RESPONDING TO QUESTIONS ABOUT THE 100% CONDOM USE PROGRAMME (2ND EDITION)

A JOB AID FOR PROGRAMME STAFF

World Health Organization
Western Pacific Region

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Introduction

This document is intended to help the 100% condom use programme (CUP) technical staff to:

- anticipate the kinds of questions that may be asked about the programme; and
- identify strategies and points of information that may help them to respond appropriately in their settings.

Contained in this document are samples of questions that have, at one point or another, been posed to programme staff about the 100% CUP. Points that might be addressed in response to these questions are also included.

In real life situations, questions are invariably formulated within the context of the local or community situation. Several issues may also be combined within a lengthy statement. Sometimes there are "hidden questions" in what may appear to be a simple, straightforward query. It is imperative that responses to questions address these different issues. It may be useful in situations to "disaggregate" a compound question into its parts, restate what is interpreted as the second or third separate question, and then respond to each separately. In the following situation, it would be helpful to pause and rephrase the "hidden question." For example, *"I hear that most sex workers are getting infected with STI by their boyfriends and husbands. What is the 100% CUP doing about this?"* The CUP technical staff could respond by saying *"I think I can best answer your question if I clarify first 'What the 100% CUP is' and describe how it works."*

In responding to questions, it is imperative that attention be paid to the person who is asking the question, to his or her educational background, the extent of knowledge they have about the 100% CUP generally, and the underlying perspectives that they may be bringing to the conversation. Language must be tailored accordingly, such as using or avoiding acronyms like STI (sexually transmitted infections), VCT (voluntary counselling and testing), BSS (behavioural surveillance survey), HSS (HIV sentinel surveillance), or technical words. Using unknown acronyms may confuse or bore the audience.

Though a rigorous separation is not possible, an attempt has been made to divide the questions into two broad categories:

- questions from persons seeking basic information about the 100% CUP; and
- questions from more knowledgeable persons who may be critical of one or another aspect of the programme.

Basic questions about the 100% Condom Use Programme (CUP)

1.1 What is the 100% CUP?

The 100% CUP is a programme to prevent sexual transmission of HIV and sexually transmitted infections (STI) in the general population by promoting high level condom use among sex workers and their clients. The main principle of the 100% CUP is to create an enabling environment to empower ALL sex workers to refuse sex services if clients do not want to use condoms - that is to monopolize sex business regarding universal use of condoms. As a result of the CUP, clients will no longer control whether or not condoms are used during sex services.

The 100% CUP is a collaborative programme between local authorities (governor's or mayor's offices, police, health, and other concerned government sectors) and all "sex entertainment establishments" (owners, managers, and sex workers) that aims to reduce the sexual transmission of HIV and STI by assuring that condoms are used:

- 100% of the time;
- in 100% of risky sexual relations; and
- in 100% of the sex entertainment establishments in a large geographic area such as a town, district, province or country.

Several key concepts in this definition may need clarification.

"100%" is a clear goal and not a critical numerical objective. The 100% CUP has been shown to work with a high level (90% plus) of compliance.

"Risky sexual relations" refers to sexual practices that involve penetration and/or the risk of exposure to bodily fluids that spread disease. There are some sexual practices (e.g. kissing, fondling, and masturbation) that are not risky and that do not necessarily require condom use.

"Sex entertainment establishments" refers to places where commercial sex is negotiated and sometimes conducted under the general supervision of an owner or manager.

It should be noted that the 100% CUP strategy has proven feasible for non-establishment sex work as well. In such case, the phrase "100% of sex establishments" means "100% of sex business sectors".

1.2 What is the basic strategy of the 100% CUP? How does it work?

The 100% CUP is a strategy to reduce the transmission of STI and HIV where it is associated with transmission linked to sex work that is taking place in the context of "sex entertainment establishments," such as brothels, guesthouses (brothel-like) and, in many cases, night clubs, beer halls, bars, karaoke bars, massage parlours, and saunas.

Though there are other programmes that "promote" the use of condoms for high-risk sexual relations in these types of places, the 100% CUP is designed to address a serious difficulty that has been widely observed: sex workers may lose clients to other persons or places where condoms are not required if they insist that a client use a condom. In effect, there is a perception that it is an "economic disincentive" for owners and workers of sex entertainment establishments to promote condom use.

An essential strategy of the 100% CUP is that it is implemented on a "total geographic area coverage basis" (which can be a town, district, province or country). Also, the programme requires ALL sex entertainment establishments in the area to require condom use. If it is too sensitive to single out sex establishments, then all types of entertainment establishments could be required to participate. The result is that clients simply will have little opportunity to go to elsewhere if all establishments insist on condom use.

1.3 Who are the key players to ensure success of the programme? What is the role of each player? Who should take leadership in implementing the CUP?

The 100% CUP cannot be implemented without the participation and collaboration of many key players in the community. Such key players include local authorities (health, police, and governor's and mayor's offices) and all "sex entertainment establishments" workers (owners, managers, and sex workers). Depending on the local situation, other players may include tourism and cultural sector officials (those involved in issuing or renewing licenses of entertainment establishments), bar owners, sex workers associations, and social welfare department staff.

Under the leadership of the local governor or mayor, the health sector (either the local health office or the local HIV/STI control unit) will be responsible for monitoring and coordinating activities relating to the programme implementation. The local governor will provide policy and advocacy as well as financial support to the programme. Local policy, regulation, and/or ordinance on the 100% CUP will support its implementation by convincing all key players to follow the local government's requirement in order to prevent HIV/STI transmission.

The police will be instructed to support the implementation of the 100% CUP (openly or silently depending on the local context). The police could be involved in supporting the warning or sanctioning of entertainment establishments that do not conform to the policy of "No Condom, No Sex." In cases where sex workers are being abused by their clients, the police should protect the sex workers and arrest the clients. Local police should be informed of the rationale for implementing the 100% CUP and the need for their support. They should be updated on information related to the risk of HIV. Programme managers should ensure that any policy that penalizes sex workers carrying condoms be revised.

In the implementation of the 100% CUP, it is important to develop good coordination with local STI service providers. Key areas of collaboration include: providing STI treatment and care services; advocating for STI/HIV prevention among clinic clients by promoting safe sex practices and condom use; supporting staff

training; disseminating information, education, and communication (IEC) materials for clients; supplying condoms to entertainment establishment workers; collecting information on condom use among male STI clients; and possibly providing outreach services where applicable.

Sex workers (both male and female) also have important role in the implementation of the 100% CUP. Their main activity is to convince clients to always use condoms and refuse sex services if clients do not agree to use condoms. Peer education activities among sex workers can ensure solidarity with regard to the practice of "No Condom, No Sex" and help new sex workers understand the condom use requirement that complies with the 100% CUP implementation.

The 100% CUP will be unsuccessful if there is only limited support from the owners of entertainment establishments. The owners are responsible for creating an enabling environment to empower ALL sex workers to refuse sex services if clients do not want to use condoms, thus conforming to the 100% condom use policy. The owners are also requested to inform all new staff about the 100% CUP and the need for their participation, and to support sex workers in any case that clients refuse to use condoms.

For the implementation and expansion of the CUP, there is a need to develop a national policy to promote the programme. Experiences from Thailand, Cambodia, and other countries show the need to have endorsement from the highest level, such as the Prime Minister, if the strategy is to be expanded nationwide. At the local level, government authorities, owners of sex businesses, and the sex workers should be involved. The choice of leadership should be one that can facilitate coordination of policy development and implementation plans.

1.4 What are the practical steps for starting a 100% CUP?

The steps will depend on the local situation. In general, the practical steps are as follows:

- Holding a meeting of local HIV/AIDS committee (or any AIDS-related multisectoral coordinating body) to obtain consensus

on the 100% CUP implementation and preparation to start the programme;
- Holding a meeting of the local HIV/AIDS committee, owners of sex businesses, and senior sex workers to get cooperation for the implementation of the 100% CUP;
- Educating sex workers on the programme (including peer education);
- Providing logistics support (condoms, STI services, educational materials, water-soluble lubricants);
- Monitoring and evaluating the programme; and
- Managing uncooperative sex business owners or managers through monitoring of condom use.

1.5 How can a sex worker require that a client use a condom if he does not want to? Won't the man just force her to have unprotected sex? How can we protect/support women from being abused if they refuse to have sex with clients who do not wish to use condoms?

