



*Mapping for the health and well-being of mobile sex workers
and the communities they serve*

The case of Cambodia

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Many efforts to help sex workers in their health problems are designed as if they always worked in the same location, whereas in many developing countries they are a highly mobile population. This results often in ineffective health services to the detriment of the sex workers. For example, they have difficulties in accessing health services or in continuing treatments when they change work locations.

In 1999, the Cambodian National Centre for HIV/AIDS, Dermatology and STD (NCHAD), in partnership with the UNDP South East Asia HIV and Development Project (see box), conducted a mapping assessment along National Routes 1 and 5 of Cambodia to assess the HIV vulnerabilities of people along the route.¹

After a national training workshop conducted in Phnom Penh on mapping methodology for mobility, the NCHAD staff and provincial AIDS Secretariats staff along the routes jointly conducted a mapping exercise with local communities, using a standardised questionnaire, between late August to early September 1999.

Subsequent to the assessment, consultations with local communities and national dissemination workshops were conducted. Through this participatory approach, responses have been devised and implemented since 2000 to remedy the identified HIV vulnerabilities. An impact evaluation was conducted to ascertain whether there were any actions taken based on the mapping findings locally and if so,

what were the impacts.² This article reflects the findings from the mapping impact evaluation in Cambodia.

Putting services on the map

In Cambodia, rather than just targeting sex workers in a brothel, a broader strategy has been evolving that covers the various types of sex work, situates them in their environment and recognises the fact that they often move from town to town. The local AIDS authorities conceived of such a strategy after a mapping assessment of both the entertainment and health services along national Highway Route 5 and conducting a behavioural survey to identify the factors of vulnerability to HIV infection.

For example, between the capital, Phnom Penh and the Thai border, along the 300 km of Route 5, 99 brothels were found which were strategically located from a business and leisure perspective. To these numbers, one has to add many karaoke lounges, guesthouses, night-clubs and beer bars. Hospitals, health centres, STI clinics and private clinics were located and marked on the same map as the entertainment places. The researchers and local community could thus visualise relationships between the locations of supply (health services) and the places of demand (sex work establishments) as well as the movement of sex workers from town to town.

Both the mapping and the survey were carried out through participatory research. Instead of using mostly outside experts to conduct the research, information was collected and analysed mainly by local people, including sex workers.

Understanding social networking

This exercise was co-ordinated in the context of the Cambodian 100% condom expansion programme to understand the social networks along Routes 1 and 5. Routes 1 and 5 are the major East-West highways linking Phnom Penh with Thailand to the west, and with Vietnam to the east. The Ministry of Public Transport and Public Works was also involved in facilitating the mapping study. The NCHAD staff contacted the available karaoke bar owners, pimps, sex workers, brothel owners, clients, taxi drivers, guesthouse receptionists and local authorities including police and health centre staff. Available sex workers and clients at the time of assessment were approached in a friendly manner with the assistance of pimps and brothel, guesthouse and karaoke bar owners.

The brothels are often located along a stretch of a street. For example, in one of the cities along Route 5, the brothels are clustered along the railroad behind the major railway station where rail carriages are parked. The entire stretch of the road is lined with entertainment facilities on both sides. Prostitutes sit on the benches or chairs along the road outside the facilities to chat with potential clients as well as to solicit passers-by. The entertainment facilities are frequented by local residents as well as by passing visitors.

Locally driven surveillance

Some snacks or drinks were provided to informants but no direct monetary payments. The data collection staff of AIDS committees, however, were provided with transportation to reach the sites. The initial mapping assessments were conducted locally within a few

days by local staff who already were familiar with the local people. However, the post-assessment efforts were done monthly with the community as they determined that was what they wanted. It is now a regular gathering since the local consultation efforts began.

The assessment resulted in stimulating a sexual health system surveillance that is locally driven. Through participation of local people and sex workers, the communities were better able to identify gaps of services and other problems that induced sex workers' HIV vulnerabilities. They were able to find solutions which are practical and feasible in local circumstances.

Shift of focus

It became clear that it was to every one's best interest to promote sex workers' health instead of singling them out as source of HIV infection while overlooking the role of local residents, who are the clients, in sexual health-related problems. This is a critical shift of focus because sex workers are usually from other communities (relatively distant rural areas or other countries – mostly from Vietnam but recently there were other foreigners coming into the trade) with few local women serving local men. Cambodian sex workers tend not to do their trade within their own hometowns. They migrate to towns away from home so as not to bring shame to their families. This is another factor contributing to the frequent movement of sex workers in and out of a location because they do not belong to the communities where they work. Local communities and officials often felt little if any commitment or obligation to sex workers' health, as they do not 'belong'. The combined effect of the frequently found stigma against sex work with the indifference or hostility towards outsiders creates barriers for sex workers to access local health services in order to maintain their health. Local health officials came to realise that simply having health facilities available in local communities does not equate access for sex workers, who face real and perceived obstacles in using these services.

