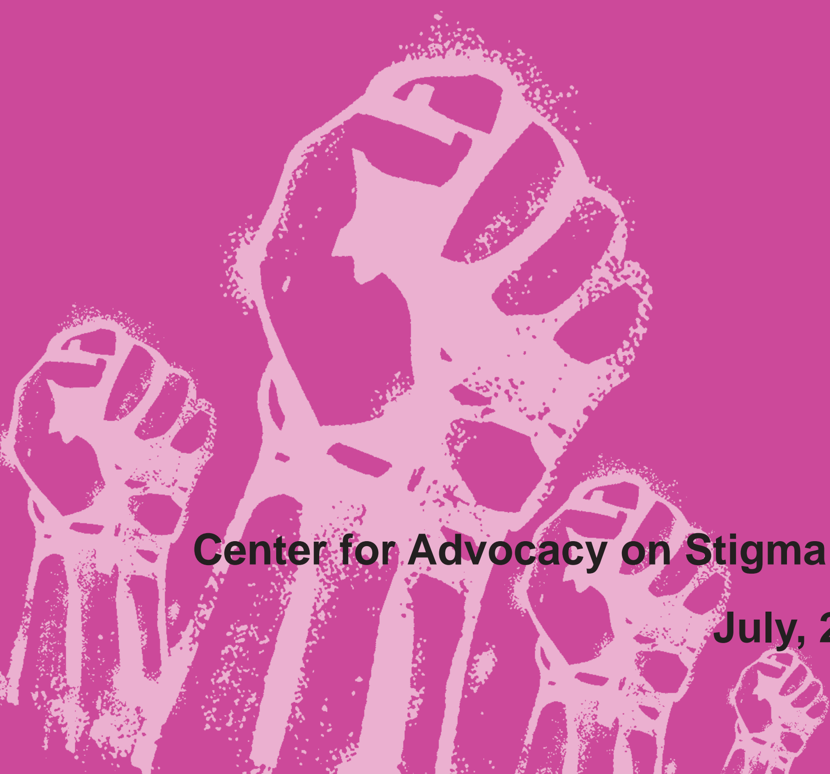
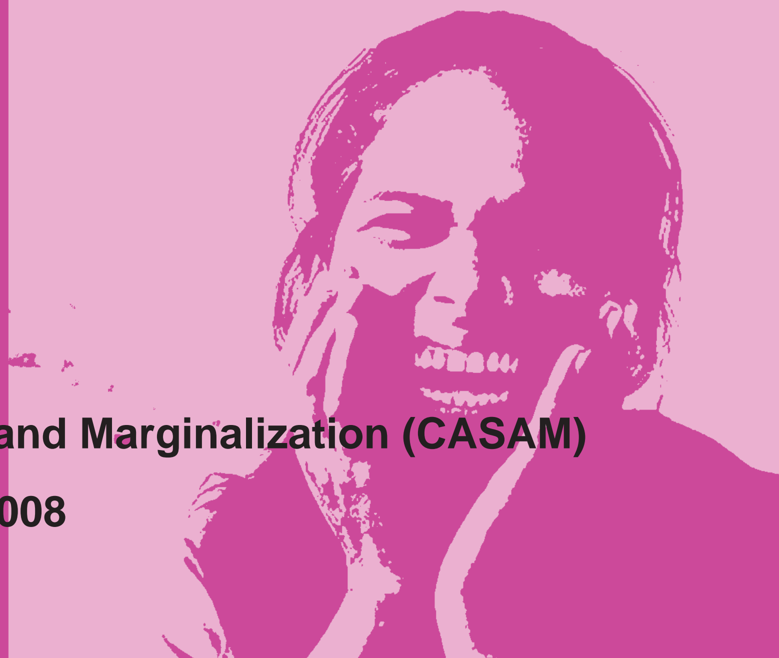
Rights-Based Sex Worker Empowerment Guidelines:

An Alternative HIV/AIDS Intervention Approach to the 100% Condom Use Programme





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Arohan, Ghanshyam Nagar,
Madhavnagar Road,
Sangli – 416416, Maharashta
India
Tel: +91-233-2312191 / 2311644
E.mail: sangram.vamp@gmail.com
www.sangram.org

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About this monograph

This report was researched and written by Professor Chi Mgbako, Meghan Gabriel, Laura Garr and Laura Smith, under the auspices of the Walter Leitner International Human Rights Clinic at Fordham Law School in New York City. The project was co-supervised by Supriya Pillai, formerly program officer for Asia in the International Women's Health Coalition.

The Walter Leitner International Human Rights Clinic aims to train a new generation of human rights lawyers and to inspire results-oriented, practical human rights work throughout the world. The Leitner Clinic works in partnership with non-governmental organizations and foreign law schools on international human rights projects ranging from legal and policy analysis, fact-finding and report writing, and human rights training and capacity-building.

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EXECUTIVE SUMMARY

HIV/AIDS intervention programs targeting sex workers rarely utilize a rights-based empowerment approach. One such program that fails to embrace this approach is the 100% Condom Use Programme (100% CUP), a public health program implemented in South East and East Asia that aims to prevent HIV/AIDS among the general population through the promotion of condom use in the commercial sex industry. The 100% CUP's main objective is to reduce HIV transmission from sex workers in brothel-based sex establishments to their clients.[1] This approach, which targets sex workers as a "core transmitter group," affirms the stereotype that sex workers are vectors of disease and perpetuates the stigma and discrimination that hinder sex workers' ability to advocate for their rights. While not all aspects of 100% CUP are negative, there exists a need to re-center HIV programming targeting sex workers within the framework of a rights-based and justice-based sex worker empowerment model.

The 100% CUP was first launched in Thailand in 1989 and was based on a program developed by the Japanese military during its occupation of Thailand in World War II.[2] The program has been implemented in Cambodia, the Philippines, Vietnam, Myanmar, Indonesia and China.[3] The program's goals are to: require use of condoms 100% of the time; in 100% of risky sexual relations; in 100% of sexual acts taking place within sex entertainment establishments.[4] The 100% CUP applies a simplified solution to a complex problem. The 100% CUP's designers ignored the effect stigma, discrimination, violence and power imbalances have on a sex worker's ability to negotiate protection during sex or seek health and social services.[5] These existing barriers, along with other economic and social factors, are more likely to influence a sex worker's ability to negotiate condom use than the risk of contracting HIV.[6]

The program's negative outcomes in Asia are a direct result of fundamental flaws in 100% CUP's underlying approach.[7] Because the program failed to recognize that sex work is an occupation that exposes its workers to certain diseases instead of a shameful behavior, sex workers were not recognized as legitimate and vital partners in the program's design and implementation.[8] Sex workers' knowledge of sexual behavior coupled with their access to clients should make them an invaluable resource in any HIV/AIDS intervention program. Yet, in direct contradiction to current notions about the value of community participation in HIV programming,[9] the creators of 100% CUP, despite limited knowledge of the internal dynamics of commercial sex, never attempted to support collaborative efforts by sex workers to address the epidemic. This has encouraged the conventional notion that sex workers lack the power to be agents of change and should defer to outside "experts" who too often fail to put sex workers' rights and wellbeing at the center of HIV/AIDS program design.

