



EXPERIENCES OF 100% CONDOM USE PROGRAMME IN SELECTED COUNTRIES OF ASIA



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ABBREVIATIONS AND ACRONYMS

100% CUP	100% condom use programme
BSS	behavioural surveillance survey
EE	entertainment establishment
EEW	entertainment establishment worker
FSW	female sex worker
HIV	human immunodeficiency virus
HSS	HIV sentinel surveillance
IDU(s)	Injecting drug users
IEC	information, education and communication
MSM	men who have sex with men
NAP	national AIDS programme
NCHADS	National Center for HIV/AIDS, Dermatology and STD
NGO	nongovernmental organization
PLWA	people living with HIV/AIDS
STD	sexually transmitted diseases
STI	sexually transmitted infection
SW	sex workers
VCT	voluntary counseling and testing



1 INTRODUCTION

1.1 Purpose of this document

This report is an attempt to document a rich and growing experience with a remarkable strategy to prevent the transmission of HIV where it is associated with heterosexual transmission linked to sex work: the 100% condom use programme (100% CUP).

First piloted in Thailand in 1989 with impressive results, it was adopted nationally two years later. The success of Thailand's experience sparked the interest of neighbouring countries, and a 100% CUP pilot project was initiated in Cambodia in 1998. Having equally notable results, this programme too was expanded nationally two years later. Other countries in the Asian region have looked to the potentials of the 100% CUP to confront their own growing concern with the HIV/AIDS epidemic. These include China, the Lao People's Democratic Republic, Mongolia, Myanmar, the Philippines and Viet Nam, where this approach has been implemented on a demonstration basis at some pilot sites.

Though essential strategic elements of the 100% CUP are a constant feature of each of these different country programmes, they have clearly been implemented in the context of a wide variety of epidemiological, cultural and legal contexts. Some specific features of the Thai 100% CUP have been reproduced and others have been adapted to local needs and situation.

This document attempts to review this growing experience with the 100% CUP in countries in the Asian region and to elucidate the lessons learnt and challenges that remain.

1.2 Sexual transmission of HIV in Asia

The HIV/AIDS pandemic in the Asian region has largely been fueled by heterosexual transmission. First and foremost, HIV is a sexually transmitted disease (STD). Though very high levels of HIV infection can be found in some population groups such as injecting drug users (IDUs), blood product recipients (much more in the past than currently), and among newborns of HIV-infected women, on average more than 90% of the total adult infections globally and in Asia are believed to have been transmitted through heterosexual exposures, though high and important levels of infection are also sometimes documented among populations of men-who-have-sex-with-men (MSM).



Throughout the early-to-mid 1980s, while alarm about the ensuing new epidemic was growing rapidly in other regions of the world, there were seemingly few reported cases of HIV/AIDS in the Asian region, linked initially to foreign residents and MSM.

By the mid-to-late 1980s, however, a high prevalence of HIV infection began to be documented among IDUs and sex workers (SWs) in a number of the region's countries. The first detection of rising HIV transmission in sex workers in Thailand started in mid 1989. At this same time, heterosexual transmission linked initially to SWs and their clients was also believed to have begun in Myanmar and Cambodia. As the HIV sentinel surveillance (HSS) systems of other countries matured and accumulated data, these data were found to be consistent with highlighting the critical role that sex workers and their clients were playing in the evolution of their national epidemics. These findings have also alerted other countries in the region to monitor closely the role that sex work may be playing elsewhere.

1.3 Development of the 100% condom use programme

The 100% CUP is a strategy that was first developed and pioneered in Thailand. Sporadic sero-prevalence testing in the late 1980s seemed to indicate the national epidemic was concentrated mainly in IDUs. A national HSS was organized in 1989 and soon thereafter documented what appeared to be high levels of HIV infection among sex workers, especially those working in brothels in the country's northern provinces. Follow-up and expanded surveys a year later, in June 1990, documented an alarming increase in HIV infections among sex workers, from 3.1% in 1989 to 9.3% (increased to 15.2% in 1991). Also documented were rapidly growing HIV infection rates in male military conscripts, from less than 1% in 1989 to 2.1% a year later (increased to 3% in November 1991).

