Research for Sex Work

This publication is the result of an open call for exchange of experiences of those active in the field of Research for Sex Work. It appears that many action groups, research institutes, public health facilities and NGOs active in the field of research of STDs/HIV/AIDS among sex workers and their clients in developing countries, are facing the same problems. We received so many reactions on our call that we thought it important to share them. This publication about peer education is the result. We hope that other publications about syndromic approach, improvement of STD/AIDS facilities for sex workers in countries with repressive policies et cetera, will follow. This publication is made by volunteers in their own time, with only small support from HIVOS, The Netherlands, for the printing costs. We hope to find a place in one of the sex workers' or AIDS networks to continue these activities, in order to contribute to capacity building of grassroot organizations and researchers.

CONTENTS

Research for Sex Work is a publication that can be used by researchers, sex workers, public health workers and local politicians, who professionally have to do with sex work and think they can contribute something to important discussions on research for sex work. We hope that we can quickly work from a website through which we can make the exchange of ideas and experiences function more easily. Until then you can send your reactions to:

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WHY THIS INITIATIVE IS IMPORTANT

Since the campaigns to increase global awareness of high-risk behaviour concerning HIV/AIDS infection started, there has been a lot of emphasis on behaviour change in sexuality. Condom use and faithfulness towards one partner have been promoted as means to limit the dissemination of HIV. In addition, there have been public health campaigns targeting specific groups. These include men who have sex with men, adolescents and sex workers (SWs).

Interest in sex workers has not always been focussed on the well-being of sex workers themselves, but often out of fear that they would be multipliers in the dissemination of HIV. In the wake of the campaigns to influence the behaviour of SWs much research has been done to measure the impact of certain policies or to understand the context of sex work. A lot of this research is taking place in relative isolation. Problems and experiences in one place are hardly known in another, while there is so much to share and from which to learn. Though there are networks and platforms where there is a possibility to exchange experiences, knowledge and views, there is a need for more sharing of insights and experiences.

Appropriate interventions

International organizations have stressed the following important interventions for sex workers and their clients: appropriate STD-services, because sexually transmitted diseases (STDs) are a proven important cofactor for HIV infection, and improved and consistent condom use among SWs and their clients through health education. However, sex workers and their clients in developing countries are not always easy to reach with STD-services and health education. This has made it difficult to develop appropriate official strategies to make STD-services and health education available for SWs and a community approach has become indispensable. There are three issues that are of immediate concern when we look at interventions and related research with regard to SWs. These are:

1. Peer education as the most appropriate means to educate sex workers about the importance of STD-services and condom use.
2. Improved, appropriate low-threshold STD-services for SWs, so that it becomes easier for them to attend these services.
3. Syndromic approach in countries where there are no means to develop good clinical facilities. This is the latest advice of international organizations, but will it work for sex workers?

MASS TREATMENT VERSUS SYNDROMIC MANAGEMENT

For those not familiar with different public health treatment policies for STDs:
Mass treatment is the approach in which sex workers are given a shot of penicillin each fortnight. The rationale behind this was that they are so often infected with STDs that it is for their own good and their clients' when they are continuously treated. In countries where this is/was done the two-weekly penicillin shot was a precondition to get a permit. However, the opinion of SWs themselves was never asked and it appeared to lead to the micro-organisms responsible for the STDs to rapidly develop resistance to penicillin. For humanistic and practical reasons mass treatment has been discontinued in most countries. Each person has a right to individual attention and appropriate treatment and there is no reason to make exceptions for SWs.
The syndromic approach is the basis for treatment of STDs in which the choice of therapy is not based on clinical diagnosis (including tests to certify which micro-organism is causing the STD) but on the presence of a few symptoms. The rationale behind this is that if there is no money for a sophisticated healthcare system that can provide the diagnosis, it is better to assume that the presence of certain symptoms implies that there may be a STD. If the choice to undergo syndromic treatment is put in the hands of the SWs themselves it may be an important tool for empowerment. If it is just a cheap and second-class healthcare system, one can wonder what the advantage for the SWs is. For a general population with a relatively low rate of STDs the syndromic approach may be rather effective. For SWs with a rather high rate of STDs the chances for undertreatment or overtreatment are big. There is a need for thorough discussion in the networks of SWs to agree their priorities on this issue.

Will it lead to under- or overtreatment? Will it become another form of mass treatment?

Of course, these three different policies are ideally integrated in good services for sex workers. In this first Research for Sex Work product we concentrate on the issue of peer education. The first part of the publication (pages 3-10) is devoted to this topic. Some examples of more or less successful peer education programmes are given, and problems experienced with setting up such programmes are described.
The second part (pages 11-13) focuses on involving sex workers in research. Some valuable ethical guidelines, and some other comments concerning this issue, are given. Almost 90% of research results are never used for the simple reason that the people who have to implement the conclusions were not involved in the research. Researchers are alone in the learning process of the research and are often not skilled in transferring the knowledge and insights gained to sex workers and public health workers. It is therefore useful to develop networks of researchers with other stakeholders in the research and intervention process, in the first place the sex workers themselves.

Sex work seems easy to define. Day (1988) defines it as 'the exchange of sexual services for money or goods between two or more people'. In a cross-cultural context we realize that this definition is sometimes hard to use in Africa or Asia, and a technical/pragmatic approach may produce simplistic pictures of determinants of sexual behaviour, which will lead to ineffective interventions (Zalduondo 1991). What public health experts see as sex workers may be very different from how these men and women see themselves. They do not only have the sex worker identity, but they have what is called multiple identities. They are also mothers, sisters, girlfriends, daughters. The lines drawn by epidemiologists and doctors may not be applicable to the SWs themselves and it is what they see and think, that is important. However, SWs are often targeted as a homogeneous group, which makes interventions inappropriate, because the target group is not clear. The article 'The concept of high risk groups' in the third part of this publication highlights this problem.

More knowledge and understanding of sex work and how STD-services and health education fit in is needed. Most researchers in this field have been confronted with similar problems and some have expressed their needs at international congresses. There is a need for new partnerships and new methodologies to come to real 'demand-driven' research.
Discussions on the need for new interventions and improvement of existing interventions are essential. This publication is a tool for this. It is not targeted at a rather restricted academic audience, but tries to report briefly on important topics for an audience of all stakeholders in sex work research.

References

Day, S. Prostitute women and AIDS: anthropology. AIDS 2, 421-428, 1988.
Zalduondo B.O. de. Prostitution viewed cross-culturally: Toward recontextualization of sex work in AIDS intervention research. J Sex Research, 28, 223-248, 1991.

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TERMINOLOGY

The words we use say something about how we think. This is also true for the way we talk about sex work. Therefore, the terminology we use can be very revealing. For non English speaking populations who are forced by the globalization to communicate in English, it is not always easy to understand why one word should not be used in English, while another is without objection. The reality is that many sex workers and other people object to the terms prostitutes and commercial sex workers. In this publication, we will respect their wishes and will only use the terms sex worker and its abbreviation SW.

ABOUT PEER EDUCATION

International organizations (UNAIDS, WHO, UNICEF, UNDP, World Bank) all state that peer education for sex workers is the best policy. It almost sounds like the gospel, because these donors rarely have suggestions about how peer education has to be done in order to be effective. We readily want to believe that peer education is the best approach to educate and empower sex workers so that they are better able to defend themselves against being infected with STDs or HIV infection. But is all peer education effective? Who is educating who? Does one sex worker educate the other? Does the pimp educate the sex worker? Does the former sex worker educate the sex worker? Or does the sex worker also have to educate the clients? One can argue that it is not important who educates whom, but that it is essential that the education is driven by the peers. Many questions can be raised. It is useful to share the experiences that grassroot organizations and researchers have collected over the years.

Does peer education work in every country? In countries like Vietnam, where the authorities are very repressive towards sex work (according to them it is one of the 'social evils' that have to be eradicated), authorities organise peer education with former sex workers and expect reports from them about whom they spoke with. In Vietnam peer education is not functioning well, because there is no trust in the peer educators. Reports about peer education from Latin America sound more positive than those from Asia. Is there really a difference and on what is it based? In the contribution from China in this publication we see that peer education is practically impossible there. Is that a matter of the organization of the project or of the national context? Joyce Djaelani Gordon suggests that in Indonesia the Indigenous Leader Outreach Model might function better than the peer education model. Is that because in Indonesia leadership is traditionally respected and seen as important?

Another question is if there are specific approaches in peer education that are more effective than others. Licia Brussa describes the TAMPEP method that is used in an European project for migrant sex workers and that is quite effective in that context. Can this approach also be used in developing countries? Hotline Surya's approach in Surabaya was well designed, but research revealed that not the colleagues in the same brothel were influenced most by the peer education message, but the friends with whom the peer educators spend their free time.

