

Field experience
from the East
and Horn of Africa

**HIV AND SEX WORK IN REFUGEE
SITUATIONS: A PRACTICAL GUIDE TO
LAUNCHING INTERVENTIONS**

AN ISSUE AFFECTING WOMEN, MEN, GIRLS,
BOYS AND COMMUNITIES



June, 2010

This document forms part of a series of publications that document field experience in HIV and AIDS. Should you have any questions about this document, please, contact the Public Health and HIV Section at UNHCR Headquarters; hivaids@unhcr.org

Other titles in the HIV/AIDS Field experience series:

Assessment of HIV/AIDS Behaviour Change Communication Strategies employed by NGOs in Kakuma Refugee Camp, Kenya (December 2002)

Evaluation of the Introduction of Post Exposure Prophylaxis in the Clinical Management of Rape Survivors in Kibondo Refugee Camp, Tanzania (October 2005)

Community Conversations in Response to HIV/AIDS: A capacity building project with refugees and the host population. Republic of Congo (December 2005)

Introducing the Female Condom in Refugee Settings: A Guide for Implementation. Kenya. (March 2006)

Mobile Refugee Males and HIV Vulnerability: Tips and Tools for Behavior Change Communication (BCC) formative assessment and beyond. Field experience from Thai-Myanmar border camps (March 2010)

DEDICATION

This publication is dedicated to the many courageous women and men who narrated their stories and shared their visions and dreams. They are struggling to build better lives for themselves and their children, where equality is the norm and HIV a common enemy. We sincerely hope that this manual will enable UNHCR staff and partners – working in protection, community services, health, livelihood and legal services – to assist them in their efforts.

ACKNOWLEDGEMENTS

This manual was prepared by Professor Elizabeth Ngugi, consultant with the UNHCR Regional Office Nairobi and Richard Steen, consultant with UNHCR Public Health and HIV Section in Geneva. The aim is to provide a step-by step guide to implementing HIV interventions and services for sex workers in humanitarian settings. The methods are based on over two decades of field experience in developing programmes with sex workers, initially in Nairobi, then in other Kenyan cities and towns, and most recently in refugee camps, settlements and urban areas in the Horn and East of Africa.

We acknowledge important contributions from other team members, notably Marian Schilperoord, Patterson Njogu, Maria Mangeni, Bernadette Nzisi and dozens of UNHCR staff and partners who were involved in developing and reviewing this manual.

All photos in the document are from Richard Steen

Photos on cover

Men from the community show keen interest in the female condom

Discussing HIV with women in the community

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral treatment
CBO	Community-based organization (run by sex workers themselves)
GBV	Gender-based violence
HIV	Human immunodeficiency virus
MSM	Men who have sex with men
PHHIV	Public Health and HIV
PMTCT	Prevention of mother-to-child transmission
PPT	Periodic presumptive treatment
SRH	Sexual and Reproductive Health
STI	Sexually transmitted infection
TOT	Training of trainers
UNHCR	United Nations High Commission for Refugees
VCT	Voluntary (HIV) counseling and testing
WHO	World Health Organization

GLOSSARY

Best Interests Determination (BID)	A formal process with strict procedural safeguards designed to determine the child's best interests for particularly important decisions affecting the child. It should facilitate adequate child participation without discrimination, involve decision-makers with relevant areas of expertise, and balance all relevant factors in order to assess the best option.
Gatekeepers	A broad term to define people – such as bar owners, brothel managers, etc – who have influence over how sex work takes place.
Multi-functional team (MFT)	A multi-sectoral arrangement for coordinating work done by different agencies. An MFT is, at a minimum, composed of protection, programme, and community service staff. Ideally, it should include sex worker representatives, female and male staff, both national and international and of different levels. The aim of the MFT is to work with refugees, to analyze protection problems together, discuss capacities to face protection problems and find solutions together.
Peer	Someone from the same background who shares common experiences. In this document, peer involvement refers to activities carried out by sex workers themselves. (as in peer outreach, peer educator, etc)
Refugee	The 1951 Convention relating to the Status of Refugees describes refugees as people who are outside their country of nationality or habitual residence, and have a well-founded fear of persecution due to their race, religion, nationality, membership of a particular social group or political opinion.
Snowballing method	A common method used in outreach programmes as well as for sampling in community-based surveys. Outreach workers contact people meeting certain criteria and these people are then asked to refer others to the programme.
Sex worker	Female, male and transgender adults 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 is used in this document both for those who self-identify as 'sex workers', and those who do not.
Sexual exploitation of children	Anyone engaged in sex work under the age of 18 years is a victim of child sexual exploitation under international law. Children cannot be sex workers, but are sexually exploited.

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OVERVIEW

Building a programme on HIV and sex work, 6 months to implementation, step by step

This guide is intended to assist those working to slow transmission of HIV and other sexually transmitted infections (STIs) in humanitarian settings. The focus is on intervening where HIV spreads quickly – with sex workers and their clients. By doing so, fewer infections will spread in refugee and surrounding communities, to married women, and other sexual partners. And with fewer parents becoming infected, there will be less mother-to-child transmission, fewer HIV infections among newborns, and reduced perinatal morbidity and mortality. In other words, by focusing prevention efforts on few high risk individuals, the entire community benefits.

The approach described is based on experience from several countries of the East and Horn of Africa. It was developed by Professor Elizabeth Ngugi of the University of Nairobi and adapted with support of UNHCR to urban and camp-based refugee programmes in the East and Horn of Africa. With good planning and implementation, sustainable multi-sectoral interventions and improved comprehensive services can be set up within a six month period.

The following chapters go into some detail on different aspects of entering and involving communities and setting up interventions and services for sex workers. In doing so, the focus is on the first 6 months – the start-up and consolidation phases. Further strengthening of interventions and services in established programmes will be addressed in separate modules covering 1) protection, 2) clinical services and 3) livelihood and micro-credit interventions.

Using this guide

The approach and methods described in this manual are not meant to be rigid or prescriptive. Many of the recommended steps overlap and some may need to be carried out in a different order. You may also need to adapt some recommendations to find solutions that work in your specific setting.

A word about high level programme support

The focus of this manual is local level implementation.

It is assumed that the necessary high level advocacy has already been carried out to ensure support for the programme. If this support has not yet been secured, it is important to present arguments and evidence to show that HIV and sex work programmes are essential to reduce the spread of new HIV infections in communities.

For more information, see UNHCR/UNFPA *Technical note: HIV and sex work in humanitarian settings* and the UNAIDS *Guidance note on HIV and sex work*.

The first important step in starting a new intervention is sensitiation; to gain the understanding and support of policy makers, the community and key partners. This involves meeting with the administration, implementing/operational partners and community groups – women, men, youth, including community leaders / workers. The purpose of these dialogues is to seek their active support – by reminding them of the importance of HIV and other STIs, by answering questions, by discussing the proposed interventions with sex workers and describing how these complement other activities, by building consensus to work together, and to avoid “labeling” any members of the community.

