Community-led Services
Community-led Services

1. Community Empowerment
   - Starting, managing, monitoring and scaling up a programme— from both a centralized and community perspective

2. Addressing Violence against Sex Workers
   - Community mobilization and structural interventions

3. Community-led Services

4. Condom and Lubricant Programming
   - Fundamental prevention, care and treatment interventions

5. Clinical and Support Services

6. Programme Management and Organizational Capacity-building
What’s in this chapter?

This chapter:

• **defines community-led services** (Section 3.1)
• describes **how to design and implement** three kinds of community-led services:
  › community-led outreach (Section 3.2)
  › safe spaces (drop-in centres) (Section 3.3)
  › community committees and advisory groups (Section 3.4).

The chapter also provides a list of **resources and further reading** (Section 3.5).
3.1 Introduction

Community-led services, in which sex workers take the lead in delivering outreach and overseeing an HIV prevention programme, have demonstrated significant benefits in terms of HIV outcomes. They also enable sex workers to address structural barriers to their rights, and empower them to change social norms to achieve a sustained reduction in their vulnerability that goes beyond HIV.

Community-led services are interventions designed, delivered and monitored by sex workers (or with sex workers) that:

- build adequate and reliable access to commodities (condoms, lubricants, and needles and syringes) and clinical services through outreach and referrals
- respond to violence against sex workers and implement other structural interventions
- offer a progressive approach to behaviour and social change that strengthens not only knowledge but also skills and systems, in order to make prevention, care and treatment viable and sustainable
- feature formal and informal systems for the community to provide feedback to enhance the quality of clinical and other services and to engage in other ways, such as with social services beyond the HIV prevention programme.

Involving sex workers as individuals and as a community creates a foundation for strong HIV interventions, for a more enabling environment and for community empowerment. It also makes programmes more efficient and effective. With sustained support, community-led services may develop into strong initiatives that address structural barriers and underlying conditions of vulnerability and risk.

Community-led services incorporate tools and methods for frontline workers that also support programme management. A community-led approach ensures that sex workers have a leading role in interventions, including in their design, implementation and oversight. Many kinds of interventions can incorporate a community-led approach. This chapter describes three of the most important for scaling up HIV prevention programmes with sex workers: community-led outreach, safe spaces (drop-in centres) and community committees and advisory groups (Figure 3.1).

Box 3.1

Implementation of best practice for sex worker programmes

HIV prevention interventions are often implemented by nongovernmental organizations (NGOs). In some contexts it is challenging to immediately engage sex workers to do outreach with the sex worker community, and in the initial phase of a programme (the first year, for example), NGO staff may need to take a lead role in outreach. Where this is the case, the programme should be designed so that sex workers are recruited, trained and involved as quickly as possible and take on increasing responsibility within the programme.

Some of the guidance in this chapter is written assuming that the implementing organization is an NGO that is not formed entirely of sex workers. The guidance should be interpreted differently if implementation is being done by sex worker community-led organizations. Chapter 1 offers a vision and examples of high-quality, sustainable programmes run by community-led organizations.

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1 In most contexts in this tool, “community” refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to sex workers, “community-led interventions” are interventions led by sex workers, and “community members” are sex workers.

2 An implementing organization is an organization delivering a prevention intervention to sex workers. It may be a governmental, nongovernmental, or community-led organization, and may work at a state, district or local level. Sometimes an NGO provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.
Community-led outreach is an essential link between the community and the HIV prevention, care and treatment offered by a programme. It empowers sex workers to draw on their first-hand knowledge of vulnerability and risk to problem-solve with members of their community, strengthening access to services and making HIV prevention, care and treatment viable. Community outreach workers build rapport with other sex workers, understand their needs as individuals, and on a regular basis provide them with (or link them to) appropriate high-quality services. By monitoring the relative vulnerability and risk of each individual sex worker, community outreach workers also supply the first level of data collection for the programme.

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3 In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”.

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Figure 3.1 Types of community-led services

| Community-led (sex worker-led) outreach | A trained sex worker (community outreach worker) ensures that the prevention and care needs of a defined group of individual sex workers are met. |
| Safe space (drop-in centre) | A place where sex workers may relax, socialize, and also hold meetings and other activities that strengthen them as a group. |
| Community committees and advisory groups | To help improve the quality of services by providing a channel for community feedback to the programme. |

3.2 Community-led outreach

- Main personal interface between the programme (community outreach workers) and the majority of the community
- Promotion of services and referrals linking the community to condom supplies, voluntary HIV testing and counselling and care, diagnosis and treatment of sexually transmitted infections, antiretroviral therapy, care and other services
- An entry point to strengthen community leadership
- An entry point to strengthen community-led crisis response and other structural interventions
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Box 3.2

Community-led outreach and community empowerment

When done well, community-led outreach is the part of the programme that reaches the largest proportion of the community, most regularly and with the most direct personal rapport. Community outreach workers’ understanding and personal investment in the welfare of their community is as essential to the success of an intervention as the services they offer. Therefore they should be respected and engaged meaningfully. This has two important implications:

• The term “community” should never be understood or used to imply that community outreach workers are less qualified or less capable than non-community staff outreach workers.

• Community outreach workers are not volunteers; they should be remunerated for their work at a rate comparable to that of other staff, and should have the opportunity to progress to permanent paid positions in the implementing organization.

3.2.1 What community outreach workers do

Community outreach workers typically perform a number of key functions:

• Meet regularly (e.g. monthly) on a one-to-one basis with sex workers in their assigned area. Depending on the density of the sex worker community, a ratio of one community outreach worker to 35–65 sex workers is feasible (see also Chapter 6, Table 6.4).

• Assess the HIV prevention, care and support needs of each sex worker and develop a plan to address these needs through the programme and the community.

• Assess how many condoms the sex worker requires based on their usual sexual activities, and distribute the required number to cover the period until the next contact with the sex worker.

• Promote safe spaces (drop-in centres) with the community (see Section 3.3 below).

• Encourage sex workers to visit clinics for sexually transmitted infection (STI) check-ups, explain the services, refer STI cases from the field and accompany those referred to clinics if requested to do so. Advocate for sex workers’ access to services if they encounter difficulties.

• Support sex workers to get voluntary HIV counselling and testing (HTC), and ensure that they are accompanied to referrals if requested. (See Chapter 5, Section 5.2.)