The 100% CUP involves a number of strategies to "empower" sex workers in their negotiations with clients about condom use. Basically, it employs strategies that provide:

1) Motivation for sex workers to insist on condom use as a result of both educational programmes and the knowledge that she will probably not suffer economically in making such demands because of the regulation requiring 100% condom use in all sex entertainment establishments. (See also response in question 1.2 about the removal of economic disincentives.)
2) Skills for sex workers to better negotiate condom use with reluctant clients. In many programmes, these skills also include ways to make condom use itself more sexually stimulating or techniques for proposing alternatives to risky sex that will not require a condom to be used.
3) Support for sex workers in assuring condom use in risky sex relations by creating an "enabling environment" for the sex worker in these negotiations through:
    - having a 100% condom use policy for all sex entertainment establishments;
    - increasing the responsibility of establishment owners and

managers to support sex workers in ensuring protection of sex workers from HIV/STI infections through the policy of "No Condom, No Sex," managing condom supply, negotiating condom use with very reluctant clients, protecting sex workers from any form of violence, handling other difficult situation like drunk clients; and,

- assuring that high quality condoms are accessible to sex workers and clients.

To prevent their workers from being abused by clients, the owners or managers of sex establishments should inform all clients as early as possible that sex services are available only for condom users, and that sex workers will not provide services if clients refuse to use condoms. Clients should be informed that this practice is the policy of the local government, and that clients will be punished if forcing sex workers to provide sex service without using condoms. Sex workers should also convince clients that condom use is a universal requirement in the area. Therefore, there will be no sex establishments nearby where condom use is not required.

1.6 How can you be sure that a sex worker and a client are using a condom all the time? This is taking place behind closed doors. How can you monitor condom use in this kind of situation?

Monitoring condom use is important to: ensure that condoms are used in every sexual encounter linked with sex business; identify establishments at risk of HIV transmission and thus ensure good cooperation of entertainment establishments; and ensure continuous availability of condoms in the programme. The 100% CUP can monitor condom use in the following ways. [Answer here must be tailored to how the 100% CUP is being implemented in the locality.] :

(a) The simplest and most effective method is by questioning every male client (regardless of their STI status) at STI clinics about where they may have acquired their infection, using questions like: "Which sex entertainment establishment have you visited?" and "Did you use a condom?" Information from male clients at STI clinics can be associated with sex at a particular establishment and authorities could work with the staff and managers to

encourage compliance with the 100% condom use regulation under the possible risk of temporary or permanent closure of the establishment. This type of monitoring does not require that clinics see the majority of male STI cases in the community. Only a few cases are sufficient for monitoring purposes.

Verification by this method is a safe and unbiased way to get information on condom use in sex establishments. Therefore, involvement of local STI clinics in the programme is essential. Staff in the clinic should be trained to have interviewing skills to collect information on condom non-use and to identify the entertainment establishments where condoms were not used by sex workers and clients. In places where a specialized STI clinic is not available, then the programme should seek collaboration from general health and private medical facilities where male clients go for STI diagnostic and treatment services. In this way, information can be obtained about the sex establishments their clients visited and their use of condoms. Confidentiality should be ensured in the process.

(b) In places where regular STI check-ups of sex workers are required, the 100% CUP can be an important component of such programmes. When a sex worker from an establishment is diagnosed with an STI, health staff will inquire into the possible source of the infection. It is possible that a particular sex worker acquired her STI from a regular partner (such as her husband, “sweetheart,” or boyfriend) apart from contacts in a sex entertainment establishment. In these cases, she will be encouraged to have her partner seek care. But, if health workers at the STI clinic begin to notice a pattern of STI-infected women coming from a particular sex entertainment establishment without any incident of condom breakage during use, then they can safely assume that the establishment is not effectively practising the 100% condom use policy, and an official visit to the establishment will be made. In these contacts with sex entertainment establishments, the owners will not be informed of which sex workers have become infected (there should be strict confidentiality), only that a pattern of problems has been observed.

(c) Another effective technique is called the “mystery client” where a male volunteer visits a sex entertainment establishment pretending to be a client. He then insists on having sexual relations without a condom. If the sex worker agrees to have sex without a condom, then remedial actions will be undertaken with the establishment.

(d) In locations where condoms are supplied from known sources (health units or social marketing agencies), programme staff can closely monitor the number of condoms that are provided to or procured by sex entertainment establishments. This can be an indirect monitoring method as clients may use their own condoms instead.

(e) Studies among sex workers and their clients (e.g. second generation surveillance surveys including HSS, BSS, and STI studies) are able to uncover with fair reliability how regularly sex workers are in fact using condoms, and whether sex entertainment establishment owners are assisting in enforcing the 100% condom use policy in their establishments. This method can be used for indirect monitoring as well as for evaluation of the programme.

1.7 How do you track condom use among men who visit sex workers but who do not visit STI clinics?

In situations where men do not visit STI clinics, there is a need to identify places where male clients go for treatment (e.g. general hospitals, private clinics) and include those services as part of the programme. In some areas, information from drug stores where clients seek self-treatment is helpful. The 100% CUP require tracking of male clients. However, it is not necessary to get information from all male clients. (See the answer to the question 1.6.) Information from a few clients who visited local participating STI clinics is enough for monitoring condom use in sex establishments.

1.8 How can the 100% CUP possibly succeed?

(a) If a sex worker insists on using a condom, then clients can go to another entertainment establishment where condom use is not required.

(b) Owners of sex entertainment establishments are interested in making money. Why would they cooperate with authorities when clients could go elsewhere where condoms are not required?

By design, the 100% CUP is a programme that works over a large geographic area, such as a town, district, province or country. If all sex workers in all the entertainment establishments in the whole area require condoms to be used, then clients would not be able to easily find another establishment where condoms would not be required. With this 100% CUP policy, owners of sex establishments will still make the same level of income. In addition, their participation in the programme will provide the added benefits of being recognized as active partners of the HIV prevention programme and reducing HIV and STI in their workers. By contrast, uncooperative establishments may be considered risky places and subjected to possible sanction by the authorities (including closure or discontinuation of business permit).

1.9 Why should sanctions be put on non-cooperative entertainment establishments or for non-compliance with the 100% CUP? What are the best ways to implement sanctions against non-cooperative entertainment establishments where sex work is illegal? Why is it difficult to ensure sufficient coverage without a sanction policy? What is the best strategy to deal with entertainment establishment owners who are reluctant to cooperate?

It has been found that penalties or sanctions are effective ways to change social behaviors. Following traffic light signals, wearing seatbelts or helmets during driving, avoiding drinking alcohol when driving, and not smoking in public areas are good examples. The problem is how to apply sanctions with behaviors like condom use when buying sex is illegal.

It has been observed that putting sanctions in the 100% CUP can ensure that all entertainment establishment owners collaborate with the programme “No Condom, No Sex” and put more effort into creating a supportive environment within their sex establishments. Sanctions may include temporary and even permanent closures of non-compliant entertainment establishments. This has been seen as essential in the very successful programmes in Thailand and Cambodia. There is sound reason to believe that they will be essential elsewhere. As with most public health and safety programme with sanctions (e.g. sanitary measures enforced in restaurants), they are only rarely needed. This too has been the experience in Thailand and Cambodia, but the threat of sanctions and building upon sound efforts to first educate and encourage cooperation, is a unique and integral part of the 100% CUP strategy. It should be noted that many similar programmes with only education or a request for participation almost always have very low compliance. The issue is to ensure that sanctions are applied in ways that ensures confidentiality of sex workers and protects their rights for health and safety.

1.10 How can you evaluate the 100% CUP? What is the best indicator of success of the programme?

Based on experiences from countries implementing the 100% CUP, the programme can be monitored and evaluated by using many existing data available in the countries (such as those from the sentinel surveillance system). Additional data are required for programme monitoring and supervision.

To **evaluate effectiveness** of the 100% CUP, the following areas are key for monitoring and evaluation:

- Input – strategies, policies, guidelines, financial/human resources;
- Process – human resource development, training, meetings, condom supplies;
- Output – numbers and percentage of sex workers reached, geographic coverage;
- Outcome – behaviour change; and
- Impact – disease reduction, quality of life.

Key indicators for **monitoring inputs**:

- Availability of national and local policies;
- Organizations/sectors involved;
- Availability of staff and budget; and
- Condom supplies.

Key indicators for **monitoring process and outputs**:

- Implementation plan at local level;
- Number of meetings - working group's meetings, meeting with local partners (entertainment establishment owners, sex workers);
- Number of trainings (e.g. with sex workers);
- Number of sites implementing the strategy (coverage);
- Number of condoms supplied to entertainment establishments;
- Monitoring condom use through the use of male STI data; and
- Monitoring incentive and disincentive procedures.

Key indicators for **evaluating outcomes**:

- Results of management of the incentive and disincentive schemes;
- STI infection in sex workers/male STI clients attending STI clinics; and
- Rate of condom use in sex workers/selected male targets, such as mobile population, uniform personnel.

Key indicators for **evaluating impact**:

- Incidence of STI in selected locality;
- Prevalence of STI in selected populations (sex workers/STI clients); and
- Prevalence of HIV in selected population (sentinel surveillance data) - sex workers, male STI clients, and pregnant women.