Thai public health workers, long fearing that the robust sex industry in the country would likely play a major role in the national experience with HIV/AIDS, had already begun to pilot a new approach to promoting condom use in establishment-based sex work. In mid-1989, this approach, what they called "the 100% condom use programme" (100% CUP), began to be piloted in Ratchaburi province.

The Thai 100% CUP was designed primarily to remedy two problems associated with promoting condom use in sex work: first, an "economic disincentive" for sex workers to use condoms; and, second, a power imbalance between male clients and female sex workers in any negotiation about condom use. As many clients much prefer sex without a condom, sex workers or sex work establishments that may insist on condom use would likely see their prospective clients (and their money) go elsewhere. And, female sex workers were at a clear economic and physical disadvantage in negotiating condom use to protect, at the very least, their own health.



To address these two problems, public health authorities in Ratchaburi devised a strategy requiring that all sex establishments in the province would require condoms to be used in sexual relations. This would much limit the options for reluctant clients to take their business elsewhere. In the design of this strategy, there were provisions also for engendering the cooperation of sex entertainment establishment owners and managers to publicize the 100% condom use policy in their establishments and to support sex workers in their negotiations with clients, some of whom might resist condom use. Educational programmes sought to encourage voluntary cooperation with the region's 100% CUP policies though there were also provisions that non-cooperative establishments could face the possibility of temporary or permanent closure by law-enforcement authorities.

The Ratchaburi experience with the 100% CUP demonstrated immediate and impressive results with an increase of condom use and a decrease in rates of sexually transmitted infections (STI) among sex workers and their clients. Measuring STI rates among males was a principle tool used to monitor the programme's evolution (with recognition that STI infection rates are a well-recognized indicator of exposure to high-risk and unprotected sexual behaviour that also transmit HIV). Other provinces in Thailand began similar implementation trials with the 100% CUP and, in 1991, the programme was implemented nationally with the endorsement of the Thai Prime Minister.

Extraordinary results from the Thai experience with the 100% CUP continued to accumulate with each evaluation and with documentation of rapidly declining rates of STI among sex workers and their clients, paralleling closely to increased rates of condom use in commercial sex.

The success in Thailand especially interested neighbouring Cambodia. Immediately after the first HIV infections were documented in Cambodia in 1991, the Ministry of Health, with WHO support, established the National AIDS Programme (NAP), now the National Center for HIV/AIDS, Dermatology and STD (NCHADS), focusing attention on both STI and HIV/AIDS. In 1995, an outreach programme to sex workers was providing a package of educational materials about HIV/AIDS/STI and training in skills to negotiate and use condoms with all risky sex acts. By 1998, however, a programme review revealed that consistent condom use was increasing but was still insufficient and that HIV infection rates among establishment-based sex workers had risen to an alarming 42.5%. Statistics from the seaport and beach resort town of Sihanoukville on Cambodia's western coast were even more disturbing with documented HIV infection rates of over 57% among establishment-based sex workers and 3.8% at sentinel antenatal clinics.



With these statistics and the commitment of local authorities and health staff at all levels, it was decided to pilot the 100% CUP in Sihanoukville in late 1998. Compliance with the 100% CUP pilot was very high and after 18 months of its initiation, evaluations were showing the same kind of results that had been obtained in Thailand. HIV prevalence among sex workers declined to just over 40% and a behavioural survey among client groups showed substantial increases in reported condom use.

The early evidence of success with the Sihanoukville 100% CUP pilot project quickly captured the attention of national authorities and in October 1999, Cambodian Prime Minister Hun Sen requested that all “Governors of provinces and municipalities to efficiently apply the 100% condom use programme countrywide”. In 2000 and 2001, the 100% CUP had been initiated in an additional 8 and 10 provinces respectively. Evaluations and behavioural surveys continued to show impressive declines in HIV and STI prevalence among sex workers and client groups, along with equally impressive reports of consistent condom use in sentinel groups.