• Accompany HIV-positive sex workers to treatment centres if requested, and track and encourage their adherence to antiretroviral therapy. (See Chapter 5, Section 5.3.)

• In programmes that provide services to people who inject drugs, provide clean needles and syringes and other harm reduction commodities to sex workers who inject drugs, and provide referrals to medical services as needed. (See Chapter 5, Section 5.5 for detailed information.)

• Provide information on sexual and reproductive health and refer sex workers to services as needed.

• Help to manage crisis response systems (see Chapter 2, Box 2.9). Give information on additional support systems for sex workers facing violence.

• Take part in community committees and advisory groups (make recommendations to improve clinic/staff relations, outreach, safe spaces) and community mobilization activities, and provide feedback from the field on ways to improve the programme.
3.2.2 Steps in implementing community-led outreach

Several steps are required to establish community-led outreach in a community of sex workers:

A. Map the community and design the outreach strategy with them
B. Recruit and train community outreach workers
C. Implement and manage outreach
D. Foster leadership opportunities for community outreach workers

A. Map the community and design the outreach strategy with them

Establishing a strong community-led outreach system involves the programme team, sex workers and other people at sex work locations. Reliable data collection and meaningful consultations with sex workers and other key individuals and institutions help to ensure that the programme provides acceptable and accessible services to the greatest possible number of community members, and that it is seen as useful by the community and receives its support.

Understanding where sex workers are and how to reach them is essential. This starts with programmatic mapping and size estimation (see Chapter 6, Box 6.4 and Figure 6.5). Once mapping focuses on individual sex work locations within a coverage area, the participation of community members is needed to help assess the quality of services and characteristics of the environment, as well as the relative risks and vulnerabilities of individual sex workers.

The steps for local consultations to inform mapping are:

1. Recruit a core group of sex workers to participate in the mapping. They should be people with detailed knowledge of the locations and preferred working habits in the community.
2. Work with the sex workers to develop maps that identify sex work locations (such as bus stations, brothels, bars, military barracks, etc.) in the most densely populated locations in the coverage area (Figure 3.2). Also identify service points, e.g. places where condoms are available (or a commercial establishment where they could be sold if there is a condom social marketing programme) (see Figure 3.3).
3. With the core group of sex workers, identify and build rapport with “key informants” in these locations, including other sex workers and brothel or bar owners and managers. Through group discussions with the key informants, arrive at consensus estimates of the number of sex workers at each location (see Figure 3.4). Record this information for follow-up to recruit community outreach workers once strategic planning for outreach is done.
4. Plan services using the information from the key informant meetings, including where to locate them, and the best timing for them. In order to maximize access to services, clinics and drop-in centres should be located near the areas with the greatest density of sex workers. Additional service components should also be considered. For example, if many sex workers in an area have children, a low-cost health check-up for children may be added to services offered by the clinic; and if police are considered to be a major problem, violence response interventions should be prioritized.
5. Through the key informants, meet and build rapport with additional sex workers who could become community outreach workers.

Safeguarding sex workers in mapping

Key informants: The influence of key informants, such as brothel or bar owners and managers, on the lives of sex workers should always be considered when doing mapping. While they may be able to promote condom use and service referral and offer protection against harassment and violence,
it is also possible that they will oppose services. Care should therefore be taken to ensure that sex workers make decisions about any efforts to engage these people, and that activities cause no pressure, harm or unwanted exposure to sex workers.

**Maps:** Maps containing information about the location and/or identity of sex workers should be considered confidential and stored securely at a central location. Programme planners and implementers should guard against the possibility of maps being obtained by law enforcement authorities or other groups who might use them to locate and close sites or otherwise cause harm to sex workers. If these confidential materials are disclosed, it is likely that the programme will lose the trust of the community.

**Figure 3.2 Community map**

This map, created by a sex worker, shows the locations and numbers of community members in a town, as well as places where services are available.

Source: India HIV/AIDS Alliance, Andhra Pradesh, India
This map, based on one created by sex workers, shows condom distribution locations by hours of operation.

Source: Karnataka Health Promotion Trust, Karnataka, India
This chart gives information about sex workers in a particular area for the purpose of planning outreach. It is designed to be completed by sex workers who are not literate. Simple drawings are created by the sex worker to identify the individual sex workers whom she knows, and to show where the sex worker lives, solicits clients and has sex with clients. Similarly, symbols identify the time of day when the sex worker is best available for conversation. The chart can be used by the sex worker to help recall each person in greater detail, when needed.

Source: Karnataka Health Promotion Trust, Karnataka, India

B. Recruit and train community outreach workers

The steps presented below represent an optimal process for recruiting and training community outreach workers. If a new intervention is being established, these steps may be implemented over time, as the programme reaches out to a greater number of community members. In practice, a programme might start with a small number of community outreach workers and a more informal organizational structure, but formalize as it starts to reach more sex workers.

1. **Develop terms of reference** for community outreach workers that outline the necessary selection criteria (see Box 3.3) and roles and responsibilities. Include policies on remuneration, travel allowances, per diem, etc.

2. **Develop guidelines for recruiting, retaining, assessing and promoting** community outreach workers. The selection process should be well publicized in the community so that all those interested in being community outreach workers may be considered. Collaborate with other programmes in the state/country to ensure that, where possible, remuneration for community outreach workers is consistent and transparent across programmes.

3. **Training curriculum**: check whether a curriculum is available and appropriate for the particular outreach setting. Ideally, the curriculum should be developed and standardized at the central/regional level, but it may need to be adapted to address local language and cultural issues (see Box 3.4 and the resources listed in Section 3.5). Check whether trainers are available.
4. **Adapt outreach tools for community outreach workers.** These may include daily and monthly tracking forms that assess each individual’s risk and vulnerability factors as well as their access to services. Outreach tools should be pictorial for community outreach workers with low literacy (see Figure 3.7).

5. **Develop a tiered training plan** to enhance community outreach workers’ skills, confidence and leadership (see below, and Box 3.4). This should incorporate regular training of new community outreach workers to ensure that an adequate number is always available. Training should also advance community outreach workers’ skills and exposure to all components of the programme, e.g. making sure that community outreach workers are able to explain clinic procedures to sex workers.