For overall programmatic assessment, the 100% CUP can be evaluated objectively through external reviews of the programme. This was conducted in Cambodia in 2003, in Myanmar in 2005, in the Philippines in 2007 and in Mongolia in 2009.

In order to say that the programme is successful, there should be a correlation between the outcomes of a high level of condom use in

sex workers and a decline in STI and HIV prevalence and/or incidence among sexual risk populations (sex workers, STI clinic clients and their partners).

1.11 Does this 100% CUP really work? Is there "evidence" that it works? How long will the 100% CUP have to be in place before you can see results?

YES. There have been very good evaluations of the 100% CUP in several countries that have implemented this programme over a number of years. Good evidence has come from Thailand, for example, which has been implementing the 100% CUP since 1989 and Cambodia, which has implemented it since 1998. In both of these countries, when the programme was being piloted in one or a few provinces and later when the programme was implemented nationally, careful evaluation of the programmes revealed that there was a dramatic increase in the use of condoms by sex workers and an equally dramatic decrease of STI and HIV infections in sex workers and their clients. In Thailand, the incidence of STI dropped from almost 400 000 cases per year before the programme to less than 15 000 annually in recent years. Similarly, the decline of HIV prevalence has been observed in all sexual risk populations. In countries with low HIV, the impact of the 100% CUP can be seen quickly from STI trends if results are routinely recorded in STI clinics or through regular surveys conducted among specific groups, such as sex workers and their clients.

In all implementing countries, the benefit of the programme in terms of STI reduction can be seen within a few weeks after the implementation, which suggests that the programme has prevented the transmission of both STI and HIV. However, the decline of HIV prevalence may not be detected in the short term, as data on HIV prevalence is not sensitive enough to reflect the concurrent decline of HIV transmission.

1.12 Can the 100% CUP work and be effective without the support of the local government?

It is difficult to implement the 100% CUP if there is no local government support. The political, social, cultural, and legal contexts in which the 100% CUP is being implemented all vary immensely. That the programme has been accepted and implemented in some communities and countries where sex work is illegal, should, however, serve as encouragement for others to initiate the 100% CUP in their locality.

Obtaining local government support may require policy endorsement from the central government. In Thailand the National AIDS Committee chaired by the Prime Minister set a resolution in August 1991 requiring all provinces in the countries to implement the programme. Similarly in Cambodia, the Prime Minister sent policy instruction to provinces to implement the approach since October 2000. Such high-level endorsement has been similarly observed in China and Mongolia.

1.13 Currently, which countries are implementing the 100% CUP and have they documented evidence of success?

Thailand initiated the 100% CUP in 1989, followed by Cambodia in October 1998. Since then, the 100% CUP has been implemented in China, the Lao People's Democratic Republic, Mongolia, Myanmar, the Philippines, and Viet Nam.

In all the countries with proper monitoring and evaluation, evidence has been both clear and growing that the 100% CUP works to increase condom use and reduce the prevalence of STI among sex workers and their clients. When the programme was expanded, significant reduction of HIV prevalence was also reported. As per the announcement of the Prime Minister of Thailand during the 15th International AIDS Conference in Bangkok in 2004, "The 100% condom programme has already prevented over five million HIV infections in Thailand." This is the best indicator of success for the implementation of the 100% CUP in Thailand. Similar results were seen in Cambodia after the expansion of the 100% CUP nationwide. The trends of HIV prevalence among adults have dropped gradually for the past few years.

It is also clearly a programme strategy that has been found to be feasible and applicable across different political, cultural, and epidemiological settings, and it has attracted much favourable attention in the public health community.

1.14 Can we be sure that the 100% CUP will work in our community and be consistent with our legal and cultural traditions?

Nobody can be 100% sure about anything in the future. That is why the 100% CUP has been tested in one or two pilot projects in every country in which it has been implemented. The 100% CUP is now being implemented in a number of different Asian countries. All of the initial studies in these countries strongly suggest that the programme is achieving notable results. Feasibility and effectiveness of the programme as observed in pilot areas have successfully convinced these countries to scale up the programme with a target for nationwide expansion.

Also, a recent academic study in the Dominican Republic indicates that the 100% CUP was also feasible and effective in that region as well. Overall, it is quite clear that the 100% CUP is a strategy that can work in many different countries, regions, and cultures to increase condom use and decrease the toll of STI and HIV among establishment-based sex workers and their clients.

1.15 How should you address the question that by promoting the message “No condom, No sex” you promote promiscuity?

There have been many studies and reports in the world showing that promoting condom use does not promote sex or promiscuity. The 100% CUP can be implemented in a way that does not need public awareness about the programme. This can be done by working ‘quietly’ among key implementers and the sex work sector. This type of practice can reduce the concerns about promoting sex work or promiscuity.

Surveillance data in both Thailand and Cambodia have shown

no indication of an increase in men visiting sex workers after the implementation of the 100% CUP. On the contrary, there has been a reduction of the number of visits to sex workers. Moreover, there is also no evidence that sex work has risen due to condom promotion in any of the countries or regions implementing the 100% CUP.

1.16 I keep hearing such terms as "direct," "indirect," "establishment-based" and "freelance" when referring to sex work. Can you explain these terms? With which kind of sex worker or establishment is the 100% CUP effective?

In the 100% CUP, these terms are defined as follows:

a) A "direct sex establishment" is a place, such as a brothel and brothel-like guesthouses, where sex is the primary service for sale and often takes place on site.

b) An "indirect sex establishment" is a place where sexual services are offered or negotiated in the context of other services, e.g. massage parlour, karaoke, bar or beer hall, and where sex usually, but not always, takes place at some other site.

c) Sex workers are classified by the type of establishments: direct sex workers for direct sex establishments and indirect sex workers for indirect sex establishments.

d) A "freelance sex worker" is someone who works relatively independently and is not formally involved with an "establishment." This person may be a streetwalker on the corner, a beach sitter under a tree, or a student who sometimes visits a hotel or bar to meet prospective clients. Some of these women are probably working for someone else, such as a pimp, or are in a network of organized sex work. Their "managers," however, are usually not obvious and they are often inaccessible.

The 100% CUP is designed to work in situations involving "entertainment-based sex workers." It is a programme that is designed to engage the cooperation of the owners and/or managers of establishments where sex is negotiated and sold, and where these owners/managers have a business relationship with or influence on their workers. This could include permitting some but not all to work in the establishment, receiving a fee or percentage of what clients pay the workers for sexual relations, and paying workers a percentage of

the money if they convince clients to order high-priced drinks. Efforts should be made to ensure that both types of establishments (direct and indirect) are covered in the programme, even including gay bars if any exist in the coverage area. It has also been shown in Mongolia that it is possible to extend the 100% CUP to freelance sex workers.

1.17 As the 100% CUP is mainly dealing with sex entertainment establishments, how can it solve the problem of the mobility of sex workers? Does the CUP strategy also apply to sex workers working on the "rice field" (e.g. serving farmers for exchange of rice)?

The mobility of sex workers may be a problem during the initial pilot phase. It is crucial, however, that all new sex workers coming to work in sex entertainment establishments are informed by the owners/managers or peers about the local requirement, "No condom, No sex." For those sex workers moving to other areas where the 100% CUP is not implemented, they should be able to continue their condom negotiation practice and educate other sex workers on the need to use condoms. Mobility will not be a problem when the good coverage of the programme is ensured. In the long run, when the 100% CUP is implemented nationwide, the issue of mobility may not be relevant as all establishments will practice the same rule of "No condom, No sex."

The 100% CUP should be primarily targeted to sex settings (rather than individual sex worker) where there is unsafe sex as indicated by monitoring STI and behavioural data. All types of sex work should be identified by various means, such as interviewing male STI clinic clients and conducting behavioral surveys or research studies. It has been proven that the 100% CUP can be applicable for most types of sex work (direct, indirect, and freelance). Local implementers should be able to decide on how unusual forms of the existing sex work can be included in the 100% CUP.

1.18 Do condoms have pores? How sure are you that neither the virus nor any other bacteria pass through the surface of condoms?

Quality control tests are conducted on condoms during the manufacturing process. For certain companies, this may involve selecting samples at various stages in the process, and subjecting them to various tests, mainly the freedom from holes and inflation tests to the appropriate standards. It is, therefore, important to work closely with national regulatory authorities and inform them of the procurement procedures and testing protocols that will be used to verify the quality of the condoms before they are shipped to the country. For more information, please refer to the document "The Male Latex Condom – Specification and Guidelines for Condom Procurement, 2003" published by the World Health Organization.

