Documenting the Experiences of Sex Workers

Draft Report
to the POLICY Project

David Lowe Consulting – Asia
December 2002

Table of Contents

Acknowledgements

Most focus groups and all interviews with sex workers were conducted by David Lowe (Consultant) and Uy Chanthon, (Program Officer, POLICY Project/Cambodia). We are very grateful to the *Oxfam Womyn's Agenda for Change* project for recruiting 30 sex workers to participate in focus groups and for facilitating these groups. We are also grateful for the assistance provided by Kha Sovannara in recruiting male sex workers to participate in a focus group. David Lowe and Dr. Phong Choun conducted most of the interviews with nongovernmental organizations (NGOs), with Uy Chanthon participating in some NGO interviews.

We are grateful for the support of the POLICY Project staff in providing guidance and logistical assistance with this project. In particular, we would like to thank Felicity Young, Director/HIV/AIDS Advocacy, who was the supervisor for this project, and Misha Coleman, Deputy Director/Program Development, POLICY Cambodia.

Dr Carol Jenkins, USAID Asia/Near East Regional HIV Advisor, provided invaluable technical assistance and this report would not be possible without her vision and guidance.

Finally, and most importantly, we would particularly like to thank all of the sex workers who participated in focus groups and interviews.

David Lowe has written this report. The opinions expressed in the report are those of the author.

The report was kindly funded by the United States Agency for International Development (USAID). Contract number etc to be added.

Executive Summary

To prevent HIV transmission via commercial sex, a number of countries in the Asia and Near East (ANE) region, including Cambodia, have adopted "100% Condom Use Programs" (100% CUPs). These programs mandate consistent condom use during all commercial sex acts and outline sanctions against brothel management (e.g., warnings, brothel closure) for failure to comply. While adoption of this program demonstrates strong political commitment to address HIV and recognizes the need to use a public health approach when targeting the sex industry, little is known about the implementation of these programs from the perspective of the sex workers themselves. This report documents the experiences of sex workers in Cambodia's 100% CUP and explores how the program contributes to or hinders the delivery of effective interventions to prevent transmission of HIV and other sexually transmitted infections (STIs). Using this analysis, the report makes recommendations on how HIV/STI interventions can be enhanced. Understanding the perspectives of sex workers is important, because it can enhance the program's implementation, thereby contributing to the attainment of program objectives, and can also highlight policy and programmatic reforms necessary for respecting and upholding the human rights of the sex workers.

However, it is emphasized, that this is not an evaluation of the 100% CUP. This consultancy is a qualitative work. Information was gathered through focus groups and individual interviews with sex workers from Koh Kong, Phnom Penh, Siem Reap, and Sihanoukville. Nearly 150 female direct sex workers (DSWs) and female, male, and transgender indirect sex workers (ISWs) participated. This information was supplemented with interviews with NGO staff members working with sex workers and a focus group discussion with male clients of sex workers.

Key Findings

Condom Use

The existence of the 100% CUP *per se* is not enough to ensure consistent condom use. While DSWs report high levels of consistent condom use, they are not able to solely rely on brothel managers to enforce client use of condoms. DSWs identified the continuing need to negotiate condom use with some clients.

Registration

One of the key components of the 100% CUP is the registration of all DSWs and monitoring their attendance at STI clinics. While a significant majority of DSWs had been registered, many were not told why this information was collected and others were given misinformation. Most DSWs also reported that they were not told how their information was stored or who had access to it – raising concerns regarding the DSWs' right to confidentiality. Another concern was the practice of hiding sick or under-age sex workers. Some DSWs were hidden because police were said to sometimes demand bribes where the bribe amount was based on the number of registered sex workers in the brothel. DSWs also reported that a large number of brothels had not even been identified – thereby leaving them beyond the reach of the 100% CUP. Additionally, only one ISW participating in the project had been registered, demonstrating the challenge of reaching the indirect sector of the sex industry through the 100% CUP.

STI Clinics

With few exceptions, government STI clinic staff were said to be very judgmental and this was demonstrated by rude comments to the sex workers, blame following diagnosis of an STI, and rough, painful vaginal examinations. Prior to the 100% CUP, many DSWs had attended NGO clinics and, therefore, had a benchmark for comparison. While regular attendance at government STI clinics is a key provision of the 100% CUP, DSWs can avoid attendance – either by giving their medical controls card to other sex workers to attend in their place or, at one site, by bribing clinic staff. In addition, some DSWs said they went to NGO or private clinics to receive treatment if they had STI symptoms. If the STI had been effectively treated elsewhere before the DSW attended the government clinic, the absence of symptoms would have been taken as an indicator of consistent condom use. Besides the threat of sanctions, lack of choice over which clinic to attend (e.g., government vs. NGO), staff attitudes in government clinics, the charging of fees in some sites for services that are supposed to be provided for free (e.g., up to 5,000 riel per month), and the cost of transportation can all be disincentives for sex workers to attend STI clinics on a regular basis.

Perceptions Regarding Police

Cooperation among police, brothel management, and sex workers is an essential element of successful implementation of the 100% CUP at the local level. However, in all sites visited, it was reported that police either owned some of the brothels and/or were taking bribes from brothels. All of the sex workers appeared to be frightened of the police. While this was partly related to claims of bribery, many reported incidents of violence when police visited brothels and police demanding free sexual services. There was also a fear of brothel raids and being arrested, particularly in Phnom Penh. Additionally, there was a belief that police will not take action following reports of physical violence toward sex workers and that the only successful way for sex workers to initiate police action was through payment of a bribe.

Sex Worker and NGO Involvement in the Operation of the 100% CUP

There is very little evidence of any sex worker participation in the operation of the 100% CUP, apart from passive requirements regarding compliance. Sex workers were not consulted in the program design or in its implementation. There was also little evidence of attempts by local authorities to meet with sex workers and explain how the program is intended to operate. There have been only minimal attempts to support the mobilization or empowerment of sex workers to enable them to increase their control over interventions directed at the sex industry. Another finding was the exclusion of NGOs from working with DSWs. Where NGOs were previously providing STI services, they have had to abandon DSW projects and confine their activities to working with ISWs. There were some exceptions to this practice, particularly in Sihanoukville.

Strengths and Challenges of the 100% CUP

Some of the strengths of the 100% CUP include:

- the official recognition of the need to work with the sex industry;
- the potential for creation of a normative behavior surrounding condom use;
- placing responsibility for condom use with the owners of brothels (not just sex workers);
- involving local authorities in HIV/AIDS prevention strategies;
- working to enhance the STI infrastructure; and
- improving DSW access to STI clinics.

These achievements provide the foundation on which improved strategies to target HIV/STI interventions to all those involved in the sex industry can be built.

However, increasing consistent condom use may be difficult for a number of reasons. There are some situations in which DSWs said condoms might not be used (e.g., where clients pay more money for sex without a condom). Additionally, there are a number of hurdles to be overcome when applying the 100% CUP to ISWs. Qualitative data suggest that, currently, there may be a trend for DSWs to move from direct to indirect sex work and for an increasing number of clients to seek commercial sex from ISWs. The shift of male clients may be associated with seeking sex without condoms. It may be that the 100% CUP has been largely successful in creating a monopoly of condom use in brothels, creating a greater demand for non-condom use with ISWs.

Reports from sex workers revealed the potential for and the reality of corruption within the system, both on the part of local authorities (e.g., police and clinic staff taking bribes) and those involved in the sex industry (e.g., brothel managers hiding sex workers). In particular, the conflict of interest in having police register sex workers and in monitoring compliance, while at the same time taking bribes, creates an environment of fear and distrust. Given the significant involvement of police in the 100% CUP, this level of distrust can only harm the program's credibility. Financial and other disincentives (e.g., judgmental attitudes of STI clinic staff) further undermine program compliance.

Many aspects of the 100% CUP violate the human rights of sex workers. While most of the sex workers expressed concerns regarding human rights issues, other issues did not attract adverse comments. However, this needs to be placed in context. Many sex workers have minimal schooling and have only a limited, if any, understanding of their rights. As sex workers, they experience constant harassment, consistent with their very low social status. To some extent they have come to expect unfair treatment as the norm. Violation of sex workers' human rights, even unintentional, is not an acceptable consequence of the 100% CUP and serves further to hinder the achievement of the program's goals. Program models from sex worker-driven NGOs in other countries document the success of using strategies that meaningfully involve and empower sex workers to improve their lives and health.

Recommendations

Based on information obtained in this consultancy, the following recommendations are made to all stakeholders:

1. Strengthen the policy framework for the 100% CUP to ensure there are clear statements of principles and operational guidelines for all key aspects of how the program is intended to operate.

2. Ensure supervision of sites for greater standardization of performance and strengthen adherence to key guiding principles across sites.

3. Enhance the standard of care at STI clinics, consistent with the *Guidelines for Implementation of STI Services*. These services need to address a broad range of health issues for sex workers and not be confined just to STI management. In order to enhance sex worker access to regular STI management, emphasis needs to be placed on creating a sex worker friendly environment and the cost of clinical services, including treatment, should be provided free of charge.

4. Develop high profile HIV/STI prevention campaigns targeting the clients of sex workers, in recognition that the responsibility for consistent condom use rests with brothel management, sex workers, and clients.

5. Develop peer-led sex worker organizations and other strategies to ensure that under-age sex workers have access to both sexual and other health care services.

6. Give priority to the development of programs that more effectively target the risk of HIV infection and STIs among ISWs.

7. Develop strategies that address the risk of HIV and STI infections among male sex workers and their clients. NGOs and peer outreach approaches should play a primary role in these efforts.

8. Promote the social marketing of condoms, as well as subsidized female condoms and water-based lubricants as a way of encouraging condom use.

9. Undertake a re-design of the 100% CUP to minimize the opportunities for corruption. Where voluntary compliance can be achieved, mandatory aspects of the program should be eliminated.

10. Modify the 100% CUP *Strategy and Guidelines* so that they uphold the human rights of sex workers. In particular, ensure that the guidelines state that:

    - Attendance at STI clinics for all sex workers should be strongly encouraged, but not be compulsory.
    - Health care workers, both government and NGO, should be charged with the responsibility of encouraging DSWs to regularly attend STI clinics, including follow-up of sex workers who do not attend.
    - Police should not be involved in the collection of personally identifying data for sex workers for the purpose of ensuring attendance at clinics.
    - STI clinics should only collect personally identifying data which are necessary for the provision of clinical services. Clinic cards held by sex workers should use a code instead of the sex worker's name. All personally identifying data held by clinics should be treated in a confidential manner.
    - Sex workers should have a choice of which STI clinic to attend, where more than one clinic exists in the local area.
    - STI management of sex workers should be undertaken with their consent.
    - The use of mystery clients as a monitoring tool should be discontinued.
    - Methods for monitoring the program do not compromise the rights of sex workers and that recognize that brothel managers, clients, and sex workers all have a role to play in ensuring consistent condom use should be developed.

11. Support the development of sex worker controlled and driven community mobilization programs/organizations with a focus on increasing sex worker solidarity and with a particular emphasis on helping sex workers understand and use their human rights protections. Additionally, develop strategies to enable sex workers to improve their safety with non-commercial partners. Encourage involvement of NGOs in addressing the health and social development needs of all sex workers, not just the need for sexual safety.

12. Expand the nature of the program to include a far greater emphasis on client education and an expanded set of priorities among sex workers (including prevention of sexual violence and provision of services for SWs who have been raped).

13. Foster senior level commitment and support for the 100% CUP at the local level. Additionally, consultations should be conducted with sex workers and their advocates on meaningful ways of including sex workers in the operation of the 100% CUP. This should include the option of establishing sex worker consultative groups in each province where the 100% CUP is operating and sex worker representation on CUWGs and CUMECs.

14. Encourage the involvement of NGOs in addressing the health and social needs of DSWs by:
    - STI clinics being jointly staffed by government and NGO health care workers, where NGO clinical staff are available,
    - Encouraging NGOs to undertake outreach work with DSWs, and
    - Facilitating the provision of broader social health services to sex workers, where NGOs provide these in provinces where the 100% CUP is operating.
15. Develop a national steering committee for HIV prevention in the sex industry and place sex workers and police on this committee.
16. Develop a sex worker-police liaison unit in each area; educate police about human or citizen's rights and address issues of police violence, corruption, free sex on demand and failure to handle sex workers' complaints as a high priority.
17. Ensure representative sampling of sex workers for HIV surveillance through community negotiation, mapping and procedures that involve sex workers as partners.

Section 1: Introduction

To prevent HIV transmission via commercial sex, a number of countries in the Asia and Near East (ANE) region, including Cambodia, have adopted "100% Condom Use Programs" (100% CUP). These programs mandate consistent condom use during all commercial sex acts and outline sanctions against brothel management (e.g., warnings, brothel closure) for failure to comply While adoption of these programs demonstrates strong political commitment to address HIV/AIDS and recognizes the need to use a public health approach when targeting the sex industry. However, little is known about the implementation of Cambodia's 100% CUP from the perspective of those who are most disempowered – the sex workers themselves. For example, what are the barriers to effective implementation of the program? Are there any unintended side effects of the program's application? How might the program be improved to ensure even greater success?