6. **Develop a career progression** plan for community outreach workers to ensure they have the opportunity to take on greater leadership responsibility for programme activities, and to oversee outreach and other aspects of the programme, including roles that may have belonged to NGO staff. Link this to activities that enable community outreach workers to demonstrate leadership through outreach, safe-space activities, community committees, etc.

7. **Explain sex worker progression** in the NGO to non-sex worker staff if necessary, to ensure there is no perception of competing interests (see Chapter 6, Section 6.2.8).

**Recruiting community outreach workers**

In the initial stages of a programme, selecting community outreach workers may be an informal process: the implementing organization may invite sex workers who have been involved in the initial mapping and planning stages to remain involved in the new programme as community outreach workers, and/or to identify other sex workers with the potential to fulfil this role. In either case, the selection criteria listed in Box 3.3 should be considered. It is also important to observe the rapport between sex workers involved in mapping and other members of their community.

**Box 3.3**

**Suggested selection criteria for a community outreach worker**

- Currently active as a sex worker, and has time to do outreach
- Committed to the goals and objectives of the programme
- Knowledgeable about the local context and setting
- Accepted by the community
- Accountable to the community as well as to the programme
- Tolerant and respectful of other sex worker communities where differences may exist
- Able to maintain confidentiality
- Good listening, communication and interpersonal skills
- Self-confident and with potential for leadership
- Potential to be a strong role model for the behaviour she/he seeks to promote with others
- Willing to learn and experiment in the field
- Committed to being available to other sex workers if they experience violence or an emergency
As the programme matures, a more structured process for selecting new community outreach workers may be adopted:

1. An informal committee of community leaders and programme staff, including current community outreach workers, defines the criteria for new community outreach workers, identifies potential community outreach workers, contacts them to see if they are willing to serve and conducts a basic interview with them. The candidates are ranked based on the criteria listed in Box 3.3.

2. The candidates are asked to take part in a social network mapping exercise, facilitated by outreach co-ordinators, to determine the size of their social networks of sex workers (see Figure 3.5).

3. Current community outreach workers talk to some of the potential community outreach worker’s contacts to see whether the candidate would be acceptable to them as a community outreach worker.

4. Based on the interviews, social network mapping and consultations, the committee selects the appropriate number of new community outreach workers.

5. The committee discusses methods for community monitoring of the community outreach worker’s performance. (This could be through a formal community committee: see Section 3.4.3.) Community members should be able to contact the project if they have any issues related to the community outreach worker.

Figure 3.5 Social network map

A social network map represents how sex workers at a particular location are linked by relationships of acquaintance or friendship. The map is created by a sex worker to show his or her degrees of connection to other sex workers. Each circle represents an individual sex worker, and the arrows point to other sex workers whom that individual knows. Effective community outreach workers have large networks. The map may be used to assign a community outreach worker to a group of sex workers for outreach, and to ensure that each community outreach worker is contacting the sex workers they know best.

Source: India HIV/AIDS Alliance, Andhra Pradesh, India
Training community outreach workers

Training should take place regularly and may be done at several levels:

1. basic training at the beginning of engagement in the programme
2. advanced training sessions at least quarterly to build knowledge and skills
3. informal mentoring by an outreach supervisor/manager to support community outreach workers (daily)
4. group discussions and mentoring with community outreach workers (weekly).

Training curricula should be interactive. The strength of community outreach workers in bringing their own experience and initiative to their work should be emphasized. This means that training may be most effective when facilitated by trainers who are themselves sex workers. (Trainers should be remunerated.)

**Basic training** may include:

- interpersonal communication skills to build confidence and individual agency (the choice, control and power to act for oneself), including discussion of the need to be tactful and non-judgemental, and to ensure confidentiality as a professional requirement
- condom gap analysis (to identify gap between demand and supply), condom negotiation and distribution rationale
- social network mapping
- managing prevention and care, micro-planning tools, record-keeping
- STI symptoms and disease processes, referrals and treatment of STIs, HIV, AIDS and TB
- promotion of voluntary HTC
- identifying and discussing violence, providing psychosocial support
- community mobilization.

**Advanced training** may include:

- advanced communication and counselling skills
- leadership skills
- dealing with stigma, discrimination and harassment
- legal literacy, negotiating with police and calling upon the community for support
- violence and crisis intervention
- counselling for drug and alcohol abuse
- creating links to other services (e.g. reproductive health)
- care and support for HIV-positive people
- interacting with the media (to promote a positive image of the community).
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Case example: Approaches to training community outreach workers

Kenya’s National STI and AIDS Control Programme has developed a toolkit for male and female community outreach workers (peer educators) consisting of a reference manual, a training manual and a participant notebook (not currently available online). The toolkit uses simple language and drawings. The manual consists of seven modules:
1. Peer educators: Who we are and what we do
2. All we need to know about HIV, STI and sexual and reproductive health
3. How to prevent HIV and STIs
4. Knowing our HIV status: promotion of HIV counselling and testing
5. Planning our future
6. Creating an environment for behaviour change
7. Recording and reporting our progress

In Macedonia, Health Options Project Skopje (HOPS) has a less formal training programme and curriculum that are tailored in content and duration to the background, education level and skills of each group of community outreach workers. Topics include:
- History of HOPS, its mission, programmes, organizational structure
- The role of the community outreach worker in HOPS
- HIV and AIDS and STIs
- Outreach work and principles of outreach work
- Human rights and sexual rights
- Human trafficking and sexual exploitation
- Introduction to HOPS’ harm reduction programme
- Types of drugs and consequences of drug use
- Site visit to sex work location and to the programme’s safe space (drop-in centre)

Awarding participation certificates to community outreach workers for completing training or other courses encourages them, and acknowledges their efforts to learn and build professional skills. This is especially true for sex workers who have not had basic formal education.

C. Implement and manage outreach

How community outreach workers promote access to services

**Condoms and lubricant:** Community outreach workers support behaviour change (i.e. adopting and/or adhering to safer sex behaviours) by demonstrating, promoting and distributing condoms and lubricants. They are often the most relied-upon source of condom distribution in areas where programming is new and sex workers have not adopted consistent condom use with clients and regular partners. Even in longstanding programmes, sex workers’ need for relatively large numbers of condoms gives community outreach workers an essential role in the supply chain.