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[1] Bebe Loff, "Can Health Programs Lead to the Mistreatment of Sex Workers," The Lancet, Vol 361, June 7, 2003 at 3.
[2] *See* http://www.empowerfoundation.org.
[3] *See* Third Asia Pacific Intergovernmental Meeting on Human Resources Development for Youth, Bangkok, June 4-8, 2001, Speakers, Wiwat Rojanapithayakorn. UNODC website: http://www.unodc.un.or.th/press_releases/rc_2001_04.htm (providing a brief biography on W. Rojanapithayakorn and noting how 100% CUP is now recognized by UNAIDS, WHO, World Bank, and other international organizations as a "best practice" in HIV/AIDS/STD prevention).
[4] World Health Organization, *Experiences of 100% Condom Use Program in Selected Countries of Asia*, (2004) at 9.
[5] UNAIDS, 2006 Report on the Global Aids Epidemic at 14.
[6] "100% Condom Program – the views for and against," *available at* http://apnsw.org/r/ForandAgainst100CUP.htm at 4.
[7] In addition to the human rights abuses listed throughout the report, data collected in Vietnam, Indonesia, Fiji and Papa New Guinea, where 100% CUP has been implemented, show condom use in high risk population remains very low. In Lao People's Democratic Republic, the prevalence of HIV among sex workers has been increasing despite the presence of 100% CUP (WHO, Joint UNFPA/WHO Meeting on 100% Condom Use Program, Oct 2006, at 2-4).
[8] Bebe Loff, Can Health Programs Lead to the Mistreatment of Sex Workers, The Lancet, Vol 361, June 7, 2003.
[9] Network of Sex Workers Projects, *The 100% Condom Use Policy: a Sex Workers' Rights Perspective*, Jan. 22, 2003 (last modified Jan. 6, 2007), *available at* http://www.nswp.org/safety/100percent.html.

An original objective of 100% CUP was to increase free, voluntary access to health services for sex workers. Yet, since its implementation, health services under the program are often mandatory with punitive results for sex workers who are diagnosed with a sexually transmitted infection (STI). Sex workers who contract STIs often hide from public health authorities or pay bribes to health workers to obtain clean health reports. Those who test positive for HIV are often forced to leave brothels and shift to non-brothel based sex work where there is no regulation by 100% CUP.

Initially, 100% CUP sought to create a collaborative environment where local governmental authorities, police, health workers, sex workers, and brothel owners would work together to increase condom use within commercial sex establishments.[10] Yet, sex workers remain vulnerable to abuse, corruption, and exploitation at the hands of police, local authorities, and brothel owners who are charged with enforcing the program's condom use policies.[11] While the aim of fostering a collaborative approach is a worthy goal, the program fails to incorporate any meaningful effort to encourage a sense of community among sex workers in order to combat the power imbalance between the above-named actors and sex workers. As long as 100% CUP treats sex workers as objects rather than agents of the program, it will result in the abuse of sex workers.

In addition, many vital actors necessary for a truly collaborative approach receive scant attention or are absent in 100% CUP's design. For instance, 100% CUP focuses on the brothel-based sex industry and ignores "indirect" sex workers, despite the fact that a large portion of the sex industry is located outside of brothels. Sex work is often divided into two broad categories: "direct" sex work which refers to sex work taking place in brothels and "indirect" sex work which serves as an umbrella term encompassing sex work that occurs in hotels, clubs, bars, restaurants, massage parlors, spa and sauna centers, street corners, roadside inns, truck stops, and private homes.[12] In addition, 100% CUP also pays little or no attention to clients, sex workers' intimate partners, male sex workers and transgender sex workers.

The objective of any HIV/AIDS intervention program targeting sex workers must be the rights-based empowerment of people in prostitution. The rights-based empowerment of sex workers in HIV/AIDS intervention programs necessitates three key components: sex worker involvement and leadership in all aspects of program design and implementation; the creation of a sense of community among sex workers in order to facilitate collaborative action; and the elimination of stigma and discrimination associated with sex work. Sex workers possess fundamental rights and can be empowered to fight for justice in their communities.

This paper will highlight the fundamental flaws of 100% CUP. More importantly, the paper seeks to provide alternative guidelines for HIV/AIDS intervention programs aimed at sex workers rooted in a rights-based empowerment approach. The alternative guidelines in this paper are inspired by interviews conducted in February 2008 with sex workers in Sangli, India and are rooted in the work of Sampada Gramin Mahila Sanstha (SANGRAM) a voluntary organization that works at the grassroots level with activists, volunteers and paid workers in Maharashtra State, India. SANGRAM, which works in partnership with Veshya Anyaya Mukti Parishad (VAMP), a collective of sex workers against injustice, is gaining importance as a practical training ground for other NGOs interested in working on HIV/AIDS. SANGRAM started its work with women in prostitution and sex work from South Maharashtra and North Karnataka in 1992 and has since fanned out among diverse populations.

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[10] W. Rojanpitayakorn, Thai Medical Society for the Study of Sexually Transmitted Infection, "Response to the Lancet Article: Can Health Programmes Lead to Mistreatment of Sex Workers?," 362 Lancet 328 (July 26, 2003).
[11] David Lowe Consulting, "Documenting the Experiences of Sex Workers: Draft Report," (Dec. 2002), iv-v, 15-26.
[12] The term indirect sex work may also encompass what is coined "survival sex" – persons who engage in sex work not as a livelihood but in exchange for basic necessities.

1. 100% CUP: HISTORY AND METHODOLOGY

The late 1980s marked the beginning of the AIDS epidemic in South East Asia. In Thailand, studies showed that 1.5% of the general population and 44% of brothel-based sex workers in northern Thailand were infected with HIV.[1] Fearing a widespread epidemic, government officials, policy makers and epidemiologists sought to curb the spread of HIV to the general population by increasing condom use in commercial sex transactions thereby preventing the concentrated epidemic from becoming generalized.[2]

In response to the crisis, the Thai government implemented the 100% Condom Use Programme in Thailand's Rachaburi Province.[3] The program's aim was to make condom use in commercial sex establishments the accepted norm so that sex establishment owners would no longer have an economic incentive to allow unprotected sex (brothel owners often feared that enforcement of condom use would drive away clients who would go elsewhere to seek sex without condoms).[4] Documented success of the program (measured by a reduction

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[1] Kate Hendricks & Patricia Thickstun, *Thailand's 100% Condom Use Policy: Success is in the Eye of the Beholder*, Technical Paper MISH/MCHB/TP-20050728, Austin, TX: Medical Institute for Sexual Health (July 28, 2005) at 12.

[2] There are two categories of the AIDS pandemic: generalized epidemics are those where "adult HIV prevalence among the general adult population is over 1% and transmission is mostly heterosexual" and concentrated epidemics are ones "where HIV is concentrated in groups such as men who have sex with men, injecting drug users, sex workers and their sexual partners whose occupation or behaviors expose them to a high risk of HIV infection." *See* data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf. Though the AIDS epidemic in Asia has not yet reached generalized proportions, high levels of HIV infection among high risk groups have caused alarm. UNAIDS reports that in 2007, approximately 446,000 Asians/Pacific Islanders were newly infected with HIV, bringing the total number living with HIV/AIDS in Asia and the Pacific to 4.9 million. *See* http://www.amfar.org/cgi-bin/iowa/asia/aids/?record=4.

