COMMUNITY-LEVEL
GOOD PRACTICES IN
HIV PREVENTION
CARE & SUPPORT
FOR POLICY CONSIDERATION:
TWO CASE STUDIES
COMMUNITY-LEVEL GOOD PRACTICES IN HIV PREVENTION, CARE AND SUPPORT FOR POLICY CONSIDERATION:

TWO CASE STUDIES
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PREFACE

With over 9 million people living with HIV/AIDS in Asia and the Pacific at the end of 2004, the disease has gained a firm foothold in a region that is home to over 60 per cent of the world’s people. More than 1 million people were infected with HIV in 2004 in Asia and the Pacific and the number of newly infected people in the region has been increasing each year.

There is an urgent need to stem the tide of HIV/AIDS in Asia and the Pacific. International bodies, the public sector, the private sector, civil society organizations and community-based organizations must join together in a comprehensive response to the pandemic. For such a response to be successful, it is the responsibility of Governments to create an enabling environment for a multi-sectoral approach that tackles HIV/AIDS as a development challenge.

In formulating a response, Governments need to draw on the wealth of experience of those who are living with the disease. At the community level, vulnerable groups and people living with AIDS have devised their own innovative and inspiring responses to the pandemic. In many cases, their experiences can provide useful insights for policy-makers on successful approaches in HIV/AIDS prevention, care and support.

The two case studies in this publication serve as examples of how community-level responses to HIV/AIDS could support the development and implementation of government policies, to address the impact of the epidemic. The case studies also underscore partnership with civil society, including non-governmental organizations, faith-based organizations, the public sector, and the private sector, as central to action and results. Furthermore, the case studies highlight the importance of involving people living with HIV/AIDS as key actors in developing policies and programmes that have an impact on their lives and the lives of their communities.

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PART I

PARTNERS FOR HEALTH: PEOPLE LIVING WITH HIV/AIDS EMPOWERING THEMSELVES AND HELPING OTHERS
I. PARTNERS FOR HEALTH: PEOPLE LIVING WITH HIV/AIDS EMPOWERING THEMSELVES AND HELPING OTHERS

The World Summit on Sustainable Development (WSSD) was held in Johannesburg, South Africa, in 2002. At that Summit, member governments of the United Nations agreed on the WEHAB agenda - a call to action to provide basic services to the poor. These services were identified as water, energy, health, agriculture and bio-diversity.

In a unique departure from previous United Nation conferences, the WSSD resulted in the launch of over 300 voluntary partnerships among governments, non-governmental organizations, inter-governmental organizations and businesses to harness additional resources for the implementation of sustainable development. These partnerships, tied to government commitments, provided a stronger mechanism for implementation.

ESCAP, the largest of the five regional commissions of the United Nations, took a lead in immediately embarking on WSSD follow-up in the Asian and Pacific region on a new approach to results-oriented projects for sustainable development. ESCAP developed the project entitled "Providing Basic Services to the Poor through Public-Private Partnerships". Initiated in January 2003, the ESCAP project encompassed water, energy, health and bio-diversity.

Under the ESCAP initiative, it was determined that the health component of the 5Ps project would be located in Thailand and would focus on supporting public health services for PLWHA, specifically antiretroviral treatment (ARV) delivery. The health component of the ESCAP project was popularly referred to as the "Partners for Health" (PfH) project.

The PfH project was subsequently developed by three main project partners: ESCAP; Thailand Business Coalition on AIDS (TBCA); and the Department of Disease Control, Ministry of Public Health (MoPH), Government of Thailand. The PfH project was implemented from July 2003 through December 2004.

The target group for the project intervention was the Centre for People and Families Affected by AIDS (CPA) and its beneficiaries in Bangkok.

The project aimed to improve access for people living with HIV/AIDS to quality-assured HIV/AIDS-related services through public-private-community partnership (PPCP). This was to be achieved through establishing an income-generation system capable of sustaining the delivery of health-care services to PLWHA project beneficiaries.
Introduction

People living with HIV/AIDS (PLWHA) and their families confront major challenges in addressing the impact of HIV/AIDS on their quality of life. Many are forced to leave their jobs due to persistent stigma and discrimination or they simply become too ill to continue working. They thus lose essential income that they need to cover their medical expenses and the basic living costs for themselves and their households.

In accessing comprehensive care and treatment, especially ARV treatment (ART), PLWHA often encounter an overstretched health system that is ill-equipped to deal with the complexity of treating AIDS and the opportunistic infections (OI) that accompany it. Access to the life-saving ARV medication is often limited and the high cost prohibits many PLWHA from receiving the medicines they require to stay healthy. Government resources are limited and cannot cater to the complex needs of all PLWHA. PLWHA therefore depend on alternative sources of support, including assistance provided by non-governmental organizations, community-based organizations, religious institutions and AIDS hospices.

Since its establishment in 1998, CPA has provided a wide range of support services to PLWHA in the Greater Bangkok Area. CPA is a non-registered entity that functions as peer-support and peer-education group for PLWHA. It was founded in 1998 by TBCA and the Wednesday Friends Club (WFC), one of the first peer-support groups for HIV-positive people in Thailand.

In recent years, CPA has become increasingly involved in supporting its beneficiaries in accessing and adhering to ART, as an increasing number of PLWHA accessed the life-saving drugs through ambitious government programmes. As the number of PLWHA receiving ART increased, so did the challenges for hospital staff involved in the complex and time-consuming treatment of PLWHA. In many cases, the already overstretched health-care infrastructure was unable to provide patients with the comprehensive care and support to ensure proper adherence and compliance to ART. In some cases, this resulted in long waiting lists for ART, as hospitals were unable to support the Government expansion of ART delivery, although the drugs were available. This meant that doctors were left to decide who would get the drugs and who would not - a decision that did not sit lightly. “It is a troubling decision to make about who will get the drugs and who won’t,” said an HIV-clinic doctor in Nong Jok Hospital, a small hospital on the outskirts of Bangkok. “We base it on a combination of factors - who needs it most, good compliance to ART and who came first,” the doctor said (Macan-Markar 2003).

In early 2003, CPA peer-counsellors recognized the psychological and social needs of their PLWHA friends who were patients at Nong Jok Hospital, some of whom received ART and required additional support to maintain proper adherence and compliance. CPA counsellors requested Hospital staff to allow them to accompany their friends when they visited the Hospital on HIV-clinic days. Approval was granted. What followed was a collaboration that benefited both the PLWHA patients and the staff at Nong Jok Hospital. In July 2003,
PLWHA peer-counsellors initiated support to doctors and nurses in the substantial task of providing psychosocial counselling to PLWHA patients. In this way, Nong Jok Hospital became the first Bangkok hospital to participate in the PfH project initiated by ESCAP.

