



# Sex work and HIV/AIDS



**UNAIDS**  
**Technical Update**

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# At a glance

- While sex work is a universal phenomenon, it is also frequently illegal and, therefore, clandestine. This makes it difficult to determine the true extent of the sex work industry, although it is acknowledged to be substantial and has apparently been increasing in recent years. This increase has been attributed to various factors, including changes in political, civil and socioeconomic conditions and increased population mobility.
- Effectively addressing the HIV/AIDS epidemic among sex workers and their clients calls for a multi-faceted approach that coordinates a range of diverse responses. To determine which responses will be appropriate, it is important to understand the forces that drive people into sex work. These forces can vary—sometimes widely—in any given community and among the subpopulations in that community. Many people enter sex work for economic reasons; that is, it may be the only, or the best-paying, employment option. Others are coerced into sex work through violence, trafficking or debt bondage. Some, particularly adults, freely choose sex work as their occupation. Entry into sex work can also have socially rooted causes that can be traced to traditions, beliefs and norms that perpetuate gender inequalities. For example, most societies have different sexual standards for men and women. Thus, when sex work intervention programmes are being designed, they must take into account cultural as well as socioeconomic determinants of entry into sex work.
- Significantly higher rates of HIV infection have been documented among sex workers and their clients as compared to most other population groups within a country. HIV infection often spreads among sex workers before spreading into the general population. The true extent of HIV transmission from sex workers and their clients to other populations remains generally unknown.

Studies indicate, however, that sex workers are among those most likely to respond positively to prevention programmes relating to HIV and sexually transmitted infections (STIs)—for example, by increasing their use of condoms with clients. Efforts to support sex workers' extending safer sex practices to their regular or stable sexual relationships need to be strengthened as well.

- Factors that appear to heighten sex workers' vulnerability to, and risk of, HIV infection include:
  - stigmatization and marginalization
  - limited economic options, in particular for women
  - limited access to health, social and legal services
  - limited access to information and prevention means
  - gender-related differences and inequalities
  - sexual exploitation and trafficking
  - harmful, or a lack of protective, legislation and policies
  - exposure to risks associated with lifestyle (e.g. violence, substance use, mobility)
- The HIV/AIDS epidemic has highlighted the need for responses on three levels:
  - prevention of entry into sex work
  - protection of those involved in sex work;
  - assistance in exiting from sex work.
 Each of these can, in turn, be addressed on three levels:
  - individual
  - community
  - policy-making.

At all response levels, it is necessary to have clear policy standpoints and to establish programmes with multiple components.

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## At a glance

This Technical Update focuses on the challenges in the protection of those involved in sex work and discusses the key elements of various interventions.

- Successful HIV/AIDS prevention and care programmes for those involved in sex work use a mix of strategies. The effective key strategies that have been identified to date are:
  - promotion of safer sexual behaviour among sex workers, clients and institutions or groups associated with sex workers, such as police and sex workers' partners:
    - condom availability and correct use
    - negotiation skills
    - supportive policies
  - promotion and availability of STI prevention and care services
  - outreach work that includes health, social and legal services
  - peer education among sex workers, clients and associated groups
  - care of people living with HIV/AIDS (PLWHA)
  - advocacy for policy and law reform at national and local levels, including respect of human rights.
- Current HIV/AIDS prevention programmes involving sex work are sometimes limited in terms of coverage, inclusion and coordination of stakeholders, and long-term effectiveness and sustainability. When developing, implementing, monitoring and evaluating programmes, it is important to consider the following:
  - the active involvement of sex workers themselves in all phases of project development, implementation and evaluation;
  - within AIDS-related programmes, at least, the establishment of ethical and protective policies since sex workers become increasingly visible through their involvement in HIV prevention activities;
  - incorporating a situation analysis and mapping exercise for design and subsequent monitoring and evaluation (this exercise should include people and authorities affiliated with the sex trade, e.g. third parties);
  - coordination of responses and resources; this should include use of a national planning exercise and prioritization of interventions;
  - identification and inclusion of a range of project partners, including sex workers, communities, private enterprises and sectors other than health; and
  - taking a longer-term and broader perspective on ways to decrease vulnerability of sex workers by addressing the conditions (including economic and gender issues) surrounding sex work.

### Defining sex work

Policy and programme development is best served by language that is not stigmatizing and recognizes that many of those involved in sex work regard it as their source of livelihood. It should be noted, however, that no single term adequately covers the range of transactions taking place worldwide that involve sex work. The appropriate term to use for sex work is best defined relative to the local context. This definition may change over time as attitudes evolve. Priority must be given to reflecting how those involved in sex work perceive themselves in that role. Note, however, that the majority of sex workers do not define themselves as such and consider the work to be a temporary activity.

For the purposes of this document, sex workers are defined as "female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating."

The term **sex worker** has gained popularity over **prostitute** because those involved feel that it is less stigmatizing and say that the reference to work better describes their experience.

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## Background

Until recently, a member of the general public, asked to characterize his or her perception of sex work, might first ask if the questioner meant "prostitution" and then mention well-known red light districts in cities such as Amsterdam, Bangkok, Berlin, or Rio de Janeiro. Slowly, over the past two decades, however, public understanding of the nature and extent of sex work has increased, due, in part, to the information and education campaigns focusing on HIV/AIDS. It has become increasingly evident that sex work is extremely widespread, if not universal. It is practised, in one form or another, in urban centres, towns and rural areas in both developed and developing countries. Indeed, the accumulated evidence indicates that it exists nearly everywhere.

Sex work appears to be fostered when a demand for sexual services and a favourable setting coexist. The context in which it usually takes place includes: a concentration of a sexually active population, sufficient anonymity, a high ratio of males to females and, more importantly, the socioeconomic disparities that make sex work affordable by the client and an economic opportunity for the worker. In addition to urban centres, these circumstances may be found in mining and industrial areas, ports, communities along main transit and transport routes, military barracks, frontier market towns, etc. Increasingly, sex work is also associated with some forms of travel and tourism, and specifically with the recent growth of sex tourism.

There are considerable differences from one location to the next in the way sex work is organized and in its level of visibility. Studies have also revealed that the impetus driving the sexual transaction can vary widely within and between communities.

Sex work can be classified as either 'formal' (organized) or 'informal' (not organized). Generally, formal

sex work is establishment-based and managers and/or pimps act as clearly defined authorities and as intermediaries between the sex worker and client. This type of sex work is often found in Asia, for example, where establishments such as brothels, night-clubs, drinking houses, and massage parlours are the venues for commercial sex transactions or activities. Informal sex workers, such as streetwalkers and self-employed call-girls or -boys, usually find their clients independently. Occasional sex workers perform another type of informal sex work. They may sell or trade sex to meet short-term economic needs (e.g. school tuition, a family financial crisis). This type of sex work predominates in most African settings, where sex work is less likely to be a full-time occupation.