A further question raised is if everyone can be a good peer educator. What are the best selection criteria for educators? Should they be sex workers who understand that behavioural change is important? In this case we might be selecting exceptions in most developing countries. Or should we look for the 'old sinners' that have bettered their lives, as Tom Barton from Uganda writes. Gabriela Silva Leite and Flavio Lenz Cesar from Rio de Janeiro mention in their contribution that the peer educators in their programme are put in an exceptional position by being a peer educator, which may be a risk for building solidarity among sex workers. Does that mean that we have to look for others to give the education? At the 4th International Conference on AIDS in Asia and the Pacific a sex worker active in peer education confessed that she was getting tired of being a peer educator. After all, she did not become a sex worker because she wanted to be some kind of social worker. This confronts us with an important issue: Should the SW be the agent of change for the whole society? In most developing countries, and especially in those where women have minimal power, female SWs are the last to have enough influence to function as agents of change.
Is peer education that is only based on education about STDs and condom use sufficient? Or should it be more than that? Should it include empowerment through education on many other topics too? In many contributions in this publication we see how the feeling to have learned something about STDs and AIDS also empowers the SWs in other aspects.

These are just some of the insights we get through reading these contributions about peer education. We realise that research can play an important role in investigating the dynamics of peer education. We need to understand the details. Research at many different levels can contribute to that.

Ivan Wolffers

FRIENDS OF PEER EDUCATORS

Whatever the goals and methods of any peer education programme, it is obvious that before peer educators can be trained, it has to be clear what kind of 'peers' they are supposed to educate. The example of Hotline Surya's Indonesian peer education programme shows that this is not always easy to assess from the start.
In 1995/96 a collaborative research-project of Dutch and Indonesian universities and NGOs evaluated the impact of a peer health education programme in Surabaya set up by one of the research partners. The peer education programme of the NGO Hotline Surya exists in training voluntary peer health educators (PHEs), who are sex workers. The three day training programme focuses on self-esteem and knowledge about their own health and health risks related to their work.

To find out to what extent sex workers are influenced by the peer education programme, the research staff identified four groups of sex workers who were more or less exposed to the health messages of the programme. The first group identified was the PHEs themselves, the second group their colleagues in the brothels, and the third their friends. The fourth group consisted of people who did not know anybody trained by Hotline Surya, and therefore were the least exposed group. Much to their surprise the researchers found that the friends of PHEs had more knowledge about HIV/AIDS transmission and prevention than the other non-PHEs, including those working in the same brothels as the PHEs. Also, the use of condoms with clients during the last night before the interview was highest among PHEs and their friends.
In focus group discussions PHEs expressed their difficulties to talk about AIDS-related issues with women in the same brothel. These women are not so much their colleagues, but their competitors in attracting clients. The PHEs do not like to present themselves as the ones who know everything better, because that could give them an isolated position. They discuss health matters and other problems more easily with friends working at other places, who usually come from the same villages.

An important lesson learned is that it is difficult to predict the possible effects of a peer education programme if the real networks in the community are not well known. Health information is spread in different ways than is often thought. A good programme therefore needs an analysis of the social environment, before engaging in training.

THE INDIGENOUS LEADER OUTREACH MODEL REACHING OUT TO SEX WORKERS IN INDONESIA

The Indigenous Leader Outreach Model (ILOM) was developed by the University of Illinois in Chicago, US, to reach out specifically to 'unreachable' populations affected and infected by HIV/AIDS. The ILOM model uses peer educators who spread the health messages to their friends.

ILOM was initially used in the greater Chicago area, to reach out to injecting drug users severely stricken by the epidemic. After ILOM was introduced, evaluation results have shown a dramatic decrease in the number of new infections within that particular population in a way that was never thought possible. Impressed by the results of this approach, PATH (Program for Appropriate Technology in Health) brought ILOM to the local NGOs in Asia, starting in Thailand, then moving to Indonesia. PATH was specifically interested in looking into the promise of adapting this approach for sex workers in Asia.

Now, not using condoms is viewed as being very irresponsible and stupid

PATH found that the Indigenous Leader Outreach Model worked well, without having to modify the approach in a significant way. The concept of ethnography is fundamental to this approach. ILOM uses the available social structure and existing networks to spread the news about AIDS, to reach out to sex workers and 'effect changes'. It does take time, concentration and energy to reach into the community, to get an understanding and identify key people within the target population. However, once this first step is completed, the rest becomes relatively easy.

Agents of change

Trained outreach workers from NGOs work in the target areas for a considerable amount of time. Over time, they are usually accepted as members of the community. They also work as 'beginner to skilled ethnographers', observing what happens within the community, learning about life styles, habits, beliefs, values, norms, and how things can be accomplished. They do not try to force any changes, or to be adamant in giving out AIDS prevention messages. Trained outreach workers simply are present, to talk with anyone who wants to talk with them.

Slowly, they begin to recognize the key people who can serve as the best agents of change from within the population and community. This of course, means that they need to identify people from within the community who have the greatest network of friends, are well liked, listened to, highly respected and have qualities of the model behaviours that we want to instil within the community. Once identified, these people are invited to participate in AIDS training sessions that are sensitive to their needs and situations, and many become quality Indigenous Leader Outreach Workers (ILOW). ILOWs are not necessarily sex workers. Since the ILOM approach is sensitive to local needs, ILOWs are chosen based on their social networks, and their ability to facilitate relevant changes within their community.

After the training the ILOWs 'carry the message' to their personal network of friends, through behavioural examples and through conversations. They help their friends in any way possible, when this pertains to HIV/AIDS intervention, information, treatment and counselling. ILOWs also become a 'very strategic and important bridge' between their own communities and NGOs.

Changing norms

There are many advantages to the ILOM model. It is a solid approach and it works exceptionally well in Indonesia, especially since the SWs live in localized areas of residence where culture and habits can be easily observed, studied and intervened. ILOM works its way through the community, and it can and does mobilize the community in the right direction. The model allows individual contact with members of the community and can change the 'culture' of the intended targets in terms of habits, values, beliefs and norms. Often the norm has been that using condoms is considered not macho, but with the implementation of the ILOM model, this norm has been changed. Now, not using condoms is viewed as being very irresponsible and stupid. In this way, designing and sharing new values of behaviours can be accomplished without commanding and 'overselling'.

Of course there are also disadvantages to the ILOM approach. In Indonesia SWs are very often a mobile population, a population that migrates from one area to another. It often happens that, after the baseline ethnographic part of the work has been completed, potential ILOWs move to other areas or cities. Educating ILOWs to be effective also takes time, due to the lack of basic or formal education within the population of SWs. Sex workers have difficulty in grasping (comprehending) the many different aspects of AIDS education, street-based counselling skills, and the more subtle nuances of AIDS prevention and intervention. Another problem is the sustainability: organizations like PATH cannot always support these programmes over long periods of time.

Esteemed members

The difference of ILOM compared to other less successful peer education methods is that ILOM only chooses peers who have natural capabilities to effect change within their communities. When one educates

INTAKE ORIENTATION

Indonesian SWs, particularly in brothel areas, are highly mobile and competitive. This makes it difficult to see them as a community in which leaders can be identified who can be trained as peer educators. In addition to peer education it could be useful to provide 'intake orientations' that could be delivered when a woman 'signs in' to a brothel. This would at least ensure she receives basic STD/HIV information, and learns about treatment sources for STDs, condom use and negotiation and empowerment activities for SWs. These intakes could be done by older, less mobile SWs and by outreach workers.

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members of a community to do peer education, these peer educators are not always able to effect changes. The reason is simply because, even though they are accepted by the NGOs, they may not be widely accepted by their own community. In ILOM, these chosen people are almost always the esteemed members of the peer group to which they already belong. However, it is not an easy task to get these esteemed community members interested in becoming ILOWs in the first place. Some potential ILOWs often take more time than others to be convinced of the importance of becoming an ILOW and to participate in the programme. Once these people are convinced, we simply educate them on the necessary AIDS and AIDS-related information to carry into their communities. Until now, over 500 ILOWS have been trained.

As the interventions grow, and as the ILOWs grow in service and outreach capabilities, they become highly effective 'people bridges' between the NGOs and their community, and surrounding health services become more sensitive to the needs of the communities. In many cases, health services become a part of the ILOM intervention as the need for appropriate services grows within the community. In some areas in Indonesia, STD clinics have already been set up and are in operation.

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THE SAHELI PROJECT: EMPOWERMENT OF SEX WORKERS IN INDIA

The Saheli Project, a peer education model for the prevention and control of HIV/AIDS among SWs, has been internationally acclaimed as a successful AIDS intervention project and labelled as the 'Bombay model' for HIV prevention at the 9th International AIDS Conference held in Berlin, Germany in 1993. Initiated in 1991 by the Indian Health Organisation (IHO), this project covers 5500 SWs in Bombay and 3500 in Pune.

