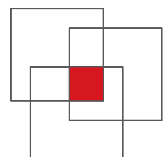




International
Labour
Organization

Leaving No One Behind: Reaching *Key Populations* through workplace action on HIV and AIDS



LEAVING NO-ONE BEHIND:

**REACHING KEY POPULATIONS THROUGH WORKPLACE ACTION
ON HIV AND AIDS**

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Key populations

The term ‘key populations’ or ‘key populations at higher risk of HIV exposure’ refers to those most likely to be exposed to HIV or to transmit HIV – their engagement is critical to a successful HIV response, i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of exposure to HIV than other people. There is a strong link between various kinds of mobility and heightened risk of HIV exposure, depending on the reason for mobility and the extent to which people are outside their social context and norms. Each country should define the specific populations that are key to their epidemic and response based on the epidemiological and social context.

Reference: UNAIDS Terminology Guidelines 2011

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FOREWORD

Globally, significant progress has been made with the HIV and AIDS response. The number of new HIV infections has declined and continues to decline, and more people than ever are receiving life-saving antiretroviral therapy. This notwithstanding, the HIV epidemic continues to grow in key populations. Scaling up programmes that provide enhanced access to HIV services for key populations is critical to ending AIDS. No-one should be left behind as we build momentum towards ending AIDS.

This literature review was commissioned as a result of the need to scale up HIV programmes targeting key populations. The aim was to bring together innovative, evidence-informed approaches that use the workplace and/or the workforce to bring HIV services to key populations. This publication presents case studies that highlight different innovative ways in which HIV services can be brought to key populations through the workplace and/or the workforce, thereby adding value to national HIV and AIDS responses. This report should challenge our thinking, and our understanding of HIV workplace programmes and help us to develop out-of-the-box solutions to some of the problems we face with regard to reaching key populations with HIV services.

This report discusses common themes that run through many of the case studies. It provides policy makers and programme managers with new ideas that will add value to HIV and AIDS programmes at the national level. It also equips national HIV workplace focal points with innovative ideas on how the workplace and/or workforce can complement national HIV and AIDS responses. The report also contains a set of practical actions to guide programme implementation at country level.

It is the hope of the ILO that this publication will enhance creativity and effectiveness in programme design and implementation, and bring HIV services much closer to key populations. The likelihood of ending AIDS in the post-2015 era is closely linked with the ability of programmes to reach

key populations. We must all make progress on this global journey to end AIDS and when we look back, there must be no-one left behind.

Alice Ouedraogo

Chief

HIV and AIDS and the World of Work Branch (ILOAIDS)

Conditions of Work and Equality Department (WORKQUALITY)

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Senior Technical Advisor
HIV and Key Populations, HIV/AIDS Branch
UNFPA

Richard Howard
Senior Specialist on HIV and AIDS
ILO Decent Work Technical Support Team
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LIST OF ACRONYMS

| | |
|----------|--|
| AIDS | Acquired Immune Deficiency Syndrome |
| ALAFa | Apparel Lesotho Alliance to Fight AIDS |
| ALFEA | Association of Licensed Foreign Employment Agencies |
| APCOM | Asia Pacific Coalition on Male Sexual Health |
| BCC | Behaviour Change Communication |
| BMA | Bangkok Metropolitan Administration |
| BRO | Bangkok Rainbow Organization |
| CATs | Community Action Teams |
| C-BED | Community-Based Enterprise Development |
| CEP | Corridor Empowerment Group |
| CHIPS | Choosing Health in Prisons |
| COYOTE | Call off Your Old Tired Ethics |
| DFID | Department for International Development |
| DIC | Drop-In Centres |
| DLPW | Department of Labour Protection and Welfare |
| DoL | Division of Labour |
| EC | Education and Communication |
| EDA | Exotic Dancers Alliance |
| EECA | Eastern European and Central Asia |
| EMPHASIS | Enhancing Mobile Populations' Access to HIV/ AIDS Services, Information and Support |
| EU | European Union |
| EW | Entertainment Worker |
| FHI | Family Health International |
| FHI360 | Family Health International 360 |
| FYR | Former Yugoslav Republic |
| GCC | Gulf Cooperation Council |
| GFATM | Global Fund for AIDS, TB and Malaria |
| GMTF | Gay Men's Task Force |

| | |
|-----------------|--|
| HASAB | HIV/AIDS and STD Alliance of Bangladesh |
| HIV | Human Immunodeficiency Virus |
| HR | Human Resources |
| HTT | Hoedspruit Training Trust |
| ILO | International Labour Organization |
| IOM | International Organization for |
| Migration ITF | International Transportation |
| Federation KACA | Karonga Cargo Association |
| KPA | Kenya Ports Authority |
| LGBT | Lesbian, Gay, Bisexual and Transgender |
| MARP | Most-At-Risk Population |
| M&E | Monitoring and Evaluation |
| MOPH | Ministry of Public Health |
| MSM | Men who have Sex with Men |
| NACO | National AIDS Control Organization |
| NECTOI | Zimbabwe National Employment Council for the Transport Operating Industry |
| NGO | Non-Governmental Organization |
| NSA | North Star Alliance |
| PASAN | Prisoners' HIV/AIDS Support Action Network |
| PATH | Programme on Appropriate Technology in Health |
| PEP | Post-Exposure Prophylaxis |
| PEPP | Peer Education at the Pump Project |
| PLHIV | Person Living with HIV or AIDS |
| PNG | Papua New Guinea |
| PPP | <i>Programme de Prévention et de Prise en charge</i> |
| PWID | People Who Inject Drugs |
| RAP | Reception Awareness Package |
| RSA | Rainbow Sky Association |
| SACCO | Savings and Credit Cooperative |
| SADC | Southern African Development Community |
| SFH | Society for Family Health |

| | |
|--------|---|
| SHAKTI | Stopping HIV/AIDS through Knowledge and Training Initiatives |
| SIDA | Swedish International Development Agency |
| SNEG | <i>Syndicate National Des Enterprises Gaies</i> |
| SLBFE | Sri Lanka Bureau of Foreign Employment |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| SW | Sex Worker |
| SWING | Sex Workers in Group |
| TAMPEP | Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe Project |
| TB | Tuberculosis |
| TBCA | Thailand Business Coalition on AIDS |
| ToR | Terms of Reference |
| TWG | Technical Working Group |
| UAE | United Arab Emirates |
| UK | United Kingdom |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| UNODC | United Nations Office on Drugs and Crime |
| USAID | US Agency for International Development |
| VCT | Voluntary Counselling and Testing |
| WBCG | Walvis Bay Corridor Group |
| YPSA | Young Power in Social Action |

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EXECUTIVE SUMMARY

The world has made considerable progress towards the global vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths. The annual number of new infections continues to decline and more people than ever are receiving life-saving antiretroviral therapy. Building on the success achieved, the world is poised to end AIDS in the post-2015 era.

Despite the progress made overall, the epidemic continues to grow in key populations. Key populations such as sex workers, men who have sex with men, transgender people and people who inject drugs continue to bear the brunt of the HIV and AIDS epidemic. For example, according to UNAIDS, the prevalence of HIV and AIDS is 22 times higher among people who inject drugs than it is for the general population. In low and middle income countries, men who have sex with men and female sex workers are, respectively, 19 and 13.5 times more likely to have HIV than members of the general population.

Sex workers, men who have sex with men, transgender people and people who inject drugs face many barriers, including criminalization. UNAIDS reports that 60 per cent of countries have laws, regulations or policies that hinder effective HIV prevention, treatment, care and support for key populations (2013). Also, often as a result of fears that they will experience discrimination if they seek services in mainstream health settings, key populations limit their own access to treatment. This is why sex workers, men who have sex with men, transgender people and people who inject drugs are often described as “*hard-to-reach*” populations.

The UNAIDS definition of key populations always includes the populations described above, but is flexible enough to additionally accommodate populations that may be key to specific countries’ epidemics. Migrant workers, truckers, ship and dock workers, health workers, transport workers, prison populations and other groups may all be considered key populations in a given context.

This literature review was commissioned to add to the body of knowledge on how to reach key populations with HIV services. It seeks to demonstrate how the workplace and/or the workforce can be creatively used to increase access to HIV services for key populations. It challenges readers to dramatically change their understanding of what HIV workplace programmes are, or should be. Presented in six chapters, the report presents 42 innovative projects from 28 countries in which the workplace and/or workforce are used to provide access to HIV services to sex workers, men who have sex with men, transgender populations, people who inject drugs, migrant workers, truckers, ship and dock workers and prison populations. The case study programmes were implemented in Cameroon, Côte d'Ivoire, Kenya, Lesotho, Malawi, Namibia, South Africa, Southern Africa, Zambia and Zimbabwe (*Africa*); Canada, Guyana and the USA (*the Americas*); United Arab Emirates (*Arab States*); Bangladesh, Cambodia, China, India, Papua New Guinea, Sri Lanka, Thailand and Vietnam (*Asia and the Pacific*); and Albania, Austria, the European Union, Scotland and the United Kingdom (*Europe and Central Asia*).

In most of the case studies, formative research, mapping techniques and micro-planning tools were used by HIV-programme designers to gain insight into the knowledge, attitudes and behaviours of key populations. Programmes used a variety of approaches involving the workplace and/or the workforce to reach key populations with HIV services. For example, workplaces such as brothels, hotels, massage parlours, bars, nightclubs, restaurants, health facilities, barbers' shops and hair salons were used to bring HIV services to sex workers (SW) and their clients. Men who have sex with men (MSM) were reached through a variety of workplaces such as gay saunas, saunas, gay pubs, clubs and bars. Some of the programmes aimed at MSM promoted codes of good practice, which set out minimum standards and sought to create a safer environment for staff and clients, to minimize the number of new STIs and HIV infections. People who inject drugs (PWID) were reached through itinerant barbers, hotels, truck stops, karaoke bars, restaurants, sea ports, river ports and ferry crossings; and transgender populations were reached through beauty salons run by transgender people. Country-specific key populations such as migrant workers, mobile

workers, garment industry workers, port workers, fishery workers, transport workers and prison populations were reached with HIV services through their workplaces.

Organizational features that many of the case study programmes have in common may contribute to the success of HIV workplace programmes targeting key populations. These features include the following.

1. To ensure that the planned interventions meet key populations' specific needs, it is important to identify the problem, and potential solutions – ideally making use of opportunities that exist locally – through careful initial research. Evidence must underpin and lead HIV workplace programmes.
2. Follow-up research was undertaken in many countries to ensure that the approaches and interventions were continuously adapting to change. Key populations are sometimes very mobile, and hence it is important to make sure that programmes continue to consistently meet their needs.
3. There is, currently, some knowledge on *what works* with key populations. It is important that the information available be used to inform the design of HIV workplace programmes targeting key populations.
4. Various mapping techniques proved useful in identifying key populations, as well as workplaces that could be used to reach them. It is important to determine which specific HIV services key populations need. A workplace is only useful if it serves as a channel to reach key populations, and if, through it, they can be provided with services that benefit them.
5. The direct involvement of key populations in the design, implementation, monitoring and evaluation of programmes is essential. No-one understands the needs of key populations better than they themselves.
6. Institutional involvement, and commitment from the management of workplaces, are important elements of workplace programmes. Whether services are made available at the workplace, or the workplace

is simply a conduit for access to information and services, management commitment and support is crucial.

7. It is important to make businesses aware that such interventions make sense and can benefit them. A business case for an intervention can ensure buy-in and ownership. The gains for businesses may be, *inter alia*, financial or reputational, or improvements in the quality of service or in the customer or client care that they are able to provide.
8. Peer education plays a significant role in many of these programmes. Carefully selected, well trained, well equipped and effectively monitored peer educators are key to reaching key populations through HIV workplace programmes.
9. Involving communities and local government authorities, through advocacy and direct partnerships, is key to ensuring buy-in at community, or local, level. The involvement of traditional authorities, when possible, also enhances local buy-in. Working with local government supports the sustainability of programmes.
10. Interventions should be closely linked to high-quality, non-judgmental and accessible public health services and other public services, to enable key populations to access a wide range of services according to their needs.
11. A good partnership with the police and other law enforcement agencies is essential, especially when programmes' focus is on key populations.
12. Policies and codes of good practice for entertainment institutions can be useful means for ensuring that all the women and men workers in those institutions adhere to minimum standards of protection.
13. Addressing underlying factors that contribute to key populations' vulnerability to HIV and AIDS – for example, focusing on the economic empowerment of key populations and finding ways to increase their income levels – is an important part of these programmes.
14. In some countries, multi-media and entertainment approaches were instrumental in reducing the high levels of stigma associated with working with key populations. Enter-educational approaches are extremely useful tools for breaking the ice and reducing stigmatization and discrimination.

-
15. It is important to ensure that programmes include mechanisms for continuous learning, adaptation, monitoring and evaluation. We can only truly learn about the effectiveness of a programme if, embedded in it, it has a system that allows it to track its progress.

The case studies also highlight some common challenges. Monitoring and evaluation often emerge as weaknesses. Quite a number of promising interventions were not robustly monitored, therefore, there is an absence of information on their outcomes. Other promising interventions had to be cut short, or discontinued entirely, due to challenges in obtaining funding.

In conclusion, this global literature review provides a broad overview of how the workplace and/or the workforce has been, and can be, used to reach key populations. It serves to expand our understanding of the value HIV workplace programmes can bring to national HIV programmes. This study shows that whether the programme is in the formal or informal sector, or the private or public sector, it is possible to:

- a) implement programmes at the workplace to reach workers (who may be members of key populations); and
- b) implement programmes at the workplace to reach the workplaces' clients (who may be members of key populations).

The evidence makes it clear that workplaces and workforces have a key role to play in extending HIV services to hard to reach populations. It is hoped that this report will inspire and support policy makers and programme implementers to strengthen national responses to HIV and facilitate global efforts to end AIDS in the post-2015 era. Representatives from ministries of labour, employers' organizations, workers' organizations, national officials working with national AIDS programmes, ministry of health officials, HIV and AIDS programme managers, HIV programme practitioners working to reach key populations, NGOs, as well as international development agencies, could all benefit from this research and analysis.

BACKGROUND

The ILO's Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200), which provides a framework for action in the workplace context, specifically promotes interventions targeting key populations.

According to the Joint United Nations Programme on HIV/AIDS the terms “key populations” and “populations at higher risk of Human Immunodeficiency Virus (HIV) exposure” refer to those most likely to be exposed to HIV or to transmit HIV (UNAIDS, 2011). In all countries key populations include people living with HIV (PLHIV). In most national epidemics, key populations also include men who have sex with men (MSM), transgender persons, people who inject drugs (PWID) as well as sex workers (SW) and their clients. There is no single definition of key populations for all countries. For example, the Non-Governmental Organization (NGO) Good Practice Guide, which was developed by the International AIDS Alliance, includes prisoners on its list of universal key populations (HIV/AIDS Alliance, n.d.). UNAIDS stresses the importance of ensuring that countries “define the specific populations that are key to their epidemic and response based on the epidemiological and social context”. (ibid., p. 18) In practice, in many countries mobile and migrant workers, as well as prisoners, are also key populations. In other countries key populations may also include women and girls, men and boys, children and young people, older people, female partners of male prisoners, partners of men who inject drugs, female partners of male migrants and populations in emergency situations.

Regardless of who comprises key populations, their engagement is critical to the HIV response. In many regions of the world, HIV epidemics are concentrated in key populations. However, key populations are typically harder to reach than the general population due to a range of structural factors. For MSM, transgender persons, PWID and SW, stigma and discrimination (linked to social and cultural factors as well as criminalization) can be critical factors that threaten their rights and hinder their access to HIV and Acquired Immune Deficiency Syndrome (AIDS) and Tuberculosis (TB)

services. Migrant and mobile populations, by virtue of their mobility, their kind of work and their legal status, can also be difficult to reach. Various kinds of mobility are also linked to heightened risk of exposure. The level of risk depends on the reason for, and the type of, mobility, and the extent to which people are outside their normal social context. Prisoners are at exceptional risk of exposure to HIV, TB, sexually transmitted infections (STI) and other diseases because of overcrowding, unsafe conditions, and widespread unsafe drug use. For this reason, prisoners are considered key populations in some countries. It is important to remember that key populations are often not adequately reached with HIV services and that the definition of key populations is country-specific. This report will use the UNAIDS definition of key populations.

According to the UNAIDS Division of Labour (DoL), the ILO is responsible for scaling up workplace programmes and policies. Experience has shown that workplace structures, policies and programmes can provide key populations with access to services in many countries. Coordinated action and a broad interpretation of which actors and workplaces comprise the “world of work” are important in this regard.

The ILO considers “the workplace” to encompass “*all sectors of economic activity, including the private and public sectors and the formal and informal economies*” (ILO, 2010a, p. 3). Workplace structures, policies and programmes are important entry points for reaching key populations in many countries. National non-discriminatory HIV workplace policies provide the broad framework for enterprise or workplace level action, and can be used as both a point of reference and as leverage in mobilizing structures as well as individual workers.

“The workplace” can refer to a formal setting in the traditional sense of the word, such as a formally established institution in the public or private sector. It can also refer to workplaces of a far less formal nature, such as transit points for truck workers or hair salons within informal workplace settings. In this document the following definitions, endorsed by the ILO in its Recommendation concerning HIV and AIDS and the World of Work,

are used: “workplace” refers to any place in which workers perform their activity; and “worker” refers to any persons working under any form or arrangement (ILO, 2010a, p. 3).

This report is divided into six chapters. Following this background chapter, Chapter 2 provides an overview of the purpose and scope of the report, while Chapter 3 outlines the methodology. The discussion of the findings of the report is divided into two chapters. Chapter 4 discusses examples of workplace-based interventions targeting the four UNAIDS key population groups: SW, MSM, PWID, and transgender persons. Chapter 5 concentrates on other key populations who have been identified as being at risk in some settings by nature of the work that they do or where they find themselves. This includes a discussion of workplace-based HIV prevention programmes targeting migrant workers, truckers, ship- and dockworkers and prison populations. Chapter 6 presents a number of lessons learnt from this review.

PURPOSE AND SCOPE

To understand the content of this paper, it is important to understand its purpose.

This study aimed to identify – from published, grey and more informal sources (such as newspapers) and interviews with key informants – multiple examples of how workplaces, and workplace programmes, have been used to reach different key populations to increase access to HIV and/or TB services. The study is therefore not a comprehensive overview of all interventions; rather it aims to provide a snapshot of initiatives – implemented by a variety of actors in different contexts – that illustrate a range of ways in which work settings and workplaces have been, and can be, used to reach key populations.

A first function of this document is thus to present information on a selection of HIV programmes from different epidemic settings, which have used workplaces or workers to increase access to services for key populations. By presenting this variety of experiences, this document hopes to broaden people's understanding of what is meant by "the workplace" and, more importantly, to generate ideas on creative ways to reach key populations through workplace structures.

The report interprets the terms "the workplace", "workplace programmes" and "workplace policies" broadly. It includes programmes designed for different epidemic settings (concentrated, generalized and hyper-endemic), both public and private sector programmes, and programmes that were run in both formal and informal economies.

In many settings gender inequality facilitates the spread of HIV among key populations, making gender dimensions of HIV and AIDS and TB programmes particularly important. Gender inequality frequently restricts and controls the decisions that key populations make regarding their sexual and reproductive health choices. Gender differentials, often characterized by

violence, are also embedded in social and economic contexts and determine risky behaviours. Therefore, a particular effort was made to include examples of programmes that addressed gender issues.

This report's primary target group is policy makers and programme implementers at national level. This includes the individuals and organizations mentioned at the end of the Executive Summary, namely representatives from ministries of labour, employers' organizations, workers' organizations, national officials working with national AIDS programmes, ministry of health officials, HIV and AIDS programme managers, HIV programme practitioners working to reach key populations, NGOs and international development agencies.

