

# Access to HIV treatment and care amongst commercial sex workers in Malawi



## A Participatory Reflection and Action (PRA) Project Report



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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in Masters courses, specific skills courses, student grants and mentoring. This report has been produced within the capacity building programme on participatory research and action (PRA) for people centred health systems following training by TARSC and IHI in EQUINET. It is part of a growing mentored network of institutions, including community based organisations, PRA work and experience in east and southern Africa, aimed at strengthening people centred health systems and people's empowerment in health.

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## Executive Summary

Malawi has over the years intensified its fight against AIDS, through policies, guidelines, services and programmes. Some policies explicitly mention the need for focus on services for commercial sex workers because of their susceptibility to HIV infection and the potential risk they have of spreading the virus. The National AIDS Commission highlights commercial sex workers (CSW) as a high risk group, and a key group for access to treatment. The challenge remains to translate these policy commitments into practice, especially given the illegal nature of commercial sex work. Of concern CSWs themselves are not included in developing the design, implementation and evaluation of policies and programmes affecting them.

This study aimed to explore and address barriers to coverage and uptake of HIV prevention and treatment services among CSWs in Area 25 Lilongwe district, Malawi, using Participatory Reflection and Action (PRA) methods. We set out to introduce and test the power of bottom-up approaches, and particularly community (sex workers) participation and involvement as an approach to increase access to HIV and AIDS services. The research explored barriers to accessing HIV and AIDS treatment and care services amongst CSWs and, in a participatory manner, ways of overcoming the barriers that includes empowerment of a group of CSWs in the study location. The work was implemented within a programme of the Regional Network for Equity in Health in east and southern Africa (EQUINET) that aimed to build capacities in participatory action research to explore dimensions of (and impediments to delivery of) Primary Health Care responses to HIV and AIDS. The programme was co-ordinated by Training and Research Support Centre (TARSC) in co-operation with Ifakara Health Institute Tanzania, REACH Trust Malawi and the Global Network of People Living with HIV and AIDS (GNPP+). TARSC and REACH Trust in particular provided peer review support and mentorship to this work.

An initial baseline survey in 20 health workers and 45 CSWs showed high knowledge but poor rating of access and uptake of HIV prevention, testing and treatment services, due to both barriers in the community and in the services themselves. A PRA process drew out further detail and experiences of the barriers faced, with priorities identified as:

- Lack of early treatment seeking practices amongst CSWs
- Ill treatment of CSWs at health facilities by Health practitioners
- Lack of adherence to treatment by most of CSWs.

The separate feedback from the CSWs and HCWs on their experience of HIV services for CSWs indicated some areas of shared perception, and some of different concerns. For the CSWs, the way they are treated by service providers was an important issue that health workers did not raise, while health workers raised the poor compliance with service and drug procedures that CSWs did not refer to. Both raised shortfalls in the health care environment and the resources for HIV related services relative to need.

In the short time frame of the PRA process, we did not expect to address all the issues between CSWs and health providers, given that many are structural and deeply rooted and need longer term processes. The PRA process itself raised issues of gender violence and abuse that CSWs face (including through attitudes and practices in health care services) that dehumanise them, and perpetuate their own harmful behaviours.

The group of CSWs and health workers as a whole identified interventions that were immediate and feasible to address the three barriers they prioritized to CSWs accessing the HIV prevention, testing and treatment services they need. An intensive intervention,

involving door to door counseling, engagement at places of work, formation of joint committees between CSWs and health workers and sensitization of health workers was implemented, steered and reviewed by the team with the CSWs and health workers themselves. A committee was set comprising health workers and CSWs that met weekly to review progress and address problems raised. We observed and documented quantitative and qualitative outcomes, monitored progress markers set by the group itself and also kept a record of reflections on the process.

Health workers and CSWs reported in a follow up survey improvements across all areas in the assessed baseline, except for quality of health services. Health workers reported improvements in the same areas noted by the CSWs, although their rating of improvements were generally a little more modest than the CSWs. It may be that the greater impact was felt by the CSWs, noting that this is a subjective rating. It is however interesting that both groups perceived positive impact, triangulating the evidence on the reported trend. The findings suggest that the process used has some effect on addressing these barriers and mobilizing demand for and uptake of HIV prevention and treatment services in CSWs.

We suggest that a public health PHC oriented approach to services for CSWs recognize, listen to, involve and build capacity in CSWs and ex-CSWs, and the civil society organisations that work with them, as a primary group for reaching and mobilizing uptake of services in CSWs; ensure messages for health promotion are developed with and locally relevant to the barriers CSWs face to healthy behaviours and health service uptake, and invest in mechanisms, skills and tools for enhancing communication between health workers and CSWs and within CSWs as peers on issues such as adherence and compliance with treatment regimes; acknowledge the presence of stigma, sexual harassment within health services and put in place training, guidelines, mechanisms and actions to check it; and ensure that HIV and AIDS services integrate through relevant linkages issues of sexual abuse and gender based violence on groups like CSWs, and reach out through civil society, leaders from affected groups, to places where CSWs are found, and involve key stakeholders in those environments in enabling this outreach.

PRA approaches were valuable in achieving the communication needed to prioritise and build consensus on barriers and actions, sometimes unearthing painful and harsh realities, and providing learning and collective empowerment for the team. Yet the process is demanding, particularly of time and leadership. We recognize that CSWs are the best people to reach their fellows, and that PRA processes are time intensive and demand facilitation skills that will be difficult to spread rapidly in the many CSWs in Lilongwe, and nationally. A dissemination workshop conducted after the intervention identified areas for follow up, including continued door-to-door campaigns, building HIV counseling and testing skills in CSWs, intensifying the outreach provision of testing and counseling, ART and sexual reproductive health services like family planning close to the sex workers' environment, and linking the CSWs with institutions that lend capital to women, and with those that provide vocational skills.

We were not able in this intervention to address deeper structural issues of laws, policies, employment, incomes, health service infrastructure and resourcing for health care and inadequate human resource capacity that we found also block CSW access to services. Yet it would not be possible to discuss a PHC oriented approach to HIV related services without recognizing the need to take on the wider environments of deprivation that both lead to commercial sex work, and that expose CSWs and their families to risk. These need attention by government and its local and international partners if the declared universal access to HIV and AIDS prevention, treatment and care and support is to be achieved. In a context where alarming increased numbers of girls join the sex industry annually, engaging CSWs and HCWs is essential to address these drivers of commercial sex work and bring health promotion and health care as a whole closer to such affected communities.

# 1 Introduction

An estimated 40 million people now live with HIV globally, 70% in sub-Saharan Africa (SCF 2004). HIV has a high sero prevalence in sub-Saharan Africa, with higher than average rates in particular social groups (Buve et al 2001). HIV prevalence in Malawi is generally higher amongst females than males, and prevalence in the 15-24 year age group is four times higher in females than in males, at 9% and 2% respectively (NSO Malawi and ORC Macro 2005). HIV prevalence levels among sex workers have been found to be as high as 73% in Ethiopia, 68% in Zambia, 50% in South Africa, and 40% in Benin (UNAIDS 2000). In Malawi, while adult HIV prevalence is 12%, it is estimated that 70% of commercial sex workers are HIV positive (NSO 2006). Malawi has experienced an increase in the number of women, including girls as young as 12 years of age, joining the sex industry (WHO 2005).