Scope of Work and Objectives

This consultancy focused on documenting the experiences of sex workers in Cambodia's 100% CUP and through an analysis of the data, explored how the program contributes to or hinders the delivery of effective HIV/STI interventions for the sex industry. The objectives were:

1. To document the experiences and operational issues for the sex industry regarding the application of the 100% CUP.
2. To explore the extent of sex worker involvement and participation in the implementation, monitoring, and evaluation of the 100% CUP.
3. To explore how the 100% CUP contributes to or hinders the delivery of effective HIV/STI prevention and care strategies for sex workers.
4. To explore how sex workers can more actively participate in the design and delivery of interventions targeting the sex industry.
5. To make recommendations about strategies for improving HIV/STI interventions for the sex industry in the ANE region from the perspective of sex workers and the NGOs that provide them support services.

These objectives were not intended to serve the purpose of being an evaluation of the 100% CUP.

Methodology: A Qualitative Focus

This consultancy is a qualitative work. Data obtained from sex workers were gathered through focus groups, supplemented with individual interviews, conducted between mid-September and mid-October 2002. A semi-structured interview format was used. While the report emphasizes the strength of evidence, and highlights different viewpoints, given the qualitative focus of the work, data have not been translated into percentages.

Box 1. Key Elements of the Methodology

1. A review of relevant documents and selected literature.
2. Focus groups and individual interviews with sex workers (both female and male).
3. One focus group with male clients of direct sex workers.
4. Interviews with NGOs working with sex workers.
5. Analysis of data collected.

Key Informants

The sex industry consists of sex workers, clients, brothel management, madams, and bar staff. However, this project deliberately focused on interviewing sex workers, because sex workers are the least powerful members of the industry and their voice is not often heard; clients can be difficult to access; information obtained from brothel management is likely to be highly biased towards what they perceive as their business interests; and time constraints.

Table 1 presents a breakdown of the types of key informants. The project primarily focused on direct sex workers (DSWs) as the 100% CUP appears to be largely confined to brothels at this stage of its development. Some indirect sex workers (ISWs) were also recruited to participate since many had previously worked in brothels and to determine whether the attitudes of ISWs to HIV/STI prevention differed significantly from DSWs. The male ISWs who participated in a focus group have male clients. One client focus group was conducted with 10 fishermen from Sihanoukville. Thirty-sex (36) individuals representing 12 different NGOs participated in interviews. Many of the NGOs that participated in interviews also facilitated access to sex workers.

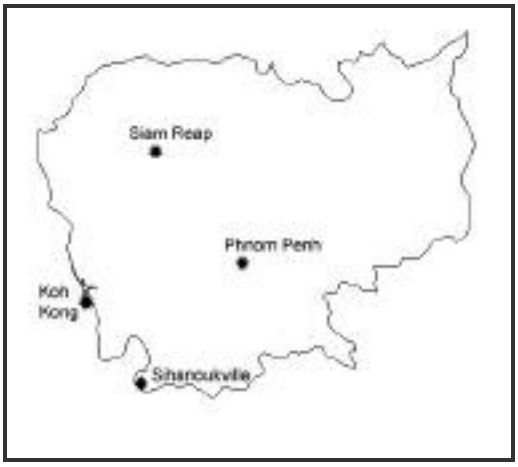
Table 1: Key informants

Key informants	Focus group participants	Individual interviews	Total participants
Level 1			
Direct female SW	86	5	91
Indirect female SW	43	2	45
Transgender SW	5	-	5
Male ISW	7	-	7
Total sex workers	**141**	**7**	**148**
Level 2			
Clients	10	-	10
Level 3			
NGOs	-	36	36

Total (Other)	**10**	**36**	**46**

Site Selection

The map indicates the project's sites. These sites were chosen for the following reasons: **Phnom Penh** has the largest number of sex workers in Cambodia; **Sihanoukville** is where the 100% CUP pilot was conducted and also has a large sex industry, with an itinerant population; **Siem Reap** is a large tourist center with a significant sex industry catering to both locals and foreigners; and **Koh Kong** is a border town, with a significant number of visitors from Thailand and is relatively isolated from other major centers in Cambodia. While these sites may not be wholly representative of the sex industry in Cambodia, they do represent a very large proportion of the industry and provide a substantial variety of locales.



Limitations of the Methodology

As with all qualitative work, there are questions regarding the reliability and accuracy of the information collected. Some of the factors that could affect the findings of this report are that the goal was to hear the views of sex workers, not to conduct an evaluation of the 100% CUP; sex workers may have felt the need to give "correct" or socially acceptable answers (e.g., regarding level of condom use); a small number of focus groups were conducted in the presence of brothel managers, which could have affected the responses of sex workers; access to under-age[1] sex workers was not possible; and the low social status of sex workers in Cambodia seemed to affect their perceptions of how they are treated (e.g., they did not necessarily think in terms of their own human rights). Some of these limitations have been minimized by the large number of sex workers who participated and this, therefore, enabled a check for consistency in responses within and between sites visited. At the commencement of all focus groups and interviews, sex workers were encouraged to give an accurate picture of their behaviors and perceptions rather than what they thought was the "correct" answer.

Reporting of Data

There are significant differences in the way the 100% CUP is being implemented in Phnom Penh and the provinces (which are discussed in more detail in Section 4). Given the general nature of the National Centre for HIV/AIDS, Dermatology and STIs (NCHADS) 100% CUP *Strategy and Guidelines* and the variation in provincial practice, it can be difficult to determine what is and what is not an authorized practice. Care also needs to be taken in generalizing about the 100% CUP as what is occurring in one location, may be different in another. This report therefore names the site, where this is relevant. There are, nonetheless, many common themes in how the program is implemented and these are highlighted.

During interviews, both sex workers and NGOs made claims of corruption and other malpractice by police and other local officials. Care has been taken in the way claims of corrupt behavior have been reported. Firstly, claims had to be made by another source before they were included in this report. Secondly, while the report contains the detail of alleged corruption, the location of where these practices are said to be taking place has been omitted. This is because of concern for repercussions against sex workers and others. The different sites visited have therefore been referred to as site A, site B, etc. The number of sites referred to in the report totals six: Phnom Penh has been separated into three sites, based on the different brothel areas visited; and Koh Kong, Siem Reap, and Sihanoukville are counted as one site each. Where the report contains information which is specific to one site, which would potentially identify the site, the alpha code has not been used. For more on the methodology, see Attachment I.

Section 2:
HIV/AIDS and the Sex Industry

The HIV/AIDS Epidemic

HIV/AIDS was first detected in Cambodia in 1991. Since then, Cambodia has witnessed the fastest growing epidemic in Southeast Asia. With an estimated national adult (15-49) HIV prevalence rate of 2.7 percent in 2001, it has the highest prevalence within the region (UNAIDS, 2002). Table 2 presents estimates of national HIV prevalence, the number of people living with HIV/AIDS (PLWHA), and prevalence rates for some key subgroups. In general, HIV and STI rates at the national level and among subgroups have been declining in recent years. For example, according to HIV sentinel surveillance studies conducted by NCHADS), HIV prevalence among female DSWs declined from 42.6 percent in 1998 to 28.8 percent in 2002. However, now that the epidemic has become more generalized (e.g., HIV prevalence over 1 percent among pregnant women), the threat of a renewed rapid increase in national HIV prevalence remains. (For more information on trends and the HIV/AIDS epidemic in Cambodia, see Attachment II).

Table 2: HIV/AIDS in Cambodia

National adult (15-49) HIV prevalence (2001)	2.7%
Number of PLWHA (2001)	170,000
HIV Prevalence by Subgroup (2002)	
Female DSWs	28.8%
Female ISWs	14.8%
Tuberculosis patients	8.4%
Police	3.1%
Pregnant women	2.8%

Sources: NCHADS (2002); UNAIDS (2002).

The Sex Industry

Unprotected heterosexual contact is the primary mode of HIV transmission in Cambodia and the sex industry is a significant contributing factor to this transmission route. It is this mode of transmission that is the subject of Cambodia's 100% CUP. NCHADS estimates the total number of female sex workers (both direct and indirect) in Cambodia to be 12,290[2]. This does not include street- and park-based sex workers. The vast majority of sex workers are female, although there is said to be an increasing number of under-age male sex workers. Adult male sex workers who participated in a focus group for this project estimated there was a minimum of 450 adult male ISWs in Phnom Penh.

Direct and Indirect Sex Workers

The sex industry is made up of direct and indirect sex workers. The term **"direct sex workers"** (DSWs) refers to women who work in brothels. While most of the sex workers are Khmer, there are some women

who are trafficked from other countries, especially Vietnam. Many DSWs, both Khmer and foreign, have been sold into prostitution and have bonds as high as $700 which need to be repaid to the brothel owner. Many of these sex workers come from rural families that are lured by brokers offering jobs described as honest and well paid. It is common for women who have entered brothels "voluntarily" to also have a significant debt to brothel owners. They often borrow money to send back to their families and may be charged by the owner for rent, food, clothes, cosmetics, and jewelry. In many brothels, outstanding debts attract very high interest rates. DSWs commonly live in the brothel where they work. Box 2 presents a profile of DSWs from the 2001 NCHADS Behavioral Surveillance Survey[3].

Box 2. Profile of DSWs in Cambodia

- A mean age of 22.5 years old
- 44% had no schooling
- 52% had been tested for HIV
- A mean duration in sex work of 1.7 years
- A mean of 5 months in the brothel they were currently working in
- 52% had been tested for HIV
- A mean of 4.2 clients in the last day
- A median brothel size of 9 sex workers
- 56.5% had regular clients and about 50.8% had sweethearts
- A mean monthly income of 545,000 riel (US $140)

The term **"indirect sex workers"** (ISWs) refers to people who sell sex in settings other than brothels (see Box 3). There appears to have been a significant increase in the number of ISWs in recent years. Factors that may be responsible for this include sex workers deciding to leave brothels, to have more freedom, to try to avoid police harassment, or to keep a greater share of their earnings; and the growth of the urban poor, with many people moving to Phnom Penh and regional centers because of lack of opportunities in rural areas. Freelance ISWs, (i.e. those working in parks) reported that they were subject to a significant degree of police harassment as they do not enjoy the degree of protection offered by working in bars.

Box 3. Settings for Indirect Sex Workers

Karaoke bars: Sex may occur on or off the premises.

Bars and restaurants: Many "beer promoters" and waitresses may sell sex in addition to their job. Sex will usually take place in a guesthouse or hotel.

Freelance women: Women working from their own house or a group of independent sex workers in a house, which they manage, as opposed to brothel management.

Street- and park-based sex workers. Includes both male and female sex workers.

Female factory workers and orange sellers: Women who supplement their very low incomes with informal sex work.

Male Clients

The Cambodian sex industry predominantly serves Khmer men, with sex tourism taking up a much smaller portion of the market. Sex work in Cambodia is characterized by a low fee for service – 5,000 riel per sexual act appears to be the common fee[4]. The common reported practice is for brothel management to take 50 percent of the DSWs' earnings. Virgin sex workers attract a considerably higher fee and foreign male clients generally pay more for sex. Use of sex workers by Cambodian men is very high. In 2001, the percentage of men aged 15-49 reporting sex with a sex worker in the last 12 months ranged from 22.2 percent in Battambang to 46.1 percent in Sihanoukville. The figure in Phnom Penh was 26 percent[5]. As shown in Table 3, there has been a decline in the frequency with which some male groups reporting having sex with female sex workers[6].

Table 3: Sex with a Female Sex Worker Reported by Male Subgroups, 1997-2001

Year	Military (%)	Police (%)	Moto Drivers (%)
1997	75.8	74.8	52.4
1998	69.3	69.8	58.6
1999	67.2	58.5	51.2
2000		data not available	
2001	32.0	32.8	17.9

Source: NCHADS Behavioral Surveillance Surveys. ***1997-2001***

Self-reported Condom Use

There also has been a significant increase over the past five years in self-reported consistent condom use among groups at high risk of HIV infection, including female DSWs and ISWs (see Table 4) and selected male clients of female sex workers (see Table 5).

Table 4: Self-reported Consistent Condom Use Among DSWs and ISWs, 1997-2001

Year	Female DSWs (%)	Female ISWs (%)
1997	37.4	10
1998	51.3	26.4
1999	80.3	39.7
2000	Data not available	
2001	89.8	56.3

Source: NCHADS Behavioral Surveillance Surveys. ***1997-2001***

Table 5: Self-reported Consistent Condom Use with Female Sex Workers by Male Clients, 1997-2001

Year	Military (%)	Police (%)	Moto Drivers (%)
1997	42.9	65.4	53.8
1998	55.3	69.3	61.8
1999	69.8	81.3	69.6
2000	Data not available		
2001	86.7	85.1	78.8

Source: NCHADS Behavioral Surveillance Surveys. ***1997-2001***

Self-reported condom use data was not totally reliable as people may feel the need to give the socially acceptable answer. Nonetheless, trends over time may give an indication of the extent to which condom use has increased. A confounding factor may be that as programs such as the 100% CUP take on a higher profile, there is greater pressure, particularly on DSWs, to give the socially acceptable answer. If this is the case, trend data may be less reliable. Attributing changes in behavior to particular interventions is always problematic as it is not possible to determine the extent to which other factors, including other programs, may have contributed to the outcome. *It is interesting to note that the most significant increases in condom use by DSWs occurred up to 1999, prior to the national implementation of the 100% CUP.*

Section 3:
Cambodia's 100% Condom Use Program

The Cambodian Policy Framework

In late 1999, following the evaluation of the Sihanoukville pilot program (see Box 4), a decision was made for national expansion of the 100% CUP. Currently, priority is being given to establishing the program in major urban areas and border towns where there are large sex industries. National rollout has been phased, with most of the expansion occurring over the last 12-18 months. The policy framework for the Cambodian 100% CUP is contained in the following Ministry of Health documents:

- *Strategy and Guidelines for Implementation of 100% Condom Use in Cambodia*,
- *Policy for HIV/AIDS and STI Prevention and Care in the Health Sector in Cambodia*,
- *Guidelines for the Implementation of STI Services*,
- *Policy, Strategy and Guidelines for HIV/AIDS Counseling and Testing*, and
- *The Outreach Program: Strategy and Guidelines for Implementation*.