Sex workers worldwide often share some common characteristics. Many formal sex workers become involved while still children or young adolescents. (Informal sex work encompasses a wider age range and includes a larger number of adult women.) Commonly, they migrate from rural areas or small towns to an urban setting, either because they were procured by brothels or pimps or as job seekers. They generally lack the skills to meet the challenges of urban life or to establish new social networks. The majority of these sex workers are expected to contribute to family incomes; indeed, they are commonly the sole supporters of their family. In addition to this 'voluntary,' economically-driven migration to urban centres, in regions such as Asia and Eastern Europe, girls and women are increasingly trafficked for commercial sexual exploitation.

The number of people involved in sex work is difficult to determine. Although some countries may make figures available through law enforcement or health-service registers, these are generally considered unrepresentative of the large 'hidden' populations involved in sex

work. Efforts have recently been made to develop research methods that can provide more accurate estimates, but most often these cover only specific subpopulations of sex workers. Countries that have evolved systems to obtain a quantitative sense of the sex work populations are shown in the table opposite.

Although far fewer in number than female sex workers, transsexuals and men also engage in sex work in diverse social and cultural settings. There is growing evidence that male sex work is not a phenomenon that is limited only to certain regions. Although information from countries in the developing world remains very limited, male sex work has been reported in various countries in Latin America, Asia and Africa, as well as in most Western countries. Male sex workers frequently report sexual contacts both with male and female partners, representing a potential for heterosexual and homosexual transmission.

Studies seeking to distinguish between different types and conditions of sex work look at a number of criteria: Is it regular or occasional? What is the nature of the settings where contacts are made with clients (brothels, streets, hotels, bars, massage parlours, cinemas or other locations)? What is the socioeconomic and educational status of those involved? Is the price charged relatively high (for example, for hotel- or escort-agency-based sex workers) or low (for certain types of street-, brothel-based or occasional sex work)? Attention is also paid to the considerable differences in sex workers' working conditions, relative independence, sexual behaviour (both chosen and coerced) and access to health services.

The legal status of sex work in a given region has significant bearing on the effectiveness of AIDS programmes targeting sex workers. Where sex work is illegal, legislative frameworks are often oriented

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### SEX WORKER POPULATION RATES

Country	Sex workers (SW)			% 15–49-year-old female population			Total population (UN, 2001 estimates, medium variant)	15–49-year-old population (UN, 2001 estimates, medium variant)
	Low	High	Average	Low	High	Average		
Netherlands	20,000	30,000	<b>25000</b> <sup>1</sup>	0.50	0.75	<b>0.6</b> <sup>3</sup>	15,929,536	7,997,459
Belize	3,600 <sup>2</sup>	5,300 <sup>3</sup>	<b>4,450</b>	6.05	8.91	<b>7.4</b> <sup>8</sup>	230,996	118,942
Dominican Republic	14,000 <sup>4</sup>	70,000	<b>42,000</b>	0.61	3.07	<b>1.8</b> <sup>4</sup>	8,506,651	4,560,598
Haiti	14000 <sup>5</sup>	70,000	<b>42,000</b>	0.69	3.45	<b>2.0</b> <sup>7</sup>	8,270,270	4,052,705
Bolivia	3,000 <sup>6</sup>	6,000	<b>4,500</b>	0.15	0.29	<b>0.2</b> <sup>2</sup>	8,516,495	4,131,460
Colombia	70,000 <sup>7</sup>	100,000	<b>85,000</b>	0.61	0.87	<b>0.7</b> <sup>4</sup>	42,802,735	23,002,907
Peru	17,000 <sup>8</sup>	34,000	<b>25,500</b>	0.24	0.49	<b>0.3</b> <sup>7</sup>	26,092,567	13,878,017
Venezuela	80,000 <sup>9</sup>	120,000	<b>100,000</b>	1.23	1.85	<b>1.5</b> <sup>4</sup>	24,632,072	12,984,927

#### References:

<sup>1</sup> Mobility in Prostitution in the Netherlands, 1990–99. EUROPAP

<sup>2</sup> Country Programme data

<sup>3</sup> Country Programme data

<sup>4</sup> National AIDS Programme, reported to UNAIDS March 2001

<sup>5</sup> National AIDS Programme, reported to UNAIDS, March 2001

<sup>6</sup> National AIDS Programme, reported to UNAIDS, March 2001

<sup>7</sup> National AIDS Programme, reported to UNAIDS, March 2001

<sup>8</sup> National AIDS Programme, reported to UNAIDS, March 2001

<sup>9</sup> National AIDS Programme, reported to UNAIDS, March 2001

towards penalizing individual sex workers. In such settings, sex workers are less likely to seek health services and more likely to conduct their activities underground.

In most developed countries, sex work is legal, and sex workers are entitled to the same rights and benefits as other workers. Very importantly, where sex work has legal standing, laws against abuse and exploitation are more likely to be enforced, thus reducing the incidence of violence against sex workers, especially as perpetrated by corrupt enforcement authorities. Legal sex work is often confined to designated geographic areas and is usually regulated by a system of registration and health checks. Suited to formal or establishment-based sex work, this system will not reach informal sex workers; and while limiting legal sex work geographically has benefits from a public health perspective, it encour-

ages social stigma against sex workers.

The current understanding of the extent to which men frequent sex workers remains equally limited. Although the likelihood of under-reporting is high, surveys have been carried out both in general populations and among specific subpopulations. In some societies, a substantial percentage of men report having had sexual contacts with sex workers. For example, anecdotal evidence in Thailand suggests that 15-year-old youths are not considered 'real men' until they have visited a commercial sex worker. A survey of military conscripts reports a history of multiple sexual partners and frequent visits to sex workers. Behavioural surveillance studies in Tamil Nadu reported 25–38% of truck drivers visiting sex workers<sup>1</sup>.

A large proportion of men who use sex workers' services are married,

but while the lack of sufficient or satisfying sex within marriage may be an issue, many men feel it is their right to enjoy a variety of partners. Strong cultural attitudes and socialization mechanisms that support male sexual privilege help foster this perspective.

Since the beginning of the AIDS epidemic, significantly higher rates of HIV infection have been documented among populations involved in sex work than in most other population groups, and recent studies continue to confirm this pattern among female, male and transsexual sex workers. In numerous countries, sex workers face higher rates of HIV infection. For example, in Dakar, the infection rate among pregnant women and blood donors is 1.7%, while, among female sex workers, the infection rate is 10%<sup>2</sup>. In Viet Nam, the infection rate among pregnant women was 0.12%, whereas rates among sex workers

<sup>1</sup> FHI/UNAIDS Best Practices in Prevention Collection, 2001.

<sup>2</sup> *Gender and AIDS Almanac*, Gender and AIDS Resource Packet, UNAIDS, 2001.