[3] World Health Organization, *Experiences of 100% Condom Use Program in Selected Countries of Asia*, (2004) at 2.

[4] *Ibid.*

in STI rates among commercial sex workers) led to the adoption of similar programs in other Thai provinces.

In 1991, 100% CUP was implemented on a national scale in Thailand and supported by the Thai prime minister. [5] In the same year, the first HIV infections were discovered in Cambodia. Subsequently, the Cambodian Ministry of Health established a national AIDS outreach and education program, but infection rates among sex workers continued to increase to around 42.5%.[6] In 1998, the Cambodian government decided to implement a pilot 100% CUP project in Sihanoukville. By 2001, the government had implemented 100% CUP in ten more provinces.[7] Currently, the program is being piloted or implemented in China, Lao, Mongolia, the Philippines and Vietnam.[8]

The 100% CUP is not a "stand alone program."[9] Instead, it was designed to compliment a country's national strategy for reducing the spread of HIV/AIDS. The 100% CUP depends on cooperation between local government, national government, clients, sex workers, brothel owners, healthcare providers, and police. The goals of the program are to: require use of condoms 100% of the time; in 100% of risky sexual relations; in 100% of sexual acts taking place within sex entertainment establishments.[10] The 100% CUP implementation differs according to the adopting country, available resources, and services provided. However, activities common to most 100% CUP projects include: mapping of sex work establishments; information gathering about the number and location of sex workers; outreach activities at brothels; condom distribution; information, education and communication; and STI testing and treatment.[11] The World Health Organization (WHO) suggests six essential strategic components of the 100% CUP: high-level political commitment; multi-sectoral institutional structures; promotion and accessibility to quality condoms; identification and collaboration with sex entertainment establishments; mechanisms for monitoring condom use; and methods for evaluating outcomes/impact.[12]

Most countries implementing 100% CUP begin by mapping the locations of direct sex work establishments followed by identifying the numbers and locations of sex workers. The common next step is to launch an advocacy campaign to inform the community about the new regulations. Meetings with stakeholders such as police and health workers are initiated. The registration of sex workers under 100% CUP is intended to ensure that they attend STI clinics for required testing. During registration, brothel-based sex workers are photographed and their personal information is collected. This information is often used to create medical control cards to document clinic visits and health status. A positive STI diagnosis is often used an indicator of non-condom use and thus non-compliance with the program.[13] Countries looking to implement 100% CUP usually launch pilot programs to examine the feasibility of establishing a nationwide program.

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[5] *Ibid.*

[6] *Ibid* at 3.

[7] *Ibid* at 4.

[8] *Ibid*. Although WHO lists Myanmar as a 100% CUP country Myanmar has not officially been part of 100% CUP for years. Myanmar redefined 100% CUP to mean 100% access to condoms and set up true voluntary services. It's ironic that the country with the most repressive regime in the region has one of the best sex worker programs, but it also demonstrates that programs with meaningful involvement of sex workers can be done anywhere.

[9] *Ibid* at 9.

[10] *Ibid.*

[11] World Health Organization, Joint UNFPA/WHO Meeting on 100% Condom Use Programme (Oct. 2006).

[12] World Health Organization, *Experiences of 100% Condom Use Program in Selected Countries of Asia*, (2004) at 4, 10.

[13] David Lowe Consulting-Asia, "Documenting the Experiences of Sex Workers: Draft Report," (Dec. 2002), at 12.

2. RIGHTS-BASED EMPOWERMENT APPROACH

"I am a sex worker but I also have human rights."[1]

The 100% Condom Use Programme neglects to follow a rights-based empowerment approach, choosing to focus on containing the disease at the expense of protecting the rights and dignity of those most vulnerable to contracting HIV. Human rights-based principles for development should serve as a framework for those working in the field of HIV/AIDS. These principles include: express linkage to rights, accountability, empowerment, participation, non-discrimination and attention to vulnerable groups. HIV/AIDS programs targeting sex workers should have at their core a commitment to sex worker leadership in program design and implementation; formation of collective identity and action among sex workers; and the elimination of stigma and discrimination related to sex work.

A. Sex Worker Leadership in Program Design and Implementation

"Outsiders working with sex workers must be democratic and not bureaucratic. They must let sex workers come up with the answers to their own problems."[2]

Sex workers must be the driving force in the development, implementation, and enforcement of targeted HIV/AIDS prevention programs aimed at sex workers. It is not enough to "consult" with sex workers before creating a program.[3] Rather, programs should be based on sex workers' needs, perceptions and experiences. "Outsiders" or non-sex workers working on HIV/AIDS intervention programs targeting sex workers must build relationships of trust within the sex work populations where they work. They must nurture true partnerships with

[1] Interview with sex worker from VAMP, Sangli, India (February 25, 2008).
[2] Interview with sex worker from VAMP, Sangli, India (February 25, 2008).
[3] "Sex Workers: Participation and Inclusion," *available at* http://apnsw.org/vtpage.shtml?n=42e4 (March 13, 2008).

"insiders" in order to create a collective wall of solidarity that can stand as a defense against the HIV epidemic.

In order to gain the trust and confidence of sex workers, whose cooperation and leadership is crucial to success, it is important to employ peer educators and outreach workers who are themselves sex workers in the implementation process. Sex workers are more effective than outsiders in empowering and educating other sex workers therefore decreasing the internalization of stigma and increasing feelings of self worth and collective solidarity. In addition, sex workers possess invaluable knowledge about the sex industry that can translate into outreach activities to other target groups such as clients and indirect sex workers. Sex workers are less likely to be afraid to discuss sensitive or intimate issues related to sex, such as condom negotiation. As outreach workers, sex workers can launch interventions among clients and indirect sex workers to enhance HIV/AIDS awareness and to increase accessibility to condoms in these populations.

B. Formation of Collective Identity and Action Among Sex Workers

"We must be together in all of our problems. We must be with each other in our good and bad experiences and only then will condom distribution have an impact."[4]

Collective identity and action is especially important for marginalized groups, such as sex workers, whose voices are often subjugated in matters of personal health and self-autonomy. Solidarity among sex workers is essential to free sex workers from internalized shame and enable them to realize their rights and fight for justice. The rights-based empowerment process cannot occur unless sex workers come together in supportive environments where they can systematically and effectively address collective needs.[5] The development of collective identity redefines community problems as emerging from a lack of power while strengthening the community's power to deal with them. Collectively, a community is in a stronger position to deal with police, health workers and government officials.[6]

Developing collective identity and action among sex workers is a challenging process that requires innovation. HIV/AIDS programs must be sensitive to the diversity of cultures of people working in the sex industry. Thus, what it means to be part of a sex work "community" will vary depending on the culture, location, and socio-economic position of the particular sex work population. Sharing common experiences and collectively acting to address common problems, such as police harassment and discrimination by health workers, can create collective solidarity among sex workers. Meetings among different groups of sex workers, such as brothel-based, street-based and male sex workers, can foster a deeper sense of community.