The second step is to begin identifying who is involved in sex work. Often people will come forward after the initial discussions to offer information about themselves or others who may be selling sex. Invite these people to return and bring other sex workers to meet with the team. These first contacts are important entry points to reaching sex workers. Mapping of “hotspots” is also conducted to identify where sex work takes place.

There are many reasons why displaced people may get involved in sex work. While some may choose it, many are driven by poverty and related circumstances of being displaced. Step 3 thus focuses on primary prevention – ensuring that no one is forced into sex work against her or his will. This involves expediting registration and strengthening protection systems to prevent gender-based violence (GBV), and ensuring safe access to shelter, food and other basic needs. Rather than cover this area in detail, this guide makes reference to existing protection standards and guidelines.

When sex workers come forward to identify themselves, it is important that they see some benefit from participating in the programme. Step 4 starts by conducting individual interviews, or profiling, to hear their stories, to offer counseling and to plan for moving forward. Such attention and assistance helps to build trust and ensure active participation in other activities.

Carrying out these different activities requires the attention of a number of different people with a range of skills and experience. Step 5 describes formation of multi-functional teams (MFTs) involving health, community services, protection, and with representation from among sex workers themselves. The programme will provide training of trainers (TOT) for select MFTs members to enable them to train and support peer groups, provide sex worker oriented social and health services, and monitor programme progress.

It is through the participation of sex workers themselves that most of the interventions with sex workers will be carried out. In step 6, a peer-led system is developed from initial sex worker contacts and based on participatory methods. Sex workers are encouraged to continue meeting together to begin finding solutions to problems they face. Group leaders are chosen by their peers

to receive additional training as peer leaders. Peer groups should remain open to enable other sex-workers who are identified later to join.

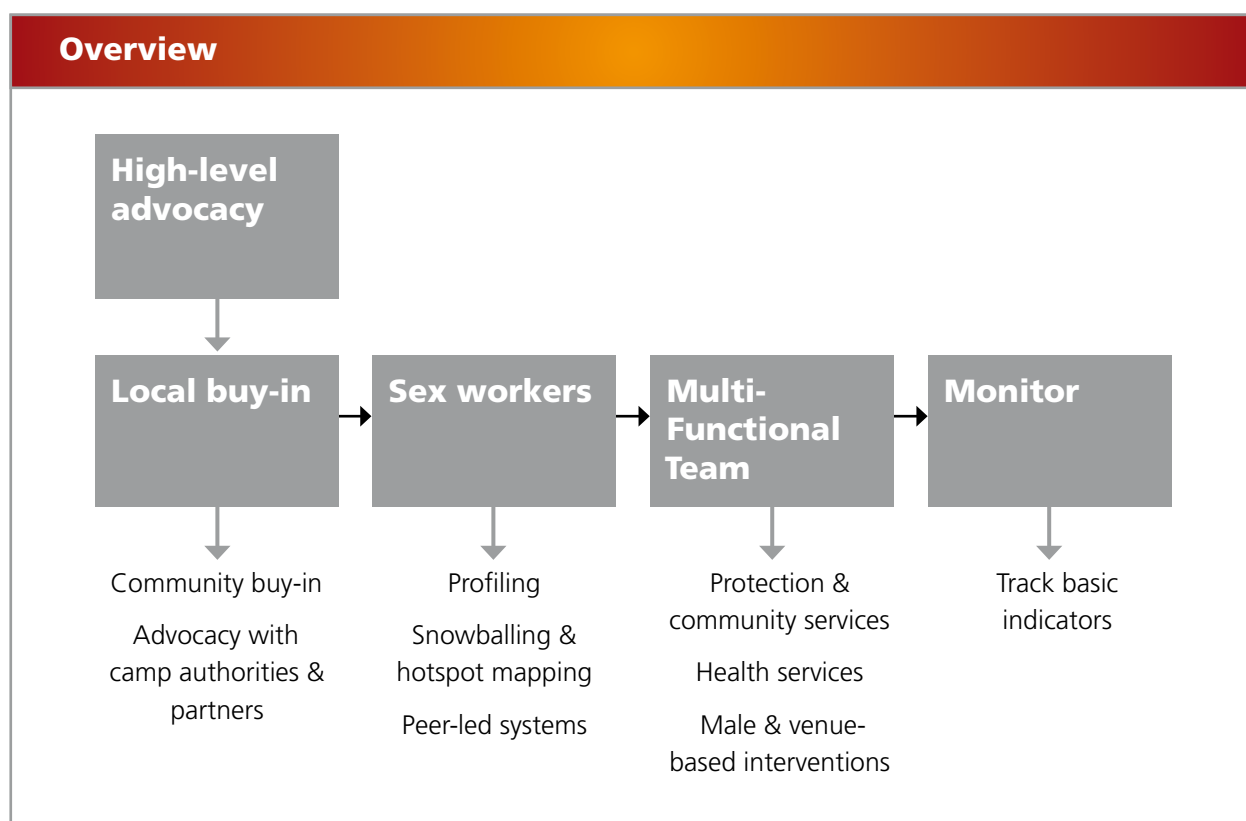
Health services have an important role to play as sex workers have special health needs. Health services recommended for sex workers in step 7 build on existing HIV, Sexual and Reproductive Health (SRH) and GBV programmes with attention to confidentiality and other special needs of sex workers and their clients.

Step 8 involves working with men to support prevention efforts with sex workers and in the community. Men can be effectively reached with peer-based interventions, as well as at sex work “hotspots” through venue-based interventions.

Codes of conduct should also be in place for staff who work with refugees.

Monitoring progress should be part of the activities described previously. Simple indicators that can be collected in the course of carrying out activities and providing services will be presented.

Finally, several programme inputs to support implementation of the above activities are described. These include initial site visits and subsequent TOTs to build the capacity of front-line field workers.



The activities described above comprise the first level of interventions addressing HIV and sex work in refugee situations. We divide this period into 2 phases – start-up and consolidation. Start-up begins with the initial field visits, consolidation with the first TOT. With adequate support, these can be accomplished over a period of approximately six months. By that time, the following outcomes should be achieved:

1. HIV interventions with sex workers prioritised in strategic plans
2. Support of community, camp/settlement administration and implementing/operational partners obtained
3. Protection systems strengthened. With a very strong protection response addressing sexual exploitation of children and prevention of GBV
4. Sex workers contacted and profiled, and pressing issues addressed
5. MFTs formed, trained and holding regular meetings
6. Sex worker peer groups formed and peer leaders trained
7. Confidential, respectful, quality health care offered by service providers
8. Involvement of men

Once these objectives are in place, there are opportunities to build on and extend the programme to better address conditions that create vulnerability and risk for sex workers and others.

A word about children

The vulnerability of children to sexual exploitation and abuse is heightened during humanitarian crises. While conditions, factors and possible responses may overlap with those for adults, there are fundamental and important differences (see box).