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reached as high as 13% in some provinces<sup>3</sup>. In contrast, countries as diverse as Australia, Bolivia, Madagascar and Mexico continue to report rates of infection of 1% or less among female sex workers.

Given the role of STIs as a co-factor of HIV infection, high rates of STI among sex workers can be interpreted as a precursor to a relatively rapid spread of the epidemic. HIV epidemics affect sex workers, their clients and their respective

families and societies. In the context of sex work, the important factors correlated with HIV epidemics are: the daily number of clients, the frequency of use of commercial sex by men, the rate of regular condom use, history and current levels of other STIs, and injecting drug use or violence. In addition, most populations of sex workers report substantially less use of prevention practices with their regular non-paying partners than with their paying customers.

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<sup>3</sup> *ibid*



# Challenges

The factors that can increase sex workers' vulnerability to HIV infection are often the same factors that cause an individual to enter sex work. The challenges associated with this area of work are often both intricately related and mutually exacerbating. These challenges, as well as a number of programmatic issues, need to be considered when developing or implementing programmes in sex work settings.

## 1. Addressing fundamental conditions that contribute to entry to sex work

The life circumstances that compel people into sex work, at whatever age, are commonly the same circumstances that contribute to their general lack of personal power; yet personal power is essential to negotiating condom use and other forms of safe sex. The following determinants often play a major role:

- *Poverty and limited economic opportunities*, in particular for women and young people, are the key factors in entering sex work, either willingly or through coercion. While some individuals may choose sex work even though they have other, equally profitable options, the vast majority have few other income sources, often because their education and marketable skills are limited. Individuals who have low-income jobs or other sources of partial support may supplement their income with part-time or short-term sex work. As they may not identify themselves as sex workers, these individuals may be particularly difficult to reach.
- *Gender inequalities* contribute to women entering into sex work. Although their rights and economic independence are often limited (in some instances, severely), women frequently bear the major burden of family obligations. In addition to hav-

ing limited access to employment, women in many societies have few prospects of financial support outside of marriage other than sex work. On the other hand, when bride payments or dowries change hands, young women may come to realize that they are being treated as a commodity. Sex work may offer them more control of their sexuality than their society affords to either married or marriageable women, and using that sexuality for their own profit may seem a viable alternative to marriage.

In many societies, men's sexual needs are accorded priority status—sometimes to the disadvantage of women. Social norms that emphasize male dominance in sexual matters encourage an environment in which violence against women becomes a potential or real threat. Several studies of sex workers reveal that many of them have been victims of sexual or physical abuse.

- *Sexual exploitation, including trafficking*. Vulnerable to the pressures of poverty and easily deluded by promises of economic gain, families may be easily induced by traffickers to push their young daughters towards commercial sex work. Commercial trafficking in women and children occurs on a large scale within countries and at the regional and global levels. In this era of AIDS, young girls have proven to be especially vulnerable to being trafficked or coerced into sex work, as their youth and virginity are associated with freedom from disease.

The increased mobility of contemporary life can also make women and young people more easily prey to sexual exploitation. Women who migrate for economic reasons (either to

another country or from rural to urban settings) are especially vulnerable to sexual exploitation or to being trafficked because of their relative naïveté about the new city or country, possible language barriers, and tenuous financial situation. Women and young people in refugee or other emergency settings are also particularly vulnerable to sexual exploitation, as the exchange of sex for money, services or goods can often be a matter of survival.

- *Cultural and/or traditional beliefs and practices* can also increase vulnerability to entering sex work as well as increasing men's reliance on sex workers. Some traditions, for example, have for generations encouraged young men to have their first sexual experience with an experienced woman—usually a sex worker. Others believe that it can be physically harmful for a man not to release his sexual tensions as soon as possible, thus increasing the number of travellers, migrants and unmarried men who rely on sex workers. Such norms can put a great deal of social pressure on men. Young men, especially, may feel obliged by peer pressure to prove their manhood. In some cultures, it may be acceptable—or even expected—that unmarried girls augment the family income, and sex work may be their only income-generating opportunity.

The traditional belief that having sex with a young girl (presumably a virgin) was a cure for syphilis has re-emerged in present-day myth as a cure for, or means of preventing, STIs or HIV/AIDS. This belief may have increased the number of very young brides (usually for older, already-infected men) and the demand for very young female sex workers.

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Social, economic and political disruption often involve simultaneous, sudden increases in the numbers of prostitutes and migration of populations, which tend to be gender-specific, leading to an increased demand for sex work and increases in immigrant, foreign prostitutes. Migrant prostitutes often come from countries with higher STI/HIV prevalence than the countries of destination. The available data indicate that most women enter prostitution as a result of poverty, rape, infertility and/or divorce. Larger social patterns that contribute to the initiation of prostitution may also contribute to the movements of prostitutes.

Source: *Commercial sex work and STD: the need for policy interventions to change societal patterns*, Aral So, Mann JM, *Sexually Transmitted Diseases*, Oct 1998.

### 2. Factors that increase sex workers' vulnerability to HIV infection

- *Stigmatization and marginalization* are often linked to sex workers, though not necessarily to their clients or to third parties involved in sex work (such as sex workers' partners, police, etc.). The double sexual standards found in most societies are succinctly characterized by an African sex worker: "It is only a woman who is downgraded from sleeping around, not a man. Men will always retain their dignity, but women will lose dignity." Social norms often acknowledge only a limited range of 'acceptable' roles for females—daughter, wife, mother, homemaker. 'Sex worker' does not fit into these categories, and therefore cannot be considered respectable. The resulting social isolation fosters discrimination that can limit sex workers' access to legal, health and social services, thus increasing their vulnerability to HIV.
- *Lack of protective legislation and policies.* Laws and policies to protect sex workers (and their clients) are often non-existent or inadequately enforced. For example, sex workers everywhere have little hope of successfully bringing charges against someone who rapes them. In contrast, laws, policies

and policing methods that perpetuate poor working conditions for sex workers and encourage unscrupulous behaviour by third parties are common. This combination of circumstances makes both sex workers and their clients more vulnerable to HIV infection. In some countries—for example, most of the United States of America and parts of the Middle East—selling sex is forbidden and has been made both illegal and punishable. In the face of oppressive laws and policies, sex work is likely to become increasingly clandestine, making HIV/AIDS and STI prevention and care activities nearly impossible to implement.

Countries as diverse as Australia, Bangladesh, Brazil, Greece, Guatemala, Kenya, Peru and the Philippines, among others, allow or tolerate commercial sex under certain conditions<sup>4</sup>. These conditions may include registration and medical testing for sex workers, confining sex work to specific geographical areas, and banning advertising, public solicitation and/or the involvement of third parties. Despite existing protective legislation, however, the police and other authorities or interest groups have been known to choose to take punitive or more restrictive actions. Punitive and restrictive regulations can violate sex workers'

right to voluntary and confidential medical testing, alienate them from available health services and discourage them from seeking safer sex-related information and education.

