

PN-ACT-946

REPORT OF EXPERIENCE/LESSON-LEARNING
MEETING ON FEMALE SEX WORKERS INTERVENTIONS IN NIGERIA - HELD AT DFID
NIGERIA CONFERENCE CENTRE - 6TH JUNE 2002

Background/Introduction

The trend in HIV/AIDS infection in Nigeria indicates a steady increase among the general population. Statistics indicate that productive age group of 15 - 45 years is the hardest hit. It is believed that the activities in the sex trade industry have contributed to this situation. Over the years, a lot of groups and organizations have carried out intervention programs with Female Sex Workers (FSW) in different parts of the country to reduce high-risk behaviour among them. Considerable data and information exist on the work of these organizations. However, these experiences are not adequately shared to improve learning, programming and development of best practices for intervention among FSWs. DFID and USAID have over the time supported various non-governmental organisations working on HIV and STI prevention with FSWs. It is against this background that USAID in conjunction with DFID jointly agreed to bring their partners together to share experiences on their work with FSWs. It is envisaged that the experiences gained will be useful in the development of appropriate strategies for intervention among FSW in different geographic locations; as well as in contributing to development of national behaviour change strategy. Twenty-two participants were at the meeting.

Objectives

The key objectives for the exchange meeting were to: -

1. Share information, strategies and lessons learned from interventions with Female Sex Workers (FSW) for HIV/AIDS prevention.
2. Develop mechanisms for future coordination and collaboration among organizations working with Female Sex Workers.

Methodology

The meeting adopted facilitator-led participatory approaches to enable adequate participation and contribution by everyone present. The programme entailed short presentations by 5 organizations on their work with FSWs, followed by question-and answer sessions. It was jointly agreed that the presentations should reflect geographic coverage, strategies, lessons learnt, challenges, implications and recommendations, based on field experiences by the various organizations.

Presentation Outline

Participants at the meeting agreed on the following outline for presentation:

- 1 Geographical area of work
- 2 Strategies for working with FSW and their clients
- 3 Lessons learnt - what has worked and what didn't work?

- 4 Challenges and constraints
- 5 Implications and recommendations

It was also observed that classroom-sitting arrangement would not encourage sharing and therefore participants agreed and changed their sitting arrangement to a semi circle arrangement. The Women's Health Education and Development (WHED), Family Health International (FHI), Life Link Organization (LLO), Society for Family Health (SFH) and Liverpool Associates for Tropical Health (LATH) took turns to make presentations.

PRESENTATION BY WHED

Founded in Kano about nine years ago, WHED focuses on women. With funding from the British High Commission, the organization conducted a baseline survey on HIV/AIDS and STDs in Kano, establishing that the population had little knowledge as many attributed HIV/AIDS and STI infection to acts of God while some did not believe sex was the main infection route. Following the state adoption of the Sharia legal system, the programming environment in Kano became very difficult, thus forcing WHED to relocate to the Federal Capital Territory (Abuja). The NGO currently programs in Mabushi and Apo villages, targeting brothel based Female Sex Workers (FSWs).

Lessons

- Peer Health education raises self-value of FSWs, enabling some of them to attract men for marriage.
- Provision of stipend to peer educators encourages commitment.
- Availability of STI clinics to provide services to FSWs beef up their confidence and help to achieve project goals

Challenges

- In the Sharia environment gatekeepers such as traditional and religious leaders could constitute hindrance to project work. The introduction of Sharia necessitated relocation of project from Kano to Abuja.
- Frequent police harassment of sex workers tend to slow down work with FSWs

Family Health International

Family Health International, Nigeria, started programming with FSWs in 1988 and has accumulated diverse experiences and skills working with sex workers in the northern and southern parts of the country. FHI worked in Abia, Anambra, Cross River, Jigawa, Kano, Lagos and Taraba States but lately only in Abia, Anambra, Lagos and Taraba States. Experiences from its initial work with FSWs in Calabar have been documented. The publication, which details the structure in brothel-based sex work, procedures for rightful entry into the sex workers community and development of local policies, was given out.

