



Situation Assessment Sex Work and HIV Prevention in Pakistan

Final Report

Technical Assistance for the Delivery of HIV
Preventive Services for Female Sex Workers in Pakistan

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List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
CBO	Community-Based Organization
CIDA	Canadian International Development Agency
D&C	Dilation and Curettage
DFID	Department for International Development
EOI	Expression of Interest
FGD	Focus Group Discussion
FHI	Family Health International
FSW	Female Sex Worker
GD	Group Discussion
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GP	General Practitioner
GRHF	Gender and Reproductive Health Forum
HASP	HIV/AIDS Surveillance Project
HB	Home-Based
HIV	Human Immunodeficiency Virus
HRG	High-Risk Group
IA	Implementing Agency
IBBS	Integrated Behavioral Biological Survey
IDU	Injecting Drug user
IEC	Information, Education and Communication

ILO	International Labor Organization
IPC	Interpersonal Communication
IWW	Interact Worldwide
KK	Kothikhana
LHV	Lady Health Visitor
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSW	Male Sex Worker
MTR	Mid-Term Review
MWT	Mehran Welfare Trust
NACP	National AIDS Control Program
NGO	Non Governmental Organization
NWO	Network Operator
ORW	Outreach Worker
OSD	Organization for Social Development
PACP	Provincial AIDS Control Program
Pak Plus	Pakistan Plus Society
PAPS	Pakistan AIDS Prevention Society
PAVHNA	Pakistan Voluntary Health and Nutrition Association
PE	Peer Educator
PHC	Primary Health Care
PLYC	Pakistan Lions Youth Club
PM	Program Manager
PO	Program Officer
RLA	Red Light Area
SB	Street Based
SDP	Service Delivery Project
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
SW	Sex Work
SWOT	Strengths, Weaknesses, Opportunities and Threats
TA	Technical Assistance
TACA	Technical Advisory Committee on AIDS
UAE	United Arab Emirates
UNAIDS	United Nations Programme on HIV/AIDS

UNDOC	United Nations Office on Drugs and Crime
UNDP	United Nations Development Program
UNESCO	United National Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and HIV Testing
WHO	World Health Organization

Executive summary

In 2009, the NACP selected Family Health International to provide technical assistance to NACP, PACPs and local organizations for strengthening HIV prevention interventions. One of the deliverables under the technical assistance is this Situation Assessment Report, documenting lessons learned in Pakistan and forming the basis of the design of other studies, strategies and interventions to be carried out under the Technical Assistance.

The size of the FSW population and their high number of sexual partners suggests that the expansion of the HIV epidemic is likely to be strongly influenced by the extent of the epidemic among FSWs and their clients, even though current HIV prevalence among FSW is low. Several recent surveys have shown that although prevalence among FSW is low, their risk is high and the epidemic potential is considerable because condom use is low and sexual partnerships of FSWs with IDUs are reported by over 10% of the female sex worker population surveyed.

Specific objectives of the assessment were to:

- Assess the structure of the sex trade, changes taking place and implications for reaching target groups
- Understand the legal and policy environment and its impact on the services for sex workers
- To assess knowledge, attitude and practice of female sex workers and sexual networking patterns
- To assess involvement of target population in the implementation of HIV prevention activities
- To explore opportunities and constraints for formation/operation of FSW self-help groups
- To assess the capacity of NGOs to deliver services for female sex workers
- To assess the roles and responsibilities of Provincial AIDS Control Programs

Findings

Structure of the sex trade

Although there is a clear categorization of the different types of sex workers that are found in Pakistan, it is not clear what this means in terms of project implementation. The FHI assessment found that the majority of their FSW respondents were working in a brothel and this was also gleaned from discussions with other NGOs. The results on awareness and practices of FSWs that are discussed in chapter 8, consistently show that brothel-based sex workers have a better score on most topics covered, which confirms the previous focus of interventions on this group. This group is the most easily identified and has a fixed location and is therefore easier for SDPs to work with. Yet, the percentage of sex workers working for a brothel base is only 2.2%.

The other group that is mostly addressed is the sex workers working in KK with madams. They are reached through the madams and that raises the question as to what extent these sex workers have the freedom to apply what they may have learned from the peer educators. The madam is completely in charge of all arrangements and her

focus is on making money rather than on improving the health and working conditions of the sex workers. What incentives can be thought of to encourage the madams to address these as well? One possibility may be to change the norm of commercial sex to safe commercial sex and to motivate the madams to promote their sex workers as working under healthy working conditions and being in a good state of health. This needs further research.

None of the SDPs that we visited was able to explain how and if they reach the home-based sex workers or the street-based sex workers who are the largest groups in the industry, and their knowledge of and participation in SDP programs is lowest. One problem that applies to the last category is that they are highly mobile, while the first category is largely hidden. SDPs should devise means to also reach these sex workers.

The sex trade is changing under the influence of mobile phones that make it easier for sex workers to directly deal with their clients. This must be a threat to the madams although they claim that they provide security and safety and therefore will remain important. We need more information on this. We also need more information on how the networks among the madams between the madams and the network operators operate – to what extent do they have a stranglehold on the sex workers and what can sex workers do to escape this hold? How easy is it for sex workers to move from one category to another?

We have seen that the average number of years spent in the trade is 5.2 and that the average age to start is 22. This means that most leave the profession before 30 years of age. What do they do next? The income they earn with the sex trade is far higher than they would (as a non- or low-educated group) in any other job. We found that interest in vocational training is very low (section 9.8) so it is necessary to find out what happens to these women and what their hopes for their future are, in order to devise strategies that will help them to gain a livelihood after they leave the profession.

Finally, there are the clients who have not yet been addressed in any of the FSW projects. International experience tells us that without involving the clients in an intervention, the likelihood of success is slim. Is it reasonable to expect the sex workers to raise the awareness of clients on safe sex? Can this be expected from the madams or network operators? They all have their own interests. Yet, in sex work interventions elsewhere, this group is being addressed and so this should also be done in Pakistan. How, is one of the examples of the importance of involving sex workers in making strategies – they would know best.

Legal and policy environment

The sex trade is illegal in Pakistan and the enabling environment that is mentioned as a strategic objective of the NSF II has to be created within the existing legislation. The NSF mentions 'the development of a wide range of rules and regulations to which institutions and practitioners should adhere'. The question that needs to be addressed is what this should be in the context of female sex workers: what rules and regulations can be developed that facilitate prevention of HIV transmission in the female sex trade. What institutions should adhere? Of course, police act as the regulators of the trade and the people responsible to pursue the law. The whole trade is conditioned by the operating policies and action of the police. What are these operating policies?

We have found no examples of interventions that successfully address the involvement of the police other than ensuring that the project can continue its activities. We have no insight in the guidelines that exist at police station level for the operations in the sex trade. We do not know what is needed to get the police to become a partner that enables the sex trade to function in a way that promotes the rights of FSW, protects them and promotes safe sex behaviors. What we do know is that police are very much involved in the sex trade and benefit from it. So what could be incentives to the police to change their attitudes? What could be incentives for local politicians to ensure sanctions against police officers who profit from the trade? International experience tells us that whatever approach is explored, it will need organization and empowerment of the sex workers themselves to have more control over their working environment. They need to be supported by NGOs in doing this and at the same time, NGOs should be advocating for social change, lobbying for change and challenging human rights violations in the sex trade.

Knowledge, attitude and practice of female sex workers

The awareness of the existence of HIV seemed fairly high at almost 70%, despite the very low prevalence in the country and among female sex workers. However, when we looked at the details of what people knew, we found that although most knew that HIV is transmitted through sex, many fewer people knew that condoms can prevent this transmission. Also much fewer people knew about transmission through needles and syringes – which knowing about the overlap between the IDU and the sex worker communities is very alarming indeed. The lack of in depth understanding is also shown by the very low risk perception that the women have. This calls for more detailed education and explanation by peer educators or outreach workers.

Most women know what STIs are because they have experienced them themselves, and they can describe symptoms in a general manner. But they know very little about different types of STIs, symptoms and complications, and many resort to home medication for treatment. Again, this points to the need for more detailed education on this.

Condom use is an issue all over the world and also in Pakistan. It is low considering the risks of the trade – but the surveys show that having been exposed to FSW interventions does make a difference and this is very promising. The most interesting finding is that some studies found that condom use with clients is actually lower than condom use with non-paying partners. This really needs to be looked at in more detail because if this is true, this means that either the sex workers want to protect their regular partners and so they know that they can transmit a disease to them or, the regular partners are aware of such diseases and the higher chance that the women may carry these and want to protect themselves. It could even be that these men having also other sexual contacts may want to protect the sex workers, although that seems unlikely.

Anyway, one of the reasons for not using condoms that is most mentioned is inability of the sex workers to negotiate condom use with their clients. This calls for capacity building in negotiation skills with the sex workers, but also calls for interventions with the clients. As the madams and network operators are in many cases the ones who negotiate with the clients, they should also be addressed. It may be useful to promote condoms not only for protection for STIs, but also as a contraceptive – unwanted

pregnancies being a regular phenomenon. This should be done alongside the promotion of other contraceptive techniques as an additional family planning method.

HIV prevention services

The issue of numbers of sex workers reported in the surveillance and number of sex workers registered by the SDPs is a matter of concern. Of course there are differences, if only because the NGOs are generally not working city-wide but in selected areas with concentration of female sex workers, while the IBBS is supposed to carry out a city-wide estimation. The mapping procedures by the IBBS are very clear, but this cannot be said for all SDPs. While it is recommended that PACP, SDPs and IBBS discuss this issue and find if variations can be explained or not, it is also recommended that for the new SDPs, the mapping process be done by sex workers themselves and by network operators. For the sex workers, this could mean the start of an involvement that treats them as partners rather than as beneficiaries, while the network operators have a better overview of what happens in different areas of the city – the two exercises can complement each other.

The purpose of registration has to be made clear for everyone involved, as this will determine if people are interested to be registered or not. Apart from the purpose, also the benefits have to be clear – free access to the clinic for instance, but what if a sex worker is not interested in the services of the clinic? Do those who are not registered not get free condoms from the peer educators? That would not help the purpose of the SDP interventions.

While it is universally agreed that BCC activities can best be done by peer educators and outreach workers, there are a number of concerns. First of all, the division of roles and responsibilities between these two positions are not sufficiently clear. It is necessary that SDPs make job descriptions for each. Then, we found that the number of peer educators is insufficient, there should be at least one per educator for 50 sex workers. We have not gained any insight into turnover of peer educators, retention strategies and incentives for them to remain doing the job. Also, it is unclear what is done with peer educators who belong to the more mobile groups. How many peer educators are supervised by one outreach worker? How do they report and do they regularly meet to discuss issues and solutions to these issues? What are their performance indicators, other than numbers – can these be developed by the peer educators themselves? In short, there should be a clear strategy that deals with all these aspects.

Another major aspect of peer educators and outreach workers is their training. There is a glaring absence of structured training modules and it seems that topics that should be covered (such as STIs) are not included. Before peer educators start working, there should be some kind of certification that they have indeed received the trainings that are necessary for them to effectively operate. No attention is given to life skills education (other than condom negotiation skills) and to skills of the trade (such as how to put a condom on in the dark, or without the client knowing, or with the mouth) or making safe sex pleasurable. Such trainings can be fun and may attract interest from the sex workers who may get tired of hearing that they have to use condoms, without getting the skills to do this. In many other countries such training is given and there are manuals available for this – but the trainers should preferably come from the target group!

With regard to condom promotion and distribution, it is clear that the number of condoms distributed by the SDPs is insufficient to cover the needs of all sex workers. However, we did not hear any complaints about this and it is also not mentioned in any of the documents reviewed. Apparently, for those who want to use condoms, there is sufficient access, whether for free or purchased. However, this issue should be researched in greater detail – and this in turn has a link to the estimations of numbers of sex workers.

VCT at the project level has not been done in many SDPs (only 2), but it seems that in view of the low prevalence among female sex workers, it may be more efficient to continue what is being done at this moment: counseling at the SDP clinic and testing at a government approved testing laboratory. To improve this system, it is suggested that more attention is given in the SDPs to developing a good referral system.

Because other STIs are much more common than HIV, the counseling services should probably focus on this. Internationally, there is a debate on syndromic management for high risk groups. It is argued that sex workers are more likely to have STIs that are not detected with syndromic management and are not cured by the treatments given. It is therefore argued that they should be tested for STIs as a norm and treatment given based on the outcome. This issue should be further explored.

The training of doctors in the SDP clinics is reported to be insufficient, especially in STI management. This has to be changed. While the sex workers who visit the SDP clinics are all satisfied with the attitude and the treatment, they are only a minority of the target group. Other sex workers prefer to visit other health care providers for a variety of reasons. We need to get more insight in these reasons in order to be able to adjust the service – it cannot be that a clinic that is specifically opened to serve sex workers only has 10% of this target group among its patients. Some interviewees have suggested that this is due to the poor rapport of the NGOs with the sex workers.

In view of the current preferences of the sex workers, another option may be to develop links (and training) with the providers that they do visit – this has not been done so far. It needs more research to find out if this is sensible and if so, how this could be done.

Although empowerment of sex workers is part of all SDP strategic plans, this has not been implemented by most, because of lack of understanding of the concept with the NGOs and because it was not part of the contract document. Therefore, all SDPs in future have to be trained in understanding what empowerment means, what attitudes it requires from them and what they could do. It means first and foremost, the involvement of sex workers in planning and implementation of activities and services as partners rather than as beneficiaries.

One aspect that could be looked at (but needs further research) is the function of the drop-in center. Is this really being used by sex workers to drop in (as is common with drop-in centers for IDUs) and if not, why is this so? How easy is it for sex workers who are controlled by their madams, to visit a drop-in center? Is it possible to have sex workers run this center and decide what activities to offer there to make it attractive to others? There are SDPs that are successfully doing this in Pakistan and elsewhere. Maybe too much focus has been on the drop-in centers as part of the clinic and therefore seen as a clinic rather than anything else. Yet, it is necessary to provide safe places for sex workers to bond and to create solidarity rather than competition. So far, sex workers have not been interested in any vocational training – whether offered or not

– but maybe they would be interested in other type of activities: for instance, saving and loan schemes have been successful as a starting point for community development in many development interventions. In some countries, literacy classes have been able to attract participants as it turned out to be a priority. What to offer needs full involvement of the sex workers themselves.

The aspect of self-help group formation needs further research. What are the barriers and how can these be overcome? What is the motivation for sex workers to join such groups? There are many examples of successful self-help formation in other countries and this should be build upon.

Finally, there is a need to differentiate in the requirement and priorities of the different categories of sex workers.

Functioning of NGOs

The lack of clarity on tasks and responsibilities with many of the staff present in the discussions points to the need for job descriptions for each staff member. These should ensure a minimum of overlap between the jobs and make clear who is responsible for what, as well as the relation to other staff members.

Although most staff members were quite positive about the performance of the SDPs, their interest in further training indicates a scope for improvement. At the start of a project, an overview should be made of the training requirements for all staff members. Structured training modules should be developed for the different topics and these trainings should be given by experienced trainers. It is probably most efficient if those modules are developed at national level, to be rolled out at provincial level – for all NGOs that are working with female sex workers – or, where relevant, for other NGOs working with different target groups. This should enhance quality assurance. Some type of certification is necessary for staff to have obtained within a certain period of working in the program. The topics that should be covered will be explored during the formative research that will follow this situation assessment. These trainings have to be budgeted for in the tender proposals in order to avoid the existing situation that the NGOs complain that there is insufficient budget for training.

One very important training that should be given at the start of the program is relates to understanding of the project and its goals and on values clarification of the staff attitudes towards the target group, including aspects of stigma and discrimination and its manifestations. It should also include sessions on empowerment, what this means and what approaches can be used to promote such empowerment in the target group. An understanding of a rights-based approach to be integrated in all components of the intervention, requires specific sessions on this topic for all staff.

Much needs to be done to improve monitoring: it is identified as a topic for training by all project managers and program officers, but it is also required for other staff members. Such training should go beyond output indicators, but should create an understanding that monitoring is a useful tool for assessing, guiding and adjusting implementation activities. It should create an understanding why indicators for field level activities should preferably be developed with the target group, the peer educators and the outreach workers – and the monitoring should be done by the target group who has a stake in the outcome.

Recommendations

Structure of the sex trade

1. Conduct mapping using different techniques in order to include all categories of sex workers as well as the different networks controlling the trade
2. Include all categories of sex workers in the intervention
3. Use innovative approaches to reach the different categories, i.e. by mobile messages
4. Develop approaches to work with clients
5. Assess motivation of madams to improve working conditions and health conditions of the sex workers
6. Assess how networking takes place between madams among themselves and between madams and network operators and develop strategies that involve them in the intervention

Legal and policy environment

1. Explore what rules and regulations can be developed that facilitate prevention of HIV transmission in the female sex trade
2. Assess current guidelines for the police working in hotspots
3. Develop advocacy tools and approaches for different stakeholders in the environment
4. Find out what is needed to get the police to become a partner that enables sex trade to function in a way that promotes the rights of sex workers, protects them and promotes safe sex behaviors. Base strategies on this and develop training modules where needed.