C. Confronting Stigma and Discrimination

"Before we were not aware of our rights. We were treated like slaves. W e would cover our faces. We were suffering in silence. We were thinking that sex work is not a good thing and anything wrong that happened to us we would accept it and cry. But we learned that we deserve to be treated not as good or bad but as women who need to know our rights."[7]

As a result of discriminatory laws and social practices, sex workers experience debilitating stigma and discrimination that erode their ability to protect their health and well-being.[8] HIV/

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[4] Interview with sex worker from VAMP, Sangli, India (February 25, 2008).
[5] Ivan Wolffers, *Empowerment of Sex Workers and HIV Prevention*, in Research for Sex Work Vol. 3 (June 2000) at 2.
[6] *Ibid* at 2-3.
[7] Interview with sex worker from VAMP, Sangli, India (February 25, 2008).
[8] Prabha Kotiswaran, *Preparing for Civil Disobedience: Indian Sex Workers and the Law, available at* http://www.bc.edu/bc_org/avp/law/lwsch/journals/bctwj/21_2/01_FMS.htm at 5.

AIDS programs must take affirmative steps to promote the idea that sex workers are human beings entitled to health, dignity, and lives free from violence, discrimination and other human rights abuses.[9] The discrimination sex workers face makes it difficult for them to access health care, housing, and supplemental employment opportunities; heightens their vulnerability to verbal, physical, and sexual abuse, arbitrary arrests, and harassment; and decreases their ability to seek protection from the courts or the police when they suffer from violence and discrimination.

The 100% CUP does not change or even challenge the subordinate position of sex workers; instead, it reinforces their stigmatization.[10] HIV/AIDS programs should teach sex workers about their legal and human rights so that a renewed sense of dignity will compel them to collectively demand justice and relief from discriminatory practices. HIV/AIDS programs should also promote acceptance of sex workers and people living with HIV/AIDS in media campaigns and health care services.[11] Furthermore, programs should participate in debates regarding how laws against sex work are affecting HIV prevention efforts.

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[9] Avini Amin, *Risk, Morality, and Blame - A Critical Analysis of Government and US Donor Responses to HIV infections among Sex Workers in India*, Center for Health and Gender Equity (2004) at 7, *available at* www.genderhealth.org/pubs/AminHIVAmongSexWorkersinIndiaJan2004.pdf.

[10] Womyn's Agenda for Change (WAC), *Pro's and Con's on 100% Condom Use Policy (CUP) in Cambodia* (2006) at 4, *available at* http://apnsw.org/apnsw.htm.

[11] Avini Amin, *Risk, Morality, and Blame - A Critical Analysis of Government and US Donor Responses to HIV infections among Sex Workers in India*, Center for Health and Gender Equity (2004) at 25, *available at* www.genderhealth.org/pubs/AminHIVAmongSexWorkersinIndiaJan2004.pdf.

3. CRITIQUE AND ALTERNATIVES TO 100% CUP'S methodology

A. Regulation of Sex Workers

"If a sex worker is found to be HIV-positive the first concern must be for her own health. We must help her get medicine, get off drugs, and start ARTs. Confidentiality must never be disclosed. The HIV-positive person is also a human being."[1]

100% CUP:

HIV/AIDS programs that make sex workers feel they are being targeted and punished will not facilitate a sense of empowerment or cooperation. The 100% CUP designers envisioned STI testing as a critical preventative and evaluative component of the program. Though one of the early framers of 100% CUP in Thailand has argued that the intention was never to include mandatory STI and HIV testing,[2] unclear policy design and inconsistent methods of program implementation have led some implementing countries, including Thailand, to make testing of sex workers compulsory.

Mandatory testing is a violation of sex workers' human rights and serves to reinforce the stereotype of sex workers as a threat to public health. The use of mandatory testing in 100% CUP violates ethical guidelines by denying sex workers the right to give voluntary and informed consent to HIV testing. Under 100% CUP, police have escorted sex workers to health clinics where they have been forced to submit to HIV or STI testing.[3] In Thailand, STI clinic staff have been known to arrive in bars and other sex worker venues with buckets of syringes and vials in order to conduct mandatory blood work on sex workers.[4] These practices strip sex workers of the right to be free from coercion, which should be an essential component of ethical HIV programming.

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[1] Interview with sex worker from VAMP, Sangli, India (February 25, 2008).

[2] W. Rojanapithayakorn, Thai Medical Society for the Study of Sexually Transmitted Infection, "Response to Lancet Article: Can Health Programs Lead to Mistreatment of Sex Workers?," 362 Lancet 328 (July 26, 2003).

[3] Network of Sex Work Projects (NSWP), *The 100% Condom Use Policy : A Sex Worker Rights Perspective* (2002) *available at* http://www.nswp.org/safety/100percent.html.

[4] Email correspondence with sex worker rights activist in Thailand (June 14, 2008).

Mandatory testing does not prevent high-risk sexual activity, but rather encourages program evasion and corruption. Fearful of the consequences that testing positive for HIV or other STIs may incur, sex workers may evade testing or pay bribes to health workers in order to obtain clean bills of health. Some sex workers report that sex workers who are sick are sometimes hidden from registration and health services to avoid detection. This can lead to false data collection at government health clinics. In addition, some sex workers infected with STIs may seek medical treatment from NGOs prior to attending government clinics in an attempt to avoid positive STI results. Those sex workers who test HIV-positive are often removed from brothels and find their way to the indirect sex industry, further distancing them from needed medical care and income.

Rights-Based Empowerment Approach:

HIV/AIDS programming presents particular ethical challenges given the urgency to find effective ways for preventing and mitigating the epidemic and the social stigma and discrimination associated with HIV.[5] Nevertheless, the ethical principles of voluntariness and confidentiality should be incorporated into the conception, implementation and enforcement of all HIV/AIDS programs, including ones focusing on sex workers. HIV/AIDS programming should adhere to the UNAIDS/WHO advocated "three Cs" approach regarding HIV testing, both as a means to ensure a rights-based approach and a way to provide sustained public health benefits.[6] The three Cs approach requires that HIV testing be: *confidential*, accompanied by *counseling* and conducted with voluntary and informed *consent*.[7] The results of HIV and STI testing should be available only to the sex workers themselves who should be afforded the option of voluntary counseling and treatment and should not be required to disclose their health status. Additionally, programs should clearly address the requisite methodology to be used in program implementation so that mandatory testing schemes or other rights violating policies cannot be employed.

Voluntary compliance is more effective than coercion. Without voluntary access to essential HIV/AIDS prevention and treatment services, sex workers are stripped of their self-autonomy. In most cases, if sex workers are educated about the dangers of HIV and are provided with non-judgmental health services there will be no need to force attendance and sex workers will choose to attend on their own terms.