Strategies:

- Advocacy/development of local policies
- Risk Reduction Communication

- STI Treatment
- Condom Access
- Capacity Building

Lessons Learnt:

- Empowerment of FSWs with negotiation skills for safer sex and recognition of STIs led to increased condom use
- Relapse in behaviour was observed among FSWs especially those that have relocated. More emphasis should be given to condoms selectively with their clients. In addition, FSWs should use condoms with all types of partners.
- STI clinics dedicated to provide services to sex workers are very expensive to run, and have not been found to be sustainable. High cost of drugs also militates against FSWs' ability to access quality STI services. However, FSWs will use the STI clinic if the services are good
- There is need for continuing training of peer educators to update the knowledge of existing peer educators and bring up new ones to cater for cases of attrition following the itinerant lifestyles of FSWs
- Special focus for HIV prevention should be given to young FSWs due to high incidence of STIs
- Involvement of clients of FSWs is critical to the success of the sex work project
- Films and audio-visuals can have a powerful impact on FSWs and clients
- The vocational schools for FSWs should admit non-FSW to avoid stigmatisation of sex workers
- FSWs trained in vocational skills will need micro-credit to enable them set up in the newly acquired skills

Challenges

- How to deepen the quality of peer education and prevent monotony of messages delivered by peer educators
- To institutionalize condom use in brothels and achieve 100% condom use among FSWs and all types of clients
- Network with other groups and players to reach sex workers who relocate
- Deal with high cost of treatment and drugs for management of STI

Recommendations

- Continuous training for peer educators to ensure constant level of educational outreach, refresh old peer educators and engage new ones
- Involvement of FSWs and their clients in HIV/AIDS/STI interventions critical to the programmatic sustainability of such interventions
- Advocacy at all levels is important in the intervention work on HIV/AIDS. All key stakeholders should be involved in Project Advisory Committee (including the police).
- The Project Advisory Committee provides a platform for critical high-level and community based interaction for relevant and appropriate feedback to improve the quality, community acceptance and overall sustainability of sex workers' projects

- Integrated approaches are better in targeting HIV/AIDS issues at the state and national levels (prevention and care should go hand in hand)
- FSWs who undergo vocational training will need revolving seed grant (micro-credit) to resettle in their skills. Groups that specialize in micro credit are required to complement work focused on Behaviour Change Communication
- Films could be used to make powerful impact on FSWs and their clients.

Life Link Organisation

The organisation was founded in 1994 as a non-profit, non-governmental organization with a mission to provide health services through dissemination of information, education and counseling to the members of the community using well-trained personnel. LLO works in 100 brothels in five local government areas in Lagos State. These are Apapa, Amuwo Odofin, Ajeromi- Ifelodun, Mainland and Ojo LGAs.

Strategy

The project relies on advocacy, peer education, referral for STI management.

Activity Description

The project works through peer educators in brothels. These Peer Educators undergo cycles of training/workshop. This is to ensure that attrition of FSWs because of their itinerant nature is compensated for. Project Advisory Committee (PAC) comprising of brothel owners/managers, LG representatives, chairladies of brothels and the police to give social support and acceptance was also constituted.

Challenges

- Non-availability of female condom to provide choice and female empowerment
- Occupational hazards for project implementers in brothels
- Gold Circle breakage by some FSWs
- Mobility of sex workers
- Project vehicle needed because sites are flung
- PHEs expect gratification after meetings/programmes.

Lessons Learnt

- Sex workers are now relaxed and see the project's benefits after the initial apprehension and hostility.
- Involvement of all stakeholders in activities like PAC and training/workshops ensure support and ownership of interventions
- Training and skill acquisition of FSWs enhances their self esteem

- o Drama is a very good tool of IEC
- o STI counseling enhances FSWs health seeking behaviour.
- o User friendly IEC materials enhance better understanding of subject matter

Recommendations

- o Brothel-based workshops/training for FSWs should be regular due to their high mobility.
- o Consideration should be given to drug/substance abuse integration into FSWs' HIV/AIDS intervention.
- o Due to the relative stability of the brothel managers and barmen, they should be a special group for targeting; LLO intends to have a special intervention for them.