Knowledge of HIV and AIDS among women and men in Malawi is almost universal, across all age groups, areas of residence, marital status, wealth and education levels (NSO Malawi and ORC Macro 2005). However, behaviours such as condom use and having multiple sexual partners do not match levels of knowledge (ibid). Condom use nationally is below 30% (Njikho 2008), and levels of unsafe sex are indicated by levels of sexually transmitted infections (STIs) in the past 12 months of 8% in women and 6% in men in 2004 (NSO Malawi and ORC Macro 2005). STI rates have been found to be higher in urban and semi-urban populations, women and young people (NACP 2001). Reported rates may underestimate real levels given the asymptomatic nature of many STIs in women, and many people with STIs are reported to seek advice and treatment from friends and traditional healers respectively (Njikho 2008).

Malawi has over the years intensified its fight against AIDS, through policies, guidelines, services and programmes. Policies have been developed for AIDS prevention, treatment and care, including Prevention of Mother to Child Transmission (PMTCT), Ante-retroviral (ART) scale up, and strategies for specific sectors. Some policies explicitly mention the need for focus on services for commercial sex workers because of their susceptibility to HIV infection and the potential risk they have of spreading the virus. The National AIDS Commission highlights commercial sex workers (CSW) as a high risk group, and a key group for access to treatment.

The challenge remains to translate these policy commitments into practice, especially given the illegal nature of commercial sex work. The HIV and AIDS policy and strategic framework note that the transport sector is one where CSW interaction with drivers poses risk of infection. The strategy suggests the provision of civic education with involvement of the faith community as an activity to address the problem, while strategies also include lobbying for regulation of CSW and access to condoms. Of concern CSWs themselves are not included in developing the design, implementation and evaluation of policies and programmes affecting them.

Effective access and uptake of HIV prevention, treatment and care programmes for CSWs in Malawi is affected by wider limits to coverage in the general population and specific barriers for CSWs. Coverage of prevention services is greater than 75% for youth, 25% for CSWs, 51-75% for counseling and testing (VCT) services, 25% for clinical services and over 75% for home based care and orphan care support programmes respectively (UNAIDS 2008).

There is low uptake of HIV testing nationally, with only 13% of women and 15% of men having had an HIV test and received their results, lowest in adolescents (NSO Malawi and ORC Macro 2005). (Malawi Demographic Health Survey 2004). Knowledge of testing is high, but uptake low. A study conducted in Blantyre and Lilongwe with a sample of 114

youths found that only 14.5% had gone for testing despite 85% knowing where and how to access it (Jiya 2005),

Government and civil society initiatives offer services to CSWs for VCT, reproductive health, STI prevention and treatment and vulnerability reduction, including income generation, condom promotion and measures to address stigma and discrimination. These programmes have usually been small projects, and not coordinated or integrated into the national response. Two well known interventions targeted at CSWs are those by Banja la mtsogolo (BLM) and the Family Planning Association of Malawi (FPAM). BLM through its TV programme 'BLM talk show' interviews commercial sex workers randomly selected from different pubs across the country and provides or mobilizes for CSWs with start-up capital for small scale businesses. FPAM has worked with CSWs in Lilongwe district to build business skills in mushroom growing, hair dressing and tailoring, women football clubs and competitions, civic education on prevention, treatment, care and on safe sex negotiation skills and distribution of prevention measures to CSWs in their bars or pubs in Lilongwe.

These initiatives indicate a range of barriers to uptake of services. Poverty is the main motivation behind the choice of commercial sex work, and the CSWs cite their work places as horrible and risky, exposing them to several dangers, including sexual harassment, violence, murdered and contracting HIV. CSWs note when seeking redress for these problems that they experience further abuse from health care workers (HCW) and the police. The principal secretary in the office of the president and cabinet is cited by FPAM as recognizing the poor uptake of services (Calisto 2009). She cautioned that both CSWs and their clients need to be involved in the options for prevention, treatment and care for HIV and AIDS, and the buyers of the sex, mainly men, need to be recognized as part of the issue.

This study therefore aimed to explore and address barriers to coverage and uptake of HIV prevention and treatment services among CSWs in Area 25 Lilongwe district, Malawi, using Participatory Reflection and Action (PRA) methods. We set out to introduce and test the power of bottom-up approaches, and particularly community (sex workers) participation and involvement as an approach to increase access to HIV and AIDS services. The research explored barriers to accessing HIV and AIDS treatment and care services amongst CSWs and, in a participatory manner, ways of overcoming the barriers that includes empowerment of a group of CSWs in the study location.

The work was implemented within a programme of the Regional Network for Equity in Health in east and southern Africa (EQUINET) that aimed to build capacities in participatory action research to explore dimensions of (and impediments to delivery of) Primary Health Care responses to HIV and AIDS. The programme was co-ordinated by Training and Research Support Centre (TARSC) in co-operation with Ifakara Health Institute Tanzania, REACH Trust Malawi and the Global Network of People Living with HIV and AIDS (GNPP+). TARSC and REACH Trust in particular provided peer review support and mentorship to this work.

Specifically we sought to

- assess sex workers' knowledge and experience of available HIV prevention and treatment services (with a specific focus on HIV Testing and Counseling (HTC), access to condoms and ART treatment);
- Identify the reported barriers to access and uptake of HIV and AIDS programmes particularly HTC, condoms and ART) within and beyond the primary health care (PHC) services;
- assess health workers perception of factors within and beyond the PHC services and the community affecting provision and uptake of HIV prevention and treatment services for CSWs.

- improve communication between health workers and CSWs on the barriers, identify shared priorities for action and propose, implement and assess actions to overcome barriers and improve PHC oriented provision of HIV prevention and treatment services for CSWs.

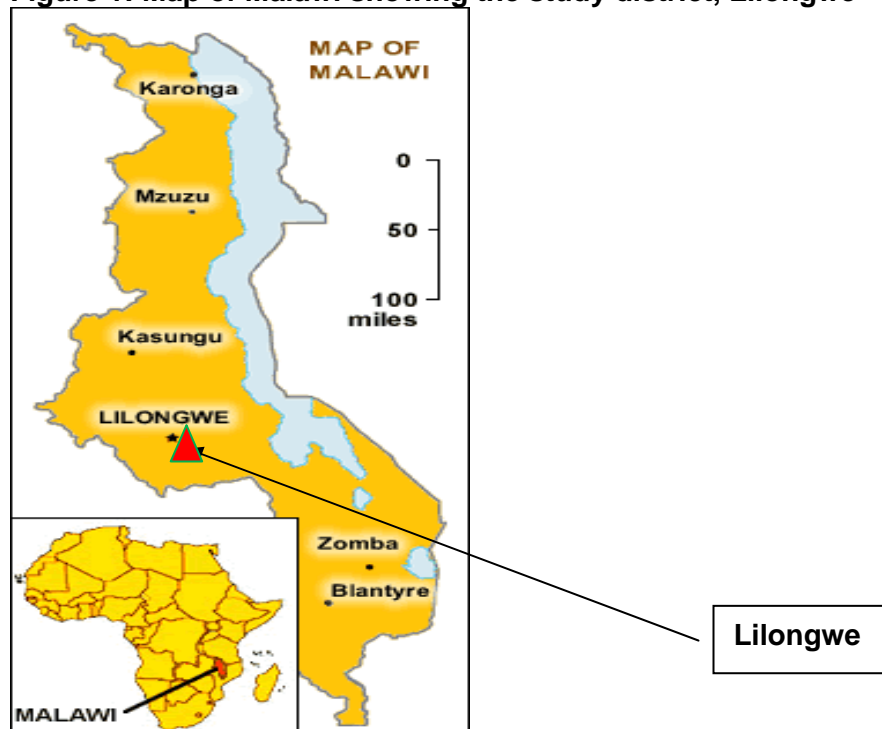
Through this we hoped to

- Increase shared knowledge / understanding by CSWs and health workers of the available HIV prevention and treatment services and the barriers to their coverage and use in CSWs
- Increase report of confidence in health workers in managing prevention and treatment services for sex workers
- Increase report by CSWs of uptake of HTC and ART services and of quality of care for these services at primary health care facilities
- To have both health workers and CSWs report improvements in communication on HIV prevention and treatment services, and on their health and health care.