METHODOLOGY

The main sources of information for this report were published and grey literature. A web search was conducted of online reference books, books and eBooks, journals and newspaper articles, reports from the UNAIDS Secretariat and co-sponsoring agencies, government publications, project reports, evaluations, monitoring and evaluation (M&E) reports and references and bibliographies.

The search was a key word search, and was used to identify workplace interventions. Key populations (MSM, SW etc.) were the primary key words. These terms were searched in combination with:

- terms related to the *nature or purpose of the intervention* (e.g. prevention, treatment, services, empowerment, economic empowerment); and
- *workplace settings* (e.g. sex establishment, hotel, hospitality industry, hairdresser, drugstore).

A full list of the terms searched in order to identify interventions can be found in Annex 1.

Information collected from the various sources was collated in a database and the most relevant and comprehensive programmes for each of the main key population groups were selected for presentation and discussion in this report.

For a workplace intervention to be included, there had to be, as minimum requirements:

- identification of the workplace;
- information or background on the rationale for the choice of setting; and
- an explanation of how the workplace was used to reach the key population group.

Descriptions of programmes that included information on what changed as a result of the intervention and on what factors made the workplace a

successful or a relevant entry point for reaching particular key population groups were prioritized in the selection process. However, this information was not always available and therefore is not systematically discussed in the report in relation to every intervention.

Interventions that were clearly innovative and provided new insights or new potential approaches were also given priority, as were those that focussed on gender issues. The principal researcher, who is external to the ILO, selected the programmes for discussion in consultation with the ILO.

Following the search for a diverse range of interventions, the draft report was circulated to a group comprised of ILO staff and external readers. Interviews with selected readers were the basis for the next stage of the selection process, in which the initial collection of interventions was carefully reduced to a manageable number, additional interventions relevant to the key themes were identified for inclusion and the structure of the document was refined.

The findings of this study should be considered in the light of the following limitations.

- This report does not constitute a review of all the available literature, and therefore should not be seen as a comprehensive review, nor even as a representative sample of all existing initiatives.
- This report does not focus only on case studies with solid evidence of changes resulting from the interventions (although, as mentioned above, discussions of interventions that included this information were given priority). The discussions of the case studies therefore do not always contain evidence of results and outcomes in all areas.
- The report discusses gender findings and factors in relation to programmes when such information was available. However, this assessment is limited by the fact that, although there is policy and planning documentation that highlights the importance of a gender dimension to workplace interventions – such as the ILO Recommendation concerning HIV and AIDS and the World of Work (ILO, 2010a) – relatively few interventions specifically concerned with gender were found. This is an area that merits future attention.

WORKPLACE INTERVENTIONS FOR SEX WORKERS (SW), MEN WHO HAVE SEX WITH MEN (MSM), PEOPLE WHO INJECT DRUGS (PWID) AND TRANSGENDER PEOPLE

The sample workplace interventions are grouped in this document according to the key population groups that they target. This section of the report provides an overview of a selection of interventions aimed at the four “universal” key populations – SW, MSM, PWID and transgender people. An overview of the interventions, with details of their locations, objectives, periods of implementation, participating partners, as well as whether or not they were evaluated, is presented as a table in Annex 2.

The only individuals discussed here who are defined as a key population by their work are sex workers. The other key populations are defined either by sexual identity (MSM and transgender people) or by a specific behaviour (PWID). Thus, as the previous chapter highlighted, workplace-based interventions are unlikely to specifically target these groups, although intervention efforts may address risk behaviours.

In some cases the workplace interventions targeted more than one key population – often because of links between different risk factors and/or behaviours – and could therefore not be neatly categorized under one heading. Where interventions had multiple target groups this is highlighted in the discussion. However, for convenience they have simply been included in the section on one of the target groups that they reached out to.

The next section presents a selection of interventions where workplace involvement was either the basis for, or a component of, an HIV or TB prevention effort for sex workers. These examples cover a variety of geographical and epidemiological settings. However, all of them made use of innovative strategies and worked with or through “unconventional” business venues, using locations where sex work takes place to reach their target population. “Sex workers” as a category includes women, men and transgender people involved in sex work.

1.1 SEX WORKERS

Sex work is often associated with high levels of risk of sexually transmitted infections and violence. The fact that sex work is often illegal, and the stigma attached to it, means that women, men and transgender people who engage in sex work are at a high risk of becoming HIV-positive. The criminalization of sex work in many countries makes the situation complicated, and often makes it more difficult to access sex workers with HIV services, as they are driven into hiding.

AFRICA

Case Study 1: Cameroon – Fighting HIV in male and transgender sex workers in Cameroon (Source 59)

Context: Cameroon faces a generalized epidemic, with an estimated adult HIV prevalence rate of 4.6 per cent in 2011. Sex work is illegal in Cameroon. The legal system and cultural and societal beliefs make sex workers vulnerable to abuse and violence – committed by clients, pimps and law enforcement officers. Male sex workers are doubly marginalized as the law forbids homosexual practice. The risk of danger and abuse, already high for sex workers, is even greater for transgender sex workers, who are often forced into hiding and thus are very difficult to reach with prevention services.

Workplace link: AIDS-ACODEV Cameroon uses sex work venues and contacts with their owners to contact sex workers and their clients, and to garner community support for its efforts. Venues include brothels, bars, nightclubs, restaurants and massage parlours. However, the criminalization of sex work has created a very difficult environment in which to operate.

Aims/activities: AIDS-ACODEV was born in Cameroon out of a demand for HIV services tailored to the needs of male and transgender sex workers. Since 2009, AIDS-ACODEV Cameroon has run an “education night patrol” that visits brothels, bars, nightclubs, restaurants and massage parlours. AIDS-ACODEV is also active on online dating sites, and gives talks in sex workers’ homes on HIV prevention and care. More recently the initiative

has targeted Cameroon's religious community, which traditionally has been very closed.

Outcomes: The programme provides male and female sex workers with critical information about condoms, STDs and other issues related to HIV and AIDS. There are no documented outcomes of the intervention.

Lessons learnt: A major objective of AIDS-ACODEV Cameroon is to build coalitions of different sex worker organizations, and to engage a wide range of community actors (such as gatekeepers at sex establishments). However, the organization has found this challenging. It has found that most organizations only work with female sex workers, and not with transgender people, and that they often adopt moralistic approaches. Such attitudes make it difficult to engage with the transgender community.

Case Study 2: Côte d'Ivoire – Sex worker education at or near worksites using a peer education approach (Source 60)

Context: Côte d'Ivoire, along with several other African countries, saw an early and strong increase in its AIDS epidemic in the late 1980s, with AIDS the leading cause of death of adult males by 1989. In 1990, when HIV prevalence among female sex workers in Abidjan was 69 per cent, a prevention campaign directed at female sex workers – *Programme de Prévention et de Prise en charge (PPP) des MST/SIDA chez les femmes libres et leurs partenaires* – was set up by the Institute of Public Health as part of the national AIDS programme.

Workplace link: Sex workers' worksites (which are workplaces) were included in a comprehensive approach that linked work settings to services and to the community.

Aims/activities: The PPP initially targeted sex work locations in three districts and expanded over the next three years to all ten districts of Abidjan. The intervention mobilized community leaders, provided health education and peer education by sex workers and former sex workers at or near worksites and created a clinic exclusively for sex workers and their stable sex partners.

Outcomes: The programme had promising results. Reported condom use with last client increased from 63 per cent in 1991 to 91 per cent in 1997, and the proportion of women who visited any clinic increased from 9 per cent in 1993 to 37 per cent in 1997. Those attending clinics were more likely to use condoms, and there were dramatic increases in consistent condom use for those attending for the first time: from 20 per cent in 1992 to 78 per cent in 1998. There were also very clear impacts on the prevalence of STI and HIV between 1992 and 1998 among sex workers in the programme: gonorrhoea prevalence decreased from 33 per cent to 11 per cent and, astonishingly, HIV prevalence decreased from 89 per cent to 32 per cent.

Lessons learnt:

- It is important to combine prevention activities with access to services.
- Data-monitoring must be used to ensure that activities are tailored to the recipient population and to their places of work. In this programme monitoring showed that the population of female sex workers was constantly changing (the initial population was mainly women from Ghana, but later included far more Ivorian and Nigerian women), and where they worked also changed.

Case Study 3: Malawi – ILO: Backing young sex workers as entrepreneurs to reduce HIV risk (Source M23)

Context: Malawi has a generalized AIDS epidemic, with an adult prevalence of 10 per cent in 2011 (down from 14 per cent in 2003). AIDS is the leading cause of death amongst adults in Malawi, and the main cause of the country's low life expectancy. The scale of the epidemic, as well as the lack of data on high-risk groups and laws that criminalize them, has worked against the recent impressive Government and donor efforts to contain the disease.

With support from ILO, the project, implemented from 2010, focuses on providing entrepreneurial training in collaboration with the Karonga Cargo Association (KACA). The KACA group represents over 4,000 (mostly young) bicycle taxi riders. These bicycle riders work on the M1 highway border area between northern Malawi and Tanzania. They are key to the transportation of informal workers in the area.

Workplace link: The workplace in this case is the road along which the bicycle riders operate. The existence of KACA provided an entry point for reaching the bicycle riders with entrepreneurship activities and prevention messages. KACA extended its scope by deciding to include sex worker networks in its organization, and many sex workers have become members. This has been instrumental in ensuring the project's relevance, and in increasing the membership of the organization. Taxi riders actively encourage their customers to join and full membership has now reached 7,000.

Aims/activities: The work of the bicycle riders puts them at risk because many customers are sex workers or traders who are so poor that they often want to pay with sex rather than cash. Female and male bicycle riders are often subject to violence.

With funding from Swedish International Development Cooperation Agency (Sida), ILO training tools have been used to enhance the business-development skills of KACA's members and to strengthen KACA's organizational structure and procedures.

Outcomes: The project has so far trained 54 master trainers, who have, in turn, taught business-development skills to 500 others. Anecdotal evidence shows that sex workers who are KACA members have been able to save money from sex work and start small businesses to supplement their income and reduce their dependency on sex work.

Lessons learnt: A number of lessons of relevance to workplace efforts can be learnt from this initiative.

- Tackling the underlying factors that lead to risk-taking behaviour is of great value. In this case the programme focussed on the economic empowerment of men and women to reduce their vulnerability.
- Sex workers should be actively included in the design and implementation of the approach, to broaden its scope and to enhance the relevance of activities.

AMERICAS

Case Study 4: Georgetown, Guyana – Barbers and hairdressers as information hubs for young people and sex workers (Sources 14a and b)

Context: Guyana faces a generalized epidemic. It has one of the highest HIV prevalence rates in the region: 1.6 per cent for pregnant women, and over 25 per cent among sex workers. AIDS is the leading cause of death for those aged between 20 and 49.

Workplace link: Young people and sex workers are reached with HIV information and services through barbers and hair salons.

Aims/activities: Starting in 2008, the United Nations Population Fund (UNFPA) supported an HIV-prevention programme that targeted sex workers and young people through barbers' shops and beauty salons. Shops and salons were chosen based on their location in malls, parks, popular attractions or low-income communities. Small-business owners who opened their doors to the project got added marketing exposure and were provided with incentives. Once the locations were identified, two employees from each shop were sent for training on basic HIV and AIDS education and prevention. In addition to

Training for salon workers included ...

- teaching them about safe working practices, including ensuring the sterility of hair-cutting machines, razors, needles for stitching and weaving, manicure and pedicure implements and tattooing and body-piercing equipment;
- putting them in charge of dispensing male and female condoms;
- enabling them to provide basic on-site counselling and testing; and
- training in project monitoring.

(Source 14 a)

training participants about sexual and reproductive health and gender issues, the project also used a life-skills approach, which focused on issues such as communication, healthy relationships and leadership.

Outcomes: The initiative distributed over 7,000 male and 400 female condoms per month. Participants reported that the project resulted in gains in their personal life in the form of improvements in relationships with friends, family and clients. Businesses reported an increase in clientele, partly because of the reputations of the participating salons as being sanitized and safe.

Lessons learnt:

- Adequate training for hairdressers and barbers is critical to the quality of the response.
- Good links to non-discriminatory, accessible services and service providers need to be established so that clients can access these.

Case Study 5: San Francisco, USA – Health project for female sex workers at massage parlours (Sources 75 and 203)

Context: In the context of a concentrated epidemic in the USA, women of colour are one of the highest risk groups for new HIV infections (Karon, Fleming, Steketee and De Cock, 2001). Within this group, women working in the sex trade are particularly vulnerable¹.

The Health Project for Asian Women (HPAW) targeted Asian female sex workers at 26 massage parlours in San Francisco, California, and was implemented over a four-year period from 2001 to 2004.

Workplace link: HPAW used the massage parlours to reach both owners and masseuses, with the objective of promoting health and preventing HIV.

Aims/activities: Two interventions were designed and rolled out, namely:

- a massage-parlour owner education programme; and
- a masseuse counselling programme led by health educators.

¹ The 2006 USA Morbidity and Mortality Weekly Report (MMWR) showed that among all racial groups in the U.S.A., Asians and Pacific Islanders (APIs) had the only statistically significant increases in HIV/AIDS diagnosis rates over the four year preceding period

HPAW staff escorted masseuses to health clinics, handed out safer sex kits and provided translation, referrals and advocacy services. Masseuses participated in a three-hour counselling session and massage-parlour owners received an education session.

Outcomes: The intervention significantly increased masseuses' knowledge about AIDS. This was measured by a test given to masseuses both pre- and post-intervention.

Lessons learnt:

- Additional time was needed to establish a good relationship with Asian masseuses and massage-parlour managers and owners because of the high levels of stigma attached to these hard-to-reach groups. Flexible planning and realistic timeframes, as well as specific strategies for reaching these populations, are therefore critical to any future interventions' success.
- The provision of services specifically tailored to their needs (e.g. escort services for masseuses and information about laws and regulations for owners and managers) increased adherence.
- Recruiting culturally-sensitive health educators, and providing them with training and support on how to take cultural issues into account, increased uptake of services and contributed to the success of these interventions (Source 203).

Case Study 6: San Francisco, USA – The Saint James Infirmary and the Occupational Health and Safety Board: Health services run by sex workers (Sources M3 and M21)

Context: The Saint James Infirmary in San Francisco, USA, is a unique example of a workplace that was established by sex workers who self-organized to address HIV and health needs. It provides free, confidential health services aimed at sex workers, as well as people working as nude models, adult actors and exotic dancers.

Workplace link: The Saint James Infirmary is a peer-led clinic, founded and run mostly by people who have worked in the sex industry themselves,

and who are thus very familiar with the day-to-day realities of sex work. Former sex workers have made use of their experience to reach out to other sex workers with relevant prevention and treatment efforts.

Aims/activities: The Infirmary's work is based on the premise that one of the biggest obstacles for sex workers in obtaining health care, regardless of their financial situation, is the difficulty of establishing a trusting relationship with their health care provider.

A coalition formed of sex worker rights group Call Off Your Old Tired Ethics (COYOTE), the Exotic Dancers Alliance (EDA) and the San Francisco Department of Health founded the clinic in 1992. This partnership has resulted in access to office space and to the City Clinic, and has enhanced the legitimacy of the Infirmary. The clinic provides services and goods including STD and HIV testing, legal referrals, gynaecological and urological care, immunizations, donated clothing and food, acupuncture, massage therapy and access to a smoking cessation programme².

Research has been used to identify services of particular value to sex workers. For example, the tobacco cessation programme was established based on research that showed that almost half the sex workers smoked. The clinic has helped to demonstrate the benefits of peer-provided health services for the health-care situation of this target group. This research has shown, for example, that sex workers who access peer-provided services have lower rates of HIV than those who use regular medical services.

Outcomes: The clinic has provided approximately 2,000 medical services to sex workers annually, run between 1,500 and 2,000 street- and venue-based outreach events and provided peer education workshops to over 500 sex workers. While the clinic has been used for medical studies, a comprehensive evaluation of its approach does not appear to have been done.

Lessons learnt: This example highlights the importance of:

- a deep understanding of the nature of sex work;

² Instances of sex workers organizing to provide health services are scarce. Other USA based examples include the Adult Industry Medical Health Care Foundation, in Sherman Oaks, California, which was founded by adult movie star Sharon Mitchell in 1998 to address rising HIV infection in the adult movie industry. Danzine, an advocacy group for sex workers in Portland, Oregon, also maintains a thrift store and combines this with a needle exchange programme. But the variety of services and clientele at the St. James Infirmary is unique.

- the advantages of using (former) sex workers and a peer-based approach to overcome issues of stigma, distrust and discrimination, which are often faced by key populations attempting to access medical services; and
- research, to identify what activities or services might be of greatest relevance to the target group.

ASIA AND THE PACIFIC

Case Study 7: Cambodia – The SMARTgirl initiative for entertainment workers (Source 74)

Context: Epidemiological data over the past twenty years illustrate how Cambodia has transited from generalized to concentrated epidemic status (adult HIV prevalence of 3 per cent in 1997, to 0.7 per cent in 2012), with over 90 per cent of PLHIV who are in need of treatment receiving services. In the earlier period transmission was driven by the mobile poor working population, as well as by prevailing gender norms and inequalities³ and an extensive sex industry. More recently the epidemic has been concentrated in certain groups who are exposed to high levels of risk – men who are clients of sex workers as well as their spouses; people who inject drugs; male, female, and transgender sex workers; and MSM.

The SMARTgirl initiative was established in Cambodia in 2008 to specifically target entertainment workers (EW), as HIV prevalence was as high as 14 per cent for some groups of EW⁴. It is part of a broader programme, PRASIT, which also targets MSM and clients of EW, and is led by FHI-360, with funding from USAID. SMARTgirl has partnerships with the private sector (e.g. with Coca-Cola and Smart Mobile).

The initiative was established to respond to research that indicated an urgent need to update and reposition HIV messages. After two decades of prevention efforts, these were no longer bearing fruit, and an anti-trafficking law that was introduced in 2008 had resulted in many brothels shutting down and sex workers moving into less easily-accessible entertainment venues.

³ A USAID report refers in this context to the Khmer saying, “Men are gold, women are cloth,” to illustrate the lower value which society places on women. The report quotes Amnesty International in saying that “it is widely believed that women can be worn, torn, and stained; men cannot”.

⁴ A recent study by the National Aids Authority in India on the Cost and Cost-Effectiveness of HIV Prevention and Mitigation Efforts find that targeting EW is the ‘best-buy’ option among a series of strategies that target high-risk populations (Source: 201).

Workplace link: The workplace is used as an avenue for reaching EW. The strategy includes training volunteer EW to deliver monthly information sessions on family planning, reproductive health, HIV testing and counseling and general health and beauty. The sessions take place in entertainment venues whose owners have agreed to provide a space. SMARTgirl also supports drop-in centres where similar monthly group sessions are held for club members, who can get health check-ups, health information, free hairdressing services and makeup instruction.

Aims/activities: The objectives of the SMARTgirl initiative were to:

- change behaviours through the implementation of targeted, and branded, activities – such as peer and outreach education, SMARTgirl clubs, special events, social mobilization and advocacy – that emphasize risk reduction and promote safer sexual practices;
- promote, and increase EW access to, health information, products, and services;
- build the capacity of implementing agencies to plan, implement, manage, and monitor SMARTgirl programmes; and
- build a supportive environment for EW sexual health by mobilizing key stakeholders, including workplace-based groups such as entertainment-establishment owners, police, health-care providers and others.

The SMARTgirl approach included:

- the promotion of a brand identity associated with empowerment, through the use of a unique logo and positive role models whom its target audience would want to emulate;
- a standard package of STI- and HIV-prevention interventions, including peer outreach and education, condom provision and promotion, systematic referral for STIs and HIV and other sexual health services;
- a system of tokens with different colours and shapes to distinguish individuals who had been contacted for the first time from those who had had multiple contacts over quarterly periods. The system includes the use of referral slips given to individuals and used to track service uptake; when

people seek services and produce a referral slip, they may be eligible for lotteries and prizes; and

- clinical services targeting groups who engage in risk-heavy activities.