Society for Family Health

SFH brothel work started in 1994 with the recruitment of 5 Motorcycle Sales Representatives (MSRs). This was later scaled up with the recruitment of more men and women to work in all SFH regions (12) throughout Nigeria. As the name suggests these people were to ensure the availability of condoms in the brothels. In the course of their duty, it became obvious that they needed to add IEC to complement condom distribution. This was achieved with the use of audiovisual materials – video and television to really bring home the reality of HIV/AIDS in Nigeria. Condom demonstration was also an integral part of the IEC as there were a lot of myths surrounding its use.

To enhance the MSRs' skills in handling objections encountered in the field, comprehensive sexuality education training was done by SEICUS from US in 1996. This started SFH progress from being just a condom distribution organization to a behaviour change entity. A shift was made in 1998 from using audiovisual equipment's in IEC to flipchart. This was done to make the program more interactive, less cumbersome and less expensive.

In June 1999, two-week effective outreach communication training was organized for the field by John Hopkins University Baltimore USA. This was followed by the development of Regional Communication Plan by each region. After a year of using the Regional Communication Plan, an evaluation of this method was done among FSWs to see if it was effective. In various Focus Group Discussions (FGDs) conducted by SFH, one finding was very common – FSWs that insisted on condoms were always likely to get their way with the clients. This gave birth to the "Listening Communication Approach" in which SFH field staff got training on in June 2000. It was designed to empower the FSWs to negotiate condom use with their clients with four key discussion points.

SFH cover all the states and FCT except Niger and Kaduna through the following base towns - Sokoto, Kano, Abuja, Jos, Maiduguri, Makurdi, Aba, Enugu, Calabar, Benin, Ibadan and Lagos.

Strategies

- Extensive Interpersonal Communication using flip charts
- Mid – mass interventions at junction towns and brothel areas via Group Africa
- Listening communication approach that offers FSW to learn from best practices of colleagues
- Condom distribution and promotion in and around brothel areas
- Other PLA approaches offer some training from ARFH and Prof. David Wilson's – Participatory led community approaches.

Lessons Learnt

- IPC and junction town intervention gave a wide reach, which did not translate to better condom use amongst exposed FSWs.
- The shared lifestyles, concerns and social exclusion of FSWs provide a powerful context for peer education and solidarity approaches.
- Salary or stipend is critical to sustain high level of commitment among selected and trained FSW peer educators.

Challenges

- How to combine both the wide reach and high intensity to FSW HIV/AIDS interventions
- How to develop structured replicable approaches in FSW interventions that has both reach and intensity
- How to translate high risk knowledge into positive behaviour change especially consistent and correct condom use amongst FSWs

Recommendations

- Approaches with explicit result chain should be followed
- FSW interventions must include intensive training cycle to sustain high level of impact
- Salary and or stipend should be part of the package for peer educators in FSW interventions

Liverpool Associates for Tropical Health
Managing partners for DfID FSW interventions

Activities

- Peer Education with FSWs, Hotel managers and chairladies in Otukpo and Sagamu

Structure

- Task teams to manage and coordinate
- PE support Group – support and supervision
- Monthly Ladies Forum – support and data collection

Strategies

- Target gatekeepers (hotel managers/bar boys, union of hotel directors and chairladies/madams)
- Sensitisation interventions with clients and other key stakeholders (police, local community leaders and service providers/patient medicine stores/traditional medicine sellers)
- Participatory approaches at all stages of project management cycle
- Flexible management and targeting strategies

Challenges/Lessons Learned

- Difficult to target and sustain interventions with highly mobile groups (FSWs and truck driver clients)
- Targeting FSWs increases stigmatisation, scapegoatism and reduces general public self-risk assessment.
- Community/home based care strategies for HIV + FSWs returning home
- Access to integrated, holistic and equitable services.
- Difficulty in determining health-seeking behaviour and providing services that are financially, geographically, culturally and functionally appropriate and that are accessible when required (e.g. Starlight Clinic established in one of the hotels in Sagamu closed down because of low utilization and failing to meet all needs (provision of drugs and trained medical staff i.e. doctor) and may have contributed to stigmatisation and ostracism.
- Syndromic management approach may not be efficient for identifying "high risk" women with cervical infections/
- High intake of antibiotics impact on effective STD diagnosis and treatment
- Judgmental attitude and behaviour of frontline staff/implementing partners may create barriers to effective implementation of strategies + impact on developing self-esteem. They often drive demand for vocational training.
- CSW not a homogeneous group, in fighting and competition rife.
- Inconsistent condom use
- Training manpower intensive "TOT training"
- High level of knowledge – but difficult to gauge impact in behaviour change.
- Innovative approaches to message delivery
- Research fatigue – need identified and discussed constantly, but needs not addressed.
- Quality of training – methodologies + content – need to be informed by monitoring information and feedback
- No capacity
- Sustaining interest – motivation, commitment – without monetary incentives – if paid, who monitors performance?
- Capacity + readiness of implementing partners to use monitoring information to inform change interventions.
- Behaviour change is complex as there are many factors involved.
- Participatory monitoring and evaluation is critical in improving quality and informing design of interventions.