Box 4. The Sihanoukville Pilot Program

In October 1998, the Cambodian Ministry of Health launched a pilot 100% CUP in Sihanoukville. A survey of sex workers in Sihanoukville showed an increase in self-reported consistent condom use from 43 percent prior to the program to 93 percent after full implementation. Other data suggest that this may be an overestimate. A survey of fishermen in Sihanoukville found that while 79 percent were aware that condom use was the best way to protect themselves against HIV, only 48 percent of fishermen who visited a sex worker in the last year reported "always" using a condom[7].

Nonetheless, there was a significant drop in STI rates for sex workers following program implementation. Syphilis and trichomonas rates dropped significantly from 9% and 5.6% respectively before the program to 1.8% and 2%, post implementation[8].

Among the factors that have been cited by the World Health Organization (WHO) as contributing to the success of the pilot program are high-level support from local officials (including the Governor) and an emphasis on building cooperation between local authorities, police, outreach workers, health care workers, entertainment establishment owners, and sex workers.[9] Another factor which has been attributed to the success of the trial is the strengthening of the government STI clinic, with a specific management strategy for female sex workers. Significant efforts were made to turn the clinic into a sex worker friendly environment.

Strategy and Guidelines for the Implementation of 100% Condom Use in Cambodia

The program operates within the framework of the *Strategy and Guidelines for Implementation*, prepared by NCHADS. The document highlights five elements of the strategy:

- Involvement and commitment of a wide range of stakeholders. Specifically, the cooperation of government authorities (e.g., local government and police) and the owners of all entertainment and sex establishments is seen as central: "This will see that general brothel 'crackdown' and closure does not happen, as this drives commercial sex underground and out of reach. It also ensures that sex workers are able, or assisted to attend the STI clinic regularly";
- Regular STI checking and treatment of sex workers;
- Ensuring the availability and accessibility of condoms;
- Effective information, education, and communication (IEC) activities through a variety of channels to make condom use the social norm; and
- Outreach activities to reinforce the messages of the program.

In addition to these five key elements, the strategy contains some guidance on program philosophy and approach, including collaboration between government and NGO partners in the strengthening of STI services and the need for STI clinics to become sex worker-friendly. Highlights from other policies which may influence the implementation of the 100% CUP are presented in Box 5.

Box 5. Highlights of Other Supporting Policies

NCHADS Guidelines for the Implementation of STI Services. These March 2001 guidelines further develop the context for the intended implementation of the 100% CUP. They reinforce the fundamental importance of a non-judgemental attitude in the provision of STI services. Other key policy elements, directly relevant to the 100% CUP, are recognition of the need to: 1) develop different services and approaches for DSWs and ISWs (especially since the latter may not necessarily consider themselves to be sex workers); 2) collaborate with NGOs; and 3) address other needs of sex workers (e.g., physical violence) through integrated care as a way to improve overall health and health-seeking behaviors.

HIV Counseling and Testing. NCHADS' *Policy, Strategy, and Guidelines for HIV/AIDS Counseling and Testing* requires that all testing for HIV should be with the full and informed agreement of the person being tested. Adequate pre- and post-test counseling should be provided by both public and private services. Compulsory testing for HIV in any circumstances is prohibited, unless required by law.

The Outreach Program: Strategy and Guidelines for Implementation. The Outreach Program has recently been redesigned to focus on three conceptual changes:

- The need to target all forms of sex workers, not only brothel-based;
- The need to include all players in the industry, not only sex workers; and
- The need to design interventions which are aimed at the health and safety of sex workers and their clients, not just the provision of HIV/AIDS and STI information.

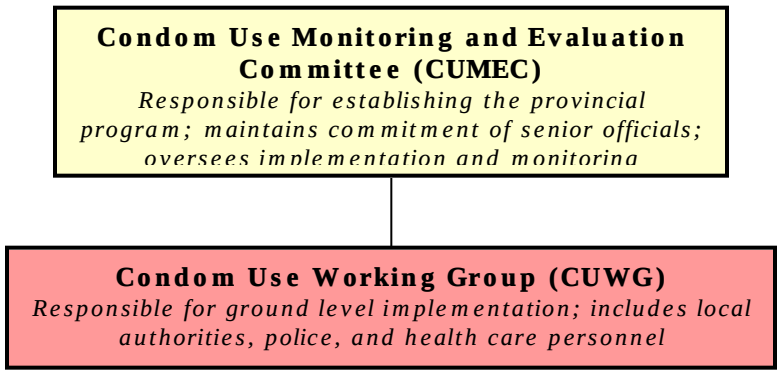
The Outreach Program is intended to integrate with the 100% CUP. One of the focal points of the revised Outreach Program is to identify peer leaders among sex workers.

Implementation and Monitoring at the Provincial Level

The 100% CUP is implemented at the provincial level through Condom Use Monitoring and Evaluation Committees (CUMECs) (see Figure 1). These committees are chaired by the Governor or Deputy Governor and are responsible for the establishment of the Program within the province. The CUMEC is also charged with maintaining the commitment of senior provincial authorities and overseeing effective implementation. The CUMEC is the local "owner" of the program. A Condom Use Working Group (CUWG) is responsible for ground level implementation. It is made up of local authorities, police, the military and health care workers, and reports to the CUMEC. The CUWG is responsible for mapping the location of sex establishments in the planning stage, and is charged with visiting brothels on a weekly basis to monitor program performance and provide advice.

Decisions on what indicators to use for monitoring and evaluation appear to be determined at the local level. The *Strategy and Guidelines* state that "the CUWG must define in advance what monitoring and evaluation will be used." Suggested indicators in the *Strategy and Guidelines* are condom sales; STI data from clinics; mystery clients (e.g., men posing as clients); information from sex workers, through STI clinics and outreach teams; and the percentage of sex workers with a "medical control card" out of the total number of sex workers in each brothel.

Figure 1. Implementation of the 100% CUP at the Provincial



Gaps in the Policies Governing the 100% CUP

The *Strategy and Guidelines* document lacks details on how various aspects of the program are to be implemented, including:

- ***Monitoring attendance at STI clinics.*** While there is mention of the need for all sex establishments to be identified, along with a census of sex workers, there is no detail on how attendance of sex workers at STI clinics will be monitored. There is a brief reference to the creation of clinic cards ("control cards for each sex worker *can* be introduced – with a reference number") but no detail on what data should appear on the card and how the card is linked to the census of sex workers.

- ***Voluntary or Mandatory Attendance at STI Clinics.*** Another key area where policy guidance is missing is whether attendance at STI clinics is voluntary or mandatory, with different descriptions being used in a number of places in the *Strategy and Guidelines*. The description of the Sihanoukville trial says "sex establishments were requested to send their staff". In another place, the language changes to "sex workers are able or assisted to attend the STI clinic regularly" and still later "brothel and entertainment managers have the obligation to send their sex workers to the clinic each month. " The *Guidelines for the Implementation of STI Services* indicate that there may be a different approach to compulsory STI clinic attendance for direct and indirect sex workers. They state "indirect sex workers … cannot be forced to attend the STI clinic services", suggesting that DSWs can be made to attend.

- ***Consent for STI Management.*** None of the policy documents give any indication as to whether STI management of DSWs requires their informed consent.

- ***HIV Testing.*** While the document makes it clear that the focus of monthly attendance at clinics is for STI management, there is no reference to HIV testing. The policy documents could be read to suggest that HIV testing does not take place as part of the 100% CUP. This could be inferred from the *Policy, Strategy, and Guidelines for HIV/AIDS Counseling and Testing* which prohibit compulsory testing. The *Guidelines for the Implementation of STI Services*, in the section on sex workers, states "voluntary counseling and testing for HIV should be offered once specific services for HIV+ patients are in place", although the setting in which testing will take place is not indicated.

- ***Confidentiality of STI Diagnoses.*** The only reference in the document to confidentiality is that diagnoses should not appear on the control card. There is no statement on who should and should not be told if a DSW is diagnosed with an STI. Given that diagnoses of STIs appear to be one of the principal indicators of failure to use condoms, this is a significant gap. Are brothel owners to be informed of the diagnosis? If so, are they told the name of the sex worker? The only reference to confidentiality in the companion document *Guidelines for the Implementation of STI Services* relates to efforts to "ensure confidentiality during the consultation process".

- ***Sanctions.*** No specific sanctions are mandated. Rather, it is stated that a clear and feasible policy for taking action against "offenders" needs to be established at the local level. While closure of brothels is indicated as an option, the guidelines warn that it is counter productive to threaten this if it is not possible and that 'other measures' may be more feasible.

- ***Coverage of Indirect Sex Workers.*** The *Strategy and Guidelines* do not clearly define the extent to which the 100% CUP applies to (all parts of) the indirect sex work industry. The policy states that "it is necessary to instruct or require ALL sex workers to use condoms in ALL sexual encounters" (their emphasis). Nonetheless, the focus appears to be on sex establishments ("direct, beer, bar, karaoke, etc"). It is not clear whether the policy applies to those ISWs not working in establishments (e.g., parks, orange sellers, garment factory workers). Additionally, the operational difficulties of applying the 100% CUP to ISWs, such as beer promoters, particularly in relation to identifying all beer promoters and ensuring clinic attendance, are not directly addressed. In places, the *Strategy and Guidelines* refer exclusively to brothels. This reinforces the question of the extent to which the 100% CUP applies, in an operational or implementation sense, to ISWs.

  Lack of clarity on these issues contributes to variations in the way the 100% CUP is implemented at the local level. Additionally, the absence of clear guidelines for implementation make it difficult to determine whether particular practices being used in various provinces have any level of endorsement from NCHADS.

  It is worth noting that while there are significant differences on how the program is being implemented, there is also a large degree of consistency. For example, virtually all of the sites visited had a consistent method of "registering"[10] DSWs, and this appears to be linked to ensuring their attendance at STI clinics and following up in cases of non-compliance. This consistency in implementation occurs even though the method is not mentioned in the *Strategy and Guidelines*.

  Box 6 identifies key differences between the Thai and Cambodian 100% CUPs that have the potential to hinder the implementation of the program in Cambodia.

Box 6. Key Differences Between the Thai and Cambodian 100% CUPs

- While the Thai program relies on the testing of male clients to verify the use of condoms in commercial sex, the Cambodian program relies on the testing of sex workers. The reason for this difference is that there is a very low rate of STI clinic attendance by Cambodian men[11], making it impractical to use STI diagnoses in men as an indicator of non-condom use with sex workers. DSWs also said that clients often go to more than one brothel, making it difficult to establish the source of infection.
- Condoms are supplied to sex workers free of charge in Thailand whereas this is not uniformly the case in Cambodia.
- Thailand had the advantage of a well-established STI clinic infrastructure prior to the

establishment of their 100% CUP.

- During its most active years, Thailand's 100% CUP supplemented activities focused on sex workers with active advertisements regarding condom use and commercial sex targeted at clients through mass media for one-minute per hour every hour, every day.

Section 4:
Sex Workers' Perceptions of the 100% Condom Use Program

This section sets out the information collected from focus groups and interviews with sex workers and is supplemented with information from NGOs. .

Core Compliance Elements of the 100% CUP

Before outlining the perceptions of sex workers, an overall description of the core operational elements of the program that are intended to ensure compliance with 100% condom use is provided. This description is based in part on the program's *Strategy and Guidelines* and on actual practice, where the guidelines are silent or ambiguous. This outline provides a broader context in which to read this section.

Identification of Brothels and Registration of Sex Workers

The first step, before the program can be established, is to identify the location of all sex establishments in the area. This is done by local officials. Brothels are usually allocated a number or a letter (that is placed on a sign, fixed to the building). Secondly, sex workers in each brothel are photographed and personal information is collected. This includes name, age, parent's names, place of residence, nationality, and former occupation. This information is used to create the medical control card at the government STI clinic. The card does not contain the DSW's photograph. The registration of sex workers is intended to ensure that they attend the STI clinic for monthly check-ups, with an STI diagnosis being taken as an indicator of non-condom use. Registration also enables local authorities to check brothels for the presence of new sex workers. The identification of both brothels and sex workers is central to the concept of creating a "monopolized market" where it is meant to be impossible to purchase sex without using a condom.

Role of Brothel Management

Brothel management essentially has four roles: to assist with the registration of sex workers; to ensure that sufficient condoms are available; to instruct all sex workers and clients that condoms must be used on all occasions and to provide support for sex workers when clients refuse to use condoms; and to ensure that all sex workers attend the STI clinic for their monthly check-up.