Under international law children under 18 cannot choose to engage in sex work, and the selling or buying of sex involving children is considered a crime. Children engaged in exchange of sex for money or other benefit should not be treated as 'sex workers' but as victims of sexual exploitation. While improving conditions related to sex work is part of the response for adults, the programmatic response to sexual exploitation is protection and removal of the child from the conditions of exploitation.



Step 1: Sensitisation and buy-in

- **Meet with administration responsible for refugees (in camps or urban areas) to ensure their support**
- **Meet community groups and leaders to introduce the programme**



An open dialogue with community women

Aims

The first and most important step in starting a new intervention is to gain the understanding and support of the community. This involves meeting with camp/settlement administration, implementing/operational partners and community groups – women, men, youth – and with community leaders and workers. The purpose of these dialogues is to seek the active support of both communities and camp authorities – by reminding them of the importance of HIV and other STIs, by answering questions, by discussing the proposed interventions with sex workers and describing how these complement other activities.

How to

Arrange meetings with key staff and community groups. This should include:

- i. Camp/settlement/urban administration and implementing/operational partners
- ii. Community leaders/workers, women, men and youth
- iii. HIV is the entry point for discussions. As the audience becomes engaged, the discussion should be guided to sex as the main mode of transmission. Let them raise the key issues, then supplement with additional information. Ask about who is most affected and sex workers will likely be mentioned. During these discussions, reinforce positive attitudes and point out that stigma and discrimination – whether against people living with HIV/AIDS, sex workers or other marginalised group – is counterproductive and harmful.
- iv. Ask about how people can prevent HIV. Condoms should be mentioned along with other prevention methods. Prompt and supplement as needed, giving information about both male and female condoms. Show a female condom to stimulate interest. Explain that it is up to each individual to choose the prevention method that will work for him or her. Use input from the group to talk about key elements of the programme that will be introduced.

Activity 1. Suggested outline for community discussions

- Start with an icebreaker, a story or culturally appropriate joke to make people comfortable. Ask if anyone has a song or prayer to share.
- Talk about HIV. Give information about the HIV epidemic and discuss common modes of transmission. Ask about existing stigma and discrimination in the community. Give some information about the extent of the problem and ask about modes of transmission.
- Give basic information on how HIV spreads, emphasising sexual transmission. Discuss misconceptions. Ask and discuss who is most at risk of HIV.
- Let participants bring up sex work and the reasons for it. Poverty will often be mentioned as a root cause, and this can lead to discussion of economic alternatives. Discuss reasons why men buy sex.
- Talk about sex work and transmission of HIV and STIs. Explain that men as clients are equally responsible, and that stigma and discrimination make matters worse.
- Talk about what can be done. Explain that the programme intends to work with sex workers and others to stop HIV/AIDS together.
- Finish with a summary of the discussion. Stress the importance of working together on HIV and sex work, and ask for their support.
- **Emphasise that confidentiality and rights must be respected.**

Step 1: Sensitisation and buy-in



Discussing HIV with young girls

During and after these initial meetings, people will come forward to offer information about themselves or about others who may be selling sex. Experienced facilitators will soon learn to identify possible sex workers from questions asked during discussions. Invite these people to return, together with any friends who may be engaged in sex work. These first contacts are important entry points to reaching other sex workers. More detail on the approach to take will be given in Chapters 3, 4 and 6. It is important to make time and space for individual meetings – for example, one team member may sit in a private room to talk to sex workers privately while community meetings are taking place.

Planning 1. Time planning for initial buy-in visits

Activity	Time needed	Summary
1 Meet with camp administration	1 hour	(activities in white are done once per camp; activities in blue need to be multiplied by the number of communities in the camp)
2 Meet with community women	1.5 hours	
3 Meet with community men	1.5 hours	
4 Meet with community youth (female)	1.5 hours	
5 Meet with community youth (male)	1.5 hours	
6 Meet with community leaders	1 hour	
8 Meet to form MFTs	2 hours	
7 Visit health facility	1 hour	
9 Conduct hotspot mapping	2 hours	
10 Debriefing with camp administration	1 hour	
Total	14 hours	

Planning ahead

The initial visit is also an opportunity to assess existing services and begin hotspot mapping, which will be described in later chapters. Given the importance of gaining full support from communities and staff working in humanitarian settings, be sure to plan enough time for these initial buy-in meetings.

The following table is a general guide to time planning. Note that camps, settlements and urban areas where refugees live are usually made up of multiple communities (with separate identity and leaders). The activities in white are done once per 'area', while activities in blue need to be multiplied by the number of 'communities' in the area.

A good facilitator uses many skills:

- Listen to what people have to say.
- Encourage people to talk and come up with answers themselves.
- Build on what people have to say, highlighting positive points and gently correcting misconceptions.

Step 2: Identification, hotspot mapping and snowballing

- **Collect basic information and assess risk**
- **Offer condoms, invite participation and encourage snowballing**
- **Map hotspots and estimate numbers of sex worker and clients**



Know your community

Aims

Step 2 is to identify those who are involved in sex work. Often people will come forward after initial discussions to offer information about themselves, about people they know or places where sex work takes place. With experience, facilitators will learn to identify those who may have experience or information. Encourage these people to return and bring others who are involved in sex work. These first contacts are important entry points to reaching sex workers. This method of using a few initial contacts to refer many others is called 'snowballing'.

A complementary activity is 'hotspot' mapping to identify places where sex workers meet clients and where sex work takes place. Hotspot mapping helps in identifying other sex workers and is a starting point for venue-based interventions – for example, by ensuring that male and female condoms are available and promoted at each of the identified hotspots.

How to

This step is one of the most important since all other activities depend on it. If few sex workers come forward, interventions and services will have minimal impact. If, however, sex workers can be made to feel comfortable, agree to talk and to refer others, participation in the programme and impact on HIV transmission will be much higher.

The key to success at this stage is to ensure confidentiality and build trust. Care must be taken to invite sex workers to meet in private settings where they will not feel stigmatised. Sex workers will also be more likely to come forward if they believe that the programme can offer solutions to at least some of the problems they face.

During this first meeting it is important to start discussing prevention, including knowledge and experience in using condoms. Provide condoms and information, and ask about barriers to accessing and using condoms.

Sex workers should also be told about programme plans and the importance of sex workers' participation. They should be asked about places where sex work takes place. This information will help with hotspot mapping and venue-based interventions.

Activity 2. Hotspot mapping

Hotspot mapping itself can start with a walk-around tour of the streets that sex workers and other community members have mentioned. This should be done by a small team with assistance from one or several sex workers.

- Together, locate hotels, guest houses or other places where sex may take place, and try to estimate numbers of sex workers and potential clients.
- Draw a simple map of the area and indicate bars, video halls, discos and other venues.
- Ask the sex workers whether sex takes place on the premises or is only negotiated there, and about the number of clients usually present.
- Talk to venue managers or owners. Offer condoms and discuss how they can be made available to sex workers and their clients.
- Ensure that mapping information remains confidential and is not used to disrupt sex work or related activities.

