selected countries. Pacific Island HIV and AIDS Response Fund & Secretariat of the Pacific Community. (Source M7).

Mainkar, M., Pardeshi, P., Dale, J., Deshpande, S., Khazi, S., Gautam, A., Goswami, P., Adhikary, R., Ramanathan, S., George, B., and R. Paranjape . (2011). Targeted interventions of the Avahan programme and their association with intermediate outcomes among female sex workers in Maharashtra, India. BMC Public Health, v. 11(Suppl 6), pp. 1-16. (60b)

Mind Caviar. (2002). The St. James Infirmary: A Safe Medical Haven for Sex Workers

Originally published in Mind Caviar, Fall, 2002. Accessed online on March 10th, 2014 at: <http://literateperversions.com/writing/the-st-james-infirmary-a-safe-medical-haven-for-sex-workers/> (Source M21)

MSMGF Blog. (2013). Adonis Tchoudja on Fighting HIV among Male and Transgender Sex Workers in Cameroon. Accessed online on the 15th of September 2013 at: <http://msmgf-blog.blogspot.fr/2013/02/adonis-tchoudja-on-fighting-hiv-among.html> (Source 59)

Mupemba, K. (1999). Chapter 12 – The Zimbabwe HIV prevention programme for truck drivers and commercial sex workers: a behaviour change intervention. In “Resistances to Behavioural Change to Reduce HIV/AIDS Infection”. (Source 43).

Nemoto, T., Iwamoto, M., Oh, H., et al. (2005). Risk behaviors among Asian women who work at massage parlours in San Francisco: Perspectives from masseuses and owners/managers. *AIDS Education and Prevention*, vol 17: pp. 444-456. (Source M25)

Ogden, J., Howson, J., Bockh, E. & K. Tureski (2011). Global best practices – Effective practices to inform SBCC programming and reduce HIV risk for sex workers and men who have sex with men in Jamaica and the Bahamas. *Communication for Change & USAID* (Source 60)

Olfarnes, T & A. Alikhan (2009). Feature Story – Barber Shops and Beauty Salons Promote HIV Education in Guyana. UNFPA. Accessed online on 15th September 2013 at: <http://www.unfpa.org/public/News/pid/2128> (Source 14a)

Press, B. (n.d.). HIV/AIDS Prevention Among Migrant Workers in Thailand's Seafood Industry. Raks Thai Foundation. PowerPoint Presentation (Source 26b)

Rahnama, R. (2008). What are sex workers' HIV prevention needs? Centre for AIDS Prevention Studies. (Source M24)

Research Unit in Behavior and Social Issues (2013). The Everywhere Project – Designing a Multisectorial Network for prevention of HIV/AIDS Amongst Men Having Sex With Men (MSM). Accessed online on 15th September 2013 at: <http://www.rubsi.org/en/projects/designing-multisectorial-network-prevention> (Source 65)

Ross, M., Crisp, B., Månsson, S. & S. Hawkes. Occupational health and safety among commercial sex workers. *Scandinavian Journal of Work and Environmental Health* Vol. 38(2), pp.105-119 (Source 75)

Sanders, E. (2004). Seattle HIV programme enlists barbershops – Black men get a trim and a frank discussion. *The Boston Globe*. January 1, 2004. Accessed online on 15 September 2013 at: http://www.boston.com/yourlife/health/diseases/articles/2004/01/01/seattle_hiv_programme_enlists_barbershops/?page=full (Source 12)

Sfetcu, O. and M. van de Laar (Eds.). (2013). STI and HIV prevention in men who have sex with men in Europe – Technical Report. European Centre for Disease Prevention and Control. Stockholm, Sweden. (Source M5).