The strategy of the 100% CUP clearly works and merits the attention of other neighbouring countries who are also witnessing a disturbing rise in STI and HIV infections linked to sex work. At present, this strategy is being implemented in China, the Lao People’s Democratic Republic, Mongolia, Myanmar, the Philippines and Viet Nam.



2 OVERVIEW

2.1 What is the 100% condom use programme?

The 100% CUP is a collaborative programme between local authorities (health, police/public security and Governor/Mayor's office) 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, 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 in the context of a place of business under the general supervision of an owner or manager.

Although there is not a "one size fits all" approach to the 100% CUP, there is at least one common strategy and that is the mobilization of local authorities to empower sex workers to refuse unprotected risky sexual practices that are a danger to their health. Supporting this common approach are six essential strategic components of the 100% CUP that are, 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) identification and collaboration with sex entertainment establishments;



- 5) monitoring of condom use; and,
- 6) evaluation of the outcomes and/or impact.

These components can 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/Mayor’s office), health sector and police/public security sector. These sectors must also 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 that:

- governmental agencies accept and understand better the realities of sex work in their communities, and their 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);
- the community, if and when they may become aware of it, and clients understand clearly that high levels of the government are behind 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 strong political commitment is obtained so that local government units and communities can indeed “take charge.”

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

2) Multisectoral institutional structures

The 100% CUP must have structures that meet the management requirements of this unique programme. This will include especially 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 that are established generally include participation from a broad spectrum of those involved in the implementation and impact of the programme, such as:

- community, political, business and professional leaders;
- technical and professional staff from government agencies, especially local administrator, health and police/public security;
- representatives of the 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. Responsibilities include:

- assignment of responsibilities and ground rules for the different parties;
- coordination with other policies and programmes in the community such as those involved with public security, building and business codes, condom social marketing, voluntary counseling and testing (VCT), STI services, surveillance, etc.;
- identification of the types of “sex entertainment establishments” to be included in the programme, how the programme may be phased and the kind of 100% condom use policies (e.g. No Condom – No Sex) and education programmes that are to be instituted in these establishments (see #4); and,
- establishment of the 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 implementing a programme like the 100% CUP that will need to reflect the legal and organizational traditions of the communities in which they are 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 quality condoms

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 entertainment establishments. More than just their physical presence, the establishment workers (both managers and sex workers alike) must be adequately trained in how to ensure that condoms will be used. A 100% condom use policy (probably requiring 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 between countries on how condoms are made available within entertainment establishments. They may be given away free in some, or sold in others. Differences between countries will also exist on 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) Identification and collaboration with sex entertainment establishments

The 100% CUP must clearly identify the “places” where commercial sexual relations are negotiated and/or conducted. The “place” where these activities take place will vary between 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 have no access to 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 work and that they are supported when confronting a non-compliant customer. In places where sex work is not under control of the owner or manager, effort 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) Monitoring of condom use

A way must be found and instituted by which compliance with the 100% CUP can be monitored. Ultimately, this boils down to verifying that condoms are used in all risky sexual relations conducted in an establishment that is part of the 100% CUP.

This is the area where one finds the most variation in how the 100% CUP is being implemented in different countries. In several of the countries where the 100% CUP was first implemented, there was already in place 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 entertainment establishments “by proxy”. These facilities instituted procedures to question all male clients about their recent visits to entertainment establishments and whether they used condoms (regardless of STI status). If it was found that a particular entertainment establishment appeared to provide sex service without using condoms, 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 is especially attractive as it is 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 where male clients seek STI services.

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 to use “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 than ideally 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 outcome of the programme in assuring that condoms are used in all risky sexual relations.

6) Evaluation of outcomes and/or impact

In #5 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 cooperation/compliance with the 100% CUP policies. In addition to this essential management component, the 100% CUP must have procedures to evaluate the outcome and or impact of the programme goals of reducing the transmission of STI and HIV associated with entertainment establishment-based sex work among sex workers, their clients and ultimately among the general population.



