National Strategy on HIV Preventative Services for Female Sex Worker in Pakistan

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behaviour Change Communication
DIC	Drop-in Centre
EU	European Union
FSW	Female Sex Worker
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HSW	*Hijra* Sex Worker
IBBS	Integrated Behavioural and Biological Surveillance
IDU	Injecting Drug User
KK	Kothi Khana
LSHTM	London School of Hygiene and Tropical Medicine
MIS	Management Information System
MSM	Men who have Sex with Men
MSW	Male Sex Worker
NACP	National AIDS Control Program
NGO	Non-governmental Organization
NOW	Network Operator
NSF	National Strategic Framework
PACP	Provincial AIDS Control Programs
PHAPCP	Pakistan HIV and AIDS Prevention and Care Project
PHC	Primary Health Care
RH	Reproductive Health
SDP	Service Delivery Package
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCCT	Voluntary Confidential Counseling and Testing

Chapter 1: Background

The Government of Pakistan through Provincial AIDS Control Programs (PACPs), contracted out service delivery projects (SDPs) 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 and UNFPA have been supporting similar service delivery packages since 2004.

The Integrated Biological and Behavioural Surveillance (IBBS), Round 2 found that although 11.4% of female sex workers (FSWs) were aware of HIV prevention programs in their cities, only 2% reported utilizing the services. It was 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 were reluctant to become involved or visit the services on a regular basis. Yet, utilization of the services by the target population does appear to result in improved knowledge and corresponding practices. It was noted that programs and interventions will only be effective if they reach a critical mass of people who need them. (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. It was also concluded that a strategy should be developed to address HIV prevention in the female sex work sector in Pakistan. This document forms the foundation for the future strategy and has been developed with involvement of key stakeholders in Pakistan. Before the development of the strategy, a situation assessment was carried out on Female Sex Work and HIV Prevention in Pakistan to provide the basis of the strategy. The outcome of this assessment is presented in Chapter 3.

The National Strategy for Female Sex Work in Pakistan is an elaboration of one of the identified priority areas of the National HIV & AIDS Strategic Framework 2007-2012. This framework gives the direction for the future national response against the emerging HIV epidemic.

<u>The National HIV & AIDS Strategic Framework 2007-2012 (NSF II)</u>

The framework goal 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.

The area of concern to the strategy on female sex work is priority area 2: High risk, vulnerable and bridge populations.

Area objective: To reduce risk of HIV infection amongst high-risk, most-at-risk, vulnerable and bridge populations.

Justification and implementation requirements

Pakistan has a concentrated HIV epidemic that can be most efficiently controlled by working in a targeted manner with high-risk, most-at risk, bridge and vulnerable populations that include:

- Injecting drug users;
- People who engage in sexual behaviour that puts them at risk (FSWs, MSM, and HSWs);
- Migrant workers;
- Long-distance truck drivers and associated populations;
- Jail inmates; and
- Sexual partners, spouses and children of the people in these groups.

The primary focus of the HIV prevention efforts will be on reducing HIV infection risks among these populations. These populations will have to be reached and provided with services to meet their specific requirements in order to reduce transmission of HIV to and from other members of the group and to the general population. Sustained behaviour change interventions through coverage of population at the highest risk with a package of preventive services, creation of an enabling environment conducive for community mobilization and empowerment will be the important strategies that will significantly contribute to the halting and reversal of the epidemic.

Major strategies

More specific, the major strategies for this area that are mentioned in the Framework are:"

1. Scale up interventions, geographically as well as by service, to reach a much greater proportion of the key and target populations through:
   (i) Coordination with relevant partners and programmes;
   (ii) Expand coverage;
   (iii) Encouraging an increased uptake of services through enabling environment;
   (iv) Empowerment activities e.g. more Drop-in Centres (DICs); and
   (v) Improving monitoring and evaluation.
2. Improve and encourage access of the key populations to HIV care and treatment (including putting in place patient support groups, facilitating access to ART centres, ensuring on-going counselling, and resolving issues related to ART for IDUs).
3. Enhance the technical scope of HIV intervention projects so that, to the extent possible, they offer VCCT and testing services (HBV, HCV and syphilis as appropriate) to their clients with minimal referrals.
4. Focus on interventions to increase the uptake of STI services.

5. Ensure pre- and post-test counselling and referral for all groups (notably migrant workers).
6. Design interventions to increase the consistent use of condoms supported by messages that emphasize the transmission of HIV and STIs through non-regular sex partners.
7. Include VCCT, promotion of safer sexual practices including condom provision and implement harm reduction interventions in prisons.
8. Design specific interventions for bridging populations, including support groups for partners of IDUs, migrant workers and other target groups as appropriate.
9. Examine and resolve the issues concerning testing for HIV, notably the confusion among NGO service providers concerning the accuracy of different tests.
10. Re-examine the appropriateness of HIV communication messages and materials for the key populations, increase the engagement of members of these groups in BCC design and activities, and revise accordingly (NACP, 2007).

Chapter 2: HIV context for the Female Sex Trade in Pakistan

The estimated HIV prevalence rate in Pakistan is less than 0.1% among the general population and hence Pakistan can be characterized as having 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 shows a concentrated HIV epidemic among injecting drug users (IDUs) across the country with prevalence ranging between 7% 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 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 Behavioural Surveillance pilot round field work conducted September-December 2004.

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

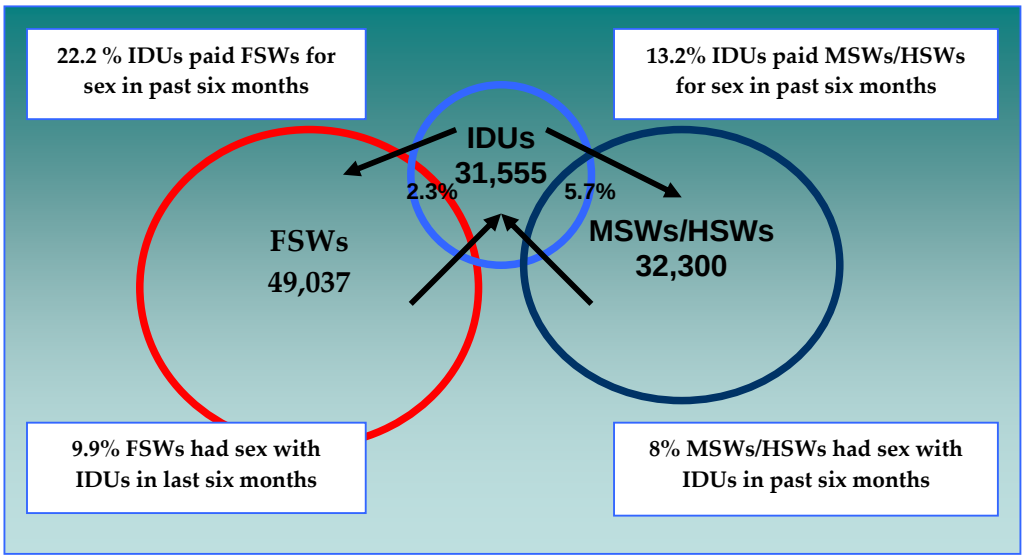
[4] IBBS Round 2 = Integrated Biological and Behavioural Surveillance Round 1 in 8 cities, field work conducted, September-December 2006

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 behaviours, 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 FSW population surveyed (see figure 1, IBBS, 2007; NACP 2005) .

The linkage between IDUs and FSWs 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 FSWs 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 FSWs 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 1: Interactions between the IDU, FSW, MSW and HSW populations (12 cities)



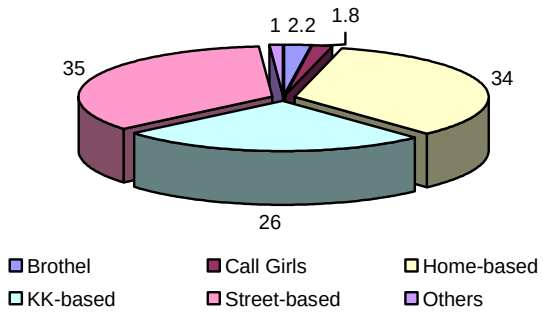
Chapter 3: Major findings and recommendations from the situation and response analysis for female sex workers[1]

3.1 Structure of the sex trade

Female sex workers

The estimated number of FSWs who are working in Pakistan is based on different mapping studies carried out between 2004 and 2008 and carried out in different cities. At present (2009) NACP estimates a total number of 136,000 female sex workers[2]. There are six categories of female sex workers identified in Pakistan. The proportion of sex workers working in each category is shown in Figure 2. It should be noted that these categories are overlapping and fluid.

Figure 2: Categories of female sex workers in Pakistan



Chapter 4 gives the definitions of the different categories of female sex workers in detail.

The average age of FSWs is 27.4 years, with the majority between 25 and 29 years of age and 10% between 15 to 19 years of age. The marital status among FSWs varies across cities; the majority is currently married (60.7%), while a small proportion is reported to be either separated/divorced (8.6%) or widowed (2.7%). FSWs initiated sex work at an average age of 22 years and report being involved in sex work for an average period of 5.2 years. The majority of FSWs are illiterate (59.2%).

Most FSWs (78%) belong to the city in which they work. Brothel-based FSWs are least likely to be natives, with nearly half of brothel-based FSWs having migrated from another city. City-specific analysis shows that FSWs in Karachi, Lahore, Larkana and Peshawar have higher proportions of FSWs who have migrated from smaller cities. In contrast, in smaller cities such as Bannu and Sukkhur, nearly all FSWs are natives. The migratory pattern of the four provincial capitals shows that most of the FSWs in Peshawar and Lahore migrated from different cities within the

[1] This assessment was carried out between April and June 2009 by FHI and was based on a literature review and field work.
[2] NACP shared this in a meeting with stakeholders on July 30, 2009

same province. In contrast, FSWs in Karachi mainly migrated from Punjab and large numbers of Quetta-based FSWs report originating from different cities of Sindh.

Analysis of sex work income reveals that the median monthly income for FSWs is approximately PKR8,000. The highest income is reported by brothel-based FSWs (median income PKR14,000 per month) while home-based FSWs report the lowest income levels (median income PKR6,000 per month). Income has an inverse relationship with age (i.e. younger sex workers earning more than older sex workers).

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 network among themselves while remaining in competition and they also connect to network operators who may be operating in different parts of the city and district.

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 centres (NACP, 2007).

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 sub-types (IBBS, 2007). Clients 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.

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.