Knowledge, attitude and practice of female sex workers and sexual networking patterns

1. Develop structured training plans and a peer educator manual for peer educators and outreach workers and implement these sessions before they start working. Develop certification for this. Plan for refresher sessions, also for new recruits
2. Train outreach workers and peer educators on formative research and let them do the research. Involve them in the planning and implementation of a baseline survey.
3. Develop standardized training modules for peer educators and outreach workers, covering the roles and responsibilities connected to these jobs and their function in the intervention. Topics of sessions have to include: HIV and STI information – more in depth than before, prevention measures including condoms, different types of skills needed for safe sex, relative risks of different types of sex and preventive measures, understanding of transmission chains between different sexual networks, monitoring and record keeping.
4. Conduct weekly or bi-monthly meetings between peer educators and outreach workers

HIV prevention services

1. Review the surveillance data on female sex workers and match these with the estimates of the SDPs. Discuss if variations can be explained or not and rectify, using various techniques.
2. Ensure that all concerned are clear about the registration process, including the reasons for registration and the benefits of registration. Develop SOP for registration
3. Expand coverage of the intervention using outreach approaches
4. Plan the different services in consultation with female sex workers and staff involved in the implementation of the services
5. Establish the drop-in center in consultation with sex workers, at a location that is convenient for a majority of the sex workers. Offer activities in line with sex worker priorities
6. Make job descriptions for peer educators and outreach workers including reporting requirements
7. Develop retention strategies, incentives and
8. Organize training in behavior change communication, interpersonal communication and counseling as well as sessions on the topics mentioned above. Include topics on how to reach different segments of the target groups. Have all participants develop a BCC plan in the training
9. Research the differences between condom distribution and reported condom use. Find out why and where condoms are purchased, if they can also be obtained from the project for free. Adjust condom need, distribution and coverage figures and use this for procurement planning
10. Include counseling in all SDP interventions, but develop links with testing services for the tests.
11. Diagnosis and treatment for STIs should be superior to that of other providers. Most STIs are asymptomatic, syndromic management may not be suitable. Specialists in STI management for sex workers will be needed to make an assessment of the current services in sex worker projects and make suggestions for improvement.
12. Ensure doctors and other staff in the clinic are well trained on STI management and counseling and include sessions on value clarification, attitudes and stigma and discrimination
13. Explore possibilities for linking with existing health care providers in the formative research
14. Develop empowerment strategies in consultation with different categories of sex workers, including formation of self-help groups

NGO management and capacity

1. Develop job descriptions for all positions
2. Develop standardized training packages for different job levels and include management and monitoring aside from specific topics related to the sex work intervention
3. Develop a capacity building plan for all staff and coordinate with other NGOs to avoid duplication of efforts
4. Hire experienced trainers to conduct the trainings

5. Eliminate discrimination as discriminatory attitude of NGOs towards female sex workers has restricted their involvement in the program as well as their access to services. Provide training and establish a code of conduct
6. The national M&E framework needs to be modified/adapted to the specific monitoring needs of the FSW program and all implementing agencies should be made to utilize a unified monitoring method. This method should follow the basics of the national M&E framework.

Chapter 1: Background to the assessment

The Government of Pakistan through Provincial AIDS Control Programs (PACPs), contracted out service delivery packages for female sex workers to local organizations in Karachi, Lahore, Multan, Hyderabad and Peshawar since April 2004, with funding from the World Bank. In addition, other donors including EU, USAID, UNFPA, have been supporting similar service delivery packages since 2004.

A study on HIV risk in Karachi and Lahore (Bokhari et al, 2007) found that women who had access to specific HIV interventions reported consistently more beneficial risk reduction indices than those who did not, and a highly significant increase in condom use with last client of 53% versus 30%. However, a study conducted on the effectiveness and coverage of HIV preventions in Pakistan (Khan, 2008) found that although nearly all indicators were better for SDP cities compared to non-SDP cities, the differences were minor. The Integrated Biological and Behavioral Surveillance, Round 2 (IBBS, 2007) found that although 11.4% of FSWs were aware of HIV prevention programs in their cities, only 2% reported utilizing the services. They concluded that

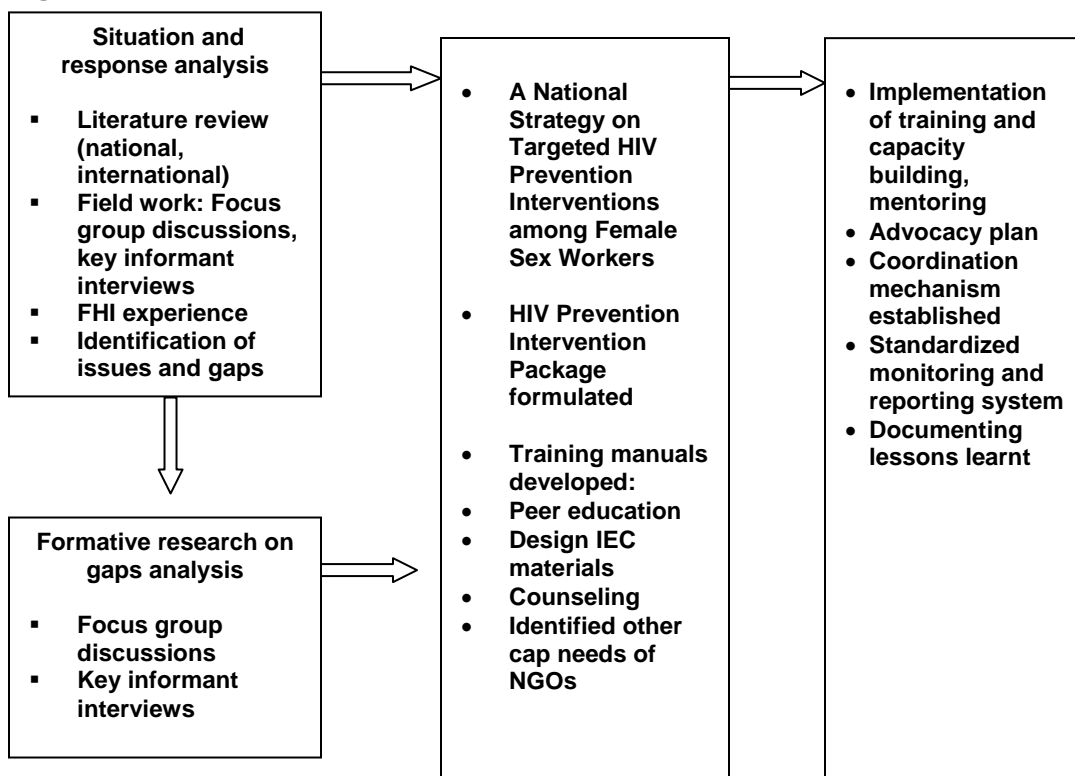
“although SDPs have been developed and implemented in various cities where surveillance data was collected, only a negligible fraction of FSWs were aware of such services. Even FSWs who knew of the services, showed a reluctance to participate in such activities on a regular basis. However, utilization of these services by the target population does appear to result in improved knowledge and corresponding practices. For FSWs who had been utilizing a SDP, there were significant differences seen in their knowledge and awareness level as compared to those FSWs who had not been in contact with SDPs. It should be recognized that programs and interventions will only be effective if they reach a critical mass of people who need them. There is an urgent need to identify the reasons for non-utilization and non-compliance, and look at ways to scale up interventions and improve coverage.” (IBBS, 2007)

This evidence has led the NACP to conclude that the performance of the service delivery packages has not had sufficient impact on HIV prevention in the female sex trade and that there is a need to scale up HIV prevention services to female sex worker populations and to improve the effectiveness of these services. The NACP in 2007 invited EOIs from international NGOs and selected Family Health International in April 2009 to provide technical assistance to NACP, PACPs and local organizations for strengthening HIV prevention interventions, with the following objectives:

- To develop a strategy to address HIV prevention in the female sex work sector in Pakistan,
- To translate the strategy into a comprehensive service delivery package for female sex workers of Pakistan based on formative research.
- To build capacities of major stakeholders including National and Provincial AIDS Control Programmes, NGOs, and development partners in designing, implementing, managing and monitoring the interventions among female sex workers.

One of the deliverables under the technical assistance is this Situation Assessment Report, documenting lessons learned in Pakistan and forming the basis of the design of other studies, strategies and interventions to be carried out under the Technical Assistance. The process can be illustrated as follows:

Figure 1: The Process of Technical Assistance



Chapter 2: Epidemiological context

The estimated HIV prevalence rate in Pakistan is less than 0.1% among the general population and hence can be characterized as a low level epidemic. However, the HIV infection rate has increased significantly in last few years and, since 2004, the country has moved from a low prevalence situation to a concentrated epidemic among IDUs and male and hijra sex workers. Table 1 indicates a concentrated HIV epidemic among injecting drug users (IDUs) across the country with prevalence rates ranging between seven to 51% in major cities of Lahore, Quetta, Faisalabad, Larkana, Hyderabad, Karachi and Sargodha. Among male sex workers (MSWs), HIV prevalence was highest in Karachi (7.5%), Bannu (4%), Faisalabad and Larkana (2.5%). Hijras have greater than 2% prevalence in Hyderabad, Larkana and Bannu with Larkana at 14%. The latest round of surveillance (IBBS, 2007) also confirms that the HIV epidemic has not yet moved to female sex workers (FSWs); only one FSW was tested HIV-positive.

Table 1: HIV Prevalence among High-Risk Groups

City/Study	Date of field work	IDUs	FSWs	HSWs	MSWs
Karachi ¹	Aug 2004	23%	0%	2%	4%
Karachi ²	Sept-Dec 2004	26%	0%	0%	7%
Karachi ³	Sept-Dec 2005	NA	0.8%	1.5%	4%
Karachi ⁴	Sept-Dec 2006	30%	0%	3%	7.5%
Lahore ¹	Aug 2004	0.5%	0.5%	0.5%	0%
Lahore ³	Sept-Dec 2005	3.8%	0%	0.5%	0%
Lahore ⁴	Sept-Dec 2006	6.5%	0%	0%	0%
Rawalpindi ²	Sept-Dec 2004	0.5%	0%	0%	0%
Quetta ³	Sept-Dec 2005	9.5%	0.7%	0.5%	0%
Quetta ⁴	Sept-Dec 2006	9.5%	0%	0%	0%
Hyderabad ³	Sept-Dec 2005	25.4%	0%	1.0%	0%
Hyderabad	Sept-Dec 2006	29.8%	0%	2.0%	0%
Sukkur ³	Sept-Dec 2005	19.2%	0%	0.17%	0%
Sukkur ⁴	Sept-Dec 2006	5.3%	0%	0%	0%
Faisalabad ³	Sept-Dec 2005	13.3%	0%	0.5%	0%
Faisalabad ⁴	Sept-Dec 2006	13.3%	0%	0.5%	2.5%
Peshawar ³	Sept-Dec 2005	0.4%	0%	1.01%	0%
Peshawar	Sept-Dec 2006	2.2%	0%	0.9%	0.9%
Multan ³	Sept-Dec 2005	0.3%	0%	0%	0%
Multan ⁴	Sept-Dec 2006	0.3%	0%	0%	0%
Sargodha ⁴	Sept-Dec 2006	51.5%	0%	0.5%	1%
Gujranwala ⁴	Sept-Dec 2006	1%	0%	0.5%	0%
Larkana ⁴	Sept-Dec 2006	16.8%	0%	14.1%	2.5%
Bannu	Sept-Dec 2006	1.4%	0%	5.7%	4.0%

World Bank, 2007

Sources:

¹ RTI = National Study of Reproductive Tract and Sexually Transmitted Infections - Survey of High Risk Groups, field work conducted March to August 2004.

² IBBS pilot = Integrated Biological and Behavioral Surveillance pilot round field work conducted September-December 2004.

³ IBBS Round 1 = Integrated Biological and Behavioral Surveillance Round 1 in 8 cities, field work conducted September-December 2005, National Report.

⁴ IBBS Round 2 = Integrated Biological and Behavioral Surveillance Round 1 in 8 cities, field work conducted, September-December 2006

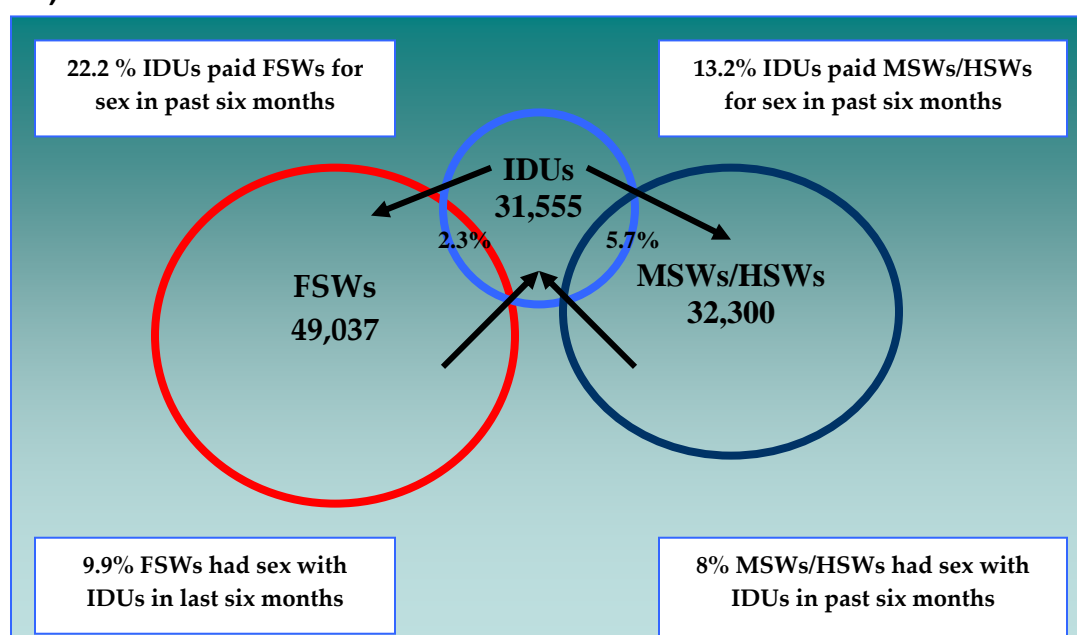
With a concentrated epidemic, Pakistan fits the typical or 'average' Asian concentrated HIV epidemic model whereby the number of new infections is initially confined to specific groups but grows rapidly later in the developing epidemic. The HIV epidemic in Asia typically starts with IDUs, but reaches the general population through sexual networks among IDUs, prisoners, MSM, and FSWs. HIV continues to be transmitted among persons in these key populations due to their lack of knowledge and risky behaviors, especially unprotected sexual activity. Persons in these groups are interconnected and also connected with the general population through clients or bridging populations by social, sexual and drug use networks. Interconnection by marriage, sharing injecting equipment and by buying and selling unprotected sex provides open channels for HIV transmission (Commission on AIDS in Asia, 2008).

The size of the FSW population and their high number of sexual partners suggests that the expansion of the HIV epidemic is likely to be strongly influenced by the extent of the epidemic among FSWs and their clients, even though current HIV prevalence among FSW is low (Blanchard, 2008). Indeed, several recent surveys have shown that although

prevalence among FSW is low, their risk is high and the epidemic potential is considerable because condom use is low and sexual partnerships of FSWs with IDUs are reported by over 10% of the female sex worker population surveyed (see figure 2, IBBS, 2007; NACP 2005) .

The linkage between IDUs and female sex workers is also documented in a research article on HIV risk in Karachi and Lahore, Pakistan (Bokhari et al., 2007), which found that 29.5% of IDUs in Karachi and 33.9% of IDUs in Lahore bought sex from female sex workers and, of these, only 17.2% and 31.5% respectively used a condom the last time they paid a woman for sex. Twenty per cent of the female sex workers reported that they had male clients who also injected drugs, and in addition, 14% who had sex with non-paying partners, knew that these injected drugs.

Figure 2: Interactions between the IDU, FSW, MSW and HSW populations (12 cities)



IBBS, 2007

Chapter 3: Objectives of the assessment

This assessment was designed to provide up-to-date knowledge on the context in which sex work takes place and on the knowledge and behavior of female sex workers. It reviewed the capacity of NGOs to implement interventions that will prevent an HIV epidemic take root among female sex workers. It will identify gaps in information needed for the development of a strategy for female sex work and will document lessons learnt from past interventions.

More specific objectives of the assessment were to:

- Assess the structure of the sex trade, changes taking place and implications for reaching target groups

- Understand the legal and policy environment and its impact on the services for sex workers
- To assess knowledge, attitude and practice of female sex workers and sexual networking patterns
- To assess involvement of target population in the implementation of HIV prevention activities
- To explore opportunities and constraints for formation/operation of FSW self-help groups
- To assess the capacity of NGOs to deliver services for female sex workers
- To assess the roles and responsibilities of Provincial AIDS Control Programs

Chapter 4: Overview of the report

After the introductory chapter describing the background to the assessment report, the epidemiological context of the HIV situation is given, in which HIV prevalence of different risk groups are presented as well as the interactions between these groups. This is followed by chapters on the objectives of the assessment and the methodology used.

Chapter 6 discusses the structure of the sex trade. This covers different categories of sex workers and their socio-demographic background. It also discusses other stakeholders in the trade such as madams, network operators and clients and the operating mechanisms between them. The chapter closes with a discussion on the findings.