After evaluating various approaches for condom promotion like social marketing and door-to-door vending, we opted for a peer education model for our work among sex workers. The need for their empowerment, adequately supported by STD/AIDS education, is vital. The organisation of prostitution is multi-layered and the SW is at the lowest end of a hierarchy dominated by brothel managers and brothel owners. To intervene effectively, we had to influence the entire hierarchy, with a final goal to empower SWs to change their destiny. We have invented a three-tier system of peer leaders:

1. One Saheli (friend) from among the sex workers for 25 girls.
2. One Tai (sister) from the brothel managers for 10 sahelis.
3. One Bai (mother) from the brothel owners for each major area.

A Saheli earns Rs.150 ($5) per month for 1 hour daily time, a Tai Rs.700 ($20) per month for part time work and Rs.1500 ($45) per month for full time work. We do not pay a Bai, nor does she expect monetary compensation, as she is usually an influential and affluent lady from the community.

Constructive relationships

A community needs assessment revealed that the SWs needed regular medical check-ups and health care. As the premises to run a clinic in a red light area are very costly, we could not afford to buy or hire. Hence running a mobile clinic was the best option. Besides offering primary health care and serving as a referral point, the mobile clinic essentially attempts to reach out to the community and develop constructive relationships with SWs. Out of these contacts suitable peer leaders appear and these are offered peer education training. A team comprising a physician, social workers, a health educator and the peer leaders of SWs works at the clinic. We first started service in 1990 and at present we run such services in Bombay and Pune. A network of clinics for SWs all over India is a dream we cherish.

The selected peer leaders are provided with training on: techniques of client negotiations, STD, HIV/AIDS and prevention, and the promotion and distribution of condoms. Their responsibilities are: to educate the girls about HIV/AIDS, STD and safer sex, to distribute condoms, to bring sick girls to the mobile clinic or to other facilities and to visit in-patient girls regularly for support.

Badge of pride

The Saheli peer education model appeared to be a successful approach from the beginning. We choose leaders from among the sex work population, train them, pay a nominal honorarium and provide them with a 'photo-identity card'. More than just an incentive, this photo-identity card also serves as a badge of pride and provides them with respectability. For the first time SWs realised that they could earn money through means other than sex work. They now take pride in themselves. Their attitudes and health care seeking behaviour have improved significantly. This has reduced their spending for medical care, especially for STDs. After fully understanding the dangers of contracting HIV, they impart knowledge and negotiating skills to other SWs.

Apart from educating their peers, Sahelis act in IHO street-plays to educate large groups, address public meetings and give television interviews. Some of them even conduct training programmes for health care workers and social workers all over India.

INDIAN HEALTH ORGANISATION

IHO is a non-profit, apolitical and secular NGO with 19 branches in eight states. It employs 18 full time staff and has hundreds of members. IHO has been spearheading the fight against child prostitution since it was founded by Dr Gilada in 1982. Since it started India's first AIDS Awareness campaign in 1985 AIDS is a major theme as well.

While working at the Sexually Transmitted Diseases Department of the Government-run J.J. Hospital, in the close proximity of Bombay's largest red light areas, it was a matter of surprise that within one year (1981-82), merely 300 SWs sought treatment, whereas the number of male STD patients was about 100 a day. With his colleagues, Dr Gilada visited the SWs in their areas and tried to facilitate their free treatment at the clinic; which materialised into the first ever health camp organized for SWs in June 1982 at Kamatipura, Bombay's largest conglomeration of SWs. Regular health camps continued offering specialist care and diagnostic facilities to SWs until 1989, and these then culminated in a regular mobile STD/AIDS clinic.

If funds are available IHO plans a rehabilitation centre for HIV-positive people and children rescued from prostitution, a residential school for AIDS orphans, an AIDS hospice and an AIDS training institute. For the realisation of these plans, IHO has already acquired 10 hectares of land on the Bombay-Goa highway.

SOME RESULTS OF THE SAHELI PROJECT

Condom usage rate for sexual encounters has gone up from 5% in 1991 to 70% in 1996 in the control group and over 95% in the Saheli project group. The number of new infections contributed by SWs has come down from 500 daily in 1991-92 to less than 100 daily, despite the HIV prevalence rate jumping from 32% in 1991 to 72% in 1996 among SWs. The STD incidence among young people has declined by 75% and similarly the clinical practice of STD consultants has been reduced by 70 to 80% in the last 5 years.

Transformation into Health Care Workers

In the city of Bombay, where most Sahelis work, the HIV prevalence has been static for at least two years, while in the rest of India it is still increasing steadily. At a time when the rate of HIV infected people developing clinical illness escalates and hospital services becomes scarce, Sahelis will emerge a major strength of AIDS Care Givers, though 95% are illiterate themselves. The Saheli Project envisages transformation of the Sahelis into Health Care Workers and Barefoot Care Givers, so that the load on the existing out-patient and in-patient medical services will be reduced to a great extent. Home Based AIDS Care is promoted, since a large number of HIV-positive SWs will need to be cared for in the community itself. Obviously, the Sahelis will be the most appropriate persons to do this job. Until now 60 out of 220 Sahelis in Bombay have been trained as Health Care Givers.

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SOME PROBLEMS CONCERNING PEER EDUCATION

Based on five years experience with an European project of health education for migrant sex workers, TAMPEP project workers Licia Brussa and Hanka Mongard describe some problems concerning peer education.

The proper use of peer education

While the notion of peer education might represent a basic principle widely accepted on an international level, the concrete application of this concept is not always clear. In many cases, peer education for sex workers has become a catchword for AIDS funding, but the practice of such education is different in different contexts.

In some countries, the absence of spokespersons for the rights of sex workers or autonomous community-based organisations, makes it difficult for sex workers to intervene with funding institutions which could assist in initiating and managing peer support and education projects. In such cases, projects are often initiated and controlled by governmental public health systems. This might lead to situations in which a peer education group is ruled by a whole hierarchy of individuals from outside the 'milieu'. As a result, the members of the group might be obliged to adapt themselves to socially acceptable behaviour which could be counterproductive to their role. Often such hierarchically-structured organisations omit elementary teaching on individual rights and empowerment and thus the members of the peer education group run the great risk of being further alienated and marginalised. This way they are in danger of becoming low-cost workers in the field of AIDS prevention, without a clearly defined professional position and mandate.

This absence of a clear definition of the concept of peer education can lead to more misunderstanding. For example, it often happens that official service providers have a tendency to incorporate all sorts of things under the general term peer education. Their use of the term peer is intended to differentiate between health professionals and non-professionals, between individuals hired by the public health system and those external to this system. This implicit misconception is a way of affirming that anything which is different from the official and dominant method of performing one's professional tasks can easily be integrated into possible peer support and/or peer education programmes.

Too much expectation

Establishing peer educators should never be considered as the main and only goal of the AIDS prevention project. It ought to be seen as one of the prevention activities among others such as seminars, workshops and regular field activities directed towards sex workers.

The peer educators are trained to influence the behaviour of their peer group. At the same time, it is unrealistic to expect that a sex worker could always effectively influence or act as a peer educator for clients or owners of sex establishments. After all, the educational work conducted by peer educators among sex workers is limited to this group and does not cover other audiences whose behaviour however indirectly conditions that of the sex workers. This model would be ideal only if, parallel to the interventions targeting sex workers, there were analogous projects involving other groups.

Frequently the sense of frustration experienced by those who work within peer education projects is determined by an awareness of the causes of the unsafe working conditions in which their colleagues find themselves and by an awareness of repressive police measures which lead to dangerous and unprotected working conditions. In such situations, the peer educators are usually unable to significantly influence or intervene.

Relations within the group

Another factor which might make the role of peer education difficult is the feeling of competitiveness and jealousy among the members of the target group - they might have difficulty in accepting that some of them want to show up well through more knowledge and power. The position of a sex worker/peer educator might create divided loyalties and a position between two stools: the peer educator is supposed to find a balance between being an insider and an outsider.

Mobility

The dynamics of international migration within the sex industry is becoming more and more characterised by the extreme mobility of groups both in a transnational context as well as within any single country.

On the one hand, this frequent mobility may limit the impact of projects which base their effectiveness on repeated contact with the target group and on in-depth peer support and training to migrant sex workers. It also evokes the necessity of continuous repetition of cycles of activities for the peer workers because there is a constant stream of newcomers to their territory.

On the other hand, as we learned from TAMPEP's experience, such mobility can contribute to a further spreading of health promotion messages within that same circuit of migratory sex workers. This way the sex workers employed as health messengers are in an optimal position to spread the messages to a broad audience of colleagues frequently on the move between cities and between countries. If these movements are monitored (project workers might know how long sex workers usually stay in a given place and how often they return to cities where they once stayed), it might even be possible to maintain contact with these health messengers.