**Clinical services:** Community outreach workers form a link between the community and clinical services. Upon the request of sex workers, they may accompany them to clinical services and advocate for them as needed. Community outreach workers promote, explain and record STI clinic and voluntary HTC referrals and visits. Community outreach workers provide essential insights to the
programme about how to make services more available and accessible, and how to ensure that sex workers use them regularly. They also ensure that the quality of services is high and that there is no coercion at the facility. Community outreach workers may also offer ongoing post-test counselling and ensure that those who test positive and disclose their status are linked to care.

**Structural interventions:** Community outreach workers mobilize members of their community to take part in initiatives to address stigma and discrimination, confront violence and harassment by police, and create social support systems, e.g. securing access to schooling for sex workers’ children.

**Community-led services:** Community outreach workers offer insights from their direct contact with the programme and the community that are essential for programme planners and policy processes at local, national and global levels.

**Managing outreach**
Management of outreach happens at two levels: the community outreach worker manages his or her own outreach to sex workers; and programme staff supervise and support the community outreach workers.

**Figure 3.6** Illustrative example of management of a sex worker’s needs by a community outreach worker

**Community outreach workers as outreach managers**
The community outreach worker uses a prevention and case management approach for each sex worker, consisting of several steps that are re-assessed and repeated, as circumstances require.

1. Assess the range of needs of the individual sex worker, using a standardized tool (see “Micro-planning” below).
2. Develop a plan of action with the sex worker based on needs that can be addressed.
3. Provide commodities, information and counselling to ensure that the sex worker is committed to addressing those needs with community support.
4. Facilitate referrals to other services, as needed.
5. Follow up referrals with support and information, as needed.
6. Re-assess and evaluate the needs of the individual on a regular basis.

Figure 3.6 above presents an example of the ways a community outreach worker may support a sex worker through direct services, links and follow-up.
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Case example: Sexual health diary

In Thailand, the Service Workers in Group Foundation (SWING) has worked with male sex workers to develop a sexual health diary as a tool to help them monitor their own sexual risk and engage regularly in self-diagnosis for STI symptoms. The diary gives them a way to track and maintain their preventive behaviour, including STI screening and treatment. The sex worker records the following information on a daily basis:

- number and type of sexual encounters (anal/oral/other):
  - whether with customer or partner
  - whether without condoms
  - whether without lubricant
  - whether with a condom used incorrectly

- STI symptoms (yes/no/not sure, for a list of different symptoms)

- any medical test or treatment (and for what symptoms), including STI screening and HIV test.

Each diary has enough pages for a month. The sex worker fills in a weekly summary sheet in the diary and gives this to his outreach worker from the programme, and they discuss it. The information is also recorded in the database and used for risk assessment and to customize services for the sex worker. When STI symptoms are reported, the sex worker is encouraged to see a doctor for testing and treatment. Using the diary is not a pre-condition for receiving any services from the programme, but it is widely used, and the male sex workers report that they like it. SWING plans to adapt the tool for use by female sex workers.

Micro-planning

Micro-planning gives community outreach workers the responsibility and authority to manage their own work. In this approach, community outreach workers use their knowledge of the community, and the information they record during their contacts with sex workers, to prioritize and manage outreach.

In micro-planning, community outreach workers are trained to use tools to capture data on the vulnerability and risk of each individual they serve, and the services they deliver. Micro-planning tools are designed to be user-friendly, e.g. they are pictorial and can be used by people with low literacy skills (see Figure 3.7). They may be adapted so that routine monitoring can be reported using a mobile phone, in addition to recording data on paper.

Community outreach workers record data at each encounter with the sex worker, and aggregate them onto a weekly or monthly reporting form (unless the data have already been submitted electronically), with the assistance of a supervisor/manager, if necessary. Some of the aggregated information may be reported by the programme according to regional or national reporting requirements, but its primary purpose is to enable community outreach workers to analyse their outreach efforts and plan their outreach according to the most urgent needs of the sex workers they are serving (e.g. those with the highest risk or vulnerability, or those who have not been met for a significant period of time). The community outreach worker may do this planning in the context of weekly review sessions with the supervisor/manager (see “Supervising and supporting outreach” below).
This micro-planning tool is used by a community outreach worker to capture information about individual sex workers’ risk and vulnerability and the services they receive from the programme over the course of a month. The top row of this calendar has not been completed by the community outreach worker; the lower row shows how information on an individual sex worker is recorded.

- In the far left column the individual sex worker is identified using a colour-coded ID system (bars and circles), supported by a sticker with a symbol (e.g. pair of scissors) as a memory aid for the community outreach worker.

- In the middle of the chart, eight blue squares represent different risk and vulnerability factors (e.g. the top left square shows a condom with a cross through it, meaning inconsistent condom use). When the tool is being designed, such factors are decided upon through consultations with community outreach workers about risk and vulnerability in the community they are serving. The community outreach worker uses white stickers to cover the factors that do not apply to the individual sex worker, leaving the relevant ones exposed as a reminder to discuss them with the sex worker.

- When an individual sex worker has more than three risk and vulnerability factors, the community outreach worker adds a purple sticker to mark the individual for priority follow-up.

- In the four columns (one for each week of the month) on the right-hand side of the calendar, the community outreach workers uses stickers to record the services provided at each contact.

Source: Mukta Project, Pathfinder International, Maharashtra, India

Further considerations for outreach

Using IDs:
A form of identification for community outreach workers can help them in their work. For example, a credit card-sized programme ID card endorsed by a recognized public official, such as a senior police officer, can be shown to police who stop them.

However, some incentives for community outreach workers, such as t-shirts or other clothing that identify them as working for the programme may cause other sex workers to feel separate from them. Visible identifiers may also by association expose the sex workers they are meeting with.
**Setting:**

- In urban areas, programmes should consult with community outreach workers to decide whether outreach to sex workers who work on the streets should be conducted in pairs for safety.
- It may be difficult to reach sex workers who work in urban bars, brothels or lodges. Outreach to managers and owners, to encourage them to allow community outreach workers access into the establishments, should be undertaken in pairs, with other programme staff if necessary. Since these sex workers often live together in groups, outreach to them in their residences may be more productive, but only if welcomed.
- Outreach to home-based sex workers or those who choose not to self-identify as sex workers requires a discreet approach, such as framing it as health promotion for low-income women.

**Age:**

- Younger sex workers may have concerns about family planning and maintaining their physical appearance, while also wishing to maximize their client load.
- Older sex workers may be more concerned with protecting their children, providing support for HIV-positive family members and participating in programme management.