There is compelling evidence that male latex condoms, when used consistently and correctly, protect against unwanted pregnancy and the transmission of HIV. Condoms also protect against several other STI, such as gonorrhoea, but may be less effective in protecting against STI that are transmitted by skin-to-skin contact since the infected areas may not be covered by the condom. Evidences in STI clinics shows that it is rare to see an STI in a client who is using condoms regularly. The success of the 100% CUP in Thailand and Cambodia attests to the effectiveness of condoms in preventing both HIV and STI.

1.19 Are all condoms made out of the same material? What is the best type of material to prevent HIV and other sexually transmitted infections (STI)?

The most common materials for manufacturing male condoms are made from natural rubber, usually called latex condoms. Other types of materials currently being used for making condoms include polyester polyurethanes, polyether polyurethanes, and styrene-based elastomers. Do note that evaluation and testing of non-latex materials for condom manufacture has represented an exhaustive effort involving considerable time and resources. As a result, non-latex condoms are usually more expensive, e.g. the female condom. Introduction of non-latex condom into the marketplace is recent, and information is slowly emerging about their acceptability, safety, and effectiveness in actual use.

1.20 Do condoms really prevent the spread of disease? Don't they ever leak or fall off? Are there low quality condoms in our country? Is there a specific type or brand that is most effective?

A good quality condom that is properly used is almost 100% effective in preventing the spread of most STI and virtually all HIV. Analysis of the impact of the 100% CUP in Thailand revealed a very strong correlation between the percentage of condom use and the decline of the national incidence of STI. The 100% CUP is collaborating with other national programmes to ensure the availability of good quality condoms in sex entertainment establishments and help train sex workers how to properly use condoms. All brands of condoms are effective if they pass the quality control process. Unfortunately, such quality control programmes have been in practice in only a few countries. Efforts should be made to promote activities and programmes on condom quality assurance that are in line with ISO standards and WHO specifications.

1.21 Who should provide the condoms? Should they be given for free? Why is it important for the government to provide free condoms to entertainment establishments? Why are condom social marketing programmes targeting non-traditional outlets still needed while condoms are easily available in pharmacies?

The 100% CUP requires that good quality condoms are accessible to sex workers and their clients. Condoms could be provided through various ways or a combination of those mentioned below:

- Free from STI and family planning services;
- Social marketing programmes;
- Pharmacies, public or private;
- Condom vending machines ; and
- Condom funds.

It is not always necessary for the government to provide free condoms to entertainment establishments. The only country that is providing

free condom is Thailand; while in many other countries the main condom supply is through condom social marketing. In Cambodia and Myanmar, Population Services International (PSI) provides condoms to sex establishments through social marketing. Other social marketing agencies working in Asia include DKT International and Marie Stopes International. Condom social marketing can help increasing access for most-at-risk populations to good quality condoms at reasonable prices.

The cost of condoms is always very small when compared to the price of sex services. In many settings, condoms are free but their cost has been included in the price for sex. A free supply of condoms from the government to entertainment establishments symbolizes the support of condom use and is often used as a strategy to gain trust and cooperation of the establishment owners and sex workers, particularly at the initial phase.

The idea of targeting non-traditional outlets is to ensure that condoms are widely available to those who need them. Non-traditional outlets include food stores, petrol kiosks, supermarkets, barbershops, tiny shops selling condoms, cigarettes and matches as well as outlets that may be associated with high-risk sexual activity such as bars, nightclubs, hotels and motels, and brothels.

A condom fund is an initiative to ensure the sustainability of condoms in locations where resources are limited. The strategy is to seek an initial fund (from a donor) to purchase a large supply of condoms (at wholesale prices), which will be sold with minimum profits to sex establishments. The fund from this direct sale will be used to replenish the condom supplies.

1.22 Will using lubricant with the condom make the condom more or less effective? Is there any role for water-based lubricants in the 100% CUP?

Most condoms are manufactured with a lubricant on them; silicone fluids are the most commonly used lubricants. When necessary, additional lubricants such as glycols and water-based lubricants may be used. Oil-based lubricants, such as lotions or petroleum jelly, cannot be used because condoms are significantly weakened by

contact with oils. Studies have shown that an appropriate lubricant reduces breakage for both vaginal and anal sex. However, excessive lubricant may increase the likelihood of slippage.

Lubricants have no effect on HIV. This includes those with nonoxynol-9, which was found to be ineffective in preventing the transmission of HIV. However, using a lubricant with condoms can make condom use more enjoyable and acceptable. Lubricants can help to reduce painful sensation during sex and also reduce condom breakage. If intercourse is particularly prolonged or if sex workers have many clients per day, more lubricants may be added to avoid abrasions and painful sensation during intercourse. Given these benefits, the use of lubricants will increase the acceptability of condoms for both sex workers and clients, and thus support the implementation of the 100% CUP.

1.23 Can the 100% CUP really eliminate the threat of HIV and STI in our country (or community)?

The major benefit of the 100% CUP is the prevention of HIV and STI among sex workers and clients. It prevents introduction of HIV and STI into households, and thus prevents HIV transmission to wives as well as boyfriends and girlfriends. Therefore, the programme can significantly reduce the threat of HIV in the communities. The programme can help to prevent Asian countries from developing a generalized HIV epidemic.

The 100% CUP cannot entirely eliminate the threat of HIV/STI from the communities. It is not a 100% solution programme. However, where sex work is present, the 100% CUP has proven to be very effective in reducing the spread of HIV among sex workers and clients as well as the general population.

There are other important sources of HIV infection in communities, such as among injection drug users (IDUs), men who have sex with men (MSM), and those exposed to improperly protected blood supplies. The 100% CUP is not a solution to the whole problem of STI and HIV, but it is an effective way to reduce the spread from one type of high-risk sexual behaviour.

1.24 Doesn't the 100% CUP deal with more than establishment-based sex? This programme sounds like a very narrowly conceived idea that addresses only a small part of the HIV/AIDS problem. Does it have any indirect benefits?

It is true that the 100% CUP is primarily designed to reduce the transmission of STI and HIV associated with establishment-based sex, and this is where the programme will have its greatest impact. However, in the evaluations that have been conducted in countries with longer experience of implementing the 100% CUP, it is being recognized that there are indeed some important indirect benefits derived from the programme. It appears probable that the 100% CUP achieves the following results.

a) The 100% CUP helps to prevent indirectly the sexual transmission of STI and HIV to the general population. As with some other infectious diseases, it is recognized that there are "bridge populations", such as persons with high-risk behaviours or exposures to an infectious disease (e.g. clients of sex workers), who then transmit the disease to those with low-risk behaviours, such as spouses. In Thailand, for example, the prevalence of HIV among pregnant women has been gradually declining without any significant increase in condom use among husbands and wives. This decline is most probably related to the increased use of condoms among husbands where they have been involved with establishment-based sex. Their protection also protects their wives from being exposed.

b) The programme is a good example of multisectoral collaboration in HIV/AIDS programmes. It has resulted in strong cooperation among various sectors and stakeholders in the society, including the health sector, the police, the local administration authorities, and the owners and/or managers of entertainment business. In some settings, entertainment owner association took part in site visits and convinced their peers to enforce condom use in sex work.

c) The 100% CUP contributes to the increase of condom use by freelance sex workers. This increase has been documented

in some places. Information about the programme and use of condom circulates among sex workers of all types and influences everybody's practices. It is also recognized that there is some mobility of women between different types of sex work. It is supposed that the information and skills they learn in the establishment-based 100% CUP have some spillover effect if and when these women change their venue of operation. To be sure, there are other programmes that work primarily with freelance sex workers, but it is thought that the 100% CUP influences these programmes indirectly.

d) The programme is associated with a general reduction of entertainment-based sex work in some communities. The 100% CUP has played a role in generally changing "social norms" regarding sex work, and sensitizing prospective clients to the health risks of commercial sex.

e) It contributes to reducing the stigma and abuse of sex workers by some law enforcement authorities, and reduces corruption, which may have existed between authorities and sex entertainment establishment owners. Policies are planned and implemented cooperatively with the involvement of multisectoral committees and teams. Communication between law enforcement is facilitated and understanding on both sides is increased.

f) The 100% CUP sensitizes decision-makers and community leaders to the issues of sex work and HIV/STI and to the need to take action.

Though these indirect effects are not primary objectives of the 100% CUP, they have been recognized as programme results in different countries and localities.

1.25 I keep hearing about "the" 100% CUP, but it seems that the programmes being implemented in various countries have many differences. What are the similarities or essential components of the 100% CUP that tie these different programmes together?

Differences in how the 100% CUP is being implemented in different areas are inevitable. Many countries have different cultural groups, social traditions, legal settings, and epidemiological conditions, even within their borders. There are also differences among countries and areas in terms of their existing health care infrastructure and the kinds of public health programmes that may already be in place and how the 100% CUP will interface and coordinate with them.