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TAMPEP (Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe/project) is an European project which spans four countries: The Netherlands, Italy, Germany and Austria. It is a model of intervention, reaching a total of 23 different migrant groups of women and transgender people from Eastern Europe, South East Asia, Africa and Latin America. TAMPEP provides migrant sex workers with culturally appropriate HIV and STD education, and resources and materials appropriate to sex work. It seeks to increase empowerment and responsibility. From the start of TAMPEP in 1993 until now, some 80.000 sex workers of 23 nationalities have been approached and contacted by TAMPEP workers.
The main objectives of TAMPEP are the collection of information on the target groups, the production of health education materials in different languages, the unfolding of didactic and educational activities and the exchange of materials and results.

TAMPEP's methodology is based on two professional roles: cultural mediators and peer educators/peer supporters. Cultural and linguistic mediators are professional field workers who have the same ethnic and/or cultural backgrounds as the members of the target group. They can help to support new models of intervention and stimulate the social integration of immigrants within the domain of public health services, an area of primary importance for the migrant population. Peer supporters and peer educators are sex workers who spread prevention messages among their peers of the same nationality and help facilitate behavioural change. They assist in the development of prevention materials adapted to the needs of the various nationalities of the target group. Also, they have the possibility of participating fully in the analysis and evaluation of the activities, which might stimulate their motivation and involvement further.

ORGANISATION AND CARRYING OUT OF TRAINING FOR PEER EDUCATORS

This article contains practical advice and a detailed description of all the steps required to start and pursue a training course for peer educators, based on the experiences of TAMPEP.

1. The role of the project worker
The project worker plays a very active and complex role during the organisation, execution, evaluation and follow-up of the peer educators' training. During the course she/he is also the main trainer. Her/his tasks include among others:

- gaining trust of the members of the target group
- identifying and selecting trainees
- recruiting and guiding an instructor for (some of) the lessons and inviting guest speakers
- setting up the contents of the lessons and preparing materials needed during the lessons
- conducting (some of) the lessons
- stimulating active participation of the trainees
- maintaining contact with the peer educators after the course and guiding them in their peer activities.

2. Requirements for selection of instructors
The instructors should be qualified professionals, if possible medical doctors, highly competent in medical and social matters, preferably having the same ethnic and cultural backgrounds as the trainees. They should also have some pedagogical talents and be familiar with the phenomenon of prostitution.

3. Requirements for selection and recruitment of peer educators
Characteristics desirable in a candidate for peer educator are given below. Obviously, it is difficult to find a person fulfilling all these demands. However, the project worker should strive to find persons who possess as many of these traits as possible.

The peer educator:
- is a member of the target group and is of similar ethnic origin
- is a recognised leader of the group
- has a basic knowledge of health matters
- has some pedagogical talents and has excellent communication skills
- has high levels of ambition and motivation.

4. Methodology of the training

▲▲▲ **Identification and selection**
Selection of candidates who might fulfil the criteria should be carried out during field work among sex workers.

▲▲▲ **Assessment of knowledge**
Prior to each course, an assessment of their knowledge concerning STD, AIDS, reproductive female organs, contraception, the use of condoms and professional attitude should be carried out among the participants. This is tested by means of a questionniare especially developed for the purpose. The survey should also include questions about the individual wishes of the women concerning the contents of the course. After the training, their knowledge should once more be evaluated.

▲▲▲ **Formation of trainee classes**
In general, one should try to limit the number of trainees per class to ten to twelve persons. A larger number would certainly be detrimental to the learning process.

▲▲▲ **Continuous evaluation**
At the end of every training session, the participants should be requested to fill out an evaluation form on the contents of the particular session.

▲▲▲ **Active participation**
Active participation of the trainees should be asked for in all phases of the training, including the preliminary phase which comprises the organization of the course. The trainees should be encouraged to ask questions and share their experiences with other colleagues.

▲▲▲ **Guest speakers**
During every training some guest speakers, such as a physician from the local clinic, an employee of a contraception counselling centre, a trained peer educator or a social worker should be invited to share their experience with the trainees.

▲▲▲ **Economic compensation**
The course's participants should be given economic compensation for attending the training. This (small) amount of money rewards the time and energy put into the training, as well as covering possible loss of earnings during the course.

▲▲▲ **The title of the course**
Many sex workers view prostitution as a temporary condition and in no case as an identity. One should avoid name, title, invitations and all other formal issues being associated with the profession of the sex workers. An appropriate title could be: 'Prevention and Hygiene'.

▲▲▲ **Public lesson**
During the last gathering, a public lesson might be conducted by one of the trainees. This should be treated as an excercise for a future peer educator in passing on knowledge to her/his peers. The contents of the lesson should cover the material treated during the course.

▲▲▲ **The diploma**
At the end of the training all participants are awarded a certificate of completion of the course. This serves as a sign of recognition not only vis-à-vis the colleagues of the peer educators, but also via-à-vis members of public service agencies.

▲▲▲ **Monitoring the effects**
After the course, the project worker should maintain frequent contact with the peer educators in order to supervise and support their activities.
These follow-up activities include:
- facilitating contact between peer educators and their peer group, the members of official agencies and public health personnel
- preparing peer educators for the role of mobile health messengers
- supplying peer educators with additional knowledge which was not included in the basic course
- providing peer educators with folders and other educational materials.

▲▲▲ **The duration of the course**
From experience of TAMPEP we have learned that a period of two to three months is needed for completing all activities related to selection of peer educators, conducting the course and realizing follow-up activities.

SELECTION OF PEER EDUCATORS AND THEIR PERFORMANCE

Experience from peer education projects among the general population in Africa suggests that peer education programmes should look into the following issues: the selection of peer educators, their behaviour, the nature of contacts and the use of incentives.

●●● **Selecting good role models or former misbehavers?**
Many programmes among the general population select 'peers' who are respected in the community and are already known for 'good' behaviour. The difficulty is that such people may be able to discuss the task of 'sustaining' good behaviour, but they are not the best people to talk about behaviour change from bad to good behaviour, because they have not experienced it. Persons at low-risk could be useful with some target audiences, e.g., presexual adolescents, but for late adolescents and young adults it is better to select peer educators who have changed their behaviour, even persons living with AIDS.

●●● **Behaviour of peer educators**
Peer educators are expected to be role models, exhibiting as well as promoting 'good' or 'safe' behaviour. However, in many programmes, detailed interviews with peer educators frequently reveal that as many as half or more of their group are promoting condoms while never using them themselves.
Training as a peer educator can often be as short as one to three days. One has to seriously question if that amount of classroom time is enough to get the selected people to change their own behaviour.

●●● **Nature of contacts: one-to-one or group wise?**
Peer educators are usually taught in classroom settings where they see their instructors using didactic methodology for information sharing. Rarely does the training of peer educators address the personal behaviours of the trainees and try to motivate change in their group. In addition, many programmes focus on one-on-one activities by the peer educators in the field. Meanwhile, some evaluation experience suggests that peer educators who work in small groups may be as effective or more effective than those relying on individual contacts. It seems that the process of discussing issues in groups leads to greater likelihood that embarrassing questions will be asked, thereby

leading to better information sharing. Perhaps even more importantly, people's personal commitment for change is stronger when it is expressed in front of others.

● ● ● Incentives, voluntarism and monitoring performance

Most peer educators are 'volunteers'. In many societies the lack of reward or reciprocity leads to attrition of the volunteer effort. Programmes have coped with this through using a variety of incentives or benefits, from T-shirts to badges, from food at meetings to token payments. Once the process of motivation through incentives starts, then expectations are created on both sides (programme staff and peer educators) about what the incentives are for. When programmes link benefits or incentives for peer educators to the numbers of clients they work with, there is a tendency for the educators to emphasize mostly new contacts, like persons met on the street, in bars, etc. In contrast, some of the more effective behaviour change projects emphasize a more limited and identifiable clientele, like working with all of the residents in a specific small geographic area. In this case it is easier to monitor knowledge and behaviour change in the clientele.

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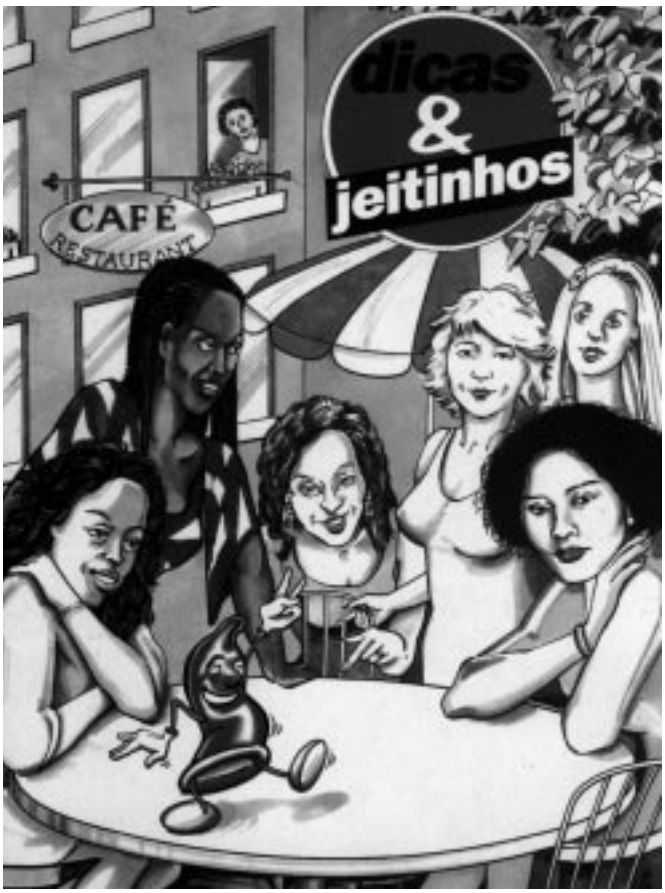

QUALITATIVE INDICATORS FOR THE EVALUATION OF HIV/AIDS OUTREACH EDUCATION IN ZAMBIA

Evaluations of peer education programmes sometimes only mention the numbers of condoms distributed, the numbers of people spoken to, the numbers of plays performed etc. We still know relatively little about how specific interventions relate to changes in condom use, or how education influences people's behaviour. The use of intermediate indicators, which focus specifically on the interaction between intervention personnel and the community target group, might give us more insight into these behavioural changes.