What has worked well ...

- strong monitoring
- provision of both on-site (i.e. at entertainment centres) and off-site support to EW
- the referral slip strategy, which proved to be a useful way to track uptake of services

(Source 74)

Outcomes: The SMARTgirl programme was implemented in nine provinces in Cambodia and involved 120 outreach workers and peer educators, reaching 34 per cent of all entertainment workers in Cambodia in 2009. A number of output-level indicators show that in terms of impact, the initiative produced:

- a dramatic increase in the number of health service referrals;
- a high increase in the uptake of health referrals by EW; and
- an increased uptake of social marketing of condoms (Source 200).

Case Study 8: Kolkata, India – The Sonagachi Project: Involving brothel owners in the empowerment of sex workers: (Sources 34, 71 and 74)

Context: India is the second-most populated country in the world, after China. HIV prevalence in India is relatively low at 0.3 per cent, and has seen a drop in recent years, but in absolute terms the number of people living with HIV is substantial, making it the third-largest HIV-positive population, after those of South Africa and Nigeria. Extensive labour migration, low literacy levels, gender disparity as well as unsafe drug use and sex work, especially in northeast India and urban areas, have contributed to the spread of HIV.

The Sonagachi Project in the city of Kolkata is often cited as a “best-practice intervention”. The intervention was initiated in 1992 by the All India Institute of Hygiene and Public Health, and has been run by a sex worker-led organization, the Durbar Mahila Samanwaya Committee (or “Durbar”), since 1999.

Workplace link: Brothels, and their owners and staff, are used to reach sex workers and their clients.

Aims/activities: A combination of strategies involving brothel owners has steadily reduced HIV risk for sex workers.

- The project’s HIV intervention efforts specifically targeted brothels.
- “Madams” were encouraged to take an active role in efforts and to promote healthy regimes.
- The intervention focused on structuring sex workers’ economic transactions and sexual performances, to standardize sex-related behaviour.
- It promoted community empowerment among brothel residents.

Outcomes: The Sonagachi project has benefited more than 65,000 sex workers. The intervention has resulted in a reduction in the number of madams and pimps. It has also resulted in many SW choosing to move into hotels or SW-managed cooperatives. These establishments provide SW with a greater degree of safety and independence than brothels do.

The project has evolved over time to include the management by Sonagachi sex workers of a co-operative finance scheme. The scheme provides skills training, conducts sustained social marketing of condoms, and makes concerted efforts to reduce trafficking of girls and women.

In terms of outcomes, the achievements of the Sonagachi programme are well summarized in a recent publication which states that the programme “*achieved markedly increased rates of consistent condom use with clients, and the prevalence of syphilis has been dramatically reduced* (Population Council

2002). *Trials of the Sonagachi model demonstrated significant condom use increases among female sex workers, compared to a control community receiving standard care of Sexually Transmitted Disease (STD) clinic, condom promotion, and peer education (Basu et al. 2004). The Sonagachi model also significantly: 1) improved HIV and STI risk reduction knowledge; 2) instilled a hopeful future orientation, reflected in a desire for more education or training; 3) improved skills in sexual and workplace negotiations, reflected in increased refusal and condom decision making; 4) built social support by increasing social interactions outside work, social function participation, and helping other sex workers; and 5) addressed environmental barriers of economic vulnerabilities by increasing savings and alternative income. It did not, however, increase members' ability to take leave or to shift location, nor did it reduce loan-taking*" (Source M7, p. 38).

Lessons learnt: Various studies have looked at the lessons learnt from Sonagachi. These include the importance of:

- working closely with brothel owners;
- conceiving and implementing strategies for neutralizing brothel owners' power bases and connections in those cases where they show resistance, and in this manner putting pressure on owners to participate;
- focusing on behaviour-change communication, and rights and negotiation skills training, in close collaboration with brothel owners;
- ensuring access to high quality, non-judgmental support from public health services so that sex workers can gain the confidence to utilize such services; and
- working with local government, advocating for sex workers' needs and rights and bringing community issues to the attention of local politicians.

Case Study 9: India – Avahan: SW, MSM and PWID – A combination prevention programme (Sources 60, 60b and M20)

Context: The Avahan project in India⁵ has worked on interventions with high-risk populations (SW, MSM and PWID) under India's National AIDS Control Organization (NACO) with funding from the Bill and Melinda

⁵ Avahan means "a call to action" in Sanskrit.

Gates Foundation, since 2004, in six high-prevalence states, including the state of Maharashtra, for which evaluation data is available.

Workplace link: The programme specifically used workplaces to reach out to sex workers. Other critical aspects of the programme were the use of:

- peer-mediated outreach to address difficulties reported by SW, MSM and PWID and to promote condom use and regular STI screening;
- advocacy with police and local government officials through various workplace initiatives, and the establishment of 24-hour crisis-response teams;
- dedicated health services for sex workers and their regular partners;
- drop-in centres that provide welcoming safe spaces, community kitchens and literacy classes; and
- mobilization and capacity-building to support community-based organizations in implementing prevention programmes.

Aims/activities: The purpose of the programme was to provide focused HIV-prevention interventions and services for these three groups. Research, including participatory mapping and enumeration exercises to estimate the number and typologies of the target groups and their workplaces in each geographical area, was a key component of the approach. This included, for SW, the identification of locations of street-, brothel- and lodge-based sex work.

Outcomes: Eighty-five per cent of sex workers reported being in contact with a peer educator and had visited a project STI clinic to follow up on this contact (Ramesh et al., 2010). Reported condom use at last sex with repeat clients also increased significantly, from 66.1 per cent to 84.1 per cent. In sex workers, significant declines were observed in prevalence of syphilis (15.8 to 10.8 per cent), chlamydia (8 to 6.2 per cent) and gonorrhoea (7.4 to 3.9 per cent) between two rounds of testing in 2006 and 2009, although HIV prevalence increased in some areas (probably because of the mobile nature of sex work and an increase in the number forced/violent sex acts).

Lessons learnt: After the Avahan Project scaled up services, it produced a guide to support the implementation, elsewhere, of its approach for hard-to-reach populations. It is predicated on the facts that...

- highly-trained individuals who are in a high-risk group can reach their peers effectively, and
- mapping and micro-planning tools can be used to plan and track service delivery at individual level, and to position individuals, as well as small businesses, as leaders and managers of service provision.

Case Study 10: Thailand – ILO and the Empower Foundation: Sex workers learn business skills (Source M1)

Context: Thailand has effectively used public policy to prevent the transmission of HIV on a national scale. Early on in the epidemic a countrywide programme to control HIV was put in place. The programme reduced visits to sex workers by half, increased condom use, substantially reduced new HIV infections and decreased the prevalence of STIs. Today HIV prevalence is concentrated in certain key populations – PWID (21.9 per cent in 2010), female SW (1.8 per cent in 2011) and MSM (20 per cent). In Thailand, as in many other contexts, sex workers often have no additional source of income and may have no choice but to accept work conditions that risk exposing them to violence and that may be detrimental to their health. Sex workers are also particularly vulnerable to HIV – 3 per cent of brothel-based sex workers in Thailand were living with HIV in 2009, and this statistic was over 20 per cent in Bangkok and Chiang Hai.

Since 2010 the ILO, in collaboration with Empower Foundation (a sex-worker advocacy group), has worked to reduce this economic vulnerability with a programme that creates access to additional forms of income generation for sex workers in Thailand.

Workplace link: The Community-Based Enterprise Development (C-BED) programme trains SW for new work opportunities and supports them to establish small businesses. It also addresses HIV and AIDS.

Aims/activities: The C-BED training builds the capacity of current and future entrepreneurs. This approach aims to enhance the connection between positive labour conditions and positive health outcomes for sex workers. Research shows that this connection can be developed most effectively using a community-empowerment model. Enhanced community collaboration, which might be manifested in the establishment of cooperatives, for example, is an especially powerful tool to support SW.

C-BED conducts training sessions, which typically last for three days, and take the form of self-facilitated business skills modules, relying on activity-based, participant-run social learning. The modules focus on important topics for entrepreneurs, including marketing, bookkeeping, productivity, personnel management, costing and quality control. The approach to these skills includes the use of drama, drawing and discussions. The three-day training concludes with participants drawing up a business plan. The modules are designed to be facilitated by literate, but uninstructed, community members.

Outcomes: This initiative has not yet been evaluated. The programme has, however, collected anecdotal evidence of sex workers setting up their own supplementary income-generating activities – these have included baking, delivering food, shoemaking and selling traditional clothes. The ILO is currently expanding the programme to Cambodia, Sri Lanka and Vietnam.

Lessons learnt: Lessons learnt from this initiative include the value of:

- using research to identify specific needs and opportunities (in this case research highlighted the strength of a community-based approach);
- recognising, and sharing, community knowledge, and using community members as instructors;
- entrepreneurship training that uses activity-based, participant-run social learning; and
- providing access to other work opportunities to reduce the risks associated with sex work.

Case Study 11: Thailand – Service Workers in Group (SWING): Providing services to male and transgender sex workers and expanding these to cover all sex workers (Source M4)

Context: In the course of her work with female sex workers in Bangkok, Thailand, in the 1990s, Ms Surang Janyam noticed that an increasing number of male and transgender sex workers were in need of HIV services. To better understand the issues, Ms Janyam – with a team of like-minded people, comprised mainly of former sex workers – began mapping male sex work hotspots and interviewing male and transgender sex workers, in order to assess their needs. Ms Janyam’s study highlighted a need for services to diagnose and treat STIs, including HIV. This work was conducted with technical assistance from Family Health International 360 (FHI360).

Workplace link: SWING has worked very closely with entertainment venues, using them as access points through which to reach sex workers with prevention efforts and services. In particular, SWING works with a lot of bars and bar owners. The entertainment establishments are workplaces for sex workers.

Aims/activities: As the scope of SWING’s work has expanded (to three cities in Thailand) and its organizational capacity has grown, donations from other donors have increased. Over the years SWING has progressively extended its services to all sex workers. SWING runs drop-in centres that provide medical and other services, including Voluntary Counselling and Testing (VCT), pap smears, family planning counselling, distribution of condoms and other forms of contraception, HIV testing, counselling and skills-development training. They also have clubs offering activities such as make-up instruction, sports and cooking. In addition, the clinics run outreach programmes – SWING volunteers go out into the streets to encourage sex workers to visit the centres. The drop-in centres’ counselling services are linked to follow-up STI services. Additionally, informal education and English classes are taught. All these services were put in place after addressing initial challenges of stigma, discrimination and limited funding for these particular target groups. Local communities, who have been

successfully mobilized and have provided critical donations – enabling the local organization, SWING, to set up an office and to initiate and sustain its activities – have been important partners in this initiative.

Outcomes: SWING has grown from a staff of eight in 2004 to having, in 2011, 39 full-time staff, 150 volunteers and over 200 peer educators; and operates in Bangkok, Pattaya and the island of Koh Samai, through more than a dozen different projects. In this manner SWING provides services to several thousand sex workers on a yearly basis. As noted in a recent report *“the lack of rigorous data collection and analysis of interventions are a limitation of this programme. This is not unique to SWING ... there is a greater need for investment of financial and technical resources to ensure high-quality monitoring and evaluation”* (Source M4, p.66).

Lessons learnt: SWING used research to map the entertainment venues and establishments where sexual services were available. It then developed a strategy for approaching the owners of these establishments and for effectively communicating with the sex workers whom they employed. The mapping highlighted differences in establishments’ accessibility – which often depended on whether establishments were legal (e.g. karaoke bars) or illegal (illegal establishments frequently employed illegal immigrants); as well as the need for different approaches – to overcome language barriers and to address the mobility that is often concomitant with illegal work, for example.

The key critical lessons that can be learnt from the collaboration with the entertainment venue partners are as follows.

- It is vital to engage with the business community in a mutually beneficial way – entertainment-venue owners must understand that healthy workers mean better business.
- Buy-in from the community at large is critical to earning the trust of venue owners.
- Cultivating friendship with venue owners requires engaging, listening, providing feedback and building a reputation across the sector. This was achieved by SWING through frequent meetings with owners to discuss

solutions to issues that concerned them, such as business problems, HIV prevention and raids.

EUROPE AND CENTRAL ASIA

Case Study 12: Austria, Germany, Italy and the Netherlands – Using peer educators to reach out to female and transgender sex workers (Sources M7 and M8)

Context: In 2012, UNAIDS and the WHO estimated that 2.2 million people were living with HIV in the WHO European Region, including 1.3 million in Eastern Europe and Central Asia (EECA), representing an estimated adult prevalence of 0.7 per cent in EECA and 0.2 per cent in western and central Europe.

Workplace link: Prostitution venues (i.e. workplaces) were used to reach sex workers with HIV services. As part of this intervention, the project's implementers conducted interviews and discussions with owners of prostitution venues. They sought to determine the feasibility of the target population employing safe sex practices, and to influence target groups' behavioural patterns – including those of owners of prostitution venues and other key persons such as forces of public order, and, at times, venues' clients.

Aims/activities: In Austria, Germany, Italy and the Netherlands, the Transnational AIDS/STD Prevention Among Migrant Prostitutes in Europe Project (TAMPEP), has sought, since the early 2000s, to work with female and transgender sex workers who have migrated from Africa, Eastern Europe, Latin America and South-east Asia. TAMPEP makes regular use of data collection and mapping as standard techniques to identify where sex work is taking place and to monitor and report on changing trends within the sex industry, sex venues and the living and working conditions of sex workers.

The TAMPEP approach includes seminars and workshops aimed at empowering sex workers and creating an environment that supports safer sexual behaviour. TAMPEP uses cultural mediators and peer educators, the latter being trained continually because of the migratory nature of their activity.

TAMPEP spends a relatively long period (two to three months) on the selection, training and following-up of its peer educators. Peer educators receive a small bursary while undergoing training, and they participate in the course design. They receive a certificate on completion of the course. The role of the cultural mediators is to follow this training up by supporting the peer educators, providing additional information and materials and facilitating contacts with public health personnel.

Outcomes: TAMPEP national teams, consisting of cultural mediators, peer educators and street operators of different nationalities, contacted more than 30,000 migrant prostitutes.

Lessons learnt: The programme's first five years highlight the importance of peer education programmes. In implementing these, organizations should seek to:

- value sex workers' views, knowledge and life experiences, and to include them in the development and implementation of interventions;
- conceptualize sex workers as highly motivated to improve their health and well-being as part of the solution;
- build sex workers' capacity and leadership to facilitate effective participation and community ownership;
- recognize the role of clients, third parties and the working environment in HIV transmission; and
- continuously adapt to change.
- *Advocacy and community buy-in provide interventions with significant support.*

Various example programmes go beyond prevention and treatment to address the underlying causes of vulnerability, e.g. by promoting entrepreneurship and/or supporting target populations to develop alternative or supplementary sources of income.

Lastly, while there are quantified results and outcome assessments for some of the cases presented, these examples show that such data is not always systematically collected.

Summary: *This section of the report has reviewed interventions in different settings that used workplaces, work or workers as entry points for HIV and TB prevention among SW of differing sexual orientation, including MSM and transgender people.*

The examples highlight a wide range of approaches. Workplaces used by these programmes are places where sex work is practised – and these may be easy or difficult to identify as such (they range from brothels and hotels to transportation routes); as well easy or difficult to access. These workplaces are sometimes extremely informal, and sometimes they change – which can pose a particular challenge.

Many of the interventions have features in common that are worth highlighting; these include the following.

- *A deep understanding of the nature of sex work informs the design of initiatives.*
- *Mapping and data collection are used to establish a good understanding of the situation and opportunities.*
- *Peer education and counselling are key strategies.*
- *Interventions recognize the role of third parties, such as managers and owners.*
- *Access is provided to non-discriminatory services in support of HIV and TB prevention and treatment.*

1.2 MEN WHO HAVE SEX WITH MEN (MSM)

MSM are among the populations most seriously affected by the HIV epidemic across different epidemic contexts. They are often difficult to reach because of stigma, discrimination and some countries' legal frameworks, which criminalize homosexual sex.

Nonetheless, reaching key populations with effective HIV prevention programmes and services is critically important to curbing, and reversing, the spread of HIV. MSM are particularly important because they are often a “bridge” to the general population (Source 60).

This section of the report reviews interventions that seek to bring HIV prevention and support to MSM communities through work or workplaces. As noted in the introduction, programmes targeting MSM are relatively scarce. The way in which these interventions use workplaces in the context of HIV prevention is different to the way in which programmes work through workplaces of SW. MSM are not a category of workers; reaching out to them through workplaces therefore involves identifying and using places that they frequent (barbers' shops, bars, saunas etc.) as points of contact.

AMERICAS

Case Study 13: Seattle, USA – “Black men get a trim and a frank discussion” (Source 12)

Context: The Down Low Barbershop Programme was initiated in Seattle, USA in the early 2000s with support from the Department of Public Health. At the time in the USA about half of all new HIV infections were contracted by African-Americans. The prevention effort targeted black men in general, but the problem was most severe among those who had sex with other men.

Workplace link: This programme used a specific kind of workplace (barbers' shops) to reach this key population.

Aims/activities: In this programme African-American barbers were enlisted to contribute to HIV prevention efforts. The programme's strategy was to capitalize on the trusting relationship that often exists between barbers and their clients.

As part of the programme, barbers received an eight-hour training session focusing on HIV prevention, basic counselling and how to access referral services. The barbers reported using the training to develop their own favoured techniques for getting their clients to talk about HIV and AIDS. They would inquire after their clients' love lives and then ask questions such as: “Are you protecting yourself? Do you know what AIDS is? Do you know that it is growing fastest in the African-American community?”.

In addition to encouraging “in-shop chat”, the Down Low programme organized safe-sex workshops for clients after hours. At the workshops, condoms, as well as printed materials, were distributed. Participants had an opportunity to ask questions and engage in hands-on activities. Participants reported being attracted to participate through curiosity and concern. They also received a \$20 gift voucher towards a haircut and a \$30 money order to spend as they pleased. Shop owners were paid \$250 to host the workshops. In addition, barbers trained selected clients as outreach people to extend the web involved in prevention and support activities.

Outcomes: Workshops attracted large numbers of customers and were filled to capacity.

Lessons learnt: No formal documentation on lessons learnt was identified. However, this intervention shows how places that are frequented by key population groups can be used to reach these populations. It also demonstrates how such interventions can be incentivized for business owners – this programme offered owners both financial perks and the opportunity to offer their clientele a valuable service.

ASIA AND THE PACIFIC

Case Study 14: Bangkok, Thailand – ILO: Reducing HIV vulnerabilities of MSM who have sex in saunas (Source 64)

Context: In Thailand, MSM remain one of the most vulnerable populations to HIV infection. Epidemiological research forecasts that up to two-thirds of new infections in the country between 2011 and 2015 will be in men who have sex with men, and MSM will account for a third of all the new infections in Bangkok.

Workplace link: This intervention uses saunas to effectively reach at-risk MSM. Sauna workers can be trained in peer education and support, and to maintain and promote HIV-prevention and HIV-management standards in the workplace.

Aims/activities: This initiative, rolled out in 2012, identified saunas (and sauna workers) as one of the most important and potentially effective points for targeting risky behaviours of MSM in Bangkok. Non-transactional sexual behaviours frequently take place at saunas. The ILO, in partnership with owners and managers of Bangkok sauna venues and two local peer-based organizations – Bangkok Rainbow Organization (BRO) and Rainbow Sky Association (RSAT), led the project. Other organizations involved included the Bangkok Metropolitan Administration (BMA), the Ministries of Public Health (MOPH), the Department of Labour Protection and Welfare (DLPW), the Asia-Pacific Coalition on Male Sexual Health (APCOM), the United Nations Development Programme in Thailand (UNDP), the United Nations Educational, Scientific, and Cultural Organization (UNESCO) and UNAIDS.