Chapter 7 reviews the legislation and policies guiding the interventions in the sex trade and also discusses the role of the police in what is actually taking place on the ground. It ends with a discussion on findings.

Chapter 8 discusses the knowledge, attitudes and practices of female sex workers. There are separate sections covering awareness and risk perception, condom use and behavior with different types of sexual partners. The discussion of findings pulls these all together.

Chapter 9 gives an overview of all HIV prevention services carried out in the various SDPs. Its sections follow the different components of the SDPs: coverage and registration; behavior change communication; training of peer educators and outreach workers; condom promotion and distribution; VCT; STI and PHC services and empowerment of sex workers. The findings are discussed at the end of the chapter.

Chapter 10 reviews the functioning of the NGOs as an indication of the training requirements at a later phase in this TA.

Chapter 11 gives a very short indication of PACP performance, but findings need to be strengthened with the outcome of the formative research.

Chapter 12 gives recommendations based on the discussions of findings.

Chapter 5: Methodology

The assessment was conducted in the period between April and June 2009 by the FHI team that consisted of a project manager, an organization specialist, a monitoring and evaluation officer, a technical officer on STI management and a technical officer on BCC.

The team started with a literature search on sex workers in Pakistan and Asia and on other topics relevant for the assessment. This was done in databases such as PubMed, Science Direct, the databases of WHO and UNAIDS, as well as the NACP database. This was followed by a desk review of reports and papers found at the NACP resource centre, donors and other partners. In addition, discussions were held with the HIV/AIDS Surveillance Project (HASP) team, focal persons for FSWs in NACP, managers of donor-funded projects in national and international NGOs and donors in Islamabad.

To complement the secondary information, field visits were conducted to six NGOs in Punjab and Sindh, who were carrying out SDPs with female sex workers. Here, the FHI team conducted group discussions with NGO staff responsible for FSW interventions and focus group discussions with target groups (FSWs).

The FHI team visited: Organisation for Social Development (OSD), Rawalpindi; Pakistan AIDS Prevention Society (PAPS) Okara; Pakistan Plus Society, Faisalabad; Contech International Consultants, Lahore; Pakistan Lions Youth Club (PLYC), Multan; and Mehran Welfare Trust (MWT), Larkana.

Table 2: Respondents (FSWs) of FHI assessment

NGO	City	FSWs #	PEs and FSWs	Outreach workers and FSWs	Total FSWs
Organisation for Social Development (OSD)	Rawalpindi	5	0	2	7
Contech International Consultants	Lahore	0	4	0	4
Pakistan Lions Youth Club (PLYC)	Multan	7	0	0	7
Pakistan AIDS Prevention Society (PAPS)	Okara	7	1	0	8
Pakistan Plus Society	Faisalabad	4	4	0	8
Mehran Welfare Trust (MWT)	Larkana	6	0	1	7
		29	9	3	41

A special mention should be made of the very recent (2009) research report Sex work and HIV in Pakistan: situation and response analysis, written by Dr. Faran Emmanuel for UNFPA. In discussion with NACP, it was agreed that the FHI team could make use the

information in this report, but would complement this with its own desk research and field visits.

Finally, the assessment took into account the outcome of the National Dialogue on HIV Prevention in Sex Work held in December 2007 with all functional SDPs, and members of key stakeholders in Pakistan, as well as the insights gained during the National Consultation on Female Sex Work in Pakistan, organized by the NACP with support from UNFPA, Interact Worldwide and Family Health International and held in Karachi on May 5 and 6, 2009.

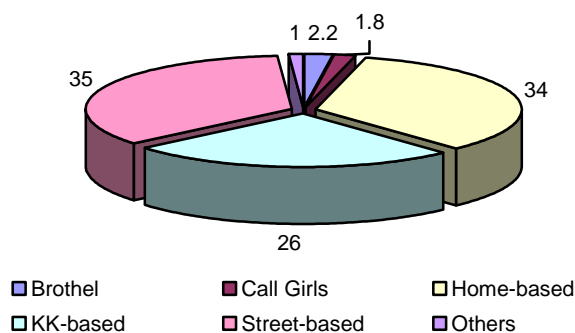
Chapter 6: Structure of the sex trade

6.1 Female sex workers

The estimated number of female sex workers that are operational in Pakistan is based on different mapping studies carried out between 2004 and 2008 and carried out in different cities. Emmanuel (Emmanuel, 2009) has combined and extrapolated these studies and has come to an overall estimate of around 150,000 female sex workers. However, he cautions that this estimate may be 20-25% too low because of the illegal nature of the sex trade; the wide varieties in categories of sex workers and the geographical spread; as well as the difficulty to come to realistic estimates based on mapping as enumeration.

The IBBS (IBBS, 2007) has categorized different types of sex workers in five categories (brothel-based, kothikhana-based, street-based, home-based and call girls), a category 'other' was added by Emmanuel covering sex workers who are hotel-based and sex workers who work out of massage parlors or beauty salons. The percentages of sex workers working in each category are shown in Figure 3 (Emmanuel, 2009).

Figure 3: Categories of female sex workers in Pakistan



The description of the different categories is as follows (adapted from IBBS, 2007):

Brothel-based FSW (2.2%): Brothels are fixed venues which are owned and/or operated by madams and/or other individuals or groups. A number of FSWs live in such houses which are licensed for singing and dancing, and are located in a larger sex work or red-light district where clients are entertained. The typical feature of brothels is that they have a stable location that is known by local clients and brokers. Sex work takes

place either at the brothel or at a venue decided by the client. Sex workers are usually full-time. Traditionally, the trade was controlled by families that have been working and living in the area for generations and who were specializing in classical dance and singing and who would provide sexual services for known clients only. This situation is changing rapidly, and the areas are more and more becoming locations of sex work.

Kothikhana-based FSWs (26%): “*Kothikhana*” (KK) is a colloquial expression for a sex work venue that literally means ‘grand house’. However, kothikhanas are generally small premises, which are rented by a madam and/or broker where a small number of FSWs live and entertain clients. Kothikhanas are often in residential areas and are largely clandestine. A key feature is that their location moves from time to time (time intervals are getting shorter) when the madam determines that the current location is unsafe or unsuitable or when neighbors have complained to the police. Sex workers operating from a kothikhana may provide services in the establishment or in another venue determined by the client.

The FSWs living in a KK are not related to the madam and usually come from other cities (NACP, 2007). They do not stay with one KK for a long time (from a few days to a few months) before moving back to their own cities and districts or moving to another KK or another category of sex work. However, FSWs in this category may also have been bought or given advance money and thus have an obligation to stay with the KK for the contract duration (NACP, 2007).

Street based FSWs (35%): Street-based FSWs solicit clients in public places such as busy streets and intersections, bus and train stations and marketplaces. Sexual transactions then occur at a venue chosen by the FSW or the client.

Home-based (34%): These sex workers usually live with their families and are based at their own houses. Clients are solicited using mobile phones and/or through network operators. Sex work takes place either in the client's home, in a hotel or a place provided by the network operator; the FSW only come out on the street to be picked up by the client from a spot where they have agreed to meet. Sex workers are usually part time, operating when required for financial purposes. Their work in the sex trade is not known to their neighbors and sometimes also not to their families. In the larger cities, HB sex workers are operating more independently and able to solicit their own clients, while in the smaller cities this is more difficult and more dependent on network operators (see 6.4).

Mobile FSWs - Call Girls (1.8%): A relatively small number of female sex workers have been identified as operating as call girls. This category comprises girls belonging to middle class who operate through mobile phones to directly contact clients and this category is extremely hidden and hard to reach.

Others (1%): This includes hotel-based FSWs who solicit their clients in lobbies of hotels. So far, none of the mapping studies has researched the dynamics of hotel-based sex workers and it is unclear whether these sex workers overlap with the other categories of form a category on their own. It also includes FSWs based in massage parlors or beauty salons who operate under the pretext of massage or beautification services and provide sexual services to clients.

6.2 Socio-demographic profile of female sex workers

The most comprehensive source of information is the IBBS Round 2. The descriptions following below are taken from this report (IBBS, 2007).

Age: The average age of FSWs across the 12 cities was reported to be 27.4 years with little variability between different types of FSWs. The largest proportion of FSWs fell between 25 to 29 years of age and 10% were between 15 to 19 years of age.

Marital status and children: The marital status among FSWs varied across cities; the majority were currently married (60.7%), while a small proportion reported to be either separated/divorced (8.6%) or widowed (2.7%). The largest proportion of unmarried FSWs was found in the call girl/other category (44.7%). Of those who were married, 16% of the FSWs reported having no children; 34% had one to two children, 31% had three to four children and 19% had 5 or more children.

Initiation in sex work: FSWs initiated sex work at an average age of 22 years and reported being involved in sex work for an average period of 5.2 years. Brothel-based FSWs started sex work at a slightly younger age (average 19.2 years) in comparison to other types of FSWs and continued in sex work for longer (average 7.9 years)

Education: The majority of FSWs interviewed were illiterate (59.2%), with the highest proportion of illiteracy (80%) reported among brothel-based FSWs, followed by street-based and home-based (60%). Education status of FSWs varied substantially across cities, with the highest levels of illiteracy reported in the smaller cities of Larkana, Sargodha and Gujranwala.

Migration status: As in Round 1, the analysis for Round 2 showed that about 78% of all FSWs belonged to the city in which they worked. Brothel-based FSWs were least likely to be natives, with nearly half of brothel-based FSWs having migrated from another city. City-specific analysis showed that FSWs in Karachi, Lahore, Larkana and Peshawar had higher proportions of FSWs who had migrated from smaller cities. In contrast, in smaller cities such as Bannu and Sukkur, nearly all FSWs reported to be natives and virtually no migration was reported. Looking at the migratory pattern of the four provincial capitals, most of the FSWs in Peshawar and Lahore migrated from different cities within the same province. In contrast, FSWs in Karachi mainly migrated from Punjab, and large numbers of Quetta-based FSWs reported to have migrated from different cities of Sindh. Cross-border migration from Afghanistan was also reported by FSWs in Quetta and Peshawar. However, the latter type of migration may describe a general migratory pattern for the population and may not be associated with sex work.

Income: Analysis of sex work income revealed that the median monthly income for FSWs was approximately PKR8,000. The highest income was reported by brothel-based FSWs, median income PKR14,000 per month; home-based FSWs reported the lowest income levels, median income PKR6,000 per month. It was also discovered that income had an inverse relationship with age (i.e. younger FSWs had higher incomes than older FSWs). Further analysis showed that about 44% of all FSWs earned more than PKR10,000 per month. In addition, approximately 45% of FSWs had an income source other than sex work, with the main reported occupations being domestic work, factory labor and beauty parlor work.

The other major source of information regarding socio-demographics is the Survey on Sexually Transmitted Infections and HIV among people at High Risk in Islamabad and Abbottabad, carried out by the London School of Hygiene and Tropical Medicine (LSHTM, 2008). This survey found a slightly higher age (31 years), an average of 2 years education and the vast majority of the women currently married (over 88%) with only 1 to 2% being single and having a mean of three children.

Emmanuel states, without citing a source, that qualitative studies show that FSWs travel from one city to another city if the client demands or wants to take them along. Another reason behind the mobility of FSWs is the aversion of working in the districts or cities of their family homes. Usually, FSWs visit their homes after a few months or on a monthly basis. Their families are often not aware of the exact nature of their work. Movement from rural areas to major cities is the most common phenomenon observed, followed by movement into another province and movement in and out of the country. This latter category is usually handled by larger networks and involves sex workers who can also perform in dancing and singing (Emmanuel, 2009).

6.3 Madams

Madams (also called *naikas*) are the backbone of the sex trade in Pakistan. They control a number of sex workers and may own a brothel or a kothikhana. It is also possible that the madam who owns the venue may hire another woman (“aunty”) to operate the business. Usually, madams have entered the sex trade as sex workers and have gained sufficient influence to operate on their own managing a number of FSWs. Many madams continue to work as sex workers themselves. Madams also network among themselves while remaining in competition. How this really works is, as yet, not clear. In some SDPs, madams are trained as outreach workers or peer educators, but the extent of this is not known. Madams negotiate the fees with the clients, bring FSWs to their clients (if the sex work is not conducted in their own kothikhana or brothel) and receive the money. The operational mechanisms will be further explored during the formative research. Madams are also connected to network operators who may be operating in different parts of the city and district.

6.4 Network operators (NWOs)

The network operators are usually men and sometimes have the same function as madams in which case they are called pimps. They may also connect clients to various madams and/or FSWs of different categories or may be working full-time for only one madam. The NWOs help to provide clients; help with police protection and may also induct girls into the network. They may negotiate fees with the client (on behalf of the madam). This group also includes a variety of persons who are involved in the trade additional to their other work including taxi drivers, rickshaw drivers and shopkeepers. They receive a commission on each client they connect to a madam or a sex worker. The role of NWOs varies in different cities; their role in smaller cities being more significant than in larger centers (NACP, 2007).

6.5 Clients

Clients are solicited by madams (25.9%), pimps and network operators (12.3%), telephone (20.1%), roaming around the street (32.3%) or client referrals (8.6%). The

number of clients per day was between 1.8 and 2.6 with brothel-based sex workers having the most clients (4.3) and little variation in other subtypes (IBBS, 2007). The field assessment carried out by the FHI team found higher number of clients; FSWs reported attending to 8-10 clients per day.

Clients were found to differ per city and per category of sex worker and come from different socio-economic backgrounds. Very little research has been carried out on clients and SDPs have not undertaken any activities regarding clients.

The LSHTM survey in Islamabad and Abbottabad differentiated between 'favorite', 'other' (regular), 'one-off', 'pimp/brothel owner' and 'police' and found that in Rawalpindi, half of the clients are 'favorites' and 'regulars', slightly over a quarter are 'one-off' and the last quarter divided between pimp and police. In Abbottabad, 'favorite' and 'other' clients are slightly over half and vast majority of the other half are one-off clients, pimps and police being a very small percentage. (LSHTM, 2008)

Population Council carried out a study on STIs among urban men in Pakistan and found that:

"Across all cities, 141 men in the bridging population (out of a total of 2,400 respondents) reported sexual intercourse with a female sex worker during the last 12 months. The mean age of the bridging population was 25 years and the median age was 23 years; and 50 percent had a middle-school education. Fewer married men fell into the category of the bridging population – 74 percent were unmarried. The results of the multivariate model, which controlled for possible type of partner and marital status, suggest that the bridging population was more likely to include men below the age of 27 years, with less education (having up to ten years of schooling), and who lived with extended family as opposed to joint or nuclear family situations". (Population Council, 2008)

6.6 Networking between FSWs, madams and network operators

The study on networks of FSWs in Kothikhanas and private homes revealed variations in the networks: the smaller ones are running independently with no links to larger networks. They are confined to three to four adjoining residential areas, drawing clients from the locality. The larger networks operate in many different parts of the city, the province, the country and even internationally – Dubai being a destination of female sex workers from Pakistan.

If FSW are home-based and not working independently, the NWO/madam solicits with the client and then calls the FSW to the KK or the place decided by the client to meet. The madam/NWO, if involved, would never let the FSW receive money directly from the client or meet him in her absence. Home-based FSWs who operate individually seem to have the freedom to solicit with clients and do not have to share the money. The madams/NWOs, on the other hand, claim that they ensure security of the FSWs when they negotiate with the clients, and the FSWs who are doing business on their own have no security and clients can treat them in whatever way they want to including being abusive or not paying them; in which case, the FSWs have few other supports.

Carol Jenkins states in her report that:

“Where pimps or madams maintain control over sex workers’ lives, they are likely to resist any empowerment of sex workers. Specific work must be done to neutralize their resistance, but in no case should the controllers of sex workers be themselves empowered by the intervention” (Jenkins, 2006).

It is not clear to what extent the SDPs have been working with and through the madams, but the saying “we can only reach the sex workers through the madams” is often heard.

6.7 Discussion on findings

Although there is a clear categorization of the different types of sex workers that are found in Pakistan, it is not clear what this means in terms of project implementation. The FHI assessment found that the majority of their FSW respondents were working in a brothel and this was also gleaned from discussions with other NGOs. The results on awareness and practices of FSWs that are discussed in chapter 8, consistently show that brothel-based sex workers have a better score on most topics covered, which confirms the previous focus of interventions on this group. This group is the most easily identified and has a fixed location and is therefore easier for SDPs to work with. Yet, the percentage of sex workers working for a brothel base is only 2.2%.

The other group that is mostly addressed is the sex workers working in KK with madams. They are reached through the madams and that raises the question as to what extent these sex workers have the freedom to apply what they may have learned from the peer educators. The madam is completely in charge of all arrangements and her focus is on making money rather than on improving the health and working conditions of the sex workers. What incentives can be thought of to encourage the madams to address these as well? One possibility may be to change the norm of commercial sex to safe commercial sex and to motivate the madams to promote their sex workers as working under healthy working conditions and being in a good state of health. This needs further research.

None of the SDPs that we visited was able to explain how and if they reach the home-based sex workers or the street-based sex workers who are the largest groups in the industry, and their knowledge of and participation in SDP programs is lowest. One problem that applies to the last category is that they are highly mobile, while the first category is largely hidden. SDPs should devise means to also reach these sex workers.