B. Availability and Accessibility of Condoms

100% CUP:

Because 100% CUP operates under the motto of "no condom, no sex," the program depends on a guaranteed and regular supply of condoms.[8] In countries where 100% CUP has been adopted, governments may provide condoms to STI clinics, brothel owners, NGOs and sex workers for free or at reduced cost. Difficulties arise because the availability and accessibility of condoms is largely dependent on available resources. Therefore, the cost and provision of condoms varies between countries and sometimes within a single country. In certain countries sex workers are given free condoms for compliance and involvement in 100% CUP.[9] Governments may also distribute condoms to regional disease control offices that then redistribute the condoms to provincial health services offices.[10]

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[10] UNAIDS, *Evaluation of the 100% Condom Use Program in Thailand*, July 2000, at 17-18.
[5] Family Health International, *Ethical Issues in Data Collection for HIV Programming and Evaluation* at 1, *available at* http://www.fhi.org/en/HIVAIDS/pub/fact/ethicaldatacol.htm.
[6] UNAIDS/WHO, *Policy Statement on HIV Testing* (June 2004) at 3, *available at* http://data.unaids.org/una-docs/hivtestingpolicy_en.pdf.
[7] UNAIDS/WHO, *Policy Statement on HIV Testing* (June 2004) at 1, *available at* http://data.unaids.org/una-docs/hivtestingpolicy_en.pdf.
[8] *See* World Health Organization, *STI-HIV 100% Condom Use Program in Entertainment Establishments* (2000) at 9.
[9] World Health Organization, Joint UNFPA/WHO Meeting on 100% Condom Use Program (Oct. 2006) at 52.

Afterwards, condoms are distributed directly to sex workers during STI checkups. In other countries, brothel owners have to pay for condoms.[11] Some governments simply do not have the resources to provide free condoms. Often sex workers must pay for condoms themselves which increases their economic vulnerability. In Cambodia the price of condoms, even though subsidized, is extremely high in comparison to a sex workers daily earnings.[12] Moreover, 100% CUP is focused on the distribution of male condoms – very few countries have considered the need to supply female condoms as well.[13]

Rights-Based Empowerment Approach:

While condom provision should not be the sole focus of programs targeting the sex industry and should be supplemented with a variety of other health and support services for sex workers, they are a crucial defense against the HIV/AIDS epidemic. Thus, programs should require assurances by implementing governments that ample supply of quality lubricated condoms, including female condoms, will be available to sex workers. Lack of access to or availability of quality condoms is best addressed through collective action. Community efforts spearheaded by sex workers, such as letter writing campaigns or rallies, that draw attention to program deficits can prompt state or private actors to address these problems. Finally, in countries with scarce resources and high HIV infection rates, HIV/AIDS programs should work together with social marketing programs, donors and commercial suppliers to guarantee sufficient and quality supplies of condoms.[14]

C. Enforcement

100% CUP:

The 100% CUP relies on police, local authorities and brothel owners to ensure that sex workers are using condoms during commercial-based sex transactions in brothels. Police also sometimes escort sex workers to their mandatory visits to STI clinics. Sex workers who do not comply with 100% CUP requirements and are discovered to be infected with HIV or another STI usually face severe consequences, such as being dismissed from their brothels in a process that deprives them of income and healthcare. Sex workers are then likely to be absorbed into the indirect sex work sector where 100% CUP has little or no reach. By requiring that sex workers either follow program mandates or risk losing their jobs, 100% CUP places sex workers in a precarious and even desperate situation. If sex workers in certain areas of Cambodia miss their scheduled monthly health checks for any reason, a letter is sent to their brothel owners, receipt of which may lead to violent situations where sex workers are beaten, punished or strongly reprimanded.[15]

Since punishment is seen as a solution to noncompliance, 100% CUP creates a deepening dependency on program enforcers, which leaves sex workers more vulnerable to exploitation. Photos of women are sometimes displayed in brothels so that clients can identify women they allege to have infected them with an STI or agreed to sex without a condom. Sex workers' photos, STI and HIV results and other identifying documents may also be distributed to police.[16] These practices violate sex workers' rights to dignity and privacy.

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[11] David Lowe Consulting-Asia, "Documenting the Experiences of Sex Workers: Draft Report," (Dec. 2002), at 18.
[12] Email correspondence with sex worker rights activist in Thailand (June 14, 2008).
[13] The Myanmar program, which has veered away from the 100% CUP model, distributes affordable female condoms for female sex workers which are also used by male and transgender sex workers.
[14] World Health Organization, STI-HIV 100% Condom Use Program in Entertainment Establishments (2000) at 9.
[15] Womyn's Agenda for Change (WAC), *Pro's and Con's on 100% Condom Use Policy (CUP) in Cambodia* (2006) *available at* http://apnsw.org/apnsw.htm.
[16] Network of Sex Work Projects [NSWP], *The 100% Condom Use Policy : A Sex Worker Rights Perspective* (2002) *available at* http://www.nswp.org/safety/100percent.html.

Brothels often face sanctions, fines or closure for non-compliance with 100% CUP and are therefore more likely to hide sick sex workers or drive them out of the brothels. In Cambodia, sex workers have reported that if they miss a single STI check-up appointment local authorities have threatened to close down the sex workers' brothels.[17] Many countries that have adopted 100% CUP employ a "three strikes" approach for brothels: if brothels turn up positive STI or HIV/AIDS results three times they are closed down by the police.[18]

Rights-Based Empowerment Approach:

The difficulty in enforcing compliance with 100% CUP lies in the private nature of the act being regulated. It is vital that HIV/AIDS programs working with sex workers rethink how they will respond to acts of "non-compliance." Education about the positive health impact and importance of using condoms and STI/HIV testing should be the primary method of encouraging compliance. Program enforcement should be a community effort, aimed at empowering sex workers to take control of their own health. Punishment for non-compliance should be avoided and replaced with supportive corrective measures that will ensure better program adherence. If a sex worker is not using condoms with her clients, efforts need to be made to understand the reasons why condoms were not used. If financial hardship is the reason for noncompliance, small loans or other support can be offered to help the sex worker through a difficult time.

[17] Womyn's Agenda for Change (WAC), *Pro's and Con's on 100% Condom Use Policy (CUP) in Cambodia* (2006) *available at* http://apnsw.org/apnsw.htm.
[18] *Ibid.*

4. CRITIQUE AND ALTERNATIVES TO 100% CUP'S COLLABORATIVE APPROACH

The 100% Condom Use Programme attempts to enlist the aid of administrative and health authorities, police, sex workers, and brothel owners and managers to make it impossible for clients to purchase sexual services without a condom.[1] However, the collaborative approach envisioned by 100% CUP's designers neglects to address the power imbalance that often exists between sex workers and police, government officials, health authorities, and brothel owners. The power given to police and brothel owners for 100% CUP implementation often reinforces already exploitative power dynamics, rendering sex workers open to further abuse and corruption. In addition, 100% CUP's collaborative approach leaves out many key actors including clients, sex workers' intimate partners, non-brothel based sex workers, male sex workers, and transgender sex workers.