Hotspot maps can be improved over time by adding information about the number of sex workers and clients found at different times of the day and night.

Step 2: Identification, hotspot mapping and snowballing

Remember that the purpose of mapping is to improve programmes, to better reach and provide services to sex workers and clients. Under no circumstances should the programme allow maps or related information to be used for punitive measures (such as destruction of venues or police roundups). Doing so would quickly drive sex work underground and make conditions more dangerous.

In conducting mapping, be sure to talk to the venue managers or owners. Explain that you are working to improve conditions and reduce transmission of HIV and other STIs. Make it clear that you do not intend to disrupt business, but are seeking partners for HIV prevention efforts. Offer



condoms and discuss how these can best be made available to sex workers and their clients. These and other venue-based activities will be discussed in more detail under Step 6.

Snowballing is a term that means building something big from something small. With a few initial sex worker contacts, it is possible to make contact with many others. The key to this is convincing the few that the programme respects them as human beings and can do something for them, that they are 'part of the solution'. With this belief, they will inform others and refer them to the programme. This is the beginning of a peer-led system that is at the centre of all effective sex work intervention programmes.



Step 3: Protection

- **Promote prompt registration and ensure safe access to basic needs**
- **Reinforce and build on GBV prevention and child protection activities**



Strengthening child protection includes listening to what young people have to say

Aims

There are many reasons why displaced people may get involved in sex work. While some may choose it, many are driven by poverty and circumstances relating to their displacement. This may include sexual exploitation or other forms of GBV. An essential part of the programme is, thus, to ensure that no one is forced into sex work against her or his will. This involves strengthening protection systems to prevent GBV and sexual exploitation of children. Equally important is ensuring safe access to shelter, food and other basic needs. Since protection and community services are integral parts of refugee services, these subjects will not be covered in detail here. Refer to relevant guidelines with attention to issues raised in this section.

How to

Protection activities are a major focus in all refugee operations. It is essential to establish safe access without delay to shelter, food and other basic needs. In many settings, programmes have been started to prevent GBV, and codes of conduct have been put in place for humanitarian staff. All these protection activities are important to reduce sexual exploitation and forced entry into sex work. Existing guidelines and tools should be used.

Activity 3. Reinforcing prevention of gender-based violence and sexual exploitation

In many refugee situations, protection and community services are inadequate to protect the most vulnerable. Essential protection activities – such as Best Interest Determination (BID) for children, adequate and regular monitoring of children in foster care or ensuring that most marginalised have access to food items – may be delayed or poorly implemented. This may be true even in stabilised settings where refugees have been present for a long time.

Whether in an emergency or stabilized context, strengthening of existing protection mechanisms is a critical step to reduce GBV, sexual exploitation and transmission of HIV and other STIs.

Some people are especially vulnerable to sexual exploitation and abuse. These include, but are not limited to unaccompanied minors and female and child-headed households. If there are delays in registration and meeting basic needs, or if protection is inadequate, the likelihood of exploitation increases and some will turn to sex work. Extra attention is needed to identify the most vulnerable and to provide protection early.

Reinforce prevention of gender-based violence

Remember that sex workers often suffer higher levels of discrimination and vulnerability, both from authorities and in the community. As a result, they may face difficulties accessing adequate health care and other services, or receiving food distribution cards, food and non-food items. Unless sex workers share the same human rights and protection from discrimination and violence as others, they will remain marginalised and at high risk of acquiring and transmitting HIV. When programmes start by protecting sex workers, however, it becomes possible to gain their active participation in fighting HIV.

Step 4: Profiling and case management

- **Develop a deeper understanding of sex work in the community**
- **Identify sex workers who are most vulnerable and at highest risk**
- **Develop case management plans to address urgent problems**



Profiling

Aims

Together with identifying sex workers must come some actions that are of perceived benefit to sex workers who come forward. This can be started by conducting individual interviews, or profiling, to hear a person's story, to offer counseling and to develop a plan for moving forward. Usually such plans will involve participation in larger peer group activities but there may also be concrete steps to take for individuals with specific medical or social problems. Such attention and assistance to individual as well as group needs helps to build trust and ensure active participation in other activities.

How to

As mentioned in Step 1, time and space should be set aside from the beginning to interview sex workers who come forward to identify themselves. This interview process is called 'profiling' and should be carried out in a confidential and systematic manner to build trust, collect needed information, identify pressing needs for immediate case management and engage the person in the programme.

Activity 4. Profiling – an outline of key questions

- Ensure the person that her/his privacy and confidentiality will be respected.
- Confirm that the person is indeed engaged in sex work, record identifying information (such as registration care number or ration card number) and give a pseudonym. The pseudonym can be widely used by the programme while the ration card number (the identifying link) is guarded in a safe place to maintain confidentiality.
- Ask who the clients are, how many clients are seen per day, and charges per client.
- Ask about where sex work takes place – this information can help guide mapping.
- Ask about condom use, in general and specifically with last client.
- Ask how many children she has.
- Ask whether any family planning methods other than condoms are used.
- Ask about current or previous STIs and if and where they went for treatment.
- Ask whether the sex worker has experienced abuse or violence, and what was done.
- Identify minors who need referral to protection services.
- Ask about the circumstances of their involvement in sex work.
- Identify any urgent medical or social problems that may require immediate action.
- Explain the objectives of the sex worker programme and invite the person to become involved.
- Give information about the next meeting (individual follow-up or group meeting).
- Ask the person to refer any friends who are also involved in sex work to the programme.
- **Anyone with urgent needs should be referred immediately** to UNHCR or relevant implementing partners.
- **Any child (<18 years old) requires immediate referral** to appropriate protection services. It is essential to ensure confidentiality and effective follow-up during the process to ensure that intervention does not cause further harm.

Step 5: Multi-Functional Teams (MFTs)

- Promote and guide programme implementation
- Identify roles and responsibilities
- Strengthen partnerships
- Ensure coordination and monitor progress



Forming an MFT

Aims

Carrying out these different activities requires the attention of a number of different people with a range of skills and experience. This guide promotes the formation of MFTs involving health, community services, protection, livelihood and legal services, including participation from newly formed sex worker groups. MFTs members need training to be able to train and coordinate peer groups, provide sex worker specific health services and monitor programme progress.

How to

A multifunctional team with active and committed membership is critical to the success of the programme. The MFTs can be formed before the end of the first set of field visits drawing from among those who participated actively during the visit. This should include all those with responsibility for different parts of the programme. Activity 5 provides a suggested meeting agenda for forming the MFTs.

Review and agree upon the terms of reference for the MFTs. These should include:

- Identifying lead organizations and focal persons.
- Holding regular meetings to coordinate activities.
- Developing a workplan.
- Identifying human, material and financial resources to carry out the work.
- Monitoring progress.
- Inform the MFTs that a TOT will be held to build capacity of the MFTs coordinator and several others, depending on programme needs. Those chosen for training should be the ones with key responsibility for implementing the work and keeping other MFTs members informed.