The sex trade is changing under the influence of mobile phones that make it easier for sex workers to directly deal with their clients. This must be a threat to the madams although they claim that they provide security and safety and therefore will remain important. We need more information on this. We also need more information on how the networks among the madams between the madams and the network operators operate – to what extent do they have a stranglehold on the sex workers and what can sex workers do to escape this hold? How easy is it for sex workers to move from one category to another?

We have seen that the average number of years spent in the trade is 5.2 and that the average age to start is 22. This means that most leave the profession before 30 years of age. What do they do next? The income they earn with the sex trade is far higher than they would (as a non- or low-educated group) in any other job. We found that interest in vocational training is very low (section 9.8) so it is necessary to find out what happens to

these women and what their hopes for their future are, in order to devise strategies that will help them to gain a livelihood after they leave the profession.

Finally, there are the clients who have not yet been addressed in any of the FSW projects. International experience tells us that without involving the clients in an intervention, the likelihood of success is slim. Is it reasonable to expect the sex workers to raise the awareness of clients on safe sex? Can this be expected from the madams or network operators? They all have their own interests. Yet, in sex work interventions elsewhere, this group is being addressed and so this should also be done in Pakistan. How, is one of the examples of the importance of involving sex workers in making strategies – they would know best.

Chapter 7: Legal and policy environment

7.1 Legislation and policies

HIV legislation was drafted in 2006 and finalized in 2007 and is entitled The HIV & AIDS Prevention and Treatment Act, 2007, but approval is still pending. The law is designed to support the government in providing services to marginalized populations (whose members have quasi legal status) and are at high risk of acquiring HIV infection due to their occupation and/or behavioral practices. The Act defines the establishment of National and Provincial AIDS Commissions to oversee the implementation of HIV & AIDS prevention and control programs and monitor the compliance with the Act in both public and private sectors (UNGASS report, 2006).

Another law that does have major implications for the female sex trade is the Women Protection Bill, enacted in 2006. Extramarital sex (both fornication and adultery) was made illegal in Pakistan through the *Hudood* ordinance of 1979. The ordinance was widely criticized for its discrimination against women by allowing room for false incrimination of women for extramarital sex and denying justice for rape victims. In an attempt to amend the heavily criticized law, a Women Protection Bill was enacted on November 15, 2006. The Bill removes the right of police to detain people suspected of having sex outside of marriage, instead requiring a formal accusation in court. However, consensual (hence commercial) sex outside marriage is still a crime under the new law and places the burden of guilt on sex workers rather than on clients (articles 371 A, 371 B, 377). Through the requirement of a formal accusation in court, women have been provided a bit more protection from exploitation especially by police. The law treats children working in the sex trade as adults in the legal system subjecting them to punishment rather than support or protection. Yet, the Round 2 surveillance found that 10.2% of the female sex workers were in the 15-19 age bracket (IBBS, 2007).

A National HIV and AIDS Policy was finalized in 2007 but has yet to be approved by the Ministry of Health. A key aim of the draft policy is to provide and maintain an enabling environment for HIV prevention and care programs and services. The draft HIV policy promotes the integration of HIV services into existing programs, in part to avoid unnecessary and unsustainable HIV-specific services, but it does not refer explicitly to FSWs (LSTHM, 2009).

A National HIV and AIDS Strategic Framework 2007-2012 has been drafted, to update the earlier strategic framework (NSF I) because the country witnessed a surge in HIV

prevalence over the past few years. The National HIV and AIDS Strategic Framework for 2007-12 articulates a vision for Pakistan in line with the recently formulated national policy on HIV and AIDS and elaborates through guiding principles, goal, strategic objectives and priority areas, the direction for future national response against the emerging HIV and AIDS epidemic.

The goal of the national response to HIV and AIDS is to prevent a generalized epidemic in Pakistan by containing the spread of HIV and elimination of stigma and discrimination against those infected and affected. The purpose is to expand and scale up effective national response to the threat of HIV.

NSF is based on four key strategic objectives:

- Scale up program delivery
- Create an enabling environment
- Build the right capacity
- Strengthen the institutional framework

These four strategic objectives are the cross-cutting themes across twelve identified priority areas and are the roadmap to address the emerging HIV epidemic in Pakistan (NACP, 2007).

7.2 Involvement of police and other law enforcement agencies in issues of HIV and female sex work

In spite of the protection accorded by laws, female sex workers are routinely harassed by law enforcing agencies. Police assume various roles in the sex industry from networking sex, running brothels to taking monthly/weekly *bhatta* (protection money) from brothel owners or sex workers. It is extremely difficult to nearly impossible to run a sex business without assistance from police in Pakistan (FHI assessment/experience, NACP 2007). Thus, madams and pimps keep a regular liaison with police and provide benefits in terms of pay-offs or free sex or both. The sex networks which deny providing these benefits to police are at risk of being raided and arrested. Sex workers working without the protection of the network operators or madams have to surrender a significant proportion of their incomes to gain protection from police (FHI assessment/experience; NACP 2007). The laws at this moment are used not to control sex work but to make money for the police and law enforcement agencies.

Nearly all NGOs working in the various SDPs with FSWs that were visited during the assessment reported having conducted various activities e.g., sensitization meetings and seminars with police and other political authorities. However, in the SDPs that FHI visited, this cooperation does not really seem to have been extended beyond information exchange and ensuring that outreach workers and peer educators could do their work without harassment of the police. Also in the third party evaluation report, is mentioned that advocacy sessions were organized by all 4 NGOs evaluated, but one NGO did not even keep a record and the performance of two other NGOs was also deemed unsatisfactory as the sessions lacked focus and there was no indication of any outcome (SoSec, 2007). There is at the moment no information regarding guidelines given to police officers working in areas where the sex trade takes place, nor any evidence of training of police on issues of an enabling environment and requirements of STI/HIV preventive services.

7.3 Discussion

The sex trade is illegal in Pakistan and the enabling environment that is mentioned as a strategic objective of the NSF II has to be created within the existing legislation. The NSF mentions 'the development of a wide range of rules and regulations to which institutions and practitioners should adhere'. The question that needs to be addressed is what this should be in the context of female sex workers: what rules and regulations can be developed that facilitate prevention of HIV transmission in the female sex trade. What institutions should adhere? Of course, police act as the regulators of the trade and the people responsible to pursue the law. The whole trade is conditioned by the operating policies and action of the police. What are these operating policies?

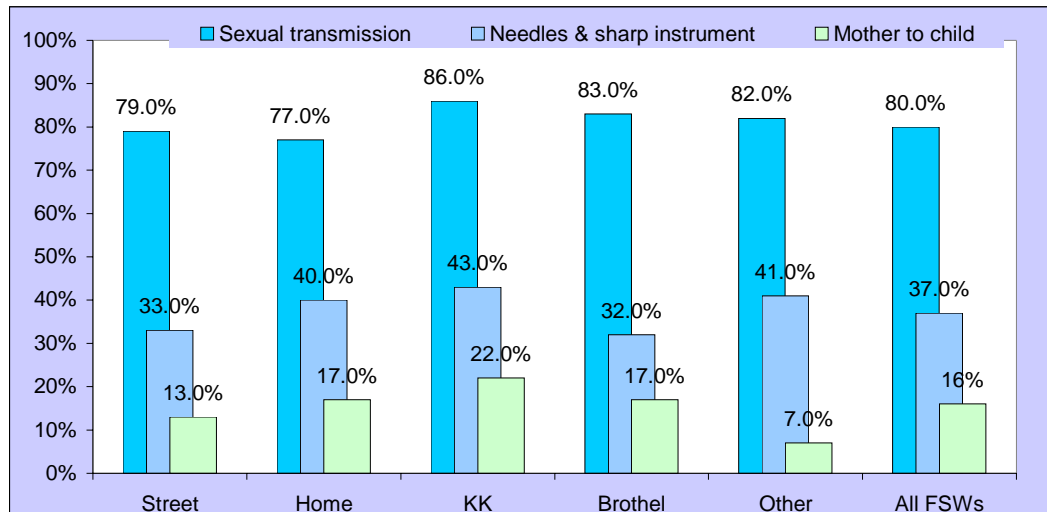
We have found no examples of interventions that successfully address the involvement of the police other than ensuring that the project can continue its activities. We have no insight in the guidelines that exist at police station level for the operations in the sex trade. We do not know what is needed to get the police to become a partner that enables the sex trade to function in a way that promotes the rights of FSW, protects them and promotes safe sex behaviors. What we do know is that police are very much involved in the sex trade and benefit from it. So what could be incentives to the police to change their attitudes? What could be incentives for local politicians to ensure sanctions against police officers who profit from the trade? International experience tells us that whatever approach is explored, it will need organization and empowerment of the sex workers themselves to have more control over their working environment. They need to be supported by NGOs in doing this and at the same time, NGOs should be advocating for social change, lobbying for change and challenging human rights violations in the sex trade.

Chapter 8: Knowledge, attitude and practice of female sex workers and sexual networking patterns

8.1 Awareness and risk perception:

The major sources of information on this topic are again the IBBS and the LSTHM study. The IBBS found that 68.7% of FSWs have heard about HIV. The highest level of awareness was reported by brothel-based FSWs at 82.3% while street-based FSWs were least aware of HIV (62.9%).

Figure 4: Knowledge of the routes of HIV spread among FSWs in Pakistan



Source: IBBS, 2007

Of those FSWs who were aware of HIV, almost 60% knew that a healthy looking person can have HIV. Knowledge of sexual intercourse as a mode of transmission of HIV was present among 80% of these FSWs, but only 64% knew that condom use is an effective method of prevention and only 37% knew that HIV can be transmitted by a sharp instrument or needle (syringes).

However, even with these fairly high knowledge levels, the perception of self-risk for HIV was low and only 38% of the FSWs interviewed believed that they are at a risk of acquiring HIV (IBBS, 2007). The FHI assessment found a similar attitude among sex workers. One FSW who was interviewed stated: *“Nothing is safe under the sun, as is our profession. All that are born will die one day, so will we. Then, why should we be afraid?”*

The knowledge about HIV and AIDS found in the LSTHM survey was lower, with only 29% of respondents having ever heard about HIV and AIDS in Rawalpindi and 62% in Abbottabad.

With regard to STIs, the IBBS found an awareness level of 67% and, of these, 24% self reported an STI in the past 6 months, with 24% receiving treatment. LSTHM found that a large majority of women in Rawalpindi (and a smaller majority in Abbottabad) had suffered with symptoms of possible STIs or other reproductive tract infections (RTIs) in the past year. For most women these symptoms had been within the past month. Common symptoms included reports of genital discharge and genital ulcers. The majority of women who had experienced such symptoms had then sought care – among a wide variety of health care providers, mainly in the private sector. Only a small minority of women report seeking health care (for symptoms of possible STIs/RTIs) within government or public sector systems. (LSTHM, 2008)

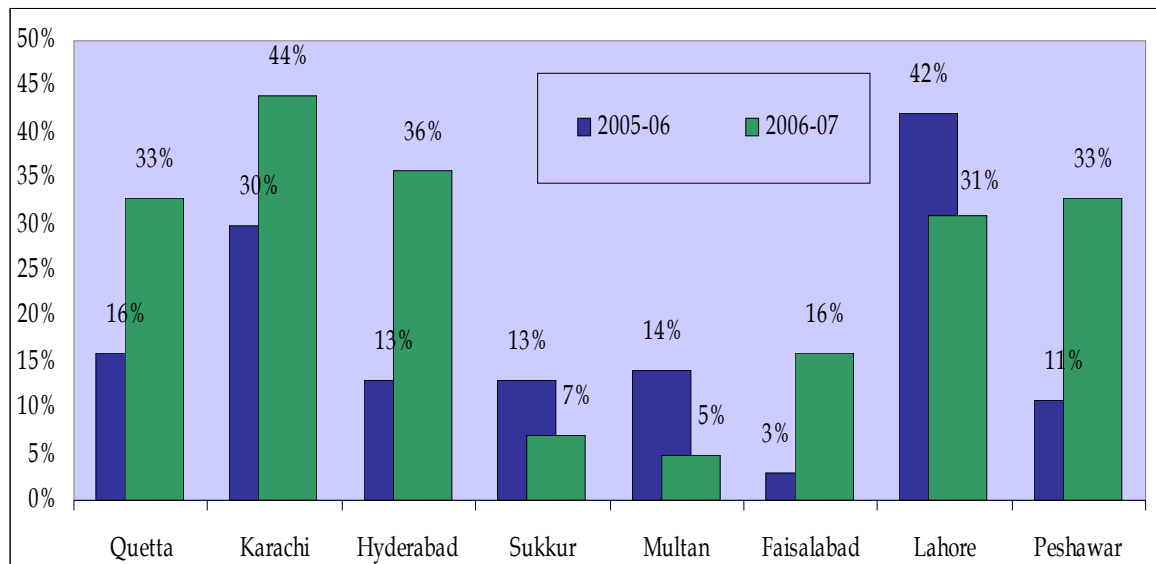
In the FHI assessment, no questions were asked about awareness on HIV, because all FSWs interviewed were part of the core target group having been involved in the SDP intervention. Four FSWs from Lahore and three from Faisalabad informed that due to

excessive sexual activity, they were facing vaginal swelling, itching, ulceration and warts. Nine (out of a total of 41) FSWs told that STIs caused painful urination, white vaginal discharge, weakness, backache and hepatitis-B. One FSW from Rawalpindi informed that STIs caused weakness in the womb. On the whole, FSWs knew very little about STIs and most were unable to identify any sign or symptoms of STI and its severe consequences in the case of no treatment. However, FSWs from Districts Larkana, Multan, Okara and Rawalpindi said “*We can guess in advance if some client has a sexual disease and we do not have sex with them*”. The FSWs who were more knowledgeable about STIs were peer educators and outreach workers who had been given information on this during their training or during informal discussions with NGO staff.

8.2 Condom use

The IBBS found condom use during sexual activity with clients to be low. Only 22.6% of FSWs reported that they ‘always used a condom with their clients’ in the past month. Consistent condom use with clients in the past month was reported highest for brothel-based FSWs at 42%, and lowest for home-based and street-based FSWs. Overall, only 18% of FSWs were carrying a condom with them at the time of interview. Consistent condom use showed a slight improvement between Rounds 1 and 2, particularly in cities where SDPs are functional (i.e., Karachi, Quetta, Hyderabad and Peshawar), with an unexplained reduction in Lahore.

Figure 5: Consistent condom use among FSWs by selected cities over time



Source: IBBS 2007

No differences in consistent condom use were observed between different age groups or marital status. But there is a strong association between consistent condom use and education level, it being lowest (19%) among illiterate women, 28% among intermediate level and highest (48%) among those educated up to graduate level. (IBBS, 2007)

LSTHM found that condom use in the last vaginal intercourse with a client of 32% (Rawalpindi) and 65% (Abbottabad). In addition, 30% in Rawalpindi and 23% in

Abbottabad reported that they never use condoms during vaginal sex, while 62% and 40% respectively said that clients only sometimes use condoms during vaginal sex.

When looked at type of sex and condom use, the IBBS found that condom use for vaginal sex was 45%, while this was only 8% during anal sex and 32% during oral sex at the last reported sexual intercourse with a paid client. Brothel based sex workers had the highest reported condom use at 67% for vaginal sex, but just over 2% reported condom use for anal sex with their most recent client. Condom use during anal sex, as compared to vaginal sex, remained unchanged and significantly low among all sub-types of FSWs between the first and the second round (IBBS, 2007)

The LSTHM had quite different results and found that although clients were paying more for vaginal sex (when compared with either anal or oral sex); clients in Rawalpindi were less likely to use condoms during vaginal sex than during oral or anal sex. During the last anal sex intercourse condoms were used in 61.3% and 60.5% respectively for Rawalpindi and Abbottabad. For oral sex this was 77.9% and 14.6% respectively (LSTHM, 2008).

The FHI assessment found that the NGOs claimed condom use of above 80% by the sex workers (unclear if this is consistent condom use or non regular condom use). They had come to this conclusion by calculating condom distribution made by the NGO, by Greenstar Social Marketing and other condom sellers (medical stores and pan shops). They claimed to have raised the awareness for condom use with FSWs to such an extent that they purchased condoms themselves to cover their need. None of the NGOs had ever done any research on this.

Almost all FSWs interviewed during the FHI assessment were aware of the use of condoms as they were trained by Outreach Workers and Peer Educators. However, FSWs from Larkana told that they had only been given condoms and no training on how to use these properly. Almost half of the FSWs said they had 2-3 packets of condoms always available with them. Two FSWs from Faisalabad informed that they always ensured use of condom by their clients to protect themselves from STIs. One FSW of Okara said, *"I use condom with 8 out of 10 clients."* One FSW from Multan said *"I only use condom to prevent pregnancy"*.

Water-based lubricant is not being promoted by any of the NGOs carrying out the SDPs. It is therefore unknown even to exist among the female sex workers.

8.3 Reasons for non-condom use

None of the surveys has looked in depth at the reasons why sex workers do not use condoms. The explanation that is most frequently heard is that clients do not want to use condoms. Other explanations given in discussions with FSWs, madams and NGO staff are that clients pay more to have sex without a condom; sex workers who insist on condom use run the risk of being beaten by their clients; sex workers do not have the skills to negotiate on condom use; non-condom use shows the trust and closeness of the FSW in her client; non availability of a condom at the moment of intercourse.