If FSWs are home-based and not working independently, the NWO or madam solicits with the client, negotiates the fee and then calls the FSW to the KK or the place decided by the client to meet. The madam or NWO brings the FSW to the client and

receives the fee. Home-based FSWs who operate individually have the freedom to solicit with clients and do not have to share the money. The madams and 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 little support.

Discussion and recommendations on the structure of the sex trade

SDPs have been working mainly with brothel-based and kothikhana-based sex workers because they are easier to reach. Yet more than 70% of the sex workers do not belong to these categories and approaches have to be developed to also reach them. This can be done by involving these sex workers already in the mapping and baseline assessment and after that in the planning of strategies.

Madams are not only controlling the kothikhanas but also providing venues and network services for home-based and street-based FSWs. It is therefore important to include them in the interventions and to motivate them to improve working conditions and health conditions of the sex workers. This may be done by agreeing with them on times that peer educators can work with the FSWs (typically between late morning and later in the afternoon when there is minimal commercial threat for the madams) and on promoting the concept of a healthy establishment where the sex workers are free of STIs. With regard to client education, again the madams are important because they negotiate with the clients on behalf of the sex workers. If they insist on condom use and bring this up in the negotiations, the burden is not placed completely with the sex workers. International experience shows that without involving the clients in an intervention, the likelihood of success is slim. How to do this is one of the examples of the importance of involving sex workers in developing the strategies – they will know best. Recommendations include:

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 FSWs 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 FSWs
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

3.2 Legal and policy environment

The HIV & AIDS Prevention and Treatment Act was finalized in 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 behavioural practices.

Also the 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. It 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.

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. It is discussed in Chapter 1.

The Women Protection Bill, enacted in 2006 does have major implications for the female sex trade as it removes the right of police to detain people suspected of having sex outside of marriage, instead requiring a formal accusation in court. Thus, FSWs are provided a bit more protection from exploitation especially by police. However, consensual (hence commercial) sex outside marriage is still a crime under the new law.

In spite of the protection accorded by laws, FSWs are routinely harassed by law enforcement agencies. Police assume various roles in the sex industry from networking, running brothels to taking monthly/weekly *bhatta* (protection money) from brothel owners or FSWs. It is extremely difficult to nearly impossible to run a sex business without assistance from police in Pakistan, and madams and pimps keep a regular liaison with police and provide benefits in terms of pay-offs or free sex or both.

Yet, police act as the regulators of the trade and are responsible to enforce the law. The operating policies and action of the police need to be changed in such a way that they provide an enabling environment for the prevention of HIV transmission.

<u>Discussion and recommendations on the legal and policy environment</u>

Within the legal context that is in place, it will be possible to change the current attitudes of the police to a more supportive role. This has been done elsewhere by liaising with senior police officers; by adapting existing guidelines and by conducting advocacy sessions with police and other important stakeholders on reduction of stigma and discrimination and to promote understanding of the goals and objectives of the HIV prevention interventions. One very concrete approach that involves sex workers, NGO staff and the police is the establishment of crisis response teams to reduce harassment of FSWs and to document rights violations. Recommendations include:

1. Assess current guidelines for the police working in hotspots and explore what rules and regulations can be developed that facilitate prevention of HIV transmission in the female sex trade
2. Explore possibilities for structural and policy change to normalize condom use in commercial sex
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 to sex trade to function in a way that promotes the rights of sex workers, protects them and promotes safe sex behaviours. Base strategies on this and develop training modules where needed.

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

3.3.1 Awareness of STIs including HIV

Awareness of HIV among FSWs is 68.7%, the highest level being reported by brothel-based FSWs at 82.3%, the lowest with street-based FSWs (62.9%). The awareness is mostly confined to knowing that HIV is sexually transmitted, many fewer people know that condoms can prevent the transmission or that sharing needles and syringes is an efficient mode of transmission. The lack of in-depth understanding is also shown by the low level of perception of self-risk for HIV (38%).

The awareness level of STIs among FSWs is 67% and, of these, 24% self-reported an STI in the past 6 months and 81% received treatment. A study by the London School of Hygiene and Tropical Medicine (LSHTM, 2008) found that the majority of FSWs suffered symptoms of possible STIs in the past year. Common symptoms included genital discharge, genital itching and genital ulcers. The majority of women sought treatment from a wide variety of health care providers, mainly in the private sector.

3.3.2 Condom use

Condom use during sexual activity with clients was 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 highest for brothel-based FSWs at 42%, and lowest for home-based and street-based FSWs. No differences in consistent condom use were observed between different age groups or marital status. But there was 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. There was also an association between condom use and having been exposed to FSW interventions (IBBS, 2007).

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 have 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. Reported use of condoms at last sex with a non-paying partner was relatively higher than with paying clients (LSHTM, 2008).

The explanation for non-use of condoms most frequently given was that clients do not want to use them and sex workers do not have the ability 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. To what extent the madams and network operators promote and insist on condom use is not fully known. Yet, this is a very important aspect of intervention strategies that aim to promote condom use, because they are the ones who negotiate with the client.

3.3.3 Discussion and recommendations on the knowledge, attitude and practice of female sex workers

Knowledge, attitudes and practices of female sex workers are influenced by the effectiveness of the peer education and outreach approaches in the project. This not only applies to the education sessions (and hence to the training received by the peer

educators and outreach workers), but also to a thorough understanding of the barriers to safe sex behaviour. For this, research is likely to be needed and this can best be done by the peer educators and outreach workers. Recommendations include:

1. Develop standardized training modules for peer educators and outreach workers, covering: 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.
2. Promote condoms not only for protection for STIs, but also as a contraceptive alongside the promotion of other, back-up contraceptive techniques.
3. Develop structured training plans and a peer educator manual for peer educators and outreach workers on the roles and responsibilities connected to these jobs and their function in the intervention, as well as monitoring and record keeping.
4. 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 (which will include current awareness on STIs including HIV, condom use and its barriers) which will guide the intervention strategies.

3.4 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:

- Behaviour change communication activities
- Condom promotion and distribution
- Voluntary counselling 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 drop-in centres 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 or kothikhanas) and raising awareness regarding HIV and STIs, while providing condoms and promoting health seeking behaviour. The SDPs also provide referral mechanisms for FSWs to access VCT services and for HIV-positive women for care and support.

3.4.1 Coverage and mapping

While overall coverage of SDPs for FSWs 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 2: 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%

City	Year	FSWs registered	Total No of FSWs (IBBS estimate)	% Registered
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

The estimates of total numbers of FSW differ considerably, but NACP in a stakeholder meeting in July 2009, gave an estimate of 136,000 FSWs in Pakistan. The difference between the IBBS estimates and the SDP registrations can be explained because the SDPs do not work city-wide but only in selected areas with high densities of FSWs, while the IBBS is supposed to carry out a city-wide estimation. The mapping procedures by the IBBS are very clear but the registration procedures by the SDPs differ per NGO and there are no clear guidelines on when, how and why FSWs need to be registered. Yet, there is a lot of emphasis on the registration process because registration is a performance indicator, not only of the NGO, but also for the outreach workers. NGOs use the number of registered FSWs as an indicator that they are being reached with services, but this may not be the case because there is often no connection between registration and uptake of services.

3.4.2 Behaviour change communication

In all SDPs, behaviour change communication (BCC) is carried out by peer educators and outreach workers who are trained by the NGO to do this. The level of this training varies considerably between the SDPs, but there are no common training modules and the topics on which peer educators and outreach workers are trained are rather limited, focusing on HIV awareness, condom use and referral to the clinics. There is insufficient attention for STIs and no attention to skills of the trade (e.g., how to deal with abusive clients) beyond condom use and negotiation skills.

There are no standard guidelines for the roles and responsibilities of peer educators and outreach workers, nor a standardized training package and Standard Operating Procedures indicating the ratio of peer educators versus FSWs and outreach workers versus peer educators. There are also no guidelines on retention of peer educators, incentives and levels of fees. With an estimated five years in the trade, the turnover of sex workers involved as peer educators and outreach workers can be high and needs to be planned for.

3.4.3 Condom promotion and distribution

All SDPs include condom promotion and distribution in their service package and distribution through peer educators and through the NGO clinics is done free-of-charge. As with the numbers of registration, the number 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 NGOs, but even the NGOs admit that their distribution is below actual need of the FSWs. A study carried out by SoSec found that average condom distribution per sex per year had a ratio (number of condoms per client per year) of 24:1 (Lahore), 16:1 (Multan), 6:1 (Hyderabad) and 31:1 (Karachi) (SoSec, 2006). Other studies have also found that that coverage is far below the actual need, while it could be expected that demand for condoms will increase with coverage of SDPs.

3.4.4 Voluntary counselling and testing

Most of the NGOs involved in the SDPs for female sex workers provide their own counselling but do not do their own testing and outsource this to VCT centres situated away from project sites. It has been observed that only a small proportion of FSWs actually go for HIV testing if they are referred by SDPs. If testing with same-day results is offered in the SDP clinic, the number of FSWs taking up the service increases (PHACP experience). On-site and mobile rapid testing (including syphilis testing) integrated with STI clinical services is the likely successful model to improve access and enhance early diagnosis.

3.4.5 PHC and STI services

All NGOs implementing SDPs for FSWs have established a clinic that offers primary health care services and STI services as well as condom distribution. The clinics have the essential supplies for managing STI patients available and the FSWs who take up treatment in the clinics are satisfied with the treatment. However, it is generally reported that the clinics are underutilized by the target group – only 10% of the clients are FSWs. Most FSWs prefer to visit other health care providers for a variety of reasons, including accessibility (distance), being able to visit a doctor without having to identify as a sex worker, quality and experience of the doctors and the attitudes of the staff in the clinics.

Reviews indicate that the service providers in the NGO clinics have not received STI training and have inadequate knowledge of STI symptoms and complications and are thus not properly skilled in the management of STIs. This applies to syndromic management of STIs, but also to periodic presumptive treatment to treat asymptomatic STIs as an interim measure to reduce prevalence of gonorrhoea and chlamydia in particular.

NGOs are not coordinating with the private sector health providers in their project areas to institutionalize the syndromic management of STIs, and also 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.

3.4.6 Empowerment of FSWs

Empowerment of FSWs is one of the components of the SDP, and all functional SDPs have included various empowerment activities in their strategic plan, but these plans have not been executed and there is a large gap in that specific area of work. NGOs have very limited understanding of the concept of empowerment, while their attitude towards sex workers is one of bias, stigma and discrimination. The idea that staff have

to understand the perspective of sex workers and have to learn about the nature of their lives is non-existent. This translates into a total absence of involvement of FSWs in the planning and implementation of the project activities.