- *Lack of access to health, social and legal services* limits sex workers' options when seeking to care for their health, protect themselves from HIV and STIs and get the assistance they or their families may need to address social or legal matters.

Even where such services are available to them, sex workers may not take advantage of them. Inconvenient hours and locations, unwelcoming or judgemental attitudes on the part of staff and other clients, charging sex workers higher prices, and overall poor quality of service are often cited as deterrents.

- *Limited information, skills, negotiating power and access to means of prevention* may lead directly to behaviour that puts sex workers and clients at risk of HIV infection. Unprotected commercial sex usually occurs because one (or both) of the participants does not care to protect their sexual health, does not know how to do so, or lacks the means to do so (e.g. condoms, lubricant, safe-sex skills). Sex workers also often lack the

<sup>4</sup> *Making Sex Work Safe*, AHRTAG, 1997.



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personal power to negotiate safe sexual practices, and may be working under the threat or fear of violence in retaliation for trying to do so. Risk of HIV infection is compounded when sex industry managers actively discourage or do not support safe sexual practices and where working conditions limit opportunities to negotiate safe sex.

- *Lifestyle factors* can also increase sex workers' and their clients' risk of HIV infection.
  - The sex work milieu frequently includes alcohol consumption and, in some regions, drug use. Alcohol consumption has been shown to decrease inhibitions and is associated with increased STIs, probably due to non- or incorrect use of condoms. Alcohol also increases the amount of time it takes a man to reach climax, and this slower response time could increase the amount of vaginal or anal abrasion that occurs in unprotected sex with insufficient lubrication. Such abrasions are open portals for the transmission of HIV.
  - Violence, including sexual violence, against sex workers by clients, pimps and police has been reported in all regions. Sex workers may find, for example, that trying to negotiate safer sexual practices and/or insistence on condom use may result in violence. Violent sex often causes sensitive mucous membranes to tear, further increasing the possibility of HIV transmission.
  - Sexual transmission of HIV between a non-injecting partner and an injecting drug user is an often-overlooked mode of infection. In some regions, men and

women engage in sex work to earn money to buy drugs or they trade sex for drugs. This behaviour is more common in Western settings, such as in North America and Western Europe, where HIV infection among sex workers appears to be related primarily to drug use. Spain has Europe's highest rate of HIV infection among sex workers, reportedly due to drug injecting. Studies in Argentina (Buenos Aires), Brazil (Rio de Janeiro) and Canada show that a third or more of drug injectors have sold sex for drugs at least once.

- *Increasing mobility* has played a key role in spreading HIV around the world. Both sex workers and clients (e.g. truck drivers, salespeople) may be economic migrants who travel for, or in search of work. Clients may also be travelling as tourists or they may be armies on the move. This mobility makes effective and sustainable prevention work more difficult and increases sex workers' risk of HIV infection.

Sex workers may travel for a variety of reasons. In developed countries, sex workers migrate to conventions and other large, mostly male gatherings. Elsewhere, they will make an effort to be on site when, for example, miners, plantation workers or military personnel get their regular pay. Migrant sex workers, including those who have been trafficked, may be subject to restrictions and debt due to cultural and language barriers and a lack of information on their social and legal rights. Lack of documentation may further compound their risk if fear of deportation leads to avoidance of authorities, including health service providers. Illegal status exacer-

bates the isolation migrant sex workers may already experience. This isolation encourages strong dependency on pimps, bar owners or others, thus limiting their freedom and opportunities to practise safe sex and access health care.

## 3. Providing care and support for sex workers living with HIV/AIDS

Sex workers who become infected with HIV may find that they are doubly stigmatized—once by their profession and again by their health status—making them particularly vulnerable to the human rights violations that have come to be associated with HIV/AIDS.

*Care for sex workers living with HIV/AIDS* should not be separate from general care programmes for all PLWHA. This is, perhaps, as it should be, but sex workers experience discrimination with respect to their access to health services even when they do not have HIV, and may not even seek out HIV-related care programmes, assuming that the discrimination will extend to include family- and/or community-based care.

Another difficulty is that, in many countries, by the time care programmes are in place, HIV has already taken a heavy toll on a generation of women and men involved in sex work. Programmes rarely focus on how to provide care specifically for sex workers or how to reduce the psychological and socioeconomic impact of the high number of AIDS cases among their population. That these issues have been overlooked when developing programmes is understandable in light of the fact that, in some African countries, for example, programme participants are overwhelmed by the general tasks of facilitating health care and economic support for persons living with HIV/AIDS.

## Responses

Building a strong and ultimately long-lasting response to HIV in the context of sex work cannot be achieved by a narrow focus on STI/HIV issues alone. A far broader approach based on the concept of health promotion enables vulnerable groups to increase control over their health. The **Ottawa Charter for Health Promotion**<sup>5</sup> provides the following five guiding principles relevant to programmes for sex workers:

**Develop personal skills.** Sex workers' personal and social development can be supported by providing information and education on life skills as well as on HIV/AIDS. This can raise awareness of the range of options available to increase their control over their environment and their health and can lead to choices that are conducive to their well-being.

**Re-orient health services.** The health sector must expand beyond

its clinical and care service responsibilities to support individual and community needs for a healthier life. This means opening channels between the health sector and sectors that have a broader social, political, economic and environmental focus. This reorientation requires health services to change their attitudes and their organizations to focus on their clients as whole individuals and see the entire spectrum of their health needs, rather than just their immediate symptoms.

**Strengthen community actions.** A community-development approach to setting priorities, making decisions, and planning and implementing strategies enables the sex work community to take ownership and control of its own endeavours and destinies.

**Build healthy public policy.** This is done by ensuring that HIV/AIDS is on the agenda of policy-makers in all sectors and at all levels, and

directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

**Create supportive environments.** Sex workers' living and working conditions need to be made safer and healthier.

It is essential that these strategies be implemented concurrently so that they can strengthen and complement one another—i.e., using peer education and outreach approaches while ensuring the provision of basic health and social services and moving to decriminalize sex work. By using this approach, 'creating supportive environments' becomes a predictable outcome. The most effective actions design an appropriate mix of interventions into a community-development-oriented programme that is geared not just towards sex workers but towards *all* players in sex work.