Shahjahan, M. (2012). Expanding HIV/AIDS Prevention in Bangladesh – Providing Primary Prevention of HIV and Risk Reduction through Workplace Interventions in Garments Factories/Industries : Report on Progress Assessment of workplace intervention at Garment Factory. YPSA Consortium (Source 17c)

Sherriff, N. (2013). A European Seal of Approval for 'gay' businesses: findings from an HIV-prevention pilot project. *Perspectives in Public Health* (in print) (Source 67a)

Sherriff, N.S., and Gugglberger, L. (2013). A European Seal of Approval in HIV prevention for 'gay' businesses: findings from an HIV prevention pilot project in eight European countries. *Perspectives in Public Health* (Source 67b)

Sherriff, N.S., McDonnell, E., Tunstall, B., Bogen-Johnston, L., and O'Brien, O. (2013). Engaging 'gay' businesses in HIV Prevention 'Everywhere': findings from a qualitative study involving business owners in eight European Cities. *Health Education Journal*, 72(1), 13-23 (Source 67c)

Sherriff, N.S. (2011). A methodological model of HIV prevention in men who have sex with men (MSM). The Everywhere Project. Final report to the European Commission. Brighton: University of Brighton (Source 67d)

Sonke Gender Justice Project (2008). Addressing gender inequalities driving the spread and impact of HIV and AIDS on farms in Hoedspruit, Limpopo Province, South Africa: End of Project Report: May 2007. Sonke Gender Justice Project: HIV/AIDS, Gender Equality and Human Rights. South Africa (Source 78)

Spratt, K. & N. Kapadia (2011). PRASIT: Using Strategic Behavioral Communication to Change Gender Norms in Cambodia. *KunduAIDSStarOne Case Studies*. Arlington, USA. (Source 74).

Sultana, N. (2012). Forgotten No More: Making health care available for the most marginalized groups in Bangladesh. Accessed online on 15th of September 2013 at: <http://healthmarketinnovations.org/blog/forgotten-no-more> (Source 17a)

Tansey, E., Theyise, N., Borland, R. & H. West. (2010). Southern Africa ports as spaces of HIV vulnerability: case studies from South Africa and Namibia. *International Maritime Health Journal*. Vol 61 (4) pp. 233–240 (Source 38)

The Terrence Higgins Trust (2008). The Playzone Staff Manual. The Terrence Higgins Trust. London, UK (source 66)

The Times of India. (2009). Transgenders get their own beauty parlour. Ambika Pandit, Oct 1, 2009. Accessed online on March 10th, 2014 at: <http://timesofindia.indiatimes.com/city/delhi/Transgenders-get-their-own-beauty-parlour/articleshow/5074210.cms>

The United Nations News Centre (2009). Guyana's barber shops, beauty salons offer UN-backed HIV prevention advice. Accessed online on 15th September 2013 at: <http://www.un.org/apps/news/story.asp?NewsID=30245&Cr=HIV+prevention&Cr1=#.UjWwFRZe7dk> (Source 14b)

The Walvis Bay Corridor Group. (2013). The WBCG Wellness Service contributing to reduced infection rates. Accessed online on 15th September 2013 at: <http://www.wbcg.com.na/news-info/news/detail//the-wbcg-wellness-service-contributing-to-reduced-infection-rates/home-page.html> (Source 47)

UNAIDS (2012). Sex workers learn business skills in new community-based ILO project. UNAIDS Feature Story, Geneva. Accessed on-line 10 March 2014 at: <http://www.unaids.org/en/resources/presscentre/featurestories/2012/may/20120530ilosexwork/>

UNAIDS (2009). 'Never abandon, never give up': ILO film helps China's migrant workers challenge AIDS stigma. UNAIDS Feature Story, Geneva. Accessed on-line 10 March 2014 at: <http://www.unaids.org/en/resources/presscentre/featurestories/2009/april/20090430ilofilmschina/> (Source M13)

UNFPA, UNAIDS, Asia Pacific Network for Sex Workers (n.d.). The HIV and Sex Work Collection – Innovative Responses in Asia and the Pacific. UNFPA, UNAIDS, Asia Pacific Network for Sex Workers.

USAID West Africa. Cameroonian Apparel Maker Rides the Wave into U.S. Market. Accessed on-line on the 15th of September 2013 at: <http://www.watradehub.com/sites/default/files/resourcefiles/feb11/success-ken-atlantic-07.pdf> (Source 18)

Vallejo, M. (2010). Innovative Approaches – Raks Thai / PHAMIT –Programme: Prevention of HIV and AIDS among Migrant Workers in Thailand. UNDP Asia Pacific Regional Centre (Source 26a)

Von Kerenschazy, J. (2007). Working with brothel owners to promote HIV prevention: challenges and future directions. Insight Publication. Accessed online on the 15th of September 2013 at: http://www.kit.nl/net/KIT_Publicaties_output/showfile.aspx?e=1281 (Source 34)

WHO. (2011). Evidence for Action Technical Papers – Effectiveness of Interventions to Address HIV in Prisons. WHO. Geneva, Switzerland.