The PfH project was developed to demonstrate the potential of involving PLWHA directly in the provision and self-financing of HIV/AIDS-related health-care services to support public health-care providers in Bangkok hospitals, especially in the delivery of ART. The motivation for CPA to participate in the project was clear. Supporting hospital staff members in caring for PLWHA would increase the quality of care for their friends who were patients at hospitals participating in the PfH project. In addition, the reduction in consultation time that was facilitated by CPA, could potentially enable hospitals to increase their delivery of ART and shorten waiting lists. CPA peer-counsellors were aware that by increasing the quality of care in hospital outpatient departments they were putting in place a system that they themselves might have to depend on at a later stage of the disease. Last but not least, a self-financing system would limit the dependence of CPA on external funding required to undertake their care and support activities.

Similar interventions in Thailand had demonstrated the benefits created by the involvement of PLWHA in the provision of hospital care and support services for PLWHA. However, in addition to the health-care intervention, the PfH project aimed to establish a viable PLWHA income-generation system that could finance the sustainable delivery of such services. The system proposed by CPA was a private sector company, set up and managed by PLWHA, to retail products made by PLWHA and affected communities.

This case study provides an insight into the project undertaken by CPA and the PfH project partners. The first section describes the policy context that not only gave cause to the project intervention but also provided guidance on how to address the problems identified. The second and third sections describe the health-care activities undertaken by CPA and the income-generation system they developed to finance these activities, respectively. The final section identifies key lessons for policy and practice.

A. Policy background

Following his election as Prime Minister in 2001, H. E. Thaksin Shinawatra initiated extensive policy reform in the health sector. An important part of this reform was the 30-Baht Scheme, which aimed to provide standardized and equitable public health service coverage at 30-Baht per visit. The Scheme combined capitation funding with a shift to delivery led by primary care to help keep costs under control. The Government
planned to fund the Scheme by pooling the Ministry of Public Health budgets for public hospitals, and other health facilities with existing public risk protection schemes, in addition to providing some extra financing.

The 30-Baht Scheme provided a framework for the increased access of PLWHA to HIV/AIDS-related care and support services, including ART. Although the Government of Thailand is widely recognized for its progressive policy reform in this area, implementation of the Scheme and related national programmes was not without problems. Extensive public health sector reforms and progressive policies have created severe challenges for the public health-care infrastructure to support implementation of such policies. Initial problems included a shortage of doctors to staff primary care units, necessitating the use of hospital doctors in rotation, and little attention being paid to preventive and health promotion services (Towse et. al. 2004). The increased access of PLWHA to care and treatment in particular required an increase in the capacity of health-care providers.

However, at the same time, these reforms and policies have created an enabling environment at policy-level for PLWHA to access care and support services and for PLWHA and civil society actors to be involved in the delivery of such services. The policies of the Government of Thailand on community participation in public service delivery indicated the important role that community-level support could play in supporting health-care providers to address the needs of PLWHA in Thailand.

**Access of PLWHA to anti-retroviral treatment**

Since 1992, the development of Thailand's ARV programme may be viewed as consisting of three phases.

Phase I (1992 – 1997) involved the introduction of ART. It aimed to assess the readiness of the health system on the use of ART, and to identify the most appropriate way to provide the service to patients. Due in part to the high cost of ART, only a small number of PLWHA were provided with Zidovudine mono-therapy at a handful of participating hospitals.

Phase II, the Clinical Research Network Phase (1997-2000), aimed to strengthen clinical service centres with a strategy to integrate ART into a comprehensive care and support programme for PLWHA. It involved the participation of 58 hospitals. Mono-therapy, dual therapy and, in the last year of Phase II, highly active anti-retroviral therapy (HAART) treatments were used. However, the number of patients involved was only a few thousand. Of these, a few hundred participated under co-payment.
The lowering of ARV prices and the expansion of local generic ARV production at the turn of the century were among a number of factors that catalyzed the onset of Phase III of Thailand’s ARV Programme, the expansion of ART towards the goal of universal coverage. With continuing reductions in ARV prices, the production of generic drugs, particularly GPO-VIR (a triple therapy ARV combination developed by the Government Pharmaceutical Organization (GPO), Thailand) in early 2002, and growing political pressure to provide such vital treatment to the large numbers that required it, the Government initiated significant efforts to introduce ART into the universal health coverage scheme and to expand access to ARVs. The Access to Care (ATC) Programme and the National Access to Anti-retroviral Programme for PHA (NAPHA) aimed to achieve the national policy target, set in 2003, of 50,000 people on ART by the end of 2004. The Government of Thailand was expected to achieve this goal by mid-2005.

The National Policy Framework on the Provision of Anti-Retroviral Treatment for People with AIDS in Thailand (2003) stated that by the end of 2004, all health service centres must be able to provide ARV to those in need. In addition to expanding the number of sites providing ARV, policy also focused on the development of appropriate drug combinations, negotiations on price reductions as well as drug purchases from the GPO, the training of health care professionals involved in providing ARV delivery (physicians, nurses, pharmacists, counsellors and laboratory technicians) and the development of CD4 count laboratory capacity. The national ARV programme also emphasized issues of adherence, highlighting the role of PLWHA and family members to support adherence to ARV medication and encouraging hospitals to work closely with NGOs, PLWHA groups and family members to support patients taking ARV.

Access of PLWHA to a comprehensive continuum of care

As HIV/AIDS is a chronic infectious disease, prevention and control services were included under the general services provided through the 30-Baht Scheme, including health check-ups and the provision of counselling and support. Specific reference to HIV/AIDS was made in the context of the prevention and treatment of OIs which were included under the 30-Baht Scheme, and to the provision of ART, which were unavailable to PLWHA in the earlier years of Scheme implementation.

Government policy on the access of PLWHA to care services was also dictated through the 3rd National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand (2002-2006), launched in 2001, with one of

“Treatment is not only an issue for doctors. People living with HIV/AIDS should be in the driving seat.”

Mr Kamon Upakaew, Chairman, Thai Network for People Living with HIV/AIDS (Kumphitak et. al. 2004).
its stated objectives to assure that people living with and affected by HIV/AIDS receive health care and support and to assure that access to basic health care services cannot be discriminated.