The initiative was designed to support Bangkok sauna owners and managers, through local peer-based organizations, to develop an enterprise-based model for HIV prevention and management. Key components of the initiative included:

- development of a positive policy environment for HIV-prevention work at saunas;
- HIV and AIDS education and training for sauna staff, to enable them to protect themselves as well as reach out to customers who were MSM; and
- identification and installation of new “infrastructure” for the distribution of condoms and lubricant in saunas.

Outcomes: The initiative is ongoing and has not yet been evaluated. However, preliminary information indicates that, as of July 2013, the initiative had contributed to:

- assessment, and improvement, of knowledge and understanding of HIV-prevention and management needs in the Bangkok sauna industry;
- capacity-building of local peer-based organizations to support workplace programmes in saunas;
- establishment of new infrastructure for distributing condoms and water-based lubricants, in compliance with international standards for sauna venues;

- development of a training package on HIV prevention and management for Bangkok sauna staff, which focuses on self-protection, strategies for reaching out to customers and upholding minimum standards in the workplace;
- drafting of workplace guidelines and a policy that establishes minimum HIV-prevention and management standards for the Thai sauna industry; and
- provision of technical support to the Government to help it to establish a licensing system for the sauna industry that includes HIV-prevention measures and standards.

The intervention is being implemented as a pilot. New partnerships for prevention have been identified and a network of 19 sauna venues (out of the 31 enterprises operating in Bangkok) has been mobilized through consultation with their operators. Sixteen sauna venues have adopted the staff training package.

EUROPE AND CENTRAL ASIA

Case Study 15: European Union – The Everywhere Project: Encouraging responsible business owners to adopt codes of good practice (Sources 65 and 67a, b, c and d)

Context: A consortium of 17 partners working in public health/health promotion from eight European countries (Italy, France, Poland, Cyprus, Slovenia, Hungary, Spain and the United Kingdom) ran this initiative. These partners included public health organizations, academic institutions, NGOs active in HIV issues, and organizations that unite owners of “gay businesses”. The Everywhere Project was a two-year pilot project co-funded by the European Commission between 2008 and 2010, under its Public Health Programme.

Workplace link: As part of the initiative, businesses including gay dating websites, hotels, travel agents and sex venues were approached in the eight countries.

Aims/activities: The Everywhere Project aimed to develop and validate an innovative and culturally-adapted European model of HIV prevention targeting MSM, for use in cities across Europe. It aimed, through a network of “social mediators”, to encourage businesses to become more socially responsible with regard to the prevention of HIV. Social mediators are sexual health experts who specialize in working directly with gay businesses to improve their safety standards and ensure that their staff have up-to-date knowledge about HIV and AIDS, among other things. The programme awards two tiers of Everywhere Seals of Approval (Minimum and Premium), which reflect businesses’ levels of commitment to maintaining a safe environment and ensuring the availability of information. Each country had at least one full-time social mediator. Social mediators were responsible for using outreach methods to reach businesses with a view to initiating dialogue, building relationships and brokering agreements concerning specific HIV-prevention activities for each establishment.

The Everywhere Project’s specific aims are to:

- join forces with businesses associated with MSM tourism and entertainment in Europe (sex venues, hotels, travel agencies and gay dating websites) in order to make information and preventive materials available to clients in settings where sex between men is practised;
- create and train a network of social mediators to identify and access businesses, and to harness the commitment of the business sector to prevent HIV in MSM; and
- define action protocols for business owners whose clientele are mainly MSM, the adoption of which will certify businesses as socially responsible venues participating in the response to HIV.

Outcomes: A number of businesses were awarded the Everywhere Seal of Approval for their HIV- and AIDS-prevention efforts. Developed in France by *Syndicate National Des Entreprises Gaies* (SNEG) in collaboration with project partners, the seal is a visible indicator of quality that allows MSM to identify businesses that are socially responsible in HIV prevention, wherever they travel in Europe.

Businesses displaying the Everywhere Seal of Approval ensure:

- condom and lubricant provision
- the availability of information
- staff knowledge about Everywhere
- a safer environment
- a welcoming environment for outreach workers
- regular knowledge updates for staff
- a commitment to anti-discrimination

The Everywhere model was implemented as a pilot in 140 establishments, and was subsequently scaled up to include more establishments. During a five-month pilot, 83 gay businesses were certified with the Everywhere Seal of Approval. By the end of the action, social mediators had distributed a total of 30,000 leaflets (16,000 to MSM; 14,000 to businesses); as well as 5,000 branded bookmarks and 71,812 condoms and lubricant sachets in specially-designed Everywhere wallets, through gay businesses. All materials were either health-promotion materials or marketing and profile-raising tools, and were translated into eight languages and distributed strategically by partners.

Lessons learnt: The implementation of this pilot highlighted the following.

- Gay businesses can be important channels through which to reach MSM and deliver public-health and health-promotion interventions.
- Gay businesses are willing to commit to HIV-prevention activities targeting MSM, and non-monetary incentives can be an effective way of encouraging them to do so.
- It is possible to develop prevention standards that can be applied in varied cultural, social and political settings.
- It is important to bear in mind that the number of gay businesses may vary considerably by location, depending on social, cultural and legal factors.

Case Study 16: Scotland – Gay Men’s Task Force (GMTF): Bar-based, peer-led, community-level sexual health promotion (Sources M5 and M9)

Context: In Scotland in the 1990s sex between men was the primary channel for HIV transmission.

Workplace link: Bars, as workplaces, were used as a contact point with the MSM community.

Aims/activities: To address the growing HIV epidemic among men, a number of community-level agencies in Glasgow decided to combine their preventive efforts to form the Gay Men’s Task Force (GMTF). The aims of this intervention were to improve the sexual health of MSM by encouraging them to reduce the risky sexual behaviour that made them vulnerable to HIV infection, and to increase their use of health services.

The initiative involved education in bars, the provision of MSM-specific medical services and a free phone hotline. GMTF put in place a system of peer-led sexual health promotion in five exclusively gay bars in Glasgow. The peer educators were recruited from many *milieux* including the commercial gay scene and existing voluntary HIV-related organizations.

Peer educators received two days of training, which covered communication skills, strategies for approaching men and what specific messages to deliver. They were also provided with ongoing support throughout the intervention. When approaching MSM, the peer educators had distinctive uniforms (t-shirts, jackets and bags), and they distributed sexual health promotion materials in the five bars. They engaged men to discuss a variety of sexual health issues (e.g. hepatitis B, HIV testing and HIV risk). The MSM-specific health services were provided in both hospitals and gay community settings. The free phone hotline provided details of local sexual health services.

Outcomes: The intervention had a direct impact in Glasgow, reaching over one-third of the city’s MSM. Importantly, the intervention reached men of all ages and social classes. Subsequent research showed that men reached

through the intervention were more likely to have been tested for HIV and vaccinated against hepatitis B, and to use sexual health services. These men were also more likely to have used the MSM-specific sexual health services. As a form of health outreach, peer education was found to be effective in increasing uptake of sexual health services, but it is less effective in changing actual sexual behaviour in MSM.

Lessons learnt: Research showed that the peer education had a “dose effect”: MSM who had more than one contact with a peer educator were even more likely to proceed with HIV testing, reduce unsafe sex and contact the hotline and the medical services.

Case Study 17: London, United Kingdom – Venue-based interventions for MSM (Source 62)

Context: In the UK just under 100,000 people were living with HIV in 2012. Around one in five people (22 per cent) was undiagnosed and unaware of their infection. A total of 6,360 people were diagnosed with HIV in 2012. A particular concern is the continual increase in UK-acquired infections in MSM and heterosexuals. Infections acquired abroad continue to decrease.

Workplace link: Like the previous intervention, this one used workplaces (gay pubs, clubs and bars) to reach out to MSM.

Aims/activities: In the mid 2000s, a group of local community organizations targeted homosexually-active men living in London, particularly sub-groups identified as being at a greater risk of infection – i.e. those who had tested seropositive, those who had more than ten sexual partners per year and those aged 25 and under. Two associations put in place outreach to MSM in a total of 29 gay pubs, clubs and bars. The aims of the intervention were to:

- increase men’s desire not to expose themselves to HIV;
- strengthen negotiation skills;
- enhance knowledge about HIV and HIV testing;

-
- increase awareness of how their own behaviour could expose them to HIV; and
 - strengthen knowledge about HIV and sexual health services and increase the likelihood of MSM seeking referrals to clinics.

The programme was based on empowerment and ecological models of health promotion; it aimed to address biological, psychological and social “unmet needs” to enable men to reduce their vulnerability to HIV infection.

Outreach for managers focused on the above, as well as on how to provide a safe environment for clients. A team, mostly consisting of gay men, conducted outreach activities targeting venue managers and the people frequenting the venues. At the outset, interviews with venue managers were conducted to enhance understanding of the context and to develop their initial motivation.

In addition to the initial research to identify venues and liaise with/motivate managers, the work also included: visiting a sufficient number of venues to meet targets; staffing a stand displaying leaflets; engaging in conversations with men at the stand and near the venues; providing information, advice and referral; and distributing leaflets, condoms and lubricant to men and ensuring that these were available at the venues.

Outcomes: Follow-up research showed that gay men generally found the outreach acceptable and useful, and that professionals were not regarded negatively. An impact on knowledge was frequently reported; impacts on negotiation skills and reflection on personal behaviour were reported more commonly by men who had longer contact with the programme.

Lessons learnt: The conclusion was that professional HIV-prevention outreach in gay venues in large cities is a feasible and acceptable form of intervention with significant potential impacts. The inclusion of venue managers and workers should be an essential part of this kind of approach. To maximize impact, outreach workers need to be well briefed and trained.

Case Study 18: United Kingdom – Promoting codes of good practice for saunas, bars and clubs (Source 66)

Context: In another effort to address the rising number of HIV infections among MSM in the UK, in 2008 the Terrence Higgins Trust launched a Code of Good Practice for saunas and other entertainment venues such as bars and clubs, under the title “Play Zone”.

Workplace link: By participating in the scheme, owners, promoters and managers of workplaces frequented by MSM give a clear message that they recognize the importance of a safe, clean environment for customers and staff. Venues that meet the standards set out in the Code receive Play Zone branding and certificates, which they can display. This makes identification of such safe places easier for customers. Participating establishments also work with similar venues throughout the country to improve sexual health.

Aims/activities: The main aims of the Code were to create a safer environment for all users and staff of sauna venues, to raise awareness about sexual health and to minimize the number of new STIs and HIV infections.

The Code established minimum standards for saunas’ environments in terms of lighting, cleaning, provision of sexual health information and staff training. It also emphasized the importance of ensuring adequate access to condoms and lubricants. Venues in London and Brighton were invited to participate in the Code’s pilot phase. Since 2013, the programme has been expanding.

As part of the strategy owners sign up to a Code pledge. The pledge demonstrates a commitment by establishments to promoting the sexual health of their customers, and the wider gay community. The development of a manual for sauna staff was a way to disseminate the Code. The manual also provides information, links to additional important resources and services, and contact numbers. Through the programme venue, staff also have access to free training on HIV, sexual health, post-exposure prophylaxis (PEP), drug and alcohol awareness and first aid.

Outcomes: Evidence on this initiative's acceptability, both to venue owners and gay men, remains to be collected as the initiative expands. Evidence would provide an idea of the extent of saunas' and other venues' compliance with these agreed requirements. Information on levels of condom use and new infections, for example, would also provide insight into the extent to which the Code of Practice has contributed to safer behaviours.

Lessons learnt:

- The project has shown that getting involved in the community is not only a good way to reach those who might slip through the system of sexual health clinics, but it is also a way to find new leaders.
- New leaders open the door to new partnerships and innovative ways to reach even more people.

Summary: *These example interventions, taken from different settings, focus on using places that are frequented by MSM as points of contact through which to work for prevention and make services accessible.*

As in the SW examples, the use of peer education and mapping; the establishment of links with services; and the development of connections with owners/managers – and encouraging their involvement, are important strategies. These activities also employed some additional strategies of particular importance:

- *employing innovative ideas for promoting safety standards, such as the development of codes of conduct and seals of approval;*
- *providing incentives for businesses caring for workers, including by drawing attention to social responsibility; and*
- *ensuring strong technical support and giving inputs to third parties, including government entities (for example in drafting legislation and establishing standards).*

The examples also highlight the fact that workplace approaches in the broad sense are easier to implement in some countries than others – depending on the legal environment and cultural and social barriers.

1.3 PEOPLE WHO INJECT DRUGS (PWID)

Very few workplace-based programmes specifically targeting people who inject drugs were identified by this study. However, injecting drugs was a focus of some of the above examples, given the close association between injecting drugs and other risk behaviours such as sex between men and sex work.

ASIA AND THE PACIFIC

Case Study 19: India – Itinerant barbers reach out to PWID and other persons at risk (Source 3)

Context: In India the focus was on itinerant barbers – workers who move from place to place to provide their services in locations that are convenient for customers.

Workplace link: The intervention used workers in informal workplaces to reach PWID and SW.

Aims/activities: This programme, which was rolled out in 2004-2005, specifically targeted men who engage with sex workers or who are PWID, or both, and did so by mapping high-risk areas. The programme recognized that in many crowded cities men are often alone in search of work, having few friends, and no family, and that in this context, barbers (who are visited weekly or more) may be one of the few regular points of contact. The programme thus trained barbers in sterilization techniques, as well as in promoting condom use, recognizing the symptoms of HIV and AIDS and techniques and approaches for discussing the disease with customers. Barbers who suspected a client might be at risk were provided with information that allowed them to refer the client to a nearby HIV and AIDS facility. The programme was developed by the Switzerland-based aid organization Association Francois-Xavier Bagnoud. India's National AIDS Control Organization provided the condoms and educational materials at no cost.

Outcomes: The initiative trained over 10,000 barbers in India. No other information on results and outcomes was identified.

Lessons learnt: While lessons learnt were not identified for this initiative, the available information does point to the importance of carefully mapping and identifying opportunities for relaying information and for persuading key populations to access services.

Case Study 20: Vietnam – Using barbers, shoeshine boys, motorcycle taxi drivers and workplace advocates in HIV prevention and in promoting access to treatment (Sources 5 and 8)

Context: In Vietnam, which has a concentrated epidemic, unsafe sex – including inconsistent condom use, and injecting drug use (in particular needle-sharing), were identified in the early 2000s as major factors in the spread of the HIV.

Workplace link: Various types of informal workers were used to reach out to difficult-to-reach key population groups. The approach also used unconventional workplaces where PWID and SW are found.

Aims/activities: In order to design an intervention to address this concentrated epidemic, the Provincial Health Department, the Provincial AIDS Standing Bureau, and FHI (with funding from USAID) conducted formative research to gain insight into the knowledge, behaviour and attitudes of PWID and SW and their clients, as well as to gain a better understanding of their social and cultural environment.

The information thus gathered led to the decision to engage a variety of somewhat unlikely “health leaders” in the response to HIV and AIDS – namely barbers, shoeshine boys, motorcycle taxi drivers and workplace advocates from the workplaces concerned. The rationale was that members of these groups had been identified as potentially important peer educators and “*in a position to speak to and influence large numbers of people (predominantly men)*”. Their particular role related to “*convincing men to be more responsible*

in sexual health matters in their roles as citizens, fathers, husbands, friends, and employees” (Source 8).

The peer educators were provided with training and a variety of print materials (leaflets, magazines, comic books etc.) were developed to assist in disseminating messages. Motorcycle taxi drivers were identified as a particularly important peer education group because their work takes them close to many of the hotspots for commercial sex or drug use, such as hotels, truck stops, karaoke bars, restaurants, major highways and intersections, factories and commercial areas, sea ports, river ports and ferry crossings.

Outcomes: The intervention produced encouraging results. Within six months, 135 workplace peer educators were trained and initiated outreach activities. These peer educators reached almost 18,800 employees at eight factories. Through their day-to-day work, 290 motorcycle taxi peer educators worked with over 62,857 customers, 92 barbers reached 67,825 customers, and 20 shoeshine boys reached 10,766 customers. Because of its success, the intervention was subsequently expanded to other major cities in Vietnam.

The project included a strong monitoring component that assessed progress against baseline self-reported data. This monitoring showed encouraging results. Condom use increased in the targeted areas and attitudes towards unsafe behaviours changed. The project also contributed to raising the self-esteem of barbers and motorcycle peer educators, in particular because it enhanced public respect for their jobs and there was recognition of the fact that their work was making a difference to people in the community.

Lessons learnt:

- One of the campaign’s key successes was that it built positive images of male personal responsibility with regard to HIV.
- The focus on dispelling ideas of sex work and injecting drug use as “social evils” facilitated, and enhanced the effectiveness of, the contact with drug users and sex workers.

Summary: *Very few relevant and sufficiently documented programmes related to the workplace were identified; this highlights the limitations of a workplace approach with regard to populations who cannot be accessed by virtue of their employment – such as MSM, PWID and transgender people.*

The difficulties are compounded by the underground nature of much drug use. Key informants whom this study contacted noted that this may be a key factor in making it difficult to identify good example interventions that have a link to workplaces or workers. In the words of one informant: “This may be an area where good things may be happening, but on a relatively small scale, and which are not being recorded/picked up”.

Nonetheless, the examples presented highlight:

- *the importance of bridge populations (e.g. itinerant barbers) in reaching difficult-to-reach key populations such as PWID – these may be “bridge workers” and therefore may be reachable by virtue of their professional activity;*
- *the mobile nature of the “workforce” that is in contact with PWID; and*
- *the importance of addressing social conceptions of sex work and of specific key population groups.*

1.4 TRANSGENDER PEOPLE

Lesbian, gay, bisexual, and transgender (LGBT) people face discrimination, stigmatization and marginalization in society and in the workplace based on their sexual orientation. “These challenges often limit economic opportunities, affect mental health, and may place members of this population at an increased risk for HIV infection. Factors including needle sharing and substance abuse, high-risk sexual behaviours, commercial sex work, health care access, lack of knowledge regarding HIV transmission, violence, stigma and discrimination, and mental health issues are identified in the literature as risk factors for the acquisition of HIV infection by members of this population” (De Santis, 2009). For transgender sex workers, the risk of danger

and abuse is often even greater. Transgender sex workers are usually forced to live in hiding.

LGBT people and their needs have tended to be under-researched. Although this has changed somewhat in recent years, the specific needs of transgender people are often not used, or are insufficiently used, to inform the design of HIV approaches. The absence of approaches focussing on transgender people made it particularly difficult for this study to identify relevant workplace-related initiatives.

ASIA AND THE PACIFIC

Case Study 21: Delhi, India – Transgender beauty parlour (Source M22)

Context: The Pahal Foundation, an Indian NGO that works on community awareness about HIV and AIDS, identified a lack of access to transgender people as a particular constraint. Transgender people are often hidden within society, and subject to stigma and trauma, which makes them especially difficult to reach. Also, they often do not have access to economic opportunities.

Workplace link: The Pahal Foundation decided to set up a transgender beauty parlour. This initiative illustrates how establishing work opportunities for transgender people can give them increased economic stability, and can improve the integration of this traditionally marginalized population into the community.

Aims/activities: To break the cycle of stigmatization, the NGO decided to experiment with establishing a beauty parlour exclusively for transgender people, which it set up in 2009. Initially conceived as a pilot project, the Queer Beauty Parlour has been a very big success. It was established exclusively for transgender people in and around the capital. The parlour is not only dedicated to transgender clients; it is also run by transgender individuals. Uniquely, the suggestion to establish the beauty parlour came from the local community, who had identified the trauma and exclusion faced by transgender populations as an issue, and had also highlighted the need for economic opportunities for the community.

The beauty parlour is a unique centre that provides transgender people with beauty treatments and their own space, and it has been successfully integrated into the community. Stories about the worldwide gay and lesbian movement are pasted on the wall. The shop itself provides beauty products, as well as access to condoms, lubricants and HIV and AIDS information.