Many of the NGOs figure that by enlisting FSWs as peer educators and by hiring FSW as outreach workers, they have done as much empowerment as is possible. There is no SDP in which a self-help group of FSWs is operational and NGOs do not understand the benefits of such an initiative. Yet, all SDPs operate a DIC which can be used as a starting point for empowering sex workers by creating a safe space and by offering activities that are based on priorities of the sex workers.

3.4.7 **Discussion and recommendations on HIV prevention services**

It is very important to establish from the start the number of sex workers and the different categories of sex workers working in a city as this information provides the basis for monitoring the performance of interventions. Registration of FSWs by NGOs providing services is a much debated issue. While registration has been seen to improve monitoring by assuring verification of data, it is also argued that it may deny access to services for those who are unable to register for various reasons (e.g., not willing to disclose their identity). Most of the time, registration by local NGOs shows improved figures of outreach and clinical services while not focusing on the quality of services at the same time. Thus, registration should not be mandatory (if at all necessary) and should not replace quality improvement and quality assurance procedures.

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 is not sufficiently clear. It is necessary that SDPs make job descriptions for each. It also needs to be established how many sex workers can effectively reached per peer educator and this also depends on the number of hours a peer educator is operational. In projects elsewhere, an average number of 50-60 FSWs per peer educator is indicated, assuming that each FSW should be approached twice a month.

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. These trainings have to include life skills education (other than condom negotiation skills) and 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 acceptable for the client.

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.

Because of the failure of referral systems for FSWs to VCT centres, the consensus in Pakistan is that VCT should be offered in the clinics. When this is not possible, a more formal referral system has to be established which may involve training of

health care staff, especially on attitudes towards FSWs, and monitoring of services in the referral hospitals.

With regard to STIs, syndromic diagnosis still successfully treats symptomatic cases (if cephalosporins rather than quinolones such as ciprofloxacin are used for gonorrhoea). Asymptomatic cases are excluded, but they can be reached only through active screening programs. Recommending diagnostic test-based treatment is not feasible as facilities are not available in most of the places. A mix of syndromic and periodic presumptive treatment offers a better option as an interim measure to reduce the high prevalence of gonorrhoea and chlamydia in particular. Doctors and other health staff will need to be trained in this and also in attitudes and stigma and discrimination because the current attitudes of clinic health workers are a barrier for FSWs to attend the clinics. This training can also be attended by other health care providers that provide services to FSWs, which in turn can lead to a situation where referrals from those providers to the clinics can be formalized and peer educators can also refer to these providers.

Although empowerment of sex workers is part of all SDP strategic plans, this has not been implemented by most because of a lack of understanding of the concept by 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 should do. First and foremost, it means the involvement of sex workers in planning and implementation of activities and services as partners rather than as beneficiaries.

Recommendations include:

1. Review the surveillance data on FSWs 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 FSWs and staff involved in the implementation of the services
5. Establish the drop-in centres in consultation with sex workers, at locations that are convenient for the 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 and incentives for peer educators and outreach workers
8. Organize training in behaviour change communication, interpersonal communication and counselling as well as sessions on the topics mentioned in Section 3.3. 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 and 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 counselling in all SDP interventions, and develop links with testing services for the tests if these are not offered in the clinics
11. Diagnosis and treatment for STIs should be superior to that of other providers. Most STIs are asymptomatic and, aside from syndromic management, periodic presumptive treatment to treat asymptomatic STIs as an interim measure should be explored as an option. Specialists in STI management for sex workers will need 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 counselling 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

3.5 Functioning of Service Delivery Packages

All SDPs employ a project manager, project coordinators, program officers, doctors, counsellors and outreach workers. Surveys indicate a lack of clarity on roles and responsibilities of different jobs of the staff of SDPs and these seem often to overlap. There is also a lack of understanding of the project and its goals and the strategies to reach these goals. This also applies to the understanding of the need for values clarification of staff attitudes towards the target group, including aspects of stigma and discrimination and their manifestations; of a rights-based approach to be integrated in all components of the intervention; and of the promotion of empowerment of the target group. All SDPs use the same strategies for different categories of FSWs, not conceiving that different categories of sex workers may have different risks, that they may need different approaches to be reached and that those with the highest risk should be prioritized for intervention.

Although staff have received training, this is not consistent and there is no standardized training package that staff in different positions is required to follow before or soon after starting to work. This applies to specific trainings on different aspects of HIV interventions for FSWs, but also on programme management and monitoring and evaluation.

Very few staff have a clear understanding of monitoring as a method to improve and modify project activities and design. Monitoring and evaluation is seen as a requirement for the donors to put in their quarterly reports. The indicators are only concerned with outputs (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.

3.5.1 Discussion and recommendations on functioning of Service Delivery Packages

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 have

to 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.

In addition, a basic orientation package for all staff should be developed as well as standardized training packages for different functions. It is probably most efficient if those modules are developed at national level and rolled out at provincial level – for all NGOs that are working with FSWs – or, where relevant, for other NGOs working with different target groups. This will enhance quality assurance. Some type of certification is necessary for staff to have obtained within a certain period of working in the program. 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.

A very important training that has to be given at the start of the program relates to understanding of the project and its goals and on values clarification of staff attitudes towards the target group, including aspects of stigma and discrimination and their manifestations. It also has to include sessions on empowerment; what this means and what approaches can be used to promote 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 has to go beyond output indicators, and has to create an understanding that monitoring is a useful tool for assessing, guiding and adjusting implementation activities. It has to create an understanding of why indicators for field-level activities should preferably be developed with the target group, the peer educators and the outreach workers – and why the monitoring should be done in part by the target group who has a stake in the outcome.

Recommendations include:

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 since discriminatory attitudes of NGO staff towards FSWs have 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 and 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.

3.6 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 including counselling, 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 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 behaviours through the provision of services in geographically defined areas to a particular vulnerable population. The contracts specified measurable targets in areas of behaviour 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 PACPs face challenges related to procurement, financial management, delays of payment and authority of the PACP staff over disbursements. The implementation of the PACPs is of varying quality. Punjab PACP is said to be the most efficient. Here, the NGOs are monitored on time and receive most 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).

Another issue mentioned has been the lack of clarity on the criteria for selection of NGOs to implement the SDPs. This has resulted in the selection of NGOs to implement the SDPs that were not really qualified or experienced to do this with a disappointing performance of the intervention.

One of the roles of the PACPs is to promote knowledge exchange between NGOs operating on similar interventions within the province and within the country. This has not been done in a systematic manner. This also applies to the organization of trainings for SDP staff which has been inconsistent, both in terms of timing and in terms of quality.

Due to turnover of staff in the PACPs and hiring of staff that do not necessarily have a background in HIV interventions to oversee the SDPs, there is a perceived lack of understanding of the project interventions and the difficulties in implementation of these interventions, especially with regard to the enabling environment.

3.6.1 Recommendations on the functioning of Provincial AIDS Control Programmes

1. Train relevant staff on the project and its goals and the strategies to reach these goals. Include training on a rights-based approach to be integrated in all components of the intervention; and of the promotion of empowerment of the target group as well as aspects of stigma and discrimination and their manifestations.
2. Develop selection criteria for SDP packages and carry out the selection in a transparent manner

3. Appoint a focal person for the SDP who also conducts the monitoring and supervision
4. Hold regular workshops where NGOs involved in female sex work interventions (or other SDPs for different target groups) come together to exchange experiences and learn from each other
5. Organize standardized trainings, conducted by experienced trainers for the different topics relevant for the SDP on female sex workers

Chapter 4: Definitions and categories of female sex workers

There are six categories of female sex workers identified in Pakistan, the percentages of sex workers working in each category are given in brackets. It should be noted that these categories are overlapping and continuously changing. It is important to distinguish between the different categories because the sex workers in these categories are likely to have different risks and vulnerabilities and require different approaches to be reached with services. Those with the highest risk should be prioritized for intervention.

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 neighbours 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 FSWs 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 neighbours 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.

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 parlours or beauty salons who operate under the pretext of massage or beautification services and provide sexual services to clients.

Chapter 5: Goal, purpose, objectives and principles of the National Strategy for Prevention and Control of HIV Transmission among Female Sex Workers in Pakistan

Goal of the strategy:

To prevent HIV transmission among female sex workers and their sexual contacts

Purpose of the strategy:

To ensure delivery of quality HIV prevention interventions for female sex workers by SDPs/NGOs and other public and private institutions in Pakistan

Objectives of the strategy:

1. To improve the conduct of
    a) The mapping of the female sex trade in terms of location, categories of sex workers, estimation of numbers in each category, volume of sex work, and gatekeepers and
    b) Baseline assessments
2. To create an enabling environment in which rules, regulations and services are provided to female sex workers that respect and protect their rights, remove stigma and discrimination and support them in preventing HIV transmission
3. To reduce the vulnerability of female sex workers, their clients and their partners for HIV transmission
4. To increase access of female sex workers to quality STI, reproductive health and primary health care services
5. To mobilize and empower female sex workers to enable them to participate in all levels of decision-making regarding their own lives and working conditions
6. To strengthen the management and implementation capacity of institutions carrying out interventions with female sex workers

Chapter 6: Priority Areas for Intervention

Priority Area 1: An enabling environment

Objective:

To create an enabling environment in which rules, regulations and services are provided to female sex workers that respect and protect their rights, remove stigma and discrimination and support them in preventing HIV transmission

Interventions:

1. Review the HIV and AIDS Prevention and Treatment Act, the National HIV and AIDS Policy and the Anti Trafficking Laws with regard to their public health impact on the sex trade
2. Develop guidelines, regulations and training for Law Enforcement Agencies that are working in areas where sex work takes place
3. Prepare guidelines and minimum standards for creating safe spaces for FSWs whether they be drop-in centres, kothikhanas or brothels
4. Conduct a stakeholder political analysis to identify and strategize to address the various stakeholders who influence the female sex trade because these people can help to create an enabling environment
5. Conduct advocacy to reduce stigma and discrimination and to promote understanding and support for HIV prevention interventions
6. Develop a strategy for the media to support the reduction of stigma and discrimination and to promote understanding and support for HIV prevention interventions
7. Identify mechanisms to establish and maintain crisis response teams to deal with harassment of sex workers, outreach staff and peer educators
8. Develop partnerships with organizations that are working in the field of development to increase access of female sex workers to programs addressing improvement of their living conditions