Sanctions

The diagnosis of an STI would appear to be taken as evidence that sex workers have not been using condoms with all clients, although this is not explicitly stated in the *Strategy and Guidelines*[12]. While the *Strategy and Guidelines* do not specify sanctions for non-compliance, DSWs and NGOs in all sites were of the understanding that a graded system of sanctions apply. Initially, a brothel owner will be warned, either in writing or orally, that they are non-compliant and could face temporary or permanent closure if breaches continue.

Sex Worker Attitudes and Behavior Regarding Condom Use

HIV Awareness

All the female sex workers who participated in focus groups had an awareness of HIV/AIDS, including recognition that their occupation put them at considerably heightened risk of HIV infection. All were aware that condoms prevented HIV infection and they appeared to have a strong motivation to use condoms. Apart from a fear of HIV and STIs, the fear of pregnancy was a strong motivator. Given NGOs were the main method of contacting sex workers, those who participated in focus groups may have had a greater exposure to HIV education compared to other sex workers.

Consistent condom use

All the female sex workers reported that they were aware it is a government requirement that condoms should be used with all clients. A large majority of sex workers reported that they consistently used condoms, even if the clients offered more money for sex without a condom. Most of the sex workers reported an increase in their use of condoms over the last few years. The 10 fishermen who participated in a focus group in Sihanoukville reported that DSWs would not allow them to have sex without a condom. DSWs identified some situations where condoms may not be used consistently (see Box 7).

Box 7. Situations Where Condoms May Not Be Used Consistently

- Client offers substantially more money (most sex workers said they would still insist on condom use, although a small number said they would not).
- Sex takes place outside the brothel, especially if there are multiple clients, as there may be a short supply of condoms and/or the DSW has less control over the situation.
- Client looks healthy, wealthy, and handsome (most sex workers said they would still insist on condom use).
- Violent clients who force sex without a condom.
- Powerful clients, such as the police or military police (one sex worker claimed she was forced to have sex without a condom by a policeman who held a gun to her head).
- Clients who "cheat" by using a condom to start with and secretly take it off during sex (reported by a small number of DSWs).
- Foreign clients who are presumed to be less likely to have HIV (and may offer more money).
- If the sex worker uses illicit drugs.
- With regular commercial clients, sweethearts and boyfriends.
- Transgender sex workers, based on the client's belief that these sex workers are less likely to be infected with HIV.

Negotiating Condom Use

Sex workers were asked what they did when a client did not want to use a condom. Almost uniformly, their initial response was to attempt to persuade the client to have safe sex. Very few DSWs indicated that their first response is to seek the help of the brothel owner. Initial resort to the brothel owner was reported by some DSWs to be unacceptable as it indicates conflict between the client and DSW and may unnecessarily escalate a problem that can be resolved through sex worker-client negotiation. This is an

important finding as sex workers are reporting that there is *a continuing need for them to negotiate with clients*, rather than simply relying on the brothel owner to inform clients that condoms need to be used.

The vast majority of sex workers said they successfully attempted negotiation with the client. Many appeared to be quite sophisticated in their negotiation skills. They would try to personalize the risk to both themselves and the client and talk about the possibility that either of them could be infected. The risk of the client infecting his wife or sweetheart is often raised as part of this process, as is the risk of the sex worker becoming pregnant. A small number of sex workers reported having non-penetrative sex where clients refused to use condoms. Many DSWs indicated the need to negotiate condom use only occurred with a minority of clients.

Successful negotiation of safe sex in most instances removed the need to seek the help of the brothel owner. It was also common to get assistance from other sex workers to help persuade clients to use condoms. If clients refused to cooperate, many sex workers said they would walk out of the bedroom and refuse to have sex. This would usually bring the situation to the attention of the brothel owner.

Brothel Management Support for Consistent Condom Use

An economic incentive for owners to support condom use is that it is usual for the price of sex to be based on the number of times sexual intercourse takes place. For example, if a client has sexual intercourse twice with the one DSW, the cost will be double. One DSW reported that her brothel owner would check the numbers of condoms used per client to make sure clients were paying the correct price. It is not known how commonly this is practiced.

Brothels in Sihanoukville had signs which read “No condom – no sex”, along with other IEC material. There was also a copy of the decree from the Provincial Governor, proclaiming the 100% CUP. Decrees from the Governor were also posted at brothels in Koh Kong.

DSWs from one brothel in site A said the owner would check the condom for the presence of sperm following sex to check that it had actually been used. It is not known if this is done in a safe way to guard against the risk of infection

At sites B and C most brothel owners were said not to be supportive of consistent condom use. If the sex worker refuses clients who do not want to use condoms they are blamed for not keeping the client happy and told they will not be able to repay their bond. A small minority of “nice” brothel owners were said to support consistent condom use at site B.

Some brothel owners at site D were described as supporting sex workers in consistent condom use, including talking to resistant clients. Other DSWs at site D said that their brothel owner left the decision on whether to use condoms to them, but would give support if clients did not want to use condoms and the sex worker did. This brothel owner also warned DSWs about the danger of HIV and STIs.

At some of the brothels at site E there is no apparent owner, and the DSWs claimed to be renting the house collectively. On further checking, it is understood that the brothel owners come to their brothel infrequently, for brief visits, to collect money. This is to hide their identity from the police. This was said to be a way of avoiding payment of substantial bribes. In this circumstance, the brothel owner obviously cannot be of any assistance to the DSWs in insisting on condom use. DSWs in other brothels at site E said their owner supported consistent condom use.

At site F DSWs reported that most of the brothel owners provided them with support for consistent condom use because they were worried they would get into trouble with authorities if condoms were not

used. A minority of brothel owners were described as being unsupportive, especially with clients who are high ranking officials.

Brothel owners were said not to support consistent condom use in the following circumstances:

- If the brothel is not attracting many clients the owner will "force" DSWs to have sex without a condom;
- Foreign clients: many owners say the foreigners are healthy so there is no need to use a condom. There is a strong incentive to do this as the foreign clients will pay substantially more for sex without a condom and the owner will take 50 percent; and
- For police or other powerful clients, particularly if they are violent or drunk, the brothel owner will not insist on condom use.

Violent Clients

Many sex workers said they would hide or run away from violent and drunk clients. Getting the help of other sex workers and/or the brothel owner to "kick the client out" was also mentioned. Some sex workers said they have been trained by an NGO on how to "network" within the brothel so they can assist each other with violent clients. In Koh Kong, the Provincial AIDS Office (PAO) has established a system for DSWs to report both violent clients and those who refuse to use condoms. Sex workers report the client to the brothel owner who in turn makes a report to the police member of the CUWG. In one case a violent client who refused to use a condom was arrested and detained for one night as well as made to pay compensation to the sex worker. The vast majority of sex workers stated they did not report any problems, including rape, to the police as they were both scared of the police and did not think anything would happen.

Reliability of the Level of Self-reported Consistent Condom Use as Indicated by Observed Syndromic STI Diagnoses

Some of the NGO staff who organized and observed focus groups with DSWs said that the reports of consistent condom use were probably inflated. At sites A, B, and C, NGO estimates of condom use ranged from 50 to 80 percent. These estimates were generally based on the day-to-day experience of NGO staff and the level of STIs and pregnancies at the site, which suggest that condoms are not used 100 percent of the time. Some NGO workers suggested that DSWs overestimated condom use because they knew what the "correct" answer is, particularly in the presence of NGO workers who had been educating them about HIV/STIs. Nonetheless, male clients at site D had told the NGO that because they now have to use condoms at brothels they are now seeking sex from ISWs.

Many women – both low- and high-risk, will most commonly present with vaginal discharge as a symptom that might indicate an STI. It is well-established that vaginal discharge is a poor indicator of the presence of an STI.[13, 14] Thus in settings where even STI clinics are unable to provide laboratory confirmation of an STI, relying on syndromic diagnoses in sex workers will inevitably lead to over-diagnosis of STIs even when condoms are not being used consistently. In other words, where sex workers are presenting with vaginal discharge, the stakeholders may well be misled if they conclude that the women are presenting with definite STIs and, thereby, conclude that they are non-compliant with the CUP. This dilemma is compounded where other syndromes that more reliably indicate the presence of an STI (e.g., genital ulcers and warts) but are less predictably prevented by condom use and thus might well be present in women who are consistent condom users. These problems underscore a fundamental flaw in the thinking behind the CUP where it depends on the unreliable syndromic diagnosis of STIs as "evidence" of non-compliance with the CUP.

Supply and Quality of Male and Female Condoms

The common practice is for brothel owners to pay for condoms. DSWs reported this to be the case at sites A, C, D, and F. At site B most of the brothel owners pay for condoms, but others sell condoms to sex workers for between 500 to 1,000 riel per condom or make the client pay. At site E, some brothel owners pay for condoms, while in other brothels the sex workers purchase bulk supplies of condoms from PSI. Condoms appeared to be in ready supply. There were no reports from DSWs of brothels running out of condoms. In one province, an NGO has been selling condoms to brothels due to a shortage of government funds to enable the purchase of condoms.

Virtually all sex workers reported using the PSI *Number 1* condom. The vast majority of sex workers were satisfied with the quality of the *Number 1* condom. However, in a focus group held late in the consultancy, there were complaints from sex workers about the quality of the 'new' *Number 1* condom. This condom has a silver foil packaging, compared to the white plastic packaging of the 'old' *Number 1* condom. The 19 sex workers in this focus group reported that the 'new' condom breaks more often and also has less lubrication. If sex takes a long time the condom causes discomfort and then breaks.

Water based lubrication is not commonly available in brothels. This does not appear to be an issue for sex workers, except for the reported problems with the 'new' *Number 1* condom. Other SWs reported some condom breakages, but this did not seem to be a frequent occurrence. Quantified data on the extent of condom breakages were not collected.

A small number of sex workers at different sites reported they had heard that condoms have been deliberately infected with HIV at the point of manufacture. This fear was also voiced in the male client focus group. Despite this concern, it did not appear to effect condom usage rates. It was also common for sex workers to report that their clients often brought "special" condoms to brothels. These condoms are made from animal skin. Sex workers uniformly said that they rejected using these condoms. They also reported a high incidence of suspicion about latex condoms supplied by clients. Some said they would reject the use of these condoms while others said they would inspect the condoms to see if the client had made any holes. There was a high degree of suspicion that some male clients try to deliberately infect sex workers with HIV.

The female condom was available at some sites through NGOs. Some DSWs found it useful for drunk and other difficult clients who do not want to use a male condom. Others said foreign and older Khmer clients preferred the female condom. Most of the DSWs who had access to the female condom said they preferred to use the male condom.

Registration of Sex Workers for the 100% CUP

Taking Photos and Collecting Personally Identifying Data

With few exceptions (e.g., at site F), all of the DSWs reported that they had their photos taken and had other personally identifying information collected by local officials. DSWs said that these data were commonly collected by local police. Many of the sex workers claimed they were required to pay authorities 5,000 riel for the photo. At site B, the cost was 10,000 riel, which was paid for by brothel owners. Where brothel owners pay, it is common for the amount to be added to the sex worker's debt. There were also reports of brothel owners paying 5,000 riel for the photos, but charging sex workers double this amount. In some sites, police would return on a weekly basis to take photos of and collect data on new DSWs, and in others this occurs every three months.

Many of the sex workers were not told why their photos were being taken, and many were still unaware of the purpose at the time of this field work project. A common explanation given to many DSWs was that the authorities need to have a record of where they are working so if "anything bad" happens to them their parents can be informed. A variation of this explanation was that there needs to be a record of where the women are working in case their parents coming looking for them. In some instances, they said no explanation regarding the purpose was given. Some Vietnamese sex workers claimed they were told that their photos were being taken so they could be given identity cards. They welcomed this as they thought it would assist in their relations with police, especially considering their illegal immigrant status. To date they have not received identity cards. At site E sex workers claimed they were informed that the registration process would result in a monthly salary. This has not happened to date. At site D, DSWs said the police have promised the photos will be destroyed when they cease sex work.

Only a very small number of DSWs said that they were told the photo was taken so they could be registered at the STI clinic. Most sex workers were not aware of where the photos were stored. However, some sex workers and NGOs said the photos were put in a book that was either stored at the local police station or kept by the CUWG.

None of the DSWs at site F reported to have been through the usual registration process. None had any personally identifying information collected by authorities, nor had they been photographed. They said that there was no requirement for them to go to the STI clinic, but the vast majority went at least once a month to an NGO clinic.

Sex Worker Attitudes Toward Registration

Sex worker attitudes to the registration process varied. Trafficked women from other countries were concerned that the information could be used to deport them. Many other sex workers expressed fears that their parents would be told they were sex workers or that the photos would end up in newspapers or on television. A significant number of sex workers said they did not have any concerns about the registration process. Many thought it was good there was a record of where they worked so that if "anything bad" happened to them their parents could be informed.

A Different Registration Process

A major variation to the registration process was adopted in one of the brothel areas in Phnom Penh. Brothel owners held a meeting and said they did not want DSWs registered out of fear that the records would be used by police to collect additional bribes, on a per capita basis. Instead, a system is being used where all DSWs have been issued an STI clinic card that contains a code rather than their name. (The card does not have a photo, as is the case at other sites.) This system is reported to be working effectively, with all sex workers attending the clinic each month. Nonetheless, some DSWs from this area claim that police recently took passport size photos of some sex workers and collected other personally identifying data, of the type collected when DSWs at other sites have been registered under the 100% CUP. The police said the purpose of this exercise was to "keep records".