**Gender:**

The needs of male, transgender and female sex workers may overlap, but also differ in some respects:

- Male sex workers may require counselling and referrals for such issues as sexual dysfunction.
- Transgender sex workers may need information on the risks associated with injecting hormones.
- Female sex workers may need support related to family planning and abortion services.

**Supervising and supporting outreach**

An outreach supervisor/manager has the responsibility to train, motivate and monitor the work of five to twenty community outreach workers. The role may be filled by a community outreach worker who has progressed into this supervisory role or by an NGO staff member until community outreach workers are trained.

The outreach supervisor/manager observes community outreach workers in their day-to-day outreach work, reviews their data on components of the service package (number of one-to-one contacts, group contacts, referrals or accompanied visits, condoms distributed, etc.), and may input the data into a computerized management information system if there is no dedicated data entry officer. The supervisor/manager has weekly meetings with his or her group of community outreach workers, usually at the safe space (drop-in centre), to discuss high-priority individuals and any problems the community outreach workers may be encountering, and to provide informal training.
Case example: Opportunity gap analysis

In Karnataka, India, community outreach workers use a simple tool to analyse the specific barriers that hinder individual sex workers’ access to programme services. Gaps in access are identified, whether due to internal factors that the programme can control (e.g. the working times of community outreach workers) or external factors (e.g. high mobility of sex workers resulting in dropouts from the programme). Site-specific action plans are then developed to overcome these barriers.

Figure 3.8 shows an opportunity gap analysis by a community outreach worker responsible for 140 men who have sex with men at a particular site. (Although these men are not necessarily sex workers, and although the ratio of community outreach workers to men who have sex with men is very high due to the density of the urban area in this example, the principle is the same.) The community outreach worker has assessed his activity during the month by listing the number of men who have sex with men who are enrolled, the number whom he regularly contacts, the number who have visited a clinic in last three months, and the number who were tested for HIV in the last month. The community outreach worker then analyses with his supervisor/manager those community members who were not reached by various services and the reasons for this, and a plan is developed to address these gaps.

The opportunity gap analysis helps both the community outreach worker and the supervisor/manager to assess whether the programme is reaching the community members with specific project services. The exercise identifies areas where the community outreach worker needs to focus and areas where the supervisor/manager needs to support the community outreach worker.

**Figure 3.8 Opportunity gap analysis**

<table>
<thead>
<tr>
<th>OPPORTUNITY GAP ANALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zone:</td>
</tr>
<tr>
<td>Site:</td>
</tr>
<tr>
<td>Hotspot:</td>
</tr>
<tr>
<td>Actual number</td>
</tr>
<tr>
<td>Estimation</td>
</tr>
<tr>
<td>Registration</td>
</tr>
<tr>
<td>Regular contact</td>
</tr>
<tr>
<td>Clinic visit</td>
</tr>
<tr>
<td>Syphilis</td>
</tr>
<tr>
<td>Integrated Counselling and Testing Centre (ICTC)</td>
</tr>
</tbody>
</table>

Source: Karnataka Health Promotion Trust, Karnataka, India
**Remunerating community outreach workers**

Community outreach workers should always be remunerated for their work. However, certain approaches may be problematic: for example, paying community outreach workers for each individual they persuade to come to the clinic or drop-in centre for services can distort demand and lead to coercion. Less coercive and more effective incentives include phone credit, non-monetary gifts, leadership opportunities and recognition that is not linked to the number of sex workers who are brought to the programme. Offering the chance to participate in national or international trainings and meetings, where possible, may also be an effective way of recognizing outstanding community outreach workers.

Table 3.1 shows the various activities for which community outreach workers may require remuneration.

<table>
<thead>
<tr>
<th>Resource spent by community outreach worker</th>
<th>Remuneration</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time on outreach (includes time for travel, meeting with sex workers, reporting, planning further outreach)</td>
<td>Salary</td>
<td>Agree upon a rate that is acceptable to community outreach workers and feasible for programme sustainability. If possible, rates should be set consistently across state and national programmes.</td>
</tr>
<tr>
<td>Time on extra training</td>
<td>Stipend</td>
<td>Hours spent in training are lost work time, and programmes should recognize that community outreach workers have another job and personal obligations that cannot be fulfilled when they are in training.</td>
</tr>
<tr>
<td>Travelling between venues, for referrals, training, etc.</td>
<td>Bus, train, taxi charges, as required</td>
<td>It is usually most efficient to map travel routes and fix travel allowances for groups of community outreach workers depending on the requirements. They should be given travel stipends in advance on a routine basis (since most may not be able to pay first themselves and then wait for reimbursement).</td>
</tr>
<tr>
<td>Mobile phone airtime (predetermined is usually best)</td>
<td>Mobile phone airtime</td>
<td>Whether using text messages or limited talk time, community outreach workers should be remunerated for on-the-job phone use.</td>
</tr>
<tr>
<td>Mobile phone batteries</td>
<td>Chargers, access to power and safe charging</td>
<td>Community outreach workers need their phones for outreach, and phone battery chargers should be made available at agreed-upon charging locations.</td>
</tr>
</tbody>
</table>
Community-led Services

Case example: Using technology in sex worker networks

Some sex worker organizations use mobile phones or the Internet to enable community members to seek and offer support among themselves.

In South Africa, a sex worker community-based organization operates a helpline to disseminate information. Calls to the helpline from a landline phone are free, and mobile phone users can send an SMS text message to receive a call back so that they do not have to pay for a call from their mobile phone. The helpline offers an SMS alert service that sends information to community members who have enrolled for the service. A sex worker can report bad clients (e.g. for non-payment or assault) to the helpline, which will transmit this information via the SMS network.

The New Zealand Prostitutes Collective (NZPC), an organization of sex workers, operates a closed Facebook page that functions like a blog and has a message board for sex workers to post questions, provide support to one another and provide information about services for sex workers.4

The Ukrainian sex worker-led organization LEGALIFE runs a website5 on which members may post questions about their rights and about LEGALIFE’s activities. Responses are written by a local human-rights expert and a consultant on practical psychology affiliated with LEGALIFE. The webpage also features a blog and a forum section for its members, and local and international news. It is managed by a group of sex workers with previous experience in managing web content or who have been trained to do so.