Williamson, L., Hart, G., Flowers, P., Frankis, J. & V Der. (2001). The Gay Men's Task Force: the impact of peer education on the sexual health behaviour of homosexual men in Glasgow. Sexually Transmitted Infections, vol. 77:pp 427–432 (Source M9)

Wu, R. (2011). Thematic Update – Migration. HIV doesn't stop at borders: A human rights approach to protect migrant and cross-border workers. ILO. Geneva, Switzerland. (Source 25).

Young Power in Social Action (n.g.). Workplace Interventions in Garment Factories (HIV/AIDS GFATM 912). Accessed online on the 15th of September 2013 at: <http://ypsa.org/workplace-interventions-in-garments-factories-hiv-aids-gfatm-912/> (Source 17b)

ANNEX 1 – OVERVIEW OF KEY WORDS USED FOR THE LITERATURE SEARCH

All	And	Key populations	Workplace/where	Other
HIV AIDS TB	Prevention Treatment Care Support Services Economic Empowerment	PLHIV PLWHIV Intravenous Drug User Sex worker Prostitute Men who have sex with men Gay Lesbian Bisexual Transgender LGBT GBT Key population Migrant Truckers Refugee(s) Mobile populations Prisoner(s) Uncircumcised men People with disabilities Rickshaw puller(s) Commercial Sex Worker Dock workers Sailors Entertainment worker Performer	Massage parlour Massage parlor Sex establishment Hospitality industry Hotel Motel Brothel Workplace Work Market Border Hairdresser Health facility Clinic Barbers Fairs Department of motor vehicles Drugstores Motorcycle taxi drivers Shoe shiners/shoe shine stores Beauty salons Hairdressers Nail salons Liquor stores Check cashing services Army Police/ police department Wine shops Domestic workers Law offices Pawn shop Butcher Bar Club Fast food restaurant Bodegas Laundromat(s) Kareoke lounge Escort services Hostels Go-go bars Beer garden Discoteque Ballroom Entertainment services	Policy Policies Programme Program Gender Hyperendemic Generalised Concentrated Best practice Innovative Case study Pilot Management Managers Staff Owners Business

ANNEX 2 – OVERVIEW OF INTERVENTIONS RETAINED FOR THIS REPORT BY KEY POPULATION GROUP

No.	Title of the intervention	Intervention purpose/type	Year	Country	Target group	Leading organization	Workplace link	Evaluation/ results available
1. CONVENTIONAL KEY POPULATION GROUPS (FOUND IN ALL SETTINGS)								
<i>1.1. KEY POPULATION: SEX WORKERS</i>								
1	The Sonagachi project – Involving brothel owners in the empowerment of SW	Provision of a co-operative finance scheme, skills training, social marketing of condoms, and prevention of trafficking	1992	India	Sex workers and brothel owners	All India Institute of Public Health and Durbar Mahila Samanwaya Committee	Brothels	Yes
2	The SMART girl initiative for Entertainment Workers (EM)	Promote risk reduction and safer sexual practices among EM	2008	Cambodia	EW and clients	PRASIT/ FHL-360	Clubs, special events, other entertainment events	Yes
3	Health Project for Asian Women (HPAW)	Providing HIV prevention training to massage parlor owners as well as access to counseling	2001-2004	USA, San Francisco	SW	Department of Health	Massage parlors	Yes
4	Programme de Prevention et Prise en Charge (PPP)	Condom promotion, and general SRH promotion	1990-1999	Cote d'Ivoire	SW and sex partners	Institute of Public Health/ National AIDS Programme	SW worksites and surrounding areas	Yes
5	Avahan	Provide focused HIV prevention and services for SW, IDU and MSM	2004 onwards	India	SW, MSM, IDU	National AIDS Control Organization	Brothels, lodges, health service providers, drop-in centers	Yes
6	Community Based Enterprise Development Training for Sex Workers	Reduce dependency and vulnerability of SW	2010	Thailand	Sex Workers	Empower Foundation with support from ILO	New business activities by SW	No