### A voice from the field:

#### Serial Novel

*Woman of the life, a prostitute am I.  
Ageless, I may be a child, a teenager, or an adult,  
known, discriminated, and forgotten.  
Plying my trade on the city square, on the street,  
on the sidewalk, or on the beach,  
I play to the fantasies of others,  
but forget my own.....  
Hunger and despair have driven me  
to this nocturnal life.*

*Cast out, harassed, and disillusioned,  
I act my part in a serial novel of disgrace,  
in this cursed society.  
Leaving me helpless in this perilous life, justice  
also forsakes me.  
Enslaved, duped, and despised,  
I am afraid, I have dreams,  
but I am a turned page, ripped out  
of the serial novel of disgrace. Still I say  
with grace that I too am part  
of this ruthless society.*

**Rosarina Sampaio**  
Leader of the Ceará State Association of Prostitutes  
Brazil

<sup>5</sup> International Conference on Health Promotion, Ottawa, Canada.

# Responses

HIV/AIDS prevention among sex workers calls for a three-tiered approach: prevention of entry into sex work, protection of those involved in sex work, and assistance in leaving sex work. Each of these can, in turn, be addressed on three levels: individual, community and policy-making. At all response levels, it is necessary to have clear policy standpoints and to establish programmes with multiple components. These components can range from non-discriminatory legal enforcement, accessible social services (e.g. health and education) and viable economic opportunities, to fostering more perceptive development schemes aimed at minimizing the negative impacts of macro socio-economic policies.

## I. Preventing entry into sex work

Successful vulnerability reduction responses revolve around broad-based programmes that focus on the socioeconomic forces driving entry into sex work. For example:

- *Expansion of education and employment opportunities for young women.* Successful approaches that reduce entry into prostitution include, for example, programmes that provide continuing education scholarships to young women living in particularly vulnerable communities, or the creation of local industries that employ young women.
- *Strengthening the family and community structure* to create a strong culture of protecting young people from sexual exploitation. A basic strategy is to address the conditions of poverty that force parents barely able to meet survival needs to approve of children engaging in sex work. Religious leaders, educators and other community leaders who have access to, and credibility with, vulnerable fami-

lies must be mobilized to advocate an environment that will not tolerate exploitation.

## II. Protection of sex workers: reducing vulnerability and risk

### 1. Individual-level approaches

Various approaches addressing individual behaviour that puts the sex worker or client at risk of HIV infection have been introduced over the years. The best practices on this level are outlined below; but it must be stressed that addressing the issues exclusively at this level will limit the extent and sustainability of prevention activities.

- *Focus information, education and communication (IEC) on the specific culture of various types of sex work*

Subpopulations among sex workers and their clients must be taken into account and, ideally, be addressed individually when designing IEC programmes. Most HIV prevention programmes for the sex work industry begin with IEC campaigns that focus on information for the sex worker and, sometimes, for clients. These campaigns are usually conducted through mass media, group education discussions and distribution of printed material. Their main thrust is to promote healthy behaviour by providing the basic facts and correcting misperceptions or myths that surround HIV/AIDS. Any such campaign must specifically address the traditional and cultural sexual behaviours in the local sex work environment and take into account the various forms of sex work that occur there (e.g. brothel-based, indirect or occasional sex work, male or transgender sex work, etc).

- *Establish/expand peer education approaches within the various levels of the sex work system*

Peer education enlists members of a specific group to help effect behavioural change among their peers. Its initial goal is usually to modify individuals' knowledge, attitudes and beliefs to bring about healthy behaviour. When peer education is available, the sex worker community no longer has to rely on outsiders for health-related (and other) knowledge, giving it increased control over its own health. Successful peer educators need both training and the respect of other sex workers. Therefore, effective peer education may be more difficult to achieve in areas where sex workers are particularly mobile and/or lack group cohesion. On the other hand, it is unrealistic to expect them to reach clients, pimps or brothel owners/managers with equal success.

Some features of safer sex work that can play an important role in protecting sex workers from HIV and STIs are best taught to their peers by experienced sex workers. These would include, for example, knowledge of sexual techniques that cause less abrasion and therefore limit paths of HIV transmission as well as an increased repertoire of non-penetrative sexual acts. Improved variation in sexual services, combined with different pricing for different modes of service, can offer sex workers options, which they can exercise based on their risk assessment of the client.

If taken to scale, peer education can eventually influence and change community social norms and activate programme and policy changes at a higher level. Because an individual's sexual behaviour is strongly influenced by social norms, these norms become entry points for peer educators, either to be challenged or built upon, depending on the social context. Effective peer education aims to create a supportive environment for sex workers to apply the assertive skills they need to negotiate safe sex and improve their living and working conditions.

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### ■ **Make STI prevention and care services accessible to sex workers**

STIs and HIV are linked on three levels: they share the same risk behaviour, STIs facilitate the acquisition and transmission of HIV, and some STI pathogens become more virulent in the presence of HIV-related immunodeficiency. STI control programmes, as an essential element in prevention programmes, have been shown to reduce or prevent increased HIV incidence. Effective STI treatment reduces not only the rates of STI complications but also the efficacy with which HIV is transmitted. In addition, individuals are more receptive to condom use and other prevention messages when they are delivered along with good-quality, non-judgemental curative services ('prevention-care synergy'). It is therefore vitally important that programmes addressing sex workers include an STI component.

There are guiding principles to be applied when offering early and effective STI prevention and care services—indeed, when offering any services successfully.

1. **Accessibility:** Clinics need to offer services at schedules and locations geared towards the unique working conditions of sex workers, and outreach health services are important for hard-to-reach sex worker groups.
2. **Acceptability:** Many clinics have introduced new policies and training for health-care workers in an effort to improve services to sex workers. It is important that such training address judgemental and discriminatory attitudes and practices. Clinics and other health facilities can also increase their acceptability and provide a more welcoming environment by employing sex workers at their facilities.
3. **Affordability:** Services, including medicines, need to be within the means of the sex workers and

the other patients they are designed to serve.

4. **Quality:** The quality of care that patients receive can influence both how well they comply with prescribed treatment regimes and whether they will return to the clinic if necessary. Good-quality care includes appropriate and effective treatment and referrals and ready access to necessary drugs, where possible, as well as respect for client confidentiality. It also includes providing information about the STI in question and its prevention, including condom demonstration and promotion. Voluntary HIV counselling and testing may also be appropriate as part of STI services, and if this is not feasible, referrals to such services must be readily available.

### **Examples of effective peer education**

The Saheli Project in Mumbai, India created a three-tier system of peer leaders that includes sex workers, brothel managers and brothel owners. The Sahelis perform typical peer educator tasks such as providing other sex workers with information on HIV/AIDS, STI and safer sex, distributing condoms, taking sex workers to health facilities and visiting them as inpatients.

*Clinique de Confiance*, an integrated prevention and care project in Abidjan, Côte d'Ivoire, has successfully integrated these four principles into its friendly and confidential medical services for sex workers and has thus increased their health-seeking behaviour. Peer educators have been instrumental in referring other sex workers to this clinic for confidential services such as STI diagnosis and treatment, as well as for HIV counselling and testing and health education.