Interventions	Implementation details
Review laws and policies	▪ All laws and policies that regulate the female sex trade will be reviewed on their impact on public health and the rights of female sex workers and their impact on an enabling environment ▪ An advocacy process will be developed for those aspects that hinder the prevention of HIV among female sex workers and their clients
Develop guidelines for law enforcement agencies and conduct training	▪ Meetings will be organized with PACPs and senior police officials operating in the intervention areas to assess current policies and guidelines for law enforcement in the sex trade and their impact on the proposed HIV interventions with female sex workers with the aim to creating directives (signing ID cards for project staff and peer educators, carrying a condom no reason for arrest, active action against perpetrators of violence against FSWs, humane and friendly attitudes and treatment for FSWs arrested, respecting human rights laws, support to crisis response teams). As a result of

Interventions	Implementation details
	these activities police higher management will write letters to local police officers for implementation of the above mentioned directives. ▪ Training modules will be developed with the police covering: o Understanding of the project and its objectives o General issues of FSWs and their impact on FSW risk and vulnerabilities o Prevention of HIV and STIs o Stigma and discrimination and its impact on HIV prevention o Crisis response teams ▪ The training should be carried out with involvement of senior police training officers
Prepare guidelines and minimum standards for creating safe spaces	▪ In each intervention area, a DIC will be established preferably adjacent to the clinic and location selected in coordination with FSWs ▪ See also under priority area 5
Stakeholder political analysis and strategies for involvement	▪ Political analysis will be carried out with peer educators in their training and can then be repeated by the peer educators with FSWs with whom they work ▪ The objective of the political analysis is to identify the various stakeholders who influence the living and working conditions of FSWs, the source and extent of their power, their expected role in the intervention and strategies to get their support for the intervention as well as the expected output. It is critically important that all stakeholders and FSWs are involved in the project planning process right form the beginning. ▪ Community-based monitoring needs to be introduced and practiced
Advocacy	▪ In order to create support for the HIV interventions with FSWs, advocacy will be needed with public sector officers (from health, social welfare and police), elected officials and key organizations in the community (women organizations and religious organizations). The political analysis will direct the type of advocacy necessary with these different stakeholders ▪ An advocacy plan will be developed based on relative influence and hence priority for advocacy ▪ This plan will identify topic of advocacy, target group, messages and methods of dissemination
Strategy for the media	▪ Analyse media coverage on female sex workers in terms of risks versus potential benefits for stigma and discrimination ▪ On the basis of the analysis develop a strategy to increase understanding in the media of the project and its objectives; of rights of sex workers; of HIV prevention interventions; and of stigma and discrimination and its impact on HIV prevention

Interventions	Implementation details
	▪ Develop short sessions or advocacy tools on these topics for different types of relevant media ▪ Develop training curriculum and guidelines for media
Crisis response teams	▪ The aim of the crisis response teams is to give support to FSWs being harassed and in violent situations and to document rights violations ▪ The team will consist of peer educators, outreach workers, NGO staff and legal resource persons and will be on call 24 hours a day where feasible ▪ It is an effective mechanism to forge solidarity and networking between FSWs among themselves and between FSWs and NGOs, police, legal advisors and the media ▪ It will take time for the team to be formed but this may be helped by inviting crisis response teams that are functional and can advise on organization and experiences
Partnerships with development organizations	▪ Based on priorities for development prioritized by FSWs (such as their own literacy, schooling of their children, setting up of saving and loan schemes, micro-credit, income generating activities, legal aid) identification is needed of development organizations that offer such schemes ▪ After identification, possibilities for linking will be explored as well as mechanisms and modalities for implementation

Priority Area 2: Mapping of the female sex trade and conducting baseline assessments

Objective:

To ensure that interventions reach all different categories of female sex workers with approaches and services that are relevant for each category, to develop a baseline on which to monitor performance of the intervention and to conduct formative research

Interventions:

1. Selection, recruitment and training of mapping team consisting of female sex workers, network operators and NGO staff
2. Implementation of mapping and analysis of data
3. Selection of priority locations for interventions
4. Selection, recruitment and training of baseline assessment team consisting of female sex workers
5. Implementation of baseline assessment

Interventions	Implementation details
Selection, recruitment and training of mapping team	▪ Mapping guidelines developed by HASP need to be reviewed to see if adaptations are required due to changing situations in the sex trade ▪ Selection criteria will be developed of mapping team of female sex workers and network operators (keeping in mind that they will not only do the mapping but also the analysis) ▪ Systematic and transparent recruitment procedures will be

Interventions	Implementation details
	followed ▪ Training will include also NGO staff and data analysis staff ▪ Training modules will be developed covering understanding HIV and STIs, sex and sexuality, family planning, attitudes and values; understanding mapping, scope, methodology, tools and techniques; understanding field work process, data collection and documentation and data compilation; accounts and contracting, field implementation scheduling and roles and responsibilities ▪ Training with field mapping testing will be carried out ▪ A mapping guide will be developed
Implementation of mapping and analysis of data	▪ Field interviews of key informants of tertiary and secondary stakeholders will identify places of high-risk activities ▪ Places will be ranked based on high-risk activity, frequency of mention; consolidation ▪ Mapping will be done through interviews at all spots with high risk activity ▪ At least one group discussion with FSWs will be held to validate information from interviews and also provide information about cross-cutting issues like STI providers, movement of sex workers, timing, etc. ▪ Results will be compiled, analyzed, and reflected upon
Selection of priority locations	▪ The selection of the priority locations for interventions will be based on the volume of the trade
Selection, recruitment and training of baseline assessment team	▪ Implementing agency should do the baseline assessment in collaboration with other stakeholders ▪ Criteria will be developed for the assessment team consisting of female sex workers: use people who have performed well in the mapping and ensure representatives of all categories of sex workers ▪ Training modules will be developed for participatory baseline assessment covering: o mapping of area, categories of sex workers, timings of operation o mapping of services accessible and available for sex workers for HIV/STI prevention o mapping of risk and vulnerability factors o sexual behaviours including range of sex partners and type of sex
Implementation of baseline assessment	▪ The baseline assessment will be a series of participatory exercises done by FSWs with FSWs to validate findings of mapping, to contact female sex workers and generate interest, to gain details of risks and vulnerabilities per category of sex workers, to initiate interventions and to identify potential peer educators. The compensation to be paid for the interviews should be sufficient to enable surveyors to reach all FSWs not just very low income FSWs.

Interventions	Implementation details
	▪ The outcome of the baseline assessment will guide the planning and development of interventions

Priority Area 3: Reduction of vulnerability to STI and HIV transmission

Objective:

To provide female sex workers with knowledge about STIs including HIV and their prevention, develop better health seeking behaviour, build skills to negotiate condom use and safe sex practices, provide condoms and referrals for services.

Interventions:

1. Develop an SOP for peer educators and outreach workers
2. Select and train peer educators
3. Develop and/or adapt information materials for FSWs
4. Implement peer education activities
5. Promote correct and consistent condom use through ensuring availability and accessibility of condoms and lubricants
6. Develop mechanisms to assess condom requirements and to monitor distribution and availability, accessibility and usage.
7. Develop or supply communications materials on family planning for sex workers
8. Involvement of lady health workers (LHWs)

Interventions	Implementation details
Develop SOP for peer educators and outreach workers	▪ The SOP will specify selection criteria, remuneration, working hours, roles and responsibilities, performance indicators, training, supervision and opportunity for career progression
Select and train peer educators	▪ Selection criteria will be followed and started with the sex workers that have already been involved in the mapping and baseline assessment. Peers will be recruited from all categories of sex workers ▪ Training modules for peer educators will be developed covering: • Rationale for the project, components of the project • Roles and responsibilities of peer educators and outreach workers • Registration process and reasons • Sexual and reproductive health • Basics of HIV and STIs • Prevention of HIV and STI • Basics of STI treatment • Gender and gender based violence • Sex and sexuality • Family planning • Risk and vulnerability (including drug use) • Rights and self esteem • Condom use, promotion and distribution

Interventions	Implementation details
	• Interpersonal communication • Client HIV and STI education • Networking • Empowerment and self help groups • Crisis response teams • Referral and follow-up • Monitoring and record keeping ▪ Regular refresher sessions will be conducted ▪ Sex workers will be invited from successful projects that have empowered sex workers to help guide local sex workers drive and own the interventions. This may have to be from outside the country.
Develop and/or adapt information materials	▪ Coordination with NACP and PACP will be sought to obtain existing information materials, to identify gaps and to make adaptations needed ▪ Peer educators will be involved in the adaptation of materials – ensure usefulness for illiterate audience; test new materials; print and distribute
Implement peer education activities	▪ Weekly/bimonthly outreach plans will be developed, indicating topics for attention (these should change regularly) ▪ Weekly/bimonthly meetings will be conducted with all peer educators/per outreach worker to discuss issues, new developments, plans and changes needed ▪ Outreach, referrals and condoms distributed will be monitored
Promote correct and consistent condom use	▪ Peer educators and outreach workers will have a sufficient supply of condoms to distribute among 'their' sex workers ▪ Barriers to condom use will be discussed with peer educators and outreach workers and innovative approaches will be developed with their help ▪ Condom use with different types of sex and different types of paying and non-paying partners will be researched
Develop mechanisms to assess condom requirements and to monitor distribution and availability, accessibility and usage.	▪ Regularly review stocks ▪ Calculate needs ▪ Identify all sources of condoms to understand condom coverage better ▪ Assess preferences of type of condoms with female sex workers ▪ Develop innovative approaches to measure condom use
Develop or supply communications materials on family planning for sex workers	▪ Identify existing communications materials on family planning, especially for low literate and illiterate populations ▪ Assess if these need to be adapted for the FSW population ▪ Adapt or obtain the relevant materials for distribution by the peer educators and the clinic

Interventions	Implementation details
Involvement of lady health workers (LHWs)	▪ LHWs have good access to home-based sex workers in rural and peri-urban settings. They should be trained to provide awareness about HIV and promote condom use

Priority Area 4: Increased Access to Quality STI, Reproductive Health and Primary Health services and VCCT

Objective:

To increase access of female sex workers to STI, RH, PHC and VCCT services for prevention of STI and HIV transmission that are client-friendly and demand-responsive and to increase the status of health of the sex workers and their families

Interventions:

1. Establish SDP clinics and decide on services offered located with DICs
2. Recruit and train health provider staff in the clinics
3. Effective and quality provision of STI syndromic treatment, regular screening, STI presumptive prevention treatment, reproductive health services, primary health care services and counselling, using national guidelines
4. Develop referral mechanisms to government or private VCCT and STI testing services if these are not offered in the clinics
5. Identify other health service providers used by female sex workers, train them on STI service provision using syndromic approach and on presumptive treatment of STIs
6. Training of non-qualified general practitioners (quacks, hakims and non-qualified doctors)
7. Develop and implement health care outreach mechanism
8. Standardize referral and follow-up mechanisms with peer educators and outreach workers
9. Develop a monitoring system for quality of services for STIs (own clinic and other providers) using mystery clients, exit interviews and peer educators interviews with clients

Interventions	Implementation details
Establish SDP clinics	▪ Barriers for uptake of STI services will be explored and taken into account in the planning for the clinics ▪ Location, opening hours and services offered will be decided with the FSW populations ▪ Clinic infrastructure will be set up following NACP guidelines and will ensure privacy and confidentiality
Recruit and train health provider staff	▪ Health staff have to have the right attitude towards FSWs ▪ Training modules will be developed for health provider staff covering: ▪ Syndromic treatment of STIs ▪ Treatment of asymptomatic STIs ▪ Presumptive treatment of STIs ▪ Screening, referral and testing ▪ STI/HIV counselling ▪ Condom promotion ▪ Outreach (referral, follow-up, adherence) through peer

Interventions	Implementation details
	educators and outreach workers ▪ Attitudes towards FSWs, understanding of risks and vulnerabilities of FSWs, rights of FSWs ▪ Client-friendly services
Provision of STI, RH, PHC, VCCT services	▪ Effective and quality services will be provided for STI syndromic treatment, regular screening, STI presumptive prevention treatment, reproductive health services, primary health care services and counselling, using national guidelines and based on priority services identified by the FSWs ▪ FSWs will be involved in the organization of the services and in monitoring of the performance of the services with respect to quality of the services and client friendliness of the service ▪ A system of regular monthly check-ups will be explored ▪ STI services will also be offered to clients and partners of FSWs
Referral mechanisms	▪ Where the clinics do not offer STI and HIV testing, formal referral mechanisms to public and private providers offering these services will be established ▪ Such referrals will be documented and followed up by the outreach workers ▪ To ensure a supportive attitude of such services, it may be necessary to develop an "active" referral mechanism which includes accompanying FSWs to such providers and giving additional counselling
Identify and train other health service providers in the area	▪ FSWs are often using health service providers other than an SDP clinic for a variety of reasons. These providers will be identified and discussions will be held to link them up to the project interventions. ▪ In case these providers offer STI treatment but are not trained in STI management or presumptive treatment, such training will be offered to them (can be done at the same time as the training of SDP clinic staff). Also referral mechanisms to the SDP clinic for services these providers do not offer, will be developed and agreed upon
Training of non-qualified general practitioners (quacks, hakims and non-qualified doctors)	▪ Many general practitioners (GPs) who are not qualified are treating STIs symptoms through various medications. Many clients visit them for seeking STI treatments. As syndromic treatment can be provided by trained non-qualified personal, the GPS and other providers can be identified and trained by SDPs.
Develop and implement health care outreach mechanism	▪ In addition to the clinic offering services at the DICs, outreach of the doctor/nurse to different locations in the intervention area will be organized. This can be in a brothel or kothikhana, locations to be identified and organized by the outreach workers. ▪ Develop a collaborative mechanism between outreach

Interventions	Implementation details
	activities and provision of health care services in order to identify potential sites and partners (in terms of peer educators and private health care providers) for facilitating outreach clinical services ▪ Service provided will be on a fixed day at a fixed time at a fixed location
Standardize referral and follow-up mechanisms	▪ Most referrals to the clinic will be through peer educators and outreach workers. A standardized form will be developed for this, as well as a standardized procedure for follow-up in case clinic visit did not take place or as a follow up for the clinic visit to ensure treatment adherence
Develop a monitoring system for quality of services for STIs	▪ Supportive supervision and monitoring of the SDP clinics will be organized through PACP staff or their consultants, according to established monitoring guidelines ▪ In addition, monitoring of the services will be done by the peer educators or outreach workers among FSWs who have used the clinic – or have not used it in which case reasons have to be assessed. Monitoring indicators will be developed together with the peer educators and outreach workers

Priority Area 5: Empowerment of female sex workers

Objective:

To mobilize and empower female sex workers to enable them to participate in all levels of decision-making regarding their own lives and working conditions, to influence norms for safe sexual behaviour and to address structural barriers

Interventions:

1. Establishment and management of drop-in centres (DICs) at locations that are convenient for the sex workers (linked to the clinic)
2. Conduct networking activities in the DICs based on priorities of the sex workers (discussions, psycho-social counselling, information and support to build a sense of community)
3. Conduct skills training sessions for FSWs
4. Conduct training sessions on identified priorities
5. Develop linkages with other key support activities such as children schooling, legal support and economic development programs of other NGOs on income generating activities, micro-credit etc.
6. Establishment of self-help groups
7. Social, economic and political empowerment

Interventions	Implementation details
Establishment of DICs	▪ In each intervention area, a DIC will be established preferably adjacent to the clinics and locations selected in coordination with FSWs ▪ The DICs will be managed by an outreach worker from the FSW target group and should be open at times preferred by FSWs ▪ The objective of the DICs is to provide a place to meet, rest, seek advice, organize activities and pick up condoms

Interventions	Implementation details
Activities in DIC	▪ Activities in the DIC will be decided on by the outreach workers and peer educators based on suggestions and demand from the FSWs

Skills training sessions in DICs	▪ Skills training sessions by peer educators or outreach workers or external facilitators will be held in the DICs as peer educators may not have the possibility to address larger groups of women in the area where they operate. It is also good to facilitate networking between FSWs.
	▪ Skills training sessions will be based on demand but are likely to include:
	  ▪ Gender and gender-based violence
	  ▪ Sex and sexuality
	  ▪ Family planning
	  ▪ Techniques and tricks of the trade
	  ▪ Safe sex and pleasure
	  ▪ Risk and vulnerability (including drug use)
	  ▪ Rights, self esteem and assertiveness
	  ▪ Dealing with clients who are abusive and/or under alcohol or drugs influence
	  ▪ Links between sex work, HIV and injecting drug use
	  ▪ Empowerment, community organization and self help groups
	  ▪ Crisis response team
	▪ The skills building sessions will be using participatory techniques and may be facilitated by anyone from the community with experience on the topic, with support from the outreach worker

Training sessions on identified priorities and linkages with relevant development organizations	▪ Once trust has developed between outreach workers, peer educators and FSWs and after sessions on rights, self esteem and empowerment, and the use of the DICs as safe places, FSWs may indicate priorities for trainings not directly related to their work but to their capacity to control their lives. Such trainings may include: literacy and numeracy; bookkeeping and investing money; massage and beauty therapies; rights and legal assistance; saving and loan schemes ▪ Experienced trainers on these subjects will need to be identified and contracted or these may be referred to other organizations that are specialized in these subjects
Linkages with key support activities	▪ If priorities identified by FSWs include subjects in the realm of services offered by government departments (such as education), private organizations or NGOs, the SDP will need to explore possibilities for cooperation. They have to ensure that FSWs or their children will be treated with respect and not with stigma and discrimination.
Self-help groups formation and training	▪ Self-help group formation is the outcome of a long process of peer-led interventions and networking and a sense of sharing common threats and seeking common benefits. It cannot be ordered by the project, but once interest is

Interventions	Implementation details
	generated, FSWs will have to be trained on different aspects of management of self help groups, including: roles and responsibilities of group members, financial management, inclusive processes, conducting meetings, democratic decision-making, agenda-setting etc. ▪ The NGOs will have to give technical support to these processes and organize the trainings
Social, economic and political empowerment	▪ Rather than having a concept of overall empowerment, specific types of empowerments in various areas should be considered e.g. social empowerment, economic empowerment etc. SDPS should try to solve issues related to social capital, e.g., birth certificates of FSWs' children, their admission in school and above all national identity card. In this way, SDPs will be able to approach and focus highly important issues and would be able to measure empowerment as well.

Priority Area 6: Strengthened management and implementation capacity of institutions carrying out SDPs for female sex workers

Objective:
To ensure that NGOs have an understanding of the different components of the SDPs, the approaches to implement these components and the capacity and skills to implement and monitor them.

Interventions:
1. Develop a standardized basic orientation program for all NGO staff
2. Develop a code of conduct for NGOs that are working on interventions with female sex workers
3. Develop job descriptions for all staff positions
4. Develop manuals and implement specialized training courses for selected staff
5. Develop a standardized management information system for all female sex worker interventions that feeds into the national monitoring database
6. Organize regular thematic workshops for PACP and NGO staff, and peer education and outreach workers to share experiences and learn from each other
7. Document successful interventions

Interventions	Implementation details
Standard basic orientation program	▪ Modules will be developed covering: ▪ Program vision and design ▪ Rights, living and working conditions of female sex workers ▪ Structure of the sex trade ▪ Self attitude and value clarification ▪ Gender ▪ Basic knowledge on STIs and HIV and prevention

Interventions	Implementation details
	▪ Participatory and empowerment approaches ▪ The trainings of these modules will be given at the start of the project and project managers have to ensure all staff working in the project have certification that they have completed the modules; for new staff recruited during the project, strategies will be developed to also certify them before taking up their project activities.
Code of conduct	▪ One of the findings on the past SDPs was that the attitudes of the NGOs towards FSWs were a barrier to successful project results. It is therefore necessary that staff of the NGOs implementing the SDPs develop a Code of Conduct that spells out guiding principles of the NGO based on a human rights paradigm, organizational principles that describe ways of working, programming principles that guide the program interventions, including services, program components and advocacy. ▪ It would be good if such code of conduct is one of the outputs of the basic orientation program as this will ensure the involvement of all staff and a shared understanding of the work to be carried out
Job descriptions	▪ Job descriptions for all staff positions will be developed indicating job duties and responsibilities, reporting lines, relationships with other positions, trainings to be followed and performance measurement
Training modules	▪ Modules will be developed on: ▪ Mapping and baseline assessment ▪ Advocacy and creation of an enabling environment ▪ Outreach and peer education ▪ Outreach planning and management ▪ Interpersonal communication/ behaviour change communication ▪ STI management ▪ VCCT and counselling ▪ Condom programming ▪ Family planning ▪ Program management ▪ Management information systems and monitoring techniques and approaches ▪ Financial management ▪ These trainings will be given by experienced trainers, preferably organized at provincial or even national level, depending on the number of staff to participate in the trainings. The trainings are obligatory for the positions in which this is indicated in the job description
Management information system	▪ An MIS will be developed that facilitates SDP management and also feeds into the key national M&E indicators. This MIS will cover indicators for all priority areas and will cover outputs and outcomes ▪ Where relevant, indicators will be developed in

Interventions	Implementation details
	coordination with peer educators and outreach workers ▪ Approaches have to be developed where monitoring data will be collected by those who have a stake in the outcome ▪ Monitoring information will be used to adapt strategies
Thematic workshops	▪ Within provinces and within the country, NGOs working on HIV prevention for FSWs will each have their own positive experiences, difficulties in implementation and strategies to overcome these difficulties. In order to learn from each other thematic workshops will be regularly organized on topics of interest for all NGOs and PACPs. ▪ These workshops will be organized by PACPs, who will have a budget for this
Documentation	▪ Interventions that are effective will be documented and disseminated nationally and internationally ▪ This will require the organization of a writing workshop that will at the same time facilitate sharing of experiences

Chapter 7: Monitoring and Evaluation

In the past, SDP monitoring has been regarded by the NGOs as a requirement for the donors and not as a method to modify and improve project activities and design. The indicators were only concerned with outputs and not with outcomes of the activities. This will be changed in the new strategy. Development of monitoring indicators then becomes an activity that is done together with the target group and becomes part of the project planning cycle. It is therefore not possible to have the indicators for the SDPs defined in the strategy, but possible indicators and milestones are suggested below.