A. Police and Local Authorities

"Now anytime a sex worker is arrested, all the women go to the police station together to demand that the sex worker be released. The sex workers have started gaining confidence."[2]

100% CUP:

Police are oftentimes the primary source of violence against sex workers; yet, coordination between the government and police

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[1] UNAIDS, *Evaluation of the 100% Condom Use Program in Thailand* (July 2000) at 39

[2] Interview with sex worker from VAMP, Sangli, India (February 25, 2008).

is considered crucial for 100% CUP's effective implementation. Since police are given the authority to shut down brothels in violation of 100% CUP regulations, sex workers commonly report unlawful imprisonment, and brothel owners are unlikely to speak out against police who may abuse their power. In some instances, police have confiscated condoms from sex workers and used them as evidence of illegal prostitution.

Police have used their regulatory role under 100% CUP to extort bribes from both sex workers and brothel owners. Brothel owners sometimes deflect the cost of police bribes onto sex workers by requiring them to pay increased rent and other fees.[3] A study in Cambodia found that police often extort money from brothel owners when sex workers in their establishments fall sick.[4] Police may also require sex workers to pay exorbitant fees for registration cards or coerce sex workers into having sex with them without a condom only to require that the sex workers pay a bribe to avoid being reported. As a result of the 100% CUP policy, the police often view sex workers as "walking wallets."[5]

Rights-Based Empowerment Approach:

Employing police to enforce condom use is misguided. Sexual acts involve only two persons – the sex worker and the client – so successful rights-based programs should focus on empowering sex workers to enforce condom use in their own way and on their own terms. HIV prevention programs targeting sex workers should focus on educating sex workers about their rights as they relate to police harassment in order to enable them to stand up to the police and fight for justice. Development of strong, supportive communities of sex workers is important so that sex workers can use collective force to combat police abuse.

In addition, police must be trained and educated so that they view sex workers as partners rather than as criminals or easy targets of abuse. This, however, may prove difficult, as police may be skeptical of attending such trainings. A working relationship between police and sex workers can develop if sex workers assist police in tracking criminals and enforcing underage and trafficking laws and if police support sex workers in dealing with violent clients, abusive brothel owners, or general harassment.

B. Brothel Owners

100% CUP:

One of 100% CUP's main objectives is for the owners and managers of all sex work establishments to enforce condom use as a condition of commercial sex.[6] Without the cooperation of brothel management, providing STI testing and condoms to brothel-based sex workers is difficult and access to sex workers for educational, informational and medical purposes is limited. Under 100% CUP, the role of brothel management is to: assist with the registration of sex workers; ensure that sufficient condoms are available; instruct all sex workers on how to use condoms; provide support for sex workers when clients refuse to use condoms; and ensure that all sex workers attend STI clinics for their monthly check-ups.[7]

In practice, involvement of brothel owners has sometimes led to corruption, as noted above, and reinforced sex workers' dependency on brothel owners. Reports have surfaced of brothel owners hiding sick, illegally trafficked or underage workers. Brothel owners may use written communications from the government regarding 100% CUP as instruments of control

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[3] World Health Organization, *STI-HIV 100% Condom Use Program in Entertainment Establishments* (2000).

[4] "100% Condom Use Policy in Thailand: A perspective from EMPOWER," *available at* http://apnsw.org/r/100CUPThailandEmpower.htm

[5] Womyn's Agenda for Change (WAC), *Pro's and Con's on 100% Condom Use Policy (CUP) in Cambodia* (2006) at 2, *available at* http://apnsw.org/apnsw.htm.

[6] World Health Organization, *STI-HIV 100% Condom Use Program in Entertainment Establishments* (2000) at 6.

[7] David Lowe Consulting-Asia, "Documenting the Experiences of Sex Workers: Draft Report to the Policy Project," (Dec. 2002), at 14.

over sex workers[8] and as methods of reinforcing their position of dominance. Domineering brothel owners and managers often silence sex workers' concerns.

Rights-Based Empowerment Approach:

Incorporating brothel owners into HIV/AIDS programming is not wholly misguided. Their position of influence can be utilized to the benefit of all interested parties if the power structure is rebalanced. Engaging brothel owners in discussions about HIV/AIDS and sex workers rights may help brothel owners to work with, rather than against, sex workers. In addition, brothel owners who are themselves sex workers may be in a better position to understand the challenges sex workers face. However, programs following a community-based approach have recognized the importance of allowing sex workers to collectively determine what role brothel owners should play in specific HIV intervention programs. When sex workers are able to define the role of brothel owners, weeding out those intent on maintaining abusive policies, it aids in rebalancing the uneven power dynamic.

C. Health Workers

"Collectively we went and demanded that the times for hospital visits be changed because we work through the night. So the health clinic changed appointment times so it could work for us. It is our right to get health services in the public hospitals."[9]

100% CUP:

Discrimination and stigma in the health care setting result in tremendous problems for sex workers. Health workers often treat sex workers in a humiliating manner. As a result, sex workers may avoid medical treatment until their health has deteriorated. One of the touted successes of 100% CUP was that it made health services accessible to sex workers. The program has relied on government STI clinics to monitor the STI rates of brothel-based sex workers. However, since 100% CUP's implementation, one of the most consistent and vocal complaints regarding the STI clinics is the standard of care sex workers receive.[10] Sex workers interviewed in Cambodia noted that, in contrast to NGO clinics not affiliated with 100% CUP, health workers at 100% CUP clinics were often judgmental, made rude comments, and sometimes denied sex workers treatment.[11] Clinicians reportedly shamed sex workers in instances when sex workers were diagnosed with STIs. In addition, as compared with NGO clinic visits, sex workers complained of rough, painful vaginal examinations.[12]

Rights-Based Empowerment Approach:

In order to combat discrimination and stigma among health workers, educational programs for health workers are necessary to ensure that sex workers receive the proper standard of care. In some instances, however, educational programs alone will not be sufficient. Program-appointed point-people placed in government hospitals and clinics may be necessary to assist sex workers in navigating the system. Such point-people could ensure that sex workers receive care from knowledgeable, friendly clinicians and avoid those with whom they or others have had bad experiences. The point person could also act as a liaison between health clinic staff and sex workers, assisting with follow-up and medication monitoring when needed.

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[8] Paulo Longo & Melissa Ditmore, *100% Condom Use Programs: Empowerment or Abuse?*, in Research for Sex Work Vol. 6 (Sept. 2003) at 3.

[9] Interview with sex worker from VAMP, Sangli, India (February 25, 2008).

[10] David Lowe Consulting, "Documenting the Experiences of Sex Workers: Draft Report," (Dec. 2002) at 21.

[11] *Ibid.*

[12] An exception to the complaints was found at one site in Sihanoukville which was the pilot site for 100% CUP. This site is thought to have increased training and receives supplemental salary for working with 100% CUP that other sites do not receive. Broader services including counseling, contraception and other reproductive health services are offered at the site. *Id.* at 22

D. Clients

100% CUP:

Clients are nearly invisible in 100% CUP. The 100% CUP does not address the fact that a commercial sex transaction involves two people and therefore the responsibility of condom use should be shared equally. As designed, 100% CUP places the burden of promoting condom use on sex workers who often have the least power to negotiate and the most at stake in refusing a paying client.[13] A study found that even after 100% CUP's implementation, condoms were used primarily at the suggestion of sex workers.[14] Furthermore, the condoms distributed to sex workers under 100% CUP are usually male condoms placing control of condom use entirely on the client.