Qualitative intermediate indicators are those which are not easily measured but which are still valid if used in combination. They indicate the nature and extent of attitudinal and behavioural change in the target group. In relation to (peer) education outreach work on the basis of one-on-one house visits the following intermediate indicators can be identified:

1. Changes in the refusal rate. Initial scepticism is related to a number of misconceptions, e.g., the belief that the educators themselves are HIV-positive, which incites fear. Experience suggests that over time the refusal rate should drop to around zero, from a high initial starting point.

2. Numbers (and nature) of questions asked by clients. Educators could record these questions which could then be categorized. Over time the complexity of the questions should increase as knowledge levels rise.

3. Interest in published materials. Follow-up can reveal understanding and intake of information and subsequent distribution of materials by clients. Are the materials understood? Are the materials passed on by the clients to other people or not? Over time requests for materials usually rise, and the need for local language materials is consistently emphasized.

4. The knowledge of the existence of peer group educators. This indicates discussion about the educators and their work within the community. Should ultimately reach 100 per cent.

5. Numbers of requests for condoms. For example, many women are now requesting the female condom. Follow up on this issue can assess whether female condoms are seen as a contraceptive device or as a means of preventing STDs (or both).

Minimum of training

From the experience with peer educator groups in Lusaka, Zambia, under the auspices of Southern African AIDS Training and Unicef, we learned that such indicators could produce valuable baseline information. The methodology used was that 1330 sample households were visited by peer educators on routine house visits. Data was collected during these visits using questionnaires. Follow-up visits took place within the next few weeks with separate questionnaires. The information received not only assisted the project in assessing progress but informed on changes which may be required in terms of targeting and the nature of the educational messages and materials. Another outcome was that the exercise was conducted with the minimum of training, and the educators themselves found the experience useful, not only in terms of data collection techniques but also in understanding their own work better.

Experience from this research provided encouragement that such a technique is viable and relevant to similar outreach projects, and ultimately is not confined to only health projects but has application in all community behavioural change/development projects.

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The continuity of peer education in Brazil

Peer education, as proposed to the Brazilian government by the National Network of Sex Workers 10 years ago, became a reality as a methodology in AIDS prevention projects with sex workers in Brazil. The problems associated with peer education are being discussed nowadays, as they should. But back in 1988, when the Health Department established the first AIDS prevention programmes for sex workers, to insist on peer education was a political matter and a matter of self-esteem for this group. At that time, sex professionals were in danger of being objects of other professionals, since AIDS became such a big issue. And one year before, during the First National Meeting of Prostitutes, the sex work community had decided to speak for itself, instead of letting physicians, clergymen, police officers and jurists take the decisions concerning sex work.

After big resistance in the beginning, peer education prevailed. Nowadays, it is a kind of model for NGO outreach work in Brazil, although it is not a condition for funding. Some of the reasons for the adoption of this methodology are well known: peer educators have easy access to prostitution areas and to other sex workers. They have knowledge of the target group and they have credibility among their peers.

There are, of course, also some disadvantages of peer education. Some 'agents of information' tend to consider their participation in temporary AIDS prevention projects as a job. They adopt a new social and professional identity. "Now I am a health agent", used to say a sex worker who worked with us at Davida in Rio. The result of this is a certain bureaucratization in the outreach work, with less involvement (solidarity, support) of the community, which is a basic condition for peer education.

Global results of these projects have shown us that peer education with sex workers has made history. This does not mean that it should be acclaimed the ideal methodology. There are reasons enough for discussing its advantages and disadvantages. But, if we see problems associated with peer education, we should not just turn it down. We'd rather realize the need for permanent improvements in the partnership between AIDS prevention professionals and sex professionals.

Gabriela Silva Leite and Flavio Lenz Cesar

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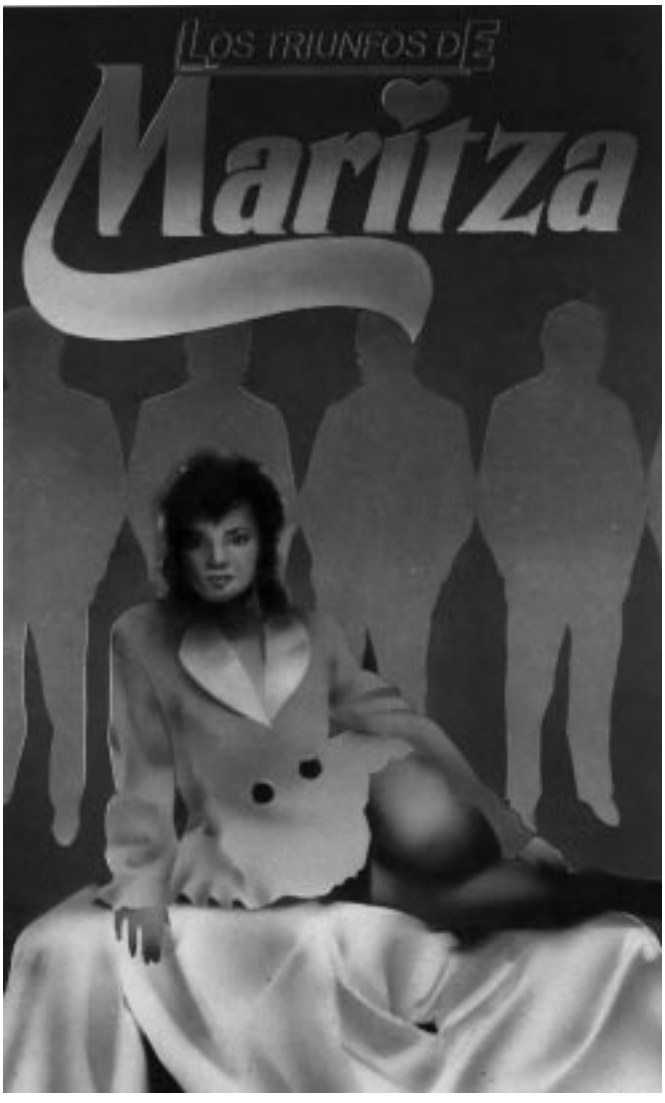

Los Triunfos de Maritza

This comic book, produced by the Centro de Orientación e Investigación Integral (COIN), was the product of a large and complex process to understand the world of female sex work. In October 1988 a first study was done among sex workers in Santo Domingo, Dominican Republic. These women were involved in the research process, with the object to understand more of their KABP concerning HIV/AIDS and the use of condoms.

The results showed that the women had no major objections to the use of condoms. They said that their clients caused the problems. To understand what were the reasons for refusing condoms, a qualitative research was held with focus groups of sex workers. The reasons given by the SWs, were analysed and worked out in typical client profiles, based on clients' argumentations against condoms. In the comic book *Los triunfos de Maritza*, five of these typical clients were portrayed. By reading the comic strips sex workers can learn from their colleague Maritza how to use contra-arguments and actions against the arguments of refusal of their clients.

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IN TOUCH WITH THE NEEDS OF SEX WORKERS

This spring, at the network steering committee meeting in Calcutta of the Asia Pacific Network of Sex Workers and Support Groups, discussions were held about how this network links to Research for Sex Work. The following recommendations were made.

If researchers are going to be sensitive to the needs of sex workers, service providers, legislators and those developing policy on the sex industry, then research should not only be driven by the personal and academic interests of researchers alone but they should try to support the research needs of sex workers and their supporters. The Asia Pacific Network of Sex Workers and Sex Work Groups would strongly recommend that researchers link in with these organizations to ensure that they are in touch with the needs of sex workers.