The 100% CUP invariably documents the level of HIV, STI and condom use among sex workers, clients and the general population before the programme is instituted, i.e. “baseline” level, and at time intervals after it has been implemented. These evaluations of outcome 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 HSS, behavioural surveillance survey (BSS) and monitoring of condom supply. These programmes 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 programmes to evaluate the outcome and impact.

2.2 What the 100% condom use programme is not

In understanding essential components of the 100% CUP, it is also helpful to be clear what the 100% CUP is not. In this regard, there are at least four aspects of the 100% CUP that are commonly misunderstood. It is important to note that the 100% CUP:

- 1) is not a “stand-alone” programme that works in isolation from other HIV/AIDS prevention programmes;
- 2) is not a programme that “targets” or seeks to place unreasonable burdens on sex workers already in a difficult position;
- 3) is not only a public education programme to educate people about the need to use condoms in risky sexual relations; and
- 4) is neither encouraging nor seeking to legalize prostitution.

Each of these aspects of the 100% CUP merits elaboration.

1) Not a stand-alone programme

As noted previously, the 100% CUP is not a 100% solution to a community’s HIV/AIDS problem and it is not a stand-alone programme. Though the 100% CUP clearly needs a coherent organizational structure, it is not a programme that can operate independently from other public health measures to combat HIV/AIDS. The 100% CUP must be integrated in and draw upon those other essential aspects of community HIV/AIDS activities.



The 100% CUP should be built upon an existing sound surveillance system that can accurately assess the burden of HIV/AIDS and STI in the community and identify the groups who may be at risk, and are in need of assistance. Similarly, the 100% CUP could be built upon a public health education programme that has properly sensitized the public to the threat of HIV/AIDS and the efficacy of condoms. The availability of good quality condoms in the community will also draw upon wider institutional capabilities in procuring, storing and distributing essential supplies.

The 100% CUP depends upon these and other vital components of a community's response to the challenges of HIV/AIDS and the programme must be seen as yet another component that can effectively address challenges posed by unsafe and risky sexual practices that are associated with establishment-based sex work.

2) Not a programme that "targets" sex workers

The risk that sex workers and their clients face, both in terms of acquiring and transmitting HIV and STI, is indeed the primary concern of the 100% CUP. There are educational activities that are directed at addressing their personal needs and those of the public health. If there is a unique "target" in this prevention strategy, it is those interventions that are directed toward the owners and managers of sex entertainment establishments. Special to the 100% CUP are those strategies that are intended to secure the cooperation of owners and managers of sex entertainment establishments to support sex workers in assuring that clients always use condoms when engaging in risky relations. And, in the absence of "cooperation", there are (or should be) provisions for sanctions targeted at these owners/managers (see #3 for further elaboration on this aspect of the programme).

There are two other sometimes misrepresented aspects of the 100% CUP related to "targeting sex workers". These, too, merit clarification. First, the 100% CUP does include the possibility of sanctions that include temporary or permanent closure of a sex entertainment establishment. Since such an action would undoubtedly cause the loss of employment for sex workers, this, too, has sometimes been misunderstood as an unfair "targeting" of sex workers. It cannot be denied that sex workers will be impacted adversely by the closure of a non-compliant entertainment establishment. But again, the principal strategy of the 100% CUP is to help or empower sex workers in their negotiations with clients about condom use. It is not the programme's primary motive to punish, though this unfortunate consequence might occur where there is evidence of non-compliance and in the interest of protecting the public health.



Second, it has sometimes been inaccurately assumed that the 100% CUP is targeting sex workers by advocating for regular HIV/STI screening of sex workers as a way to monitor their compliance with the 100% CUP. Screening of sex workers is not a part of the 100% CUP strategy. In fact, in the very successful programme in Thailand, it is the monitoring of males with STI, and the questioning of them about condom use “in particular establishments, and not with particular sex workers” that was the key strategy in identifying problem sex entertainment establishments. It has been strongly advocated in the 100% CUP that, where public health and safety officials have a need to approach an establishment suspected of non-compliance, the medical condition and the personal identity of any “informant” or “sex worker or client with an STI or HIV infection” be kept strictly confidential.