It is also unclear to what extent the madams and network operators promote and insist on condom use. Because they are the ones who negotiate with the client, it is a very important aspect of intervention strategies that aim to promote condom use.

The research of Population Council on urban men, showed that of the men who had sex with a FSW, 67% never used a condom, 16% sometimes and 10% used a condom consistently. Main reasons for not using a condom were: Didn't think of it (36.5%); it was not necessary (15.8%); don't like them (20.7%); reduces pleasure (9.9%); and not available (9.4%) (Population Council, 2008). The answer 'not necessary' points to the concept of condoms as a contraceptive rather than as prevention for STIs including HIV.

8.4 Type of sex and type of partner

LSHTM has looked at different types of sex (vaginal, oral and anal). Asked for last anal sex with a client today or yesterday, 36% in Rawalpindi and 24% in Abbottabad had anal sex. The same question related to oral sex gave 10% in Rawalpindi and 23% in Abbottabad. The IBBS only asked about condom use during oral and anal sex, not about frequency.

The FHI assessment did ask the question, and were told that most clients demanded anal or oral sex. However, this type of sex is considered shameful and the sex workers were reluctant to answer the question. An FSW from Larkana said *"We do not perform this type of sex, but some Pushto speaking women, do"*. Another FSW (from Multan) said that they were compelled to do oral sex because clients like it more and two sex workers from Faisalabad also related that they performed anal sex.

The study of Population Council found that it is quite common for men to engage in extra-marital sex and that one of the reasons is sexual inhibition with their spouses to do not do anything other than 'conventional' sex. With sex workers, there is no inhibition and it was felt 'you could do anything' (Population Council, 2008).

IBBS found that 61% of the female sex workers were married and that 43% had at least one non-commercial partner (we assume that this is not the husband). The LSTHM survey found that 87% of the sex workers were married and that the women reported a wide variety of non-paying partners – from both within their professional network as well as their neighborhood and local environments. The reported use of condoms at last sex with a non-paying partner was relatively higher than with other types of partner (husband and paying clients).

8.5 Discussion

The awareness of the existence of HIV seemed fairly high at almost 70%, despite the very low prevalence in the country and among female sex workers. However, when we looked at the details of what people knew, we found that although most knew that HIV is transmitted through sex, many fewer people knew that condoms can prevent this transmission. Also much fewer people knew about transmission through needles and syringes – which knowing about the overlap between the IDU and the sex worker communities is very alarming indeed. The lack of in depth understanding is also shown by the very low risk perception that the women have. This calls for more detailed education and explanation by peer educators or outreach workers.

Most women know what STIs are because they have experienced them themselves, and they can describe symptoms in a general manner. But they know very little about different types of STIs, symptoms and complications, and many resort to home medication for treatment. Again, this points to the need for more detailed education on this.

Condom use is an issue all over the world and also in Pakistan. It is low considering the risks of the trade – but the surveys show that having been exposed to FSW interventions does make a difference and this is very promising. The most interesting finding is that some studies found that condom use with clients is actually lower than condom use with non-paying partners. This really needs to be looked at in more detail because if this is true, this means that either the sex workers want to protect their regular partners and so they know that they can transmit a disease to them or, the regular partners are aware of such diseases and the higher chance that the women may carry these and want to protect themselves. It could even be that these men having also other sexual contacts may want to protect the sex workers, although that seems unlikely.

Anyway, one of the reasons for not using condoms that is most mentioned is inability of the sex workers to negotiate condom use with their clients. This calls for capacity building in negotiation skills with the sex workers, but also calls for interventions with the clients. As the madams and network operators are in many cases the ones who negotiate with the clients, they should also be addressed. It may be useful to promote condoms not only for protection for STIs, but also as a contraceptive – unwanted pregnancies being a regular phenomenon. This should be done alongside the promotion of other contraceptive techniques as an additional family planning method.

Chapter 9: HIV prevention services

The service packages for the delivery of preventive services for female sex workers in Pakistan, all follow the same approach, independent of the donor. The service package includes the following components:

- Behavior change communication activities
- Condom promotion and distribution
- Voluntary counseling and HIV testing
- Primary health care and STI services
- Development of an enabling environment
- Empowerment activities for female sex workers

Nearly all projects under implementation function through the establishment of a Drop-in-Centre where primary health care services are offered as well as STI services – this is the core of all project activities. Peer educators provide outreach by contacting FSWs at their homes and workplaces (brothels/kothikhanas) and raising awareness regarding HIV and STIs, while providing condoms. The SDPs also provide referrals mechanism for target group to access VCT services and of HIV-positive women for care and support. While overall coverage of SDPs for female sex workers is not very high, comparisons between SDP cities and non-SDP cities show that nearly all indicators are better for SDP cities, although the differences are minor.

Table 3: Knowledge, attitude and practice of female sex workers in cities with and without SDPs.

FSW	City without an SDP	City with SDP	Total	p
Commercial clients last month	25	18	24	<0.001
Used condom during the last sex with a client	43%	51%	46%	<0.001
Condom use with last anal sex with a client	37%	43%	39%	<0.001
Number of non-paying partners during the past month	0.80	0.82	0.81	0.665
Condom use with last vaginal sex with a non-paying partner	30%	33%	31%	0.007
Condom use with last anal sex with a non-paying partner	30%	42%	33%	0.018
Currently carrying a condom	15%	24%	18%	<0.001
Bought condom from a shop	23%	28%	24%	<0.001
Bought condom from a pharmacy	15%	28%	20%	<0.001
Obtained condoms from NGO	4%	6%	5%	0.004
Tested for HIV	4%	12%	7%	<0.001
Knowledge of HIV	63%	82%	69%	<0.001
Knowledge of STIs	64%	79%	70%	<0.001
Suffered from any STI	23%	28%	25%	<0.001
Sought treatment	80%	86%	82%	0.003
Know of NGO	12%	11%	11%	0.244
Use NGO (among those who were aware of such a program)	5%	39%	16%	<0.001

Source: Khan (2008)

In the next sections details of the different components are discussed in more detail.

9.1 Coverage and registration

The table below gives the number of female sex workers that are reached by the SDPs. The category 'total numbers of sex workers' is based on the IBBS and the category 'FSW registered' is the number of sex workers that NGOs have registered.

Table 4: Number of FSWs registered by various SDPs in different cities of Pakistan

City	Year	FSWs registered	Total No of FSWs (IBBS estimate)	% Registered
Lahore	2004-08	8,000	25,000	32%
Sargodha	2007-09	1,500	7,000	21%
Multan	2007-10	800	7,000	11%

Okara	2006-08	238	2,000	12%
Karachi	2004-08	7,000	25,000	28%
Faisalabad	2008-09	200	10,000	2%
Rawalpindi	2005-08	2,000	5,000	40%
Larkana	2005-08	670	2,000	34%
Peshawar	2006-08	700	2,000	35%
Quetta	2007-08	500	3,000	17%

Source: UNFPA, 2009

Khan notes that estimates of FSW in a city by IBBS vary widely from registrations by NGOs – 42% in his calculation and, according to him:

“Large differences between registration figures and estimates cause a problem with the metric against which NGO performance may be judged. It also poses a problem for NGOs. It has been observed that if the NGOs register more clients than are estimated for the city, they seldom end up serving that many clients and it appears that they are under-serving their clientele. If they register fewer clients than are estimated by IBBS then they look like they are providing partial coverage. Either scenario makes the NGOs look inefficient. It is recommended that the AIDS Control Programs, NGOs and HASP address the issue of how to interpret these variations” (Khan, 2008).

Coverage is a major problem for NGOs working with FSWs – Khan calculates an even lower coverage of 9% of all estimated FSWs in Multan, Hyderabad and Lahore (Khan, 2008). All rely heavily on Drop-in Centers in which they provide Primary Health Care and STI services to reach FSWs and seem to reach the maximum achievable capacity for that modality (unless they decide to increase the number of DICs in the cities they work in). Further coverage will depend on the ability to expand through peer education and outreach (Khan, 2008).

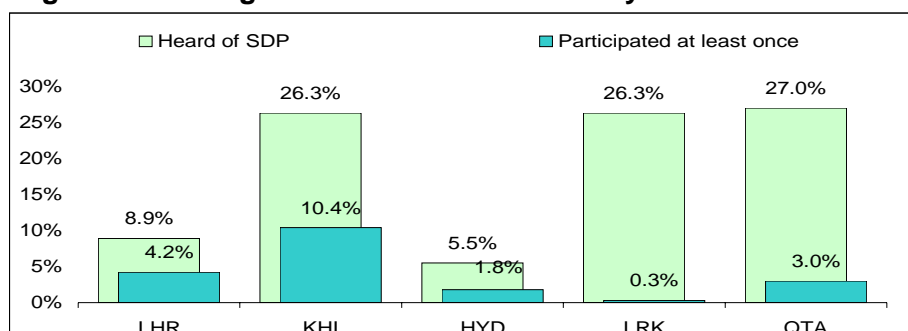
There are no clear guidelines on when, how and why female sex workers need to be registered. Because registration is seen as a performance indicator, not only of the NGO, but also of the outreach workers, there is a lot of emphasis on the registration. The numerous surveys use the number of registered FSWs as an indicator that they are being reached with services. At the same time, the concept of the registration, other than for health care services, is not clear to the FSWs or even the NGO staff. World Bank also noted this focus on numbers: “Quarterly milestones of numbers of clients registered create incentives for rapid and superficial expansion rather than on more intensive interaction and quality of services that is necessary for behavior change” (World Bank, 2006).

The FHI assessment also found that one third of the outreach workers were given targets for registration by the NGOs. They did not register the FSWs by name but gave them codes to ensure confidentiality. FSW registration seemed to be a critical issue at all SDPs. Each member of the NGO team described it in his/her own way, and there was a lot of confusion among team members on this issue. One Program Manager reported that their NGO never pressured FSWs for registration, but registration was only on a voluntary basis. Almost all NGOs had over-achieved targets given by the donors for FSWs registration except one. The representatives of three NGOs informed that FSWs

were issued registration cards with names instead of codes. FSWs used to change their names after the characters of Star Plus dramas thus creating a problem for the clinics.

To assess the uptake of services of the SDP, the IBBS asked female sex workers about their knowledge and utilization of the services offered by the NGOs in their SDP. The result for the five cities shows that knowledge and uptake is fairly low and probably contained to one specific area where the SDP is operational. Emmanuel found that better coverage was reported by brothel-based sex workers, which is due to the fact that most drop-in-centers/clinics of the SDPs are located in the brothel area and activities are focused on the brothels (Emmanuel, 2009). The fact that the percentage of FSWs that actually work in brothels is only 2.2% says something about the reach of the SDPs.

Fig. 5. Knowledge and utilization of SDPs by FSWs in Pakistan



Source: IBBS, 2007

9.2 Behavior change communication

In all SDPs, behavior change communication (BCC) is carried out by peer educators and outreach workers, who are trained by the NGO to do this. The review by SoSec looked at BCC services in the SDPs in Lahore, Karachi, Hyderabad and Multan. They were all said to use printed materials and interactive IPC (not defined) while one each used also audio cassettes and video cassettes. Topics covered in the trainings were condom use, sexual health, VCT, prompt treatment of STIs (done by all four) and substance use by only one NGO. These data were subsequently triangulated with discussions with the peer educators themselves (n=15). The most common services that peer educators, according to this review, were providing were referral of STI patients and supply of condoms, while the most neglected area was the supply of health education materials to FSWs on safer sex/HIV and STIs. (SoSec, 2006).

Table 5: Topics taught to Peer Educators (n=15)

Number	Name of topic	Response	%
1	Ways to convince for use of condom	15	100
2	Correct use and disposal of condom	15	100
3	Interpersonal communication techniques	15	100
4	Common presenting complaints of STIs	12	80
5	Mode of STIs and HIV spread	15	100
6	Protection from HIV and STIs	14	93
7	Maintenance of record/logbook	5	33

Source: SoSec 2006

The FHI assessment found that, out of the nine peer educators, (see Table 2) only one was able to describe her role realistically: “A Peer Educator works within a network of friends or colleagues (mainly within her own social network), who, by using her knowledge, role-model attitudes and peer influence, raises awareness about some specific issue, helps prevent risks associated with that particular issue and ensures that members of her network(s) seek care and support and access to services”. The rest were unaware of the meaning of the concept of peer educator. The Peer Educators also told that they got in-house training but discussion with them on their work showed that they had very scanty, vague and confused knowledge of STIs, and were not equipped with communication skills for their assignment. The Peer Educators from Faisalabad, Lahore and Rawalpindi informed that they were given in-house training, among other topics on referral procedures for the treatment of STIs (but not for VCT). The peer educators went from door-to-door in kothikhanas, and brothels to transfer knowledge and skills to FSWs on STIs and the use of condoms.

The outreach workers – being different from peer educators – described their role as:

- To approach FSWs through Peer Educators
- Visit home-based and brothel-based FSWs and provide information on HIV, STIs, primary health care and use of condoms.
- Register FSWs in a confidential manner and issue codes for blood testing.
- Visit KK-based FSWs identified by pimps and cartels (Radriwalas).
- Maintain record keeping during field visit.

There is an overlap with the tasks of the peer educators and also the NGOs could not really explain the difference, apart from the fact that outreach workers are always paid and peer educators are mostly volunteers and the outreach workers are given targets for registration. They may or may not come from the target group.

The number of peer educators and outreach workers is low compared to the number of FSW they are supposed to reach (it may be inferred that these are at least the registered FSW. There are few numbers available of the ratio peer educator – FSW, and SoSec found that the ratio was variable and noted a ration of 1:180 in Multan, a ratio of 1:94 in Hyderabad, 1:408 in Lahore and 1:500 in Karachi. The peer educators interviewed in this survey also complained about their heavy workload (SoSec, 2008). Where the ratio is discussed in available reports, there seems to be a consensus that for effective outreach there should be no more than 50 FSW per worker, assuming that each FSW should be approached twice a month.

Although some of the NGOs visited in the FHI assessment, claimed to have logbook on peer educators and outreach workers, we found that Peer Educators/Outreach Workers were asking or telling a defined set of questions to sex workers at every visit. No attempts were made to measure condom use other than self-reported condom use.

9.3 Training of peer educators and outreach workers:

The table below shows the type of training received in a more or less organized manner by peer educators and outreach workers from the target group. It gives a different picture than the findings of SoSec above and shows that the NGOs do not really have a structured approach to training. There also does not seem to be a certification that peer educators and outreach workers have to have before they can start their work. It is quite

startling that the training which has been received by most peer educators and outreach workers is the training on HIV, while none has been trained on STI symptoms and management. Of course in a HIV prevention project, HIV education is important, but the reality at this moment in Pakistan is that STIs are much more common and therefore training on this more relevant and needed.

Table 6. Number and types of training received by FSW

Paid/non-paid workers	Total	HIV Know.	STIs	Counseling	Communication	ORW tasks	PE tasks	Record Keeping	Research
Peer Educator (FSW)	9	3	0	0	0	0	2	1	0
Outreach Worker (FSW)	3	2	0	0	1	1	0	0	0
Total	12	5	0	0	0	1	2	1	0

Source: FHI assessment

In addition to these organized trainings, peer educators mentioned that they had been having informal discussions with SDP staff on referral procedures for the treatment of STIs, awareness on STIs and condom use. One problem with the training is the turnover of peer educators and outreach workers. This means that the NGOs will have to plan for repeat and refresher trainings, which as far as the FHI assessment team has found, is not taking place.

When asked about their training needs, almost all peer educators and outreach workers wanted to be trained in most of the topics, with the exception of research where only the outreach workers were interested and only 5 out of 9 peer educators were interested to be trained in counseling. Peer educators were also not interested in being trained on outreach tasks.

9.4 Condom promotion and distribution

All SDPs include condom promotion and distribution in their service package, distribution through peer educators and through the NGO clinic is done free of charge. As with the numbers of registration, the numbers of condoms distributed is a performance indicator and therefore a focus of the program. The numbers are impressive, but data on whether these condoms are actually used are not available. Few data are available on sources of condoms other than the NGO, but even the NGOs admit that their distribution is below actual need of the FSWs. In fact, the NGOs that were covered in the FHI assessment said that their condom promotion had been so effective that FSWs were now buying their own condoms if they were running out of supply given by the peer educators. The SoSec study found that average condom distribution per client per year has a ratio of 1:24 (Lahore), 1:16 (Multan), 1:6 (Hyderabad) and 1:31 (Karachi) (SoSec, 2006).

Khan made a calculation of condom needs, distribution and coverage based on the IBBS estimates of numbers of FSWs and the NGO registration numbers.

Table 7: Condom need, distribution and coverage

FSW	HASP projected FSWs	Actual client registrations by NGOs	Percent registered	Condoms per quarter	needed	Condoms supplied last quarter	Coverage
Punjab	82,445	10,390	13%	7,852,860		72,830	1%
Sind	29,980	12,861	43%	2,124,862		134,850	6%
NWFP	6,568	120	2%	394,060		1,500	<1%
Balochistan	3,502	0	0%	196,983		0	0%
Nationwide	122,495	23,371	19%	10,568,765		209,180	2%

Source: Khan 2008

This shows that coverage is far below the actual need, while it could be expected that demand for condoms will increase with coverage of SDPs. NGOs have to be much more active in condom promotion and distribution, while at the same time developing a system where they can measure the actual use of these condoms. Khan suggested that:

“In order to understand condom coverage better, it will be useful to quantify all sources of condoms including supply by the NGO, those bought or procured by the sex workers or their clients. Furthermore, other methods of measuring condom use besides HASP (i.e. other independent research studies, 3rd party evaluations etc) may also be valuable”. (Khan, 2008).