Choose MFTs committee members from among partners who will actively support the programme. These may include:

- **Camp administration**
- **Protection**
- **Community services**
- **Health services**
- **Legal**
- **Livelihood**
- **Sex worker peer leaders (once groups have been formed)**

Step 5: Multi-Functional Teams (MFTs)

Activity 5. Talking points for an initial MFT meeting

Invite everyone to share impressions of the field visits and clarify comments.

Ask an open question about the meeting – why we are here? Explore this question to summarise objectives together. Responses should include: 1) to make sex work safer, and 2) to provide options.

Ask why we are forming a MFT? Without leadership and coordination (e.g. government, partners, UNHCR), it won't work.

Ask how do we go forward?

Review key points

- Sex work exists; it won't go away.
- HIV and other STIs spread easily without prevention programmes for sex workers.
- Need to do something.

Share information about cases (without identifying people)

- Vulnerable children, orphans require protection.
- Adults should have options and can make their own decisions.
- Married women and men may be involved in sexual networking.

Decide what systems to put together

- Talk about mapping, review general approach.
- Form peer groups (if 100 sex workers, form 4 groups of 25).
- Provide training on HIV and STI's, gender and human rights, services to be provided.
- Improve access to health services, social and community services (point out that health facilities offer special clinics in many areas).

Talk about the dangers of giving out money

- Promote income generating activities, revolving funds to reduce dependance on sex work (don't give fish, but teach people to catch the fish).
- Promote merry-go-round and other savings/credit schemes (which strengthen sisterhood).

Form the MFTs

- Choose coordinators and committee members.
- Review terms of reference – each person should have a clear role.
- Set a time and place for first meeting.

Activity 5. Talking points for an initial MFT meeting (cont.)

Summarize

- Issues that need to be follow up (e.g. mapping, building peer-led systems)
- MFTs members will be trained in TOT.
- Following TOT, peers need to be trained.

Closing

- Remind them that sex worker programmes have been effective in many countries.
- Invite any remaining questions and comments.



Talking with young people about HIV

Step 6: Building peer-led systems with sex workers

- Call a first meeting and review programme objectives
- Introduce the verbal contract about participation in the peer group
- Ask sex workers to choose their leaders and agree to meet regularly
- Provide training for peer leaders
- Supply peers with condom education, promotion and distribution kits



Forming peer groups

Aims

It is through the participation of sex workers themselves that most of the interventions with sex workers will be carried out. To accomplish this, encourage development of a peer-led system from the initial sex worker contacts.

How to

Soon after making initial contacts with sex workers, invite them to meet together as a group. The purpose of meeting together should be explained – it is to continue finding solutions to the problems raised during the initial discussions and profiling. Explain that there is strength in numbers. Sex workers are most vulnerable when they are isolated and marginalised. As a group, and with the support of the programme, they can begin to address the problems they face.

Activity 6. Initial peer group meetings

At the first peer group meeting

- Review the objectives of the programme, which are to:
 1. Support sex workers to reduce their dependence on sex work, and
 2. Make sex work safer for those who choose to continue doing it.
- Recall with sex workers what was said during earlier meetings; sex work may be largely poverty-driven, but change is possible. Through peer groups, sex workers can work together at different levels, such as supporting condom use and safer sexual behaviour, developing saving schemes and income generating projects to improve their conditions.
- Then ask the sex workers to agree to a verbal contract. These are to:
 1. Respect each others' decisions about continuing or leaving sex work, and
 2. Work together to improve their conditions and make sex work safer.
- Group leaders should then be chosen by their peers. Start with a chair, a secretary and committee members for each group. Explain that these peer leaders will receive training in peer-led systems and will work closely with the MFTs to ensure that sex workers have a say in all decisions affecting them.
- Before ending the first meeting, make sure that the group has agreed to a time and place for their next meeting.

Subsequent meetings should build on the verbal contract. An MFT member, preferably from community / social services, should attend the peer group meetings, especially at the beginning. Remind them of what they agreed to do in the verbal contract and ask what they have done since the last meeting. Offer advice and technical assistance where needed.

The programme should make sure to maintain momentum generated by these first peer interventions. Initial peer group meetings raise expectations that need to be met, at least partially. If sex workers see no activity, they will lose interest and become skeptical, and it will be very difficult to lure them back to the programme. Try to promptly manage the most important issues raised by peers, but avoid raising expectations that cannot be met.

Two activities that are critical at this stage are 1) the TOT training for MFTs members and 2) the training of peer leaders by the MFTs following the approach taught in the TOT.

Step 7: Health services

- **Assess services looking at HIV/STI-related areas**
- **Ensure that sex workers have access to non-judgmental services**
- **Advocate for special services for sex workers**



Planning to provide respectful and confidential health services for sex workers

Aims

Health services have an important role to play as sex workers have special health needs. Health services are responsible for condom distribution which should be targeted to reach sex workers and the places where sex work takes place. Health services for sex workers build on existing SRH, HIV and GBV programmes with attention to confidentiality and other special needs of sex workers and their clients.

How to

Begin by visiting health centres and hospitals during the initial field visits. Introduce the programme to the medical staff and explain that you would like to see what medical services are offered and how they are provided. Start with general services, both outpatient and inpatient, and try to assess staffing levels to handle existing patient load. Specific services to be reviewed include:

- Outpatient services which should have up-to-date STI flowcharts and drugs
- PMTCT to prevention of mother to child transmission (PMTCT)
- Laboratory services which should have reagents for HIV and syphilis testing (RPR or equivalent)
- Voluntary Counselling and Testing and Antiretroviral Treatment

Try to assess whether services are provided confidentially with attention to privacy and with respectful attitudes towards patients. Registers should be reviewed at each service to see if important information is recorded with disaggregation of refugee and nationals.

The following checklist can be used to guide the assessment.

Activity 7. Assessing clinical services

Assess	Standards
1. Internal structure The internal structure of the clinic should provide physical privacy, auditory privacy and confidentiality for patients.	Ensure standards are met in the following rooms and areas: <ul style="list-style-type: none">- Waiting and registration area- Consultation and examination room, with door- Laboratory area (if feasible)- Counseling room, with door- All areas should have adequate lighting and ventilation.
2. Staffing Staffing should be adequate for clinic functions to be carried out in an efficient and timely manner, to avoid long waiting periods for patients.	<ul style="list-style-type: none">- Clinic administration, patient registration, record-keeping and reporting- SRH history-taking, clinical examination and treatment, including counseling and education- Laboratory-based diagnostic testing (where applicable)- Maintenance of clinical standards for STI management- Procurement and maintenance of clinic supplies.

Step 7: Health services

Activity 7. Assessing clinical services (cont.)