Registration of ISWs

Only one ISW, out of the 45 interviewed, reported that her photo had been taken by government officials. This sex worker worked in a restaurant in Phnom Penh. No other ISWs were able to recall any process where government officials photographed them or collected their names and other personal information. All of the NGOs contacted indicated that the 100% CUP was only operating in the direct sector of the industry.

Hiding Sex Workers

An NGO working in site B indicated that it was common practice for brothel owners to hide sex workers and said that its own census revealed that only 51 percent of sex workers in the area were registered. Hidden sex workers are reported to include under-age girls and boys, trafficked illegal immigrants, and sex workers who are sick. An additional motivation for hiding sex workers was said to be that the police collect a bribe from brothel owners each month based on the number of DSWs registered.

At site A, brothel owners were said to instruct under-age DSWs to give an older age to avoid sanctions against the brothel. Hiding of DSWs was also said to be common. It was reported that a brothel may have ten DSW, and hide 2-3 from the registration process. It was also claimed that each brothel in site A paid the police a monthly bribe of 5,000 riel per sex worker, plus an annual amount of 50,000 riel.

At site E, an NGO claimed to have identified 26 percent more DSWs compared to the number of registered sex workers. At site C, approximately 40 percent of DSWs appear not to be registered.

At site D, where brothel owners paid the cost of registering DSWs, it was reported that in at least one brothel, DSWs were hidden to reduce costs. New sex workers are not always registered, for the same reason. There was also a significant disparity between the number of brothels identified at site D for the purposes of the 100% CUP and claims by sex workers as to the actual number of brothels. DSWs stated there was 10 times the number of brothels actually operating, compared to the number identified for the 100% CUP. Most of the brothels which had not been identified were said to have 2-3 workers and operating from private houses. They also claimed that some large brothels had not been identified.

STI Clinics

Attendance at STI Clinics

All DSWs, except those at one site, reported that they were required to attend a government STI clinic on a monthly basis. They said that failure to attend could lead to brothel closure or the termination of their services. Their "medical control card" was checked by the clinic staff. The only valid reasons for non-attendance were said to be menstruation or illness. In these circumstances attendance could be delayed. Most sex workers reported that the CUWG or staff from the clinic would visit the brothel, each month, to inform them of the date of their next appointment.

Sex workers in site B said their clinic card contained the date of their next appointment and was stamped when they went to the clinic. The sex workers reported that they have been told by the CUWG that if they attend the clinic without their clinic cards, they will be arrested. If they miss an appointment they are charged 5,000 riel for a new card.

Failure to attend the clinic was said to result in follow-up action and warnings to the brothel if compliance is not achieved. For example, at site C, government STI clinic staff sent an outreach worker to a brothel if a DSW had not been to the clinic. If this failed to result in attendance, the name of the DSW was given to the police, who visited the brothel to tell the sex worker she must attend.

Some brothel owners were reported to be unhappy with sending DSWs to STI clinics, out of fear they may escape, and it is common practice to accompany bonded sex workers to clinics to prevent escapes. Some NGO workers reported that the bonded workers are often hidden.

DSWs said they could not choose which clinic to attend. Those who were attending NGO or private clinics prior to the 100% CUP were required to transfer to a government clinic. The one exception was at site F, where DSWs attend an NGO clinic. These sex workers reported that they are not required to

attend the clinic, but that the majority does – partly as a result of a peer network which encourages attendance. None of the DSWs from this site had provided any personally identifying information to government authorities (part of the usual registration process) even though they are working in an area where the 100% CUP is operating[15].

DSWs in one of the brothel areas in Phnom Penh attend a government clinic which is jointly run by government and NGO staff. It is understood that this is a special arrangement negotiated between the NGO and government health officials. An NGO working at another site, site B, reported that they approached the government clinic with a proposal for their staff to assist in the clinic. They were informed they would need to pay a per diem to the staff of the government clinic if this was to occur. The NGO declined to do so.

Some DSWs reported attending STI clinics more frequently than once a month if they developed STI symptoms. On these occasions, sex workers usually attended an NGO or private clinic. This means that government clinic-based information on STI diagnoses in DSWs underestimates the scale of the problem. Attendance at non-government clinics in response to symptoms of STIs could also be a way of circumventing any sanctions resulting from an STI diagnosis. If the STI has been effectively treated by the time the DSW attends the government clinic, this would be taken as an indicator of consistent condom use.

Avoiding Clinic Attendance

A large majority of the sex workers indicated that they attended a government STI clinic every month, although avoiding attendance is possible, at least in some places. For example, at site A, an NGO reported that it was easy for a DSW to give her "medical control card" to another sex worker, who would attend on her behalf. This practice was also reported at other sites.

DSWs at site B claimed they could avoid clinic attendance by paying 3,000 riel to clinic staff. Police have recently closed most of the brothels at site B. The closure is not related to sanctions under the 100% CUP but is in response to an order by the provincial governor in an attempt to end prostitution. Many of the brothels are still operating, albeit secretly, or have moved to nearby locations. Prior to the closures, many of the sex workers said they were paying 3,000 riel and not attending clinic. An NGO reported that in August 2002, 66 percent of sex workers registered under the 100% CUP, attended the government clinic which serves site B. Since "closure" of the brothels, the DSWs said they have been told by clinic staff that there is no need to attend the clinic, but that they must continue to pay 3,000 riel per month. The DSWs said they did not know what the fee was for, but because they are scared they just pay without questioning. The money is now collected by the Committee (presumably the CUWG), which comes to the brothel once a month. New sex workers are required to pay 5,000 riel per month. Now that the sex workers have stopped attending the government clinic they go to an NGO, private clinic, or pharmacy if they have symptoms of an STI.

Perceptions of Staff Attitudes Toward Sex Workers

The most consistent and vocal message from the sex workers was their complaints regarding the standard of service at STI Clinics. Staff were said to be very judgmental and this was manifested in rude comments to the sex workers, especially relating to their occupation. Sex workers reported that they were frequently blamed for their occupation. Blame also frequently accompanied a diagnosis of an STI. Some DSWs said the clinic staff made them feel like beggars. Many sex workers also complained of rough, painful vaginal examinations. A number of sex workers had previously attended NGO STI clinics and had a benchmark for comparison. The NGO clinics were uniformly rated as significantly better than the government clinics.

The only exceptions to complaints regarding the staff of government STI clinics were in Sihanoukville and one of the Phnom Penh clinics that is staffed by government and NGO health care workers. All sex workers consistently rated both these services, including staff, as good. Possible reasons for the high level of DSW satisfaction with the Sihanoukville government clinic are:

- Sihanoukville was the site for the pilot of the 100% CUP. A greater effort may have gone into the training of health care workers, especially in regard to working effectively with sex workers.
- Staff at the Sihanoukville clinic receive salary supplementation as part of the 100% CUP. This was provided as an incentive for the staff to provide high quality, non-judgmental service. Salary supplementation is not provided to STI clinic staff in other locations.
- A broader health service is provided. For example, DSWs reported that counseling, contraception, and other reproductive health services are available.

There were mixed reports from DSWs about the government clinic at site D. Some sex workers characterized the staff attitudes and treatment of sex workers as being degrading while others said the staff were kind, softly spoken, and helped motivate them with HIV prevention. The reason for this marked discrepancy was not apparent.

Sex Worker Perceptions of the Standard of Clinical Service

Some sex workers reported that they thought the standard of clinical care at government clinics was not as good as that available at NGO and private clinics. For example, sex workers at site B reported that two of their colleagues were diagnosed with an STI at the government clinic and subsequently informed by an NGO clinic that they did not have an infection. (This may be due to the use of syndromic management at the government clinic, and possibly access to laboratory facilities at the NGO clinic.) DSWs at site B also complained that equipment used in vaginal examinations was re-used, without proper cleaning.

At site B, DSWs reported that the clinic staff sometimes try to scare them by telling them they have a serious medical problem (e.g., a foetus outside the womb), when this is not the case. It was also claimed that brothel owners do not like sending sex workers to government STI clinics because the staff scare their workers.

An advantage of government clinics over private clinics, mentioned by some DSWs, was that the former are able to provide treatment medication, where private clinics usually refer them to a pharmacy. The preference was based on cost and convenience.

Many DSWs complained about long waiting time at clinics, although the waiting time at the Sihanoukville clinic was reported to be a maximum of half an hour, which was seen as acceptable. A small number mentioned that they were required to go to the clinic early in the morning. They complained that this was not convenient if they had been working late.

Confidentiality of STI Diagnoses

The vast majority of DSWs said that, as far they as they were aware, the sex worker herself was the only person told when an STI was diagnosed. This was based on what clinic staff have told them. DSWs at one brothel at site A said the brothel was sometimes informed of an STI diagnosis. This was reported to result in scolding by the brothel owner and advice to always use condoms in future. None of the other DSWs reported any punitive action against them or the brothel, resulting from an STI diagnosis.

If brothel owners are not informed of test results, this raises the question of what system is used to feed back compliance data to brothel owners. For example, how is a brothel owner warned regarding non-compliance, based on STI diagnoses? It is possible that a brothel owner could be informed that a sex worker has been diagnosed with an STI, without the name being revealed. This was said to be the practice at site D. However, if the SW does not comply with treatment, and the STI has not been cured, the brothel owner will be informed in order to obtain assistance with ensuring compliance. Given claims of an overall lack of confidentiality protection by health care workers in Cambodia, some NGOs questioned the extent to which diagnoses are kept confidential.

Payment for Clinic Attendance

A large majority of DSWs reported that they did not pay for the STI check-ups or medication. There is no charge for clinical services or medicine at the government STI clinics at sites A, C, E and F. However, the clinic that sees DSWs from site B charges 3,000 riel per check-up, with medicine provided free. At site D some DSWs reported paying 5,000 riel for a check-up, while others said the service was free. It is understood that the local policy is for the service to be free, but that the staff are asking some DSW to pay. It was reported that the STI Clinic at site D frequently runs out of medicine to treat STIs. When medication is available through the clinic it is provided free. When there is a shortage, it is claimed that staff offer to sell sex workers the same medicine from the private clinics they conduct at night. Some sex workers claimed to be frightened of the staff at this clinic. It was reported that sex workers sometimes have to borrow money from brothel owners to pay for medicine, thus ensuring greater indebtedness.

Where the STI clinic is far away from the brothel, the cost of transportation can be a barrier to access. This was particularly the case if there were NGO and private clinics nearby. Free transport is provided to STI clinics at sites E and F. DSWs pay for transport at sites A, B, and D. Brothel owners pay for transport at site C. Sex workers at site B said they had to pay 3,000 riel (return) for a motodop to take them to and from the clinic.

HIV Testing

Sex workers said they were not tested for HIV when they attended STI clinics for their monthly check-up, as part of the 100% CUP. The focus is on other STI management. HIV testing is not available at all STI clinics. Sex workers who want to be tested need to be referred to other sites.

Of those sex workers who had been tested for HIV, all except two reported that they had received pre and post-test counseling and that testing was voluntary. Sex workers often said that counseling staff would ask them if they were seeking the test under coercion or on a voluntary basis.

Sex workers may be tested for HIV as part of the NCHADS HIV Sentinel Surveillance program. This program undertakes de-linked, anonymous testing. Members of sentinel groups have the right to refuse testing. In 2002, 4.8% of DSWs and 11.6% of ISWs refused to participate[16]. A description of how the surveillance program operates was provided by NGO staff from site B. They said that government officials go to each brothel in the local area and say they need to test two SWs. The brothel owner chooses the sex workers to be tested. It was claimed brothel owners choose new SWs, as they are less likely to be infected. Testing takes place at the brothel. Counseling was said not to be available and the SWs were said not to be asked for their consent.

Two DSWs at site B, who reported non-consensual HIV testing, provided an independent account that was consistent with the above description by NGO staff. The SWs said they were not aware of the purpose of the testing. They have not received the test result. The process of being tested appears to have resulted in anxiety, as these sex workers said they are now worried about their HIV status. This has been

reinforced by the non-communication of the test results. It is possible they were tested as part of the NCHADS HIV Sentinel Surveillance which is de-linked, so results cannot be communicated.

Sanctions for Non-Compliance with the 100% CUP

With one exception, none of the DSWs or NGOs was aware of the closure of brothels at any site for reasons of non-compliance with the 100% CUP. Warnings of non-compliance were reported at most sites. The one exception was at site A, where a brothel was reportedly closed for one month following the visit of a 'mystery client' who was successfully able to negotiate sex without a condom. This brothel has now re-opened as a karaoke bar. Warnings appear to have been more common in the early stages of implementation, particularly for non-attendance at STI clinics.

Sex Worker Perceptions of Police and the 100% CUP

In all of the sites visited, it was claimed that police either owned some of the brothels and/or were taking bribes from brothels. The claims regarding taking of bribes were both related and un-related to the operation of the 100% CUP. Bribes were said to be collected on a daily and/or monthly basis. In some of the brothel areas in Phnom Penh, the bribes were said to be for police protection from gangs. Given the regular demands by police for money, sex workers in one brothel said "here, it's just like the bank." DSWs regularly reported that bribes paid by brothel owners would be financed by levies on sex workers.