SUMMARY OF RESEARCH FINDINGS

Family Health International

1. Behavioural Surveillance Surveys (BSS)

In 1999, FHI conducted the BSS, which provides data about HIV/AIDS related knowledge, attitude and behaviours in sub-populations at particular risks of infection (such as FSWs). The data presented below captures key results from FSWs.

Discussion:

Amongst FSWs, knowledge of the main HIV prevention methods was poor. There is a high prevalence of incorrect beliefs, which contributes to low acceptance of PLWHA. There is also evidence of significant unprotected high-risk sexual activities shown by data on condoms. In all, 49% of the FSWs had ever been married, however, 38% of the FSWs from Jigawa were living with a sex partner at the time of the study. Reported knowledge of HIV prevention methods was low and prevalence of incorrect beliefs about HIV/AIDS high, leading to a very low comprehensive HIV knowledge for FSWs at three sites. Further analysis on reported condom use revealed that FSWs were much more likely to use condoms if they could access it in less than one hour and if they had knowledge of HIV prevention methods. However, FSWs with good knowledge of HIV prevention methods reported better condom use, regardless of time taken to access condom.

The issue of STI awareness is critical to the successful implementation of the syndromic management approach to STI treatment. The percentage of women who could name two or more female STI symptoms stood at 48%.

2. Focus Group Discussions

A total of 7 FGDs were conducted February 2002 with FSWs in Aba, Umuhia, Awka and Onitsha. There were 10 FSWs in each FGD session. Key findings centered on reasons why FSWs engage in sex work, Knowledge, attitude, beliefs and practices of FSWs and health seeking behaviour of FSWs. Most FSWs get involved in sex work because they were unemployed, need to provide financial assistance to their family members and meet other financial needs. With this group, STIs are common, HIV is believed to be real, condom use is high and can be obtained from fellow FSWs under 5 minutes in the brothels. FSWs also prefer to get condoms from doctors and NGOs working with them.

Generally, FSWs seldom seek traditional care because they believe the after effect can be dangerous. They believe traditional medicine could destroy the womb or damage the pelvic. Few visit the patent medicine stores, STI clinics, Family Planning centers and counseling centers because workers in these places look down on them. They prefer seeking treatment from the doctors or those in the laboratories because these categories of health workers ensure some level of confidentiality. (See appendix for details).

Society for Family Health

SFH conducted 2 National Behavioural (NBS 1 and NBS 2) Surveys (sample size 2578 in 1998, sample size 2792 in 2001) and a Focus Group Discussion among 54 sex workers in 1999. The studies were limited to brothel based sex workers in cities and junction towns because are more accessible, have structures in place to aid interventions and they are at the highest risk of infection because of the high rate of partner change and they also have high risk- clientele.

Objectives:

To track trends in key behaviour change indicators and to provide information for programmatic interventions.

Results quoted are from NBS2

Methodology

Cross sectional survey using multi stage sampling design was used in the quantitative surveys. The headquarters of each of Nigeria's six health zones (Ibadan, Enugu, Port Harcourt, Jos, Kaduna, Bauchi) in addition to Lagos were purposely selected. In each location, brothels were systematically selected after which a proportionate number of respondents were systematically selected from the list of all sex workers in each brothel. Interviews were conducted in the appropriate local languages in respondents' rooms by trained female interviewers.

Main findings:

Median age 26 years

Average number of sex partners per day – 4.43

Median charge per sex act was N200 in city/ N100 in junction town

25% combine sex work with other trade.

43% had ever been married before.