9.5 Voluntary Counselling and HIV Testing

There is a large number of HIV testing and counseling sites across Pakistan although precise information on practice is difficult to obtain; services tend to be very fragmented and there does not appear to be adequate monitoring to ensure the quality of these services. It is noteworthy that funding had ceased for 16 national stand-alone VCT sites in June, 2008. These may be transitioned to being supported by the Provincial AIDS Control Programs and integrated into hospital settings but little information is available as yet on when, where and how these services will be provided. These 16 VCT sites are currently being evaluated as part of the close out on the Global Fund grant but the opinion from many was that the planning of these sites focused on general population was poor and access was low. HIV testing and counseling is currently being provided at 11 HIV treatment sites located in hospitals in all four provinces (FHI internal report, 2008).

Most of the NGOs involved in the SDP for female sex workers, provide their own counseling, but do not do their own testing, but outsource this to other entities. The FHI assessment found that two SDPs namely OSD and MWT have an established VCT component as well as trained counselors. PLYC and PAK Plus draw samples and refer them for HIV test at linked hospitals; PLYC not providing counseling and PAK Plus doing the counseling. Contech International (Lahore) informed that initially their project had a provision of all paramedical staff including counselors, but no built-in VCT component. They were asked by the PACP to establish linkages with VCT centers established under the GFATM grant. However, these VCT centers were established only after one and a half years of the FSW project and when they sent clients for pre-test, they were not given the service. They subsequently referred the clients to the Lahore government hospital. The program manager at Okara said that they started referring FSWs for HIV

testing but most of FSWs did not want to go for testing because the center was located too far away. In brief, four of out of six SDPs did not perform any HIV testing at their center but referred FSWs for HIV testing at different hospitals.

Emmanuel states that:

“While there are currently a limited number of functional VCT centers, political leadership and commitment have shifted significantly in favor of establishing VCT centers and providing access to ART. Nearly all SDPs developed entry points to facilitate the link to HIV testing and counseling which function as a gateway to treatment services, which have been established by the government of Pakistan through Global Fund. Since the number of identified AIDS patients is not very high, the numbers of these services are limited, and in addition the access to these services was reported as a problem. Moreover, all these VCT and Treatment centers are not designated for FSWs or any other HRG, issues of stigma and discrimination have been major hindrances in utilization of these services” (Emmanuel, 2009)

9.6 STI and PHC services

All NGOs implementing SDP for female sex workers have established a clinic that offers primary health care services and STI services as well as condom distribution. Not many surveys and assessments have looked at the actual implementation of these services, so there are not many data available for this assessment. However, it is generally reported that the clinics are underutilized by the target group and that ‘ while the health center may have had a useful role in the initial phase as an entry point, it is necessary to reconsider this approach in view of its limited reach on sex workers that comprise barely 7-10% of the patients (World Bank, 2006).

SoSec found that the clinic staff in the four SDPs reviewed were using standard protocols for STI management, but their field researchers could not verify this in all clinics. Two NGOs had established a referral chain with public sector tertiary hospitals. The two clinics in Karachi and Hyderabad were regularly recording syndromic diagnosis of STIs on the outpatient register, but did not record follow-up advice. The clinics in Multan and Lahore sometimes recorded the patient by syndromic diagnosis and sometimes by diagnosis by disease; they did record follow-up advice. Actual numbers of FSWs diagnosed and treated during three months were few, i.e. 24 in Hyderabad, 31 in Multan, 45 in Karachi and 135 in Lahore. Analysis of statistics of STI patients, analysis of data and its use for the procurement of STI drugs was uncommon among all clinics. Only Karachi and Hyderabad were maintaining a record of referral to the clinic by the peer educators. All four clinics had the essential supplies for managing STI patients available. Exit interviews with FSW patients at the four clinics revealed that the FSW felt they were treated with respect, waiting time was less than 30 minutes and each patient confirmed receiving the prescribed medicines and related instructions, including to come back if the symptoms were not cured. Partner treatment was less emphasized, but all patients had been briefed about the spread of STIs and how to protect against transmission (SoSec, 2006).

The Situation and Response Analysis by Tama found that the service providers in the NGO clinics had not received STI training and thus had inadequate knowledge of STI symptoms and complications and are thus not properly skilled in the management of

STIs. NGOs are not coordinating with the private sector health providers in their project areas to institutionalize the syndromic management of STIs, including condom use. They also found that NGOs have not formalized arrangements with peer educators for the referral of suspected STI cases to health facilities other than the clinics run by the NGOs themselves. This gap is due to the fact that none of the NGOs has mapped health facilities in their project areas for training physicians in the syndromic management of STIs and then continued to liaise with them (Tama, 2007).

The FHI assessment team found that all SDP providers were delivering syndromic management of STIs according to national guidelines, although none of their doctors received any specific training on syndromic management of STIs. One NGO said that they were two to three patients a day for STI services, suffering mostly from lower abdominal pain; another had five to nine patients a day for STI services. The clinics were open to the entire neighborhood for PHC services and this constituted the bulk of the services rendered, which really is a serious waste of funds for HIV prevention. As of now, the clinic is used as the ‘face’ of the project, while this face should rather be engagement with different types of sex workers and the implementation of activities that are their priority.

There is no evidence that any of the SDPs has been linking with local health providers that are more frequently being used by FSWs – such as General Practitioners, private clinics, Lady Health Workers or hakims. The FHI assessment found that the majority of the FSWs felt comfortable with GPs, one said *“I feel comfortable in going to GP rather than visiting SDP clinic. At GP clinic, nobody knows who we are and we are not stared at, besides we feel that they are more experienced than SDP doctors”*. In Larkana, the sex workers said, *“We have a GP who knows that we are FSWs but he is always nice to us, examines us and gives us good medicine.”*

It was also found that more than a third of the FSWs interviewed were using home remedies to treat STIs such as glycerin, wax, molasses (ghur) and black salt. Half of the FSWs were using pain killers such as Ponstan®. One FSW from Faisalabad used Dettol® mixed with salt and pipe bowl water (*hookah ka paani*) as a remedy. Another one mentioned that she took medicine from a doctor who provided this without medical check-up. None of the sex workers felt comfortable consulting male doctors for STIs.

In line with all mentioned above, SoSec attributed the low uptake of STI services to:

- Inadequate training and skills development of service providers and peer educators
- Lack of referrals by peer educators to the clinics
- Lack of confidence of FSW patients in the NGO service providers
- Inappropriate working times of the clinics
- Lack of proper monitoring by the project management

(SoSec, 2006)

9.7 Development of an enabling environment

This issue has been covered in chapter 5.

9.8 Empowerment of sex workers

Although empowerment of FSWs is one of the components of the SDP, and all functional SDPs had included various empowerment activities in their strategic plan, none of those plans was executed and there was a large gap in that specific area of work. Actually, the FHI assessment found that the NGOs had very limited understanding of the concept of empowerment, while their attitude towards sex workers was one of bias as the staff of the NGOs had never before worked with female sex workers. Strong stigma and discrimination to FSWs by those who worked for FSWs interventions was observed. For example, at three SDPs offices beverages were served to the visiting team as well as to SDP/NGO team members, but not to any of the FSWs who were participating in the meeting. Interestingly, it seemed that they did not mind it all, meaning they were used to this type of treatment. The idea that staff have to understand the perspective of sex workers and has to learn about the nature of their lives was non-existent. This translates into a total absence of involvement of FSWs in the planning and implementation of the project activities. At all field sites, discussions with FSWs revealed no or very poor involvement of FSWs in the program. They were considered recipients and beneficiaries rather than key agents of change and owners of the interventions. None of them had ever participated in any meeting organized by the Project or had been invited to any workshop or conference. Options for empowering FSWs to act as peer pressure group to change and monitor their own behaviors had not been explored, affecting the projects' future sustainability.

Many of the NGOs figured that by enlisting FSWs as peer educators and by hiring FSW as outreach workers, they had done as much empowerment as is possible. Only one NGO out of six claimed to have helped to establish a CBO of FSWs, but the FHI team was unable to meet any FSW who was a member of that CBO. The rest of the NGOs reported that they neither knew the importance and the need for FSWs–CBOs or self-help group formation, nor understood the benefits of such an initiative. They admitted that they had never ever tried it as it was not mentioned in the contract document or ToR of the project. This misunderstanding of the concept of empowerment also applies to the provincial and national level, where FSWs are not represented in dialogues and conferences, except for one national meeting held for female sex workers (FHI assessment).

Sex workers who were asked in the FHI assessment what skills building activities they would be interested in, in case they would want to leave the profession at some point in time, reported that the only reason for wanting to leave was stigma and discrimination. But they also said that they would be unlikely to change profession because of lack of skills to adopt an alternative source of livelihood and they were not interested in learning stitching, beautification or candle making.

These findings were similar to the SoSec findings that state that “empowerment activities are not well organized by the contracted NGOs (except modest efforts by the NGO in Karachi), in areas of formation of self-help groups, referral systems for legal aid, literacy classes for children of FSWs and learning clothes stitching” (SoSec, 2006). The attempts for the formation of self-help groups were rudimentary at best.

As mentioned in section 6.6, Carol Jenkins advised that work must be done to neutralize the resistance of madams to empowerment of sex workers and that the madams should not be empowered by the intervention. She also stated that:

“At present, none of the sex worker interventions provide any means by which sex workers can bond. Without a safe space for them to meet, the highly competitive nature of sex work will keep them divided and more likely to have sex without condoms. Normative change cannot take place without some sense of solidarity or community. This process must be instilled in each project. Funds will be needed to establish safe spaces, perhaps beauty parlors, or women’s health clubs (on the outside), that serve as gathering spots for groups of sex workers. The role of outreach workers is to bring them in but attractive activities must be present. Workshops that allow them to design their own IEC materials, make films, dance and sing, as well as other educational and entertaining events can be developed”. (Jenkins, 2006).

While the SDPs call their clinics part of drop-in centers, they may actually not be viewed as that by the FSWs. However, there are many examples of well functioning drop-in centers for IDU target groups, and also some for FSWs, like the one in Okara as part of the project of Pakistan AIDS Prevention Society, where activities are being organized by the sex workers themselves with support of the project.

9.9 Discussion

The issue of numbers of sex workers reported in the surveillance and number of sex workers registered by the SDPs is a matter of concern. Of course there are differences, if only because the NGOs are generally not working city-wide but in selected areas with concentration of female sex workers, while the IBBS is supposed to carry out a city-wide estimation. The mapping procedures by the IBBS are very clear, but this cannot be said for all SDPs. While it is recommended that PACP, SDPs and IBBS discuss this issue and find if variations can be explained or not, it is also recommended that for the new SDPs, the mapping process be done by sex workers themselves and by network operators. For the sex workers, this could mean the start of an involvement that treats them as partners rather than as beneficiaries, while the network operators have a better overview of what happens in different areas of the city – the two exercises can complement each other.

The purpose of registration has to be made clear for everyone involved, as this will determine if people are interested to be registered or not. Apart from the purpose, also the benefits have to be clear – free access to the clinic for instance, but what if a sex worker is not interested in the services of the clinic? Do those who are not registered not get free condoms from the peer educators? That would not help the purpose of the SDP interventions.

While it is universally agreed that BCC activities can best be done by peer educators and outreach workers, there are a number of concerns. First of all, the division of roles and responsibilities between these two positions are not sufficiently clear. It is necessary that SDPs make job descriptions for each. Then, we found that the number of peer educators is insufficient, there should be at least one per educator for 50 sex workers. We have not gained any insight into turnover of peer educators, retention strategies and incentives for them to remain doing the job. Also, it is unclear what is done with peer

educators who belong to the more mobile groups. How many peer educators are supervised by one outreach worker? How do they report and do they regularly meet to discuss issues and solutions to these issues? What are their performance indicators, other than numbers – can these be developed by the peer educators themselves? In short, there should be a clear strategy that deals with all these aspects.

Another major aspect of peer educators and outreach workers is their training. There is a glaring absence of structured training modules and it seems that topics that should be covered (such as STIs) are not included. Before peer educators start working, there should be some kind of certification that they have indeed received the trainings that are necessary for them to effectively operate. No attention is given to life skills education (other than condom negotiation skills) and to skills of the trade (such as how to put a condom on in the dark, or without the client knowing, or with the mouth) or making safe sex pleasurable. Such trainings can be fun and may attract interest from the sex workers who may get tired of hearing that they have to use condoms, without getting the skills to do this. In many other countries such training is given and there are manuals available for this – but the trainers should preferably come from the target group!

With regard to condom promotion and distribution, it is clear that the number of condoms distributed by the SDPs is insufficient to cover the needs of all sex workers. However, we did not hear any complaints about this and it is also not mentioned in any of the documents reviewed. Apparently, for those who want to use condoms, there is sufficient access, whether for free or purchased. However, this issue should be researched in greater detail – and this in turn has a link to the estimations of numbers of sex workers.

VCT at the project level has not been done in many SDPs (only 2), but it seems that in view of the low prevalence among female sex workers, it may be more efficient to continue what is being done at this moment: counseling at the SDP clinic and testing at a government approved testing laboratory. To improve this system, it is suggested that more attention is given in the SDPs to developing a good referral system.

Because other STIs are much more common than HIV, the counseling services should probably focus on this. Internationally, there is a debate on syndromic management for high risk groups. It is argued that sex workers are more likely to have STIs that are not detected with syndromic management and are not cured by the treatments given. It is therefore argued that they should be tested for STIs as a norm and treatment given based on the outcome. Another option is the introduction of periodic presumptive treatment to treat asymptomatic STIs. These issues should be further explored and discussed during the upcoming national workshop on the strategy for HIV prevention among female sex workers.

The training of doctors in the SDP clinics is reported to be insufficient, especially in STI management. This has to be changed. While the sex workers who visit the SDP clinics are all satisfied with the attitude and the treatment, they are only a minority of the target group. Other sex workers prefer to visit other health care providers for a variety of reasons. We need to get more insight in these reasons in order to be able to adjust the service – it cannot be that a clinic that is specifically opened to serve sex workers only has 10% of this target group among its patients. Some interviewees have suggested that this is due to the poor rapport of the NGOs with the sex workers.

In view of the current preferences of the sex workers, another option may be to develop links (and training) with the providers that they do visit – this has not been done so far. It needs more research to find out if this is sensible and if so, how this could be done.

Although empowerment of sex workers is part of all SDP strategic plans, this has not been implemented by most, because of lack of understanding of the concept with the NGOs and because it was not part of the contract document. Therefore, all SDPs in future have to be trained in understanding what empowerment means, what attitudes it requires from them and what they could do. It means first and foremost, the involvement of sex workers in planning and implementation of activities and services as partners rather than as beneficiaries.

One aspect that could be looked at (but needs further research) is the function of the drop-in center. Is this really being used by sex workers to drop in (as is common with drop-in centers for IDUs) and if not, why is this so? How easy is it for sex workers who are controlled by their madams, to visit a drop-in center? Is it possible to have sex workers run this center and decide what activities to offer there to make it attractive to others? There are SDPs that are successfully doing this in Pakistan and elsewhere. Maybe too much focus has been on the drop-in centers as part of the clinic and therefore seen as a clinic rather than anything else. Yet, it is necessary to provide safe places for sex workers to bond and to create solidarity rather than competition. So far, sex workers have not been interested in any vocational training – whether offered or not – but maybe they would be interested in other type of activities: for instance, saving and loan schemes have been successful as a starting point for community development in many development interventions. In some countries, literacy classes have been able to attract participants as it turned out to be a priority. What to offer needs full involvement of the sex workers themselves.

The aspect of self-help group formation needs further research. What are the barriers and how can these be overcome? What is the motivation for sex workers to join such groups? There are many examples of successful self-help formation in other countries and this should be build upon.

Finally, there is a need to differentiate in the requirement and priorities of the different categories of sex workers.

Chapter 10: Functioning of NGOs

One of the objectives of this assessment was to find out the capacities of the NGOs in designing, implementing, managing and monitoring the interventions among female sex workers. While reference to the capacities of the implementing NGOs has been mentioned in most of the sections above, the FHI team has also looked in more detail at this capacity so as to assess future capacity building and training needs.

Discussions were held in the six SDPs with staff present as shown in table 7.

Table 8. Distribution of NGO Staff (Respondents) by Designation

City	NGO	Total NGOs Staff	NGOs staff participating in group discussion								
			Prog Mgr.	Prog Off	DRs	LHV	Couns	Field Sup.	Proj. Coor	ORW	Total (N)
Rawalpindi	Organization for Social Development (OSD)	18	1	0	0	0	1	1	1	2	6
Lahore	Contech International	31	1	1	0	1	0	1	1	4	9
Multan	Pakistan Loins Youth Council	23	0	0	1	0	0	0	1	5	7
Okara	AIDS Prevention Association of Pakistan	11	1	1	0	0	0	1	1	1	5
Faisalabad	Pak Plus Society	20	1	0	1	1	1	1	1	4	10
Larkana	Mahrana Welfare Trust	24	1	0	1		1	2	0	1	6
Total:		127	5	2	3	2	3	6	5	17	43

The total number of staff of six NGOs was 127 out of which the 43 that participated in the discussions were mainly responsible for FSW project. They included: five Program Managers, two Program Officers, five Project Coordinators, three Counselors, six Field Supervisors and 17 Outreach Workers.