Assess	Standards
<p>3. Health care service provision A full range of STI services and a limited range of general health services for sex workers and their clients.</p>	<ul style="list-style-type: none"> - Syndromic management of STIs - Regular monthly health checkup of sex workers (history taking and physical examination) - Asymptomatic STI treatment for at first visit and repeated if sex worker has not come for checkup for three months - Free STI treatment to all sex workers - General health consultation - Rapid simple laboratory services in selected clinics including: <ul style="list-style-type: none"> - Rapid Plasma Reagin - HIV testing (always voluntary and with counseling, as below) - Microscopic examination of vaginal swab specimens - Haemoglobin and blood group determination - Urine – routine and microscopic examination - Pregnancy test
<p>Health education and counseling services.</p>	<ul style="list-style-type: none"> - Promotion of male and female condoms - Partner notification and treatment
<p>Additional services to be provided on site or through referral.</p>	<ul style="list-style-type: none"> - Family planning services - Serologic syphilis screening, in clinics without laboratory facilities - Voluntary counseling and testing (VCT) for HIV - TB clinical screening and referral to TB clinic confirmation and treatment - Secondary care for complicated STIs and treatment failures - HIV/AIDS care and support - Food supplement as appropriate - Special counseling services - Harm reduction services for alcohol and drug users - Other social services, including legal services.



Demonstration of the female condom

Step 8: Male and venue-based interventions

- Engaging men and boys
- Simple venue-based interventions



Talking with men about sex and HIV

Aims

Men have an important supportive role to play in supporting the programme. If they are left out, they can undermine efforts to make sex work safer, reduce sexual exploitation and GBV. The programme should aim to strengthen peer-led activities to promote responsible sexuality among men in the communities. Codes of conduct should re-enforced and interventions strengthened at places where sex work is negotiated and takes place.

How to

Beginning with the initial community buy-in discussions (Step 1), talk with men about:

- Prevention and treatment of HIV and STIs
- The aims of the sex work programme including prevention for clients
- How to support the programme

These points should be reinforced among men in the community whenever possible. However, this may be more difficult in humanitarian settings where men may be idle for extended periods. Boredom and inactivity can lead to alcohol and/or substance use, and to sexual and other behaviours that put themselves and others at risk.

Peer-led interventions can be effective approaches for men as they are for sex workers. If men's groups are already in place for GBV prevention, they can be extended to support prevention related to sex work. Activities that involve men in constructive activities and raise awareness about harmful patterns of drinking, drug use and sexual behaviour complement other interventions and lead to better outcomes.

Other measures are needed for humanitarian workers. Codes of conduct should be put in place to ensure that staff do not abuse positions of power and authority to obtain sexual favours. These should be discussed in the community so that refugees are fully aware their rights and recourses in the event of abuse.

Other important interventions target men at sites where sex work takes place. We discussed 'hotspot' mapping in Step 3 and talked about the importance of ensuring condom distribution. Other venue-based interventions can be developed together with the venue managers and male peer workers. These include education of men at the sites, improved security, GBV prevention, and support for sex workers in demanding condom use.

Step 9: Monitoring

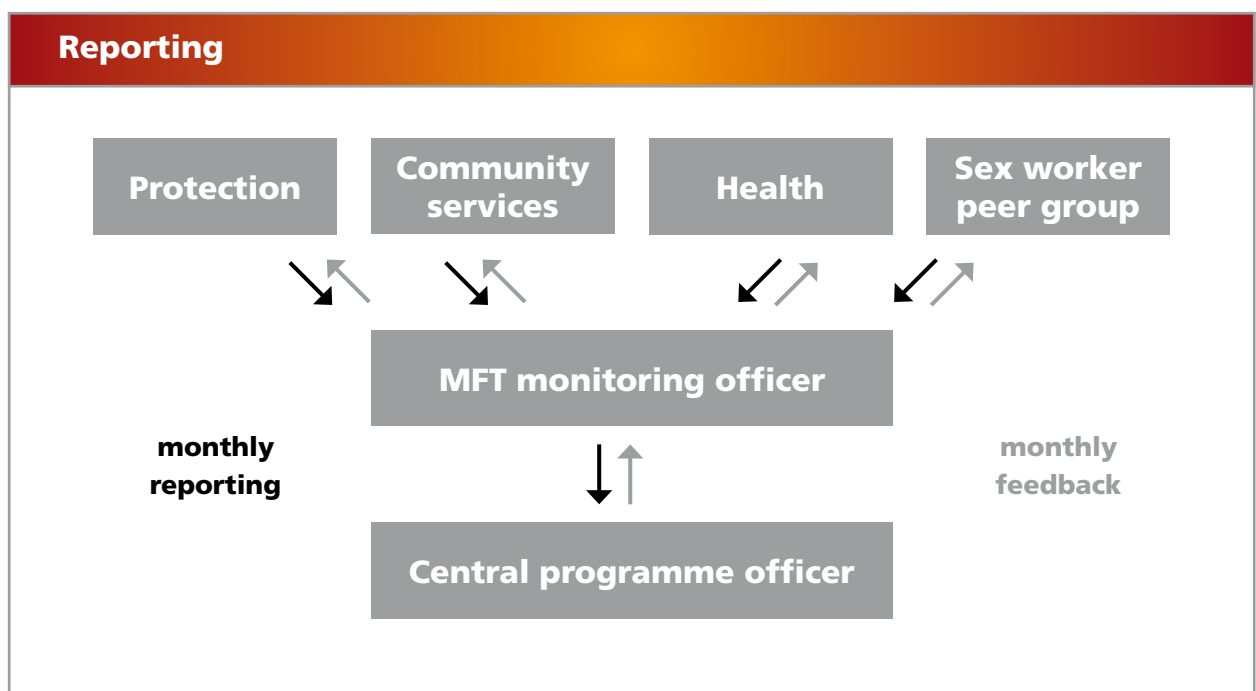
Aims

Monitoring progress should be a part of the activities described previously. Simple process indicators that can be collected in the course of carrying out activities and providing services were presented at the end of each chapter. Many of these may already be being reported as part of other programmes and services (protection, community services monthly reports or the Health Information System (HIS)). This chapter outlines how to collect and analyse data on priority programme indicators.

How to

The MFTs should delegate someone to be responsible for monitoring. The monitoring officer should receive training to introduce key indicators and data collection forms, promote monthly reporting, compile and send monthly reports to central office, conduct basic analyses and provide regular feedback to MFTs. These skills and methods should be taught during the TOT.

The following figure illustrates how the reporting and feedback loop works for each sector (protection, community services, health, MFTs, etc). A monitoring officer is responsible for collecting data from each service and feeding back results to MT and also to the central programme officer.



A reporting calendar should be developed and disseminated among those who are expected to report. The monitoring officer is responsible for ensuring that data are reported on time and are complete. The following table summarises monthly reporting deadlines.