The National HIV & AIDS Strategic Framework 2007-2012 gives the key national M&E indicators. Those relevant for interventions with female sex workers are:
"Impact:

1. Prevalence of HIV in most-at-risk population(s)
2. Prevalence of STIs in most-at-risk population(s)

Outcome:

3. Percentage of most-at-risk population(s) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
4. Percentage of female and male sex workers reporting the use of a condom with their most recent client

Outputs:

5. Percentage of most-at-risk population(s) who received HIV testing in the last 12 months and know the results
6. Percentage of most-at-risk population(s) reached with HIV prevention programmes
    a. Outreach and peer education
    b. Exposure to mass media
    c. STI screening and treatment
    d. HIV counselling and testing" (NACP, 2007)

Mapping and baseline assessment

Interventions	Possible indicators/milestones
Selection, recruitment and training of mapping team	▪ Mapping team has # female sex workers and # network operators ▪ Mapping team trained
Implementation of mapping and analysis of data	▪ Mapping report available indicating hotspots and volumes of sex trade ▪ Number of FSW mapped from # categories
Selection of priority locations	▪ Priority locations selected
Selection, recruitment and training of baseline assessment team	▪ Assessment team has # FSWs from # categories ▪ Training modules developed ▪ Training implemented
Implementation of baseline assessment	▪ # FSWs have been involved in the baseline assessment ▪ Baseline assessment report available

Registration and coverage

Interventions	Possible indicators/milestones
Registration	▪ The process of registration should be well defined. It should be made clear during the project planning that who should be registered, and what are the terms and condition FSWs or registering person should fulfil to qualify for registration.
Coverage	▪ Coverage should be defined in terms of stated goals and objectives of outreach programs and STI clinical services. An FSW should only be considered covered under the program if she has received a minimum set of services known to minimize vulnerability to HIV. Ideally, it should one one-to one counselling/BCC session, member of FSWs self help group and one visit/check-up at STI clinic.

Enabling environment

Interventions	Possible indicators/milestones
Review laws and policies	▪ Advocacy topics for law and policy review determined
Develop guidelines for law enforcement agencies and conduct training	▪ Facilitating directives in place ▪ Modules available ▪ Training conducted with involvement of police training officers
Prepare guidelines and minimum standards for creating safe spaces	▪ Guidelines and minimum standards prepared with involvement of sex workers
Stakeholder political analysis and strategies for involvement	▪ Political analysis completed ▪ Strategies to address stakeholders in place
Advocacy	▪ Advocacy plan developed for different stakeholders identifying topic of advocacy, target group, messages and method of dissemination ▪ # advocacy sessions carried out ▪ # outcomes
Strategy for the media	▪ Analysis of media coverage completed ▪ Strategies to address the media in place ▪ Modules and/or advocacy tools available ▪ # supportive articles or news items in the media
Crisis response teams	▪ # of sites with operational crisis response teams ▪ Number of reported incidents for response team ▪ Proportion of incidents addressed within a meantime of response agreed with the team
Partnerships with development organizations	▪ Mechanisms and modalities for partnership with organizations established ▪ Number of FSWs involved in partner activities

Reduction of vulnerability

Interventions	Possible indicators/milestones
Develop SOP for peer educators and outreach workers	▪ SOP established
Select and train peer educators	▪ Number of peer educators certified ▪ Ratio of FSWs to peer educators trained
Develop and/or adapt information materials	▪ Number of materials available to peer educators
Implement peer education activities	▪ Proportion of contacts made by peer educators (out of mapping numbers) ▪ Proportion of contacts made by peer educators monthly ▪ Peer educators taking up STI consultations ▪ Referrals by peers for STI consultations
Promote correct and consistent condom use	▪ To be developed by FSWs
Develop mechanisms to assess condom requirements	▪ Proportion of monthly sexual acts covered by free condom distribution through peers (no of condoms distributed divided by estimated monthly sexual acts with clients)

Increased access to STI, RH, PHC and VCCT services

Interventions	Possible indicators/milestones
Establish SDP clinics	▪ Clinic operational for # hours/week
Recruit and train health provider staff	▪ Proportion of health staff trained
Provision of STI, RH, PHC, VCCT services	▪ Proportion of FSWs coming to the clinic for each service (first time and repeat visits) ▪ Proportion of FSWs coming for regular (monthly) check-up ▪ Proportion of FSWs with repeat STI systems who come to clinic within 7 days of symptoms ▪ Number of male clients for STI service
Referral mechanisms	▪ Number of effectuated referrals to testing centres
Identify and train other health service providers in the area	▪ Number of other health service providers giving quality STI services
Develop and implement health care outreach mechanism	▪ Numbers of FSWs taking up outreach services
Standardize referral and follow-up mechanisms	▪ Standardized forms developed

Interventions	Possible indicators/milestones
Develop a monitoring system for quality of services for STIs	▪ Numbers of support supervision visits to STI services

Empowerment of female sex workers

Interventions	Possible indicators/milestones
Establishment of DIC	▪ DIC open # hours/day
Activities in DICs	▪ Proportion of FSWs visiting DICs
Skills training sessions in DICs	▪ Proportion of FSWs attending skills training sessions
Training sessions on identified priorities and linkages with relevant development organizations	▪ Proportion of FSWs attending training sessions ▪ Number of trainings offered
Linkages with key support activities	▪ Formal agreements with development organizations ▪ Number of FSWs assisted to access key support services
Self-help groups formation and training	▪ Number of groups formed ▪ Number of FSW members of self-help groups attending meetings ▪ Proportion of FSW who belongs to a self-help group ▪ Number of meetings held attended by # FSWs

Strengthened management and implementation capacity

Interventions	Possible indicators/milestones
Standard basic orientation program	▪ Proportion of NGO staff with certificates ▪ Proportion of PACP staff with certificates
Code of conduct	▪ Code of conduct developed
Job descriptions	▪ Proportion of NGO staff who know the details of their job descriptions
Training modules	▪ Proportion of staff certified in relevant modules
Management information system	▪ MIS operational ▪ Number of strategies adapted on outcome of monitoring data ▪ Development of new indicators to gauge program performance: Indicators may become progressively less sensitive and specific over time due to various reasons. The SDPs have a role to develop new indicators in order to gauge the program progress effectively. For example, if a program is focussing on improving quality of life of FSWs and their families the proportion of children of FSWs admitted to school might be an effective indicator to measure such improvement.
Thematic	▪ Proportion of relevant staff presenting in thematic

Interventions	Possible indicators/milestones
workshops	workshops
Documentation	▪ Number of documented interventions

Chapter 8: Roles and responsibilities of PACPs

The National HIV & AIDS Strategic Framework 2007-2012 (NSF II) specifies NACP and PACP responsible in the following strategies relevant for the interventions for female sex workers in Pakistan:

- Scale up interventions, geographically as well as by service, to reach a much greater proportion of the key and target populations
- Enhance the technical scope of HIV intervention projects so that, to the extent possible, they offer VCCT and testing services (HBV, HCV and syphilis as appropriate) to their clients with minimal referrals.
- Ensure pre- and post-test counselling and referral for all groups.
- Examine and resolve the issues concerning testing for HIV, notably the confusion among NGO service providers concerning the accuracy of different tests.
- Re-examine the appropriateness of HIV communication messages and materials for the key populations, increase the engagement of members of these groups in BCC design and activities, and revise accordingly.

The PACPs are responsible for the contracting of NGOs to implement the SDPs for female sex workers in their provinces. In order to do this, terms of reference have to be developed which indicate goal and objective of the SDP, scope of services to be provided, performance targets and milestones as well as timelines, responsibilities and reporting requirements. The Terms of Reference also have to indicate the selection criteria and qualifications required for the NGOs to be shortlisted.

Once the process of selection has been finalized and the projects have started, the responsibility of the PACPs includes:

- Making available to the NGOs/SDPs the latest surveys and reports relevant for the implementation of HIV prevention in female sex workers (assessments studies, results of surveys, reports of mapping studies, research papers and reports)
- Making available latest national guidelines on management of STIs, VCCT, ethical guidelines and other relevant guidelines, specifications for the procurement of essential drugs, including condoms
- Provision of technical support (through TACA), own staff or consultants on selected topics that form barriers for the implementation of services
- Organization of HIV-related trainings and standardizing the modules of the various trainings to be provided in the SDPs
- Organization of workshops that promote the exchange of knowledge and experience between different organizations carrying out SDPs for female sex workers within and between provinces
- Making available communication materials for female sex worker interventions that have been developed at national level, for use and/or adaptation by the SDPs
- Ensuring the MIS and monitoring framework of the SDPs is in line with the national monitoring framework
- Ensuring timely disbursement of project funds
- Appointment of one focal person for the SDP who will also be in charge of the organization of regular monitoring and supervision visits

In order to be able to carry out these tasks, the PACP staff involved in the SDP, and especially the focal person for the SDP, it is necessary that these staff be trained on the project and its goals and the strategies to reach these goals. The training should also include the rights-based approach to be integrated in all components of the intervention; and of the promotion of empowerment of the target group as well as aspects of stigma and discrimination and their manifestations.