## 2 Methods

The work was carried out in area 25 in Lilongwe (see Figure 1). Area 25 is a location/ township in the west of Lilongwe city. It has a population of about 77,373 (MoH 2006) data. It is a semi urban area with boundaries on the city, on rural Lilongwe, and with 'Kanengo', an industrial site of the city commonly associated with Malawi's tobacco sales at the auction floors,

**Figure 1: Map of Malawi showing the study district, Lilongwe**



Source: <http://www.overlandinfrica.com/malawi.php>

The study site was selected due to the availability of interested CSWs and their willingness to reach out to CSW colleagues with health related messages not normally easily accessible to them. This group of CSWs were 'Girls alliance towards Behavioral Change' (GABC), formed by the Youth Development and Advancement organization (YOU DAO). During the

time of this study, the tobacco sales underway in the city led CSWs to congregate around Area 25.

The study used a mix of quantitative assessment and participatory action research methods (PRA). The quantitative methods included pre and post intervention questionnaire surveys. The PRA approaches were used to identify needs and develop and guide intervention activities. The PRA approaches were qualitative methods such as key Informant interviews.

Implementation followed the steps outlined below between July 2008 and March 2009:

- Meetings were held with key stakeholders in the study area including local authorities, and health services providers to introduce and consult on the work.
- Qualitative and quantitative tools were used to collect baseline information from the key stakeholders including health workers, commercial sex workers, religious leaders and traditional leaders. A structured questionnaire was used to collect from sex workers, and health providers information on
  - knowledge and understanding by CSWs and health workers of the available HIV prevention and treatment services and the barriers to their coverage and use amongst CSWs;
  - health worker confidence in managing prevention and treatment services for CSWs;
  - perceptions of quality of care at primary health care facilities and reported uptake of HTC and ART services by CSWs;
  - reported adherence to VCT and treatment services by CSWs;
  - communication on HIV prevention and treatment services between CSWs and health workers and participation in mechanisms for communications on health and health care;
- Sixty five questionnaires were administered on 45 CSWs and 20 health providers. The CSWs were sampled using a snowball sampling approach from an initial group of CSWs identified through a youth advancement and development organization (YOUDAO). These CSWs approached colleagues who were willing to be interviewed and introduced them to the study coordinator, who briefed them on the purpose of the study and sought their consent to participate. Interviews with CSWs were conducted at a place and time convenient to the respondent, some at the offices of YOUDAO and some at their respective homes. Twenty respondents from health facilities were purposively selected with the assistance of the facility in-charges according to cadre and their involvement in activities such as reproductive health and AIDS programmes. All interviews were conducted at the facilities. These sample sizes and approaches were largely set by time and resource constraints, by feasibility and the number to work with and measure impact. The quantitative assessment did not aim to collect a representative sample of the respondents but to assess change in the same group through the intervention.
- To support the quantitative tool, four key informant interviews were conducted with community based organization (CBO) leaders and members and one with a traditional leader. They explored issues affecting health care provision and access in CSWs. The sampling of key informants was purposive and the interview used a simple guide derived from the baseline questionnaire with open ended questions. The interviews were conducted by a team from REACH Trust led by the first author (KC).
- A facilitators' team was set up for the PRA work, involving sex workers, health workers, district health officials, community based organization representatives, proprietors of bars or clubs and rest houses, religious leaders, and traditional leaders. Seven facilitators from two community organisations (YOUDAO, GABC), from REACH Trust, the Area 25 Health centre, Dzenza mission health centre, and Gika



private clinic made up the facilitation team, who developed the tools with mentoring input from TARSC and trained of co-facilitators.

- A PRA meeting involved different stakeholders including CSWs, health providers, staff from district assembly, and the general community in Area 25. It identified the priority health and health care needs for CSWs from the perspective of the different groups, particularly in relation to HIV; and mapped the services and organizations providing HIV prevention and treatment services for CSWs. It identified the challenges facing health workers in providing HIV services and the issues and barriers facing the CSWs in using these services. The meeting identified also the priority areas for action and developed an action plan to address the priorities identified.

**Figure 2: Social map drawn by participants**



Source: REACH Trust 2008

A social Map was drawn by participants to outline different services available in the area and the organizations providing them. Ranking and scoring was used to prioritise health needs identified, and a problem tree to explore their causes. Through a 'market place' tool, participants come up with actions that could be taken to deal with these problems. A wheel chart and margolis wheel were used to assess perceptions of levels of communication between CSWs and HCWs. These tools are further described in Loewenson et al, (2006).

Finally, the workshop identified major CSW needs and barriers and, together with the health workers, an action plan was drawn.

The action plans developed implemented over a period of two months, and were monitored and reviewed using progress markers set in the PRA workshop on intended changes

A quantitative post intervention survey was held with the same sex workers and health providers as in the baseline to assess change on the parameters surveyed. Further, a final meeting was held of all stakeholders to review the process and changes, to document the lessons learned and to identify the follow up.

We faced a number of limitations. During the pre survey it was found that there was no readily available statistical data on the number of CSWs accessing HIV and AIDS services from the different health facilities, making it impossible to track the number of CSWs using these services using information from facility registers. This compromised the exact measurement of the impact of the intervention before and after implementation. However, the pre and post intervention survey, progress markers and reflections by the affected group themselves give some information on the barriers to service uptake and the changes arising from the intervention. The limited resources and relatively short timeframe for the intervention limited to outreach, coverage and PRA skills transfer in the work.

### 3 The Findings

This section reports on the steps of the study and presents the information gathered and analysed. Given the PRA approach the reflections on the findings by participants to the process are integrated within the section.

#### 3.1 The baseline survey

The 45 CSWs included in the pre and post survey were all female, while 40% of the 20 health workers were male and 60% female. The age of the CSWs ranged from 14-39 years, while that of the HCWs ranged from 22-69 years. The CSWs had primary (31%) or secondary (64%) level education, with one each having college education or no education. The HCWs had higher levels of education, 60% with college education, 15% with university education and 25% with secondary level education. Most of the CSWs involved in the study were single (42%), although 9% were separated, 40% divorced and 9% widowed. Most of the HCWs were married (80%) with only 10% single and 10% divorced or widowed. The types of HCWs included are shown in Table 1 below.

**Table 1: Characteristics of health care workers interviewed in the pre and post survey**

Category	Number interviewed	Type of formal training	Period of providing services
Nurses	9	Enrolled nurses	1-10 years
Clinicians	4	Medical and Clinical	1-10 years
Health surveillance assistants (HSAs)	4	HIV counseling and testing, STI treatment	1-5years
Technicians	3	Environmental health, laboratory	1-10 years

CSWs have lower education levels and are younger than health care workers. Although most of the CSWs were young, single and of school going age, only five were still studying at the time of the survey, the others reporting having dropped out of school due to death of their parents, early pregnancy and marriage. Those who reported being divorced or separated said they left their husbands because they were abusive, and felt it was better to leave when they could still get another man to marry them. Unfortunately, when this did not happen, they joined the sex industry, seeing friends already in the business earning an income. One CSW said;

*“I couldn’t have afforded to be just staying with my child, you know I need to take good care of him... and I got fed up with the mockery that I suffered from my friends who had mocked and teased me for a long time telling me that I was wasting time thinking I would get married again...I was convinced and joined them until today I am surviving through this business”.*

Employment, incomes and livelihood are the main determinants of the choices the CSWs made, and also determine their access to services for HIV and AIDS.