Further, one of the priorities for researchers would be to write and adopt practical and ethical guidelines for research involving sex workers. This must be developed with sex workers and sex work projects. For far too long researchers have been using sex workers as guinea pigs without any benefit accruing to sex workers as the result of research. Essentially academic careers are made on our backs. Further, some research has provided ammunition to those who want to suppress the sex industry and research findings have been used to support some of those arguments. In many countries sex workers already refuse to be involved in research because they can't see anything in it for them. After all, why would sex workers give freely of their information and knowledge and then it is used to suppress their livelihood?

As a network we are sensitive to cultural differences and the political environments that people have to work in, so it may not be safe for sex workers to speak out as sex workers. On the other hand, it is really important to involve them in all areas of projects, research and programmes and empower them to have decision-making roles in their organizations. After all it is sex workers who know best the issues which affect and have impact on their work.

Ethical guidelines

There is consensus in the network that sex worker HIV/AIDS/STD education and prevention cannot happen in isolation from a range of issues. In a press statement at the Manila regional conference on AIDS the following issues were raised for delegates at AIDS conferences and future AIDS conference organisers to consider:

- Recognise that sex work is an occupation.
- Acknowledge that sex workers are female, transgender and male.
- Accept that it is unsafe conditions at work, rather than sex work itself, that causes risk of HIV infection and sexually transmitted diseases.
- Recognize and address the issue of police harassment of sex workers and police abuse of power as crucial factors in creating unsafe work environments which increase sex workers' risk of HIV and STD infection.
- Involve sex worker representation at future international and regional conferences on AIDS as planners, delegates and presenters at all forums relating to sex work.
- Ensure sex workers can participate at international and regional conferences on AIDS by protecting sex workers' right to travel.

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The Scarlet Alliance is an Australian national forum for sex worker rights organisations.

ASIA PACIFIC NETWORK OF SEX WORKERS AND SUPPORT GROUPS

The Asia Pacific Network of Sex Workers and Support Groups met for the very first time at the Third International Conference on AIDS in Asia and the Pacific in Chiang Mai in 1995. The aims of the network are:

1. To provide practical information, skills and opportunities for information and skill sharing among sex worker organizations and sex worker projects which provide services to sex workers.

2. To raise awareness and take action for health, welfare and basic needs of sex workers, regardless of their HIV status.

3. To advocate at regional and global level policies and action which reinstate and further the human rights of sex workers including: the right to health, the right to a safe working environment, free from discrimination, abuse and violence, the right to travel, the right to organize, and equality before the law.

4. To develop and maintain links between service providers, sex worker organizations and relevant regional and international institutions and agencies.

5. To facilitate opportunities for the voices of sex workers to be heard and recognized in regional and international forums.

6. To actively promote the right of all sex workers to work in whatever areas of their chosen occupation.

7. To identify and mobilize financial and other resources available to further the aims, objectives and activities of the network.

Members of the network include sex workers, sex worker peer educators, support workers, some members of organizations and projects in 20 countries which have been operating for a long time as well as those that are just setting up projects.

DOING IT TOGETHER: SEX WORKERS AND RESEARCHERS

One of the ethical guidelines for sex work research is involving sex workers in all aspects of the research process. Priscilla Pyett of La Trobe University, Australia, describes such a collaborative research programme. After an anonymous questionnaire proved to be a successful research tool among legalized brothel-based sex workers, a new methodology was adopted to reach out to the more vulnerable groups, such as drug-dependent girls working on the streets.

It probably goes without saying that researching sex work is not easy, especially when the population is unknown and hidden because of the illegal nature of their work. Furthermore, sex workers have good reason to mistrust researchers and to resist research. How do we overcome these obstacles?

First and foremost we need to develop collaborative working relationships with sex workers, so that we can both train sex workers as researchers and learn from sex workers how to do research in a sensitive and useful way. With colleagues from the Centre for the Study of Sexually Transmissible Diseases of La Trobe University, Melbourne, Australia, I have worked closely over the past six years with our local sex worker rights organization - the Prostitutes Collective of Victoria (PCV). The PCV visits all licensed brothels on a regular basis in order to provide information and support to sex workers. In addition, it provides outreach support to street workers and offers an information service at the office.

This collective asked us to carry out a survey of sex workers. We drafted a collaborative research agreement and established a working party to develop the research protocol and design a questionnaire.

Maintaining confidentiality

Working with a group of staff and volunteers from the PCV we learned a great deal about the working conditions and culture of the local sex industry. We learned what issues were important to sex workers and what language to use, so that we would ask appropriate and relevant questions sensitively. We trained members of the PCV to carry out survey research in an ethical and methodologically sound manner.

The strategy we adopted was for members of the PCV to ask all sex workers with whom they came in contact over the next six months to complete a self-administered questionnaire. The importance of maintaining the confidentiality of respondents was stressed. Questionnaire responses would be anonymous and would be seen only by the researchers, since it was felt that some workers may be unwilling to disclose aspects of their work to members of the PCV. Completed questionnaires were placed in sealed envelopes and returned to the researchers for analysis.

Using sex workers as researchers

This collaborative strategy succeeded in accessing sex workers and obtaining over 350 valid responses. The questionnaire worked - it was acceptable to and easily comprehended by respondents and appeared to have been completed honestly. For instance, the PCV were surprised that a significant proportion of sex workers admitted to providing anal intercourse to clients, which is rarely acknowledged openly in the culture of the local sex industry. Using sex workers as researchers was an essential aspect of the project's success.

At the same time, we were disappointed not to have obtained an even larger number of responses. The PCV reported that the overwhelming majority of workers who were approached were supportive and that refusal to participate was rare. However, problems of time limited the response rate. Sex workers dropping in to the PCV would not always spare the time to complete a questionnaire, it was impractical to approach workers on the street and few workers accepted the suggestion to mail their responses to the researchers. Most of the respondents were therefore sex workers from the licensed brothels. Even these did not always have time to fill out the questionnaire during the PCV visit to the brothel.

Furthermore, visits to brothels were less numerous than we had anticipated. Although staff and volunteers from the PCV had been enthusiastic in their commitment to the research process, in reality they found themselves busy with more urgent demands. The project would have had greater success had our budget provided additional funds to supplement the limited resources of the PCV.

In order to find out about some of the more vulnerable workers who had been missed by the survey methodology, we designed a second study that would have been even more difficult without the active collaboration of the PCV. The methodology depended on sex workers to define criteria for vulnerability, to recruit eligible women as participants and to carry out most of the interviews. This was a qualitative study using in-depth interviews to explore issues of health, risk and safety amongst women who were identified as vulnerable because they were very young and inexperienced sex workers, or were drug-dependent, homeless or working illegally, particularly on the street. We planned this project with a budget that enabled us to employ sex workers as researchers in a critical reference group (CRG) as well as to recompense the participants in the study. A total of eight two hour sessions were held with the CRG to explore issues relating to sexual risk-taking and health, as well as to define criteria for vulnerability and to develop a sampling strategy. Two of the sessions were devoted to training members of the CRG in interviewing techniques and research protocol, research ethics and confidentiality issues. Although we had planned to devote more time to training, some members of the CRG were impatient with the training sessions and

COOPERATION BETWEEN RESEARCHERS AND SEX WORKERS

At the International Conference on Prostitution (ICOP) last year in California a workshop on research design, accountability and ethics was held. This conference was co-hosted by NSWP with COYOTE and the University of California. A two day sex workers pre-conference was organized as well. Researchers and service providers from every region except Africa attended the conference. One of the outcomes of ICOP were the following guidelines for research:

1. *Sex workers should be equal partners in research projects, approving questions and research design.*
2. *Participants should review the results and discuss any differences of interpretations.*
3. *Organizations may want to enlist their own researchers rather than have researchers enlist their organizations.*
4. *It is desired and appropriate to have sex workers trained to conduct the research.*

felt confident in their ability to carry out the interviews as determined by the research protocol. Working together necessitates negotiation and in this case it was important for the project that we utilize the enthusiasm and commitment of the CRG without compromising the integrity of the research.

the results of this study, we consulted with the CRG and other relevant community groups and welfare agencies in order to ensure that the conclusions we drew and the recommendations we made were sensitive, relevant and politically useful to the women who were the subjects of the research.

Making Sex Work Safe: A practical guide for programme managers, policy makers and field workers

Making Sex Work Safe, a manual published by NSWP, brings together experience and knowledge on programmes working to reduce HIV and other sexually transmitted diseases among male, female and transgender sex workers. This manual uses case studies, stories and community-based projects to explore the issues and challenges facing sex workers and sex work health programmes and provides many practical suggestions for project development.

Making Sex Work Safe describes in detail:

- *how to work with sex workers, their clients, and the 'gatekeepers' in the sex industry*
- *the characteristics of good practice in developing sex work projects, including how to plan new interventions and how to monitor progress and measure success*
- *a human rights approach to sex work services with emphasis on involving sex workers.*

Single copies are free to NGOs which provide services to sex workers in developing countries and US $24 to others. The manual can be obtained from AHRTAG at 29-35 Farringdon Road, London EC1, United Kingdom, by sending a cheque. Requests for free copies can be e-mailed to: sexworknet@gn.apc.org.