D. Foster leadership opportunities for community outreach workers

Experienced community outreach workers improve the effectiveness of outreach and provide leadership in their community beyond programme services. It is important that programmes adopt an approach from the beginning that allows community outreach workers to grow as leaders. Programmes do this not only by showing respect and appreciation to community outreach workers, but by:

- providing support through training, mentoring, constructive feedback and remuneration
- offering opportunities for them to learn new skills and apply their experience in expanded ways through the programme and in their communities, so that they and other sex workers are empowered.

Training and mentoring of community outreach workers should focus not only on outreach, but also on strengthening their leadership more generally (see also Chapter 1, Section 1.2.6). Community outreach workers with leadership skills are more likely to use critical thinking and take the initiative to reach greater numbers of sex workers. They may also support the programme in other important ways:

Advocacy: Confident community outreach workers may be able to advocate with the police and sex-work establishment owners to improve interactions with sex workers. Sex workers can be the strongest advocates with establishment owners for correct and consistent condom use and other safer sex practices. Community outreach workers may initially need support in this role from non-sex worker staff of the implementing organization, but staff should be sensitive to the need to reinforce the community outreach worker as a leader for their community, only stepping in when needed.

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4 NZPC also has a public Facebook page: https://www.facebook.com/pages/New-Zealand-Prostitutes-CollectiveNZPC-CHCH/194413363949972.
Community-led Services

Programme monitoring: With experience and support, community outreach workers can participate in monitoring the programme and improving its quality. This develops naturally from the approach taken with micro-planning, where community outreach workers assume responsibility for recording, analysing and acting on data about the sex workers to whom they provide services.

Monitoring should not require literacy, and community outreach workers who collect monitoring data should also be provided with tools to analyse them (as with micro-planning) and the authority to act on the analysis. They should also be supported in monitoring aspects of the intervention that the community considers important but which the implementing organization may not monitor for its own purposes, such as trends in the service quality of referral clinics.

Programme management and leadership: Community outreach workers can train and mentor other community outreach workers, and may assume other roles in a programme. As programmes mature, community outreach workers naturally seek advancement as leaders, and jobs once done by implementing organization staff may be done by sex workers who began as community outreach workers. Outreach supervisors/managers may be former sex workers who generally work as full-time staff with a salary commensurate with that of NGO staff in similar positions.

The non-sex worker staff of implementing organizations may have to adjust their roles and expectations when sex workers, whom they may have thought of solely as programme beneficiaries, become their professional peers—and possibly even their supervisors/managers (see Chapter 1, Section 1.2.1 and Chapter 6, Section 6.2.8). Managing such a change requires a commitment from the leadership of the implementing organization. It should be seen as a positive development that helps to sustain HIV prevention in the long term.

3.3 Safe spaces (drop-in centres)

From the outset of a programme, “safe spaces” (also known as drop-in centres) should be established to bring community members together. Safe spaces are rooms rented by the programme and furnished simply that provide community members with a comfortable place to relax, rest, get information and interact with each other and with the programme. Safe spaces are multi-functional; they may also serve as:

- a place where community members may discuss programmes with programme managers to improve services
- a venue for psychosocial services and support, based on community demand
- a place to provide information on events and activities relevant to the community (not just programme-related information)
Community-led Services

- a distribution point for condoms and lubricant
- a place to strengthen community empowerment by discussing discrimination and stigma against the community and planning a response
- a place for community outreach workers to review their work and plan outreach
- a place for community trainings (of community outreach workers, but also of other sex workers, e.g. in violence response, power analysis).

Safe spaces may be located close to programme-operated STI clinics, or even in the same building. There are practical advantages to co-locating safe spaces with clinics, such as the convenience of dealing with just one landlord, and the closer links between community activities and programme services. Nevertheless, care should be taken to ensure that safe spaces remain a distinct community area. It is often important to separate an implementing organization’s office from the safe space and ensure that community leaders have clear responsibility for managing activities at the safe space.

3.3.1 Establishing safe spaces

Setting up the space

1. **Sex worker consultation and mapping:** The consultation provides guidance on where to locate the safe space, services to be provided, staffing and service hours. Services should be available when sex workers most need them, i.e. shortly before, during and shortly after their working hours with clients.

2. **Location:** The choice of location should take into consideration not only its accessibility to sex workers but also its visibility to the public and the response from the wider (non-sex worker) community in the vicinity. Care should be taken to ensure that the space is safe from intrusion by outsiders and the police.

3. **Lease agreements and landlords:** Maintaining a fixed location for the safe space is important to prevent disruption of services. The lease drawn up with the landlord should clearly state the duration of the agreement and clarify the hours and nature of use.

4. **Infrastructure and safety:** The safe space should ideally have at least two rooms: one that can be used for one-on-one meetings or counselling, and one for community activities. If possible, there should be a private bathroom with a sink and shower (Figure 3.9). The safe space should be equipped with basic equipment to handle fires and other emergencies.

5. **Designing the space:** The space should be both functional and inviting. Meeting tables and chairs may be kept to one side unless in use; couches or mattresses can make the room comfortable. Walls may be painted or decorated with art made by the community.
Operating the space

- **Management:** The programme should provide resources for the space. To ensure that the community feels ownership, sex workers should have the lead role in decisions about the space and its management.

- **Service promotion:** To ensure sex workers are aware of the safe space and its services, it should be promoted through flyers, SMS messages and community networking.

- **House rules:** These should be formulated by those using the space so that they understand what behaviour is acceptable, e.g. with regard to noise levels (this is also important so as not to disturb any neighbours) as well as drug and alcohol use.

- **Relationships with neighbours:** The safe space managers, including the community, should make plans to manage relationships with neighbours and those outside the sex worker community. Some communities have performed neighbourhood clean-ups to establish a good relationship with their neighbours.

- **Scheduling:** If the programme needs to use the safe space for programme activities that involve a limited number of participants (e.g. outreach planning, training, or interpersonal and group communication activities), these should be scheduled during off-peak hours so that they do not infringe upon access for the broader sex worker community.

- **Programme use:** Growing implementing organizations may want to use the safe space for other programme activities or as offices; efforts should be made to ensure that this does not happen or that such activities are kept to a minimum. The safe space should remain open to members of the community to use informally, even if the programme is using it.
Community-led Services

- **Sustainability**: Safe spaces can be made financially sustainable when managed by the community, for example, if the community rents out the space to the programme on a limited basis. Some community groups have developed catering services for events at safe spaces as a form of income generation that is managed directly by the community.