Ultimately, the 100% CUP is concerned with the success that sex workers have in successfully negotiating with and convincing clients to use condoms. By engaging owners/managers of sex entertainment in this objective, the 100% CUP is, in effect, fostering an “enabling” or “empowering” environment to assist sex workers in this sometimes-difficult task.

3) Not only a public health education programme

The 100% CUP goes beyond “education”. It employs strategies for sanctioning owners/managers of sex entertainment establishments if they are not adhering to 100% condom use policies. Temporary and even permanent closures of non-compliant entertainment establishments have been seen as essential in the very successful programmes in Thailand and Cambodia; and, there is sound reason to believe that they will be essential elsewhere. As with most public health and safety programmes with sanctions (e.g. sanitary measures enforced in restaurants or building safety codes), they are only rarely needed. This too has been the experience in Thailand and Cambodia. But the threat of sanctions, 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 “request for participation” almost always ended up with very low compliance, and thus public safety could not be ensured.

Educating “the public” about the 100% CUP may or may not be important as this depends upon the political environment in which the programme is being organized. As it is concerned primarily with the risks associated with the often “underground” or “extralegal” sector of sex work, it may be prudent that the programme not be highly publicized, although the full awareness and participation of political leaders is imperative.



4) Neither encouraging prostitution nor advocating for its legalization

Almost all countries deal with sex work with a great measure of ambivalence. Everyone agrees that sex work is often associated with many troublesome and undesirable aspects of society such as poverty, low social status of women, lack of education, limited job opportunities, woman and child trafficking, and now the risk of acquiring and transmitting a dangerous disease like HIV/AIDS. Criminal conduct such as trafficking in women, “slave-like practices” and debt bonding also surrounds sex work in some communities. Sex work is formally illegal in most countries of the world though most people also agree that given these underlying social circumstances, sex workers themselves are often as much victims as they are “criminals”.

While there are few countries in the world in which sex work has been fully legalized, there are even fewer countries in which sex work does not exist as some form of “underground” or “extralegal” activity and in fact quasi-tolerated with the complicity of police and local community leaders. Establishments and places where sex work is negotiated and conducted are frequently well-known “public secrets” in a community.

Notwithstanding laws, religious teachings and worthy family-oriented social norms, sex work is a reality; this is the reality in which the 100% CUP has been organized and implemented. Critics sometimes feel that the 100% CUP, by virtue of working openly with the sex work industry and the workers themselves, is itself encouraging the legalization of prostitution, contributing to corruption of youth and irresponsible sexual relations, and damaging traditional and family-oriented community values.

In truth, the 100% CUP in itself is neither encouraging nor discouraging the legalization of prostitution. Neither is it encouraging nor discouraging more police and social actions that seek to rectify those social forces that contribute to prostitution. These are political and 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 the local authorities (health, police/public security and governor’s office) as well as owners and managers of local sex work establishments and the sex workers themselves so as to limit one of the new and very dangerous health aspects of sex work—the risk of acquiring and spreading HIV.



2.3 Common experiences/lessons learnt

There are at least three common experiences or “lessons learnt” about the 100% CUP that have been shared by countries in the Asian region. These include:

- a) feasibility—it works across countries;
- b) start locally; and
- c) political support is critical.

a) Feasibility—it works across countries

The 100% CUP has clearly been demonstrated to be a preventive health strategy that has great potential to reduce the spread of STI and HIV associated with establishment-based sex work in a number of different countries and cultural and political settings. To be sure, monitoring systems in the newer 100% CUP (China, Lao People’s Democratic Republic, Mongolia, Myanmar, the Philippines and Viet Nam) are being developed and evolving. But, in these new programmes, as in the more mature and now nationalized programmes in Thailand and Cambodia, evidence has been both clear and growing that the 100% CUP “works” in increasing condom use and in reducing the prevalence of STI among sex workers and their clients. It is also clearly a programme strategy that has been found to be feasible and applicable across different political, cultural and epidemiological settings and has attracted much favourable attention in the public health community.