All of the sex workers appeared to be frightened of the police. While this was partly related to claims of bribery, many reported incidents of violence when police visited brothels. They also reported police not paying for sexual services. There was a great fear of brothel raids and being arrested, particularly in Phnom Penh.

It was claimed that police will not take any action following reports of violence towards sex workers, unless the police have witnessed the attack. It was also claimed that the only way for SWs to successfully initiate police action was to pay a bribe.

While overall relations between the police and the sex industry are characterized by corruption and fear, there was some variation between sites. Relations with the police appeared to be better, but only relatively, at sites A and D where there was a lesser number of complaints from DSWs. Relations with police were reported to be particularly bad in Phnom Penh.

While it is not directly related to the operation of the 100% CUP, good cooperation was reported at site A between the police and an NGO in the identification of under-age DSWs. Subsequent court action against the brothel owners was said to be unsuccessful.

Sex Worker and NGO Involvement in the Operation of the 100% CUP

- ***Sex workers.*** There is very little evidence of any sex worker participation in the operation of the 100% CUP, apart from passive requirements regarding compliance. Sex workers have not been consulted in the way the program has been designed or in its implementation. There is also little evidence of attempts by local authorities to meet with sex workers and explain how the program is intended to operate. Two exceptions to this are Siem Reap and Koh Kong. In Siem Reap monthly meetings are held between the PAO, brothel owners and sex workers. In Koh Kong, monthly meetings between the PAO, an NGO and brothel owners have recently expanded to include DSWs. The move to broader participation was in response to a request from DSWs to attend these meetings. In other sites, to the extent that there has been any meaningful consultation with the sex industry, this has been confined to brothel owners and

management. There has been almost no support for mobilization and empowerment of sex workers so that they are able to increase their control over interventions designed to target the sex industry.

- ***NGOs.*** Some NGOs have a history of STI service delivery to sex workers and have on occasions acted as advocates for sex workers. Given their position, some have been able to facilitate access to sex workers without the usual constraints of government. Through this, some have built up relationships with sex workers. However, one of the common themes of the way the 100% CUP has been implemented in most sites is the exclusion of NGOs from working with DSWs. Where NGOs were previously providing STI services, they have had to abandon DSW projects and confine their activities to working with ISWs. While it is probably the case that NGOs are in a better position to access ISWs compared to government, this arbitrary demarcation of the responsibility of NGO and government services is inconsistent with stated policy for cooperative work and the avoidance of duplication.

  There are exceptions in some cases. In Sihanoukville, the 100% CUP has resulted in NGO access to brothels for the first time. This has enabled an NGO to undertake HIV/STI prevention activities in brothels and to advocate on behalf of sex workers. In Siem Reap, the 100% CUP has also resulted in NGO educators having access to brothels for the first time, although the Rose Centre[17] has been excluded from providing clinical and social support services to DSWs. In Koh Kong the PAO and an NGO hold monthly meetings with brothel owners, and more recently, sex workers, to explain the requirements of the 100% CUP and to raise awareness of HIV and STIs. NGO staff have also started working in a mobile government STI clinic. In one of the brothel areas in Phnom Penh, NGO staff are transporting DSWs to a government STI clinic, which is jointly staffed by NGO and government health care workers. In another brothel area in Phnom Penh, DSWs are still attending an NGO clinic and do not appear to be registered.

  Nonetheless, the scope of the NGOs' work with DSWs has been narrowed since the implementation of the 100% CUP. In addition, punitive police action against brothels is often interpreted by owners and DSWs to be connected with NGOs, who are suspected of informing on the brothel. While there appears to be no basis for this, with the possible exception of under-age workers, this suspicion results in no or limited access to brothel-based sex workers until the NGO can re-establish a relationship of trust.

Variations in the Local Operation of the 100% CUP

There are a number of key variations in how the program is operating at the different sites that have significant implications for the effectiveness of the 100% CUP (see Box 8). The reasons for these differences may be the lack of detail in the *Strategy and Guidelines* on how the Program is intended to be implemented, and the resource poor environment in which implementation is taking place, including an under-developed infrastructure.

Box 8. Key Variations in the Local Operation of the 100% CUP

1. Consistent use of condoms by DSWs	NGO assessments of the extent of consistent condom use varied significantly between sites. (DSW self-reports of consistent condom use were uniformly high.)
2. Support by brothel owners for consistent condom use	The level of support appears to vary between sites.
3. Free supply of condoms	Most DSWs do not pay for condoms, but this is not the case in some brothels.
4. The degree of alleged corruption	Corruption directly related to the 100% CUP was said to be rife in some sites, and less evident in others.

Box 8. Key Variations in the Local Operation of the 100% CUP

5. Registering all DSWs	The hiding of sex workers from the registration process was reported in most sites, but not all. At one site, none of the DSWs is registered.
6. Taking photos and collecting personally identifying information	While this occurs in most sites, there are two sites where this was not the case.
7. Reasons for collection of personally identifying data for registration	The reasons given varied between sites, and in some places, no reason was given.
8. Payment for photographs	At some sites DSWs or brothel owners were charged, while this was not the case at other sites.
9. Registration of ISWs	With one exception, none of the ISWs had been registered under the 100% CUP.
10. Free STI check-ups and medicine	Most DSWs receive these services free, but not all.
11. The attitude of government STI clinic staff	While complaints were made about staff attitudes at most sites, Sihanoukville and the site where government and NGO staff jointly run the clinic were exceptions.
12. Compliance by DSWs with monthly STI clinic attendance	In one site no DSW is currently attending the government clinic.
13. Attendance by DSWs at government STI clinics	While most DSWs are required to attend government clinics, all DSWs at one site are attending an NGO clinic.
14. The degree of NGO involvement	In some sites, NGOs have been excluded from working with DSWs, but there is limited access in other sites.

Section 5:
Analysis and Recommendations

Based on the qualitative data from sex workers and NGO representatives, this section outlines strengths of the program, discusses the challenges and presents recommendations. The recommendations seek to enhance the efficiency of the current program; reduce corruption and barriers that undermine program implementation; bring the program in accordance with human rights principles – important in its own right and essential for success of the program; and facilitate the development of partnerships that are critical to the program.

Box 9. The Challenge of Evaluating Impacts

In recent years, Cambodia has witnessed a dramatic increase in condom use among groups most at risk of HIV. This has been accompanied by a noticeable decline in HIV and STI prevalence among these groups.

It is difficult to establish a causal link between a particular intervention and the adoption of health protective behavior, particularly when there are multiple interventions targeting the same populations. In addition, there may be other factors which have contributed to the decline in prevalence. For example, more effective treatment may have contributed to the reduction in STI prevalence and, in turn, minimized the risk of HIV infection.

Despite this constraint, it remains likely that the 100% CUP has made a significant contribution to the achievements of recent years. In the absence of an external evaluation of the program including the sampling methods for surveillance, it is difficult to claim more than this.

Strengths of the 100% CUP

The major strengths and achievements of the 100% CUP include:

- **Official recognition of the need to work with the sex industry.** Although there is a large local sex industry, attitudes towards sex workers and sex establishments remain negative. The existence of the 100% CUP provides official recognition of the need to work with the sex industry in the local response.

- **Creation of normative behavior around condom use.** The 100% CUP, along with Population Services International's (PSI) "Number 1" condom social marketing program, are the most high profile local HIV/STI programs. While there has not been a formal evaluation of the 100% CUP, it is likely that it has contributed towards creating a social norm of condom use, particularly in brothel-based commercial sex.

- **An emergency response that required quick and decisive action.** While the 100% CUP can be seen as a top-down and coercive program, imposed on brothel owners and the sex industry, the program may have been a necessary emergency response to deal with the rapid spread of HIV infection in Cambodia. Seen in this historical context, the mandatory requirements of the program can be argued to have been necessary, even if only as an interim measure, to contain the rapid spread of HIV.

- **A highly-targeted intervention.** Both behavioral and HIV surveillance data indicated that unprotected sex in brothels should be a high priority for prevention interventions. A majority of men seeking commercial sex did so in brothels[18] and it was, therefore, appropriate for the 100% CUP to target DSWs as the highest priority.

- **Political leadership and involvement across levels and sectors.** The 100% CUP recognizes that an effective response to addressing HIV prevention in the sex industry requires the cooperation and

leadership of a range of government agencies. The program has received national political support and it provides a vehicle for the involvement of local authorities in responding to HIV.

- **Placing responsibility with the owners of brothels.** For the first time, significant responsibility for HIV/STI prevention was placed on the owners of brothels. Previously, negotiation of condom use was solely between the sex worker and client. The 100% CUP sought to create an environment where the owner was responsible for ensuring condom use and sanctions for non-compliance directly targeted brothel owners, not sex workers.

- **The development of an STI infrastructure.** The implementation of the 100% CUP has contributed to the development of Cambodia's STI infrastructure. Some STI clinics now have laboratory facilities, resulting in more accurate diagnoses and more effective treatment. While many of the government STI services are still rudimentary, there are plans for their enhancement.

- **Improved DSW access to STI clinics.** It is likely that the 100% CUP has resulted in improved access to STI clinics. Prior to the introduction of the program, brothel owners may have been reluctant to send bonded DSWs to clinics, for fear they may escape. Now most DSWs are attending STI clinics on a monthly basis and this should lead to their improved sexual health.

- **Improved relations between the police and brothel owners.** While relations between police, brothel owners, and sex workers appear to be characterized by distrust, there is some evidence of an improved relationship at some sites. This appears to be the case in Sihanoukville, and to a lesser extent in Siem Reap and Koh Kong. Where relations are still poor, the 100% CUP provides a vehicle through which relations can be improved. At the very least, the 100% CUP makes relations between police and the sex industry more open to scrutiny.

- **Saving brothel owners' money.** Some brothel owners used to pay for STI check-ups and treatment at private clinics. Now that this service is mostly provided for free, there is an economic motivation to send DSWs to the clinic for regular monitoring.

- **Facilitation of NGO access to DSWs.** In some sites, the 100% CUP has resulted in better access for NGOs to brothels both to educate DSWs and to advocate on their behalf.

- **Customization of the program.** The design of the 100% CUP has been customized to take account of local circumstances. For example, given that it is uncommon for male clients to attend STI clinics, the diagnosis of an STI in clients cannot be used as a proxy indicator of non-compliance with condom use in particular brothels.

- **Capacity building of Provincial AIDS Offices.** Expansion of the 100% CUP has resulted in some capacity building of Provincial AIDS Offices.

Challenges Facing the 100% CUP

Challenges to the Efficiency and Effectiveness of the Program

- **Improving clarity in the CUP's *Strategy and Guidelines*.** The *Strategy and Guidelines* for the 100% CUP do not address key implementation aspects of the 100% CUP. There is a need to build on the existing guidelines to explicitly state how all important aspects of the program should operate. Important areas of clarification include confidentiality, the registration process, sanctions, and informed consent for STI testing and treatment, among others. In addition, lack of clear a supervisory mechanism contributes to variation in implementation between and within provinces. While it is

recognized that there may be a need for flexibility in order to respond to local circumstances, this can be effectively handled by providing explicit guidance and options.

- **Enhancing the standard of STI care and treatment.** Regular attendance at STI clinics is the primary monitoring component of the program, yet the judgmental attitudes of government STI clinic staff serve as a barrier to attendance. This also results in a lost opportunity to provide HIV education, counseling and comprehensive health care. The experience of the Sihanoukville STI clinic demonstrates it is possible to provide a quality, sex-worker friendly care in government clinics. This is reinforced by the experience in one Phnom Penh clinic where government and NGO staff provide a service which sex workers rate as friendly and meeting their needs.

- **Targeting prevention programs to male clients.** While brothel management and sex workers clearly have a key role to play in enhancing consistent condom use, the primary focus of HIV prevention programs on the sex industry has the unintended effect of giving the message that clients are not equally responsible. While there are prevention programs targeting some male clients who use brothels frequently, there is a need for a greater focus on clients.

- **Reaching under-age sex workers.** There were reports that under-age sex workers, both girls and boys, were commonly hidden by brothel owners and not registered under the 100% CUP. This raises the issue of how much exposure these sex workers have had to HIV/STI prevention education and outreach activities, and to regular health care. While all efforts need to be made to stop the entry of under-age boys and girls into the sex industry, the reality is that this is unlikely to be fully effective. From a harm minimization perspective, it is important that the sexual health needs of all sex workers, including under-age workers, are addressed. There are obstacles to this given the imperative of brothel owners and others to hide under-age sex workers and the focus of NGOs working with this group to "rescue" under-age sex workers from the industry resulting in police raids on brothels and the reality that many "rescued" under-age sex workers return to the industry in any case.

- **Coverage of indirect sex workers.** The apparent growth in the indirect sex work, coupled with evidence of its lower level of consistent condom use compared to direct sex work (brothels), makes HIV prevention programs in this area a priority. There are hurdles in applying the 100% CUP to ISWs requiring a different approach. Specific studies to document shifts from direct to indirect sex work are needed.

- **Developing prevention programs for male sex workers.** More needs to be done to target male sex workers. Adult male sex workers commonly work as ISWs and, therefore, currently fall outside the scope of the 100% CUP. While some NGOs are working with male sex workers, they are not accorded the priority that they warrant. The focus group conducted with male sex workers indicated lower knowledge of HIV when compared to female sex workers. Many did not see themselves at risk of HIV, or if they did, thought the risk was low. None practiced consistent condom use and most had never been to an STI clinic.