### Box 3.8

**Safe spaces for everyone**

When resources are limited, a single safe space may need to serve a number of groups of sex workers, such as women, men, transgender individuals, younger and older sex workers. Events should be designed to offer specific resources for groups that identify differently. It may be helpful to offer each group an exclusive regular meeting time or times each week. When multiple groups are using the same space, the leadership of the space should be ready to manage possible conflict between groups and ensure that each group has fair access to resources.

### 3.3.2 Other activities in the safe space

Safe spaces may offer a range of activities and services to suit the specific needs of the communities they are serving. Offering a wide range of services may increase community participation in the safe space and ultimately help make it more sustainable. Examples include:

- classes on beauty tips specific to different groups (female sex workers and transgender sex workers)
- classes in literacy, numeracy, information technology, nutrition and dance
- celebrations of festivals and holidays
- a simple meal or nutritious food to take away
- walk-in general health exam
- showers and laundry facilities
- lockers to store belongings while community members are working
- sleeping areas
- phone-charging stations
- use of the computer and Internet
- remaining open 24 hours a day
- crèches (child care) for children of sex workers.
3.4 Community-led quality improvement

Improving the quality, accessibility and acceptability of programme services requires collecting routine feedback on the community’s experience of local services. There are several ways to do this.

3.4.1 Community committees

A community committee is a forum for members of the community to bring important issues, problems and solutions to the attention of the programme on a routine basis. Committees review clinical services, commodity distribution, the functioning of safe spaces and initiatives to address structural barriers. Members of the committees should ideally be elected by the community on a regular basis, e.g. annually. Relevant implementing organization staff may be members of the committee or may be invited to its meetings to discuss issues that arise.

As shown in the management structure for community services depicted in Chapter 6, Figure 6.3, community committees operate primarily at the frontline level, although they may also contribute to oversight of the programme at the municipality/sub-municipality level.

Community committees should meet monthly. A meeting report like the one shown in Figure 3.10 may be used to systematically consider issues and report to the community and programme.

When action is taken by programme staff or community outreach workers themselves, the results should be shared at subsequent meetings to ensure good communication with the community. A record of these discussions and actions should be maintained. The committee can also be a communication channel for the programme to discuss any changes that are being considered, and to share monitoring data with the community.

Because the community committee may at times raise quality issues that programme staff are reluctant to address, it is essential that programme management staff from a higher level be involved than those immediately responsible for the components of the intervention locally. Confidentiality should be respected at all times and senior management should monitor the committee to ensure that the community has the freedom to be critical. An advocate trusted by community outreach workers should act as the programme intermediary; ideally this person should be a community member, although they may be paired with a staff member from the implementing organization who can advocate for changes. There should be a mechanism to communicate problems upwards and beyond local managers if they are perceived to be obstacles to change.
## COMMUNITY COMMITTEE REPORT

<table>
<thead>
<tr>
<th>Area</th>
<th>Issue</th>
<th>Proposed resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues with supply, quality or quantity (condoms/lubricants, test kits, drugs at sites or across sites)</td>
<td>Community reports that some community outreach workers who do outreach in the train station still only provide a maximum of 5 condoms during outreach.</td>
<td>1. Outreach coordinator to work with community outreach workers to provide the number of condoms required by each sex worker and not limit condom distribution. 2. Follow up at train station to ensure change.</td>
</tr>
<tr>
<td>Closure or lack of service availability at referral facilities or through outreach</td>
<td>Government Clinic on Central Rd. often will not accept people after 15:00.</td>
<td>1. Write letter to health officer documenting problem. Ask NGO director to sign along with community representative. 2. NGO health officer and community representative should visit Chief Medical Officer to advocate for compliance with agreement on later opening hours signed in May.</td>
</tr>
<tr>
<td>Service quality problems, e.g. poor treatment at facilities, discrimination in referral services, unresolved problems at safe spaces</td>
<td>Nurses at Central Rd. doing initial questioning of patients in a public area, not a private room.</td>
<td>1. NGO health officer and community representative should bring this up during visit with Chief Medical Officer to ensure compliance with STI treatment protocol. 2. Follow up with community to determine if clinic is compliant with policy.</td>
</tr>
<tr>
<td>Inability of community outreach workers to carry condoms at sites or on the street because of police, etc.</td>
<td>Police harassment of community outreach workers with condoms at bus station.</td>
<td>1. NGO field officer and four community outreach workers to schedule meeting with police to discuss and resolve.</td>
</tr>
<tr>
<td>Service overlap by other providers that may be causing confusion</td>
<td>No problems.</td>
<td>N/A</td>
</tr>
<tr>
<td>Violence response activities, perpetrators of violence and trends in violence.</td>
<td>1. Report on number of incidents was not given at last community meeting at safe space. 2. Response team members taking survivors to hospital have not been reimbursed for transport costs.</td>
<td>1. Ensure that community leaders get information from crisis response team members and double-check it with NGO data officer before monthly community meetings. 2. Outreach supervisor to check and ensure that reimbursements are made within one week.</td>
</tr>
</tbody>
</table>

Any other issues:

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**Figure 3.10** Sample community committee report

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3.4.2 Other community-led approaches to reinforce quality of clinical services

- Obtain agreement with referral clinics to display patients’ rights charters, which are a statement of government policy for all who enter a medical facility.
- Obtain agreement with senior medical personal to post information in clinics on the right to confidentiality.
- Design ways to share information about reliable services in the community, e.g. good doctors to go to for speculum exams, or trustworthy testing and counselling centres and personnel. This information may be posted on a notice board or on a protected Facebook page.
- Schedule regular contact (via visits or letters) with the chief medical officer of a facility to formally report issues and give positive feedback.
- Educate the community on patients’ rights and community-based monitoring of services.
- Formally introduce committee members to health-service providers.

3.4.3 Community quality assurance in monitoring and evaluation

Monitoring quality of community service implementation

Programmes are more effective when routine monitoring is designed with local input and there are systems for using data at the community level. Ideally, the programme at the central level should engage those managing multiple sites to determine what information is useful to them to monitor their programmes. (A simple approach is to brainstorm the aspects of the programme that they typically examine during site visits.)

Where interventions are not already community-led, community leaders should be consulted on the kinds of measures that are important to improve the quality of services and outreach.