b) Start locally

It has been the experience in all countries where the 100% CUP has been introduced that this process works best by first “piloting” the 100% CUP in one or several local communities (cities or provinces) before tackling the more complicated situations encountered in major metropolitan or capital cities. The 100% CUP is the kind of programme that must be slowly and carefully introduced to the communities and government agencies that will be implicated in its implementation. This has proven important in demonstrating both its applicability and workability within the prevailing cultural and legal setting as well as demonstrating that the programme can be effective in dealing with one of the most pressing health problems associated with establishment-based sex work.



c) Political support is critical

“Political support” has long been recognized to be one of the essential strategic components of the 100% CUP. Some level of political approval and oversight is, of course, a feature of any government-sponsored programme. In view of the sensitive social subject of the 100% CUP, namely “sex work”, and the need for multisectoral coordination in its implementation, both a high and strong level of political support has been uniformly recognized as one of the most important features linked to the success of the programme.

Strong support from the leadership of Health Ministries, backed up by sound technical inputs, will be critical at all stages of the 100% CUP introduction and implementation.

In the early “piloting” stages of the programme, good support must also be garnered from local units of government and local agency leadership. If and when the programme expands nationally, even higher levels of political support must be secured.

The two oldest and most mature countries experiences with the 100% CUP, in Thailand and Cambodia, have both benefited from “the highest” levels of political support. 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 in October 1999 was a critical stage in moving the 100% CUP nationally.

At the current time, the 100% CUP in China, the Lao People’s Democratic Republic, Mongolia, Myanmar, the Philippines and Viet Nam have already secured political support at the local level. More advocacy is needed to increase further support at the central level for nation-wide expansion of the programme.

2.4 Challenges

Countries in the Asian region that are implementing the 100% CUP are all confronting three common challenges as they move into the future:

- a) illegality versus extra-legality of sex work;
- b) effectively involving sex workers; and,
- c) freelance sex work.



a) Illegality versus extra-legality of sex work

In virtually all countries in the Asian region where the 100% CUP is being implemented, programme staff and managers find themselves in the vortex of legal and ethical debates about sex work and the need to confront public health realities. Public health threat now clearly reaches far beyond a quasi-tolerated, underground and extra-legal sector of sex work in many communities across the countries of the region. Thus far, unable simply to eradicate sex work by the strict application of formal laws, confronting now the dangerous association between sex work and an HIV/AIDS epidemic, public health and community leaders are left with special and unfamiliar challenges.

Political leaders are now brought to confront the reality of sex work that has thus far been isolated to one sector or another in the community. 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 the 100% CUP in their locality.

b) Effectively involving sex workers

Sex workers have traditionally occupied a socially marginal, disrespected and often maligned group in the community. The 100% CUP, however, depends greatly on their cooperation in working to ensure that condoms are used in all risky sexual relations. To assure this cooperation, programme managers must work against traditional prejudices against sex workers to assure that their perspectives and insights are well represented in the planning and implementation of the 100% CUP. Representatives of sex workers will need to be identified and incorporated in the administration of the 100% CUP, almost surely with the involvement of organizations of sex workers such as “unions” or with help from NGOs, which have strong ties with sex workers.



Added to the challenge of effectively involving sex workers in the planning and implementation of the 100% CUP will be the need to keep the focus on the public health goals of the programme. However well- or ill-founded the interests of sex workers and their support organizations may be, to “legalize prostitution” and to apply the protection of traditional labour laws to their work, it will be important that these interests not obstruct the programme’s already difficult and immediate personal and public health objectives.

c) Freelance sex work

The success of the 100% CUP in Asian countries in addressing the issue of disease prevention within the context of establishment-based sex work has done much to highlight the fact that there are other venues in which sex work is being conducted that pose an equal if not greater risk to the health of the workers, clients and the community at large. “Freelance” sex work, while that may be negotiated on street corners, through the telephone, via the Internet, etc. is often held to be equally deserving of 100% CUP attention. Since the 100% CUP depends greatly on the supervision and interventions of owners and managers of places where sex is negotiated and/or conducted, these opportunities may be more limited for freelancers.