- **Maintaining accurate records of the location of sex workers.** The large number of new DSWs and mobility between brothels results in the need to maintain accurate records on the location of sex workers so that attendance at STI clinics can be monitored. As the program matures, it may prove more difficult to register new sex workers and to track the movements of those who change brothels. An additional concern is that sex workers report that a large number of brothels, under the current mapping and registration process, have not been identified for inclusion in the 100% CUP.

- **Using STI diagnoses as a marker for unsafe sex.** In many of the sites where the 100% CUP is operating, syndromic STI management is used. In the absence of laboratory facilities, it is not possible to make a definitive STI diagnosis. It is difficult to impose sanctions in the absence of

confirmed rather than presumed infection. This may be the reason sex workers report no closures of brothels under the 100% CUP, despite continued syndromic diagnoses of STIs. Nonetheless, it is noteworthy that there do not appear to be any closure of brothels in sites where laboratory facilities exist.

- **Provision of male and female condoms, water-based lubrication, and other materials to support consistent condom use.** While condoms are commonly purchased by brothel owners, a number of exceptions were reported. Where DSWs are required to pay for condoms, this can act as a disincentive to consistent condom use. Given the continuing need for DSWs to negotiate condom use, the female condom can expand choice could increase condom coverage and should be made available. Water-based lubricant can also encourage increased condom use because it increases pleasure, reduces abrasion related to multiple clients, rough or violent sex, and anal sex in both male and female sex workers. Lubricant should be made available in brothels and be socially-marketed. Sex workers also suggested that they be provided with printed materials to support them in negotiating condom use with clients. One suggestion was to have graphic photographs of STIs, which they could show to clients.

- **Developing multiple approaches to address the factors that influence HIV-related risk behavior.** The 100% CUP takes an environmental-structural approach to achieving behavior change through government policy. Experience and data demonstrate that there is no single determinant of risk of HIV infection (e.g., lack of information, low self-esteem, or lack of social support)[19]. There is a substantial body of evidence to indicate that other approaches, apart from a reliance on environmental-structural support, can make a significant contribution to achieving consistent condom use in commercial sex (see Box 10). Multiple approaches, particularly those that involve and empower sex workers, need to be developed to address the range of determinants and inter-related factors that influence protective behavior. To some extent, other approaches are already being adopted in Cambodia through outreach programs and the work of NGOs, although there is significant scope for their enhancement, particularly those driven and controlled by sex workers themselves.

Box 10. Interventions that Empower Sex Workers

Sonagachi Project, India. The Sonagachi Project, which operates in a red-light district of Calcutta, was originally conceived as a health promotion project to educate sex workers about HIV, promote condom use, and provide clinical STI services. The project has evolved into a multi-faceted community effort to empower sex workers to both protect themselves from HIV and to fulfill their broader social needs and aspirations. In addition to peer education, condom distribution, and clinical services, the project conducts literacy classes using sex workers as teachers, provides care and schooling sex workers' children, operates a community-lending cooperative, and educates sex workers on their rights and other legal issues.

The project has been able to demonstrate a significant increase in self-reported condom use. In 1992, the year the project began, the percentage of clients using condoms with female sex workers always or often was 2.7 percent. By 1998, this figure had risen to 90.5 percent. There has also been a significant decline in STIs, with HIV prevalence remaining low[20].

A survey of 512 brothel-based sex workers involved in the Sonagachi Project showed a statistically significant association between consistent condom use and beliefs and behaviors indicative of social integration and participation[21]. The research also identified several strategies for effectively increasing collective ability to negotiate safe sex with clients:

- facilitating a sense of community among sex workers through activities like fairs and community meetings;
- decreasing perceived powerlessness through capacity building workshops;
- increasing access and control over material resources through micro-credit and cooperative banking; and
- increasing social participation through autonomous, self-governing sex worker organizations.

Other research, from Brazil, demonstrates a linkage between social support and condom use. A survey of 500 sex workers found that those women who felt a sense of social support and cohesion with other sex workers were ten times more likely to report consistent condom use with clients than women who scored low on this measure[22].

Dominican Republic. In the city of Puerto Plata, a combination of community mobilization and environmental-structural support has been used in HIV prevention programs in the sex industry. Community mobilization activities among sex workers, brothel owners, and staff have the goal of creating an enabling environment where condom use becomes the norm for sex workers and their clients. It includes participatory workshops, peer education, and sex worker specific printed material. This approach is paralleled with a regional government policy which requires 100 percent condom use in all commercial sex acts. The policy is enforced with a graded system of sanctions against sex establishments, including fines for repeated non-compliance.

A key feature of the Dominican 100% CUP has been the sex worker-government-NGO alliances that worked on the development, implementation, enforcement, and evaluation of the program. For example, NGOs and sex workers participated in training government health inspectors and STI clinic staff. The provincial health department reports that this approach contributed to the elimination of corrupt practices by health inspectors who conduct monthly brothel inspections[23].

A study of the impact of this intervention found an increase in self-reported consistent condom use with regular partners increased from 13 percent to 28.8 percent and was statistically significant. Condom use with new clients, already at a high level, also increased slightly. The study also compared the effectiveness of the intervention in Puerto Plata with the approach taken in another city, Santo Domingo, where only a community mobilization approach was used (e.g., no 100% CUP). Consistent condom use at follow-up in Santo Domingo was slightly lower than Puerto Plata (at 93.8 percent compared to 98.6 percent, respectively) but had increased from a lower base (75.3 percent compared to 96.5 percent). Consistent condom use with regular partners in Santo Domingo increased from 14.6 percent to 17.6 percent, significantly lower than what was achieved in Puerto Plata.

Both of the models had a positive impact. The findings could be taken to suggest that the integrated environmental-structural support and community mobilization model may lead to a more significant

Box 10. Interventions that Empower Sex Workers

increase in HIV-related protective behavior among female sex workers.

Challenges that Undermine the Program Logic

- **The assumption that brothel owner support for condom use is sufficient to achieve 100% condom use.** The program logic assumes that the support of brothel owners will be sufficient to achieve 100% condom use, based on their power in the brothel. However, a key motivation for brothel owners is to keep clients satisfied and sex workers have primary responsibility for achieving this. For some owners, this means allowing clients to have unprotected sex. For those who owners support condom use, this needs to be achieved without conflict. There is pressure on sex workers to negotiate the use of condoms amicably, without resort to the brothel owner, as this serves only to escalate the problem. This is why all DSWs report the continuing need to negotiate safe sex with clients. While the support of brothel owners in achieving consistent condom use is essential, DSWs also have a crucial role to play in negotiating condom use.

- **The economic incentive for unprotected sex.** There may be an economic incentive to accept more money from clients for unprotected sex. The incentive applies to sex workers, particularly if they are bonded, and to brothel managers, who will earn more through their percentage take of the sex worker's earnings. The 100% CUP assumes that consistent condom use will be achieved, largely through brothel owners making this a requirement and associated sanctions for non-compliance. Poverty and indebtedness undermines this assumption. Only through building self-esteem and self-value, with proven strategies such as the formation of sex worker controlled organizations and solidarity, can the attraction of larger fees with greater risk be defeated.

- **The impact of corruption on the implementation of the program at the local level.** Corruption is a fundamental challenge to the program. Corruption takes place in a variety of forms, for example:

  - Police are reported to demand bribes from sex workers or brothel management and use their power to obtain free sex. While the ultimate sanction for non-compliance is to close brothels, where police are taking bribes from brothels, there is a direct incentive not to do so as this will diminish their own income. DSWs also report that police do not take action when they register complaints about violent clients and that paying a bribe is the only way to get police to act.

  - Brothel managers hide under-age, sick, and other sex workers from the registration process and/or may prevent DSWs from regularly attending STI clinics to avoid sanctions or having to pay more bribes. There is also evidence that brothel owners choose new DSWs to be tested as part of national HIV surveillance, knowing that they are less likely to be infected.

  - DSWs at some sites can avoid regular attendance at government STI clinics by paying bribes or by giving their medical control cards to others to attend in their place. In addition, STI clinic staff, at one site, charge fees for services that are supposed to be provided for free.

  - The sanctions under the 100% CUP are supposed to be directed toward brothel management. However, some brothel managers have been said to recoup the "costs" of the 100% CUP – such as fines, bribes, or money spent on condoms – from the sex workers, who are already the most disempowered group within the sex industry.

  These forms of corruption have a number of implications for program implementation. For example, relationships between police and brothel management and sex workers are often characterized by fear and distrust and these are perceptions harm the credibility of the program. Additionally, the

incentives to hide sex workers from mandatory registration and clinic attendance (e.g., to avoid paying fines or higher bribes) undermines the program's primary monitoring mechanism. Finally, any increase in the amount of money sex workers are paying – to police, clinic staff, or brothel managers – leads to greater impoverishment and could provide an incentive to accept the offer of clients for sex without a condom.

In order to enhance the program the current opportunities for corruption must be removed or minimized. Mandatory aspects of the program serve to enhance the opportunity for corrupt practices as the payment of a bribe is an easy way to avoid compliance. Where there is good evidence to demonstrate that the aims of the 100% CUP can be achieved through non-mandatory methods (see Box 11), the program should be re-designed to remove the opportunity compulsion provides for corruption. Decriminalization of sex work, as in Australia, is one such approach known to diminish the opportunity for corruption among police.

Box 11. An NGO's Approach to Working with Sex Workers

There is good evidence to demonstrate that NGOs have been successful in identifying more sex workers than have been identified through the 100% CUP registration process and in achieving very high rates of voluntary attendance at STI clinics. Medecins Sans Frontieres (MSF) clinics were able to increase attendance at STI clinics at a number of sites in Cambodia, from around 40 percent of all sex workers to between 80 to 97 percent, depending on the location[24]. While attendance was less than 100 percent, this figure may well be higher than the percentage of DSWs currently attending government STI clinics, taking account of the number of DSWs who are not registered with clinics and tactics for avoiding clinic attendance. Factors which appear to have contributed to MSF's success were:

- flexible working hours;
- a sex-worker friendly environment at the clinic;
- good communication with brothel owners and sex workers through regular outreach at brothels;
- providing transportation for sex workers, if needed;
- subsidized or free consultations, and
- social support.

Challenge of Protecting the Human Rights of Sex Workers

Lack of clear guidelines for implementation, corruption, and the imposition of new demands on sex workers (e.g., compulsory STI testing) all contribute to the degradation of sex workers' human rights. The 100% CUP operates in the broader social environment where sex workers have low status, and the environment of the brothel where there are significant power imbalances, with sex workers being subject to substantial coercion from owners, police, and clients. The program makes additional requirements on sex workers, both directly and indirectly. Direct requirements are registration and compulsory health care. Indirectly, the burden of ensuring condom use still largely falls on DSWs, who can also become scapegoats if they are diagnosed with an STI. To the extent that brothel owners do not provide tangible support to sex workers for consistent condom use, the responsibility falls back on the sex workers. Indeed, it can be argued that the onus on sex workers is now greater, given the expectations of the program. This has occurred in the context of no enhancement of their power. In these ways, unfortunately, the program can contribute to the disempowerment of sex workers.

While promotion of sex workers' human rights is important in its own respect, it also contributes to successful program implementation. For example, as noted above in Box 8, NGOs, using voluntary approaches, have been able to achieve high rates of DSW attendance at STI clinics, which is one of the primary goals of the 100% CUP. Providing DSWs with a choice of which STI clinic to attend (e.g., government vs. NGO) could also enhance attendance rates.
Some of the specific issues pertaining to the 100% CUP and the human rights of sex workers are discussed below.

- **Improving respect for human rights.** The 100% CUP fails to respect the human rights of sex workers in the following ways:

  - *Registration.* The registration process involves police taking photos and collecting other personally identifying information from DSWs, often without obtaining consent or adequately informing sex workers of the purpose of collection. In some cases, DSWs have been charged fees for the photographs and for replacing medical control cards.
  - *Confidentiality.* There are no clear guidelines on how personally identifying information and STI diagnoses will be stored to maintain confidentiality and avoid misuse. This information needs to be treated in a confidential manner from both an ethical point of view and to ensure that individual sex workers are not persecuted by brothel owners.
  - *STI clinic attendance.* The 100% CUP mandates attendance at government STI clinics. Sex workers have no choice over which clinic to attend.
  - *Compulsory testing or syndromic management for STIs.* Ethical public health standards require that medical treatment be carried out only with the informed consent of the patient. However, the 100% CUP requires mandatory STI testing and treatment. The compulsory testing for STIs contrasts with Cambodia's policy approach for HIV testing, which is voluntary.
  - *Mystery clients.* The use of mystery clients to monitor the extent of condom use in brothels constitutes entrapment of the sex worker. Entrapment is commonly rejected as a valid form of investigation, and evidence collected in this way cannot be used in countries with ethical judicial systems. This practice is also inconsistent with the philosophy of the 100% CUP, which seeks to place the responsibility of condom use on brothel managers rather than sex workers. The information collected through entrapment targets the individual sex worker who was prepared to agree to unprotected sex, leading to the probable persecution of the sex worker by brothel management. Additionally, unless mystery clients are used on a widespread basis, the data collected will not provide a significant body of evidence regarding compliance.