Outcomes: The Queer Beauty Parlour has between eight and ten clients per day and a fully booked diary. Its success has led the lead beautician – a transgender individual who was the first to join – to introduce training for other beauticians, who will be assisted in setting up businesses in other parts of the community.

Lessons learnt: An important lesson from this experience is that the community has a valuable role to play in the identification of both problems and solutions.

Summary: *Few model programmes were identified in this area.*

Useful lessons include:

- *the importance of involving key populations in project design and implementation (this applies to all key population groups);*
- *the value of advocacy to draw attention to issues, and to create visibility and acceptability;*
- *the importance of self-organization by members of key population groups; and*
- *the significant role that government action can play in securing institutional buy-in.*

The next chapter of this report will deal with a number of key population groups – such as migrants, garment workers and prisoners – who are specific to certain contexts, and thus are said to vary by setting. These groups are not present in all settings, but are key populations in a large number of cities and countries.

WORKPLACE INTERVENTIONS FOR OTHER KEY POPULATIONS

2.1 MIGRANTS AND THEIR FAMILIES

The recent period in history has seen important technological advances, which have brought about socioeconomic development and accumulation of wealth. Transportation systems, and movements of people between places, have contributed to these. While these developments have brought opportunities, they have also been a contributing factor in the spread of HIV and AIDS. *“Particularly in marginalized areas, transport milieu are highly conducive to risk-laden behavioural patterns and are thus transformed into transmission settings and vectors of disease.”* (Apostolopoulos, n.d., in Source 45) The following examples illustrate how different groups of migrants and their families have been affected by these changes and highlight where, and to what extent, workplace responses have addressed these problems.

AFRICA

Case Study 22: Southern Africa – ILO: Reaching cross-border workers in transport corridors in Southern Africa (Source 25)

Context: An initiative that began in 2007 with support from SIDA has focused on mobile workers in many parts of the world.

Workplace link: The initiative has used formal government workers and workplaces in these locations as advocates, and contact points, for services for a highly mobile population. It has also reached informal workers in informal workplaces, such as vendors selling their wares along railway lines.

Aims/activities: The ILO transport corridor initiative has focussed on HIV prevention for mobile transportation workers who cross borders between the neighbouring countries of Malawi, Mozambique, South Africa and Zimbabwe to do temporary work. In an innovative approach to the creation of an enabling environment for HIV prevention – and as the above-men-

tioned initiative in Sri Lanka did – the ILO trained employees of cross-border institutions such as customs agencies and other regulatory bodies, as well as employees from over seventy transportation companies, in implementing HIV and AIDS programmes. Peer educators were also trained and have played a key role. Condoms are regularly distributed across the corridors. At the Ressano-Garcia border between South Africa and Mozambique, the intervention went beyond traditional prevention approaches, by reaching out to informal communities operating along the railways who play an important role in linking with migrant workers as they pass through. The initiative has included brokering an agreement between ASSOTSI (an informal sector association) and customs authorities, to ensure that informal workers are not excluded from access to HIV services at borders.

Outcomes: Over 42,000 transport workers, including long-distance truck drivers, have been reached at hotspots along key cross-border routes. In each country the approach has taken into account local conditions and opportunities. In Zimbabwe, for example, there has been significant success in mobilizing leaders from small businesses and informal sector associations. This has resulted in the establishment of a Savings and Credit Cooperative (SACCO) at one of the country's key border posts. The cooperative extends short-term loans to its members to allow them to find their feet and to give them a better chance at integration into the local community.

Lessons learnt: The liaison work with small and informal traders and communities who interact with transport workers was enormously important in understanding and addressing a number of the key factors underlying vulnerability, like difficult economic conditions and gender inequalities. Understanding, and responding to, local conditions, is key to sustainable change.

Case Study 23: South Africa – Sensitizing farm owners, supervisors and workers to gender dynamics and how these affect the spread of HIV and AIDS (Sources 28 and 78)

Context: South Africa faces a generalized epidemic and has the highest number of people living with HIV globally – 5.6 million. Many factors play

a role in the high rate of HIV: poverty; inequality and social instability; high levels of STIs; the low status of women and sexual violence; high mobility (particularly of migrant labourers); limited, and uneven, access to quality medical care; and a history of poor leadership in the response to the epidemic.

Workplace link: Farms – as workplaces for farm workers and farm supervisors – were the main entry point for the initiative.

Aims/activities: In partnership with the Hoedspruit Training Trust (HTT), the International Organization for Migration (IOM) set up the Ripfumelo HIV Prevention and Care Programme for Farm Workers in South Africa in mid-2005. Operating on 18 commercial farms in the Hoedspruit area, the project implemented a holistic approach to tackling HIV, with four interlinked components:

- the workplace;
- care and support;
- behaviour change communication; and
- gender issues.

The purpose of the intervention was to create awareness amongst farm workers, specifically amongst men and farm supervisors, about the gender dynamics that exacerbate the HIV and AIDS epidemic, and to develop their skills to mitigate the epidemic's impact. Advocacy targeted a variety of stakeholders, including farm supervisors, the local chief of police, education authorities, the sexual offences stakeholders' forum, the local media, priests and other religious leaders, the Municipal Manager and the Mayor. Video and print materials, and murals painted in prominent places, were used to make the case. The project ran various targeted workshops and training activities, one of the critical outcomes of which was the production of farm- and community-level work and action plans to address gender issues. Workshops typically covered:

- gender socialization: an exploration of gender roles; gender norms; how genders are, and should be, valued; and gender and power;

- sex and sexuality: an exploration of sexuality, sensuality and pleasure, violence and HIV/AIDS risk; and
- sex and reproductive health: an exploration of sexual rights and responsibilities, sex in marriage and long-term relationships, and attitudes towards rape and sexual violence.

Community Action Teams (CATs) were formally established to implement the work plans. Teams and support groups met on a regular basis, and also monitored and evaluated progress made with regard to the work plans.

Innovative aspects of the farm work include...

- painting of murals on premises
- drafting of farm-level and community action plans
- establishment of CATs
- involvement and training of multiple stakeholder groups
- a strong focus on gender socialization and gender concerns

(Source 78)

Outcomes: Through the intervention, farms developed HIV and AIDS workplace policies. The project evaluation revealed important changes in key stakeholder groups' attitudes and commitment. Farm supervisors showed their commitment through actions such as:

- promoting respect for women and care for children;
 - assisting in educating people about the use of condoms;
 - campaigning against HIV and AIDS, rape and domestic violence;
- developing care groups to look after the welfare of farm workers and disseminate information; and

-
- conducting advocacy activities with farms and other stakeholder groups.

The evaluation also showed that advocacy activities produced positive changes with regard to diverse areas such as housing, ARV treatment, VCT services and recreation facilities.

Lessons learnt: The initiative was able to begin to develop farm supervisors' commitment to gender issues. However, for this initiative to have a lasting impact, it would need to be complemented by the strengthening of community-level mechanisms for dealing directly with gender-based violence.

ARAB STATES

Case Study 24: United Arab Emirates – Establishment of a Department of Human Rights by the Dubai Policy Department (Source 51)

Context: The HIV situation in UAE can be characterized as low-prevalence. The majority of HIV cases are found in the emirates of Abu Dhabi and Dubai, reflecting those two cities' larger populations, as well as higher levels of risky behaviours – both cities appear to be more exposed than other parts of UAE to high-risk phenomena associated with HIV, including migration, sex work and trafficking of women. Sex work is illegal in UAE and it takes place in a hidden environment, thus it is poorly documented. Although there is very little information available on sex work in UAE, data from the Dubai police have highlighted the link between sex work and human trafficking. UAE's vibrant economy, open borders and tourism drive the demand for sex work. Reportedly, the large majority of sex workers are foreign women catering especially for the needs of foreign men, including expatriates living in UAE. The illegality of their work, their fear of social rejection and their possible connection to organized crime make it extremely challenging to reach these women with HIV-prevention programmes.

Workplace link: This initiative illustrates how an existing workplace that has regular contact with a key population group can become more effective in meeting this group's needs.

Aims/activities: As part of a broader range of activities, and to address sex work with a view to HIV prevention, the Dubai Police established a General Department of Human Rights in 2006. This was intended as a short-term intervention, but the Department has since become part of the institutional and organizational structure of the police force, and has strengthened protection of women who are victims of human trafficking.

Outcomes: Since its establishment, the Department has reported approximately 50 cases of sex work-related human trafficking per year. It has been instrumental in distributing Information, Education and Communication (IEC) materials to expatriates (translated into their languages) in various locations, including HIV-testing centres. The Department has also played a crucial role in linking persons in need to key services, such as HIV-testing and drug-treatment services.

Lessons learnt: The creation of a government-supported department essentially to protect the human rights of vulnerable populations provides a potentially powerful model for the development and implementation of similar programmes, with a view to HIV prevention for most-at-risk populations.

ASIA AND THE PACIFIC

Case Study 25: Bangladesh – Obtaining brokers' assistance to reach cross-border mobile populations (Sources 52, M12 and M15)

Context: Adult HIV prevalence in Bangladesh for the general population stands at less than 0.1 per cent. Although HIV prevalence is below 1 per cent in most groups of female and male sex workers, prevalence in casual sex workers in some geographical areas (e.g. border towns in the northwest part of Bangladesh) is higher. Large proportions of MSM and male sex workers report STI symptoms, as well as having multiple sexual partners (including women), group sex – often without condoms (and often associated with violence) and very low condom use with all types of partners. Cross-border movement into India – which has become a necessity for the economic survival of people living in areas of Bangladesh that border it – is linked to increased risk.

Workplace link: Brokers (a specific category of workers) were used to reach cross-border populations. This approach illustrates how unconventional workplaces and workplace actors can play a role in HIV prevention and access to services.

Aims/activities: EMPHASIS (Enhancing Mobile Populations' access to HIV & AIDS Services, Information and Support) is a 5-year (2009-2014) sub-regional initiative of CARE India, Bangladesh and Nepal, funded by BIG Lottery Group of the United Kingdom. The programme has three major components, one of which focuses on reaching migrants in transit areas⁶.

Outreach staff were entrusted with building a relationship with the brokers, in order to employ them as contact points. The brokers participated actively in the project; they provided input into the selection of locations for contact, for example. Preferential stopover points were identified and, thanks to the brokers' contact with the mobile populations, the outreach activities were successfully extended to both migrants and their families. This was done without posing a threat to migrant workers or putting them at risk of harassment, which would have been risks had a law enforcement agency been involved.

Building the capacity of the health service providers to increase service access for cross-border mobile populations was another important aspect of the initiative, in order to ensure that referrals provided by brokers would be effective.

The project – which initially focused on HIV interventions – gradually evolved into a comprehensive programmatic approach to migration, allowing it to address factors that impact on social and economic vulnerability. It has worked on initiatives for issues including access to education for migrants' children, a safe way to send remittances, the prevention of domestic violence and harassment at the workplace, equal wages for labour migrants and rescue and repatriation.

⁶ The other two components are self help groups for wives of immigrants to reduce stigma and discrimination related to HIV and cross border mobility, and capacity building of the health service providers to increase service access for the cross border mobile population.

Outcomes: The programme reached over 300,000 people at source, in transit and at destination locations. Over 13,500 individuals, including peer educators and health-service providers, were trained in providing services related to HIV and AIDS, life skills, technical skills, gender sensitization, health-system strengthening and vulnerabilities of migrant populations. Data on outcomes is still being collected.

Lessons learnt:

- Engaging with private sector actors such as hoteliers, transport unions, spouse groups, District AIDS Coordination Committees and district-level migrant networks effectively contributes to a comprehensive at-source response to cross-border migration and HIV and AIDS.
- Programmes, with local support, can evolve and acquire a life of their own to address issues that are of relevance to the community.

Case Study 26: China – ILO: The Hometown Fellows campaign – Innovative HIV-prevention strategies for young migrants (Sources 25 and M13)

Context: Although overall prevalence of HIV is relatively low in China (UNAIDS reported a 0.1 per cent prevalence in 2008), there are pockets of high levels of infection, in specific populations and specific localities. This programme sought to address some of these pockets, in particular those that affect young migrants.

Workplace link: The involvement of large construction companies was critical to a programme that combined workplace-based activities and peer outreach. Links with other workplaces, such as entertainment venues and train stations, were also important in the implementation of a multi-pronged communication and behaviour change strategy.

Aims/activities: In China, the ILO “Hometown Fellows” campaign focussed on disseminating HIV-prevention messages to migrant workers. The initiative, initiated by ILO, is being implemented in partnership with the Ministry of Labour; employer and worker bodies; the State Council AIDS Working Committee Organization and 19 large-scale enterprises in

the construction, mining and transport sectors based in the provinces of China that are most affected by HIV.

Formative research conducted at the start of the programme highlighted strong social bonds between migrants who have a common provincial origin, as well as the fact that such bonds can influence attitudes and behaviour. The programme therefore chose to deliver messages through the voices of migrants. In addition, the programme worked through enterprise structures, with peer educators active in workplaces, dormitories and nearby entertainment areas. Group training in enterprises, as well as targeted messages delivered through company-owned television and radio channels, aimed to reinforce the peer education messages.

With the help of Mega Info Media, which runs the national railway station television network, a short film was screened in 2009 in 850 major train stations along inter-provincial transport routes and in 500 cities in labour-sending and receiving areas. The film sought to engage young people by presenting a main character with whom they could identify. A popular Chinese movie star who was once a construction worker himself, who could identify with the role and who would be seen as a legitimate spokesperson by the target audience, played the character.

Part of the initiative focused on ensuring that young female migrants are aware of their basic employment and reproductive health rights. The “Know Your Rights Campaign” was launched in 2011, targeting 300,000 workers in Guangdong province. It includes workplace programmes on reproductive health and HIV and AIDS. To work towards sustainability, HIV prevention is being integrated into technical curricula of vocational schools so that young people receive vital information and resources as part of their training.

Outcomes: The ILO “Hometown Fellows” campaign reached approximately 40 million workers during their commutes between home and construction sites. In addition, the initiative trained over 2,000 teachers to deliver participatory training to prospective young migrant workers.

Lessons learnt: Specific lessons learnt from this initiative have not been identified, nor was an evaluation report available at the time of writing. However, the descriptive information on the project highlights the importance of baseline research to understand what influences behaviour, and to enable programme designers to develop appropriate strategies for reaching potentially complex and extremely mobile target populations.

Case Study 27: Sri Lanka – ILO: HIV doesn't stop at borders – A human-rights approach to protecting migrant and cross-border workers (Source 25)

Context: Each year, a substantial number of Sri Lankan workers seek temporary employment outside of the country, in particular in the Gulf States. Prior to departure they are required to go through various official channels, such as Sri Lanka Bureau of Foreign Employment (SLBFE) and the national Association of Licensed Foreign Employment Agencies (ALFEA), and they will likely visit one of the 13 medical centres approved by the Gulf Cooperation Council (GCC).

Workplace link: This approach uses services (i.e. workplaces) that are compulsory stops for migrant workers to provide critical information as well as access to HIV and health services.

Aims/activities: Knowledge of the process that migrant workers must go through in order to temporarily leave Sri Lanka underpinned the design of a programme, in 2010, that has focused on providing Sri Lankan migrant workers with critical information and supplies, with a view to reducing their risk. The programme has had a strong focus on the specific needs of women, who are at a higher risk of exploitation both during the migration process and once in the destination country.

The prevention programme, which has received support from the ILO, has thus worked through the various compulsory “stops” which potential migrants need to visit before leaving the country to work overseas, as well as other contact points that they must visit upon arrival in the destination countries.

Outcomes: The strategy has successfully reached some 1,500 migrant workers with information on how they can best ensure that they are protected against HIV and reduce their HIV vulnerability during the migration process.

Lessons learnt: The following lessons stand out from this experience.

- Recruiting agents, government officials and members of community-based organizations (CBOs) who have been trained in HIV prevention and outreach have been key to the strategy. Through these channels migrant workers and their families receive, along with the regular formalities, potentially life-saving information and resources on the prevention of HIV and AIDS and related diseases.
- Gender-sensitive pre-departure HIV and reproductive health training has been a particularly salient component of this approach, and has successfully responded to the risks specifically faced by women.

Case Study 28: Thailand – Migrant workers, their dependents and entertainment workers in coastal provinces and along the border with Myanmar (Sources 26a and b)

Context: Migrant workers from border countries (Cambodia, Laos and Myanmar) are a major source of labour for Thailand. These migrants are entitled to health insurance if they are documented. However, most migrants are not, and thus face barriers in accessing health care and other services, including HIV-prevention services. Migrants are vulnerable to HIV because they are far from home and use the services of sex workers, often ignorant of the risks.

Workplace link: Health assistants reached migrant workers via workplaces in various sectors (fisheries, construction etc.).

Aims/activities: The PHAMIT programme, initiated in 2003, sought to reduce the number of new HIV infections among migrant workers in Thailand and the sub-region (Thailand, Cambodia and Myanmar). In Thailand, PHAMIT focused on nineteen coastal provinces and three non-

coastal provinces bordering Myanmar. In the coastal provinces most beneficiaries were migrants working in fishing and seafood processing; migrants working in other sectors such as industry, construction, and agriculture were the main beneficiaries in the non-coastal provinces.

The programme was implemented through a partnership between eight NGOs and the Ministry of Public Health, and received funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Key objectives of the programme were to:

- increase migrant workers' and related populations' use of condoms and practise of safe reproductive health;
- equip the health system to offer migrant workers prevention and treatment services;
- improve the psychosocial environment for migrant workers and their dependents; and
- advocate for policies that support migrants' right to health care and treatment.

At all project sites, there was a special focus on sex workers and entertainment workers.

The project employed a range of strategies. These included work with existing NGOs to enhance service delivery and strengthen advocacy, efforts in partnership with Government departments to put in place "migrant-friendly services" and a focus on migrant communities through the innovative concept of "migrant health assistants". The latter were registered migrants living in Thailand, who were selected, recruited and trained to support migrants in accessing public health services.

Outcomes: The programme reached over 460,000 beneficiaries with HIV-prevention information and messages. Comparison with baseline data showed that the PHAMIT programme had the following outcomes.

- Condom use by programme beneficiaries during sex with casual partners increased from 40 to nearly 90 per cent.

- The number of migrant women receiving antenatal care services increased by up to 20 per cent in target areas.
- Nearly 2,000 HIV-positive migrants received home-based care and treatment for opportunistic infections.

The overall impact has been magnified by strategic advocacy aimed at various Government agencies. The Thai Government is increasingly recognizing migrant workers' rights, and specifically their right to access to health services. This is demonstrated by the Government's inclusion of migrant workers as a target population in the 2007-2011 National AIDS Strategic Plan, and by its decision to make subsidized ARV treatment available to a number of HIV-positive migrant workers in Thailand.

Lessons learnt: At the evaluation stage, a number of factors clearly emerged as having contributed to the success of the programme. Among the most salient of these are:

- the fact that the intervention responded to an urgent need that had been articulated by affected communities;
- strong liaison work with hospitals and Government departments, which ensured that gaps in referrals and access to health care and HIV-prevention services for migrant workers became less important; and
- a strong and concerted effort to mobilize as many partners as possible in the response, including Government departments, NGOs and local government and employers.

2.2 GARMENT INDUSTRY WORKERS

AFRICA

Case Study 29: Lesotho – The garment industry, vulnerable women and wives of migrant workers (Sources 16, 18 and M21)

Context: Lesotho, a small landlocked country in Southern Africa, has one of the highest adult HIV prevalence rates in the world – it stood at 23.3 per

cent in 2011. According to the 2012 United Nations General Assembly Special Session (UNGASS) report, major drivers of the epidemic are multiple concurrent sexual partnerships (this partially reflects the mobility of populations); poor access to health services and inadequate levels of HIV testing; inadequate frequency of condom use across all sexually active population groups; social and cultural practices; high rates of alcohol use; low demand for male circumcision; and high rates of poverty and inequality.