**Table 2: Results of the baseline questionnaire to CSWs and HCWs: rating of HIV services**

ISSUE	HCWs Responses (% total, N=20)				CSWs Responses (% TOTAL, N=45)			
	Extreme -ly/ Very High	High	Low	Very Low/ None	Extreme -ly/ Very High	High	Low	Very Low/ none
Knowledge of HIV services					33	38	27	2
Barriers CSWs face to using health care	70	25	5	0	76	22	2	0
Access to HIV prevention services	25	40	30	5	2	24	27	47
Access to ART	20	35	45	0	4	51	24	20
Condom Use	5	25	25	45	4	16	7	73
Treatment default	40	30	30	0	58	20	20	2
Quality of services	35	40	25	0	27	47	27	0
Level of communication	5	60	30	5	1	53	31	7
Availability of communication mechanisms	20	25	30	25	4	24	27	44

As discussed in the introduction, the baseline survey found knowledge to be high, with 71% of respondents asserting their knowledge on available HIV prevention and treatment services to be high or very high (See Table 2). Yet both health workers felt that CSWs faced very high barriers to using health care services that they may know about.

Interviews with stakeholders in the community pointed to barriers such the illegal nature of the business of CSWs, leading to stigmatizing attitudes by the community, and making it difficult for local community based organisations (CBOs) to develop interventions that focus on CSWs. One CBO representative said;

*“I recall that at our organization we were talking of identifying women that are either HIV positive or living with AIDS...but when somebody suggested that we should also try to get some sex workers that are living with the AIDS, the idea was shot down...they are too difficult to find and work with”.*

One of the religious leaders bemoaned the tendency by the religious institutions in condemning sex workers as a contributing factor to the social difficulty in CSWs living in society. He said:

*‘...when in that business these people develop an attitude or mentality that they have no-one to support them and when they fall sick it is also people of God who despise them and not pray for them saying that’s what they wanted. So if they can’t get some solace from the church or mosque for prayer who can they believe to say that they will be appreciated and supported...unless we change our mindset and attitudes towards sex workers it will remain difficult to get them back from that business.’*

Given these barriers, service access was reported to be low, although health workers had a more favourable perception of this than CSWs. Most CSWs rated access to HIV prevention services be low or very low (74%), although only 35% of health workers had this perception.

This was also reflected in more specific questions on access to HIV testing, and to condoms. Condom use was reported to be very low by 73% of the CSWs, and by 45% of the health workers. Views on access to ART were more variable *within* the groups than across the two groups. About half (51%) of CSWs rated it to be high, and 44% to be low or very low. For the health workers, 55% rated it to be high or very high, and 45% to be low or very low. Treatment default was felt by both groups to be high or very high, rated as such by 70% of health workers and 78% of CSWs.

The mechanisms for dealing with service access were also rated in the survey. Three quarters, 75%, of health workers rated quality of services to be very high or high, as did 74% of CSWs. The clinical quality of services provided thus seems not to be a barrier. However the provision for communication between CSWs and health services were rated much lower, with 55% of health workers and 71% of CSWs rating these mechanisms low or very low. Yet the level of communication was rated as high by 60% of health workers and 53% of CSWs. The levels and forms of communication between these two groups thus merits further exploration in the work.

We were aware of some areas of possible bias in the survey due both to understanding of the questions and concern about being monitored, and dealt with these by clearly explaining the questions and assuring of confidentiality. We also recognize that the survey was of ratings of perceptions, hence the evidence is only used as a baseline with the *same* group, both directly affected by the issue under focus, to assess how perceptions and ratings have changed after the intervention.

### **3.2 The PRA meetings**

The first PRA meeting involved CSWs, health providers, staff from district assembly, and the general community in Area 25. It aimed to identify the priority health and health care needs for CSWs from the perspective of the different groups, particularly in relation to HIV; and to map the services and organizations providing HIV prevention and treatment services for CSWs. It identified the challenges facing health workers in providing HIV services and the issues and barriers facing the CSWs in using these services. Finally the meeting identified priority areas for action and developed an action plan to address the priorities identified.

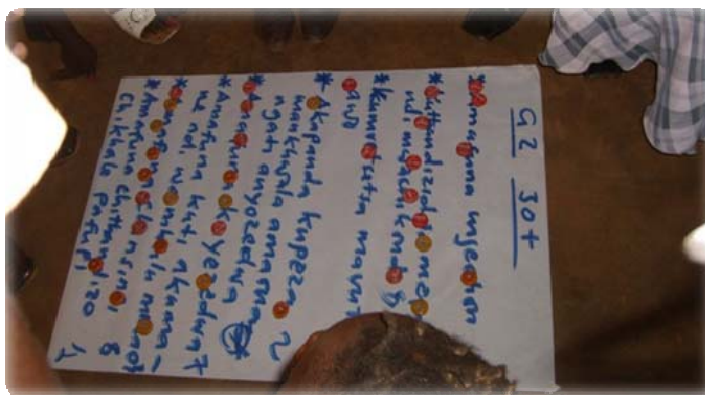
Social maps of the area were drawn by the PRA workshop participants. They showed the population groups and available HIV prevention and treatment services in the community and including but not limited to health services. The groups highlighted places where HIV services are found, and indicated those CSWs frequent most for health care seeking. The participants highlighted that there was only one government facility, Area 25 health centre, serving as the main facility for the area. It is supported by Kamuzu Central Hospital and Bwaila Central hospital which are referral facilities. Two non state non profit facilities exist, Banja la mtsogolo, specializes in reproductive health service including family planning services amongst women and the youth and a mission facility, Dzenza Mission health centre. Private for profit services mapped included Gika private clinic, Dopa, Lira and Vision Private. The map highlighted support organisations, like YODAO and Kanengo AIDS Support Organization (KASO) providing testing and HIV support services. The sites identified to be frequented by CSOs for services were those offering testing, condom distribution, STI treatment, ART and also those offering privacy, such as in the case of private clinics for STI treatment. For instance, one sex worker had this to say;

*“Normally we go to ... because we know that they are open to discussions and keep secrets while in these public hospitals, people are not open and do not keep secrets”.*

The importance of confidentiality was reiterated by a health worker from one of the health centres which was probably the farthest of all within the location, but one that see a lot of clients because of the perceived confidentiality of their services.

*“Although it is a bit difficult for us to specifically come up with concrete data on how many CSWs we treat with STIs, the average number of 34 STI patients per month that we register speaks volumes of satisfaction that such patients have in our service delivery because even if one is diagnosed with HIV we write a referral letter, conceal it and ask them to take it to area 25 clinic straight to the only person in the ART room and nobody else. This assures confidentiality as without this advice, a lot of patients have been subjected to a lot of abuse as they ended up giving this letter to any HCW they meet there who in the end spread the issue’.*

**Figure 3: Participants ranking & scoring health issues**



Source: REACH Trust 2008

To identify the health needs of the CSWs, two groups, one of CSWs and another of HCWs were asked to draw out a list of CSW health needs and rank the needs according to what they felt were the most important. The two lists were then discussed according to the ranks and scores that groups came up with. In plenary after thorough scrutiny of the priority needs as presented by the two groups, a final list of the three priority health needs that were shared and that both groups felt could be

intervened upon was agreed upon. These were:

- Lack of early treatment seeking practices amongst CSWs
- Ill treatment of CSWs at health facilities by Health practitioners
- Lack of adherence to treatment by most of CSWs.