- **Strengthening sex workers' understanding of their own human rights.** As noted above, several aspects of the 100% CUP disregard the human rights of sex workers. While most of the sex workers expressed concerns regarding some human rights issues, other rights issues did not attract adverse comments. This needs to be placed in context. Many of the sex workers have minimal or no schooling. For many, there is only a limited, if any, understanding of their rights. To some extent, unfair treatment has come to be expected as the norm and thus, accepted. However, sex workers are more likely to object when the bad treatment directly affects them. For example, they strongly object to the abuse and rough examinations which many say they encounter at STI clinics. In contrast, few have an objection to compulsory testing, as they are not aware they have a choice. The testing process itself does not appear directly to impact on their lives in the same way as abuse and rough vaginal examinations. (And most, based on the experience of NGO clinics, would readily give their consent for testing if asked.)

- **Addressing broader health and social needs of sex workers.** Because no component of the program aims at protecting sex workers from the acquisition of an STI/HIV infection from their

personal partners, the 100% CUP appears to be designed primarily for the protection of clients and not for sex workers. Developing a component that works specifically to improve sexual safety in the women's personal relationships would both address this bias and improve overall prevention levels. Support for additional services, such as safe sex negotiation skill training, literacy classes, social support, and empowerment, would help address the broader health and social needs of sex workers and provide them with the skills and confidence to negotiate safe sex, both in their personal and professional relationships.

Challenge of Meaningful Involvement of Sex Workers and Development of Effective Partnerships

The 100% CUP recognizes the need to develop partnerships between those in the sex industry and public health officials. Given the level of corruption and distrust, coupled with the limited opportunity for sex worker and NGO participation under the current 100% CUP, much remains to be done in order to facilitate partnership building.

- **Enhancing leadership at the provincial level.** While it was not a specific focus of this project, the extent of provincial level leadership and support for the 100% CUP appears to vary. In some sites, there is strong support for the program from the Governor and other senior officials. In other places this does not appear to be the case. The overall efficiency and effectiveness of the program can be significantly enhanced in those provinces where leadership is sub-optimal. In particular, improved leadership may minimize corrupt practices and lead to more cooperative relations with the sex industry.

- **Improving collaboration between government and NGOs.** As recognized by the *Strategy and Guidelines*, the 100% CUP provides great potential for close collaboration between government and NGOs. While this is occurring in some places, the implementation of the 100% CUP has been accompanied by a demarcation which mostly sees NGOs confined to working with ISWs, and government with DSWs. This can result in duplication of services or limited services where government services do not fully duplicate the range of NGO activities. Where NGOs STI clinical staff are available, consideration should be given to government and NGO staff running joint clinics. Where NGOs provide broader social services to sex workers, these should be available to DSWs. NGOs should also be encouraged to undertake outreach activities with DSWs.

- **Promoting meaningful involvement of sex workers.** With the exception of Koh Kong, where the CUWG has recently started to hold regular meetings with sex workers, there do not appear to be any meaningful attempts to actively involve sex workers in the delivery and monitoring of the program. There are substantial practical benefits to be gained by the 100% CUP taking a more cooperative and inclusive approach to sex workers. This involvement can take a number of forms:

  - Taking steps to enhance the power of DSWs in brothels so they are better equipped to negotiate condom use;
  - Using sex workers as (paid) peer educators in recognition of both the credibility they have with other sex workers and the additional reach this would provide to prevention efforts; and
  - Involving DSWs in the monitoring and implementation of the program out of an acknowledgement that their unique position means they know what is happening and have practical ideas on how implementation could be improved.

    If the involvement of sex workers in monitoring and implementation s to be done effectively, it will need to be accompanied by training and support. Consideration also needs to be given to the safety of sex workers so they are not put in the position of unprotected informants.

One way of giving DSWs a voice in the program would be to establish a sex workers consultative group in each province in which the 100% CUP is operating. This group, which could have a representative from each brothel, could meet in private with only sex workers present to ensure confidentiality and safety. If desired, the group could be assisted by a person chosen by the sex workers. For example an ex-sex worker or someone the sex workers trust (possibly an NGO staffer). The sex workers consultative group would report to both the CUWG and the CUMEC. It would also be appropriate to have a sex worker representative on CUWG and CUMEC so that these committees have the benefit of hearing the views of sex workers first hand. The representative would need training and support to fulfill this role.

- **Addressing the contrast between government authorities working with the sex industry and ongoing police harassment.** Many sex workers were appreciative of government initiatives to reduce the impact of HIV/AIDS in the sex industry and saw benefits in the 100% CUP because of its support for consistent condom use. Nonetheless, they were perplexed by the continuing harassment and persecution from authorities they face on an almost daily basis. Given the integration of a range of government officials in the operation of the 100% CUP, particularly police, they see a contrast between efforts to help the sex industry and ongoing problems with authorities. On the one hand, they see a program that is attempting to protect their health, and on the other, they interpret the harassment as an attempt to close down the sex industry. Given the economic imperatives which resulted in their entry to sex work, DSWs see ongoing harassment and closure of brothels as a threat to their livelihoods and are greatly concerned. At the same, police harassment and closure of brothels drives the sex industry underground. These closures do not stop sex work. They merely change the location of where it occurs, often to places where access to sex workers by government and NGO staff is difficult.

  Many sex workers, particularly those in Phnom Penh, asked for more protection from the authorities (e.g., corrupt police) so that they can work to support their families, pay off their bonds, and get out of the sex industry. Many DSWs and ISWs also requested a safe environment in which to work. They said if the authorities were not prepared to provide this, and were intent on closing down the sex industry, there should be support for sex workers in making a transition to other kinds of work. Areas of support which were identified included education and training, holistic health care, housing (at least during the transition phase as they have no where else to live except the brothel), and loans to allow them to establish small businesses so they would no longer have to rely on sex work to survive.

Recommendations

There are a significant number of stakeholders involved in HIV interventions for the sex industry, including: Cambodian government officials, local authorities, international donors, brothel management, sex workers, and international and local NGOs. Based on information obtained in this consultancy, the following recommendations are made to the stakeholders:

18. Strengthen the policy framework for the 100% CUP to ensure there are clear statements of principles and operational guidelines for all key aspects of how the program is intended to operate.

19. Ensure supervision of sites for greater standardization of performance and strengthen adherence to key guiding principles across sites.

20. Enhance the standard of care at STI clinics, consistent with the *Guidelines for Implementation of STI Services*. These services need to address a broad range of health issues for sex workers and not be

confined just to STI management. In order to enhance sex worker access to regular STI management, emphasis needs to be placed on creating a sex worker friendly environment and the cost of clinical services, including treatment, should be provided free of charge.

21. Develop high profile HIV/STI prevention campaigns targeting the clients of sex workers, in recognition that the responsibility for consistent condom use rests with brothel management, sex workers, and clients.

22. Develop peer-led sex worker organizations and other strategies to ensure that under-age sex workers have access to both sexual and other health care services.

23. Give priority to the development of programs that more effectively target the risk of HIV infection and STIs among ISWs.

24. Develop strategies that address the risk of HIV and STI infections among male sex workers and their clients. NGOs and peer outreach approaches should play a primary role in these efforts.

25. Promote the social marketing of condoms, as well as subsidized female condoms and water-based lubricants as a way of encouraging condom use.

26. Undertake a re-design of the 100% CUP to minimize the opportunities for corruption. Where voluntary compliance can be achieved, mandatory aspects of the program should be eliminated.

27. Modify the 100% CUP *Strategy and Guidelines* so that they uphold the human rights of sex workers. In particular, ensure that the guidelines state that:

    - Attendance at STI clinics for all sex workers should be strongly encouraged, but not be compulsory.
    - Health care workers, both government and NGO, should be charged with the responsibility of encouraging DSWs to regularly attend STI clinics, including follow-up of sex workers who do not attend.
    - Police should not be involved in the collection of personally identifying data for sex workers for the purpose of ensuring attendance at clinics.
    - STI clinics should only collect personally identifying data which are necessary for the provision of clinical services. Clinic cards held by sex workers should use a code instead of the sex worker's name. All personally identifying data held by clinics should be treated in a confidential manner.
    - Sex workers should have a choice of which STI clinic to attend, where more than one clinic exists in the local area.
    - STI management of sex workers should be undertaken with their consent.
    - The use of mystery clients as a monitoring tool should be discontinued.
    - Methods for monitoring the program do not compromise the rights of sex workers and that recognize that brothel managers, clients, and sex workers all have a role to play in ensuring consistent condom use should be developed.

28. Support the development of sex worker controlled and driven community mobilization programs/organizations with a focus on increasing sex worker solidarity and with a particular emphasis on helping sex workers understand and use their human rights protections. Additionally, develop strategies to enable sex workers to improve their safety with non-commercial partners. Encourage involvement of NGOs in addressing the health and social development needs of all sex workers, not just the need for sexual safety.

29. Expand the nature of the program to include a far greater emphasis on client education and an expanded set of priorities among sex workers (including prevention of sexual violence and provision of services for SWs who have been raped).

30. Foster senior level commitment and support for the 100% CUP at the local level. Additionally, consultations should be conducted with sex workers and their advocates on meaningful ways of including sex workers in the operation of the 100% CUP. This should include the option of establishing sex worker consultative groups in each province where the 100% CUP is operating and sex worker representation on CUWGs and CUMECs.

31. Encourage the involvement of NGOs in addressing the health and social needs of DSWs by:

    - STI clinics being jointly staffed by government and NGO health care workers, where NGO clinical staff are available,
    - Encouraging NGOs to undertake outreach work with DSWs, and
    - Facilitating the provision of broader social health services to sex workers, where NGOs provide these in provinces where the 100% CUP is operating.

32. Develop a national steering committee for HIV prevention in the sex industry and place sex workers and police on this committee.

33. Develop a sex worker-police liaison unit in each area; educate police about human or citizen's rights and address issues of police violence, corruption, free sex on demand and failure to handle sex workers' complaints as a high priority.

34. Ensure representative sampling of sex workers for HIV surveillance through community negotiation, mapping and procedures that involve sex workers as partners.

End Notes

[1] Under-age sex workers refers to people under 18 years of age.
[2] UNAIDS, UNICEF, WHO *Cambodia Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections, 2002 Update*, p 8. Based on NCHADS data.
[3] NCHADS *Behavioural Surveillance Survey*, 2001.
[4] This figure is based on responses from sex workers who participated in focus groups and interviews and is consistent with data collected for the NCHADS BSS. 5000 riel is equivalent to US$1.28.
[5] NCHADS *Behavioural Surveillance Survey V*, 2001.
[6] NCHADS *Behavioural Surveillance Survey V*, 2001.
[7] Samang P et al *HIV infection among Cambodian fishermen: knowledge and implications for prevention*
[8] Sopheap Seng *The Impact of the 100% Condom Use Campaign Combined with Systematic STI Treatment for Sex Workers in Sihanoukville*, Cambodia.
[9] WHO, Regional Office of the Western Pacific, 100% *Condom Use in Entertainment Establishments*, 2000.
[10] The word 'registration' is not used in the 100% CUP *Strategy and Guidelines*. It is used in this report to refer to the collection of personally identifying data on DSWs and using this to create medical control cards at government STI clinics.
[11] The NCHADS *Cambodian Household Male Survey*, conducted in 2000, found that 46% of men with a symptom of an STI, first seek treatment at a pharmacy. Traditional care is the first choice for 27% of men, with only 23% initially seeking medical care. The 2001 BSS, which sampled a narrower range of men, (military, police and moto drivers), found that 46% sought first treatment for an STI at a pharmacy, 16.1% through traditional care, and 38.3% sought medical care.
[12] The Strategy and Guidelines indicate that monitoring and evaluation mechanisms will be determined at the local level: "the CUWG must define in advance what monitoring and evaluation mechanisms will be used." STI data is listed as one of the suggestions.
[13] Hawkes S, Morison L, Foster S, Gausia K, Chakraborty S, Peeling RW, Mabey D. Reproductive tract infections in women in low-income , low prevalence situations: assessment of syndromic management in Matlab, Bangladesh. Lancet 1999;354:1776-81.
[14] Crabbé F, Seng S, Seng SW, Soeur S, Kiv BS, Mean CV. In Cambodia, treatment of cervical infection in lower risk women is likely to be excessive and not to contribute significantly to HIV prevention. International Conference on AIDS in Asia and the Pacific, Melbourne 5-10 October 2001 [Poster 1545].
[15] It is not known whether CUP implementation is yet to occur at this particular site, or whether there is a special arrangement.
[16] NCHADS *HIV Sentinel Surveillance 2002*.
[17] The Rose Centre is an NGO STI clinic in Siem Reap. It was established by MSF and is now operated by RACHA.
[18] NCHADS *Cambodian Household Male Survey* 2000, p 15.
[19] Moreno L and Kerrigan D, *HIV prevention strategies among female sex workers in the Dominican Republic*. Research for Sex Work 3,2000.
[20] UNAIDS, *Female sex worker HIV prevention projects: Lessons learnt from Papua New Guinea, India and Bangladesh.* UNAIDS Case Study. 2000.
[21] Horizons Report, May 2002.
[22] Horizons Report, May 2002.
[23] Horizons Report, May 2002.
[24] Por, et al *Regular Visits by Female Sex Workers for STI Control at Special Clinics are Achievable on a Voluntary Basis: MSF's Experience in Cambodia*, Presentation to the xx International AIDS Conference, Barcelona, 2002.