Government direction on the components concerning PLWHA care was expanded on in MoPH guidelines for comprehensive care and continuum of care for PLWHA. Those guidelines stated that a health-care system for PLWHA should be comprehensive, and that comprehensive care is the provision of services that covers all aspects of problems that HIV/AIDS patients and their families might confront. The guidelines classified these services as medical, psychosocial, social or legal and ethical, and included a range of activities ranging from diagnostics and nutritional therapy, to social welfare and human rights protection for PLWHA.

Community mobilization in support of HIV/AIDS-related health-care delivery

On 11 December 1996, the Chavalit Administration issued a policy statement to expand basic public health services in rural areas by encouraging citizen organizations, families and public health volunteers to play an active role in community health care. This concept of community mobilization in support of public service delivery was expanded upon in numerous policy documents relating to HIV/AIDS. This may be due in part to the fact that the complex social dimensions, determinants and impact of the HIV/AIDS epidemic have necessitated such a broad and cross-community response.

The 3rd National Plan for the Prevention and Alleviation of HIV/AIDS (2002-2006), and the 3rd Plan for HIV/AIDS Prevention and Alleviation of the Bangkok Metropolitan Administration (BMA) made a number of broad references to community mobilization. General strategies include developing the capacity of individuals, families, communities, and the broader social environment to address the HIV/AIDS problem. The 3rd National Plan for the Prevention and Alleviation of HIV/AIDS (2002-2006) further emphasizes the participation of all sectors, including the private and public sector and especially communities, in addressing HIV/AIDS. A number of policies referring to mobilizing communities as both a source of and a setting for care can be found under Strategy 1 of the 3rd National Plan for the Prevention and Alleviation of HIV/AIDS in Thailand. One such policy encourages community organizations to unite together to address the HIV/AIDS problem by jointly managing prevention, counselling and hospital treatment programmes and by jointly supporting the establishment of care facilities for people living with HIV/AIDS at primary public health care centres, health stations or other locations in the community. Furthermore, MoPH guidelines for the
continuum of care for PLWHA state that one of the essential activities is setting up group care inside and outside health-care facilities, and self-help groups, which have volunteers to conduct home visits.

Perhaps the greatest policy justification for the methods and interventions implemented under the PfH Project was seen in a speech by the Minister of Public Health, H.E. Sudarat Keyuraphan, delivered at the opening ceremony of the 9th European AIDS Conference, 26 October 2003, Warsaw, in which she indicated that experience has shown that with the assistance of people close to people living with HIV/AIDS, they can be empowered to maintain ART adherence and compliance. In the same speech, the Minister of Public Health of Thailand went on to say that “...based on this experience, hospitals providing ARV are encouraged to welcome and provide support to civil society organizations as well as to people living with HIV/AIDS groups to participate in the delivery of the ARV programme”.

B. CPA support in public health-care delivery

In addition to being guided by progressive HIV/AIDS-related policies, the PfH demonstration project aimed to build on existing community-level efforts and experiences to facilitate a comprehensive care package for PLWHA receiving ART in Bangkok hospitals. By actively involving trained PLWHA in the provision of such care, the project aimed to support the infrastructure required for the Government programme to increase the access of PLWHA to ART.

Prior to development of the PfH project, CPA had provided a wide range of psychosocial and financial support services to more than 600 beneficiaries. Services included home visits, buddy-meetings, telephone counselling, and financial support through various funds. These activities were supported by 22 PLWHA trained by a wide range of organizations, including TBCA, Médecins Sans Frontières (MSF), AIDS Access Foundation (AFF) and the Thai Network of People Living with HIV/AIDS (TNP+). The project aimed to expand these traditional peer-support services to include the additional goal of supporting access to treatment in hospitals participating in the project. To achieve this goal, eight additional CPA beneficiaries were specifically trained by MSF, AFF and TNP+ to provide care and support services in the outpatient departments of hospitals participating in the project.

“In government we treat people living with HIV/AIDS as partners... they have a very important role in educating people and communities, helping to diminish stigma and discrimination, and giving mutual support. They are very important in some of our decision-making. We recognize their outstanding work.”

Dr Sombat Thanprasertsuk Director, Bureau of AIDS, TB and STIs, Ministry of Public Health, Bangkok (Kumphitak et. al. 2004)
In addition to providing training, MSF, AFF and TNP+ played an important advisory role to PfH project partners through their participation in a similar and on-going national programme. In July 2002, MSF, AFF and TNP+ established a collaboration to develop the role of PLWHA as partners in the provision of continuous and comprehensive care in hospitals in Thailand (Kumphitak et. al. 2004). At the end of 2004, this collaboration had facilitated such partnerships in more than 100 hospitals in Thailand. Although efforts had been made to establish similar systems in Bangkok, the location for the PfH demonstration project, this proved more difficult due to a relatively higher standard of care and a perceived reluctance by hospital Directors and staff members to collaborate with civil society actors.

Under the PfH project, hospitals were identified based on information that project staff and CPA collected from PLWHA receiving care and treatment at Bangkok hospitals. It was well-known among PLWHA which hospitals had bad experiences in working with NGOs and PLWHA and which hospitals were more open to such collaboration. In the period June 2003 to June 2004, 15 hospitals were approached by project staff and CPA. However, working relationships were only established with five hospitals, of which only two were with express approval from the hospital Director. Of the five hospitals, four were under BMA purview and one was under MoPH purview.

In approaching a hospital, project staff and CPA staff first held informal consultations with the doctors and nurses to gauge interest in and support for the project concept. Based on the information gathered from the hospital staff on how best to initiate work in the hospital, and after receiving their support for the proposed

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**Developing the role of PLWHA as partners in care provision**

In April 2002, the Ministry of Public Health, Government of Thailand, expanded access to ART and invited all interested hospitals to apply for treatment slots. In each participating hospital, a Comprehensive and Continuous Care (CCC) Centre was to be established in which ART would be provided by a multidisciplinary team, viz., a doctor, nurses, a pharmacist and a laboratory technician.

In July 2002, Médecins Sans Frontières, AIDS Access Foundation and the Thai Network of People Living with HIV/AIDS initiated a partnership to develop the role of PLWHA as partners in the provision of comprehensive and continuous care. The CCC Centres were viewed as a tool that not only enabled PLWHA to access treatment, but also allowed PLWHA core members to provide treatment support.

To have sufficient knowledge to be able to undertake provision of such care, PLWHA core members were provided with training on OIs and ART, adherence support, counselling skills and the concept of care continuum.

*Source: Kumphitak, A. et. al. (2004). Involvement with people living with HIV/AIDS in treatment preparedness in Thailand: case study (Geneva, WHO).*
collaboration, a formal letter was sent to the Director requesting approval to initiate work. If formal approval was not granted, work was initiated on a more informal basis in collaboration with hospital staff.