Triggered by a picture code of a health centre showing a health worker and a CSW, participants discussed and listed the challenges CSWs faced in accessing HIV care, treatment and support.

The CSWs identified as challenges:

- poor attitude of and poor history taking by health workers when doing clinical examination;
- being shouted at, ridicule, insult and lack of respect by HCWs;
- over dosing of medication by private clinics;
- public HCWs not being punctual on starting time of their jobs;
- CSWs shyness to express themselves to HCW
- Stigma by HCWs towards HIV positive CSWs
- HCWs forcing CSWs to have sex with them when they come for health care at the hospital or not treating CSWs they have had sex with

Some of these are further discussed below, from the perception of the CSWs and of the health workers.

The CSWs pointed to a number of issues affecting quality of care at services: lack of space or rooms at the health facilities, especially in the ART clinic, affecting privacy in the consultation. In the consultation room in one facility patients are seen in twos, also affecting privacy. CSWs reported shortage of drugs, acting as a deterrent to their use of services. They reported that after HIV testing it took almost two or three years before they went for another test after the first, despite their risk environments, citing poverty and fear for children's welfare as factors restraining them from returning for the test. They felt that knowing their status made little difference to their lives.

A number of reports and allegations were made of disturbing and harsh treatment, sexual harassment and ill treatment, that are recorded here and that the study was not in a position to verify.

**Figure 4: CSWs discussing barriers they face**



Source: REACH Trust 2008

One of the CSWs reported that she was ill-treated and rejected at a facility when she went there with several cuts she sustained during a fight. She had one cut in the head, one on the upper arm and another one on the cheek. As these were deep cuts, when she was turned back from the hospital and police the wounds became infected and started to swell. She then returned to the hospital in this condition and recounted the response she got as:

*“when I arrived there they started shouting at me saying this is what I wanted and I had for these on my own. They said I wanted to disturb their peace by letting them to touch wounds of prostitutes. I was made to lie down and they stitched my wounds without giving me any painkiller but harshly worked on them while I was crying because I was in great pain. After that they never said anything or gave me drugs and just released me. And because I wasn't sure whether and when to go back for the removal of those stitches and because of the pain on the cut that was in the head, the lining used when stitching caught up with my hair I ended up removing the stitches by myself to an extent that I feel some stitches are still inside me as this part still pains me to date” (pointing at her upper arm).*

Another sex worker also shared this experience:

*“I remember that one day when I went to area 25 health I was humiliated by a nurse who was attending to us. This time I had joined one of the research surveys that was being conducted on people on ART. And this day I wanted to request if they could allow to test my kid and possibly take him on the survey as well because I noticed that his health was deteriorating and I suspected he could also be HIV+ and I thought if he is tested earlier the better. Hardly when I uttered a word, the nurse who I think had misplaced her cell phone, angrily started shouting at me that I had stolen her handset. My explanation was never taken heed of and in no time we were at a police station where I was jailed for the whole day. Later, I was released in the evening saying that the phone was found. All this happened because the nurse said that I was a sex worker and that she was convinced I had stolen her phone. And so you can imagine how I felt, my sickly child instead of getting that help I thought he would get was actually left crying all day. So this kind of attitude by HCWs*

*towards us CSWs where they regard us as thieves or people with bad manners always is what puts us off to seek health care at that facility. Unfortunately this is the only biggest and public facility here and although my child is in bad shape now I can't afford to go to private clinics at all. But with the treatment I suffered in the hands of that nurse I can't go back to that facility again. I better die together with my child."*

CSWs complained of queuing for hours due patient numbers and inadequate staff, but also reported favouritism in seeing people later in the queue earlier.

*"This eventually leaves a lot of people unattended by midday when HCWs break for lunch and since when they go for lunch they also come back very late most of us just walk back home".*

They also complained of lack of respect by female nurses in the antenatal clinic and delivery ward, citing a preference for male nurses as they showed respect and compassion.

*"female nurses are always not respectful of girls and women in general unlike male nurses or clinicians. These male health workers are so understanding and respectful of patients. Female nurses at the labour ward or antenatal clinic speak abusive words at us and they are very cruel when they are handling you especially during labour or delivery. But they needed to be more loving and caring towards their fellow women I wonder why they behave differently"?*

Some CSWs, however, felt that male nurses and clinicians be removed from ART clinics and other outpatient services as they were concerned about sexual harassment by male nurses in these services.

While these reports were made by the CSWs, during the PRA workshop the experiences of health workers in providing HIV prevention, treatment and care services were also recounted.

Health workers observed that CSWs do not bring their partners to access STI treatment, undermining their own recovery, despite health workers recommending that they do so. This was of great concern to the health workers as failure to treat both partners of an STI renders the treatment received by a single partner useless and compounds the spread of STIs and HIV.

They reported that CSWs do not adhere to appointment dates, particularly in relation to dates for ART refills and STI treatment checkups. As a result health workers feared that CSWs could develop resistance to treatment. CSWs were seen by health workers to be in a hurry, to avoid being seen by people, when they come for ART refills. This factor was said to be one of the contributors of poor communication between HCWs and CSWs. CSWs do not want people in their location know their status, and come to the facilities early in the morning hoping to get treatment when the facilities are not full. Yet the services have official opening times. As a result they blame health providers for being late, when in fact CSWs are rather asking for a scenario of care organised around their needs. CSWs shyness or fear to narrate the exact problem they presented to the facility with make it very difficult for the health workers to address their health problems. For example the health workers reported that CSWs hide having an STI, leading health workers to prescribe the wrong medication. This was confirmed during the roles plays when experiences such as CSWs sharing STI medication or reporting headache rather than STI symptoms at the clinic and being given paracetamol were reported.

Health workers observed further health system related challenges as factors affecting the provision of services. These were:

- Inadequate space to operate from
- Shortage of drugs and equipment supplies
- Shortage of expertise in some special cases relating to ART and STIs
- Mismatch between the demand from the high number of cases expecting to be assisted and the few HCWs and resources available.

The separate feedback from the CSWs and HCWs on their experience of HIV services for CSWs indicated some areas of shared perception, and some of different concerns. For the CSWs, the way they are treated by service providers was an important issue that health workers did not raise, while health workers raised the poor compliance with service and drug procedures that CSWs did not refer to. Both raised shortfalls in the health care environment and the resources for HIV related services relative to need.

In the short time frame of the PRA process, we did not expect to address all the issues between CSWs and health providers, given that many are structural and deeply rooted and need longer term processes. However we sought to improve communication and trust between the groups as a means of improving uptake and orientation of services, through initiating joint action on the shared feasible priorities they both identified as noted earlier.

From the priority concerns and the issues raised on them, participants developed an action plan that outlined actions that could be taken to address the three priorities identified by both, taking into account areas raised by both with actions for both. Using a market place tool, participants come up with actions that could be taken to deal with these problems. Participants then discussed the flipcharts and wrote their proposals on each. The charts were reviewed by all to identify actions to be taken immediately and those deferred. For the immediate actions, participants then wrote next to the actions who will take them. Again feasible proposals were taken and that were not were left out. The plan is shown in Table 3 below.