Rights-Based Empowerment Approach:

Accessing clients is an extremely difficult though important aspect of any successful HIV prevention program. One difficulty in trying to target clients is that they may overpower sex workers' voices. Thus, empowerment models have sought to achieve a delicate balance between nurturing the collective voice of sex workers and reaching out to clients. Condom distribution programs run by men can increase the number of condoms distributed to male clients.15 Outreach programs that include information about HIV and provide free condoms should be designed to target frequent client populations such as truck drivers and members of the military.

Engaging clients in HIV education campaigns and providing clients with condoms may increase their willingness to use condoms, thereby decreasing the burden placed on sex workers to negotiate condom use. Meetings or support groups for sex workers should include discussions of techniques on negotiating condom use, educating clients about HIV/AIDS, and teaching clients how to wear a condom.

E. Intimate Partners

100% CUP:

In order for HIV/AIDS intervention programs, such as 100% CUP, to be effective they must address the importance of condom negotiation in all sexual situations, including intimate partner relationships. Studies have found that a significant proportion of sex workers have unprotected sex with their intimate partners, who are not necessarily monogamous. A 2001 study of 5,646 young men inducted into the Royal Thai Army in May 1999 discovered that, of those who reported having sex with a girlfriend within the past year, only 13% used a condom.[16] Therefore, HIV transmission between intimate partners may increasingly contribute to the overall spread of HIV even as the use of condoms with clients increases.[17]

The 100% CUP promotes condom use during commercial sex but does not address the need for condom use in intimate relationships. Instead, the language of 100% CUP calls for 100% condom use in all "risky" sexual situations. By associating condom use with commercial sex work, 100% CUP may inadvertently increase the

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[13] Womyn's Agenda for Change (WAC), *Pro's and Con's on 100% Condom Use Policy (CUP) in Cambodia* (2006) at 5, *available at* http://apnsw.org/apnsw.htm.

[14] *See* http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1208909

[15] *See* http://findarticles.com/p/articles/mi_m0LJZ/is_4_22/ai_n18615812/pg_2 (For instance, Male condom distributors with the Promocion de Labores Educativas y Asistenciales en Favor de la Salud (PROFAMILIA) in Lima sold twice as many condoms per month as did female distributors).

[16] *See* http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1208909

[17] *See* http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1208909

resistance to condom use in intimate relationships. Sex workers' intimate partners may seek to differentiate themselves from paying clients and refuse to wear condoms. Because many sex workers and their partners do not consider their private sexual relations to be risky sex workers often have a harder time convincing their intimate partners that condom use is essential.

Rights-Based Empowerment Approach:

Empowerment models recognize that condom use should be encouraged as a safety precaution in all sexual relationships. Media campaigns, and meetings or workshops specifically targeting intimate partners may prove helpful in educating the male population about the risks of contracting HIV while debunking the idea that condom use is only necessary in commercial sex settings. However, targeting intimate partners may not sufficiently address the problem. Educational efforts directed by and aimed at sex workers that stress the importance of condom use with intimate partners and acknowledge the difficulties sex workers face when negotiating condom use with their intimate partners have achieved some success. Providing sex workers with concrete advice on how to persuade their intimate partners to wear condoms and empowering them to believe that they have the right to demand condom use may lead to an increase in condom use in intimate settings.

F. Brothel-Based and Indirect Sex Workers

"We decided that we needed to reach out to 'hidden women' because they are also women and sex workers like us. All of these women have the same problems so we must reach out to them."[18]

100% CUP:

The 100% CUP focuses only on direct brothel-based sex establishments. Indirect non-brothel based sex workers are sometimes mentioned, but they are not the program's main targets. Women who do not identify as sex workers but who occasionally engage in sex work in exchange for food or shelter, sometimes called "survival sex," are completely ignored.[19]

One outcome of 100% CUP has been a growth in the indirect sex industry. Many sex workers who test positive for STIs under 100% CUP are thrown out of brothels but still engage in sex work to support themselves in the indirect sex work industry, moving underground and away from the government's reach. Since 100% CUP targets only direct sex establishments, this may incorrectly lead the population to believe that only brothel-based sex workers are possibly infected, which drives clients towards the indirect sex industry. [20]

Due to the existence of the indirect sex industry, 100% CUP does not prevent clients who want high-risk services from purchasing them; it just redirects unprotected sex to the indirect sector.[21] It is often in the indirect sex industry where sex workers have the least ability to negotiate condom use and are more susceptible to violence, abuse and exploitation than brothel-based sex workers.[22] Since the indirect sex industry is often hidden, indirect sex workers become inaccessible to HIV prevention programs. Furthermore, indirect sex workers are often reluctant to identify as sex workers making it difficult to build support groups or develop a sense of community among them.

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[18] Interview with sex worker from VAMP, Sangli, India (February 25, 2008).

[19] "100% Condom Programs – the views for and against" *available at* http://apnsw.org/r/ForandAgainst100CUP.htm at 4.

[20] Womyn's Agenda for Change (WAC), *Pro's and Con's on 100% Condom Use Policy (CUP) in Cambodia* (2006) at 6, *available at* http://apnsw.org/apnsw.htm.

[21] "100% Condom Programs – the views for and against" *available at* http://apnsw.org/r/ForandAgainst100CUP.htm at 4.

[22] Womyn's Agenda for Change (WAC), *Pro's and Con's on 100% Condom Use Policy in Cambodia* (2006), at 4, *available at* http://apnsw.org/r/ProsandCons100cup.htm.

Rights-Based Empowerment Approach:

Directing efforts towards indirect sex workers is challenging due to the hidden, transient nature of this population. One of the main reasons that sex workers choose to work "underground" is to hide their identity. Thus, efforts to reach out to indirect sex workers must be coupled with efforts to reduce stigma and to increase the overall acceptance of sex workers within society.

Involvement of peer educators and outreach workers who were or are themselves indirect sex workers is crucial to any successful program targeting this group. Such persons will have insider knowledge as to where they can find "hidden" sex workers and may be able to establish trust more easily. Even so, indirect sex workers may at first shy away from outreach workers. Some outreach workers have found it helpful to develop friendships with sex workers before talking to them about HIV/AIDS. Once a relationship of trust has been established, peer educators and outreach workers can distribute condoms, discuss safe sex practices, and refer sex workers to health services. Directing outreach efforts to areas where indirect sex workers may work, such as bars, massage parlors, and hotels may also help in reaching indirect sex workers.

Another challenge is establishing a common bond between indirect and direct sex workers. Peer educators and outreach workers working in both groups can highlight common issues that tie all sex workers together so as to increase a sense of collectivity among all categories of sex workers. Rather than separating indirect and brothel-based sex workers, the aim of empowerment models should be to forge collectives that embrace all forms of sex work.