10.1 Responsibilities of Team members as described by themselves

Outreach Worker: Those outreach workers who were not from the target group were able to describe their role as: *“First we establish relationship with FSWs and then we register them; we provide knowledge to FSWs on general public health issues, about HIV/AIDS, STIs and primary health care; do confidential registration of FSWs and issue codes for blood testing; Motivate FSWs for medical check-up and refer them to hospital for HIV testing and STI treatment”.*

Five out of six ORWs informed that they approached FSWs with the help of Peer Educators. They went to FSWs daily, registered them and informed them about diseases and condom use only. One group of ORW held a seminar for FSWs at a madam’s house, conducted FGDs with brothel-based FSWs and developed an advocacy plan for the involvement of madams, but were unable to describe the objective of the advocacy and no Advocacy Plan was shown.

Commenting on the registration process, the Outreach Workers informed that first they developed a relationship with FSWs during the first three visits and then registered them in the fourth visit. During the first three visits, they provided information about general health problems i.e. primary health care, HIV and other STIs. with the help of IEC materials. However, the Outreach Workers of Lahore started developing relationships with madams first. Afterwards, with their help they registered FSWs. Outreach Workers in Multan reported having FSWs registered in the very first visit.

The Outreach Workers told that FSWs who had STIs felt more comfortable discussing their problems with them or with Peer Educators, rather than with doctors.

Counselor: All the Counselors described their role as “we do counseling” only, no further specifics. Also outreach workers do counseling, but the Project Manager did not allow them to answer questions on how many clients per day they counseled or what type of counseling was usually required. But they themselves said they could provide the monthly and quarterly reports. Many of them had not attended any training in counseling, IPC or communication.

Project Manager, Coordinators and Program Officers: NGO staff working at these three positions described similar roles and responsibilities. Almost all said that their duty was to oversee project activities, supervise teams (ORWs, PE and Counselors) and perform report writing for M&E. They had received numbers of trainings on different topics but none had attended any training in management (program management and financial management) and project coordination, for unclear reasons. None of the PMs was ready to share total project funding in front of rest of the team and promised to tell afterwards.

10.2 NGOs’ Capacity to Deliver FSWs Service Delivery Project:

NGOs were asked to assess their capacity to implement service delivery programs for FSWs on a scale of 1-10, in which 10 was the maximum capacity. Five out of six NGOs rated themselves between seven and eight. One NGO ranked itself having three to four level of capacity because the project was less than a year old, staff was newly recruited and majority of them had never worked for a similar kind of program.

However, at the end of the discussions with the FHI team, when it was clear that all project staff was interested in being trained in various topics, one project coordinator said *“We were satisfied with the sort of work we were doing so far as we had very little knowledge about the project. Now at this occasion, when we are unable to reply queries raised by you, we feel a dire need for enhancing our knowledge and skills through trainings.”*

10.3 Trainings received by project staff responsible for FSWs service delivery program

Table 9 provides information regarding trainings received by the staff.

Table 9. Trainings received by project staff

NGOs Members (designation)	# of Staff	HIV Knowledge	STIs	Couns.	Comm.	Out RW	Peer Ed.	Manag / M&E	Research
Pro. Manager	5	3	0	0	1	0	0	0	0
Pro. Officer	2	2	2	0	2	1	2	2	0
Doctor	3	1	2	0	0	0	0	0	0
LHV	2	0	0	0	1	0	0	0	0
Project Coordinator	5	1	0	1	0	1	0	0	0
Counselor	3	0	1	0	0	0	0	0	0
Field Supervisor	6	1	0	1	0	0	0	0	2
Outreach Worker	17	8	1	1	3	13	0	0	0
Total	43	16	6	3	7	15	2	3	2

What is important to note from this table is that not a single manager attended training on M&E and management that is a key skill for managers for effective implementation of the project and that on the whole they attended few trainings. This may point to a concept that a project manager is not really involved in project activities but leaves this to the project officers and coordinators. Even more reason to emphasize the need for clear functions and job descriptions.

The doctors, LHVs and counselors attended the least number of trainings. Although the doctors and LHVs may be expected to at least have followed the HIV knowledge, the STI and the counseling trainings, this was not the case for all. Since other staff of the clinics such as nurses, were not present in the discussion, we do not know if they are trained. Out of three counselors present, two had never attended any training on counseling and communication. However, OSD and MWT had trained the counselors who are delivering VCT services – they were apparently not among the staff present.

Out of 17 outreach workers, only eight had attended training on HIV knowledge and a negligible number had attended other trainings except the training of outreach workers. If these people are expected to supervise the peer educators, they should at least know the content of the trainings the peer educators have received and should have participated in these; the same applies to monitoring if the ORWs are expected to monitor the field activities.

There was no structured curriculum for any of the trainings given, and no certification that would qualify someone to carry out the work. Those who attended training had not undergone any refresher training during the three or five year duration of the project. The project coordinator of one SDP, who had recently finished her five year FSW project, mentioned that the staff did not go for any formal training but trained themselves on

every subject: they divided topics among themselves, studied different models and manuals and organized in-house trainings for each other, having 2-3 hours sessions daily for two to three days to cover a topic/subject. However, the staff were unable to produce any agenda or related material for any in-house training, they used different manuals (i.e. WHO and UNFPA manuals) for different trainings, but did not make a document out of it. Although they promised to send IEC material and M&E tools that they used in the FSW program, they did not send the documents.

Table 10 provides information on capacity building needs identified by project staff in charge of the FSW service delivery program.

Table 10: Number and Types of Trainings Desired by NGOs Staff

NGOs Members designation	# of Staff	HIV Knowledge	STIs	Comm.	Couns	ORW	PE	Manag /M&E	Research
Prog. Manager	5	0	3	0	5	5	0	5	5
Prog. Officer	2	0	0	2	2	2	2	2	2
Doctor	3	3	3	3	3	0	0	3	0
LHV	2	2	2	2	2	2	1	2	0
Proj. Coordinator	5	2	2	2	2	0	0	3	0
Counselor	3	3	2	3	3	3	0	0	0
Field Supervisor	6	1	0	1	0	0	0	0	2
Outreach Worker	17	17	10	15	17	13	0	0	4
Total	43	28	22	28	34	25	3	15	13

The interest in receiving more training was quite impressive and showed how so far, this aspect of SDP delivery has been completely underrated – and it provides an explanation for the low performance of most SDPs.

10.4 Understanding of project among NGO team members

Irrespective of what name, type, funding and project duration different NGOs had, they claimed providing numerous kinds of high caliber, comprehensive services to FSWs. They had memorized the outline of each service delivery component such as the provision of adequate service delivery package to FSWs to improve their health and enhance their knowledge; the provision of primary health care facilities at the doorsteps of the FSWs; awareness to general and targeted population on STIs, HIV and treatments; distribution of condoms as per the requirement of FSWs to promote safe sex practice and prevent unintended pregnancies; and the provision of medicine to the target population for STI treatment. SDPs of Multan, Larkana and Rawalpindi told that they also provided general medicine to the general and targeted populations from their personal accounts and made referral of critical patients to Government Hospitals and of FSWs for HIV testing. They claimed to have an established linkages and mechanism for this.

However, when they were asked about the structured approaches that they were using for each of these components, they were confused and got irritated saying “*who hee sub kuch datay hain jo package ka hisa hay or donor nay bataya hai, Aap ko nahee maloom*”

kia “We provide all what’s the part of the package and what’s been told by the donor, don’t you know about it?”

As an illustration of the level of understanding of the components of the project: none of the NGO team members or even the Project Manager was able to explain what they meant by provision of primary health care or what did it actually include. In addition, NGO staff did not possess the project document and many had never read the approved proposal. They only knew what they themselves were supposed to do and for many their only concern was condom distribution (one of the performance indicators) and thus they were able to tell that condom use in their area was above so and so percent. For others, the primary focus was on registration of FSWs, and almost all NGOs had over-achieved targets given by the donors for FSW registration (again a performance indicator).

Almost all SDPs said they provided services for more than one category of sex workers such as SB, KK, HB but they reported utilizing only one way of approaching them which was through peer educators, madams or pimps. They had not explored any other mechanism to address the large group of FSWs that are home-based or street-based and difficult to reach. They had also not conceived that different categories of sex workers may have different risks and that those with the highest risk should be prioritized for intervention.

All the SDP staff described the project design on the notion of the sex worker as ‘core transmitter’ of an infectious disease and same was reflected in the contract terms of reference. Their approach was focused on medical issues rather than social. Many of the staff had never worked before with female sex workers and were not at ease with them. One Project Manager shared he thought a new paradigm was needed in terms of design, implementation and the monitoring of progress in the upcoming contract terms of reference advertised by AIDS Control Programs.

The functioning of the NGOs regarding VCT and STI management has already been discussed under the relevant sections, 9.5 and 9.6.

With regard to empowerment, this has already been discussed in section 9.8 but it is very important to note that in all NGOs the notion of empowerment of female sex workers was completely absent. As an excuse they said it was not in their contract document (although few had read this), but for the FHI assessment team, it proved the point that there is no understanding of the rights of sex workers and no sense that an NGO may be able to assist sex workers in claiming their rights for instance with respect to self-determination, to protection and to access to basic services and the right to health. The lame excuse for not having been able to support sex workers in forming associations was that FSWs could not be part of any group easily because of their professional rivalries.

10.5 Monitoring and evaluation

Very few staff had a clear understanding of monitoring as a method to improve and modify project activities and design. Monitoring and evaluation is seen by the NGOs as a requirement for the donors to put in their quarterly reports – this is also why they did not perceive training on M&E as useful. The indicators are only concerned with numbers (numbers, registered, number of sessions, number of condoms distributed, number of

condom demonstrations held, number of patients in the clinic, number of referrals) and not with outcomes of all these activities. While numbers are fine to measure outputs, it does not help to guide and adjust activities in case the activities do not produce the intended effect.

Carol Jenkins has assessed the ongoing monitoring quite in depth and is quoted in the following:

“The draft Management and Monitoring Toolkit (Futures Group et al, 2005) contains numerous examples of inappropriate and burdensome methods of monitoring. Emphasis on numbers is full of pitfalls, for it encourages all kinds of subterfuge as seen in many other countries. Some actual examples include paying sex workers to come to clinics, using various forms of force, such as pimps or police, to bring sex workers to the intervention services, falsifying unverifiable numbers and double-counting. The formal nature of the monitoring process described in the Toolkit does not encourage open and frank interactions or the collection of accurate information and will soon be perceived as a form of policing the interventions. The best sex worker interventions let sex workers carry out much of the monitoring themselves, not NGO workers (other than the financial aspects), or government people. Unobtrusive measures of condom use must be set up and taught to everyone involved. Self-reported condom use is useless unless rapport is excellent and failure is accommodated without blame. Such data can never be collected by the very persons who are teaching the sex workers to use condoms and certainly will not be accessible to visiting government monitors”.

“There appear to be many actors involved in monitoring with different indicators and requirements (Hoppenbrouwer and Khan, 2005). The entire approach seems nearly punitive and misses the point that monitoring is a wonderful tool for the primary actors, i.e. the sex workers and associated NGO workers, to obtain feedback on the effects of their efforts. Done correctly, monitoring reveals gaps and barriers quickly to those most in need of the information. A monitoring officer in an intervention should be trained to make the best use of such data. Quarterly reports that summarize these efforts can be submitted to government, along with financial statements, but too many repeated visits from government officers will sabotage relationships and waste time and money” (Jenkins, 2006).

10.6 Challenges that SDPs mentioned in the implementation of their projects

- Difficulty in referring FSWs to the far VCT Centers for HIV testing
- Delays in securing help for confirmatory tests, management and tracking contacts
- Short duration of projects and inadequate funding
- Limited number of trainings arranged by donors and PACPs and delay in the implementation of trainings
- Police harassment faced by FSWs including ORWs
- Stigma, discrimination, and social exclusion of FSW
- Lack of transportation facility for female staff members
- Lack of group/joint advocacy

10.7 Discussion

The lack of clarity on tasks and responsibilities with many of the staff present in the discussions points to the need for job descriptions for each staff member. These should ensure a minimum of overlap between the jobs and make clear who is responsible for what, as well as the relation to other staff members.

Although most staff members were quite positive about the performance of the SDPs, their interest in further training indicates a scope for improvement. At the start of a project, an overview should be made of the training requirements for all staff members. Structured training modules should be developed for the different topics and these trainings should be given by experienced trainers. It is probably most efficient if those modules are developed at national level, to be rolled out at provincial level – for all NGOs that are working with female sex workers – or, where relevant, for other NGOs working with different target groups. This should enhance quality assurance. Some type of certification is necessary for staff to have obtained within a certain period of working in the program. The topics that should be covered will be explored during the formative research that will follow this situation assessment. These trainings have to be budgeted for in the tender proposals in order to avoid the existing situation that the NGOs complain that there is insufficient budget for training.

One very important training that should be given at the start of the program is relates to understanding of the project and its goals and on values clarification of the staff attitudes towards the target group, including aspects of stigma and discrimination and its manifestations. It should also include sessions on empowerment, what this means and what approaches can be used to promote such empowerment in the target group. An understanding of a rights-based approach to be integrated in all components of the intervention, requires specific sessions on this topic for all staff.

Much needs to be done to improve monitoring: it is identified as a topic for training by all project managers and program officers, but it is also required for other staff members. Such training should go beyond output indicators, but should create an understanding that monitoring is a useful tool for assessing, guiding and adjusting implementation activities. It should create an understanding why indicators for field level activities should preferably be developed with the target group, the peer educators and the outreach workers – and the monitoring should be done by the target group who have a stake in the outcome.

Chapter 11: Provincial AIDS Control Programs

The national response to HIV in Pakistan is led by the Federal government's Ministry of Health, through its National AIDS Control Program (NACP). The program is assisted at the provincial levels by the Provincial AIDS Control Programs (PACPs) working under the provincial Departments of Health. The National AIDS Control Program serves as a resource centre to develop country-specific guidelines and protocols and for human resources development covering various aspects of HIV and AIDS including counseling, care, support, clinical management, STI care, surveillance, and blood safety. A Technical Advisory Committee on AIDS (TACA) is a group of technical experts and specialists on HIV and AIDS and is working in close collaboration with the NACP to

provide technical assistance and guidance to the program. While the NACP plays the role of a technical and coordinating body, the PACPs are more directly involved in providing and executing sex work intervention programs. The PACPs over the past years have contracted NGOs to measurably change behaviors through the provision of services in geographically defined areas to a particular vulnerable population. The contracts specified measurable targets in areas of behavior change, improvement in knowledge and demonstration of safe sexual practices. The contracts for service delivery have been made for four or five years and continuation of the NGOs is dependent on acceptable progress on key indicators.

The various aides memoires of the World Bank discuss issues related to procurement, financial management, delays of payment and authority of the AIDS control program staff over disbursements. Khan mentions that the implementation of the PACPs is of varying quality. Punjab PACP is most efficient. The NGOs are monitored on time and receive fullest support from the PACP in their operations. Payments are issued on time. The system is less efficient in Sindh and NWFP where services have been seriously jeopardized due to improper monitoring practices and lack of timely payments. (Khan, 2008).

The FHI assessment team was only able to talk to the PACP of NWFP and not in much detail. Further discussions will be held with the PACPs during the formative research. One issue that has come forward in discussions with the NGOs is the suggestion that PACPs should organize more knowledge exchange between NGOs operating on similar interventions within the province and within the country. Furthermore, if the PACPs are responsible for organizing trainings then they should do this a lot better than has been done so far, both in terms of timing and in terms of quality.

Chapter 12: Recommendations

Structure of the sex trade

7. Conduct mapping using different techniques in order to include all categories of sex workers as well as the different networks controlling the trade
8. Include all categories of sex workers in the intervention
9. Use innovative approaches to reach the different categories, i.e. by mobile messages
10. Develop approaches to work with clients
11. Assess motivation of madams to improve working conditions and health conditions of the sex workers
12. Assess how networking takes place between madams among themselves and between madams and network operators and develop strategies that involve them in the intervention

Legal and policy environment

5. Explore what rules and regulations can be developed that facilitate prevention of HIV transmission in the female sex trade
6. Assess current guidelines for the police working in hotspots

7. Develop advocacy tools and approaches for different stakeholders in the environment
8. Find out what is needed to get the police to become a partner that enables to sex trade to function in a way that promotes the rights of sex workers, protects them and promotes safe sex behaviors. Base strategies on this and develop training modules where needed.