Participation of the five project hospitals was facilitated by using a bottom-up approach in addition to a top-down approach involving the hospital Director. It was found that simply accompanying a limited number of PLWHA patients first and building a close relationship with hospital staff was a prerequisite to introducing the programme. In this way, hospital staff often realized the difference that the PLWHA counsellor could make to the quality of life of the patients. This also demonstrated to hospital staff that the presence of PLWHA counsellors did not in any way interfere with hospital work. Following that, it was often hospital staff who suggested the programme be expanded to other patients. In this way, hospital staff was able to appreciate the value of the programme. In two of the five hospitals this supported the PLWHA counsellors and civil society actors in facilitating a more established working relationship with the Director.

It was also found that a soft-approach in approaching hospital staff proved extremely effective. Taking into consideration the experiences from other organizations, it was learned that hospitals responded poorly to an approach that involved increased quality of care for PLWHA being demanded of hospital staff. The experience of TBCA project staff in interacting with and providing training to private sector human resource managers proved a distinct advantage in communicating the benefits proposed under the project to hospital staff.

CPA provided its services in the hospital outpatient department once a week during the HIV-clinic. The PLWHA counsellors usually worked in teams of two under the supervision of a hospital nurse. Group activities were undertaken in an area designated by hospital staff. The trained PLWHA counsellors supported hospital staff through the following activities:

In the hospital outpatient department:

- Receiving patients and providing peer support.
- Providing psychosocial counselling.
- Taking care of administrative matters related to the care and treatment of patient.
- Providing information to PLWHA patients on medication regimes and side-effects, including the promotion and monitoring of proper adherence and compliance.

Outside the hospital:

- Pro-active follow-up to ensure patients keep their next hospital appointments.
- Following up with patients who had missed their appointments.
- Home visits to those unable to keep their appointments and to monitor the patient’s status, including the socio-economic situation and adherence and compliance to medication, and support home-care providers.

At the end of 2004, more than 250 PLWHA, of whom 158 received ART, were receiving care and support services from CPA in the five project hospitals. Throughout project implementation, there was a marked
increase in the number of patients receiving ART in four of the five hospitals. In three hospitals, the number of patients receiving ART doubled during the project intervention. In one hospital the number of patients receiving ART increased from 20 to 60. Staff members in that hospital credited this increase directly to the support provided to PLWHA patients by CPA and the reduction in consultation time with hospital staff members that the support facilitated.

In May 2004, a Memorandum of Understanding (MoU) was signed between CPA and BMA, witnessed by TNP+, TBCA and ESCAP. Under the MoU, CPA and BMA agreed to collaborate on identifying successful approaches, specifically in collaborating with hospital staff members, and applying such approaches to expand the PLWHA support system to other hospitals under the purview of the BMA.

C. CPA Positive Marketing Co., Ltd.: sustainability through income generation

Prior to the ESCAP project intervention, CPA was solely dependent on donations and fund-raising activities to finance its health-care services. This limited the quality and quantity of those services. To finance the comprehensive care and support services proposed under the PfH project, as well as to ensure the sustainability of both existing and new CPA services, the project aimed to establish a registered CPA company that could manage and undertake a wide range of income-generation activities. The company would be solely managed and staffed by PLWHA and would financially support the health-care activities undertaken by CPA in the Greater Bangkok Area, specifically the care and support services provided in the outpatient departments of participating hospitals. Establishment of a company would promote greater efficiency of the income-generation activities as well as ensure financial transparency. In addition, the establishment of a private sector company would enable private sector members of TBCA to provide more focused technical support to income-generation activities as there would be a “common language”.

The PLWHA Company was established by motivated PLWHA with the support of project staff, and with technical advice from TBCA private sector members. The PLWHA Company was registered as CPA Positive Marketing Co., Ltd. (PMCL) on 17 June 2004. The company had three directors,
including the PMCL General Manager, the Executive Director of TBCA, and the retired CEO of a large Bangkok-based multinational company.

Upon the registration of PMCL on 17 June 2004, company share allocation was also formalized. Of the total of 5,000 shares, valued at 100 Thai Baht per share, 4,195 were held in proxy by the Chairperson of the CPA Health Care Fund, an HIV clinic nurse, for future distribution to PLWHA beneficiaries. The remaining shares were held by individuals and TBCA.

As the primary reason for establishing PMCL was to generate enough profits to sustain the care and support programme for CPA beneficiaries, PMCL committed 35 per cent of its annual profit after tax to the CPA Health Fund to finance this programme. This commitment was formalized in the minutes of the PMCL Statutory Meeting. The first transfer of 35 per cent of company profits from PMCL to the health-care activities would take place at the end of the 2005 fiscal year.

The core business of PMCL was established as the marketing and retail of primarily textile-based products made by PLWHA and affected communities in Thailand. PMCL would focus its business activities on the event-based market, including conferences and meetings. The marketing strategy for the retail of PLWHA products focused on social and cause-related marketing strategies. Both concepts were combined in a term that has been coined “positive marketing” by PMCL staff to clearly identify the special needs of PLWHA in their struggle against the significant health-related and socio-economic impact of HIV/AIDS, including stigma and discrimination.

Through the combination of quality consumer products that could be delivered in sufficient and guaranteed quantities, and the added value of both corporate and individual social responsibility that is inherent to the purchase of PLWHA products, a competitive edge was established over similar commercial products. The market orientation initially focused on national retail, although

"Our company gives PLWHA the opportunity to get back to business. It allows us to help our friends and it increases our own self-worth.”

Khun Phet, PMCL staff member
international retail would be included in the future. Several markets were identified for the products, including the conference and event-based market, corporate gift production, and end-of-the year gifts. The conference and event-based market was found to be especially viable as Bangkok is a hub for regional events, including national and international conferences, fora, expositions, workshops and training activities. PMCL found this to be an enthusiastic market for community-made conference bags and conference accessories, including Thai-style souvenirs and products retailed through positive marketing.

Establishing a product range required an extensive product survey, which included several week-long field visits to collect sample products and assess the capacity of the suppliers. At the end of 2004, 135 PLWHA producer groups were identified through telephone consultations and site visits. Working relationships were established with 20 of these groups. National suppliers were organized under an informal umbrella organization founded under the PfH project, the Thailand Positive Trading Network (TPTN). TPTN membership benefits included the opportunity to share experiences with other groups, and perhaps develop profitable partnerships and participate in future capacity building exercises facilitated by PMCL.