No.	Title of the intervention	Intervention purpose/type	Year	Country	Target group	Leading organization	Workplace link	Evaluation/ results available
7	Provision of Entrepreneurial Training to Taxi Riders	Reduce dependency/vulnerability on SW/ by bicycle taxi drivers	2010	Malawi	Bicycle taxi riders (many of whom engage in sex work)	Karanga Cargo Association with support from ILO and SIDA	New business activities by SW	Yes, anecdotal
8	Saint James Infirmary	Prevention and treatment of HIV for SW	1992 onwards	USA	Sex workers	Occupational Health and Safety Board, and coalition of SW/ rights groups	Establishment of a peer run and peer based clinic for health and HIV needs	Yes
9	Service Workers in a Group (SWING)	Provision of HIV and health services	Late 1990s onwards	Thailand	Male and transgender sex workers, later expanded to all SW	FHI-360 Communities (providing donations)	Entertainment venues (bars, etc.), and partnerships with police and health services	Yes, limited
10	TAMEP (Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe Project)	HIV and STD prevention by promoting safer sex and access to services	2000 onwards	Europe	Migrant SW	TAMPEP – European Network for HIV and STI Prevention Promotion Among Migrant Sex Workers with support from EC and other donors	Owners of prostitution venues and key persons in the environment e.g. forces of public order	Yes
11	Acodex Night Patrols	Addressing HIV among male and transgender sex workers	2009 onwards	Cameroon	Male and transgender sex workers	Acodex	Dating sites, sex establishments (brothels, bars, nightclubs, massage parlours, restaurants, homes of sex workers)	No
12	Barbers and hairdressers as information hubs	Provide HIV and AIDS prevention information	2008 onwards	Guyana	Young people and SW	UNFPA	Barbershops/ hairdressers	Anecdotal

No.	Title of the intervention	Intervention purpose/type	Year	Country	Target group	Leading organization	Workplace link	Evaluation/ results available
1.2. KEY POPULATION: MEN WHO HAVE SEX WITH MEN (MSM)								
13	Down Low Barbershop Programme	HIV prevention, condom distribution, and promoting access to counseling and testing	Early 2000s	USA, Seattle	Black MSM	US Department of Public Health	Barbershops	No
14	Reducing HIV vulnerabilities of MSM using saunas	Promoting safer sex among high risk sauna workers and sauna users	2012	Thailand	MSM working in and frequenting saunas	ILO, the Bangkok Rainbow Organization (BRO) and the Rainbow Sky Association (RST) and various government offices and donors	Saunas	No
15	Venue Based Interventions for MSM	Increase negotiation skills, enhance knowledge, strengthen referral	Mid 2000's	UK	MSM	Local community organizations	Gay pubs, clubs and bars	No
16	'Play Zone' – Promoting codes of good practice and minimum standards for entertainment areas	Create a safer environment in entertainment areas, raise awareness of sexual health, reduce STI and HIV infection	2008	UK	MSM clients and workers in saunas, bars and clubs	Terrence Higgins Trust	Saunas, bars and clubs	No
17	The Everywhere Project	HIV prevention through adoption of Codes of Good Practice	2008-2010	Europe (8 countries)	MSM	EC Public Health Programme with 17 partners	Gay business owners (hotels, sex venues, travel agencies, gay dating websites)	Yes (for the pilot phase)
18	The Gay Men's Task Force (GMTF)	Peer education of gay men to reduce sexual risk taking and increase uptake of services	1990s	Scotland	MSM	Community level agencies in Glasgow	Bars, MSM specific medical services	Yes