Sensitive and responsive approach

The advantages of using sex workers as peer researchers far outweighed any disadvantages. The interview transcripts revealed that the interviewers were conscious of the trust placed in them by participants and were extremely sensitive and responsive to situations where participants were in any way uncomfortable or distressed. Participants were encouraged to turn off the tape recorder at any time. The interviewers invariably gave the participants the AU$10 we had allowed for coffee and cigarettes in addition to AU$50 to recompense for the time of the interview.

This project succeeded in obtaining interviews from 24 women whose vulnerability to various risks was evident in their private lives as much as in their work as prostitutes. Before reporting the results of this study, we consulted with the CRG and other relevant community groups and welfare agencies in order to ensure that the conclusions we drew and the recommendations we made were sensitive, relevant and politically useful to the women who were the subjects of the research.

The continuing relationship between the research centre and the PCV demonstrates not only that sex workers make an invaluable contribution as peer researchers, but also that if research is to make a difference to the lives of sex workers, it is to our mutual advantage that we do it together.

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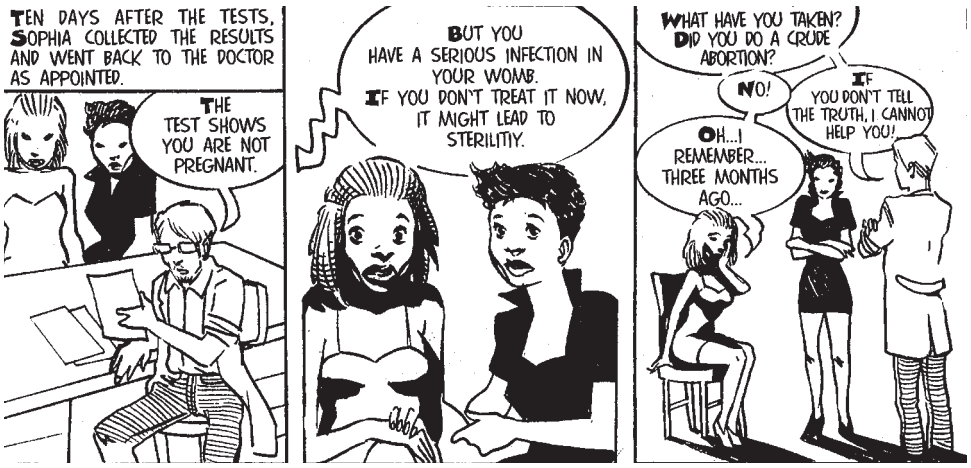

NETWORK OF SEX WORK PROJECTS (NSWP)

The Network of Sex Work Projects (NSWP) is an informal alliance that participates in independently financed projects in partnership with member organizations and technical support agencies. The NSWP was formed in 1991. It consists of sex workers and organizations which provide services to sex workers in over 40 countries. The NSWP aims to:

- provide practical information and opportunities for information sharing among organizations and projects which provide services to men, women and transsexuals who work in the sex industry
- raise awareness of the health and welfare needs of sex workers
- advocate at regional and global level for policies and action which further the human rights of sex workers
- develop and maintain links between service providers, sex worker organizations and relevant international institutions and agencies
- facilitate opportunities for the voices of sex workers to be heard in relevant international forums.

Two major publications of the NSWP are the manual Making Sex Work Safe, and the report Redefining Prostitution as Sex Work on the International Agenda, the latter written by Jo Bindman (Anti-Slavery International), with participation of Jo Doezema (NSWP).

The NSWP has dual secretariats in London, United Kingdom, and Rio de Janeiro, Brazil. They are currently staffed by volunteers.

You can join the NSWP mailing list if you are:

- an organization or project which provides health or welfare services to sex workers and your organizational philosophy agrees with the aims of the NSWP
- an individual sex worker or a sex worker organization.

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LACK OF MOTIVATION OF RESTAURANT GIRLS FROM DROP-IN ACTIVITIES TO OUTREACH WORK

Among Chinese girls working in roadside restaurants neither peer education nor focus group discussions in a women's health club appeared to be appropriate intervention techniques. The pilot project staff found that the girls were not easily motivated to become peer educators and their bosses sometimes were very hostile towards the project. Therefore the project had to change its focus to outreach activities in 'non-hostile' restaurants.

In the first half of 1997 the Department of Epidemiology of the Peking Union Medical College (PUMC) in China conducted a World Bank-funded pilot study on the island of Hainan. This island in the South China Sea is the largest free economic zone in China, which attracts thousands of migrants from mainland China. Among them are many young women, who find employment in the service industry or entertainment establishments. One of the consequences of the abundant sex services at Hainan is a rising incidence of STDs, which could facilitate the spread of HIV/AIDS.

The pilot intervention of PUMC was performed in a typical Hainan town with 30.000 inhabitants. Dozens of roadside restaurants were built side by side along the highway. In most restaurants 6 to 8 girl-attendants reside. They receive a free room and free meals, but no salary. The restaurant owners earn money through the food sold to customers at high prices or by charging a fee to clients who take a girl outside. The primary means of earning an income for the girls is through the exchange of sexual favours for money. Their customers are usually middle aged local men.

Waiting for clients makes the girls careless and apathetic

Gymnastic lessons

Eight people from anti-epidemic stations of the province and the county were chosen to work in this project. Anti-epidemic stations are the institutions responsible for disease prevention and control in China. Hainan Anti-Epidemic Station is responsible for HIV surveillance in the province, and some of the staff have experience in conducting informational campaigns in service establishments.

A five-day participatory training workshop was organized for the eight project workers and one research assistant from PUMC. In addition to classroom training activities, a practice interview with female sex workers was arranged. After the training we went to the research setting to conduct interviews with girl-attendants. During 11 days we visited 21 restaurants and interviewed more than 30 girls, in order to understand their backgrounds and needs in the prevention of sex-related health risks. At the same time we proposed the idea of a women's health club and asked these women for their suggestions and comments. Several girls who appeared to be candidates for peer educators were identified. Moreover, we had conversations with other key informants or gatekeepers such as restaurant owners, motor tricycle drivers and roadside snack-booths owners. We also contacted local governors and officials to inform them of the project and to get their support. Also, we roughly pretested the wording of a draft brochure about STD/HIV prevention.

One of the project's main plans was to open a women's health club, where drop-in educational activities would be offered besides physical exercises. In the pre-intervention interviews nearly all the girls explained that they were eager to learn more about their (reproductive) health and ways to prevent diseases and pregnancy. Most girls had limited education and very little correct information on reproductive subjects and STDs. Also, the idea of gymnastic lessons was greeted warmly by the girls and the restaurant owners, because they liked to keep a good body shape. Staying all day long at the restaurants made the restaurant personnel gain weight.

Little motivation

After the club was formally opened some girls did attend the daily physical exercises, but unfortunately fewer and fewer girls came to the group discussions on fertility, anticonception and STD/AIDS prevention. The girls had to stay at the restaurants for more than 8 hours a day and this continuous waiting for clients made them lazy, careless and apathetic. It was hard for them to be accustomed to group activities. We tried several group talks on reproductive health and STDs at the club, but participants became fewer and fewer. Eventually attempts to organize more drop-in talks had to be abandoned, and the staff shifted to more outreach efforts.

On the basis of the degree of cooperation of the restaurant owners we selected several restaurants for frequent outreach visits by our staff. Each restaurant was visited two or three times each month. At each visit our staff would give a short talk on the importance of condom use and then start a group discussion or answer questions of the girls. The little motivation of the girl-attendants was also one of the reasons to give up the idea of using peer educators. Few of the girls were motivated to take part in this work. Another problem for selecting peer educators was that the girls were highly mobile. Besides this some owners were unwilling to cooperate with the project and some even showed hostility.

Some restaurant owners were unwilling to cooperate with the project and some even showed hostility

Lessons learned

The evaluation in the final stage of the project showed that the pilot interventions had little influence on the girls' risk perception. Only a small proportion of the girls considered themselves at risk of STDs after the interventions had taken place. The condom use was far from satisfactory.

To increase the girls' risk perception and to promote and sustain behavioural change is still a primary, urgent challenge. The sustainability of an intervention like this, which primarily depended on resources from outside, is of course questionable.

The lessons learned from this pilot study are:

1. In the context of strong gender inequality men have to be involved in such interventions.

2. IEC should integrate reproductive health, STDs and HIV/AIDS in order to meet diverse needs of the women in the sex industry.

3. A supportive environment is essential to achieve behavioural change.

4. A persevering community-based IEC may be more likely to foster such a supportive environment.

5. Mobilizing local resources such as health care providers and incorporating IEC into their routine duties may assist in the establishment of a self-sustainable programme.

6. Further research is needed to understand the context of an intervention (e.g. understanding men's knowledge and attitudes towards STD, HIV/AIDS and condoms), to explore and test more practical ways of intervention (e.g. integrating STD/HIV/AIDS with other reproductive health services), and to develop various educational materials appropriate to different targeted groups.