- Although awareness of HIV is high, knowledge that a healthy looking person could be HIV positive still low at 44%. FSW still perform physical assessments of clients to determine HIV status of their clients.
- Perceived vulnerability to HIV is low. The short-term gains from the non-use of condoms (customers pay more) sometimes override the benefits of condom use. While raising personal risk assessment is important, it must be noted that raising high concerns might lead to fatalism and the reliance on God for protection. Again low risk perception may be the result of condom use as sex workers who consistently use condoms are less likely to report themselves as being at high risk to HIV infection. Reported consistent condom use in the last five sexual acts was 77%.
- Self-efficacy is related to the level of familiarity between sex worker and client: it is highest with non-regular clients but lowest with boyfriends.
- There appears to be little support and no pressure to use condoms from brothel owners and managers.

- The social structures to support condom use by sex workers are still inadequate.
- The strongest predictor of condom use is the self-efficacy to ask clients. Women who ask their clients to use condoms are more likely to be consistent condom users.
- Many sex workers use oil based lubricants that may increase the incidence of condom breakage (40% use oil based lubricants).

Recommendations

- Efforts should still be made to reinforce that the fact that "AIDS no dey show for face".
- Future interventions should include strategies that focus on self-efficacy and condom use in sex workers personal "non-professional loving" relationships.
- There is the need to enhance peer support such that there is collective efficacy within the brothels. Programs should investigate possible peer support initiatives.
- There should be advocacy with Hotel owners, bar managers and the communities to create an enabling environment for consistent condom use.
- Efforts should be made to provide affordable water based lubricants in the brothels to reduce the incidence of breakage.
- There is the need to put in place strategies that empower FSW to demand that their clients use condoms.
- The high reported use of condoms in the last five sexual acts needs to be further investigated before programmatic implications can be determined.

KEY LESSONS FOR FUTURE PROGRAMMING

- ☐ Must be holistic, integrated – linked to all other aspects in HIV/AIDS & factors driving epidemic e.g. poverty issues, livelihoods, resource allocations; linking programme interventions to advocacy at various levels
- ☐ Health service provision should be integrated – health workers providing STI treatment/drugs
- ☐ Strategies must be context-specific and take cognisance of regional/seasonal variations
- ☐ Link intervention to wider community development/stakeholder support e.g. constitution of Project Advisory Committee (PAC) consisting of members of civil societies and FSWs' representatives for community support.
- ☐ Capacity building must be an integral part. But training effectiveness should always be assessed (not training for training sake)
- ☐ Sustainability especially in terms of project – may not always be the critical consideration especially in HIV/AIDS prevention work.
- ☐ Peer Education
 - Role plays/drama/films effective in work with FSWs.
 - Relapse in BC due to re-location/attrition
 - Need to re-train FSWs
 - Attrition/Re-location
- ☐ Targeting FSWs – increases their vulnerability to society's vicissitudes!
- ☐ Recognise hierarchies/structures/power relations in FSW work.
- ☐ What to avoid:
 - Fuelling stigmatisation – e.g. being labeled as AIDS schools
 - Rush to economic interventions (micro-credit) – new skills required - and Making links with other livelihood interventions.
 - "Isolated" interventions

Issues & Challenges

- Condoms
 - Accessibility to female condoms
 - Myths/facts about condom breakage
 - Sustaining consistent condom use
- Inclusion of drug/substance education
- Incentives Vs voluntarism - what is the reality?
- Context / Location-specific application of the sustainability concept.
- Effective strategies for working with FSWs in the North (Socio-cultural, Sharia context)
- Integrating FSW prevention work with care and support for infected.
- Syndromic Management - effectiveness in work with FSWs.
- Attitudes & Behaviour of Implementing Partners - judgmental/not empowering (imbibe genuine participation)

Suggested Key Approaches

- Partnerships - to enable replication and scaling up for high impact
- Participatory "community-led" approaches
- We must collaborate (not compete!) and share more!

NEXT STEPS

1. Identify organisations/networks of organisations engaged in FSW. Mapping of what, where, who is doing what, the technical capacity available, training materials.
2. Presentation of workshop outputs to UNTG and participants.
3. Compile abstracts of research reports and disseminate.
4. Sharing strategies for the North.

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HEALTH AND RIGHTS OF WOMEN INTERVENTION NETWORK (HERWIN)

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