**Table 3: Action plan developed to enhance CSW uptake of and adherence to treatment**

<b>Problem</b>	<b>Causes</b>	<b>Action</b>	<b>Indicator</b>
<b>Issues and actions raised by CSWs on priority areas of action</b>			
Ill-treatment by HCWs	Fatigue on the part of HCWs High expectations of CSWs The way CSWs talk to HCWs Lack of understanding between CSWs and HCWs	CSWs to set up a committee that can liaise with HCWs and take up complaints of abuse	Number of meetings with HCWs over services Minutes of CSWs meetings with HCWs
CSW shyness to express themselves to HCWs	Absence of privacy at the registration place or reception. Friendships or relations with HCWs	Mass awareness campaigns Door – to – door outreach Invisible theatre (i) Hope kits (ii)	Increase in number of CSWs seeking health care at health facilities Increase in number of CSWs joining this group or participating in this initiative
CSW non-responsive-ness to treatment	Reluctance or negligence to take heed of advice Drug sharing	HCWs and CSWs to trace defaulters. Counseling for CSWs on drug regimens and	Reported number of visited defaulters Reported number of CSWs counseled on



due to default		advantages to adherence	adherence to treatment
<b>Issues and actions raised by HCWs on priority areas of action</b>			
Ill-treatment by HCWs	HCW Fatigue High CSW expectations Poor CSW communication with HCWs Lack of understanding between CSWs and HCWs	Health facilities to form committees to look after the welfare of patients (CSWs) HCWs and CSWs to show more tolerance of one another	Reduced number of conflicts between HCWs and CSWs CSWs and all other patients know where to channel their grievances
CSW shyness to express themselves to HCWs	Absence of privacy at the registration place or reception. Friendships or relations with HCWs	HCWs to practice confidentiality at all times	CSWs or other patients not presenting with the same problem recurrently
CSW non-responsiveness to treatment due to default	Reluctance or neglect to take heed of advice Drug sharing	HCWs to inform CSWs on the negative consequences of defaulting treatment HCWs to warn CSWs against drug sharing	CSWs coming for refills in time Improved CSW response to treatment

(i) Invisible theatre uses interactive drama model to promote behavior change, such as amongst young people. Actors prepare a scenario presenting issues. The scene is performed in public without letting the public know that they are involved in a created performance. Issues are introduced for public debate and awareness.

(ii) The hope kit is a tool kit for behavior change amongst young people, by providing solutions and alternatives to behaviors and environments that pose risk for HIV.

After this people split into three buzz groups to identify progress markers or indicators for each action they felt they *must* see achieved in the next two months, that is those that were seen as critical and feasible, as well as for that action they felt they would *love to* see achieved in the next two months, that is that they would want to achieve but recognize may take longer or have difficulties. In plenary these progress markers were placed next to each action and changes discussed to build with consensus and adopt a final list that would be used to monitor and review progress. This is shown in Table 4 below.

**Table 4: Progress markers set**

<b>MUST Achieve</b>	<b>WOULD love to achieve</b>
Improved CSW response to treatment	CSWs coming for refills in time
Reduced conflict between HCWs and CSWs	CSWs or any other patient not presenting with the recurring problems
Meetings held between CSWs and HCWs over services	CSWs and other patients know where to channel their grievances
Minutes of CSWs meetings with HCWs	
Increase in number of CSWs seeking health care at health facilities	
Increase in number of CSWs joining this group or participating in this initiative	
Reported number of visited defaulters	
Reported number of CSWs counseled on adherence to treatment	

These progress markers were to be reviewed and discussed by the team during and after the intervention to collectively track the progress in implementation.

## 4 The intervention

Three approaches were identified during the workshop to facilitate participatory mobilization and awareness of commercial sex-workers on HIV and AIDS and these included; Door-to-door, face-to-face talks and group meetings.

Health-workers and CSWs from Girls Alliance towards Behavioral Change (GABC) jointly worked together to reach out to other commercial sex-workers. GABC was responsible for booking appointments with CSWs. CSWs were visited either at home or at brothels. For brothel visits, GABC got consent and booked appointment with bar owners. We learned during the study that some bar proprietors are alleged to provide CSWs with accommodation for which CSWs pay only utility bills. The CSWs in their turn attract male customers to drink at the place. The CSWs had an identified leader, and the CSW leader and proprietor boss were visited with information with their consent, and these leaders informed the rest of the CSWs at that particular bar on the objectives of the intervention and the planned visit by the PRA team to discuss health with them. The approach was commended by the bar owners, who indicated that they were moved by the concept. An agreement with the bar owners and the CSWs was reached and a date for the talks was set.

**Figure 6: CSW rooms and children at a local bar**



Source: REACH Trust 2008

**Figure 5: Sex workers coming to for testing and treatment**



In the door-to-door campaign, the team provided counseling to CSWs, encouraging early reporting to services for illness. As a result of observing some problems with the health of CSW children, groceries like soap, iodized salt and sugar among others were also distributed to support some additional health promotion on hygiene and oral rehydration for children, while noting that this demands follow up intervention by the team.

Source: REACH Trust 2008

As a result of the door-to-door visits, face-to-face talks and group meetings:

- Over 60 CSWs underwent HIV testing and counseling, 25 CSWs were tested in their brothels and 35 reported for testing after the door-to-door activities. One of the CSWs who had expected her result to be positive but was actually found to be HIV negative, left after the test for her home village the same day, in her response to being not infected being in the business for several years.
- Nine CSWs were referred for ART treatment.
- Thirty four sex workers were screened, diagnosed and treated for STIs

- Forty hospital officials in the facilities around the area of intervention were sensitized on the issues identified affecting uptake of and adherence to services
- Thirty CSWs came for group therapy sessions at GABC, adding to the original number members in the group.
- Thirty five CSWs were counseled in the door-to-door and community outreach activities
- A suggestion box was introduced at Dzenza health facility

The other actions taken for each area are summarised in Table 5 below.

**Table 5: Summary of interventions implemented**

Objectives	Method	Action points identified	Activities done to address action points	Results
To improve CSWs access to HIV and AIDS services	PRA workshop with 30 people comprising CSWs and HCWs	CSWs shyness to express themselves to HCWs  CSWs non-responsiveness to treatment due to treatment defaulting	35 door-to-door one-on-one discussions with CSWs counseling them on importance of drug adherence  3 outreach campaigns with CSWs in 3 pubs encouraging early uptake of health care  HIV counselling and testing (HCT) and STI treatment to CSWs in the 3 visited pubs  10000 male condoms distributed to the CSWs visited in brothels to share Female condoms given to 8 CSWs	More CSWs seeking care  25 CSWs access HCT and STI services  9 CSWs tested HIV + and referred for WHO staging 16 tested HIV- but still treated for STIs.  Over 60 CSWs taught on correct, consistent use of male and female condoms
To improve communication between CSWs and HCWs	Suggestion boxes installation in facilities  Set up committee to oversee the sustainability of the intervention  Facility meetings and briefings by PRA team discussing challenges revealed by CSWs	Ill-treatment by HCWs	1 suggestion box installed at Dzenza Health centre  Committee holding weekly meetings and separate visits to facilities to monitor progress and review implementation  Briefing for departmental and facility meetings held to discuss issues of communication between HCWs and CSWs in facilities.	Channeling of views through the suggestion box and feedback by the health care providers to the clients  Early attention to emerging challenges and suggestions to the smooth implementation of the intervention  HCWs and CSWs appreciating each other's perspectives and communication improving.

Further to this information, to improve communication and monitor the progress of the activities, a committee was set comprising health workers and CSWs. This committee met weekly to discuss the progress of the activities. The monitoring also involved the GABC and the GABC and health workers involved in this process submitted reports on all activities conducted. The committee's weekly meetings worked as a review of the progress of

activities and findings were reported during these meetings, and the tools and processes of implementation reviewed to tackle emerging issues. Members of the PRA taskforce were also provided notebooks to record their observations of the process and the management of it by the team, and these observations were also discussed during the weekly meetings. This monitoring of both the process and the self-monitoring acted as a double check in the implementation of the intervention.