An enabling environment

Through the improved understanding of the reality of behaviours rather than acting upon desirable images of social behaviour, the attitudes of police, health and other officials changed towards sex workers. The importance of creating an enabling environment for sex workers emerged. Now the local communities realised that to protect the health of their own community, they must reduce barriers for sex workers to seek early diagnosis and treatment for STIs, improve HIV prevention by promoting condom use, etc. As a conse-

quence, sex worker health education improved with reduced discrimination. Today, the local health authorities have positive attitudes towards the sex workers and they are obliged to provide effective HIV prevention to the workers by decree of the 100% condom policy, which is prominently displayed at the entrance of each brothel. Also, the sex workers receive check-ups by the local health services. If they were found to have an STI or HIV, the owners of their establishment would be visited by the local authority to improve compliance to the 100% condom policy (see box).

UNDP South East Asia HIV and Development Project

The UNDP SEA HIV and Development Project covers the ten ASEAN member countries of Brunei, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Vietnam, and the People's Republic of China. The project focus is on the reduction of HIV vulnerability among mobile populations. Mapping has been carried out for Cambodia, Vietnam, Lao PDR, Guangxi-China, Indonesia and the 'BIMPS cluster' countries (Brunei, Indonesia, Malaysia, Philippines and Singapore). Most of the publications are available from the website: www.hiv-development.org.



Instead of feelings of shame, the sex workers realised that they ought to seek information on STIs, HIV/AIDS and monitor their own health status. The officials became less authoritarian and began collaborating with entertainment establishment owners and staff in introducing 100% condom use at entertainment facilities. This enabling environment also increased the clients' safety and health. Furthermore, with health officials monitoring sex workers' health, the officials were then able, through discussions with all involved, to encourage prostitutes to check their STI status and to alert the clinics on the numbers of visits to expect. This ensures a better coverage and services for sex workers.

The risks of 'non-hotspots'

The mapping results have also shown that sex workers normally do not stay for more than a few months in any one town because the clients want new faces. One of the patterns which emerged along Route 5 was that the youngest or freshest entrants to sex work tend to be found in major towns with the most business. Over time, sex workers slowly move to less desirable and less lucrative business settings where their earnings decline

100% Condom Use

The Cambodian 100% Condom Use Programme was modelled after the successful Thai programme, which started in the beginning of the 1990s. The programme requires brothel-based sex workers to refuse unprotected sex on the instructions of the brothel owners and managers. It is based on the presumption that sex establishment owners should be part of the solution, not the problem. In Cambodia, a pilot project that started in 1998 in Sihanoukville proved equally successful, and the Cambodian government is currently expanding the programme nation-wide.

accordingly. Meanwhile, their risk of exposure to HIV and other STIs increases. Sex workers who move frequently either do not have the opportunity to get regular health check-ups or tend to discontinue treatments started in one place as they move on to another.

There are multiple implications for these sex workers and for public health programmes and services. For example, there is a commonly held belief and practice in resource allocations that resources and services should be devoted to 'hotspots' where many entertainment establishments are concentrated, resulting in 'quieter' towns being overlooked. As the risks of STIs and HIV increase with the length of service of sex workers, the level and frequency of STI infections among sex workers in less lucrative towns can actually be higher than among the new entrants who tend to serve the more prosperous locations. According to available annual HIV and STI statistics, we found that the HIV prevalence among sex workers was higher in towns located some distance from major towns along Route 5.

It is thus critical to ensure that, in less popular entertainment towns, health services are able and ready to serve incoming sex workers who have rotated from 'hotter spots'. For sex workers, this is important as, just when they need these services the most, this type of policy and programming would ensure that services would be available where they might not have been otherwise. Finally, it would also necessitate the health services of different towns keeping contact with one another to provide referral on treatment and care. It also requires facilitating access to services, thus reducing loss to follow-up, cases of incomplete treatment and the development of resistant strains.

In conclusion, linking local health services in towns along major highways in Cambodia plus introducing a participatory and enabling environment for sex workers can improve the protection of health for all members of a community. The way Cambodian health officials handled the mapping assessment is a good example of good governance and highest level political commitment as well as local follow-through.

In addition, using mapping of HIV vulnerabilities allows intervention projects to identify HIV vulnerable communities which are not otherwise considered on the basis of commonly selected indicators of 'hotspots'. In this case, where the sex workers migrate is an important indicator to ensure capturing the communities that are most vulnerable to HIV.

Notes

1. *Cambodia HIV Vulnerability Mapping: Highways One and Five*, NCHAD, Cambodia and UNDP South East Asia HIV and Development Project, January 2000, www.hiv-development.org/publications/cambodia_mapping.asp.
2. *The impact of mapping assessments on population movement and HIV vulnerability in South East Asia*, September 2001, www.hiv-development.org/publications/mapping.asp.

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