Workplace link: The programme used garment factories to reach garment workers and their families. A deliberate strategy to sensitize factory managers was implemented to ensure institutional commitment to the response.

Aims/activities: The Apparel Lesotho Alliance to Fight AIDS (ALAFA) was set up in 2006 as an innovative HIV prevention and treatment programme targeting the largest industrial sector in the country. A large majority of workers in the small foreign-owned clothing factories is female, and 40 per cent tested positive for HIV. Many of the textile workers have male partners working in South African mines, which is a significant risk factor in their exposure to the disease.

ALAFA put in place targeted workplace-level peer-education programmes for female workers, male workers and workers 25 years old and younger. Research informed the design of these programmes, which respond to the target groups' social roles and characteristics. With men, the group discussions centre on what it means to be a responsible male: recognizing and avoiding high-risk sex, regularly testing for HIV and keeping your family safe. The programme for young people emphasizes developing male-female communication skills and HIV risk-avoidance – including reducing sexual activity or delaying sexual debut. The women's programme integrates gender dynamics, communication in relationships, factors that contribute to HIV transmission and the problems faced by HIV-discordant couples. All three programmes have a component on multiple concurrent partnerships. The programmes also include the provision of regular access to condoms and HIV testing for all workers and their families. Multi-day training sessions for factory managers are part of the approach. Sessions are conducted in both

the local Sesotho language and Mandarin Chinese (the language spoken by the Chinese managers).

The programme has also focused on expanding access to treatment, through a collaboration with the Lesotho Network of AIDS Service Organizations which has strengthening rural clinics as its aim. A medical tracking scheme ensures that appropriate action can be taken when patients miss visits. Lesotho has one of the most elevated rates of TB, and, in addition to HIV and AIDS, ALAFA's treatment programme has increasingly focused on TB.

Outcomes: About 100 Lesotho-born workers and Chinese managers received HIV training in 2011. These training programmes have improved corporate understanding of the local HIV situation and have brought about more solid and explicit company support of ALAFA's worker programmes, including financial support.

As of October 2011, ALAFA clinics had treated 443 workers for TB, of whom 397 were receiving HIV drugs at the time of treatment. TB and HIV are tracked together in medical records, and the medical visits themselves are coordinated to reduce absenteeism. The result has been a high TB cure rate.

ASIA AND THE PACIFIC

Case Study 30: Chittagong, Bangladesh – The garment industry, women and female sex workers (Sources 17a, b, c, d and e)

Context: Bangladesh has a concentrated epidemic, with HIV prevalence at less than 0.1 per cent in the general population. In 2011, the HIV prevalence in PWID, female and male SW, MSM and *hijras*⁷ was 0.7 per cent. However, prevalence in casual sex workers in some geographical areas (e.g. border towns in the northwest part of Bangladesh, and transit areas) was substantially higher, and could lead to the spread of HIV.

Workplace link: The approach for the garment workers included specific strategies that used the physical workplace as an entry point for interventions.

⁷ A hijra is usually considered a member of "the third gender", neither a man nor a woman. Most are physically male or intersex, but some are physically female.

Aims/activities: Between 2008 and 2012, Young Power in Social Action (YPSA) delivered a combination of prevention programmes targeting women working in the garment industry, some of whom engage in sex work or exchange sexual favours to supplement their income. These programmes – which were implemented with support from the HIV/AIDS and STD Alliance Bangladesh (HASAB), Family Health International (FHI), and donors such as the GFATM, Save the Children and Access Health International – sought to increase knowledge, to promote the use of condoms and to encourage the uptake of health services.

The approach developed a referral network, involving most of the big hospitals in the city, which allowed the programme to cater for different needs. The programme involved various factories, and included the development and endorsement of a workplace policy on HIV and AIDS at each factory, as well as national advocacy activities.

It employed a life skills-based peer-educator approach to changing health care behaviour. This involved recruiting peer educators from among garment workers and female sex workers. Peer educators were provided with training to encourage positive health-seeking behaviour and to enable them to educate their respective groups on HIV and AIDS prevention. The programme also included the establishment of a mobile medical team, which conducted weekly visits to rural areas, as well as a drop-in centre for female sex workers where the latter could spend time, access services and rest or engage in recreational activities. In addition, outreach activities in residential communities used a variety of media such as theatre, music and video to educate people. Since most sex workers are illiterate, pictorial training materials such as flip charts and leaflets were also used.

Factory managers, as well as staff, were engaged in lunchtime peer discussions on general health issues, and on HIV and AIDS in particular. The sessions focused on disseminating information, and encouraging workers to pose questions and to seek contact with the mobile medical team that was put in place to conduct weekly visits to the factory to treat workers.

Outcomes: Over 2,000 sex workers had been reached by the YPSA network in 2011 (Source: 17d), as well as 16,000-plus garment workers (Source: 17e). There appears to have been limited follow-up, although reports mention good adherence to the prevention sessions and a modest increase in uptake of health services (Source: 17e).

Lessons learnt:

- The use of interactive media and video; and practical, life-skills education, increase workers' engagement.
- The development of separate strategies for sub groups within key populations can be critical to success. Research can provide valuable information for designing such strategies.
- Managers of garment factories can be engaged in prevention activities, provided that the economic and social benefits of these are made clear, and that facilities exist for referring staff to health, and other, services.
- To ensure continued implementation of prevention services, refresher training for master trainers and peer educators is important.

What worked in the Chittagong programme

- conducting needs assessments of the specific target groups
- planning and implementing refresher courses for master trainers
- using adherence by some workplaces to convince others to join
- generating visibility for the initiative
- mapping health care facilities for STI, sexual and reproductive health (SRH) management and the general health of garment factory workers within, and local to, factories (Source 17a).

2.3 PORT, FISHERY AND TRANSPORTATION SECTOR WORKERS

Port, fishery and transportation sector workers are particularly vulnerable to HIV due to a multitude of factors, including the movement of populations, the long periods which people in these areas of work spend away from home, the lack of good access to HIV services and the opportunities for purchasing sex and drugs that exist in many of these locations.

Truckers are likely to engage in behaviours that expose them to STIs – including HIV – due to loneliness, isolation and long waits at truck-inspection sites. High-risk behaviours include unprotected sex with partners outside of marriage; anal sex; sexual relations with sex workers; substance abuse and misuse; injecting drugs; and gambling. The combination of substance abuse (truckers sometimes use one or more of alcohol, prescription drugs and marijuana to relax or sleep, and cocaine and/or methamphetamine to stay awake on long hauls) and high-risk sexual behaviour creates an optimal environment for STI/HIV transmission. Close to 6 per cent of truckers are women, a portion of who travel as part of husband-and-wife truck-driving teams.

AFRICA

Case Study 31: Kenya – Using peer education in an HIV and AIDS management programme for the Kenya Ports Authority (Sources 41 and M14)

Context: Kenya has one of the most widespread epidemics in the world, which has, however, seen a decline in recent years. In 2009 adult prevalence stood at 6.2 per cent and was higher among women than men. Studies have shown a high HIV prevalence amongst SW, PWID, MSM, truck drivers and cross-border mobile populations.

Workplace link: This HIV and AIDS programme was developed and implemented through the Kenya Ports Authority.

Aims/activities: The peer-education Kenya Ports Authority (KPA) HIV and AIDS programme was implemented jointly with FHI, starting in 2000.

The objective of the programme was to provide HIV prevention and treatment services to port workers. As a first step, findings from research were shared with senior management and union leaders in order to sensitize and motivate them, build a supportive environment for the HIV and AIDS programme and facilitate a discussion on current, and potential, impacts of AIDS on KPA's operations.

Dialogue with senior management resulted in a revision of KPA's HIV-prevention structure. The port was divided into six logical subunits, each treated as a discrete entity with its own focal person and peer educators. The focal person's role was to serve as a link between his or her section's prevention efforts and the senior management of the company, and to work closely with peer educators. One workplace peer educator was recruited for every 50 employees. Each peer educator was put in charge of organizing at least one participatory group outreach meeting every week. Role-play, picture cards, short dramas and games were used to convey messages at these group meetings. Additionally, each peer educator informally discussed AIDS with at least ten employees monthly. Peer educators also raised awareness off-site, identified symptoms and the need for prompt care and referred individuals for treatment. Condoms were intensively distributed at outreach meetings, in conjunction with peer-led educational activities. In one year, the peer educators distributed more than 65,000 condoms, which they placed in strategic places such as restrooms. The prevention programme received an annual budget from the KPA, reflecting the importance which senior management accorded to this work following the advocacy efforts. The budget allocation enabled the programme to go beyond the workplace, into the community, and to conduct peer-led educational activities in residential areas.

Outcomes: Research indicates that the HIV and AIDS peer-education programme has increased respondents' HIV and AIDS knowledge and that participants have developed positive attitudes towards HIV and AIDS. The programme has also reduced stigma associated with a diagnosis of HIV or AIDS. Attendance at peer-education events and the uptake of VCT have significantly increased. Over time a reduction in the percentage of the work-

force who tested positive was noted, as well as a reduction in the number of HIV-related deaths.

Lessons learnt:

- Working through workplaces supports the establishment of peer-education programmes because communities are well defined, with organizational structures, hierarchies and policies. This makes it possible to target people with common demographic characteristics.
- Advocacy, and ensuring the buy-in of senior management, is critical, in particular because management can provide the resources needed to guarantee interventions' sustainability.

Case Study 32: Kenya – Addressing stigma and secrecy surrounding HIV and AIDS among transport workers (Source 44)

Context: To address prevailing prominent stigma, and secrecy, surrounding HIV and AIDS – which have been barriers to HIV testing and to accessing treatment – in 2009 this initiative launched a multi-month storytelling programme involving Kenyan transport workers, AIDS clinicians and union members. The approach was to engage these different groups of stakeholders in listening to, and telling, stories about HIV and its impact on their lives.

Workplace link: Working with transport workers' unions made it possible to extend HIV services to women and men workers.

Aims/activities: The International Transport Workers' Federation (ITF) recruited a consultancy firm to support the mainstreaming of HIV and AIDS awareness, build knowledge, increase access to treatment and combat secrecy and discrimination by strengthening the collective voice of transport workers.

The Behaviour Change Communication (BCC) programme was designed to empower transport workers – who are especially vulnerable to HIV – to speak out openly about the disease and be ready to take action on their

own behalf; to consciously alter structures of inequality, subordination and isolation.

The consultancy company conducted an assessment of the cultural, social and political context in relation to HIV infection and provided a follow-up strategy to guide the continued use of its proposed ‘Narativ’ Listening and Storytelling Method. The storytelling was recorded on video for advocacy and training purposes and in order to raise awareness.

Outcomes: HIV-positive transport workers in Kenya built on their training and formed a network that brings together a diverse group of union members, who are committed to sharing and listening to each other’s stories and increasing awareness of HIV and AIDS in their communities. Anecdotal evidence indicates that the storytelling has encouraged stigma-reduction and voluntary disclosure.

Lessons learnt: Innovative means of recording experience can be powerful tools with which to engage workers in prevention and break silence about HIV.

Case Study 33: Namibia – The Walvis Bay Corridor Group (WBCG)
Wellness Service: promoting wellness centres and moonlight testing for truckers (Sources 38 and 47)

Context: Namibia’s epidemic is generalized. Its current HIV prevalence stands at over 18 per cent. However, the number of new HIV infections has declined in recent years. A similar downward trend has been observed in AIDS-related deaths.

Workplace link: The WBCG service was introduced and expanded as part of a company policy. Their integration into company policy and practices was critical to the successful rollout of these services.

Aims/activities: The WBCG established two wellness centres in Walvis Bay (2009) and Katima Mulilo (2011) in Namibia. These wellness centres pro-

vide peer education, HIV counselling and testing, STI screening and treatment for transport workers and the communities with whom they directly interact. The wellness centres are located at sites such as truck stops, border crossings, docks and depots where there are significant numbers of transport workers. The centres provide an informal and anonymous environment in which transport workers can, free of charge, get information and have their health concerns attended to. Key partners in the initiative include the Namibian Ministry of Health and Social Services; the Namibian Ministry of Works and Transport; and development partners such as GIZ, SIDA, the Corridor Empowerment Project (CEP), the Society for Family Health (SFH), the United States Agency for International Development (USAID), the US Embassy Public Affairs Division, Southern Africa Development Community (SADC) and North Star Alliance (NSA).

To further improve the wellness services to the transport community, particularly to address the challenges in reaching long-distance truck drivers, the Wellness Service has been expanded to include a mobile wellness service. The use of “moonlight” testing has been key to reaching the transportation workers.

Moonlight testing involves visiting hotspots and truck stops in Windhoek, Namibia with a mobile wellness clinic between 5 p.m. and 11 p.m. three times a week. These interventions include SBC communication and HIV counselling and testing for long-distance truck drivers and sex workers. While this intervention remains to be evaluated, preliminary information suggests high uptake and that the services are perceived to be relevant.

Outcomes: The WBCG Wellness Service ran HIV-prevention programmes and provided wellness-screening services for over 4,000 transport workers over 2011 and 2012, as well as reaching 18 transport companies in Namibia at their workplaces. The programme reported an estimated HIV prevalence for transport workers of approximately 15 per cent in 2012, which is slightly lower than the national prevalence of 18.2 per cent (National HIV Sentinel Survey, 2012). This is encouraging, given the higher levels of risk that transportation workers are exposed to.

Lessons learnt: The WBCG employed a mixed approach, which has had a strong impact. It has facilitated the development of efficient, effective and sustainable health services for the transport sector, tailored to the specific needs of the workforce.

Case Study 34: Zimbabwe – Truckers and sex workers (Source 43)

Context: Zimbabwe has a high rate of HIV infection and high HIV prevalence (14.7 per cent adult prevalence in 2012). Truck drivers operating on overland routes through Zimbabwe have transmitted the disease.

Workplace link: A transportation organization implemented this programme through its companies; it thus had a strong workplace focus, despite the workforce's mobile nature. In addition, it used a large number of workplaces (e.g. shops and bars) as entry points for contact with truckers.

Aims/activities: In 1992 the Zimbabwe National Employment Council for the Transport Operating Industry (NECTOI)⁸ began an AIDS education programme targeting transport workers. A major input was a baseline study that showed that drivers had poor AIDS awareness and many misconceptions about condom use. The study also identified a particular type of truck driver *“who was sexually very active on the road – some could not imagine going more than a day or two without sex – who regularly had sex with prostitutes and belittled drivers who did not”* (Source 43, p. 132).

Through the programme, a peer-based outreach scheme for long-distance truck drivers and their assistants was set up along three major highways in Zimbabwe. The objectives were to reduce STIs, encourage condom use (especially in commercial sex) and emphasize the dangers of unprotected sex and large numbers of sexual partners.

Peer educators recruited and trained by the programme included sex workers, petrol station workers, hotel workers, bar workers, police and others who had contact with truck drivers. Twenty-one project sites along the three largest transportation routes were put in place. Messages were conveyed through

⁸ NECTOI is a non-profit statutory body consisting equally of industry and labour representatives and funded by the Transport and General Workers' Union, the Transport Operators' Association and the Zimbabwe Rural Transport Organization. The transport industry is estimated to employ 80,000-100,000 people in Zimbabwe, mostly in about 2,500 registered transport companies.

a combination of peer interaction and song and drama. The approach also involved working with local authorities, including Ministry of Health units (in order to bypass the traditional hostility of STI-clinic workers towards sex workers), AIDS service organizations, local government officials and community leaders such as shop, bar and hotel owners and traditional chiefs. A weekly radio programme for truck workers helped disseminate regular messages.

Outcomes: The programme trained about 500 peer educators from 1995 to 1997, and almost all project sites established drama groups comprised of local teenagers. AIDS awareness and condom use both rose dramatically from 1992 to 1995. Most measures of risk behaviour showed smaller changes from 1995 onward, but the trends were still generally positive.

ASIA AND THE PACIFIC

Case Study 35: Bangladesh – Focusing on rickshaw-pullers; transport workers; truckers and their helpers; and port, dock and ferry workers (Source 33)

Context: In 1995, CARE Bangladesh initiated an HIV and AIDS intervention programme called Stopping HIV/AIDS through Knowledge and Training Initiatives (SHAKTI), to improve the HIV and AIDS response in Bangladesh. The programme was funded by the United Kingdom's Department for International Development (DFID).

Workplace link: Transport workers' unions were the first point of contact for the initiative, and provided a channel for the various activities.

Aims/activities: This initiative focused on groups of workers, including rickshaw-pullers, truckers, dock workers, labourers and ferry workers, with the aim of scaling up HIV prevention and treatment. Baseline information showed that over half the persons in these groups had had sex with sex workers in the six months immediately preceding the survey. Of those who had had sex during this period, only 11 per cent had used a condom. The SHAKTI project had four major work goals; it aimed to:

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- raise awareness;
 - maintain high quality contact with sex workers;
 - provide means for behaviour change (condoms and STD treatment); and
 - create an enabling environment.

The initiative prioritized the development of partnerships with transportation unions, especially truckers' unions. Outreach workers conducted regular peer HIV-education activities, as well as partner-tracking for transportation workers who tested positive for HIV or other STIs. Drop-In Centres (DIC) were established for STI syndromic management, and outreach workers systematically referred transportation workers and their sexual partners to these services as necessary.

Outcomes: By 2004, the programme was selling up to 400,000 condoms per month across the country through its outreach worker system. Comparisons with baseline data showed:

- an increase in measures of knowledge, e.g. understanding of the importance of condoms rose from 36 per cent to 87 per cent;
- an increase in self-reported intent to use condoms; and
- an increase in self-reported consistent condom use – from about 14 per cent to 28 per cent.

Lessons learnt: The initiative was rolled out over a number of years. The following lessons were retained from this experience.

- Power relations between target-group members need to be well understood and should inform the design of peer education for this to be effective.
- There is value in monitoring truckers and helpers separately because of their very different socio-economic conditions. Truckers have a steady income, and have a hierarchical relationship with the helpers. Different approaches are needed to address the different situations of these groups.
- It is important that interventions recognize the differences in different kinds of transport workers' networking systems. These differences are

reflected in different risks, therefore, peer-related activities should tailor to these specificities. For example, the programme found that rickshaw-pullers are very mobile, make small amounts of money and tend to engage with local sex workers, whereas dock workers have more resources and have frequent interactions with foreigners.

- The establishment of mechanisms for continuous learning within interventions is critical to programmes' effectiveness.
- Working with unions can provide important leverage, but this intervention found that unions often lacked organizational and technical capacity. Programmes can be more effective if they include mechanisms for providing support to strengthen unions.
- Access to health services through DIC was an important part of the intervention – however, it was not sustainable because the centres were set up as separate units with project funding, which dried up when the intervention ended. When working with or through partners, provision should be made well in advance for technical and organizational assistance to ensure that these develop sufficient capacity to continue the programme once funding subsidies end.
- Unions offer an ideal environment for HIV-prevention activities. Building the capacity of unions' leadership to carry out HIV-prevention activities under the union umbrella is important, as is the buy-in of senior management.

Case Study 36: Papua New Guinea – The TRANSEX Project: Targeting truckers, dock workers, police and other high-risk groups (Sources 33, 57 and 58)

Context: An early example programme, dating from the 1990s, was set up in Papua New Guinea. This innovative programme addressed various workplaces and sought to respond to the alarming increase, particularly among sex workers and their clients, in HIV. Papua New Guinea has an adult prevalence of 0.7 per cent, but among sex workers HIV prevalence was estimated at 19 per cent in 2011 (Source 58).

Workplace link: The TRANSEX Project held policy workshops at different workplaces (including the workplaces of the police and shipping and

security firms) to institutionalize its approach. Initial resistance from some enterprises – especially the trucking firms and some large security firms – was overcome by a deliberate strategy to increase the prevention efforts' visibility. Workshops were televised and newspapers were involved in disseminating information. This strengthened the approach's credibility and encouraged the resistant companies to cooperate.