Also, some countries are in fact "phasing in" the 100% CUP, so all of the components of this strategy may not be in place in the early stages.

Although there is not a "one size fits all" approach to the 100% CUP, there is at least one common strategy that underlies all these programmes; that is, the mobilization of local authorities to empower sex workers to refuse unprotected risky sexual practices that endanger their health. Supporting this common approach is six essential strategic components of the 100% CUP that is, or soon will be, an integral part of virtually all 100% CUP efforts in different countries. These are:

1) high level political commitment;
2) multisectoral institutional structures;
3) promotion and accessibility of quality condoms;
4) defining, identifying and collaborating with sex entertainment establishments;
5) monitoring condom use in sex entertainment establishments and managing non-compliant ones; and,
6) evaluation of the outcomes.

These components will be elaborated upon in turn.

1) High level political commitment

The 100% CUP is a somewhat "non-traditional" public health programme. It requires the close collaboration of governmental agencies in sectors that do not have a lot of experience in working together, namely the local administrator (governor or mayor's office), health sector, and public security sector. Moreover, these sectors must collaborate around a subject - sex work - that has significant political and cultural sensitivities in most communities.

Thus, before any 100% CUP can be initiated, there must be a high level of political commitment to ensure the following:

- governmental agencies better understand the realities of sex work in their communities, and the need to work together effectively to deal with the complex issues of HIV prevention associated with sex work;
- the programme is implemented fairly and equitably over a large geographic area (e.g. town, province or country), and community members and clients understand clearly that high levels of the government support the programme; and
- sex entertainment establishments are on notice that their cooperation and compliance are expected.

Since the 100% CUP is essentially implemented at the local level, it is especially important that a high level of political commitment is obtained at this level so that local government units and communities can indeed "take charge."

How this political commitment is expressed or "documented" will depend upon the locality. It may be by proclamation, decree or regulation. However it is done, it must be done in a manner that achieves the necessary effects.

2) Multisectoral institutional structures and mechanisms

The 100% CUP must have structures that meet the management requirements of this unique programme. This will include the assignment of leadership for the programme in a "focal agency" and multisectoral committees and mechanisms to facilitate coordination of policy development and implementation plans.

Committee structures generally include participation from a broad spectrum of those involved in the implementation and impact of the programme, including representatives from:

- community, political, business, and professional leadership;
- technical and professional staff from government agencies, especially local administrator, health and public security;
- sex work industry, especially establishment owners/managers and sex workers involved in sex worker associations or peer education programmes; and
- nongovernmental organizations (NGOs), especially those involved in condom promotion or condom social marketing programmes with sex workers.

These committee structures must be involved, especially in the formulation of critical policies for the programme such as:

- assignment of responsibilities and ground rules for the different parties;
- coordination with other policies and progammes in the community, such as those involved with public security, building and business codes, condom social marketing, voluntary counseling and testing (VCT), STI clinics, and health surveillance;
- identification of the types of “sex entertainment establishments” to be included in the programme, how the programme may be phased in, the kind of 100% condom use policies (e.g. “No Condom, No Sex”) and education programmes that are to be instituted in these establishments; and
- establishment of mechanisms, which will assure compliance with programme policies, including the possibility of “sanctions” that will be applied to non-compliant sex entertainment establishments.

Clearly, there are many aspects of fielding a programme like the 100% CUP that will need to reflect the legal and organizational traditions of the communities in which it is implemented. The names of structures, membership on committees, and precise mechanisms that are used in different countries or areas may be different, but the essential strategic component will be similar in all.

3) Promotion and accessibility of condom in sex entertainment establishments

In the context of a 100% CUP, the promotion of condom use has several components. Physically, high quality condoms must be readily accessible to sex workers and clients within sex entertainment establishment. In addition, establishment workers (both managers and sex workers alike) must be adequately trained to ensure that condoms will be used. A 100% condom use policy (probably requiring such things as the posting of signs saying “No Condoms, No Sex”) is also typically a component of the programme. Adequate training of sex workers in negotiating condom use and in using condoms is also an essential part of this programme.

Again, there are likely to be differences among countries on how condoms are made available within entertainment establishments. They may be given away free in some or sold in others. There will also be differences in how sex workers or managers are trained. Health Ministry staff may conduct the training in some places while “peer education” may take place in others.

However it is done in a locality, the 100% CUP requires that good quality condoms are accessible to sex workers and their clients.

4) Defining, identifying, and collaborating with sex entertainment establishments

The 100% CUP must clearly define the “places” where commercial sexual relations are negotiated and/or conducted. The “place” where these activities take place will vary among localities and, depending upon the policies that are established for the programme, may include establishments such as brothels, beer halls, massage parlours, karaoke, bars, and hotels.

All places where sex is negotiated and/or conducted should be included in the programme in order to ensure that clients cannot access condom-free sex services. The primary targets are establishments where the owner or manager is able to exercise sufficient “supervisory” and “support” functions vis-à-vis the sex workers and their relationship with clients. This is important because it is ultimately the entertainment establishment owner or manager who will need to play an important role in assuring that sex workers

use condoms in their day-to-day work and that they are supported when confronting a non-compliant client. In places where sex work is not under control of the owner or manager, efforts should be made to identify persons who would be able to supervise sex workers to comply with the 100% CUP policy. These persons may include pimps, senior workers (Mama San), or peers.

5) Instituting a way in which compliance with the 100% CUP can be monitored

A way must be found and instituted to monitor the 100% CUP. Ultimately, monitoring boils down to verifying that condoms are used in all risky sexual relations conducted in an establishment that is part of the 100% CUP.

There is wide variation in how monitoring the 100% CUP takes place in different countries.

In several of the countries where the 100% CUP was first implemented, there were already well-established facilities to diagnose and treat STI in males. This turned out to be the most convenient and effective way to monitor condom use in sex entertainment establishments "by proxy". These programmes then instituted procedures to question all male clients of collaborating STI clinics about their recent visits to sex entertainment establishments and whether they used condoms (regardless of STI status). If it was found that a particular sex entertainment establishment appeared to provide sex service without using condoms, then authorities could revisit the entertainment establishment to inform them of problems and discuss remedies. The strategy of using clients of male STI clinics as a way to monitor entertainment establishments was especially attractive as it was easy to maintain the anonymity of sex workers who might be identified by owners of establishments. In places where specialized STI clinics are not available, such information can be obtained from other collaborative general health and private medical facilities or pharmacies where male clients seek STI services.

For those establishments that repeatedly failed to comply with the principle of "No Condom, No Sex," sanctions may include verbal warning, frequent inspection visits to sex establishments, temporary closure or even removal of business permit.

Some countries utilize information on STI in sex workers obtained from routine health screening services. A precaution should be kept in mind as STI in sex workers may not solely result from no condom use in sex services. Other programmes have also adopted survey and research procedures to assess the use of condoms within individual establishments or have used “mystery clients” to test practices. Some of these other ways to monitor the success of the programmes have been controversial at times and are sometimes criticized for being less effective.

However it is done in a country or locality, the essential component of the 100% CUP is to have a credible system in place that is capable of monitoring the impact of the programme by assuring that condoms are used in all risky sexual relations.

6) Evaluation of outcomes

As mentioned above, the principal objective and design is to monitor condom use or STI levels at the level of individual sex entertainment establishments so as to assure their compliance with the 100% CUP policies. In addition to this essential management component, the 100% CUP must have procedures to evaluate the impact or outcome of the programme goals of reducing the transmission of STI and HIV associated with entertainment establishment sex work - among sex workers, their clients and ultimately among the general population.

The 100% CUP invariably documents the “baseline” level of HIV, STI, and condom use among sex workers, clients, and the general population before the programme is instituted and then at time intervals after it has been implemented. These evaluations of the 100% CUP are usually (and should be) coordinated with other ongoing systems in place for the surveillance of health status, such as the HIV sentinel surveillance (HSS), behavioural surveillance survey (BSS) and monitoring of condom supply. These progammes may be organized and implemented differently in different countries. Where the 100% CUP is piloted in one or two areas, the programme itself may institute procedures to more closely assess its outcome regarding STI levels among sex workers and clients, but as programmes mature, they will likely rely increasingly on these other established surveillance programme to evaluate outcomes.

1.26 What are the effective messages to gain support from local chief executives or local officials?

It is crucial to show the feasibility and effectiveness of the 100% CUP strategy by sharing experiences from other countries that have different epidemiological, economical, cultural, and political settings. If necessary, the 100% CUP could be piloted in one or several local communities before tackling the more complicated situations encountered in major metropolitan or capital cities. A study tour to other countries or other regions within the same country where the CUP has been implemented is one option that could be used to introduce the strategy.