Knowledge, attitude and practice of female sex workers and sexual networking patterns

5. Develop structured training plans and a peer educator manual for peer educators and outreach workers and implement these sessions before they start working. Develop certification for this. Plan for refresher sessions, also for new recruits
6. Train outreach workers and peer educators on formative research and let them do the research. Involve them in the planning and implementation of a baseline survey.
7. Develop standardized training modules for peer educators and outreach workers, covering the roles and responsibilities connected to these jobs and their function in the intervention. Topics of sessions have to include: HIV and STI information – more in depth than before, prevention measures including condoms, different types of skills needed for safe sex, relative risks of different types of sex and preventive measures, understanding of transmission chains between different sexual networks, monitoring and record keeping.
8. Conduct weekly or bi-monthly meetings between peer educators and outreach workers

HIV prevention services

15. Review the surveillance data on female sex workers and match these with the estimates of the SDPs. Discuss if variations can be explained or not and rectify, using various techniques.
16. Ensure that all concerned are clear about the registration process, including the reasons for registration and the benefits of registration. Develop SOP for registration
17. Expand coverage of the intervention using outreach approaches
18. Plan the different services in consultation with female sex workers and staff involved in the implementation of the services
19. Establish the drop-in center in consultation with sex workers, at a location that is convenient for a majority of the sex workers. Offer activities in line with sex worker priorities
20. Make job descriptions for peer educators and outreach workers including reporting requirements
21. Develop retention strategies, incentives and
22. Organize training in behavior change communication, interpersonal communication and counseling as well as sessions on the topics mentioned above. Include topics on how to reach different segments of the target groups. Have all participants develop a BCC plan in the training
23. Research the differences between condom distribution and reported condom use. Find out why and where condoms are purchased, if they can also be obtained from the project for free. Adjust condom need, distribution and coverage figures and use this for procurement planning

24. Include counseling in all SDP interventions, but develop links with testing services for the tests.
25. Diagnosis and treatment for STIs should be superior to that of other providers. Most STIs are asymptomatic, syndromic management may not be suitable. Specialists in STI management for sex workers will be needed to make an assessment of the current services in sex worker projects and make suggestions for improvement.
26. Ensure doctors and other staff in the clinic are well trained on STI management and counseling and include sessions on value clarification, attitudes and stigma and discrimination
27. Explore possibilities for linking with existing health care providers in the formative research
28. Develop empowerment strategies in consultation with different categories of sex workers, including formation of self-help groups

NGO management and capacity

7. Develop job descriptions for all positions
8. Develop standardized training packages for different job levels and include management and monitoring aside from specific topics related to the sex work intervention
9. Develop a capacity building plan for all staff and coordinate with other NGOs to avoid duplication of efforts
10. Hire experienced trainers to conduct the trainings
11. Eliminate discrimination as discriminatory attitude of NGOs towards female sex workers has restricted their involvement in the program as well as their access to services. Provide training and establish a code of conduct
12. The national M&E framework needs to be modified/adapted to the specific monitoring needs of the FSW program and all implementing agencies should be made to utilize a unified monitoring method. This method should follow the basics of the national M&E framework.

References used for the assessment

AMAL (2008). Consolidated Project Report: Service Delivery for HIV Prevention, Treatment and Prevention of Other Sexually Transmitted Infections among Female Sex Workers in Karachi.

Blanchard, J. F., Khan A, and Bokhari A. (2008). Variations in the Population Size, Distribution and Client Volume among Female Sex Workers in Seven Cities of Pakistan. *Sex Transm Inf* 2008; 84;ii24-ii27

Bokhari, A., N. Nizamani, D. Jackson, N. Rehan, M. Rahman, R. Muzaffar, S. Mansoor, H. Raza, Kanwal Qayum, P. Girault, E. Pisani, I. Thaver. *HIV risk in Karachi and Lahore, Pakistan: an emerging epidemic in injecting and commercial sex networks*. International Journal of STD&AIDS 2007; 18:486-492

Commission on AIDS in Asia (2008). *Redefining AIDS in Asia: crafting an effective response*. Oxford University Press, New Delhi 2008.

Cornish F., and Ghosh R. 2007. The Necessary Contradictions of 'Community-led' Health Promotion: A Case Study of HIV Prevention in an Indian Red Light District. *Social Science & Medicine* 64 (2007) 496–507

Emmanuel F. 2008. Sex Work and HIV in Pakistan Situation and Response Analysis". Draft Report, UNFPA.

FHI (2000). Behavioral Surveillance Surveys. BSS Guidelines for Repeated Behavioral Surveys in Populations at Risk of HIV.

FHI (2008). Summary of Key Findings. FHI Consultancy: Review of Eastern Mediterranean Regional HIV Testing and Counseling Policies and Practices. Internal document.

IBBS – HASP and NACP (2007). HIV Second Generation Surveillance in Pakistan. National Report Round II 2006-2007.

Jenkins C. 2006. HIV Prevention among Female Sex Workers in Pakistan: A Review, Assessment and Strategy for Improvement. World Bank.

Khan A. A. (2008). Effectiveness and Coverage of HIV Interventions in Pakistan: Insights from Triangulation of Program, Field and Surveillance Data.

London School of Hygiene and Tropical Medicine LSHTM (2008). Sexually Transmitted Infections and HIV among People at High Risk: Results of Behavioral and Biological Surveys in Islamabad and Abbottabad, Pakistan.

London School of Hygiene and Tropical Medicine LSHTM (2009). HIV in Pakistan. Preventing a future Epidemic in most-at-Risk Groups Programme for SRH HIV, Research Briefing 1, April, 2009.

National AIDS Control Programme (2005): A Behavioral, Mapping Study, "Female Commercial Sex Workers in Lahore, Multan and Karachi".

National AIDS Control Programme and TAMA (2006). Situation and Response Analysis, Technical Assistance Management Agency to the National Health and Population Welfare Facility, Pakistan.

National AIDS Control Programme (2007). UNGASS Pakistan Report

National AIDS Control Programme and HASP (2007). Mapping Networks of Female Sex Workers in Kothikhanas and Private Homes.

National AIDS Control Programme (2007). Revised Draft: National HIV and IDS Strategic Framework-2007-2012".

Population Council (2008). Study of Sexually Transmitted Infections Among Urban Men in Pakistan: Identifying the Bridging Population.

SoSec Consulting Services Pakistan-UK. 2007. Third Party Evaluation Report for National AIDS Control Program Round 2, Service for Female Sex Workers (FSWs) Draft Report.

UNAIDS (2007).The Global Working Group on HIV and Sex Work Policy (2007). Inputs to the Guidance Note on HIV and Sex Work April 2007. Supporting the UNAIDS Programme Coordinating Board recommendation June 2007.

UNAIDS (2009). UNAIDS Guidance Note on HIV and Sex Work.

UNFPA (2009). Draft Report, "National Consultation on Female Sex Work in Pakistan. May 2009.

UNFPA (2007). Report of the National Dialogue on HIV Prevention in Sex Work. Bhurban, Murree.

United Nations, Government of Japan and National Commission for Child Welfare and Development (NCCWD). Sexually Abused and Sexually Exploited Children and Youth in Pakistan: A Qualitative Assessment of their Health Needs and Available Services in Selection in Selected Provinces.

USAID and CARE (2003). Draft Guidelines for Behavior Change Interventions to Prevent HIV. Sharing Lessons from an Experience in Bangladesh. Based on the Application of Lessons from Sonagachi, Kolkata. UNAIDS South Asia Inter Country Team for South Asia, New Delhi (2003).

World Bank (2008). AIDS in Pakistan

World Bank (2006). Aide Memoire, June 2006

World Bank (2007). Aide Memoire, May 2007

World Bank (2007). Aide Memoire, December 2007

World Bank (2008). Aide Memoire, June 2008

World Bank (2009). Aide Memoire, March 2009

World Health Organization (WHO). (2001). STI/HIV Sex Work in Asia.

Annex 1: List of Persons met during FHI Assessment Team field visits

Organization for Social Development (OSD)-Rawalpindi

1. Haseeb-Ur-Rehman, Program Manager
2. Asim Shahzad, Manager Training Centre
3. Waheed Raza, Counselor VCT
4. Mr. Tariq Nadeem, Field Supervisor
5. Zargoona Zafar, Outreach Worker
6. Kauser Bibi, Outreach Worker

AIDS Prevention Association of Pakistan- Okara

1. Dr. Haji M. Hanif, Program Manager
2. Dr. Kulsoom, Program Officer
3. Mr. Imran Shahid, Project Coordinator
4. Ms. Samia Sakhi, M&E Officer
5. Mr. Yasar, Finance Officer
6. Ms. Shahzia Parveen, Outreach worker

Contech International

1. Dr. Qamar Salman, Program Manager/Deputy CEO. Operations
2. Mr. Iram Shahzadi, Program Officer
3. Ms. Shahida Abbas, LHV
4. Mr. Kashif Manzoor, Field Coordinator
5. Ms. Hina Nasreen, Field Supervisor
6. Ms. Lubna Ashrif, Peer Educator
7. Ms. Reena Shahzad, Peer Educator
8. Ms. Razia, Peer Educator
9. Ms. Parveen, Peer Educator

Pak Plus-Faisalabad

1. Ms. Shukria Gul, Program Manager
2. Mr. Mashhod Ilyas, Project Coordinator
3. Dr. Ghulam Mustafa, Public Health Physician
4. Mr. Haji Ashraf, Counselor
5. Ms. Rehana, LHV
6. Ms. Zahida, Peer Educator
7. Ms. Shehnaz, Peer Educator
8. Ms. Shubana, Peer Educator
9. Ms. Nasreen, Peer Educator

Pakistan Loins Youth Council (PLYC)-Multan

1. Dr. Iffat Umar Bucha, Public Health Physician
2. Mr. Adnan Bashir, Project Coordinator

3. Ms. Shama Perveen, Public Health Nurse
4. Ms. Kiran Iqbal, Outreach Worker
5. Ms. Asifa Noreen, Outreach Worker
6. Ms. Rozina Iqbal, Outreach Worker
7. Ms. Alia Perveen, Peer Educator
8. Ms. Shazia Perveen, Peer Educator
9. Ms. Razaqat Perveen, Peer Educator

Mehran Welfare Trust- Larkana

1. Mr. Panjal Khan Sangi, Project Manager
2. Mr. Rafique Rehman Soomro, Project Coordinator
3. Dr. Mazhar Ali Dhamraho, Public Health Physician
4. Mr. Nadir Hussain Junejo, Counselor
5. Mr. Sahib Khan Sangi, Field Supervisor
6. Mr. Ameer Ali Abro, Field Supervisor
7. Mr. Zahid Hussain, Social Mobilizer
8. Ms. Naheed, Outreach Worker

NWFP AIDS Control Program, Peshawar

1. Dr. Haroon, Deputy Program Manager
2. Dr. Rajwal Khan, Program Officer
3. Dr. Naseer, Program Officer
4. Maj. Dr. Tasleem, Former Manager ORA international

Annex 2: Further references related to female sex work

Avahan (2008). *Managing HIV Prevention from the Ground Up: Peer Led Outreach at Scale in India: The Experience of Avahan, the India AIDS Initiative of the Bill & Melinda Gates Foundation* New Delhi, India, 2008. www.gatesfoundation.org/avahan

Avahan (2008). *The Power to Tackle Violence: Avahan's Experience with Community Led Crisis Response in India* New Delhi, India, 2008. www.gatesfoundation.org/avahan

Avni A. (2004). Risk, Morality, and Blame: *A Critical Analysis of Government and U.S. Donor Responses to HIV Infections among Sex Workers in India*. Center for Health and Gender Equity (CHANGE).

Bebe L., Overs C, and Longo P. (2003). *Can health programmes lead to mistreatment of sex workers?* Lancet. Vol 361. June 7, 2003 www.thelancet.com

Center for Advocacy on Stigma and Marginalization (CASAM) July, 2008. Rights-Based Sex Worker empowerment guidelines: *An Alternative HIV/AIDS Intervention Approach to the 100% Condom Use Programme* www.sangram.org

Cornish F, and Ghosh R. 2007. *The Necessary Contradictions of 'Community-led' Health Promotion: A Case Study of HIV Prevention in an Indian Red Light District*. Social Science & Medicine 64 (2007) 496–507

David Wilson (2001). HIV/AIDS Rapid Assessment Guide. Project Support Group (PSG) and Family Health International.

Evans C, Lambert H. (2008). *Implementing Community Interventions for HIV Prevention: Insights from project ethnography*. Social Science & Medicine 66 (2008) 467–478

Family Health International, Bangladesh Country Office (2007). The Effectiveness and Costs of Two Methods for the Systematic Prevention and Control of STIs, Among Female Sex Workers in Dhaka, Bangladesh.

FHI (2000). Behavioral Surveillance Surveys. *BSS Guidelines for Repeated Behavioral Surveys in Populations at Risk of HIV*.

FHI Lao PDR Country Office. *An Activity Manual for Outreach Workers*. Learning about Healthy Living.

FHI Vietnam Country Office (2007). Dialogue with Female Sex Workers: *Their Perspectives on Behavior Change for HIV Prevention*.

International HIV/AIDS Alliance (2008). Sex Work, Violence and HIV. A Guide for Programmes with Sex Workers.

Jenkins C. UNFPA (2003). *Guidelines for Partnering: Scaling-up to Implement Comprehensive Sex Worker HIV/AIDS Interventions in the Asia-Pacific Region*.

Khana (2001). *Entertainment Workers and HIV/AIDS: An Appraisal of HIV/AIDS Related Work Practices in the Informal Entertainment Sector in Cambodia*

Khana (2006). *Let's talk about.... Guide for Facilitators with a Range of Activities that can be used to Lead Discussions about Sexuality, Sex & Relationships, Sexual Decision Making, Making Changes and Living with HIV/AIDS.*

Khana (2008). *Standard Package of Activities Entertainment Workers.*

Kusek Zall. J., Wilson, D. and Thomas A. (2009). *Could India's Business Skills Improve Lagging Public Health 'outcomes? World Bank Global, HIV/AIDS Program.*

Lowe D. (2002). *Documenting the Experiences of Sex Workers.* The Policy Project.

Ghose, Toorjo, Dallas Swendeman, Sheba George, Debasish Chowdhury (2008). *Mobilizing Collective Identity to Reduce HIV Risk among Sex Workers in Sonagachi, India: The Boundaries, Consciousness and Negotiation Framework.* *Social Science & Medicine* 67 (2008) 311–320.

Network of sex workers project NSWP (1999). *Making Sex Work Safe.*

Network of Sex Workers Project NSWP (2007). *Inputs to the Guidance Note on HIV and Sex Work April 2007.*

Network of Sex Workers Project NSWP (2008). *Programmes for Commercial Sex: Guidelines for Donors and Implementing Agencies.* www.nswp.org

Overs C. (2002). *Sex Workers: Part of the Solution: An Analysis of HIV Prevention Programming to Prevent HIV Transmission during Commercial Sex in Developing Countries*

Positive Muslims. *HIV AIDS and Islam: A Workshop Manual Based on Compassion, Responsibility and Justice.*

Rao Biradavolu, Monica, Scott Burris, Annie George, Asima Jena, Kim M. Blankenship (2009). *Can Sex Workers Regulate Police? Learning from an HIV Prevention Project for Sex Workers in Southern India.* *Social Science & Medicine* xxx (2009) 1–7.

Scambler G. Frederique Paoli (2008). *Health Work, Female Sex Workers and HIV/AIDS: Global and Local Dimensions of Stigma and Deviance as Barriers to Effective Interventions.* *Social Science & Medicine* 66 (2008) 1848 – 1862

UNAIDS (2009). *UNAIDS Guidance Note on HIV and Sex Work.*

USAIDS and CARE (2003). *Draft Guidelines for Behavior Change Interventions to Prevent HIV.* *Sharing Lessons from an Experience in Bangladesh. Based on the Application of Lessons from Sonagachi, Kolkata.* UNAIDS South Asia Inter Country Team for South Asia, New Delhi (2003).

World Bank, East Asia and Pacific Region, 2008. *The Road to Good Health: HIV Prevention in Infrastructure Projects* Curriculum for Commercial Sex Workers.

World Health Organization (WHO). (2001). *STI/HIV Sex Work in Asia.*

Annex 3: Relevant websites

Making Sex Work Safe: <http://www.nswp.org/pdf/MSWS.PDF>

FHI: <http://www.fhi.org/en/CountryProfiles/Asia/index.htm>

Eldis, health and development information team:
<http://www.eldis.org/go/topics/resource-guides/hiv-and-aids&id=34821&type=Document>

WHO sex work toolkit : http://www.who.int/hiv/topics/vct/sw_toolkit/en/

World Bank: Road to Good health <http://www.theroadtogoodehealth.org/>

Institute for development studies: <http://www.ids.ac.uk/ids/info/health.html>

International HIV/AIDS Alliance: <http://www.aidsalliance.org/>

Sangram organization: <http://www.sangram.org/>

Khmer HIV/AIDS Alliance: Khana: <http://www.khana.org.kh/>

Naz Foundation International: www.nfi.net

Network of Sex Workers Project NSWP: <http://www.nswp.org/>

Empower Foundation Thailand <http://www.empowerfoundation.org/>

National AIDS Control Programme, Pakistan: <http://www.nacp.gov.pk/>

UNFPA, Pakistan: <http://www.unfpa.org.pk/>

FHI, Pakistan <http://www.fhi.org/en/Publications/index.htm>

Population Council: http://www.popcouncil.org/pdfs/Pak_STIsStudyReport.pdf

AMAL: Human Development Network: <http://www.amal-hdn.org/>

Pakistan Association of Pakistan: <http://www.pap.org.pk/>

Health Communication Network Pakistan: <http://www.healthcom.pk>

American Institute of Pakistan Studies: www.pakistanstudies-aips.org/

Pakistan Lions Youth Council: www.plycngo.org/