## **5 Assessment of the changes after the intervention**

During the monitoring of implementation of the project, all except the first two progress markers on the MUST achieve column were felt by the whole group to have been met by the time the study phase ended. According to respondents during the evaluation survey, conflicts still occurred and there was still some ill-treatment reported of CSWs at facilities. The 'would' love to be achieved markers had not been achieved by the end of the intervention, although progress had been made towards them.

The post intervention assessment was conducted between December 2008 and January 2009, with the same 65 CSWs and HCWs from the pre survey.

Comparing the pre and post intervention survey results (See Table 6) The findings were

For the CSWs:

- Rating of knowledge increased
- Rating of barriers fell from 76% rating as extremely or very high in the pre survey to 38% in the post survey
- Rating of access to services improved, from 2% rating access to HIV prevention as extremely or very high in the pre survey to 54% in the post survey; and 4% rating ART access as extremely or very high in the pre survey to 47% in the post survey.
- Perceived condom use increased from 4% rating as extremely or very high in the pre survey to 42% in the post survey
- Treatment default was seen to have fallen, from 58% rating this as extremely or very high in the pre survey to 18% in the post survey.
- Communication was felt to have improved greatly, from 1% rating this as extremely or very high in the pre survey to 56% in the post survey, while presence of communication mechanisms went from 4% to 11% respectively.
- A decline was reported in perceived quality of services, from 27% rating this as extremely or very high in the pre survey to only 4% in the post survey.

Differences were thus recorded in the level of access and use of HIV prevention and treatment services, a finding verified by the data collected during the door-to-door surveys and facilities during the project implementation. For example, it was reported from Dzenza health centre that the average number of clients treated for STIs in a month rose from 34 before the intervention to approximately 50 after.

**Table 6: Pre and Post Intervention Survey Results**

ISSUE	HCW responses (% total, N=20)								CSW responses (% total, N=45)							
	Pre intervention				Post intervention				Pre intervention				Post intervention			
	Extremely/ Very high	H	L	Very low/ none	Extremely/ very High	H	L	Very low/ none	Extremely/ very high	H	L	Very Low / none	Extremely/ very high	H	L	Very Low / none
Knowledge of HIV services									33	38	27	2	89	11	0	0
Barriers CSWs face	70	25	5	0	60	30	10	0	76	22	2	0	38	38	24	0
Access to HIV prevention services	25	40	30	5	25	70	5	0	2	24	27	47	54	38	7	2
Access to ART	20	35	45	0	35	60	5	0	4	51	24	20	47	44	4	4
Condom use	5	25	25	45	10	90	0	0	4	16	7	73	42	42	13	2
Treatment default	40	30	30	0	5	40	55	0	58	20	20	2	18	27	51	4
Quality of services	35	40	25	0	45	50	5	0	27	47	27	0	4	62	33	0
Level of communication	5	60	30	5	50	50	0	0	1	53	31	7	56	24	16	4
Availability of communication mechanism	20	25	30	25	20	40	40	0	4	24	27	44	11	78	11	0

H= high L = Low

For the health workers:

- Rating of barriers fell to a lower degree, from 70% rating as extremely or very high in the pre survey to 60% in the post survey
- Rating of access to services improved slightly, with the same levels rating access as extremely or very high in the pre and post survey, and an increase in those rating this as high; Further 20% rated ART access as extremely or very high in the pre survey rising to 35% in the post survey.
- Perceived condom use increased from 5% rating as extremely or very high in the pre survey to 10% in the post survey
- Treatment default was seen to have fallen, from 40% rating this as extremely or very high in the pre survey to 5% in the post survey.
- Communication was felt to have improved greatly, from 5% rating this as extremely or very high in the pre survey to 50% in the post survey, while presence of communication mechanisms remained level at 20% in both surveys.
- An improvement was reported in perceived quality of services, from 35% rating this as extremely or very high in the pre survey to 45% in the post survey.

Health workers thus similarly reported improvements in the areas noted by the CSWs, although their rating of improvements were generally a little more modest than the CSWs. It may be that the greater impact was felt by the CSWs, noting that this is a subjective rating. It is however interesting that both groups perceived positive impact, triangulating the evidence on the reported trend.

Facilities reported CSWs coming to the clinics after referral by the PRA counselor, for testing and if positive initiation on ART. Word spread through the CSWs and services, but not always accurately. More CSWs were reported to have gone to area 25 health centres for staging. Due to some poor coordination and communication between the referral authority and the receiving facility, some CSWs went home unattended for two consecutive days, as they came on days that staging is not conducted. Unlike their colleagues who had come on right day for staging of patients for ART.

There are two areas that pose cause for concern for sustaining the progress noted. The CSWs recorded a decline in their rating of quality of services post intervention, possibly given their higher knowledge and expectations after the PRA meeting and intervention, and their greater willingness to speak about their views of services. If they do not perceive services to provide the quality they need they may revert to non use and default. Further, some respondents cautioned that the favourable outcomes were a feature of the recent timing of the intervention and the desire to impress or keep the implementers involved, and we understand that much deeper and longer term changes are needed to make a difference to the livelihoods and environments needed to sustain good practice.

## 6 Discussion

From an initial baseline of high knowledge but poor rating of access and uptake, due to both barriers in the community and in the services themselves, the intervention has changed the perceptions of both CSWs and health workers, and the reported uptake of services by both CSWs and facilities. The PRA process was able to draw out experiences of the barriers faced, with priorities identified as:

- Lack of early treatment seeking practices amongst CSWs
- Ill treatment of CSWs at health facilities by Health practitioners
- Lack of adherence to treatment by most of CSWs.

The separate feedback from the CSWs and HCWs on their experience of HIV services for CSWs indicated some areas of shared perception, and some of different concerns. For the CSWs, the way they are treated by service providers was an important issue that health workers did not raise, while health workers raised the poor compliance with service and drug procedures that CSWs did not refer to. Both raised shortfalls in the health care environment and the resources for HIV related services relative to need.

In the short time frame of the PRA process, we did not expect to address all the issues between CSWs and health providers, given that many are structural and deeply rooted and need longer term processes. The PRA process itself raised issues of gender violence and abuse that CSWs face (including through attitudes and practices in health care services) that de-humanise them, and perpetuate their own harmful behaviours. It is possible to be fatalistic about any positive change in this context, and necessary to address the more powerful drivers of risk practices, including from male clients. As one CSW said *“If you tell us to use condoms always and yet it is the sex without condom that fetches big monies, what is it that you are going to provide to us to really change our lives for the better?”*

However, the group of CSWs and health workers as a whole identified interventions that were immediate and feasible to address the three barriers they prioritized to CSWs accessing the HIV prevention, testing and treatment services they need. An intensive intervention, involving door to door counseling, engagement at places of work, formation of joint committees between CSWs and health workers and sensitization of health workers was implemented, steered and reviewed by the team with the CSWs and health workers

themselves. The findings suggest that the process used has some effect on addressing these barriers and mobilizing demand for and uptake of HIV prevention and treatment services in CSWs.

We were not able in this intervention to address deeper structural issues of laws, policies, employment, incomes, health service infrastructure and resourcing for health care and inadequate human resource capacity that we found also block CSW access to services. These need attention by government and its local and international partners if the declared universal access to HIV and AIDS prevention, treatment and care and support is to be achieved. In a context where alarming increased numbers of girls join the sex industry annually, engaging CSWs and HCWs is essential to address these drivers of commercial sex work and bring services close to affected communities.