G. Male Sex Workers and Transgender Sex Workers

"MSM sex workers used to run away from the female sex workers but now we feel we are part of a community. We have created a bond among ourselves."[23]

100% CUP:

100% CUP focuses primarily on heterosexual commercial sex transactions, placing little or no emphasis on men who have sex with men (MSM) relations despite the fact that in Asia, HIV prevalence levels among MSMs have reached as high as 18% in Andhra Pradesh, India; 15% in Phnom Penh, Cambodia; and 28% in Bangkok, Thailand. At the same time, the number of MSM sex workers is increasing. According to one study, the number of MSM sex workers in Thailand tripled to more than 30,000 between 2000 and 2002.[24] Male sex workers are more likely to be indirect sex workers and therefore outside the program's scope.

Given the immense stigma surrounding homosexuality in many parts of the world, MSM sex workers often hide their occupation from family and friends. In addition, sexual intercourse between men is criminalized in many countries. Sodomy laws force MSM sex workers to meet potential partners in places that are hidden from the general public. This in turn heightens their vulnerability to abuse from clients. Police are likely to use such laws as support for their continued harassment of MSM sex workers leaving them with nowhere to turn when they are violated or abused.

The 100% CUP also ignores transgender sex workers. This group is often more highly stigmatized than female and male sex workers because of societal conceptions of gender. Many HIV/AIDS programs seek to place these individuals in either male or female support groups instead of allowing them to work with other sex workers or providing them with their own space to create a community based on common identity and experience. In Bangladesh, for example, many transgender sex workers have opted to be incorporated into female sex worker groups,

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[23] Interview with male sex worker, Sangli, India (February 27, 2008).

[24] *See* http://ipsnews.net/interna.asp?idnews=14082; *see also* http://www.alertnet.org/ thenews/ newsdesk/ IRIN/ 288274aec3a619b1443e2b25945cf2c4.htm

while others set up distinct transgender groups. In Cambodia, transgender sex workers have been instrumental in organizing female sex workers. In terms of collective organizing, however, it is important that sex workers of all genders work together even if their HIV service delivery needs and support group activities are done separately.[25]

Rights-Based Empowerment Approach:

It is important for HIV prevention programs to include MSM sex workers and transgender sex workers as part of the larger sex worker community, but due to the distinct challenges that face this population, it is equally important to design programs and support groups that address their unique needs.[26] One approach is to establish support groups or identify safe areas where MSM sex workers and transgender sex workers can meet with other sex workers to discuss problems, fears and concerns. Such meetings are also good places to provide HIV related information, distribute condoms and refer sex workers to healthcare and/or support services.

Peer educators and outreach workers are in the best position to seek out MSM sex workers and transgender sex workers and educate them on HIV/AIDS. Peer educators and outreach workers who are themselves MSM or transgender sex workers will have a better understanding of how to approach MSM sex workers and transgender sex workers and how to best design programs that will facilitate a sense of community within these marginalized and fragmented populations. As with programs aimed at female sex workers, the most successful programs aimed at MSM sex workers and transgender sex workers seek to empower these groups by listening to their fears and needs and actively involving them in the program's design.

H. Non-Governmental Organizations (NGOs)

The policy of 100% CUP includes coordination with NGOs that work with sex workers, but unfortunately, in some areas implementation of 100% CUP has prevented active involvement by NGOs. For instance, NGOs that provided health services have sometimes been replaced by government clinics. Additionally, NGOs who are eager and willing to work with sex workers are often constrained by funding requirements that insist they refuse to support prostitution. Any HIV prevention program should strive to coordinate with NGOs that work with sex workers. NGOs can assist with involving sex workers in the program through outreach workers and peer educators, facilitate regular check-ups and testing of sex workers, and can be valuable resources for providing information about education, healthcare, and legal advice.[27] It is important, however, that programs that engage in a rights-based sex worker empowerment approach to HIV/AIDS intervention partner only with NGOs that are community-minded and have a demonstrated commitment to empowering sex workers.

[25] Email correspondence with sex worker rights activist in Thailand (June 14, 2008).

[26] *See* http://www.avert.org/msm.htm (One study of 33 behavioral interventions aimed at MSM around the world showed that these efforts reduced the number of men having unprotected anal sex by one quarter, and increased condom use by 61% populations).

[27] World Health Organization, Joint UNFPA/WHO Meeting on 100% Condom Use Programme (Oct. 2006) at 53.

5. CRITIQUE AND ALTERNATIVE FOR 100% CUP'S METHODS OF MEASURING SUCCESS

100% CUP:

Following the Thai model, most countries where 100% CUP has been implemented rely on the existence of STIs as indicators of non-compliance with the program. STI testing is meant to serve the dual function of assessing HIV infection in the sex industry and monitoring the success rate of 100% CUP. Whether sex workers or their clients are tested to evaluate the success of the program varies by country. In Thailand, male clients are tested for STIs, whereas Cambodia relies on the testing of sex workers. Using the existence of STIs as an indicator of lack of condom use is faulty for a number of reasons. Many countries cannot afford adequate testing facilities so they rely instead on symptoms of STIs such as vaginal discharge, which is a poor indicator of the presence of an STI. Furthermore, using STIs as indicators of non-compliance with 100% CUP is problematic for common sexual infections such as herpes and genital ulcers and warts that are not as easily prevented by condom use.

Statistics regarding increased condom use and decreased HIV/AIDS rates used to document the success of 100% CUP are often selectively reported. For instance, the publicized success of 100% CUP usually does not include the statistics that HIV prevalence in direct Thai sex workers peaked in the mid-1990s and that women who started sex work after 100% CUP was initiated in 1991 may actually have been more at risk for contracting HIV than those who started before 100% CUP began.[1] Nor do the statistics include the prevalence rates of HIV among indirect sex workers. The rates of HIV among the general population have actually increased in some countries where 100% CUP has been implemented.[2]

Rights-Based Empowerment Approach:

Easily measurable quantitative data should not overshadow the importance of less tangible, qualitative results. Though quantitative measurements (such as the numbers of condoms distributed and STIs reported) are important, they should not be the only measurements of success. Indicators of success may also include observations of how the lives of sex workers have improved; how the instances of police raids, arrests, and harassment have decreased; how healthcare professionals treat sex workers; and how sex workers feel about themselves.

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[1] World Health Organization, Joint UNFPA/WHO Meeting on 100% Condom Use Program (Oct. 2006) at 4.

[2] Data collected in Vietnam, Indonesia, Fiji and Papa New Guinea, where 100% CUP has been implemented, shows condom use in high risk population remains very low. In Lao People's Democratic Republic, the prevalence of HIV among sex workers has been increasing despite the Condom Use Program. (WHO, Joint UNFPA/WHO Meeting on 100% Condom Use Programme, Oct 2006, at 2-4).

6. CONCLUSION

HIV/AIDS prevention programs targeting sex workers must have the rights-based empowerment of sex workers at the core of program design, implementation and enforcement. The absence of this approach in the face of large societal discrimination against sex workers is a fundamental flaw in 100% CUP. Sex workers are human beings entitled to freedom from discrimination, a right to health, and protection under the law for violations of their rights. It is only through the rights-based empowerment of sex workers that hope of defeating the HIV/AIDS epidemic among sex workers can be realized.

Center for Advocacy on Stigma and Marginalization (CASAM)