### **2. Community-level approaches**

Sex workers' vulnerability and individual risk may be addressed at the community level through a number of approaches. As illustrated by the interventions listed below, these approaches can include: reducing individual vulnerability to HIV in the sex work setting; changing prevailing norms in sex work and in the larger community; and changing the organizational structures of sex work communities to make the work less dangerous.

### ■ **Involve sex workers in condom promotion and safer sex education**

'Safer sex' is promoted by introducing protective measures such as consistent condom use and the modification of risky sexual practices and by reinforcing behavioural change towards adopting these practices. To make safer sex more universally accessible in sex work, the focus is not on changing sex workers' behaviour alone but on building social (clients, other partners) and workplace support for condom use. It is important to continuously reinforce sex workers' personal and collective capacity to impose safer sex practices on partners. Modifications in the way sex work is organized must also be encouraged and, in some cases, this may be supported through policy enforcement. Possible approaches to building such support include enlisting sex establishment owners and managers to protect their workers' health and physical safety, working with police to reduce harassment, and promoting self-esteem and workplace solidarity among sex workers.

Ensuring that good-quality condoms are available and accessible when and where they are most needed is an integral component of safer-sex programmes. Condom social marketing programmes can make condoms available at a substantially



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reduced price through local outlets including, in many cases, at establishments where sex work takes place. These programmes are most effective when they include a health promotion component that is designed to raise condom awareness, provide information on their use and reinforce sexual negotiating capacities by involving sex workers, clients and third parties.

The promotion and use of female condoms is another approach to empowering sex workers. Though more expensive and less readily available than the male condom, the female condom reportedly offers sex workers more control in negotiating safe sex (including its use in anal sex between men or between a man and woman) as well as freedom from fear of disease and pregnancy.

Where drug use is present in the local sex industry, targeted interventions may also include harm-reduction approaches (e.g. education and information campaigns and needle and syringe exchange programmes).

### ■ **Implement outreach programmes for hard-to-reach sex worker groups**

All populations of sex workers except, perhaps, for those whose work is legal and registered, may prove difficult to reach under certain circumstances. Outreach workers find some populations particularly elusive, however. These include sex workers who do not identify themselves as such, do part-time or casual sex work, or work illegally under particularly repressive or difficult conditions. Linking outreach work to other services is an effective means of extending its range. While it is most commonly linked with peer education and mobile STI and reproductive health services, other services where offered, such as income-generating activities and livelihood skills training, are also appropriate entry points for integration of HIV/AIDS prevention and care programmes. Often, however, basic outreach services are provided by peer educators acting independently of any specific service organization.

Effective outreach work can serve several purposes. It can:

- provide services, materials (e.g. condoms) and information to those who are hard to reach and do not attend clinics, including migrant and mobile populations and informal sex workers;
- bridge the sex work and non-sex work communities by building trust and lines of communication;
- reduce the marginalization of sex workers and their social isolation through referral to appropriate social and legal services and by building community relations.

### ■ **Provide care for sex workers living with HIV/AIDS**

Sex workers who are living with HIV/AIDS are often discriminated against by health-care workers and other service providers. This can result in their receiving substandard care and is often one of the first issues needing to be addressed. It is imperative that projects work with social and legal services as well as

### **Examples of community-based prevention programmes**

Poland's TADA HIV/STI prevention initiative among sex workers in Szczecin had an outreach programme of peer educators among sex workers who distributed condoms and educational material and provided counselling. The project's most successful outcome has been the increased use of lubricants and condoms among the various client groups. (See *Summary Booklet of best Practices, Issue 1, 1999, UNAIDS.*)

The *Association de Lutte Contre le SIDA* in Morocco developed a project focusing on male sex workers. In addition to peer outreach services that provided education, counselling, condoms and referrals to health services (including HIV counselling and testing), the association also established a drop-in service along with a telephone hotline and discussion groups. (See *Best Practice Digest, 2000, UNAIDS website.*)

Successful examples of the safe-sex approach and condom promotion include the 100% Condom Use Programme in Thailand. (See UNAIDS Best Practice Collection: Case Study: *Connecting lower HIV infection rates with changes in sexual behaviour in Thailand*, June 1998; Key Material: *Relationships of HIV and STI declines in Thailand to behavioural change 1998*; Key Material: *Trends in HIV incidence and prevalence.*) This nationwide campaign provides condoms and education to sex workers through existing STI clinics and encourages brothel owners to insist that their clients use condoms. Since the start of this programme, this and other interventions have initiated a drastic decline in STI and HIV rates among sex workers and among their frequent clients (male conscripts). HIV seroprevalence among brothel-based female sex workers in Thailand peaked at 33% in late 1994. By 1998, it had declined to 21%. (Seroprevalence of HIV among FSW in Bangkok: Evidence of Ongoing Infection Risk after the '100% Condom Programme' Was Implemented, Kilmarx P et al. *AIDS*; 1999, 21(4):313-6.)

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### Examples of outreach programmes

- The AIDS Surveillance and Education Project (ASEP) undertaken by the Programme for the Appropriate Technology in Health (PATH) in the Philippines has engaged public and private sector stakeholders in the field of STI management, notably community pharmacists, NGO front-line workers, and government medical and paramedical personnel. Through the social marketing of an STI management kit that included various components, such as drug regimens, medication instructions, condoms, STI information, and partner notification cards, a large number of STI health workers in both sectors have been trained, thus expanding the channels for STI management that would reach diverse groups in the population. (See *Summary of Best Practices, Issue 1, 1999, UNAIDS.*)
- In Papua New Guinea, outreach was extended beyond sex workers to include their clients (including truck drivers, security men, sailors and dock workers) and the police. Outreach services include STI services, HIV testing and counselling, the dissemination of basic HIV/AIDS information and condom distribution. In addition, a drop-in centre was established to provide literacy and vocational training. These combined services not only had the very concrete result of increased demand for condoms, they also addressed human rights violations that had been occurring in the community. As a result, sex workers' reports of sexual harassment dropped, there was a more-than-50% decrease in police line-ups (group rape sessions), and the first successful prosecutions of police officers involved in such activities took place.

with health-care providers to ensure respect for patients' rights, regardless of their profession.

Learning the skills needed to care for sex workers living with HIV/AIDS must be made an integral part of the training for health-care workers who are to provide such services. Sex workers living with HIV/AIDS need support and assistance in several areas, including:

- accessing information and ongoing emotional support through counselling. HIV-positive sex workers need counselling that addresses HIV/STI issues and other lifestyle issues in the context of their lives, i.e. doing sex work while being HIV-positive. Counsellors should provide information to protect sex workers from re-infection and discuss the possibility of (dis)continuing sex work.
- accessing appropriate treatment and care for HIV/AIDS, TB and other illnesses and infections.
- protecting their human and legal rights and those of family members, including the rights to health care, accommodation, inheritance, schooling, etc.
- planning for the care and support of children or other dependants.