Through the survey, it was found that the basic production skills of the identified PLWHA community producers were quite comprehensive and sound. However, the community producers often lacked a sound understanding of commercial market quality, design and packaging standards. For this reason, the final product was often of lesser

**PMCL suppliers share its success**

The primary PMCL supplier identified in 2004 was the Prasarnjai (Intertwining of Hearts) Group, in Sanpatong district, Chiang Mai, Thailand. At the end of 2004, the group was composed of approximately 40 women infected and affected by HIV/AIDS.

In 1993, six HIV-positive women established the group. Faced with stigma and discrimination, they received counselling from Phra Athikarn Thanawat Techapanyo, the abbot of Wat Hua Rin, a Buddhist temple in their village. The group later moved to the Hua Rin temple grounds where space was made available for their meetings and group activities.

In 1997, members of the Prasarnjai Group initiated small income-generation activities, including the production of textile-based products for local retail. In 2004, the group received an order of 19,000 conference bags from PMCL for the XV International AIDS Conference, 11-16 July 2004, Bangkok. With the profits from the PMCL order, the Prasarnjai Group was able to:

- Purchase a truck to make it easier for the group to purchase large amounts of cloth and other materials, and take group members on emergency medical trips.
- Initiate establishment of the PLWHA group as a foundation.
- Initiate the building of a new workplace, close to the temple where they are now located, to enable the PLWHA group to expand its activities.
quality than similar commercially available products. Combined with limited to non-existent marketing skills and market links, the PLWHA community producers often failed to establish a long-term market niche and only had limited local retail opportunities. Although the basic products were of good quality, there was a need for comprehensive upgrading, branding, marketing and retail of PLWHA-made products. By harnessing private sector expertise on these issues and establishing in-house expertise through staff capacity building, PMCL supported its suppliers to achieve higher quality standards that have allowed for successful retailing of their products by the Company.

In the period January-December 2004, PMCL retail activities, including for the XV International AIDS Conference (11-16 July, Bangkok), resulted in revenue amounting to more than US$ 203,000. In addition to the profits generated by the Company, orders sourced from PLWHA suppliers provided indirect occupational support to PLWHA and affected communities. At the end of 2004, PMCL directly employed four PLWHA and had indirectly employed an estimated 120 PLWHA who undertook production to meet the orders facilitated by PMCL.

**D. Key lessons for policy and practice**

The PfH project provides PLWHA and affected communities with one example of how to increase the quality of care for their peers and themselves, and how to self-finance that care. Furthermore, the PfH project experience has demonstrated that PLWHA can be active participants in the development and implementation of progressive government policies to address HIV/AIDS. Although it is too soon to determine the long-term impact of the PfH project, it is possible to identify key lessons for policy and practice. The following observations serve as a basis for further analysis and consideration:

- PLWHA participation is essential for timely and across-the-board implementation of government policy that increases access to ART, especially in ensuring proper adherence and compliance.

- Trained PLWHA counsellors can provide significant support to public health-care providers in treating and caring for PLWHA patients, including in hospital outpatient departments. This increases the quality of care for PLWHA patients and reduces the workload of hospital staff members.

- Civil society and PLWHA participation in hospital service delivery does not interfere with hospital work, if a “soft approach” is taken when collaborating with hospital staff members.
• PLWHA can self-finance the care and support services provided to their peers with appropriate financial and in-kind support from the private sector. Such support can be facilitated by Business Coalitions on AIDS.

• Building and strengthening PLWHA networks creates opportunities for PLWHA to improve their quality of life and can facilitate the expansion of any benefits created, be it health-related or income-related.

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References


PART II

MINDING THEIR BUSINESS: WOMEN SEX WORKERS’ ACTIONS TO PREVENT HIV/AIDS
Women sex workers are mainly portrayed and treated in public discourses and policies as vessels of moral hazard, vectors of disease and objects of pity. Their everyday lives are often beset by oppressive power relations. They tend to be socially excluded as their presence might trigger moral panic in certain communities. Consequently, they find themselves at the receiving end of instrumentalist interventions because they are perceived as a public health threat to be monitored. While women sex workers have been identified as active agents in HIV/AIDS prevention and are increasingly seen as partners in health interventions, their economic situations and socio-cultural realities largely shape their life conditions and determine their access to health information and services.

Sex workers have become the focus of much bio-medical and social research, and health programmes since the beginning of the HIV/AIDS pandemic. Despite this, the stigma associated with sex work and other barriers to their self-organization often prevent the empowerment of sex workers (Overs et. al. 2002). However, the experience of women sex workers who are associated with an NGO, Sampada Grameen Mahila Sanstha (SANGRAM), based in Sangli in the Indian state of Maharashtra, presents a different picture. These women, who operate out of certain areas in the two states of Maharashtra and Karnataka, have made considerable headway towards taking control of some of the social and health threats in their lives.

The women formed a collective in 1996, and called it VAMP (Veshya AIDS Muqabla Parishad or Women in Prostitution Confront AIDS). This was an intentional reference to the social stigma they face and in an attempt to reclaim the term ‘veshya’ (‘whore’ in local parlance), by imputing meaning to it. The VAMP women mobilized to speak out about HIV/AIDS and protect themselves from infection. Their efforts brought them into direct confrontation with ambiguous laws and policies, and state agents who generally subscribe to societal perceptions of women as either ‘madonnas’ or ‘whores’.

1Dhanda/business is the term often used by sex workers in India to describe their work so as to mask their involvement in selling sex and thereby avoid social stigma.
Introduction

Women in the sex industry have witnessed the HIV/AIDS pandemic since its advent and continue to suffer high levels of HIV infection. However, health interventions tend to stigmatize them further by targeting them in isolation in programmes and often labelling them as the source of infection. There are a number of reasons for this. Some reasons are based on biased social perceptions of sex and sex workers. Other reasons are about societal notions of disease and social exclusion. A World Bank (1998) report suggests that health interventions with sex workers are often not effective because sex workers’ vulnerability to HIV is seen without reference to their vulnerability to violence, discrimination and other human rights violations.

The identification of sex workers as active agents in the prevention of HIV/AIDS has added another dimension to the complexities surrounding sex work and consequently to the social meaning of gender and sex (Kempadoo 1998). As with other diseases in the past, the concern for public health places women sex workers under intense scrutiny for HIV interventions (Overs et. al. 2002). These have implications for the way interventions perceive women sex workers and plan and implement their programmes.