No.	Title of the intervention	Intervention purpose/type	Year	Country	Target group	Leading organization	Workplace link	Evaluation/ results available
1.3. Key Population: Intravenous Drug Users (IDU)								
19	Itinerant Barbers	Uptake of services by IDU and SW	2004-2005	India	IDU	NAC India and Association Francois-Xavier Bagnoud (Swiss)	Itinerant barbers who move from place to place	No
20	Barbers, Shoshine Boys, Motorcycle Taxi Drivers & Workplace Advocates engage in HIV prevention and access to treatment	Reduce risks of HIV transmission associated with IDU and inconsistent condom use	Early 2000s	Vietnam	IDU	The Provincial Health Department, The Provincial AIDS Standing Bureau FHI, funding from USAID	Barbers, shoshine boys, motorcycle taxi drivers, workplace advocates in conjunction with places where IDU and unsafe sex takes place such as hotels, truck stops, sea ports, river ports, etc.	No
1.4. KEY POPULATION: TRANSGENDER PERSONS								
21	The Tamil Nadu Transgender Welfare Board	Provide HIV prevention services and other social services to transgender women	2008	India	Transgender women (known as Aravans)	Ministry of Social Welfare	Local businesses (to assist in awareness raising)	Partially
22	Transgender Beauty Parlour in Delhi	Promote HIV prevention and access to care for transgender persons	2009	India	Transgender persons	Pahal Foundation (Indian NGO) in collaboration with local community	Beauty parlour for transgender persons	No
2. KEY POPULATIONS THAT VARY BY SETTING								
2.1. MIGRANTS AND THEIR FAMILIES								
23	EMPHASIS – Enhancing Mobile Population's Access to HIV & AIDS Services, Information and Support	Obtaining broker assistance to reach cross border mobile populations with HIV prevention and services	2009-2014	Bangladesh	Migrants in transit areas	CARE India, Bangladesh, Nepal with funding from the BIG Lottery Group in the UK	Stop over points for migrants in transit	No,

No.	Title of the intervention	Intervention purpose/type	Year	Country	Target group	Leading organization	Workplace link	Evaluation/ results available
24	HIV doesn't stop at borders	Provision of services and supplies to reduce the risk of HIV infection	2010 onwards	Sri Lanka	Temporary migrants (especially women) to Gulf countries	ILO	Official offices that need to be contacted as part of the pre-departure procedure	No
25	The Transport Corridor Initiative in Southern Africa	HIV prevention and access to key services for cross border migrants and their families	2007 onwards	Southern Africa	Transportation/mobile workers	ILO, with funding from SIDA	Cross border routes and also cross border institutions such as customs agencies, small traders	No
26	The Hometown Fellow Campaign	Use of media (film) at inter-provincial transportation routes to provide HIV prevention information	2009 onwards	China	Migrant construction workers	ILO, Ministry of Labour, employer and worker organizations, 19 large scale construction companies	Technical training institutions, national railway stations, other stop-over points along transportation routes	No
27	The PHAMIT 'friendly skies' programme	Increase condom use and reproductive health practices, access to health services	2003	Thailand/ Myanmar	Migrants, their dependents, and related entertainment workers	Eight NGOs, the MOPH, funding from the GFATM	Key contact points along areas of migration and movement involving various types of commercial work	Yes
29	Sensitizing farm owners, supervisors and workers on gender dynamics	Create awareness among farm workers of gender dynamics and provide access to services	Mid-2000's	South Africa	Commercial farm labourers and farm managers, as well as officials such as police	Hoedspruit Training Trust, in collaboration with the IOM	Commercial farms	No
30	Establishment of a department of human rights by the Dubai police department	Strengthen the protection of women who are victims of sex work trafficking and provide access to HIV prevention and testing services	2006	United Arab Emirates	Women at risk of sex work trafficking	Dubai Police Authorities	Dubai Police Department office	No