Measuring progress

Overall and priority indicators

Type	Indicator	Source of data
Coverage	Number of sectors with programmes for sex workers	MFT reports
	Number of sex workers mapped/estimated	MFT reports
	Percentage of sex workers reached by peers	MFT reports
Process	Step 1. Sensitisation Number of meetings held with camp administration	MFT reports
	Step 2. Identification, hotspot mapping and snowballing Number of sex workers identified and profiled Number of hotspots identified Number of hotspots supplied with condoms	MFT reports MFT reports MFT reports
	Step 3a. Protection Number of vulnerable individuals identified and registered Number of cases of GBV reported	Community services / protection monthly reports
	Step 3.b. Child Protection Number of sexually exploited children identified % of children that are sexually exploited receiving protection Number of children in foster care % of children in foster care visited at home/month Number of child headed households identified % of child-headed households visited / month Number of unaccompanied minors identified % of unaccompanied minors visited at home /month	Community services / protection monthly reports
	Step 4. Profiling and case management Number of sex workers profiled % of new sex workers referred to other services	MFT reports
	Step 5. Multi-functional team Multi-functional team established	MFT reports
	Step 6. Building peer-led systems with sex workers Number of active sex worker peer educators	MFT reports

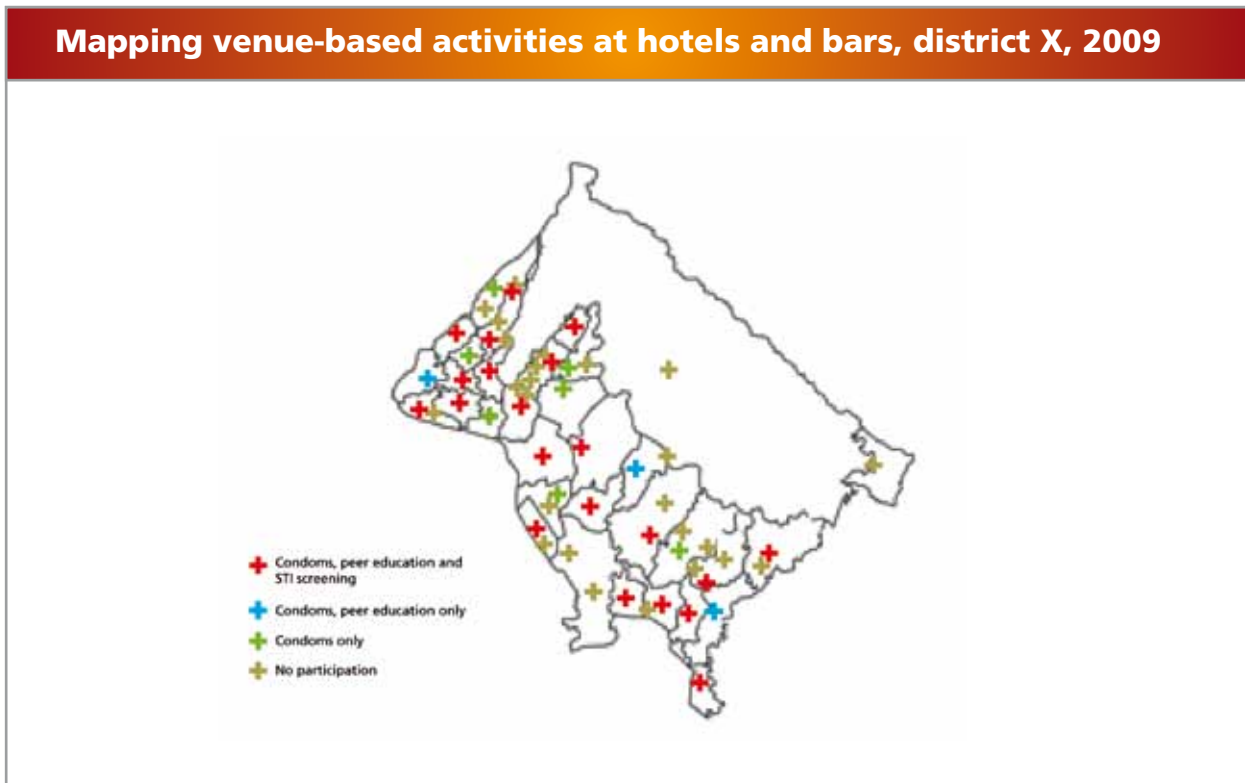
Step 9: Monitoring

Type	Indicator	Source of data
Process	Step 7. Health Services Sex workers clinical attendance (first-time and follow up) Access to services 1) STI services 2) Family planning 3) Voluntary counselling and testing for HIV 4) Care and treatment for HIV positive sex workers 5) Reproductive Health services for sex workers	Health report
	Step 8. Male and venue-based interventions Number of male peer group formed	MFT reports
Outcome	Reported condom use at last sex	Mini-survey (bi-annual)
	Reported number of clients	Mini-survey (bi-annual)
Impact	STI incidence rates (urethral discharge and genital ulcer)	HIS
	Syphilis prevalence among sex workers	Clinical records
	Syphilis prevalence at antenatal care	HIS



Examples:

5 steps to improve routine monitoring (adapted from UNHCR/UNFPA: Technical note on HIV and sex work in humanitarian settings)

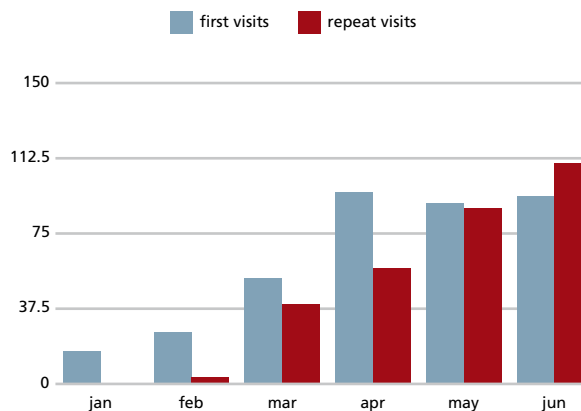


Participatory hotspot mapping serves not only to identify locations where sex work takes place, but also to estimate population sizes (which provide denominators for coverage rates). Simply ask sex workers to identify 'hotspots' where sex work takes place, and to estimate the numbers of women and men selling sex at each site. In the beginning, this will be an underestimate but if mapping is repeated (many projects do this once a year), estimates will improve as outreach and programmes become more established.

To monitor outreach efforts, ask peer workers to tally 1) new contacts and 2) repeat contacts with sex workers. Meet with them monthly to review totals and compare to targets based on size estimates from mapping.