1.27 What is an effective short message that will help convince the client to use condoms?

First, with the 100% CUP, the client should not be able to get sex services if he does not want to use condom. In other words, "No Condom, No Sex." To help convey this message, the following points could be used:

- "It is required in this community that for the sake of HIV prevention, all sex services have to use condoms;" and
- "All establishments in this area are participating in HIV prevention programme, and thus will not provide sex services without using condoms".

1.28 Can the 100% CUP incorporate high school-based sexual education, which would include HIV/STI education, correct condom use, and explaining HIV/STI transmission routes?

The 100% CUP is not a solution to the whole problem of STI and HIV, but it is an effective way to reduce the spread of HIV among sex workers and client and to the general population. This type of transmission is common in many countries in Asia. This type of approach does not require a programme to directly identify and target clients as all of them will have to use condom anyway when they buy sex services.

In general, the focus of HIV/AIDS interventions should be guided by epidemiological data and by the availability of resources linking to sources of HIV infection in communities. If there is indication of high-risk behaviour among young people (i.e. casual sex), the segment with the greatest risk should first be targeted, such as out-of-school youth. For general awareness programmes, HIV/STI information should be mainstreamed in school curriculum and workplace activities.

1.29 Is there a peer education component of the programme? What is the role of peer education in implementing the CUP?

Peer education is not a key component of the 100% CUP, but it does add value. In the CUP, there are different levels of peers: among the owners of sex businesses; among the Mama Sans (head or leaders of the sex workers); and among the sex workers themselves. Meetings or workshops can be conducted among the different groups to disseminate the information about the requirement of condom use in all sexual encounters by all sex businesses. The meetings can also outline the sanctions and/or warning for non-cooperative business owners. Other useful information could include: the transmission of HIV/STI; the availability of services for prevention, treatment, care and support of HIV/STI, and reproductive health; and condom negotiation skills for the sex workers.

1.30 Is there an economic incentive for the establishment owners to implement the 100% CUP?

The 100% CUP is a win-win strategy. Every sector benefits from the programme. For the establishment owners, both the establishment workers and their clients will be protected from HIV/STI thus reduces their costs for treatment as well as reduced absenteeism from work, business continues (and with a reputation of being healthier and safer), and in some cases, improves due to its enabling environment and better collaboration with the health sector and public security.

1.31 Does the 100% CUP have any strategies about preventing HIV/STI transmission among men who have sex with men (MSM)? Is the CUP strategy also applicable to entertainment establishment-based MSM?

The 100% CUP is applicable to all places where sex work is linked to entertainment-establishment based, regardless of the types of sex work. It is important to differentiate between MSM who are engaged in sex work and MSM as a result of sexual preference. The former are more likely to need the 100% CUP approach, though consistent use of condoms is important whenever anyone engages in sex with multiple partners.

1.32 I'm a community health worker who works with sex workers. I'm interested in trying to implement this policy with the girls and managers I see. How do I go about this?

- First, conduct a couple of meetings to gain the cooperation of government authorities and all owners/managers of sex businesses to support a policy to require condom use in all sexual encounters.
- Hold a meeting with owners of sex business and senior sex workers to get cooperation in implementing the 100% CUP.
- Educate sex workers on the programme (including peer education).
- Provide logistic support (condoms, STI services, educational materials, and water-soluble lubricants).

1.33 If in a certain region, there is no policy for sex workers to become registered, then how do you ensure that they get tested regularly for STI?

In all the countries implementing the 100% CUP, sex work is illegal and hence there is no policy for sex workers to be registered. Moreover, in the 100% CUP, mandatory STI testing of sex workers is not required (but in some countries testing of gonorrhea and syphilis for entertainment workers might be required on 6-month or annual basis) and STI in sex workers should not be used as evidence of no

condom use (sex workers usually do not use condoms with husband/boy-friends). If the 100% CUP is in placed and the sex workers are using condoms, then it is not necessary for them to get tested regularly for STIs. In a situation where there are freelance sex workers, a strategy to increase accessibility to and the trust of the sex workers is to provide free STI services. As per the experience in Mongolia, sex workers were given "green card" by local health departments to enable them to access free STI services in the local STI clinics and also drop-in-centers organized by local NGOs. In southern Viet Nam, a 'pink card' is used for record of STI services free of charge.

1.34 What are the common challenges sex workers faced after the implementation of the 100% CUP?

Almost none. In contrast, there are many positive features of the 100% CUP. Experiences to date indicate that as a result of the 100% CUP, sex work is decriminalized, sex workers are empowered to insist on condom use, and harassment of sex workers by authorities is also reduced.

A misunderstanding by many people is that the 100% CUP only works with brothel-based sex workers. The truth is the programme works with all types of sex businesses: direct, indirect, freelance or street-based sex workers as well as male sex workers. However, it is more difficult to reach freelance sex workers.

Another misunderstanding is that the closure of sex establishments by police is a failure of the programme, and that sex workers will be left stranded. Although sanctions are often proposed as a punishment for uncooperative sex establishments, countries implementing the programme rarely use them.

It should be noted that acceptance of the 100% CUP by the government does not mean sex work is legal. Sex business owners, clients, and/or parents or guardians of sex workers will be arrested if:

- they are managing sex business involving juvenile sex workers (younger than 18);
- a woman is forced, chained or beaten to sell sex; and/or
- the business involved illegal immigrants.

National laws are also changing. In Thailand, for example, sex workers are no longer subjected to punishment. It is the sex business owners, the pimps, clients and parent/guardian of the sex workers who are the targets of the law.

1.35 What particular strategies are needed for scaling up the 100% CUP right after successful pilot projects?

The main strategy is to advocate the success of the programme, particularly to gain the support of policy-makers to scale up the implementation. Advocacy measures may include:

(i) presentations in various technical meetings;
(ii) demonstration activities for other provinces to visit and observe the overall implementation process; and
(iii) documenting the process and the outcomes of the programme implementation.

It is essential that national programme managers promote and communicate their success and integrate the 100% CUP strategy into the national HIV/AIDS prevention plan. Support from national leaders or national AIDS committee may be required (as observed in Thailand, Cambodia and Mongolia).

Criticism of the 100% CUP

2.1 The impact of the 100% CUP has been greatly exaggerated. Aren't some of its alleged results really the consequence of many things that were going on at the same time?

It is absolutely correct to observe that the 100% CUP is just one part of the many strategies that are being undertaken to reduce the sexually related transmission of HIV and STI. Other strategies to reduce HIV transmission include:

(a) universal screening of blood donations;
(b) harm reduction programme among injecting drug users;
(c) improvements in STI care;
(d) behavioural change communication (as found in the promotion of traditional values and public education);
(e) improvements in the promotion and availability of condoms generally; and
(f) programmes with outreach, advocacy and IEC activities to sex workers.

The 100% CUP supports and complements these activities. It is also clear that techniques used in evaluations cannot clearly identify the role that each and every strategy plays (such as decreasing the toll of STI and HIV among sex workers or their clients). These are deficiencies in all evaluations.

However, observations in Thailand revealed that during the initial implementation of the 100% CUP in 1989-1991, only the 100% CUP pilot provinces showed a rapid decline in STI although all other educational and service delivery strategies were available everywhere. This finding was the basis on which the programme was expanded nationally.

Therefore, it would be incorrect to deny that the 100% CUP has contributed significantly to improving condom use and decreasing STI and HIV transmission among sex workers, their clients, and the general population. There have been too many evaluations in too many programmes in too many places to deny this conclusion.

2.2 What is this talk about how the 100% CUP is helping to "empower" sex workers? Isn't this programme really "empowering" the managers of entertainment establishments to exert even more control over the women working there? Aren't you distorting the power relationships and the truth here?

"Empowering sex workers" is a useful concept here although it does take some explanation. It might also be useful to think of the strategy as a "redistribution of power."

The 100% CUP strategy is taking power away from the clients of sex workers and from the entertainment establishment owners and operators. It is establishing external rules and procedures (sometimes also called "creating an enabling environment") that require 100% condom use related to establishment-based sex.

It is giving power to sex workers to better negotiate condom use with clients with full support from owners/managers and local authorities, both through the establishment of "No Condom, No Sex" rules as well as giving them training on how to negotiate condom use.

It is also helping sex workers by placing the primary responsibility for condom use in an establishment on the owner and managers. They will be motivated to help sex workers in their negotiations if clients are really reluctant or abusive.

2.3 Who will pay for the cost of condoms? We heard that sex workers were forced to absorb the cost of condoms. Is it true?