Chapter 9: Terms of Reference of SDPs / Minimum Package of Services

Background

The HIV situation is changing rapidly in Pakistan. Recent evidence indicates a concentrated epidemic among injecting drug users (IDUs) across the country and among male sex workers (MSWs) and Hijras in Karachi. The size of the FSW population (latest estimates by NACP are 136,300 women) 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 below one percent. Several recent surveys have shown that although prevalence among FSWs is low, their risk is high and the epidemic potential is considerable because condom use is low and sexual partnerships of FSWs with IDUs and MSWs are reported by nearly one-third of IDUs and 25 percent of MSWs in Lahore and Karachi (NACP 2005).

There are six categories of female sex workers identified in Pakistan: brothel-based FSWs (2.2%), kothikhana-based FSWs (26%), street-based FSWs (35%), home-based FSWs (34%), mobile FSWs - Call Girls (1.8%), and others (1%). These categories are overlapping and continuously changing. The distinction between the categories is important because the sex workers in these categories are likely to have different risks and vulnerabilities and require different approaches to be reached with services. Those with the highest risk have to be prioritized for intervention. Access to FSWs who are not working from brothels or kothikhanas has proven to be difficult and most SDPs in the past have concentrated on the first two groups.

The Pakistan Enhanced HIV-AIDS Program that was launched in 2003 with assistance from the World Bank, CIDA, DFID and other development partners includes a core component of support to targeted intervention for FSWs, IDUs and other high-risk groups. The key challenge facing the Enhanced Program is to scale up HIV prevention services to high-risk populations including FSWs early enough to contain the epidemic. The Integrated Biological and Behavioural Surveillance, Round 2 found that although 11.4% of FSWs were aware of HIV prevention programs in their cities, only 2% reported utilizing the services. It was 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 were reluctant to become involved or visit the services on a regular basis. Yet, utilization of the services by the target population does appear to result in improved knowledge and corresponding practices. It was noted that programs and interventions will only be effective if they reach a critical mass of people who need them. (IBBS, 2007)

In 2009, a Strategy for HIV Prevention among Female Sex Workers in Pakistan was developed by NACP. The purpose of the strategy is to ensure delivery of quality HIV prevention interventions for FSWs by SDPs/NGOs and other public and private institutions in Pakistan. The strategy proposes six priority areas for intervention and

outlines the implementation details as well as possible indicators and milestones for the interventions.

The Provincial AIDS Control Program, Department of Health, Government of Pakistan intends to hire the services of an NGO or other organization for the delivery of a defined package of services for FSWs aimed at controlling and preventing the spread of HIV. The five-year province-wide contract will aim to cover all major cities of the province to ensure coverage of an estimated number (IBBS figures per province) female sex workers based on results of mapping studies. The contract will include provisions for expansion to other urban centres thereby enabling a flexible response to the emerging epidemic. This approach will have the advantage of easier management with lower transaction costs, more effective use of technical assistance, easier attribution and greater accountability.

Objectives

The objective of this contract is to control and prevent the spread of HIV in the FSW population in the Province. The contractor will deliver a defined package of services for the creation of an enabling environment, the reduction of vulnerabilities for STI and HIV transmission, increased access to quality STI, Reproductive Health, Primary Health and VCCT services and empowerment of FSWs (described in the scope of services) that will be provided to all categories of female sex workers. The work will be done in close coordination with the Provincial AIDS Control Program and under technical guidance of National AIDS Control Programme (NACP) during contract execution. Services will be implemented in accordance with written NACP guidelines.

The impact of the interventions to be achieved by 2014 (after five years) is: i) HIV prevalence remains below two percent among FSWs in the project area (monitored through HIV sero-surveillance); ii) syphilis infection is reduced by half from baseline (assessed through HIV sero-surveillance); the outcome is: iii) percentage (baseline to be established to 40%) of FSWs who take up regular monthly check-ups in SDP clinics or linked health care providers (assessed through HIV sero-surveillance); (iv) percentage (baseline to be established to 60%) of condom use with the most recent client, compared to baseline (assessed through HIV sero-surveillance). Output indicators are suggested in para 19 and include indicators on enabling environment, reduction of vulnerabilities for STI and HIV transmission, access to quality STI, reproductive health, primary health and VCCT services and empowerment of FSWs.

Scope of services

The implementing NGO will provide the following package of services related to the prevention of HIV transmission in FSWs:

1. Mapping of the female sex trade and conducting baseline assessments.
   Objective: To ensure that interventions reach all different categories of FSWs with approaches and services that are relevant for each category, to develop a baseline against which to monitor performance of the intervention and to conduct formative research
   Interventions:
   - Selection, recruitment and training of mapping team consisting of FSWs, network operators and NGO staff

- Implementation of mapping and analysis of data
- Selection of priority locations for interventions
- Selection, recruitment and training of baseline assessment team consisting of FSWs
- Implementation of baseline assessment
- Updating mapping every year

2. An enabling environment

   Objective: To create an enabling environment in which rules, regulations and services are provided to female sex workers that respect and protect their rights, remove stigma and discrimination and support them in preventing HIV transmission

   Interventions:

   - Review the HIV and AIDS Prevention and Treatment Act, the National HIV and AIDS Policy and the Anti-Trafficking Laws with regard to their public health impact on the sex trade
   - Develop guidelines, regulations and training for Law Enforcement Agencies
   - Prepare guidelines and minimum standards for creating safe spaces for FSWs whether they be drop-in centres, kothikhanas or brothels
   - Conduct a stakeholder political analysis to identify and strategize to address the various stakeholders who influence the female sex trade because these people can help to create an enabling environment
   - Conduct advocacy to reduce stigma and discrimination and to promote understanding and support for HIV prevention interventions
   - Develop a strategy for the media to support the reduction of stigma and discrimination and to promote understanding and support for HIV prevention interventions
   - Identify mechanisms to establish and maintain crisis response teams to deal with harassment of sex workers, outreach staff and peer educators
   - Develop partnerships with organizations that are working in the field of development to increase access of FSWs to programs addressing improvement of their living conditions

3. Reduction of vulnerability to STI and HIV transmission

   Objective: To provide female sex workers with knowledge about STIs including HIV and their prevention, develop better health seeking behaviour, build skills to negotiate condom use and safe sex practices, provide condoms and referrals for services.

   Interventions:

   - Develop an SOP for peer educators and outreach workers
   - Select and train peer educators
   - Develop and/or adapt information materials for FSWs
   - Implement peer education activities
   - Promote correct and consistent condom use through ensuring availability and accessibility of condoms and lubricants
   - Develop mechanisms to assess condom requirements and to monitor distribution and availability, accessibility and usage.
   - Develop or supply communications materials on family planning for sex workers

- Work with clients to create awareness about HIV and increase condoms use

4. Increased access to quality STI, reproductive health and primary health services and VCCT
   Objective:
   To increase access of female sex workers to STI, RH, PHC and VCCT services for prevention of STI and HIV transmission that are client-friendly and demand responsive and to increase the status of health of the sex workers and their families
   Interventions:
   - Establish SDP clinics and decide on services offered; locate with DIC
   - Recruit and train health provider staff in the clinic
   - Effective and quality provision of STI syndromic treatment, regular screening, STI presumptive treatment where appropriate, reproductive health services, primary health care services and counselling, using national guidelines
   - Develop referral mechanisms to government or private VCCT and STI testing services if these are not offered in the clinics
   - Identify other health service providers used by female sex workers, train them on STI service provision using syndromic approach and on presumptive treatment of STIs
   - Develop and implement health care outreach mechanism
   - Standardize referral and follow-up mechanisms with peer educators and outreach workers
   - Develop a monitoring system for quality of services for STIs (own clinic and other providers) using mystery clients, exit interviews and peer educators interviews with clients

5. Empowerment of female sex workers
   Objective:
   To mobilize and empower FSWs to enable them to participate in all levels of decision-making regarding their own lives and working conditions, to influence norms for safe sexual behaviour and to address structural barriers
   Interventions:
   - Establishment and management of a drop-in centre (DIC) at a location that is convenient for the sex workers (linked to the clinic)
   - Conduct networking activities in the DIC based on priorities of the sex workers (discussions, psycho-social counselling, information and support to build a sense of community)
   - Conduct skills training sessions for FSWs
   - Conduct training sessions on identified priorities
   - Develop linkages with other key support activities such as schooling of children of FSWs, legal support particularly in dealing with sexual violence and economic development programs of other NGOs on income generating activities, micro-credit etc.
   - Establishment of self-help groups

Selection criteria for the SDP implementation

6. The criteria for the selection of the NGO are as follows:

- Experience in working with disadvantaged communities in a rights-based empowerment approach
- Experience with outreach through peer educators and outreach workers
- Experience with mapping, conducting baseline assessments and formative/operational research
- Experience in the design and implementation of behaviour change communication strategies
- Experience in the provision of health related services to low income groups
- Experience in performance-based management of complex interventions
- Evidence of capacity for financial management
- Evidence of the capacity to develop and sustain partnerships with development organisations – both public and private

Roles and responsibilities of the NGO

7. The NGO will need to employ full time managerial staff: project manager, M&E/research officer, financial officer, advocacy officer and training officer. Programme staff will include: programme officer, field supervisor, outreach workers, doctor, counsellor, and lady health visitor. Some of these positions will need more than one person each, depending on the number of intervention sites.

8. The NGO has to ensure that all staff involved in the SDP have a common understanding of the goals of the project, the different components of the SDPs, the approaches to implement these components and the capacity and skills to implement and monitor them. For this to happen, the NGO will:
   - Develop a standardized basic orientation program for all NGO staff
   - Develop a code of conduct for NGOs that are working on interventions with FSWs
   - Develop job descriptions for all staff positions
   - Develop manuals and organize/implement specialized training courses for selected staff (in coordination with PACP)
   - Develop a standardized management information system for all FSW interventions that feeds into the national monitoring database
   - Organize regular thematic workshops for NGO staff, peer education and outreach workers to share experiences and learn from each other (in coordination with PACP)
   - Document successful interventions

Roles and responsibilities of the PACP

9. In order to be able to carry out their tasks, the PACP staff involved in the SDP, and especially the focal person for the SDP, will be trained on the project and its goals and the strategies to reach these goals. The training will also include the rights-based approach to be integrated in all components of the intervention; and of the promotion of empowerment of the target group as well as aspects of stigma and discrimination and their manifestations.