All programmes need to collect and report data to monitor progress and hold the programme accountable for its objectives. It is important to develop a clear understanding in the community on what data will be collected, how this will happen, and how the data are to be used locally. Data should not simply be “reported up” to a higher level; an approach should be designed that also integrates monitoring for use at the local level. This is important because targets that are set at high levels are easily misinterpreted as being the primary goal of the programme, leading, for example, to focus on the number of people accessing services rather than the quality of those services or sex worker engagement in the programme.

Figure 3.11 shows how programme data may be collected and used at the local level as well as at higher levels of the programme.

It is useful for the local implementing organization and the outreach system (including community outreach workers and supervisors/managers) to regularly review and discuss the monitoring data shown in Table 3.2.
Figure 3.11 Routine monitoring data flow

Clinic data
Individual visits to clinics (recorded by clinic staff)

Data used to plan outreach and service promotion at community level

Individual data plus other operational data

Aggregated at NGO level and used to monitor progress locally

Aggregated at state/provincial level

Central-level management information system

Outreach data
Individual interactions (recorded by community outreach workers)

Source: Avahan India AIDS Initiative
## Table 3.2 Community-level monitoring data

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Data</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community outreach worker ratio</td>
<td>Proportion of community outreach workers to mapped sex workers</td>
<td><strong>Numerator:</strong> total number of community outreach workers</td>
<td>Analyse by local areas and by gender as outreach to urban, rural, male, female and transgender sex workers may require different ratios. Use to monitor whether sufficient community outreach workers are in place and what are the best ratios.</td>
</tr>
<tr>
<td>Outreach coverage</td>
<td>Proportion of mapped sex workers reached through one-to-one outreach monthly</td>
<td><strong>Numerator:</strong> total number of one-to-one contacts by community outreach workers in a month</td>
<td>Analyse by geographic area to determine whether geographic prioritization of risk and vulnerability is taking place.</td>
</tr>
<tr>
<td>Condom distribution through outreach</td>
<td>Mean number of condoms distributed by community outreach workers and staff outreach workers per sex worker monthly</td>
<td><strong>Numerator:</strong> total number of condoms distributed by community outreach workers and staff outreach workers in a month</td>
<td>Analyse by geographic area and by community/staff outreach workers. Trends may be helpful to highlight supply problems.</td>
</tr>
<tr>
<td>STI and voluntary HTC coverage</td>
<td>Proportion of sex workers who have ever attended:</td>
<td><strong>Numerator:</strong> number of sex workers who have visited the clinic at least once</td>
<td>This is a crude estimate that gauges basic access and is useful to analyse by gender, local area and different sex work settings, to consider different referral methods, as appropriate. Verification of consultations should be done by checking whether sex workers actually attended, not by counting referral cards handed out. Each type of visit should be recorded and analysed separately.</td>
</tr>
<tr>
<td>-STI and voluntary HTC demand</td>
<td>Proportion of sex workers receiving:</td>
<td><strong>Numerator:</strong> number of sex workers:</td>
<td>This is another crude data point, especially as it relies on self-reporting of HIV-positive status. It guides programmes on the need for resources for Positive Health when analysed by geographic area.</td>
</tr>
<tr>
<td>Positive Health – access to support</td>
<td>Proportion of HIV-positive sex workers with access to Positive Health support</td>
<td><strong>Numerator:</strong> number of sex workers reporting a one-to-one or group Positive Health support in a month</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Denominator:</strong> Number of self-reported HIV-positive sex workers</td>
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Monitoring community access to services and community agency

The following indicators have been used in behavioural surveys and qualitative research to gauge sex workers’ access to services and their levels of self-efficacy (the belief in one’s ability to take actions under specific circumstances) and collective agency (the choice, control and power to act as a group). They have been used as standalone indicators for advocacy purposes, and in indices for academic research, where they can be compared in order to determine predictors and mediators of behaviour and HIV and STI risk, and to show the degree of community empowerment.

The indicators are assessed by questioning sex workers on their levels of confidence and their actions and opinions about different situations, most of which represent potential or actual barriers to safety and health. (“You” in the question refers to the sex worker.)

• **Self-efficacy for condom use:** How confident are you in your ability to use a condom with each client:
  - even if he gets angry?
  - even if he offers more money for sex without a condom?
  - even if you have been using alcohol or drugs?

• **Self-efficacy for STI clinic service use:** How confident are you about going to the clinic for STI services, even if health workers:
  - know that you are a sex worker?
  - treat you badly?
  - don’t provide the specific service you need (e.g. no anal exam, no drugs)?

• **Self-efficacy for HTC clinic service use:** How confident are you about going to the clinic for HTC services, even if health workers:
  - know that you are a sex worker?
  - treat you badly?
  - will not keep your visit confidential?

• **Self-efficacy for clinic service use:** How confident are you about going to the clinic for treatment, even if health workers:
  - know you are a sex worker?
  - treat you badly?
  - record your name and address as part of registration?

• **Self-confidence to speak openly:** How confident are you about giving advice to fellow sex workers, or speaking your opinion in front of a large group of people?

• **Collective agency:** Have you negotiated with or stood up to the following individuals in order to help a fellow sex worker:
  - police?
  - brothel owner/manager?
  - gang member?
  - client?
  - regular partner?
3 Community-led Services

- **Collective efficacy:** Have you worked together with other sex workers to:
  - keep each other safe from harm?
  - increase condom use with clients?
  - speak up for sex workers’ rights?
  - improve sex workers’ lives?

- **Enabling environment:** How fairly do you think sex workers are treated:
  - at hospitals?
  - at banks?
  - at post offices?
  - in other public places?
  - by the police?

3.5 Resources and further reading

1. **A Guide to Participatory Planning and Monitoring of HIV Prevention Programs with High-Risk Groups.** Bangalore, India: Karnataka Health Promotion Trust and India Health Action Trust, 2011.
   b. *Module 2: Participatory Planning Tools for FSWs, MSM and Transgenders.*

2. **Community Mobilization for Female Sex Workers (Toolkit).** Bangalore, India: Karnataka Health Promotion Trust, 2009.
   b. *Module 2: Strategic Overview.*
   e. *Module 5: Responsive Governance.*

   http://www.aidsalliance.org/includes/Publication/Peer_education_manual.pdf