Rural south Maharashtra, where SANGRAM began its initial work on women and HIV/AIDS, is a region seeped in patriarchal norms and social rules that generally place women in subordinated positions. In such a socio-cultural environment, women sex workers’ voices are rarely heard and their health rights are seldom recognized. Although the public health system offers free health services, women sex workers have problems accessing these services because the public health system in many rural areas is less than adequate and they inevitably face discrimination from medical personnel and staff at municipal hospitals and clinics. Many women sex workers whom SANGRAM encountered had entered sex work because of ‘majboori’ or difficult circumstances, mainly poverty, that might have led them to look upon sex work as a way of survival (Point of View n.d.).

It is within such a socio-economic context that SANGRAM decided in 1992 to approach women sex workers in the Gokulnagar community of Sangli and speak to them about HIV and condoms. It was not easy. The women sex workers were wary of health interventions as most initiatives implicitly held the women responsible for spreading HIV infection and urged them to take steps to protect others (Point of View n.d.). SANGRAM’s approach was different as the message was about women sex workers protecting themselves from HIV infection. Thus began the early days of SANGRAM’s peer educator programme: 16 women from the sex worker community, with the tacit support of some of the madams who ran the brothels, went about telling their neighbours about HIV and distributed condoms. The programme has since come a long way with the birth of the VAMP women sex workers’ collective in 1996.

Two questions may be raised about SANGRAM’s efforts. What aspect of its work set it apart from other peer educator approaches to prevent HIV infection in the sex worker community? How did the peer educator programme initiate the establishment of the VAMP collective?
Questions that can be raised about VAMP’s initiatives include: What strategies does the collective use to build awareness about women sex workers’ rights to health? How does it mobilize relatively powerless women to take actions to protect themselves from infection and help out those whose lives are already blighted by HIV?

This case study will try and answer these questions. The first section charts the experience of SANGRAM’s peer education programme and assesses the approach used. The second section examines the story of VAMP and reviews its achievements. The final section points to some lessons learnt.

A. SANGRAM blazes a trail

The empowerment of women sex workers is often taken to mean the development of sex workers as peer educators in order to achieve 100 per cent condom use in brothels (Shivdas, forthcoming, and 2000). Most NGOs use such a peer educator approach and their empowerment strategies tend to be more about providing the women with ways to access health services and become a means for condom distribution. Rarely do these strategies consider the women sex workers’ overall socio-economic situation in order to facilitate the realization of their rights. As a consequence, empowerment strategies for women sex workers do not necessarily address the issues of exploitation, oppression and other human rights abuses in brothels, or raise women sex workers’ awareness of their rights, particularly their health and other socio-economic rights.

Two assumptions underpin SANGRAM’s peer educator programme. Insiders are more effective than outsiders in reaching out to a community. Women in sex work can reliably enforce condom use for their own protection. The peer educator programme was therefore different. It did not focus on condom distribution without reference to the community identity and perceptions of the women sex workers it intended to reach and make a part of its HIV/AIDS intervention.

SANGRAM began by exploring the life stories of some of the women sex workers in Sangli with a view to identifying and acknowledging their identity and experiences as women and as sex workers who belonged to a community. More importantly, it recognized that women sex workers had families and friends with whom they shared their happiness and problems. The capacity of women sex workers’ to protect themselves from HIV infection and assert their rights was also acknowledged. Therefore, the core principles of its peer education programme were in tandem with the assumptions made in its approach.
SANGRAM’s peer education programme was women-centred (based on the needs, perceptions and experiences of the women sex workers as opposed to what the intervention decided the women needed), process-oriented (with less emphasis on how many condoms were distributed and more importance placed on how women sex workers could effectively negotiate safe and responsible sex with clients) and placed women sex workers’ empowerment as the goal. Thus, it was able to strengthen the sex worker community from within and helped the women forge a common identity. Any notion of change in levels of awareness or in the types of preventive actions taken was therefore facilitated and not imposed.

The mobilization and collectivization efforts instituted by sex workers have been documented and analysed elsewhere (Gooptu 2000, West 2000, O’Neill 2001, Lichtenstein 2001). These studies show that collaboration with sex workers provides insights into the sex industry and opens up space for health interventions. Women sex workers’ participation in the planning and implementation of interventions assures the appropriateness of design. More importantly, it recognizes that the women are in a position to provide valuable information for interventions (Shivdas forthcoming). The success of SANGRAM’s peer educator intervention attests to such an approach.

How did this type of a peer educator approach result in the establishment of the VAMP collective? SANGRAM’s emphasis on forging a collective identity helped to build a rare solidarity among women sex workers. No longer were they only women sex workers who competed for clientele, patronage and resources, but they were also women who shared common experiences of being exposed to multiple forms of discrimination and having their rights ignored and violated. The women came to identify themselves as being members of a marginalized community who were vulnerable to HIV/AIDS and violence, among other social threats, and saw the need to galvanize themselves. They had found a voice. As Gooptu (Gooptu 2000) suggests, based on her observations of the Durbar Mahila Samanwaya Committee, a sex workers’ group in Calcutta’s Sonagachi area, a collective identity forged through activism can empower marginalized groups to assert their rights.

SANGRAM facilitated the process of identity formation and leadership building by consciously and deliberately playing a passive role when the women were devising solutions to their problems. It was a two-way learning process. On the one hand, the women sex workers learned to fend for themselves as they entered uncharted waters, and on the other hand, SANGRAM workers and volunteers gained knowledge about sex workers’ lives. They got to know first-hand about the women’s clients, as also the women’s families, and their desires to be like other women, with aspirations of love, marriage and children. They wanted to be treated with dignity and be enabled to find space for self-respect. In the process, many myths were separated from reality and some stereotypes were found to be untenable.

The idea of an independent collective with a separate identity from SANGRAM was initiated by 150 women sex workers at a meeting in 1995. They discussed the possibilities of having their own organization among themselves and with SANGRAM staff.
and made their assessments. The process was facilitated by administering a questionnaire which brought into sharp focus the aims and wishes of the women sex workers.

What emerged was that the women saw the collective as a broadening of initiatives under the peer educator programme so that they could empower themselves and other women sex workers to assert their rights. The women also saw the collective as a registered NGO, which worked in partnership with SANGRAM. SANGRAM’s role in the new arrangement was largely one of guiding and advising, while the collective was seen to function independently with its own administrative and executive board. As the women did not accept every woman sex worker in Maharashtra and Karnataka to join the collective, they viewed the collective mainly as a mechanism or facilitating initiative for women sex workers who were interested in developing a community.