No.	Title of the intervention	Intervention purpose/type	Year	Country	Target group	Leading organization	Workplace link	Evaluation/ results available
2.2. GARMENT INDUSTRY WORKERS								
31	Chittagong (Bangladesh) – Garment Industry, women and female sex workers	Provision of life-skills based peer education to change health care behavior and prevent HIV/AIDS	2008–2012	Bangladesh	Women in garment industry & in SW	Young Power in Social Action (PYPSA), with the HIV/AIDS and STD Alliance, FHI, GFATM and other donors.	Factories, with outreach to residential communities	No
32	Apparel Lesotho Alliance to Fight AIDS (ALAFA)	HIV prevention and treatment for garment industry workers	2006 onward	Lesotho	Women and wives of migrant workers	ALAFA, with the Lesotho Network of AIDS organizations and donors	Textile factories	Partially
2.3. PORTS, FISHERY AND TRANSPORTATION SECTOR WORKERS								
33	AIDS Education Project for Truckers and sex workers	Peer based AIDS education for transport workers to reduce STI, and encourage condom use	1992 onwards	Zimbabwe	SW and truckers	National Employment Council for Transport Operating Industry (NECTOI)	Truck stops along major highways	No
34	TRANSEX Project	HIV and AIDS prevention through outreach works and peer education	Late 1990's	Papua New Guinea (PNG)	Truckers, dock workers, uniformed workers, SW	PNG Department of Health with funding from AUSAID	Strategic stops along main roads, informal workplace sessions at rest stops	Yes
35	Peer Education Kenya Ports Authority (KPA) HIV/AIDS Programme	Extend HIV prevention and treatment to port workers	2000 onwards	Kenya	Senior management, union leaders, port workers	KPA, with FHI	Various workplace settings within and around ports, with outreach to communities	Yes
36	BCC programme to address stigma and discrimination among transport workers	A multi-month storytelling programme to mainstream HIV/AIDS awareness, decrease secrecy and discrimination	2009	Kenya	Truck drivers dockworkers, members of HIV positive groups, medical staff	International Transport Workers Federation	Involvement of union representatives to identify sub-groups	No

No.	Title of the intervention	Intervention purpose/type	Year	Country	Target group	Leading organization	Workplace link	Evaluation/ results available
37	Stopping HIV/AIDS through Knowledge and Training Initiative (SHAKTI)	Peer education HIV/AIDS activities and partner tracking, increasing access to services	1995 onwards	Bangladesh	Rickshaw pullers; truckers; and dock, ferry, and manual workers	Care Bangladesh, with funding from DFID	Partnership with transportation unions and informal work settings	Yes
38	The Walvis Bay Corridor Group (WBCG) Wellness Service	HIV prevention and treatment, condom distribution, entertainment facilities at high risk areas	2010 onwards	Namibia	Ports, fishery and transportation sector workers	Key Ministries, GIZ, SIDA, USAID, SADC and other partners	Shebeens, bars, other entertainment sites, truck inspection sites	Yes
39	Peer education at the pump by Shell	Provide HIV/AIDS education for fuel attendants using a peer education approach	1997 onwards	Thailand	Fuel attendants, head pump attendants, cashiers	Shell, Thailand Business Coalition on HIV/AIDS, UNICEF	Fueling stations and pump attendants and managers	No
40	Prisoners' HIV/AIDS Support Action Network (PASAN)	Decrease behaviours that put prisoners at risk of HIV/AIDS and hepatitis C in prisons	1991 onwards	Canada	Prisoners, ex-prisoners, youth in custody and their families, prison administrators/ staff	PASAN	Prisons/ correctional institutions	No
41	Choosing Health in Prisons (CHIPS)	Provision of information on HIV/AIDS, HVC, STI, harm reduction and other health concerns through peer education	Since 1990	Canada	All prisons population in targeted institutions, prison staff	Federal Government of Canada and all prisons	Prisons/ correctional institutions	Yes
42	Prison prevention programme "Prison Health is Public Health"	Provision of advocacy, sensitization, and HIV/AIDS and STI education for prison inmates	2010	Bangladesh	Inmates, prison staff, health workers	UNODC, NGOs, the Directorate of Prisons and six prisons	Prison settings	No

No.	Title of the intervention	Intervention purpose/type	Year	Country	Target group	Leading organization	Workplace link	Evaluation/ results available
43	Inmate peer education programme	Using peer education for HIV prevention, TB screening, and access to services	2010-2011	Zambia	Inmates, prison staff	Zambia Prisons Service (ZPS) and the Centre for Infectious Disease Research	Prison settings	Yes
44	Encouraging authorities to contain the HIV/ TB Hepatitis C epidemics	Increasing access to comprehensive HIV/ AIDS, hepatitis C and TB prevention for IDU	2011 onwards	Albania, Serbia, Macedonia	Drug users in prison settings, judicial authorities, CSO	UNODC, Ministry of Justice, and civil society organizations, national health services	Prisons/ correctional institutions	No



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