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THE CONCEPT OF 'HIGH RISK GROUPS'

The problems surrounding the construction of high risk groups, rather than addressing unsafe sexual practices and the context in which sexual relations take place, have been well documented (Holland et al 1990, Seidel 1993). We will briefly revisit the arguments here in relation to the 'high risk group' of sex workers and will draw implications for human resource development for appropriate health service delivery.

The emphasis on risk groups leads to assumptions that the group is homogeneous and easily identified, and that all sexual encounters within such a group are 'high risk'. However, the boundaries between high and low risk sexual encounters are much more fluid than the identification of isolated groups, such as SWs, would suggest (Holland et al 1990). Trying to understand sex work, followed by identifying sex workers, can be highly problematic in different settings. For example, in many cultures and societies sexual relations are associated with gift giving, which might range from small items of jewellery to money, school fees or accommodation. Sex work, even when defined tightly as sexual relations which impose no moral commitment from partners other than payment for services (Schoepf 1990), still consists of many different formats. Selling sex might be one part of a range of livelihood strategies employed by women. When a woman sells sex and to whom may vary according to the economic situation and opportunity. Even amongst women 'who are primarily or wholly dependent on the indiscriminate sale of sex' (Pickering's definition), not all sexual encounters are commercial (Pickering 1992).

The emphasis on high risk groups has affected perceptions of condom use in the general population. Condoms became associated with promiscuity and casual sex. To use or suggest using a condom was associated with a lack of trust in the partner. Among sex workers, therefore, condoms might be used with clients but would not be used with boyfriends, and for similar reasons condoms could not be used or suggested by married women. The close association of SWs as a high risk group and core transmitters of HIV/AIDS, further stigmatized these women. In addition, HIV/AIDS became associated with promiscuous and deviant sexual behaviour. The medico-moral discourse of blame (Seidel 1993), combined by the fear of dying, provided a powerful popular justification for extreme control mechanisms and negative responses to people who are HIV-positive and those who become ill with AIDS (Holland et al1990). This has led to an unfortunate impact on attempts to provide sympathetic care for people with HIV/AIDS.

The focus on high risk groups has diverted attention and resources away from the diversity of men and women who practise unsafe sex, and the social context in which sex takes place. The need to contextualize unsafe practices, rather than identifying membership of a particular group (Holland et al 1990), is reflected in new approaches to HIV which focus on 'vulnerability' to HIV infection. For these new approaches to be successful, health providers need to be better prepared for addressing issues around sexuality in general, and HIV/AIDS in particular. Health providers have internalised values and norms within the social context in which they live, which can render the services they provide inappropriate and inaccessible for people deviating from the 'norm'. Teaching

PROVIDING HEALTH CARE SERVICES FOR SEX WORKERS

Some sex workers prefer a service where their occupation is already known and where the professional staff understand their needs and lifestyle. However, in other situations separate services may be considered to increase the stigmatization of sex workers, and it would be preferable to improve the accessibility and sensitivity of mainstream services. A specialised STD service for sex workers can be offered within a mainstream clinic, which has the advantage of the clinic's full range of expertise and hi-tech equipment, but careful planning is needed of times, staffing, procedures and publicity to ensure its success.

Many projects have found that it is important to accompany sex workers on clinic visits, and many STD services welcome accompanied visits, as an enhancement of the quality of service offered. In the case of migrant sex workers, it is important that they are accompanied by someone who can translate and explain what is going on.

However it is provided, a clinical facility for sex workers should be free, non-compulsory, and should allow sex workers to be anonymous if they choose. It should also, if possible, include the following:

- *STD, HIV, counselling, testing and treatment*
- *hepatitis counselling, testing, vaccination and treatment*
- *cervical cytology and colposcopy*
- *breast examination, pregnancy testing and pregnancy counselling*
- *reproductive health and fertility counselling.*

If these services are not included in the clinic, there should be a well-developed referral system.

Some clinical services for sex workers even include general health care. This may improve uptake of services by addressing more immediate health problems, such as back ache, chest infections, minor injuries etc. Common needs include counselling and referral for drug and alcohol problems, and provision or referral for mental health issues.

From: Hustling for Health: Developing Health Services for Sex Workers
EUROPAP/TAMPEP, European Commission, 1998.

health providers how to diagnose and treat STDs without sufficient attention given to reflection on how their internalized norms, values and fears, influences their communication with clients and perpetuates the inaccessibility of sexual health services for different groups. One response has been setting up services exclusively for groups such as sex workers or sexually active adolescents, in which health care workers are specially trained. However, such services are inconceivable in many resource-poor settings and/or rural areas.

There is a need to redress the early focus on risk groups, and focus on vulnerability, in all interventions to control and manage HIV/AIDS. This applies equally to health care workers and educators and the communities in which they work. Initiatives are required which open up the reflection and discussion about norms and values around sexuality and sexual practices, and how that influences our responses to HIV/AIDS. The challenge for the next period is to translate and integrate successful methodologies, developed mainly in the NGO sector, into the public sector, and to strengthen collaboration between the NGO, private and public sector so that more people in vulnerable situations have a chance to address the risks to which they are exposed.

In 1995, CARE Bangladesh developed a project called Stopping HIV/AIDS Through Knowledge and Training Initiatives (SHAKTI). Although SHAKTI initially focussed on awareness raising, at present it is based on the adoption of a behaviour change model among people living in high-risk behaviour generating situations, namely brothel and non-brothel based sex workers and injecting drug users. The model recognizes the respective subcultures of these three groups and acknowledges that any success of the project depends on their acceptance.

The SHAKTI project combines the concepts of peer education, an enabling environment and need based services. SHAKTI tried to involve the sex workers themselves from the beginning of the project, which led to the training of a group of peer educators. This peer pressure strategy seems to be very successful among the brothel-based sex workers and these women do the monitoring of this programme themselves. Similar results, in the non-brothel based settings and the IDU setting can be observed also, although these interventions are 'younger' than the brothel-based intervention.

SYNDROMIC MANAGEMENT AND NEED BASED SERVICES IN BANGLADESH

It is well known that STD syndromic management has its drawbacks, especially in detecting cervical infections. The SHAKTI project of CARE Bangladesh compared the syndromic management approach and laboratory confirmatory tests during a baseline survey in a brothel in Bangladesh. This comparison revealed that the standard WHO syndromic management chart (assuming chlamydia and/or gonorrhea when seeing a discharge) would only correctly identify about 45 percent of women with chlamydia or gonorrhea. And also more than 30 percent of the women would have been unnecessarily treated. The project is at the moment looking into how to strengthen the lab facilities of the project clinic that was especially opened for sex workers and their children in the brothel. One important finding of the baseline survey is that the present flow chart of WHO might need to be revised (including provision of endocervical discharge) for further improvement to its effectiveness.

Although we had concerns about the establishment of a clinic, finally we decided to go on because of the lack of STD services for the sex workers in and outside the brothel. The clinic is open five days a week from 9 a.m. until 1 p.m. and is run by a female doctor, two nurses (male and female) and two peer educators. The STD services and the required drugs are free of cost, but medicines for other illnesses have to be obtained with a prescription from other facilities. It is only since SHAKTI and its peer educators started to work in the brothel that sex workers' children are immunized (at the clinic). The SHAKTI project is also investigating opening a clinic for clients either in the same clinic at other hours or close to the brothel.

The success of the clinic is, among other things, thanks to the accessibility and the cultural appropriateness of the intervention. The availability of STD care within the brothel and the presence of two sex workers as helpers, have contributed greatly to this success.

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References

Aggleton P. Global priorities for HIV/AIDS intervention research. International journal of STD and AIDS, 7, Suppl 2, 13-16, 1996.

Holland J., Ramazanoglu C., Scott S., Sharpe S., Thomson R. Risk, power and the possibility of pleasure: young women and safer sex. AIDS CARE, Vol. 4, no 3, 1990.

Pickering H. et al. Prostitutes and their clients: a Gambian survey. Soc Sci Med, 34, 1, 75-88, 1992.

Schoepf B.G. Sex, Gender and Society in Zaire. Proceedings of the Conference on Anthropological Studies Relevant to the Sexual Transmission of HIV, Sondeborg, Denmark, 1990.

Schoepf B.G. Women, AIDS and economic crisis in Central Africa. Canadian Journal of African Studies, 22, 625-644, 1988.

Seidel G. The competing discourse of HIV/AIDS in Sub-Saharan Africa: Discourse of rights and empowerment versus discourse of control and exclusion. Soc Sci & Med, Vol. 36, no 3, 1993.

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C O L O F O N

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CALL FOR REACTIONS

For the next issue of this newsletter we invite you to reflect on the items of syndromic management and appropriate services. You can also react on any of the articles in this newsletter. Send your comments and anything you want to share to:

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