In addition, sex workers who want to return to their families or country of origin may need social and financial assistance to do so. Sometimes, the members of a sex work community have come together to collectively assist other members in need by contributing towards the cost of their travel.

Sex workers may find the assistance they need through generally available services such as clinics as well as through support groups that respond either to sex workers in particular or to all PLWHA. In Botswana, for example, a programme that began with peer education and outreach activities subsequently added a self-support group for sex workers living with HIV and AIDS. As the programme also included activities designed to involve clients and the wider community, the support group now includes HIV-positive people from that extended population.

#### ■ **Broaden interventions within a community development framework**

In addition to reducing HIV and STI infections and providing care services, sex work programmes need

to address the issue of decreasing sex workers' vulnerability. To do so, programmes must address the conditions surrounding sex work and function as agents of social change. This requires a broad and long-term perspective, which is why sex work programmes should incorporate a community-development approach to HIV into their basic framework. 'Empowering' sex workers at the individual, community and societal level is a vital component of addressing their vulnerability. Interventions need to recognize and address issues such as low self-esteem, lack of skills/education and self-confidence, and restrictive attitudes, norms and laws within society. For example, some programmes have introduced income-generating alternatives by which sex workers can strengthen their economic position. As a result, they may be able to reduce their number of clients, feel empowered to refuse a client who insists on unprotected sex, or, eventually, leave sex work.

Sex work and its particularities vary within cities, countries and regions. A situation analysis and mapping exercise should precede programme design so that planners can identify the categories of sex work, the profile of clients and third parties, geo-



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### The Sonagachi Project

In India, the basic approach of the STI/HIV Intervention Project, better known as the Sonagachi Project, in Kolkata, India, has been to create an enabling environment based on the 'three Rs': 'respect' for sex work and those engaged in it; 'reliance' on those involved in sex work to run the programme; and 'recognition' of their professional and human rights. From the first, sex workers were dynamically involved in all aspects of the project and were viewed holistically rather than simply in terms of their sexual behaviour or reproductive tracts. It was felt that the most effective way to respond to the sex workers' needs and interests was to have a clear and full understanding of the range of issues that determine the quality of their lives. It was also recognized early on that the root causes of sex workers' vulnerability needed to be addressed simultaneously with their STI/HIV health needs. Activities such as literacy, vocational, legal and human rights training and services were undertaken to build sex workers' capacity and self-esteem. Support services for sex workers' children were also established. A cooperative society provides economic and social assistance to sex workers through savings and loans, social marketing of condoms and child-related programmes. Steps were taken against discriminatory practices (violence, police harassment, violation of human rights, etc.) through advocacy and lobbying at the local and national levels. As a result of this approach, sex workers are able to discuss their health and welfare issues with public officials and at national conferences. As those working in the Sonagachi Project have said, "Sex workers as a group will have to be enabled to break through the structural barriers that keep them excluded from access to resources as well as participation in society before any individual sex worker can be really empowered to pro-

graphical locations, coverage of existing programmes and community needs, and determine the most appropriate mix of strategies to be used. This situation analysis may also be used later to evaluate the programme's success and progress. A participatory action research (PAR) programme for sex workers is empowering, as it involves the sex work community from the early stages of the programme, offers them ownership and helps build trust.

### 3. Policy-level approaches

Strategies to sustain supportive environments that are created at the community level must be implemented at the policy level as well. Legislative changes and the development of policy and frameworks at this level can be part of promoting and creating an environment that reduces stigma and discrimination and supports some of the community-level approaches outlined above.

- **Establish clear policy frameworks for sex work**

In some countries, advocacy at the policy level for improved conditions for sex workers has resulted in pol-

icy debates leading to the repeal of laws that criminalize or otherwise penalize those involved in sex work. Policy-framers should take into account the complexity of the sex work system and address the various needs of the diverse groups of sex workers within it. First and foremost, a policy framework must establish its legal stance on sex work, be it decriminalization, regulation, or prohibition. It is also important that a stance be taken explicitly supporting international conventions governing exploitation of children. Subsequently, efforts should centre on formulating a range of specific, targeted policies. Where sex work is a recognized occupation, even if illegal, priority should be given to improving working conditions. On the other hand, when emphasis is on those who have been coerced into sex work, policy priorities should focus on their rescue, rehabilitation and protection.

Where law reform is not possible, policies that can contribute to a safer sex industry need to be identified, supported and made into a reality. For example, courts, government administrations and police can all improve their responses to violence against sex workers. They can

also refrain from impeding sex workers' access to suitable premises and/or discouraging possession of condoms, and instead encourage adherence to protective practices.

Challenging social attitudes and lobbying for policy and legal changes involve activities such as organizing and facilitating collective actions, developing associations/unions and networks, participating in public debates and involving the media in a positive way—all of which contribute to sex worker empowerment. Initiatives to spark policy changes may take place simultaneously at high government levels (through lobbying and advocacy) and at local levels. For example, efforts to introduce the Thai 100% condom use policy into Cambodia began at the local level, with the governor of the coastal town of Sihanoukville. Today, the Thai policy has begun to take hold throughout Cambodia. Cambodia's Prime Minister, Hun Sen, has worked with different sex industry stakeholders and used survey and other data as leverage to make it clear that, regardless of the legal status of sex work, those working in the industry should not be denied care, services or education. He recently signed an

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endorsement letter to urge that the 100% Condom Use Programme be efficiently applied countrywide.

### ■ **Build in more effective programming elements**

The ways in which programmes are developed, implemented and evaluated have a direct bearing on their effectiveness. The following programmatic issues continue to be areas of concern in HIV/AIDS/STI prevention interventions in sex work.

- *The degree of participation by sex workers, clients and gatekeepers in the development, implementation and evaluation of HIV/AIDS prevention programmes varies. Typically, those most concerned are not included in programme development and evaluation and participate in only a limited way (usually through peer education) in the implementation of interventions.*
- The current response to HIV/AIDS in sex work has, generally, been to *focus exclusively on addressing sexual and reproductive system issues* through distribution of condoms and STI services. Addressing sex workers' psychological and emotional needs, while also striving to influence the socio-cultural and economic context in which they work, is the exception rather than the rule.
- In countries where sex work interventions exist, their coverage is usually limited, most often to larger cities. Smaller cities and towns, and areas that attract mobile sex workers, may be overlooked or have only limited interventions that are not linked to others in the country.

- Programmes targeting sex workers have some *long-term limitations* that stem, in part, from their rapid initial growth. Given the sense of urgency in the early years of the pandemic, most programmes were implemented outside of existing health and social services. How to maintain these programmes and expand them to the national level becomes a serious question as extra-budgetary resources slowly dry up for sectoral HIV/AIDS activities. Much of the response in a given country is undertaken by international and local NGOs that, like many government-based projects, depend on donor finances. Yet *few agencies coordinate their activities to develop a collective response* in-country.