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, in terms of reducing their risk of contracting dangerous STI and HIV as well as spreading it to their customers.

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 (see Country Report from Mongolia).

Overall, it will be the responsibility of 100% CUP programme managers in the future to seek opportunities to extend this prevention strategy to other venues where it may also be useful. At the same time, it will also be necessary not to generate expectations for the programme that go beyond its strategic capabilities.



3 Country Reports

The following is a brief description of the current status of 100% CUP activities within selected countries in the Asian region. This description is supplemented with information in the Appendices. Thailand and Cambodia are not included as there are many existing documentations about the 100% CUP implementation in both countries.

Countries will be presented chronologically, starting with countries that started the 100% CUP at an earlier stage to those countries that have just initiated the programme.

Viet Nam

HIV was first detected in Viet Nam in December 1990. Within two years, epidemic outbreaks among IDUs were documented. By 31 July 2003, the cumulative toll of HIV/AIDS included 69 530 HIV-infected individuals, 10 665 AIDS cases and 5963 AIDS-related deaths. 2003 estimates suggest that the true national burden of the epidemic is 169 730 persons infected with HIV, 31 821 AIDS cases and a total of over 27 000 deaths. Almost 60% of these infections are IDU. Also disturbing is a rising trend of HIV infection among sex workers, from 0.6% in 1994 to 4.2% in 2002. Levels of HIV infection in antenatal clinics have also grown, from virtually 0% in 1994 to 0.4% in 2002.

Though sex work is illegal in Viet Nam, it nevertheless is estimated that there are some 150 000 female sex workers who work underground on the street or associated with karaoke, massage/sauna establishments especially in areas which attract tourists or leisure activities. Several studies among sex workers at several of these sites have suggested that the reported regular use of condoms by sex workers is fairly high (50% plus) for their “non-regular clients”. Reported condom use for “regular clients” and “non-paying” partners, is much lower.

The 100% CUP was first piloted in 2000 in Halong city (Quang Ninh province). This project built also on experience with a Family Health International project to promote condom use among sex workers in Can Tho Province that had started a year earlier. The 100% CUP was expanded in 2002 to Ha Tay and Dong Nai and to Thanh Hoa in 2003. With the support of Asian Development Bank (ADB) and World Bank (WB), it is anticipated that the 100% CUP will expand to 12 additional provinces. Further support from the Department for International Development (DFID) and Norwegian Agency for Development Cooperation (NORAD) will expand to a total of 21 provinces.



At this point, efforts in the 100% CUP have been directed at solidifying multisectoral coordinating roles, increasing condom advertising, promotion and availability through social marketing, improving STI services, and identifying the means to evaluate results in the programme.

China

The first AIDS case in China was reported in 1985. Reported cases of HIV/AIDS in China remained low for a decade but grew rapidly after 1994. By the end of June 2003, the accumulated number of reported HIV infections was 45 092, which includes 3532 AIDS cases and 1800 deaths. As of September 2003, it is estimated that 840 000 (650 000 – 1 020 000) persons are living with HIV/AIDS in China. Reporting systems in China have indicated that the largest majority of HIV infections in the country are linked with IDUs (45%). Just over 15% have been linked with sexual transmission including sex work and men having sex with men. Data from a 1999 study of STI among sex workers indicated HIV infection rate of 1.4%, syphilis/TPHA at 13.7%, gonorrhoeae at 8.8% and chlamydia at an alarming rate of 32.2%.