Aims/activities: The programme – which was implemented as part of a larger sexual health project run by the PNG Department of Health with funding from AUSAID – identified and targeted major sex-worker client groups (mostly truckers, dock workers, members of the police force and other uniformed persons). It also sought to address the perceived needs of sex workers, who were not in a position to negotiate for safe sex.

The initial strategy was to approach truckers while they were working. Outreach workers were recruited to talk to truck drivers and to provide them with basic information, as well as condoms. However, this strategy proved difficult to implement – truck drivers were not always receptive to the messages, and there were difficulties of access and security for the outreach workers. After further research, the programme's implementers decided to train dispatchers to provide condoms and information. After this, individual truckers started to come forward and – initially without the direct involvement of their companies – showed interest in becoming involved in the programme as peer educators.

Over time, a number of trucking firms became engaged, and formal workplace training sessions were organized for their drivers at rest stops along the road. These rest stops made it easier for outreach workers and peer educators to access the drivers and provided a secure setting where outreach workers could engage with multiple truck drivers, if appropriate.

A second major target group for this initiative were sailors and dockworkers. Contact was made with these groups through shipping companies, unions and workers' associations and cooperatives. Sailors and dockworkers proved to be very open to the project. Shipping companies, unions and workers'

associations were highly cooperative, and allowed outreach workers to enter wharves, board ships and interview men.

A more sensitive and difficult area of work involved trying to increase condom use by the police and the armed forces. The initial research had highlighted the major problems of rape and harassment of sex workers by police. Addressing the sensitive topic of line-ups by the police was particularly difficult⁹. The programme decided to directly, but privately, confront the Police Commissioner, given that addressing this issue required the commitment of the full hierarchy of the police force. The strategy also included reaching out to other stakeholder groups who were fighting for change, including police-women and policemen's wives – who were informed about the practice and the risk for them that it entailed.

Factors that contributed to the success of the intervention include...

- extensive qualitative research on the real context of risk-taking by vulnerable groups;
- use of research to develop materials and peer-education modules tailored to the specific life-situations of target groups;
- provision of options (e.g. female as well as male condoms, or the provision of lubricant for sex workers);
- inclusion of training to debunk moralistic and judgmental attitudes;
- development of meaningful relationships with target groups;
- use of workplace policy workshops;
- inclusion in the approach of care and counselling for HIV-positive sex workers; and
- involvement of the media, to encourage other companies to be part of the initiative.

Outcomes: As a result of the programme, after 18 months participation in line-ups had fallen – in baseline surveys 10 per cent of the men reported having been involved in a line-up during the previous week, and the figure

⁹ This is the term used for coercive group sex in Papua New Guinea (Source, 57).

was 4 per cent nine months later. The frequency of gang rape was halved, from 10 per cent to 5 per cent. Follow-up also established that policewomen were becoming actively involved in protecting sex workers. In a number of cases, sex workers were able to report, and ensure the prosecution of, policemen who had raped them.

Sex workers' total condom use increased from 20 to 43 per cent. Total condom use with casual and commercial sex partners increased from 49 to 70 per cent.

Lessons learnt: The success of the TRANSEX project is due to several factors.

- Extensive qualitative research on the real contexts of risk-taking by vulnerable groups can be critical to the development of materials and peer-education modules tailored to specific life-situations.
- Training to debunk moralistic and judgmental attitudes is important. It requires time and effort, but it supports the development of meaningful relationships with target groups.
- Sex workers can become a major part of the solution, despite their illegal status.
- Workplace policy workshops are highly useful but must be well prepared and implemented by knowledgeable staff.

Case Study 37: Thailand – Thailand Business Coalition on AIDS (TBCA) and Shell: Peer Education at the Pump Project (PEPP) (Source 55)

Context: In 1992 the Shell Company Thailand established a comprehensive, non-discriminatory HIV and AIDS policy as part of a much wider occupational health policy. Shell recognized at an early stage the potential impact that HIV could have on the workplace and workers, and, as a consequence, on the operations of the company.

Workplace link: For the Shell Company of Thailand, the programme has strong perceived benefits. The workplace HIV and AIDS education is considered a key instrument in improving and safeguarding staff morale and productivity.

Aims/activities: In 1997, the Shell Company of Thailand entered a partnership with the Thailand Business Coalition on HIV/AIDS (TBCA) and the United Nations Children's Fund (UNICEF), to implement the Peer Education at the Pump Project (PEPP) at its petrol stations.

This project aimed to provide HIV and AIDS education to fuel attendants at 75 Shell petrol stations in Bangkok and Chiang Mai. Fuel attendants are considered a high-risk group – the majority of them are young; they have frequent interactions with truck drivers and other transportation workers; they are mobile and have poor incomes. A percentage of pump attendants supplement their resources with sex work or use the services of sex workers based around the pump stations.

The approach included recruiting pump attendants to act as peer educators. Most of the peer educators were deliberately chosen from among head pump attendants and cashiers to ensure greater sustainability for the venture, as these groups' turnover rates are lower. The PEPP training curriculum was designed by the Programme on Appropriate Technology in Health (PATH), and covered family planning, HIV and AIDS education and prevention, STIs and drug abuse.

Peer educators were given information, education and communication materials to facilitate their role, which was to change attendees' misconceptions and banish ignorance. In order to maintain momentum and interest, the peer educators were asked to complete a personal action plan. The TBCA facilitated competitions and exhibitions at the Shell pumps, along with regional meetings for peer educators.

Outcomes: The PEPP programme has been successful enough to encourage other oil companies to replicate it at their petrol stations.

Lessons learnt:

- Workplace HIV and AIDS education can play an important role in improving and safeguarding staff morale and productivity, whereas inaction could have serious consequences for businesses.

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- The potential exists for reaching a much wider audience via trained fuel attendants, as petrol stations can be places where sex workers find their clients – particularly truckers, who can be significant vectors of HIV and AIDS.

2.4 PRISON POPULATIONS

HIV prevalence for prisoners in many countries is significantly higher than that for the general population. Many prisoners contract their infection outside the institutions prior to imprisonment. However, the risk of being infected in prison is considerable – particularly through sharing of needles and unprotected sex. Outbreaks of HIV infection in prisons demonstrate how rapidly HIV will spread in environments of this kind unless action is taken. HIV and AIDS, STIs, hepatitis C virus (HCV), and TB are thus significant health threats to prisoners, and prison staff and their families. They also constitute a burden for prison and public health authorities and governments. This notwithstanding, responses to HIV, TB, hepatitis C and other infectious diseases in prison settings have largely been inadequate, or non-existent. (UNODC, 2010).

However, there is evidence that educational activities in prisons can make a difference (Source 49). The next section contains some examples of prison-based initiatives.

AFRICA

Case Study 38: Zambia – Inmate peer educators are essential to prison-based HIV testing and TB screening (Source 29)

Context: Like many of its neighbouring countries, Zambia faces a generalized epidemic, with an adult HIV prevalence of 17 per cent. High levels of HIV and TB, poor health services, overcrowding and a lack of human and financial resources are common problems for prisons in sub-Saharan African countries, including Zambia.

Workplace link: Prisons are workplaces for prison officers and security guards. Working through prisons, it is possible to expand HIV programmes by engaging prisoners.

Aims/activities: Severe staff shortages, and the need for inmate buy-in, led to the decision to recruit and train inmates to assist in the implementation of prison-based HIV testing and TB screening. The initiative was put in place by the Zambia Prisons Service (ZPS) and the Zambian Centre for Infectious Disease Research, in 2010 and 2011.

Eligible recruits were chosen by prison officers and received five days of training to enable them to complete symptom assessments, refer inmates for TB/HIV screening, collect sputum, assist with enrolment into National HIV and TB treatment programmes and provide educational outreach and counselling. A key aspect of the programme was the recruitment, mobilization and mentoring of inmate drama-group members (from existing drama groups in prisons) to convey health messages through acting, music and dance.

Outcomes: The programme successfully trained a total of 74 peer educators and 57 drama-group members. Between November 2010 and September 2011, inmate peer educators guided 6,436 inmates through HIV testing and TB screening (on average 32 inmates were screened per day).

Lessons learnt: Some challenges that the programme faced were: requests by prisoners who worked as peer educators for incentives, concerns about TB exposure and the difficulty of maintaining adequate numbers of peer educators (the latter due to inmate release and transfer). Solutions included: promotions of prisoners within inmate hierarchies, provision of N95 respirators and additional training to maintain peer numbers and establish peer-to-peer mentorship. Close links with prison staff were essential to the resolution of these issues, and contributed to the initial success of this programme.

AMERICAS

Case Study 39: Canada – Prisoners' HIV/AIDS Support Action Network (PASAN) (Sources 69, 79 and M25)

Context: Gay men and other men who have sex with men continue to be the population most affected by HIV and AIDS in Canada, accounting for an estimated 48 per cent of all HIV infections. Estimates of HIV prevalence in Canadian federal and provincial prisons range from two to eight per cent, or at least ten times the prevalence in the general population.

Workplace link: The workplace in this case is both a place of residence and work for prisoners, as well as a place of work for prison guards and others who have regular contact with prisoners.

Aims/activities: PASAN was established in 1991 as a grassroots response to the problem of HIV and AIDS in prisons. The objectives of the PASAN initiative are to reduce behaviours that put people at risk for HIV and hepatitis C infection; enhance access to HIV, hepatitis C and STI prevention materials; and promote sexual health. In addition, the programme addresses social and economic factors that are related to discrimination, poverty, race, sexual orientation, culture, gender, language skills, age, physical or mental ability and seropositivity.

The initiative actively involves former prisoners, as board members and as outreach and activism staff. The support of the prison administration and staff is important, and PASAN has conducted educational workshops and consultations with prison staff to ensure their support.

PASAN operates the only national AIDS hotline that is specifically for prisoners, as well as providing individual support counselling, advocacy, pre-release planning and referrals for prisoners and youth in custody living with HIV or AIDS. It operates primarily in institutions in the Ontario region. PASAN has also published numerous resources, including the first-ever study on women and HIV and AIDS in prison (Source 80), and a quarterly

newsletter, Cell Count, which it distributes to prisoners, institutions and agencies across the country.

Outcomes: The PASAN approach was formally evaluated in 2002, and the report found that HIV prevalence in prisons had increased. It highlights some significant positive developments, including the introduction of innovative educational approaches. However, challenges have persisted, including: insufficiently strong government leadership; inconsistent and poor coordination between partners; insufficient supplies, and breaks in the provision of supplies and services such as condoms and testing; as well as reluctance by authorities to embrace a harm-reduction approach. The non-mandatory nature of the education programme is also highlighted as a flaw.

Lessons learnt: The problems experienced by PASAN highlight difficulties related to this particular work environment and coordination between actors, as well as the need for strong policy support for initiatives. The programme's difficulties also show that evidence of what works may not always be politically palatable.

Case Study 40: Canada – Choosing Health in Prisons (CHIPS) (Source 81)

Context: Please refer to the 'Context' section for the previous initiative.

Workplace link: Prison staff and structures are actively involved in providing services to the prison population.

Aims/activities: Choosing Health in Prisons (CHIPS) is a voluntary programme offered by Correctional Service Canada (CSC). Every prisoner entering a federal prison in Canada is eligible to be in the programme. Prison health care at Stony Mountain has made the CHIPS programme a priority at intake. The programme is run every two weeks by a designated facilitator and takes a full five days to complete, during which time prisoners receive their regular pay. This constitutes an important incentive to participate.

Ninety-four per cent of the prison population goes through the programme. Prisoners who are not able to attend CHIPS because they cannot mix with the population are given a Reception Awareness Package (RAP) in segregation, and told that they can ask questions at any time.

The programme covers HIV and AIDS, HCV, STIs, harm-reduction and other health-related concerns. The approach recognizes differences within and between groups and adjusts the course content accordingly. Facilitators use a variety of learning tools (audio, visual, verbal, kinaesthetic and written), in addition to playing games and showing videos, to keep groups engaged in the learning process. Some of the course focuses on the prison environment, and peers (i.e. other prisoners) come in to talk about how to stay safe in prison.

Outcomes: The programme has resulted in an increase in HIV and HCV testing. As a result of the CHIPS programme, about 85 per cent of the prison population has sought testing for HIV and AIDS, and there is an equally high rate of immunization against hepatitis A and B.

Lessons learnt:

- Peer education is an important part of the learning process for inmates. It has allowed new prisoners to have a better understanding of the risks involved in particular activities.
- Buy-in from prison staff is critical to the programme's success. Liaising with, and mobilizing, prison staff has ensured that the programme is part of the regular prison planning and monitoring systems. The staff responsible for prisoner intake now view the programme as a priority, which contributes to its high completion rate.

ASIA AND THE PACIFIC

Case Study 41: Bangladesh – Prison prevention programme (Source 52)

Workplace link: Prisons are workplaces for prison officers and security guards. The approach used prisons as entry points to increase access to HIV services for key populations

Aims/activities: In 2010 the United Nations Office on Drugs and Crime (UNODC) initiated an HIV-prevention programme in prisons in Bangladesh. It implemented the programme, through a partnership with NGOs and Government, in six prisons in the cities of Dhaka and Rajshahi. The basis for the programme was a situational assessment that was conducted in twelve prisons, of which six were selected for the initial activities. Major programme activities include:

- advocacy and sensitization;
- training of health workers working under prison and health authorities on HIV, AIDS, STIs and TB;
- identification and training of peer educators and peer volunteers from among prison inmates;
- provision of HIV and AIDS and STI education through peer educators and volunteers using Information, Education and Communication materials (IEC) specifically designed for prison inmates;
- STI and TB treatment; and
- provision of ART to HIV-positive people.

The programme's motto is "Prison Health is Public Health" – prisoners and prison staff are in continuous contact with the community, and prisoners come from the community and most rejoin it once they have served their time. It makes use of ideas that have proven successful in previously implemented prison programmes, including:

- innovative techniques, such as getting prisoners to script their own plays and present them to the prison community – thus enhancing the relevance of the issues to prisoners' own lives and communities;
- quiz competitions organized by jailors and site officers; and
- interactive sessions, facilitated by prison staff and external NGO staff, on health issues related to drugs, HIV and AIDS and STIs, to encourage inmates to exchange their views.

Outcomes: Preliminary findings suggest that the educational programmes have played an important role in reducing staff members' and inmates' fears about HIV and its transmission, and have increased uptake of testing by both groups.

Lessons learnt: Accurate and sufficient information for staff and inmates can affect institutional policies in ways that can profoundly alter prisoners' lives.

EUROPE AND CENTRAL ASIA

Case Study 42: Albania, Serbia and the former Yugoslav Republic of Macedonia – Encouraging authorities to contain the HIV, TB and hepatitis C epidemics (Source 70)

Context: HIV, TB and hepatitis C and B prevalence is significantly higher in prisoners in most countries of the world than in the general population.

Workplace link: Prisons are workplaces for prison officers and security guards. Through these workplaces, it is possible to extend HIV programmes to prison inmates.

Aims/activities: In 2011 UNODC introduced a project focused on “Ensuring relevant authorities act to contain the HIV/TB/Hepatitis C epidemics among drug users and in prison settings in Albania, Serbia and the FYR of Macedonia”.

The project aimed to increase injecting drug users' and prison inmates' access to comprehensive HIV and AIDS, hepatitis C and TB prevention and care services in Albania, Serbia and the FYR of Macedonia. Working with representatives of Ministries of Justice and civil society organizations, the initiative conducted policy assessments to ascertain the availability of comprehensive HIV prevention and treatment services for drug users and prison inmates in the three countries. The results were shared with key stakeholders and led to the establishment, in each country, of a national Technical Working Group (TWG). These groups include representatives

of prison health staff, prison administration, judicial authorities, national health services and NGOs. The TWGs, in cooperation with Ministries of Health and Ministries of Justice, planned specific interventions for the prevention, diagnosis and treatment of HIV and HCV in prisons. Training for prison staff has included best practice approaches in HIV/TB/HBC prevention in prison institutions.

Outcomes: As this is a relatively new initiative it remains to be evaluated and it is too early to draw lessons from it.

LESSONS AND ISSUES FOR REFLECTION

This report presented 42 case studies, highlighting a range of ways in which workplaces and/or workforces were used to provide HIV services to key populations in different epidemic settings.

Universal key populations (Chapter four)

The first case studies presented focus on access to HIV services through workplace structures, or the people working within those structures, for the groups considered universal key populations: sex workers, men who have sex with men, transgender populations and injecting drug users. These groups comprise universal key populations because, in virtually all contexts, they have a higher HIV prevalence than the general population. Key populations are *hard-to-reach* populations. Many structural and programmatic barriers make it difficult to increase their access to HIV services. Issues such as stigmatization, discrimination and criminalization compound the difficulty. The various initiatives and programmes discussed here identified innovative ways to bring HIV services to these hard-to-reach populations. Massage parlours, brothels, hotels, saunas, gay clubs, motels, restaurants, beauty salons and itinerant barbers were identified and used as workplaces (or workers) through which or through whom, reaching sex workers, men who have sex with men, transgender populations and injecting drug users was made easier. HIV information and services were made available through these workplaces. The decisions to adopt these workplace approaches were informed by research and evidence on the behaviours of key populations. In many countries, workers in the selected workplaces received training and were equipped to reach out to their clients, who tended to be members of these difficult-to-reach groups. For example, sauna workers in Thailand acted as educators, and supported men who have sex with men to access HIV services; and in India, itinerant barbers and workers in transgender beauty salons were used, respectively, to reach sex workers and transgender people. In some circumstances, workers themselves were members of key populations – certain approaches, therefore, used key populations to reach key populations. The country case studies that this report presented are

important because they provide policy makers and programme implementers with models of creative ways in which workplaces' potential can be fully harnessed to support national efforts to combat HIV and AIDS. In order to optimize the use of the workplace, a paradigm shift in the way "HIV workplace programmes" are conceived of is essential.

Other key populations (Chapter five)

This section dealt with key populations who, whilst not universal, are disproportionately affected by the HIV epidemic in their respective countries. These groups include, *inter alia*, migrant workers, transport workers, farm workers, mobile populations, garment workers, port and fishery workers, truckers and mine workers. Because of the lack of stigma, discrimination, criminalization and other barriers, these groups are easier to reach than universal key populations. In many countries, they are reached with HIV services through their workplaces, which may be in the public or private sectors and in the formal or informal economies. HIV workplace programmes that bring services to *context-specific key populations* can be described as programmes that use workplace intervention to reach women and men workers. HIV workplace programmes that bring HIV services to *universal key populations* can be described as programmes designed to reach workers' clients – hence these programmes work *through* the workplace. Many programmes combine both approaches, and cannot be straightforwardly categorized as one or the other type of initiative. However, a clear understanding of the difference between these approaches is critical for conceptualizing and designing new programmes.

Good practice, challenges and strategies

Many of the case studies presented share common features that have been identified as contributors to their success as HIV workplace programmes. These were presented in the Executive Summary, and are also compiled here.

- To ensure that the planned interventions meet key populations' specific needs, it is important to identify the problem, and potential solutions – ideally making use of opportunities that exist locally – through careful

initial research. Evidence must underpin and lead HIV workplace programmes.