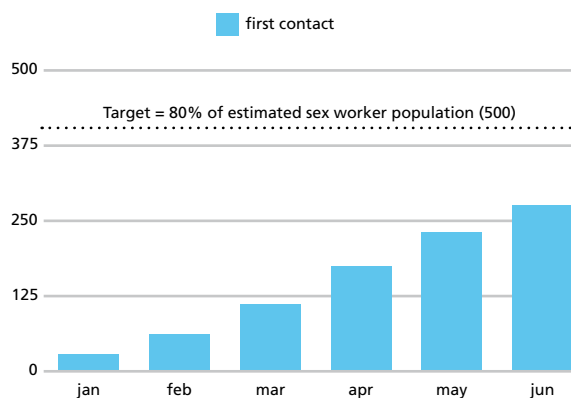
Step 9: Monitoring

Number of first-time and repeat sex worker contacts

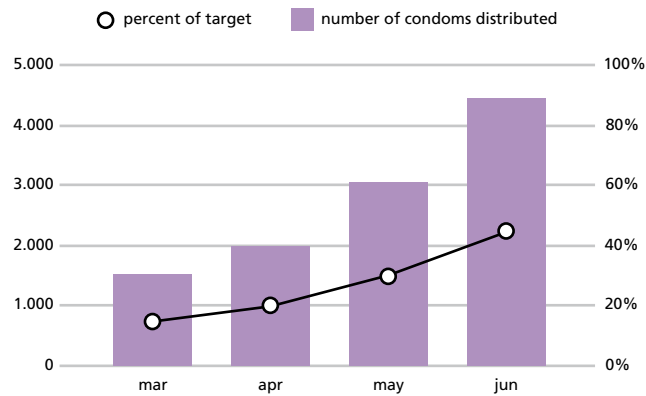


Condom distribution (both through peer outreach and venue-based interventions) should also be monitored. Information about recent condom use ('did you use a condom with your last client') can be asked either routinely (at outreach or clinic contacts) or by simple survey, and monitored on a quarterly basis.

Cumulative first-time sex worker contacts and target: All sites, 2010

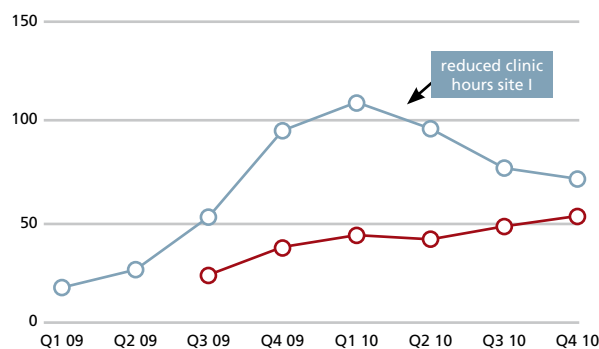


Number of condoms distributed compared to target: Region Y, 2007-2010



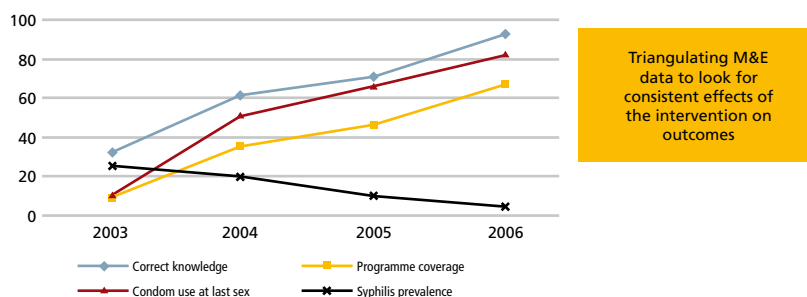
Another measure of coverage is tracking clinic attendance. Peer outreach workers can give referral cards (numbered but without names) to be presented at the clinic. Showing the card also lets the clinic know to take special care in ensuring privacy and confidentiality when providing services.

Number of sex worker clinic visits by quarter: 2009-2010

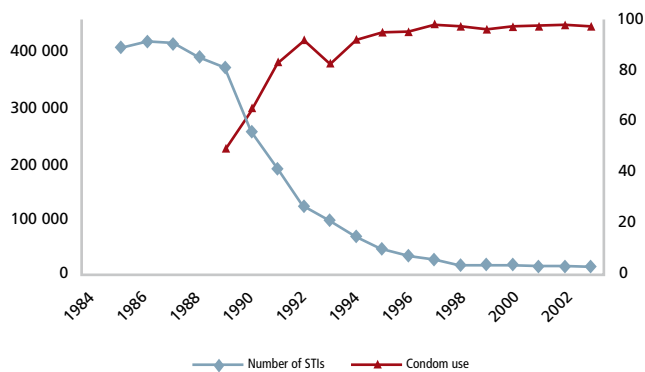


There are several ways to monitor the impact of combined interventions on sexual transmission. Sex workers should be routinely offered screening for syphilis every 6 months (using a non-treponemal test such as RPR or VDRL). Syphilis trends can then be analysed – as programmes increase coverage and condom use rises, syphilis prevalence among sex workers should decrease.

Step 9: Monitoring

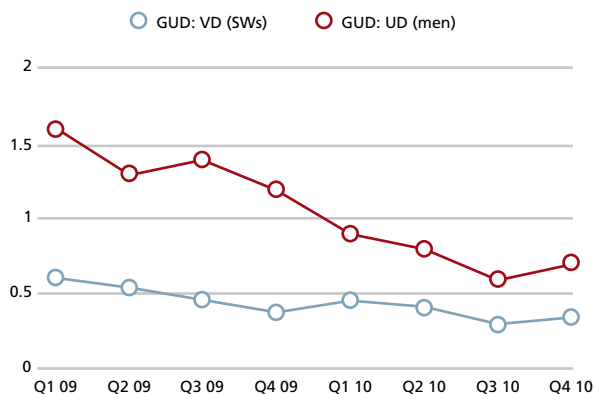


In addition, STI syndromes – urethral discharge and genital ulcer – should be recorded at outpatient clinics used by men and reported monthly. Trends of male STIs can be sensitive indicators of declining sexual transmission due to increasing condom use and other interventions.



Finally, changes in syphilis prevalence can be measured by monitoring the proportion of antenatal clinic women who test positive for syphilis. It usually takes a few years before reductions are seen in these indicators.

Ratio of genital ulcers (GUD) to non-ulcerative syndromes



Programme inputs

In order to support development of interventions and services addressing HIV and sex work in humanitarian settings, several inputs are needed at different stages. These are summarized below as three supportive activities which can be planned during the first 6-9 months of the programme. If the number of different camps or settlements exceeds 5 or 6, it may be advisable to plan for two rounds of

- Initial site visits for planning, buy-in, launching peer-led systems and MFTs
- TOT 1 for basic community interventions (outreach, protection and health services)
- TOT 2 for second-level interventions (social and legal services, livelihoods and income generating activities)





ANNEX

MINI-SURVEY OF CONDOM USE AMONG SEX WORKERS

The following survey can be used to assess condom use among sex workers at baseline and on an ongoing basis. It can be administered using population-based sampling or, more simply, as part of routine activities such as mapping, outreach or clinic attendance. First-time contacts should be analysed separately from repeat contacts/visitors.

Example: sex worker mini-survey

1. Demographic characteristics

a). Age:..... b). Sex:..... c). Nationality:.....

2. How many clients did you have on your last working day?

3. Did you use a condom the last time you had sex with a client?

4a). In the past one year, did you experience any of the following symptoms?

Women only

Vaginal discharge? Y N

Genital ulcer? Y N

Lower abdominal pain? Y N

Men only

Urethral discharge? Y N

Genital ulcer? Y N

Anal discharge? Y N

Rectal prolapse Y N

4b). If yes, did you go for treatment?

4c). If yes, where did you go for treatment