We were however able to address those local level factors that undermine the communication and effective interaction between providers and communities, when services do exist. This calls for public health to guide service provision on this area, so that CSWs are able to access to prevention and care programmes to reduce and eventually stop the spread of HIV for all. Unless we build a PHC oriented programme framework that provides for active and meaningful participation of these marginalized, most affected groups, like CSWs, we will not be able to achieve goals of universal access to HIV prevention, treatment and care in some of the groups where greatest public health demand exists. This includes enabling CSWs to not only know and recognize their risk, but to see themselves as having the means and skills to take feasible actions and use services to reduce that risk.

A PRA intervention appears to have offered a means to achieving this. Our intervention indicates that civil society is well placed to provide the sort of bridging activities needed, and we suggest that government and international agencies collaborate more effectively with civil society to hear and engage CSWs' on their concerns and health needs.

## **6.1 Implications for PHC oriented prevention, treatment and care for CSWs**

While great progress has been made in shaping and delivering HIV and AIDS prevention, treatment and care services, including the syndromic management of STI in state and non state primary health-care units, to reach and ensure uptake in CSWs, this study suggests that there is need to go a step further:

- To take a public health approach, to recognize, listen to, involve and build capacity in CSWs and ex-CSWs, and the civil society organisations that work with them, as a primary group for reaching and mobilizing uptake of services in CSWs;
- To ensure messages for health promotion that are developed with and locally relevant to the barriers CSWs face to healthy behaviours and health service uptake, and invest in mechanisms, skills and tools for enhancing communication between health workers and CSWs and within CSWs as peers on issues such as adherence and compliance with treatment regimes;
- To acknowledge the presence of stigma, sexual harassment within health services and put in place training, guidelines, mechanisms and actions to check it;
- To ensure that HIV and AIDS services integrate through relevant linkages issues of sexual abuse and gender based violence on groups like CSWs.
- To ensure that services are reach out through civil society, leaders from affected groups, to places where CSWs are found, and involve key stakeholders in those environments in enabling this outreach

## **6.2 Lessons learned on using PRA approaches**

While PRA approaches were valuable in achieving the communication needed to prioritise and build consensus on barriers and actions, sometimes unearthing painful and harsh realities, they provided both learning and challenge for the team. The PRA approach was effective in drawing out experience and views about the things CSWs and health workers felt affected their well-being or ability to provide services; and a safe constructive means to address concerns about each other that were barriers to service uptake and sources of conflict, sometimes violent. It built not simply individual but collective empowerment, and so as a process affirmed other interventions aimed at tackling gender violence by groups as a whole supporting affected individuals, including with formal authorities. The time taken may be an important investment if it acts as a base for further intervention. For example the work reported here provides an entry point for further work on the issue of concurrent partnerships, that will through working with CSWs give greater focus to men who are mostly buyers of sex.

Yet the process is demanding, particularly of time and leadership. We recognize that CSWs are the best people to reach their fellows, and that PRA processes are time intensive and demand facilitation skills that will be difficult to spread rapidly in the many CSWs in Lilongwe, and nationally.

## **6.3 Next steps**

A dissemination workshop was conducted after the intervention and three major steps resolved during this meeting as follow up to this work and the evidence and learning from it:

GABC pledged its commitment to continue the door-to-door campaigns to signal the seriousness of the initiative with the CSWs, and would build HIV counseling and testing skills in those CSWs able to take this on.

Further it was proposed that the group engage the district health office on intensifying the outreach provision of testing and counseling, ART and sexual reproductive health services like family planning close to the sex workers' environment. The group, co-ordinated by REACH Trust, proposed to consult authorities and mobilise resources to follow up on these steps.

On the deeper issue of issue of economic empowerment and employment, the meeting resolved that with REACH Trust coordination, the technical working group formed during this project should link the CSWs with institutions that lend capital to women, and with those that provide vocational skills.

It would not be possible to discuss a PHC oriented approach to HIV related services without recognizing the need to take on the wider environments of deprivation that both lead to commercial sex work, and that expose CSWs and their families to risk. We observed children with malnutrition and living in extremely poor living environments in confined and shabby rooms (shown earlier) that pose a threat of many health problems, including sexual harassment and future commercial sex work. A comprehensive PHC approach must give attention to addressing these social determinants not only of the health of the CSWs, but of their children.



## References

1. Buvé A, Caraël M, Hayes RJ, Auvert B, Ferry B, Robinson NJ, Anagonou S, Kanhonou L, Laourou M, Abega S, Akam E, Zekeng L, Chege J, Kahindo M, Rutenberg N, Kaona F, Musonda R, Sukwa T, Morison L, Weiss HA, Laga M (2001) A multi centre study on factors determining differences in rate of spread of HIV in sub-Saharan Africa: methods, prevalence of HIV infection AIDS 2001; 15-58-14
2. Save the Children Fund (2004) Children in a world of HIV and AIDS, SCF, USA Accessed at [http://www.savethechildren.org/publications/World\\_of\\_AIDS\\_1004.pdf](http://www.savethechildren.org/publications/World_of_AIDS_1004.pdf) on August 17 2009
3. Calisto S, (2009) 'Chigwiri sex workers' hope,' *The Nation news paper*, 11 February, 2009
4. Njikho HY (2008), Needs assessment for media reporting on key health issues in Malawi, Unpublished mimeo, Lilongwe.
5. National AIDS Control Programme (2001) HIV and STI sentinel surveillance report, NACP, Lilongwe
6. Jiya W. (2005), Knowledge, attitudes and practice among youths regarding voluntary counseling and testing in Machinjiri and Mitundu, National HIV/AIDS research and best practices conference, Lilongwe, 18-25 April 2005
7. Loewenson,R., Kaim, B., Mbuyita, S. Chikomo, F., Makemba, A. (2006) *Participatory methods for people centred health systems: A toolkit for PRA methods*. TARSC, Ifakara: Harare
8. National Statistical Office Malawi (NSO) and ORC Macro. (2005) Malawi Demographic Health Survey 2004, NSO and OCR Macro, Lilongwe and Calverton USA
9. NSO (2006) Malawi behaviour Surveillance survey, NSO, Zomba Malawi
10. UNAIDS (2000) AIDS epidemic update UNAIDS Geneva
11. UNAIDS (2008) Malawi National Composite Policy Index report 2008, UNAIDS at [http://data.unaids.org/pub/Report/2008/malawi\\_2008\\_ncpi\\_en.pdf](http://data.unaids.org/pub/Report/2008/malawi_2008_ncpi_en.pdf) accessed April 9 2009
12. World Health Organisation (WHO), UNAIDS (2006) HIV country profile Malawi December 2005, WHO Geneva

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We hope the report will contribute to on going discussion and debate and will be enriched by other methods of assessing evidence as well as other research questions that will further the issues raised and give attention to the means that CSWs merit in achieving equitable access to HIV and AIDS services. The authors acknowledge EQUINET, TARSC and REACH Trust colleagues for per review support and SIDA Sweden for financial support. We are indebted to the representatives of different institutions that made a broader stakeholder group for the study. Special mention to the HIV and AIDS unit from the Lilongwe District Health Office (DHO), Lighthouse clinic, Banja La mtsogolo, Family Planning Association of Malawi (FPAM), Area 25 Health Centre, Gika private clinic, Dopa Private clinic, Dzenza mission health centre, YOUDAO, GABIC and all the CSWs from Area 25 for the providing valuable input to the project. We thank also the media and in particular the state broadcaster Malawi Broadcasting Corporation Radio 1 for dissemination of the project's findings to the public.

**Equity in health** implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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