- Follow-up research was undertaken in many countries to ensure that the approaches and interventions were continuously adapting to change. Universal key populations are sometimes very mobile, and hence it is important to make sure that programmes continue to consistently meet their needs.
- There is, currently, some knowledge on what works with key populations. It is important that the information available be used to inform the design of HIV workplace programmes targeting key populations.
- Various mapping techniques proved useful in identifying key populations, as well as workplaces that could be used to reach them. It is important to determine which specific HIV services key populations need. A workplace is only useful if it serves as a channel to reach key populations, and if, through it, they can be provided with services that benefit them.
- The direct involvement of key populations in the design, implementation, monitoring and evaluation of programmes is essential. No-one understands the needs of key populations better than they themselves.
- Institutional involvement, and commitment from the management of workplaces, are important elements of workplace programmes. Whether services are made available at the workplace, or the workplace is simply a conduit for access to information and services, management commitment and support is crucial.
- It is important to make businesses aware that such interventions make sense and can benefit them. A business case for an intervention can ensure buy-in and ownership. The gains for businesses may be, *inter alia*, financial or reputational, or improvements in the quality of service or in the customer or client care that they are able to provide.
- Peer education plays a significant role in many of these programmes. Carefully selected, well trained, well equipped and effectively monitored peer educators are key to reaching key populations through HIV workplace programmes.

- Involving communities and local government authorities, through advocacy and direct partnerships, is key to ensuring buy-in at community, or local, level. The involvement of traditional authorities, when possible, also enhances local buy-in. Working with local government supports the sustainability of programmes.
- Interventions should be closely linked to high-quality, non-judgmental and accessible public health services and other public services, to enable key populations to access a wide range of services according to their needs.
- A good partnership with the police and other law enforcement agencies is essential, especially when programmes' focus is on universal key populations.
- Policies and codes of good practice for entertainment institutions can be useful means for ensuring that all the women and men workers in those institutions adhere to minimum standards of protection.
- Addressing underlying factors that contribute to key populations' vulnerability to HIV and AIDS – for example, focusing on the economic empowerment of key populations and finding ways to increase their income levels – is an important part of these programmes.
- In some countries, multi-media and entertainment approaches were instrumental in reducing the high levels of stigma associated with working with key populations. Enter-educational approaches are extremely useful tools for breaking the ice and reducing stigmatization and discrimination.
- It is important to ensure that programmes include mechanisms for continuous learning, adaptation, monitoring and evaluation. We can only truly learn about the effectiveness of a programme if, embedded in it, it has a system that allows it to track its progress.

The case studies also highlight some common challenges. Monitoring and evaluation often emerge as weaknesses. Quite a number of promising interventions were not robustly monitored, therefore, there is an absence of information on their outcomes. Other promising interventions had to be cut short, or discontinued entirely, due to difficulties obtaining funding. Stigma and discrimination also pose major challenges to many of these

programmes – especially those that focus on universal key populations. The lessons learnt from this examination of a broad selection of programmes and projects can be most usefully summarized as a set of working strategies or guidelines for policy makers and practitioners. Programme implementers should...

- understand the problem;
- raise awareness about the extent of the problem;
- create an enabling environment, including by providing means (or access to means) for behaviour change;
- ensure broad involvement – all actors should have meaningful roles and incentives to participate, and their concerns should be respected;
- establish mechanisms for listening, learning and adaptation;
- ensure access to sound technical and organizational assistance for key partners; and
- monitor and evaluate programmes.

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ANNEX 1 – OVERVIEW OF KEY WORDS USED FOR THE LITERATURE SEARCH

| All | And | Key populations | Workplace/where | Other |
|-------------------|---|---|---|--|
| HIV AIDS TB | Prevention Treatment Care Support Services Economic Empowerment | PLHIV PLWHIV Intravenous Drug User Sex worker Prostitute Men who have sex with men Gay Lesbian Bisexual Transgender LGBT GBT Key population Migrant Truckers Refugee(s) Mobile populations Prisoner(s) Uncircumcised men People with disabilities Rickshaw puller(s) Commercial Sex Worker Dock workers Sailors Entertainment worker Performer | Massage parlour Massage parlor Sex establishment Hospitality industry Hotel Motel Brothel Workplace Work Market Border Hairdresser Health facility Clinic Barbers Fairs Department of motor vehicles Drugstores Motorcycle taxi drivers Shoe shiners/shoe shine stores Beauty salons Hairdressers Nail salons Liquor stores Check cashing services Army Police/ police department Wine shops Domestic workers Law offices Pawn shop Butcher Bar Club Fast food restaurant Bodegas Laundromat(s) Karaoke lounge Escort services Hostels Go-go bars Beer garden Discotheque Ballroom Entertainment services | Policy Policies Programme Program Gender Hyperendemic Generalised Concentrated Best practice Innovative Case study Pilot Management Managers Staff Owners Business |

ANNEX 2 – OVERVIEW OF INTERVENTIONS RETAINED FOR THIS REPORT BY KEY POPULATION GROUP

| No. | Title of the intervention | Intervention purpose/type | Year | Country | Target group | Leading organization | Workplace link | Evaluation/ results available |
|--|---|---|--------------|--------------------|--------------------------------|--|--|-------------------------------|
| 1. CONVENTIONAL KEY POPULATION GROUPS (FOUND IN ALL SETTINGS) | | | | | | | | |
| 1.1. KEY POPULATION: SEX WORKERS (SW) | | | | | | | | |
| 1 | The Sonagachi project – Involving brothel owners in the empowerment of SW | Provision of a co-operative finance scheme, skills training, social marketing of condoms, and prevention of trafficking | 1992 | India | Sex workers and brothel owners | All India Institute of Public Health and Durbar Mahila Samanwaya Committee | Brothels | Yes |
| 2 | The SMARTgirl initiative for Entertainment Workers (EW) | Promote risk reduction and safer sexual practices among EM | 2008 | Cambodia | EW and clients | PRASTI/ FHI-360 | Clubs, special events, other entertainment events | Yes |
| 3 | Health Project for Asian Women (HPAW) | Providing HIV prevention training to massage parlour owners as well as access to counselling | 2001-2004 | USA, San Francisco | SW | Department of Health | Massage parlours | Yes |
| 4 | Programme de Prévention et de Prise en Charge (PPP) | Condom promotion, and general SRH promotion | 1990-1999 | Cote d'Ivoire | SW and sex partners | Institute of Public Health/ National AIDS Programme | SW worksites and surrounding areas | Yes |
| 5 | Avahan | Provide focused HIV prevention and services for SW, IDU and MSM | 2004 onwards | India | SW, MSM, IDU | National AIDS Control Organization | Brothels, lodges, health service providers, drop- in centres | Yes |
| 6 | Community Based Enterprise Development Training for Sex Workers | Reduce dependency and vulnerability of SW | 2010 | Thailand | Sex Workers | Empower Foundation with support from ILO | New business activities by SW | No |

| No. | Title of the intervention | Intervention purpose/type | Year | Country | Target group | Leading organization | Workplace link | Evaluation/ results available |
|-----|---|--|--------------------|----------|--|--|--|-------------------------------|
| 7 | Provision of Entrepreneurial Training to Taxi Drivers | Reduce dependency/vulnerability on SW by bicycle taxi drivers | 2010 | Malawi | Bicycle taxi riders (many of whom engage in sex work) | Karanga Cargo Association with support from ILO and SIDA | New business activities by SW | Yes, anecdotal |
| 8 | Saint James Infirmary | Prevention and treatment of HIV for SW | 1992 onwards | USA | Sex workers | Occupational Health and Safety Board, and coalition of SW rights groups | Establishment of a peer run and peer based clinic for health and HIV needs | Yes |
| 9 | Service Workers in Group (SWING) | Provision of HIV and health services | Late 1990s onwards | Thailand | Male and transgender sex workers, later expanded to all SW | FHI-360 Communities (providing donations) | Entertainment venues (bars, etc.), and partnerships with police and health services | Yes, limited |
| 10 | TAMEP (Transnational AIDS/STD Prevention among Migrant Prostitutes in Europe Project) | HIV and STD prevention by promoting safer sex and access to services | 2000 onwards | Europe | Migrant SW | TAMPEP – European Network for HIV and STI Prevention Promotion Among Migrant Sex Workers with support from EC and other donors | Owners of prostitution venues and key persons in the environment e.g. forces of public order | Yes |
| 11 | Acodex Night Patrols | Addressing HIV among male and transgender sex workers | 2009 onwards | Cameroon | Male and transgender sex workers | Acodex | Dating sites, sex establishments (brothels, bars, nightclubs, massage parlours, restaurants, homes of sex workers) | No |
| 12 | Barbers and hair dressers as information hubs | Provide HIV and AIDS prevention information | 2008 onwards | Guyana | Young people and SW | UNFPA | Barbers' shops/hair salons | Anecdotal |

| No. | Title of the intervention | Intervention purpose/type | Year | Country | Target group | Leading organization | Workplace link | Evaluation/ results available |
|---|--|---|-------------|----------------------|---|---|--|-------------------------------|
| <i>1.2. KEY POPULATION: MEN WHO HAVE SEX WITH MEN (MSM)</i> | | | | | | | | |
| 13 | Down Low Barbershop Programme | HIV prevention, condom distribution, and promoting access to counselling and testing | Early 2000s | USA, Seattle | Black MSM | US Department of Public Health | Barbershops | No |
| 14 | Reducing HIV vulnerabilities of MSM using saunas | Promoting safer sex among high risk sauna workers and sauna users | 2012 | Thailand | MSM working in and frequenting saunas | ILO, the Bangkok Rainbow Organization (BRO) and the Rainbow Sky Association (RST) and various government offices and donors | Saunas | No |
| 15 | Venue Based Interventions for MSM | Increase negotiation skills, enhance knowledge, strengthen referral | Mid 2000's | UK | MSM | Local community organizations | Gay pubs, clubs and bars | No |
| 16 | "Play Zone" – Promoting codes of good practice and minimum standards for entertainment areas | Create a safer environment in entertainment areas, raise awareness of sexual health, reduce STI and HIV infection | 2008 | UK | MSM clients and workers in saunas, bars and clubs | Terrence Higgins Trust | Saunas, bars and clubs | No |
| 17 | The Everywhere Project | HIV prevention through adoption of Codes of Good Practice | 2008-2010 | Europe (8 countries) | MSM | EC Public Health Programme with 17 partners | Gay business owners (hotels, sex venues, travel agencies, gay dating websites) | Yes (for the pilot phase) |
| 18 | The Gay Men's Task Force (GMTF) | Peer education of gay men to reduce sexual risk taking and increase uptake of services | 1990s | Scotland | MSM | Community level agencies in Glasgow | Bars, MSM specific medical services | Yes |

| No. | Title of the intervention | Intervention purpose/type | Year | Country | Target group | Leading organization | Workplace link | Evaluation/ results available |
|--|---|---|-------------|------------|--|---|--|-------------------------------|
| 1.3. KEY POPULATION: PEOPLE WHO INJECT DRUGS (PWID) | | | | | | | | |
| 19 | Itinerant Barbers | Uprake of services by IDU and SW | 2004-2005 | India | IDU | NAC India and Association Francois-Xavier Bagnoud (Swiss) | Itinerant barbers who move from place to place | No |
| 20 | Barbers, Shoeshine Boys, Motorcycle Taxi Drivers & Workplace Advocates engage in HIV prevention and access to treatment | Reduce risks of HIV transmission associated with IDU and inconsistent condom use | Early 2000s | Vietnam | IDU | The Provincial Health Department, The Provincial AIDS Standing Bureau FHI, funding from USAID | Barbers, shoeshine boys, motorcycle taxi drivers, workplace advocates in places where IDU and unsafe sex takes place such as hotels, truck stops, sea ports, river ports, etc. | No |
| 1.4. KEY POPULATION: TRANSGENDER PEOPLE | | | | | | | | |
| 21 | The Tamil Nadu Transgender Welfare Board | Provide HIV prevention services and other social services to trans- gender women | 2008 | India | Transgender women (known as Aravansis) | Ministry of Social Welfare | Local businesses (to assist in awareness raising) | Partially |
| 22 | Transgender Beauty Parlour in Delhi | Promote HIV prevention and access to care for transgender persons | 2009 | India | Transgender persons | Pahal Foundation (Indian NGO) in collaboration with local community | Beauty parlour for transgender persons | No |
| 2. KEY POPULATIONS THAT VARY BY SETTING | | | | | | | | |
| 2.1. KEY POPULATION: MIGRANTS AND THEIR FAMILIES | | | | | | | | |
| 23 | EMPHASIS – Enhancing Mobile Population's Access to HIV & AIDS Services, Information and Support | Obtaining broker assistance to reach cross border mobile populations with HIV prevention and services | 2009-2014 | Bangladesh | Migrants in transit areas | CARE India, Bangladesh, Nepal with funding from the BIG Lottery Group in the UK | Stop over points for migrants in transit | No, |

| No. | Title of the intervention | Intervention purpose/type | Year | Country | Target group | Leading organization | Workplace link | Evaluation/ results available |
|-----|--|--|--------------|----------------------|--|---|--|-------------------------------|
| 24 | HIV doesn't stop at borders | Provision of services and supplies to reduce the risk of HIV infection | 2010 onwards | Sri Lanka | Temporary migrants (especially women) to Gulf countries | ILO | Official offices that need to be contacted as part of the pre-departure procedure | No |
| 25 | The Transport Corridor Initiative in Southern Africa | HIV prevention and access to key services for cross border migrants and their families | 2007 onwards | Southern Africa | Transportation/mobile workers | ILO, with funding from SIDA | Cross border routes and also cross border institutions such as customs agencies, small traders | No |
| 26 | The Hometown Fellow Campaign | Use of media (film) at inter-provincial transportation routes to provide HIV prevention information | 2009 onwards | China | Migrant construction workers | ILO, Ministry of Labour, employer and worker organizations, 19 large scale construction companies | Technical training institutions, national railway stations, other stop-over points along transportation routes | No |
| 27 | The PHAMIT 'friendly skies' programme | Increase condom use and reproductive health practices, access to health services | 2003 | Thailand/ Myanmar | Migrants, their dependents, and related entertainment workers | Eight NGOs, the MOPH, funding from the GFATM | Key contact points along areas of migration and movement involving various types of commercial work | Yes |
| 29 | Sensitizing farm owners, supervisors and workers on gender dynamics | Create awareness among farm workers of gender dynamics and provide access to services | Mid-2000's | South Africa | Commercial farm labourers and farm managers, as well as officials such as police | Hoedspruit Training Trust, in collaboration with the IOM | Commercial farms | No |
| 30 | Establishment of a department of human rights by the Dubai police department | Strengthen the protection of women who are victims of sex work trafficking and provide access to HIV prevention and testing services | 2006 | United Arab Emirates | Women at risk of sex work trafficking | Dubai Police Authorities | Dubai Police Department office | No |

| No. | Title of the intervention | Intervention purpose/type | Year | Country | Target group | Leading organization | Workplace link | Evaluation/ results available |
|---|--|--|--------------|------------------------|--|--|--|-------------------------------|
| 2.2. KEY POPULATION: GARMENT INDUSTRY WORKERS | | | | | | | | |
| 31 | Chittagong (Bangladesh) – Garment Industry, women and female sex workers | Provision of life-skills based peer education to change health care behaviour and prevent HIV/AIDS | 2008–2012 | Bangladesh | Women in garment industry & in SW | Young Power in Social Action (PYPSA), with the HIV/AIDS and STD Alliance, FHI, GFATM and other donors. | Factories, with outreach to residential communities | No |
| 32 | Apparel Lesotho Alliance to Fight AIDS (ALAA) | HIV prevention and treatment for garment industry workers | 2006 onward | Lesotho | Women and wives of migrant workers | ALAA, with the Lesotho Network of AIDS organizations and donors | Textile factories | Partially |
| 2.3. KEY POPULATION: PORT, FISHERY AND TRANSPORTATION SECTOR WORKERS | | | | | | | | |
| 33 | AIDS Education Project for Truckers and sex workers | Peer based AIDS education for transport workers to reduce STI, and encourage condom use | 1992 onwards | Zimbabwe | SW and truckers | National Employment Council for Transport Operating Industry (NECTOI) | Truck stops along major highways | No |
| 34 | TRANSEX Project | HIV and AIDS prevention through outreach works and peer education | Late 1990's | Papua New Guinea (PNG) | Truckers, dock workers, union formed workers, SW | PNG Department of Health with funding from AUSAID | Strategic stops along main roads, informal workplace sessions at rest stops | Yes |
| 35 | Peer Education Kenya Ports Authority (KPA) HIV/AIDS Programme | Extend HIV prevention and treatment to port workers | 2000 onwards | Kenya | Senior management, union leaders, port workers | KPA, with FHI | Various workplace settings within and around ports, with outreach to communities | Yes |
| 36 | BCC programme to address stigma and discrimination among transport workers | A multi-month storytelling programme to mainstream HIV/AIDS awareness, decrease secrecy and discrimination | 2009 | Kenya | Truck drivers dockworkers, members of HIV positive groups, medical staff | International Transport Workers Federation | Involvement of union representatives to identify sub-groups | No |

| No. | Title of the intervention | Intervention purpose/type | Year | Country | Target group | Leading organization | Workplace link | Evaluation/ results available |
|-----|--|---|--------------|------------|--|---|---|-------------------------------|
| 37 | Stopping HIV/AIDS through Knowledge and Training Initiative (SHAKTI) | Peer education HIV/AIDS activities and partner tracking, increasing access to services | 1995 onwards | Bangladesh | Rickshaw pullers; truckers; and dock, ferry, and manual workers | Care Bangladesh, with funding from DFID | Partnership with transportation unions and informal work settings | Yes |
| 38 | The Walvis Bay Corridor Group (WBCG) Wellness Service | HIV prevention and treatment, condom distribution, entertainment facilities at high risk areas | 2010 onwards | Namibia | Ports, fishery and transportation sector workers | Key Ministries, GIZ, SIDA, USAID, SADC and other partners | Shebeens, bars, other entertainment sites, truck inspection sites | Yes |
| 39 | Peer education at the pump by Shell | Provide HIV/AIDS education for fuel attendants using a peer education approach | 1997 onwards | Thailand | Fuel attendants, head pump attendants, cashiers | Shell, Thailand Business Coalition on HIV/AIDS, UNICEF | Fuel stations and pump attendants and managers | No |
| 40 | Prisoners' HIV/AIDS Support Action Network (PASAN) | Decrease behaviours that put prisoners at risk of HIV/AIDS and hepatitis C in prisons | 1991 onwards | Canada | Prisoners, ex-prisoners, youth in custody and their families, prison administrators/ staff | PASAN | Prisons/ correctional institutions | No |
| 41 | Choosing Health in Prisons (CHIPS) | Provision of information on HIV/AIDS, HVC, STI, harm reduction and other health concerns through peer education | Since 1990 | Canada | All prisons population in targeted institutions, prison staff | Federal Government of Canada and all prisons | Prisons/ correctional institutions | Yes |
| 42 | Prison prevention programme "Prison Health is Public Health" | Provision of advocacy, sensitization, and HIV/AIDS and STI education for prison inmates | 2010 | Bangladesh | Inmates, prison staff, health workers | UNODC, NGOs, the Directorate of Prisons and six prisons | Prison settings | No |

| No. | Title of the intervention | Intervention purpose/type | Year | Country | Target group | Leading organization | Workplace link | Evaluation/ results available |
|-----|---|--|--------------|----------------------------|--|---|------------------------------------|-------------------------------|
| 43 | Inmate peer education programme | Using peer education for HIV prevention, TB screening, and access to services | 2010-2011 | Zambia | Inmates, prison staff | Zambia Prisons Service (ZPS) and the Centre for Infectious Disease Research | Prison settings | Yes |
| 44 | Encouraging authorities to contain the HIV/TB Hepatitis C epidemics | Increasing access to comprehensive HIV/AIDS, hepatitis C and TB prevention for IDU | 2011 onwards | Albania, Serbia, Macedonia | Drug users in prison settings, judicial authorities, CSO | UNODC, Ministry of Justice, and civil society organizations, national health services | Prisons/ correctional institutions | No |



**HIV/AIDS and the
World of Work Branch
(ILOAIDS)**

International Labour Office
Route des Morillons 4
CH-1211 Geneva 22
Switzerland

Tel: +41 22 799 6486
Fax: +41 22 799 6349

iloaids@ilo.org
www.ilo.org/aids



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