It is not unusual to find several organizations or agencies in the same area working on sex work issues or on related subjects such as HIV/AIDS and STI prevention, family planning or alternative income-generating schemes. Similar and complementary responses need to be coordinated in order to maximize the benefits from the initiatives and contribute to their sustainability. An important component of coordination, expansion and sustainability is participation in a *national planning exercise* to help prioritize interventions. Sharing lessons learned and pooling resources (e.g. training, developing materials, etc.) are also elements of effective coordination.

- *The economic dimensions of commercial sex work* present extraordinary programming challenges. Studies in South-East Asia, in particular, highlight the varied commercial interests that are directly or indirectly

involved. Powerful business and political sectors control structures such as law enforcement, the military and immigration, which are linked in a complex web affecting the sex industry. Addressing this web requires interventions that reach well beyond sex workers and their families. Clearly, the roles of all players in sex work need to be appraised and their support mobilized.

The 'logical' partnerships that may spearhead the direct response to sex work issues may include those directly involved in sex work, governmental and private services, NGOs and other associations. However, other allies also need to be identified. These may be community leaders or even the community at large and should include representatives of client groups such as the military. Private enterprises may also be effective and beneficial partners, especially those such as mining or long-distance trucking that employ migrant workers.

The intricacy of issues linked to sex work compels us to view our responses from both micro and macro perspectives—from individuals vulnerable to, or engaged in, sex work, to the industry's larger social and economic underpinnings. It will require great political will to confront the sensitive issues raised by sex work and devote resources to a sector characterized by stigma and discrimination. But the threat of the HIV/AIDS epidemic to those who are engaged in, or vulnerable to, sex work is much too great and too urgent for the necessary decisive action to be delayed. Responses addressing the risks and vulnerabilities of sex work are clearly rooted within a broad development context. Therefore, the benefits of such initiatives will have impacts beyond the sex work community.

## Key materials

1. Network of Sex Work Projects (NSWP) (1997) *Making Sex Work Safe; A practical guide for fieldworkers, programme managers and policy-makers*. London, ARHTAG. A user-friendly manual that includes an overview of issues and strategies for implementing and evaluating sex work projects, illustrations and examples of educational materials and activities, suggestions for further reading and lists of key contacts.
2. *Research for Sex Work Newsletter*; Health Care and Culture Medical Faculty, Vrije Universiteit, Amsterdam, The Netherlands, June 1998 and August 1999. The June publication is dedicated to peer education initiatives in sex work with contributions from projects in various countries, including Bangladesh, India and Indonesia. Issues that are addressed include training, selection of peer educators and problems encountered in peer education interventions. The August publication is devoted to issues of appropriate health services for sex workers. Articles address such subjects as integrating services into existing health services in Ghana, hotel-based STI programmes in Johannesburg, political transformation and creating enabling environments. Other contributions from country projects include Cambodia, the SHAKTI project in Dhaka, Bangladesh, the Sonagachi Project in India, and AIDS Infoshare in Moscow.
3. Lim, Lin Lean (ed.) (1998) *The Sex Sector, The economic and social bases of prostitution in Southeast Asia*; ILO, Geneva. An in-depth look at case studies that illustrate the history of sex work in the region as well as in specific countries. Issues addressed include basic human rights, morality, employment and working conditions, gender discrimination, health threats and criminality. The studies also illustrate the social components relating to unequal relations between men and women and between children and parents. There is also a chapter on child prostitution and the serious human rights violation that it constitutes.
4. Evans C (1999) *An International Review of the Rationale, Role and Evaluation of Community Development Approaches in Interventions to Reduce HIV Transmission in Sex Work*; Horizons Project, Population Council Regional Office for South & East Asia, India. A review to assess the rationale, role and evaluation of community-development approaches in interventions to reduce HIV transmission in sex work. The review consists of four parts: a) the theoretical rationale for community development in HIV interventions with sex workers; b) lessons learnt from case study examples of sex work interventions from around the world that used a community-development approach; c) critical issues for the evaluation of community-development approaches; and d) conclusions.
5. UNAIDS (1999) *Sexual behaviour change for HIV: Where have theories taken us?* UNAIDS Best Practice Collection, UNAIDS, Geneva. This review provides an overview of theoretical models of behavioural change, a review of key approaches used to stem sexual transmission of HIV, a summary of successful interventions targeting specific populations at risk and a discussion of the challenges that remain.
6. Malcolm A, Dowsett G (ed.) (1998) *Partners in prevention: International case studies of effective health promotion practice in HIV/AIDS*; UNAIDS Best Practice Collection, UNAIDS, Geneva. This publication presents four case studies (Australia, Canada, Thailand and Uganda) of communities that mobilized their resources, in partnership with governments, to respond to the HIV epidemic. This document also includes a summation of guiding principles of prevention in practice and a resource list.
7. UNAIDS (1998) *Expanding the global response to HIV/AIDS through focused action: Reducing risk and vulnerability: definitions, rationale and pathways*; UNAIDS Best Practice Collection, UNAIDS, Geneva.
8. Aggleton P, Chase E, Rivers K, Tyrer P (2000) *Successful Approaches to HIV Prevention—Case Studies*; UNAIDS Best Practice Collection, UNAIDS, Geneva. A compilation of innovative, effective and successful prevention programmes, projects and interventions that assist in identifying the principles underpinning effective HIV-related health promotion. Case studies look at sex workers and their clients as well as at young people, women, injecting drug users and men who have sex with men.
9. UNAIDS (1999) *Peer Education and HIV/AIDS: Concepts, uses and challenges*, UNAIDS Best Practice Collection, Key Material, UNAIDS, Geneva. This document discusses the definition of, and the theory behind, peer education and presents the findings of prior efforts to analyse HIV/AIDS peer education programmes. It also presents the results of the needs assessment and a literature review.
10. UNAIDS (1999) *Report of the Regional Meeting on HIV & STI Prevention among Sex Workers in Eastern Europe*, Odessa, Ukraine, 8–10 April 1999. An update on sex work and sex worker projects in the region. The report summarizes the exchange of views and information on effective approaches to issues faced in the region. Discussion also includes possible options for strengthening regional exchanges.



## Notes



## Notes



This Technical Update focuses on the challenges involved in the protection of sex workers (and, subsequently, the general population) from HIV infection, and discusses the key elements of various effective interventions.

Significantly higher rates of HIV infection have been documented among sex workers and their clients, compared with most other population groups. Though sex work is often a significant means of HIV infection entering the general population, studies indicate that sex workers are among those most likely to respond positively to HIV/STI prevention programmes—for example, by increasing their use of condoms with clients. This document explores the many issues involved in providing care and support for sex workers, preventing entry into sex work, and reducing risk and vulnerability through programmes at the individual, community and government levels.



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