This issue can be different from country to country. In Thailand, condoms are provided free-of-charge to sex workers and other target groups (such as male STI clients). Other countries with limited budgets for condom procurement may be unable to provide condoms for free. However, this should not be a barrier of the programme. Countries are advised that for sustainability, the clients of sex services should be responsible for the cost of condoms. In practice, the price for sex services is much higher than the cost of a condom; the clients will not

mind paying a few cents more. The owners or sex workers can set the price of sex service to a level that absorbs the cost of condoms. There is no intention to sell condoms to sex workers, unless they want to get more income from selling condoms to their clients.

2.4 The 100% CUP was designed to make women in entertainment establishments use condoms with their clients, but how do you address questions of gender-bias in implementing the 100% CUP?

The 100% CUP addresses both genders. The sex workers (female or male) are empowered to say no to clients who do not want to use condoms, hence protecting them from contracting any sexually transmitted infections. The clients are also protected if they use condoms, and they indirectly protect their spouses from contracting any diseases.

For programmatic purposes, it is more practical, feasible, and cost-effective to approach sex workers than to approach clients. It does not mean that the programme is gender imbalanced.

2.5 The 100% CUP is improperly blaming and targeting sex workers. They are the victims of social ills and are being abused by reckless men. They are being stigmatized and discriminated against in ways that increase their vulnerability to HIV and STI. Why is the 100% CUP not doing more to address the root causes of this situation?

The 100% CUP is NOT blaming and targeting sex workers. If there is any "targeting," it can only be properly concluded that the 100% CUP is "targeting" the owners or managers of sex entertainment establishments. The programme is working with owners/managers in ways that encourage them to help sex workers to protect their health, the health of clients, and the public health in general.

The root cause of sex work is very complicated with many competing views on how it should be addressed in different communities. The 100% CUP, in itself, is neither a proponent nor opponent to any of these

views. All health care workers are indeed concerned with combating social ills, stigmatization, and discrimination that affect people's health and health care negatively. But the 100% CUP is concerned primarily with preventing the spread of important diseases that are associated with entertainment-based sex work. This programme is not designed to solve all the problems related to sex work in a community.

2.6 The 100% CUP requires sex workers to register and carry ID/health cards, and to undergo regular examinations for STI. Isn't this a violation of the human or civil rights of sex workers?

For the 100% CUP to work most efficiently, the programme DOES NOT necessarily requires sex workers to be registered. This activity is NOT an essential component of the 100% CUP (see also question 1.25).

It is true that in many countries and localities, the 100% CUP is operating within an environment in which authorities have decided also to register sex workers and require health checks. The 100% CUP may utilize the data on STI in sex workers as a strategy to monitor condom use (see also question 1.6 for further elaboration). These activities are not in themselves unethical or a violation of human rights when properly administered.

Ethics and human rights are complicated subjects. It may be useful to step back and indeed look at some relevant ethical principles and their application in this programme.

Within medicine and public health, three ethical principles have long been identified as underlying activities and programmes: beneficence; equality; and respect for person. This means basically that health activities are clearly beneficial to people's health, the interventions and care are equally administered to all people, and that individual rights are respected. These individual rights, within the context of health care are most commonly related to being treated with respect, being informed about the care or interventions being proposed, maintaining the privacy of health records or sharing clear information about how health records will be used, and obtaining the voluntary consent to the care/intervention before it is administered.

In the case of the 100% CUP, this is a programme that is designed to be administered as many other occupational health programmes. It is designed to meet the special individual and public health problems that result from a person's occupation. It is similar to well-recognized occupational health programmes that, for example, require factory workers to be screened for exposure to dangerous industrial solvents or restaurant workers in some areas to be tested for TB and/or hepatitis.

Looking at the 100% CUP in the paradigm of an occupational health programme and in light of well-recognized ethical standards, it can be seen that, with regard to beneficence, the 100% CUP interventions are beneficial to the health of sex workers, clients and to the public. With regard to equality, the programme is designed to address ALL establishment-based sex equally in the areas it is being implemented. With regard to respect for person, the programme is predicated upon the proposition that sex work is voluntary; that is. sex workers can leave, go home to their communities, take up another line of work or move their work to another area if they do not agree with the policies and procedures prescribed by the 100% CUP. Further in this regard, the programme expects all staff to treat sex workers respectfully and to fully inform sex workers how the programme works and how their health records will be used (for decisions about treatment to be administered and, where applicable, to monitor condom use in entertainment establishments). It has been observed that active participation of sex workers is necessary for a successful programme.

In summary, there is nothing that is inherently unethical or abusive in the design and intent of the 100% CUP.

2.7 I heard that law enforcement officials have actually arrested sex workers for merely carrying condoms with them. Doesn't this incriminate sex workers?

In the past in many countries, carrying condoms has been associated with sex work and this has nothing to do with the 100% CUP. However, evaluation in countries that have implemented the 100% CUP have indicated the positive change especially in attitudes of local authorities

and law enforcement towards sex workers resulting in reduction of harassment especially by the police and owners of sex businesses.

2.8 The 100% CUP is adding to the abuse and plight of sex workers. There are all kinds of corruption in the programme. Owners can pay a bribe to police to keep their establishment open. When an STI is found in a sex worker, the sex entertainment establishment owner can punish the sex worker. And, sex workers are not really free to leave a sex establishment. There are often poor women who have "debts" to establishments because they have really been sold by their families to work in the establishment. How can you allege that they have "voluntarily agreed" with the 100% CUP policies just because they are sex workers in the community?

In most situations corruption exists either with or without the 100% CUP.

The personal medical records of sex workers are not to be shared with the owners/managers of sex entertainment establishments. Where official contact is made with entertainment establishment owners about evidence that the use of condoms is not being routinely enforced, it is based on information from male STI clinic clients and/or "trends" in the number of STI that are associated with sexual relations in the establishment. Where there is any evidence that information from personal medical records is being released to owners, this should and will be dealt with promptly.

With regard to situations where women are not working voluntarily and are sold into the sex trade, this is a clear violation of human rights and the well-recognized international agreement forbidding trafficking in women. These situations do not relate to the 100% CUP and should be dealt with by legal authorities.

Corruption and bribes involving entertainment establishments and local authorities have indeed sometimes been reported in communities where the 100% CUPs are implemented. But these practices existed before the programme and were not caused by it. In any case, the

100% CUP involves transparent multiagency actions that have been recognized to reduce the potential for corruption.

2.9 Why does the 100% CUP have provisions to punish sex entertainment establishments with the threat of being closed down? Is this really necessary or an essential part of the 100% CUP strategy? I've heard that it is rarely used in other programmes? Why can't the programme just work with entertainment establishments cooperatively?

"No" is the simple answer to the underlying question as to whether sanctions are an essential part of the 100% CUP.

"Maybe" is the simple answer to whether sanctions may be a necessary part in the 100% CUP.

"Yes" is the simple answer to whether the programme can work cooperatively with entertainment establishments.

An essential component of the 100% CUP is the application of a mechanism to assure a high level of compliance to the programme's policies (especially 100% condom use) at the level of entertainment establishment owners and managers. How this is done may vary between localities. Whether the threat of sanctions will be necessary will depend on the localities involved and the programme's success with strategies to encourage the voluntary cooperation of entertainment establishments and sex workers.

In all programmes to date, compliance is encouraged through a number of strategies to gain the cooperation and even participation of owners/managers in the planning and implementation of the programme. Owners/managers also have an economic incentive to assure that everyone cooperates, as non-compliant establishments may be able to profit unfairly by skimming clients wanting sex without a condom.

In some of the initial country experience with the 100% CUP (especially Thailand and Cambodia) provisions for sanctions were

also an integral part of the programme, along with other techniques to encourage cooperation. In these cases, the sanction was the threat of closure of establishments, temporarily or permanently, that were not complying with 100% condom use policies. This was a "carrot and stick" approach as is found in many other public health and safety programmes. And in these early 100% CUP experiences with sanctions, as in many other public health and safety programmes, the application of sanctions was needed only rarely, mainly in the early stages of the programme.

The possibility of sanctions cannot simply be ruled out completely nor can they be simply adopted without careful consideration of the national and local context, including the possibility that their implementation could be perverted and contribute to corruption.

In principle, "sanctions" can be administered fairly and have been a traditional tool in effective public health programmes. It should also be noted that a recent and highly academic study of the 100% CUP strategy in the Dominican Republic examined the question, among others, of whether the use of sanctions was necessary. This study quite clearly concluded that in the Dominican Republic, interventions were more effective in several important aspects when administered with sanctions plus cooperative strategies than they were with cooperative strategies alone. Whether this holds true for other countries remains to be seen.

2.10 I heard a lot about police arresting sex workers in some countries where the 100% CUP is implemented. Is the programme used to harass sex workers in some communities?

Arresting sex workers is NOT a strategy of the 100% CUP. As described in the response to the question 1.9, the programme is monitored through owners or managers without identifying the sex workers who did not use condoms. Implementers have been advised to pay serious attention to this matter, as it will affect the reputation and the scaling-up of the programme.