10. Once the process of selection has been finalized and the projects have started, the responsibility of the PACP includes:

- Making available to the NGO/SDP the latest surveys and reports relevant for the implementation of HIV prevention in female sex workers (assessments studies, results of surveys, reports of mapping studies, research papers and reports)
- Making available latest national guidelines on management of STIs, VCCT, ethical guidelines and other relevant guidelines, specifications for the procurement of essential drugs, including condoms
- Provision of technical support (through TACA), own staff or consultants on selected topics that form barriers for the implementation of services
- Standardizing the modules of the various trainings to be provided in the SDPs (in coordination with the NGO implementing the SDP)
- Organization of workshops that promote the exchange of knowledge and experience between different organizations carrying out SDPs for FSWs within and between provinces
- Making available communication materials for FSW interventions that have been developed at national level, for use and/or adaptation by the SDPs
- Ensuring the MIS and monitoring framework of the SDPs is in line with the national monitoring framework
- Ensuring timely disbursement of project funds
- Appointment of one focal person for the SDP who will also be in charge of the organization of regular monitoring and supervision visits

Monitoring progress

11. The implementing NGO will provide quarterly progress report within 20 days after the end of a quarter of project period. The primary means for judging progress will be the independent assessment of the appropriate indicators described in para 19. In addition, and of secondary importance, the client will judge progress towards achieving the targets described below in paragraph 19, by examining whether the NGO is demonstrating progress towards accomplishing objective semi-annual milestones, which are described below. In case that data on the indicators in para 19 are not available, the PACP will judge the progress based on information from the management information system, progress towards process milestones, and appropriate field monitoring. Any decision to terminate the contract or take other remedial action, specified in the contract will be based on past progress of the NGO, the existence of extraneous constraints, challenges, or impediments, a summary of all available quantitative information, and the latest results of behavioural and sero-surveillance.

12. For each of the components mentioned in the scope of services, milestones and/or indicators have been suggested. Progress will be measured by these indicators. These are as follows:

Mapping and baseline assessment

Interventions	Possible indicators/milestones
Selection, recruitment and training of mapping	▪ Mapping team has # female sex workers and # network operators ▪ Mapping team trained

Interventions	Possible indicators/milestones
team	
Implementation of mapping and analysis of data	▪ Mapping report available indicating hotspots and volumes of sex trade ▪ Number of FSW mapped from # categories
Selection of priority locations	▪ Priority locations selected
Selection, recruitment and training of baseline assessment team	▪ Assessment team has # FSWs from # categories ▪ Training modules developed ▪ Training implemented
Implementation of baseline assessment	▪ # FSWs have been involved in the baseline assessment ▪ Baseline assessment report available

Enabling environment

Interventions	Possible indicators/milestones
Review laws and policies	▪ Advocacy topics for law and policy review determined
Develop guidelines for law enforcement agencies and conduct training	▪ Facilitating directives in place ▪ Modules available ▪ Training conducted with involvement of police training officers
Prepare guidelines and minimum standards for creating safe spaces	▪ Guidelines and minimum standards prepared with involvement of sex workers
Stakeholder political analysis and strategies for involvement	▪ Political analysis completed ▪ Strategies to address stakeholders in place
Advocacy	▪ Advocacy plan developed for different stakeholders identifying topic of advocacy, target group, messages and method of dissemination ▪ # advocacy sessions carried out ▪ # outcomes
Strategy for the media	▪ Analysis of media coverage completed ▪ Strategies to address the media in place ▪ Modules and/or advocacy tools available ▪ # supportive articles or news items in the media
Crisis response teams	▪ # of sites with operational crisis response teams ▪ Number of reported incidents for response team ▪ Proportion of incidents addressed within a meantime of response agreed with the team
Partnerships with development organizations	▪ Mechanisms and modalities for partnership with organizations established ▪ Number of FSWs involved in partner activities

Reduction of vulnerability

Interventions	Possible indicators/milestones

Interventions	Possible indicators/milestones
Develop SOP for peer educators and outreach workers	▪ SOP established
Select and train peer educators	▪ Number of peer educators certified ▪ Ratio of FSWs to peer educators trained
Develop and/or adapt information materials	▪ Number of materials available to peer educators
Implement peer education activities	▪ Proportion of contacts made by peer educators (out of mapping numbers) ▪ Proportion of contacts made by peer educators monthly ▪ Peer educators taking up STI consultations ▪ Referrals by peers for STI consultations
Promote correct and consistent condom use	▪ To be developed by FSWs
Develop mechanisms to assess condom requirements	▪ Proportion of monthly sexual acts covered by free condom distribution through peers (no of condoms distributed divided by estimated monthly sexual acts with clients)

Increased access to STI, RH, PHC and VCCT services

Interventions	Possible indicators/milestones
Establish SDP clinics	▪ Clinic operational for # hours/week
Recruit and train health provider staff	▪ Proportion of health staff trained
Provision of STI, RH, PHC, VCCT services	▪ Proportion of FSWs coming to the clinic for each service (first time and repeat visits) ▪ Proportion of FSWs coming for regular (monthly) check-up ▪ Proportion of FSW s with repeat STI symptoms who come to clinic within 7 days of symptoms ▪ Number of male clients for STI service
Referral mechanisms	▪ Number of effectuated referrals to testing centres
Identify and train other health service providers in the area	▪ Number of other health service providers giving quality STI services
Develop and implement health care outreach mechanism	▪ Numbers of FSWs taking up outreach services
Standardize referral and follow-up mechanisms	▪ Standardized forms developed
Develop a monitoring system	▪ Numbers of support supervision visits to STI services

Interventions	Possible indicators/milestones
for quality of services for STIs	

Empowerment of female sex workers

Interventions	Possible indicators/milestones
Establishment of DIC	▪ DIC open # hours/day
Activities in DIC	▪ Proportion of FSWs visiting DIC
Skills training sessions in DIC	▪ Proportion of FSWs attending skills training sessions
Training sessions on identified priorities and linkages with relevant development organizations	▪ Proportion of FSWs attending training sessions ▪ Number of trainings offered
Linkages with key support activities	▪ Formal agreements with development organizations ▪ Number of FSWs assisted to access key support services
Self-help groups formation and training	▪ Number of groups formed ▪ Number of FSW members of self-help groups attending meetings ▪ Proportion of FSW who belongs to a self-help group ▪ Number of meetings held attended by # FSWs

NGO management and implementation capacity

Interventions	Possible indicators/milestones
Standard basic orientation program	▪ Proportion of NGO staff with certificates
Code of conduct	▪ Code of conduct developed
Job descriptions	▪ Proportion of NGO staff who know the details of their job descriptions
Training modules	▪ Proportion of staff certified in relevant modules
Management information system	▪ MIS operational ▪ Number of strategies adapted on outcome of monitoring data
Thematic workshops	▪ Proportion of relevant staff presenting in thematic workshops
Documentation	▪ Number of documented interventions

13. Because the above indicators and milestones are for the duration of the 5-year project, there are milestones indicated for the first half year of the project:

- Senior project staff have been recruited and are trained in the standard basic orientation module
- Basic infrastructure, i.e. transportation and main office, computers and programmes installed and operating;
- Job descriptions are developed for all posts
- Mapping report is available indicating hotspots and volumes of sex trade
- Baseline assessment report is available
- Stakeholder political analysis completed

- SOP for peer educators and outreach workers available
- Peer educator manuals are available, developed with inputs of FSWs
- Selection process of peer educators has started
- SDP clinic is operational, location and services decided together with FSWs
- Drop-in-centre is established, management and activities offered decided together with FSW

14. Milestones for the second half-year include:

- Staffing is completed
- Training schedule and modules for training for all staff developed; all staff have followed basic orientation module; specialized trainings have started
- Guidelines for law enforcement agencies are developed by the police in cooperation with NGO staff
- Training modules have been developed with the police
- Strategies to address stakeholders in place and implementation started
- Advocacy plan developed for different stakeholders identifying topic of advocacy, target group, messages and method of dissemination and implementation started
- Trainings for peer educators have started
- Information materials for peer educators available
- Standardized MIS is established, M&E officer trained

Duration of Contract and Geographical Spread of Services

15. The Provincial AIDS Control Program will sign the contract with the successful NGO which will remain effective for a period of five years subject to satisfactory execution of the contract. The executing NGO will provide services to FSWs in major urban centres of the province as identified by the program. Coverage could be extended to other cities in response to mapping studies or discovery of other "hotspots."

16. The contract will be a lump sum contract and therefore output-based rather than focused on inputs. The selected organization will have considerable autonomy in deciding service delivery mechanisms to achieve project objectives. Payments will be made primarily on the success of the organization in making progress towards the targets specified in Para 18 measured annually by a third party. Other sources of data for judging progress will include the management information system and integrated behavioural and biological survey (IBBS). Achievement of results on the ground will be considered of primary importance.

Compliance with National and Provincial Guidelines

17. The executing NGO will follow national guidelines (current or those that will be developed during the period of contract execution) for delivery of services to the FSWs. While procuring essential drugs including condoms, the executing firm will ensure that they meet the specifications and standards laid down by the provincial Department of Health. Where such standards or specifications don't exist, the specifications and standards laid down by the WHO will govern.

Recording and Reporting Requirements

18. The minimum recording and reporting requirements will be as follows:

- The NGO's staff (including peers educators or outreach workers) will maintain a daily log of their activities in sufficient detail to allow a review and assessment by the supervisory personnel.
- The number of clients per day using the services and the regularity of clients in using services
- Maintenance of stock registers to allow monitoring and reporting of stock-outs of essential commodities
- Maintenance of a register of patients at the drop-in centre and for VCCT services in sufficient detail to allow data analysis and its interpretation, but keeping confidentiality of records from persons not related to program management and implementation
- Maintain income and expenditure statements of the project proceeds for external annual financial audit, and provide copy of the audit report to the client or its representative within three months after the completion of a fiscal year (July 1 – June 30). The financial audit will be used solely to determine whether the organization is financially viable.
- Preparation of quarterly progress reports and their submission to the client and the management firm within 20 days after the completion of every quarter taking contract signing as the reference date. The quarterly progress report will provide at least the following information:

    - Progress made against the agreed work plan
    - Progress made in achieving the agreed semi-annual process/output
    - target(s)
    - Challenges encountered and options used to resolved them
    - Relations with stakeholders like FSWs, their Clubs (if any) or Unions/associations, local police and community leaders

Accountability and Working Relationship

19. The NGO will be accountable to the Provincial AIDS Control Program for the satisfactory delivery of the services defined. They will work in close collaboration with the National AIDS Control Program, the World Bank, other relevant development partners, and other NGOs working with FSWs.