SANGRAM’s breakthrough in mobilizing women sex workers on the issues of identity formation and leadership and capacity building has not been without problems. In a publication entitled ‘Of veshyas, vamps, whores and women’, Point of View (n.d.), recounts that in the early days of the peer educator programme, the women sex workers and SANGRAM staff faced several constraints. In some areas of Sangli, brothel owners and criminals tried to block the programme. In one case, a peer educator was even killed. Overwhelmed that stigma might ensue after their association with the peer educator programme, some women sex workers shunned the intervention. Other women sex workers were reluctant to be part of an identity forming exercise that would have called attention to their status as sex workers. Part of the women sex workers’ inability to be involved in the programme was also because many of them worked flexible hours and were difficult to reach. Moreover, some of the women engaged in sex work only for short periods. Given that SANGRAM was implementing the programme in areas where other NGOs also operated, tensions concerning differing ideologies and competing approaches were encountered. In some instances, SANGRAM could not carry through interventions when the communities were disparate and there was not enough cohesion to overcome differences.

Despite these challenges, SANGRAM continued its peer educator work and has expanded its programmes after VAMP was established. One such initiative, which reaches out to the rural population, is an information campaign on HIV/AIDS prevention and care and support of people living with HIV/AIDS. Called the District Campaign, as it is spread out over 8 talukas or administrative units of Sangli district, the initiative was conceptualized against a background of inadequate health-care systems, lack of health information and resource-poor rural settings. Furthermore, male migration from drought-prone
villages, restrictions placed on women's mobility because of socio-cultural mores, and scant knowledge about HIV/AIDS among those left behind, particularly women and adolescents, called for an information-based initiative. Household women often contract HIV from their migrant husbands but have the least access to information. Adolescents constitute a significant proportion of women sex workers' clientele. As HIV/AIDS has been reported from remote villages across the district, the outreach work involves mahila sanghatikas (women organizers), yuva sanghataks (youth organizers), samaj sevaks (social workers) and arogya sevikas (health workers).

These volunteers/workers collaborate closely and continuously in their areas to provide information on HIV, and care and support to HIV positive people. The campaign has made it possible for rural people to access information and sources of support. A significant aspect of the District Campaign is that many of the women organizers and social workers are dalit women who have been able to break caste barriers through the training and the work to make the rural elite acknowledge their existence and turn to them for information (Point of View, n.d.). While SANGRAM has blazed a trail for VAMP and continues to collaborate closely with the collective, VAMP also follows its own path.

**B. VAMP(s) have rights too**

VAMP was set up with the aims of forging and consolidating a common identity among women sex workers, as well as empowering them to assert their rights and protect themselves from HIV infection. To this end, VAMP works towards creating a safer and more enjoyable working and living environment. By functioning as a loose collective, VAMP is able to attract members in the sex worker community.

Membership is not formalized. Any woman sex worker who utilizes VAMP's services or gets involved in its activities becomes a member. The Board Members of VAMP are peer educators who are in direct contact with the community. These women are community leaders who are effective in their condom distribution work and provide care and support to colleagues. These peer educators are called tais (sisters in the local language, Marathi).

Other categories of VAMP members are community workers and field workers. Community workers assess condom requirements and monitor condom supply. They also help women with accessing medical services and offer informal counselling. Field workers are the point people who collect condoms and arrange condom distribution to community workers. They also attend VAMP's weekly meetings and report back to their colleagues who pass on the information to their constituents. Significantly, VAMP's Board Members are the peer educators, women sex workers who know the pulse of the community. Each Board Member carries an identity card which is often useful when dealing with police harassment.

VAMP emphasizes that a peer educator's portfolio spans the entire continuum of HIV: before, during and after infection. Its preventive work on HIV/AIDS is mainly through peer education, condom distribution and assisting sex worker colleagues who have sexually transmitted infections and other health problems to access medical services.
help. VAMP women have to play a supportive role when community members become HIV infected. Often peer educators become the *de facto* families and care givers of ill colleagues. Not only do they ferry these women back and forth from hospitals but they also organize food for them, look after the women’s children or even lovers who could be sick as well and offer unconditional support. When a colleague succumbs to AIDS-related health complications, they have to grapple with funeral arrangements and also deal with questions about their own vulnerability to HIV infection. Although relatives may sometimes come forward to perform the last rites according to traditional customs, in one particular district, when the men in the community refused to be the pall bearers, the women carried their colleague on her last journey to the funeral site. Taking on hitherto male prescribed roles (according to Hindu custom, *only* men can be pall bearers) has made the women conscious of deep-seated discrimination. They have realized that, as women and as sex workers, they have had to make compromises in their lives.

While HIV/AIDS forms a large part of the focus in VAMP women’s initiatives to help themselves, considerable attention is also given to the socio-economic impact of women sex workers’ health and wellbeing. VAMP plays a crucial role in promoting the interests of its constituents, the women sex workers, by mediating community disputes, lobbying with the police, helping colleagues’ access government systems and services and facilitating the development of leadership potential among its members. Women sex workers face police harassment regularly. Not only are they routinely abused and beaten, but they are also randomly picked up on charges of soliciting, which is deemed criminal under India’s prostitution law. Brothel-keeping and soliciting are criminalized under the law. Nevertheless, sex workers have been implicated more than brothel keepers and pimps (Gangoli, 1999, D’Cunha, 1992).

Before the VAMP collective was formed, women sex workers could not do much about routine police harassment. Now, they are treated with more respect when they approach police officers for help. In some cases, VAMP has successfully negotiated an end to police hostility and brothel raids. However, this does not mean that all VAMP members are able to confront and challenge police harassment. What has happened is that more women have become aware of their rights and recognize that they have the capacity to negotiate with others, including those in authority, to diffuse threatening situations. No longer are they in a position to be only told by others about how to act, they are now empowered to know what they want to do about problems and decide for themselves about conflict resolution. The peer educator programme and advocacy
**VAMP(s)' ways and means**

VAMP women have devised various innovative methods to persuade their clients to use condoms. While some of them pick up graphic pictures of STIs from the SANGRAM office to show clients, others are able to anticipate resistance to condom use from clients and coax them otherwise. Says Shabana, a peer educator from the tobacco-growing area of Nippani in Karnataka, “… there are times when clients ask for their money back. But we have learnt that pyaar, muhabbat seh sub sunte hain (everyone understands when we say it with love/affection)”. Enforcing condom use with a client entails explaining why he must use a condom and this creates a chain of much needed information on safe and responsible sex among men. Too often, in a cultural milieu that tacitly supports male sexual privilege and societal double standards about male and female sexuality and behaviour, risk taking behaviour can often be equated with machismo and result in low condom use. Here are two instances of VAMP women’s persuasive ways of condom negotiation with clients.