Arresting and harassing sex workers by the police happened

almost everywhere in the region (with or without the 100% CUP). However, it is observed that the intensity of such practices is much lower in areas where the 100% CUP is implemented, which is due to good collaboration among local authorities and the entertainment establishment sector. As mentioned in the response to the question 1.34, because of the illegality of sex work, arresting sex business owners may occur in areas where the 100% CUP is implemented if some strong illegal conducts are found in their establishments. This has nothing to do with the 100% CUP implementation.

2.11 What about streetwalkers and freelancers who don't work in establishments? Why are they not included in the 100% CUP? Are you just ignoring the risks they endure and present? Can't a client who wants to have sex without a condom just go to them and maybe pay more?

Sex workers who do not work in establishments are indeed more difficult to reach.

The strategy of the 100% CUP is to first address the easier situation of sex workers who are based in establishments with a programme that has proven effective for them, both in terms of reducing their risk of contracting STI and HIV as well as spreading it to their clients.

Freelance sex workers are not being ignored. The personal and public health problems associated with freelance sex work are being addressed in other programmes. In some countries, the 100% CUP cooperates with other agencies/ nongovernmental organizations working with freelance sex workers. There are also some indirect benefits of the 100% CUP.

It is true that a client who insists on having high-risk sexual relations without using a condom does have the option of seeking out a freelance sex worker. In general though, clients who visit sex entertainment establishments usually do so because they do not like the public exposure and other risks associated with negotiating sex on the street. The option of freelance sex workers is available only to the most determined clients who will insist on having high-risk sexual relations.

2.12 Isn't this 100% CUP just going to drive sex workers into the street to work as freelancers where they can make more money selling sex without condom use?

Some countries have seen gradual changes in the distribution of sex work and relations in their communities after a 100% CUP is implemented, especially a decline in establishment-based sex. But there has been no evidence to date that the 100% CUP is simply driving sex workers into the street and freelance work.

Studies of sex workers have generally recognized that there is a significant level of mobility. Sex workers move between towns or provinces, and they may indeed move between street and establishment-based work. Both types of sex work have their advantages and disadvantages, the money that can be made being only one of them. Studies have, for example, revealed that sex workers often gravitate to establishment-based venues for their work because of the housing usually provided, the camaraderie they may enjoy with other women in the trade, more protection they have from violent clients, and the ability to borrow money from owners in time of need. Moving from an establishment to the street is apparently not a decision that is taken lightly. However, it is noted in some countries that those workers who shift from establishments to work as freelancers are more likely to be drug injectors, or less competitive ones. Therefore, prevention programmes should also target freelance sex workers to reduce HIV and STI transmission in the communities.

2.13 Sex work is illegal and spreads diseases. Why are not health authorities and police cooperating to eliminate sex work? Shouldn't sex workers just be arrested?

All societies have approached sex work with a great measure of ambivalence. Almost everyone agrees that sex work is often associated with many troublesome and undesirable underlying aspects of society such as poverty, low social status of women, lack of education, limited job opportunities, and now the risk of transmitting a life threatening infection like HIV. Criminal conduct like trafficking in women and "slave-like practices" also sometimes surrounds the sex work industry. It is formally illegal in many countries, and most

people also agree that given these underlying social circumstances, sex workers themselves are often as much victims as they are "criminals".

Though sex work may be formally illegal, no country has been successful at completely eliminating it through laws and police enforcement. Indeed, at the local level, law enforcement officials often permit or ignore a low level of sex work to take place in selected areas of towns. As with some situations, authorities have found it more practical to "selectively enforce" laws so as to limit the most dangerous aspects of some behaviour but not to waste vast resources in pursuing what will likely be a failed effort.

Notwithstanding laws, religious teaching and family-oriented social goals, this is the reality of the situation; and this is the reality in which the 100% CUP has been organized and implemented.

In itself, the 100% CUP is NOT encouraging nor discouraging the legalization of sex work. It is also NOT encouraging or discouraging more police actions against sex work. These are social decisions that are beyond the immediate purview of medical and public health authorities. However, in the context of current realities, the 100% CUP is seeking to work cooperatively with police so as to limit one of the new and very dangerous health aspects of sex work - the risk of acquiring and spreading HIV and other STI. In some places, implementing the 100% CUP does indirectly encourage law enforcement's actions against sexual abuse of women and children.

2.14 Does 100% CUP promote condom use among young people and encourage promiscuity? All this talk about sex work and condoms is undermining the traditional family value of our culture.

The 100% CUP is NOT promoting condom use among young people, encouraging promiscuity or undermining family oriented values. It is a programme to work with the owners of sex establishments to enforce the use of condoms ("No Condoms, No Sex") to protect the public health from people who have already decided to engage in commercial sex services (either as sex workers or clients), whether they are young or old, conservatives or liberals.

2.15 Many believe that sex workers and their clients are bad people. They deserve to suffer the threat of disease and death if they behave immorally. Why are you trying to protect their health?

Almost everyone agrees that sex work is often associated with many troublesome and undesirable underlying aspects of society such as poverty, low social status of women, lack of education, limited job opportunities, and now the risk of transmitting a dangerous infection like HIV. Criminal conduct like trafficking in women and "slave-like practices" also sometimes surrounds the sex work industry. Many people also agree that given these underlying social circumstances, sex workers themselves are often as much victims as they are simply being labeled "bad people."

The situation is equally complicated with regard to the clients of sex workers who may be people who are separated from their families for long periods because of their work or displaced status (migrant labourers, minors, truck drivers, refugees). In these situations, access to commercial outlets for sexual activity is commonly observed.

No matter how one thinks about sex workers and clients, everyone must recognize that it is useful to protect individual and public health where possible. Some of the clear victims of the HIV pandemic include people like the spouses and children of clients of sex workers and the spouses or regular sexual partners of those engaged in sex work. The 100% CUP has been able to help protect these populations.

The 100% CUP is a programme that works to protect everyone's health, the public's health as well as the individual health of sex workers and their clients.

2.16 How do you effectively deal with religious opposition to the implementation of the 100% CUP? How do you implement the 100% CUP in communities/counties/districts that are highly traditional or religious? Won't there be a lot of opposition to the implementation of a city wide or national policy from these groups?

In many cases, religious opposition to the use of condom is linked to family planning. Since the 100% CUP is not promoting the use of condoms in the general population, but rather only in groups considered at high-risk of contracting HIV/STI, then the condom is considered as a prophylaxis (disease preventable device). In situations where condom promotion is sensitive, the 100% CUP could be implemented quietly without any media coverage and by only involving key stakeholders (local authorities and sex work sector).

As indicated by experience from other countries, government commitment is essential for nation-wide expansion. Thailand's national programme was launched in 1991 by a resolution of the National AIDS Committee, chaired by the Prime Minister that clearly mandated the 100% CUP policy in all areas of the country and called upon concerned ministries to issue the directives necessary for compliance. In Cambodia, too, strong support expressed by Prime Minister Hun Sen in October 1999 was a critical stage in moving the 100% CUP nationally. In the Islamic Xinjiang Region of China since 2005, local Muslim Imams have been supporting condom use among sex workers in confronting the community risk of contracting and spreading HIV and STI.

2.17 If the 100% CUP is as effective and cost-effective as you said, why have not all countries implemented this strategy?

In many countries, political leaders are now confronting the reality of sex work that has thus far been isolated to one sector or another. Public health leaders are challenged with organizing interventions that conform to well-grounded traditions of medical ethics and human rights in a situation at the nexus of, but not clearly within, a formal legal framework. Both community and public health leaders struggle now, and will continue to in the immediate future, with how to convincingly explain to the public the intent and function of the 100% CUP in the context in which it must work. There is no simple formula for overcoming this challenge. The political, social, cultural and legal contexts in which the 100% CUP is being implemented all vary immensely. That the challenge has been met successfully in some communities and countries should, however, serve as

encouragement for others to initiate and expand the 100% CUP in their locality.

2.18 How can we engage other United Nations agencies and other partners to support the expansion and implementation of the 100% CUP?

It has been the experience in all countries where the 100% CUP has been introduced that this process works best by initiating in one or several local communities before scaling-up. For nation-wide expansion, there is a need to engage with other partner agencies e.g. UNFPA, UNAIDS, the Global Fund to Fight HIV, Tuberculosis and Malaria for financial support; National Family Planning Programme, Population Services International, DKT and Marie Stopes International for condom supply, etc. This can be done through technical consultations, consensus meetings, implementing sites' documentation or experience sharing exercises.

For more information on the 100% CUP, visit WHO WPRO's publications on the 100% CUP at this link: http://www.wpro.who.int/health_topics/condom_use/publications.htm

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