**Shabana**

Shabana never says “yes” to unprotected sex because she wants to protect herself from infection. This is how she would go about negotiating with a client:

Married client: No, no, I don’t use condoms …

Shabana: I don’t know if I have AIDS or not … but you think of your wife and kids.

Married client: But the fun is in body on body

Shabana: Mazaa toh do minit ka rehta hai (fun is for two minutes only), but if you use a condom the rest of your life can be enjoyed. If your two minutes of pleasure is reduced by 5%, what is the big deal?

**Noorie**

Noorie, another sex worker and VAMP member, uses her charm and knows how to persuade a client to use condoms. She says, ‘When he is excited, all you have to do is drop your pallu and he will be in no state to refuse wearing a condom’ (the pallu is the free end of a saree that goes over the left shoulder; when ‘dropped’ a woman’s cleavage is revealed).
initiatives form the basis of VAMP, identity formation, leadership development and mobilization efforts. VAMP has expanded its work focus to include specific clientele and members’ children.

In 2000, an integrated project on sexually transmitted infection (STI) and HIV/AIDS intervention among truckers was undertaken. Truckers who ply India’s highways between Maharashtra and Karnataka are extremely mobile and have multiple sex partners. As they are also regular clients of VAMP members and form a large pool of the clientele, it was decided that the VAMP collective’s experience with the peer educator intervention could be used as a model approach for the intervention with truckers. VAMP’s emphasis on safe and responsible sex formed the core of the intervention which was then combined with the women’s knowledge of their clients’ habits and behaviour patterns. The project succeeded in raising awareness about the need for protection during sexual encounters mainly because the truckers saw the VAMP women as their friends and lovers and not as interventionists.

A VAMP initiative which is directed towards women sex workers’ children is designed to help the children cope with the stigma of their mothers’ engagement with sex work. Having a mother who is also a sex worker brings with it more than its share of stigma and marginalization. VAMP members felt that their own and their colleague’s children needed a safe space to explore and strengthen their ability to deal with the mainstream attitude towards them. Thus began the ‘Supplementary Education for Kids’ intervention. VAMP uses tuition classes for the children as an entry point to teach them core life-skills. The children examine their identity and explore ways to reclaim space for respect, given the type of work and lives that are led by their mothers.

VAMP members’ work and lives have also seen challenges and barriers to their HIV prevention and mobilization efforts. While VAMP promotes the concept of ‘responsible sex’ rather than ‘safe sex’ to emphasize that women sex workers owe it to themselves to ensure that a condom is used every time when they have penetrative sex, the collective is still grappling with how to impress this message further because women sex workers tend not to insist on condom use for certain sexual encounters. During sex with pimps, male brothel-owners, and the police, women sex workers often find it difficult to demand that condoms be used as these men have the power to refuse condoms. They are also not paying clients, so the women cannot simply turn down the business by refusing the money offered. At another level, malaks or lovers play important roles in the women’s lives. They could have fathered their children, seen them through trying times and are usually important sources of emotional support and good friends. As many women sex workers feel the need to differentiate between a client and a lover, the presence or absence of a condom helps to denote that difference. This is a complex issue and the women will continue to work at it to devise viable solutions.

VAMP members have started meeting other collectives of sex workers outside their home states and also at national and international meetings. For example, VAMP women actively participated at the World Social Forum in Mumbai, India, in January 2004 and at the XV International HIV/AIDS
Conference in Bangkok in July 2004. As they network and share their experiences with other sex-worker activists, they bring in new perspectives to their mobilization and advocacy efforts to prevent HIV/AIDS. VAMP is beginning to be an important player in lobbying efforts at the district, and state levels. VAMP members’ voices are being heard at national and international levels too. They have emerged as persons in their own rights.

C. Key lessons for policy and practice

The story of VAMP and the trail blazed by SANGRAM bear key lessons for policy and practice. The following observations may serve as a basis for further analysis and consideration:

- Any HIV/AIDS intervention with women sex workers that is initiated in collaboration with the sex worker community is more likely to succeed as women in the ‘business’ know more than anyone else about what works and what does not.

- Any intervention that is based on needs assessment that captures women sex workers’ perceptions, responses and interpretations of their lives and well-being is more likely to succeed because it does not address HIV/AIDS in isolation from the reality of the women’s lives and their daily struggle for survival.

- Identity formation, mobilization efforts and empowerment from within are key factors for successful HIV/AIDS prevention strategies among women sex workers.

- Facilitating the realization of rights entails giving marginalized women sex workers a ‘voice’ and the ‘space’ to realize their potential as change agents in transforming unequal social situations.

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## Sifting facts from fiction

<table>
<thead>
<tr>
<th>Fiction</th>
<th>Fact</th>
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<tr>
<td>Women sex workers are dirty and carry infections. They are the cause</td>
<td>Many women sex workers are infected by HIV, but they are not singularly responsible for</td>
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<td>of HIV/AIDS. HIV/AIDS is a prostitute disease.</td>
<td>the spread of the pandemic. They form links in broad networks of heterosexual transmission</td>
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<td>of HIV. Propagating the myth that women sex workers are core transmitters of HIV results</td>
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<td>in the marginalization and stigmatization of the women. Consequently women sex workers</td>
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<td>become the targets for:</td>
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<td>• increased public and police violence</td>
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<td>• demand from clients for forced and unsafe sex</td>
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<td>• denial of access to health and other services</td>
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<td>Women sex workers are poor, illiterate and incapable of knowing the</td>
<td>Although many women sex workers may be poor and not formally educated, they know more</td>
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<td>impact of HIV/AIDS.</td>
<td>about the implications of HIV/AIDS in their lives as they are vulnerable to infections.</td>
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<td>They play important roles in educating clients, even those who have had formal education</td>
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<td>but who continue to believe that using condoms reduces sexual pleasure.</td>
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<td>Society needs to be protected from women sex workers because they are</td>
<td>Women sex workers bear the brunt of the HIV/AIDS pandemic and need to protect themselves.</td>
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<td>the core transmitters of HIV.</td>
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<td>Only a client-directed strategy would be effective in HIV prevention.</td>
<td>A peer-directed strategy, with the active participation of women sex workers, is effective</td>
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<td>for HIV prevention because it is linked to self-protection and survival.</td>
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<td>Women sex workers are exploited, victimized and oppressed. They are</td>
<td>Society’s attitudes towards women sex workers are discriminatory and based on stereotypes.</td>
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<td>loose and immoral.</td>
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Point of View (n.d.). *Of veshyas, vamps, whores and women* (Mumbai, Point of View).


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