In 2000, the Chinese Ministry of Health decided to pilot the 100% CUP at two sites, Huangpi district of Wuhan city in Hubei province and Jingjiang county in Jiangsu province where it was estimated that between 1900 and 2500 sex workers were operating out of bathhouses and brothel-like establishments. Baseline data from Wuhan/Huangpi where the programme was initiated in April 2001 documented important STI infection rates among sex workers (syphilis 8%, gonorrhoeae 3% and chlamydia 30%). Sex workers also reported that condoms were used in 60% of their last commercial sex. Similar baseline data from Jiangsu/Jingjiang indicated 55% of sex workers used condoms during their last commercial sex and STI infection rates of 34%. A year later, in June 2002, programme evaluation data demonstrated impressive results with condom use at last sex increasing markedly (from 60% to 88% in Wuhan/Huangpi and from 55% to 91% in Jiangsu/Jingjiang) as well as reductions in STI infection rates (syphilis in Wuhan/Huangpi from 8% to 1%, gonorrhoeae from 3% to 0% and chlamydia from 30% to 16%).

Based on positive experiences from the two initial sites, the Ministry of Health requested WHO's support for the expansion of the 100% CUP to two additional sites in 2002 - Danzhou City in Hainan and Lixian County in Hunan. Although implementation has been hampered by the country's recent preoccupation with severe acute respiratory syndrome (SARS), initial assessments at these sites are suggesting similar impressive results: condom use rates among sex workers at last sex with clients have increased from 17% in September 2002 to 65% in September 2003 in Hainan, and from 7% in July 2002 to 86% in October 2003 in Hunan; while STI rates have decreased in Hainan (chlamydia from 11% to 6%, syphilis from 8% to 4% and gonorrhoeae from 4% to 2%) and for Hunan (chlamydia from 12.3% to 3.3%, and gonorrhea from 5% to 0% with no syphilis and HIV detected).



China is planning for a continued phased expansion of the 100% CUP. National guidelines for the implementation and expansion of the 100% CUP have been drafted and will be finalized at an International Partners meeting to be held from 17 to 19 December 2003. Expansion of the strategy to other sites will be integrated into existing condom promotion programmes supported by central and local government and other international agencies such as UNFPA country project covering 10 provinces, World Bank health 9 project covering four provinces as well as China CARES (China comprehensive care and prevention project) covering 127 counties.

Myanmar

Myanmar has witnessed a disturbing rise in HIV/AIDS. As of March 2003, the Ministry of Health had documented almost 46 000 persons who were HIV-infected, over 6700 AIDS cases and 2843 AIDS-related deaths. And this is only the tip of the iceberg. The Ministry of Health estimated just a year earlier that there were probably 177 279 (range 160 000–240 000) people living with HIV/AIDS (PLWA) in the country. Sixty-seven percent (67%) of HIV infections are judged to be as a result of heterosexual transmission; 30% are IDUs.

Since 1996, Myanmar has been rapidly expanding condom distribution through the National AIDS Programme (NAP) and through private, public, and social marketing. Beginning in early 2001, the Myanmar Ministry of Health began to pilot its 100% Targeted Condom Promotion (100% TCP) programme, its multisectoral version of the 100% CUP. Starting in four pilot townships, the programme was expanded to 11 townships by the end of 2002 and an additional 43 townships by the end of 2003. It is anticipated that the programme will be instituted in an additional 30 townships by 2004 and a total of 88 townships by the end of 2004. Future participating townships have been identified on the basis of prevalence of HIV and STI, condom use rates, number of sex workers, geographical accessibility and commitment of local authorities and health professionals. International support townships in this expansion has come from sponsorship by Joint United Nations for HIV/AIDS (UNAIDS), World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP) and Funds for HIV/AIDS in Myanmar (FHAM).

An evaluation system for the 100% TCP has been established and coordinated with the HSS and BSS. It has generally shown that the programme is contributing to the reduction of HIV and STI transmission among sex workers and has contributed significantly to the increase in condom use. It is a programme that can be tailored to the prevailing political, social and cultural milieu, i.e. it is feasible, culturally acceptable and effective. One evaluation among female sex workers in Tachileik township demonstrated that condom use increased from 60% to 90% between 2001 and 2003 while STI rates decreased during the same period.



Philippines

Between 1984 and 2002, the number of HIV infections and AIDS cases documented in the national HIV/AIDS registry grew slowly and irregularly. By June 2003, there was 1892 documented HIV infections: 1280 currently asymptomatic, 612 AIDS cases and 254 deaths. WHO estimates, however, have suggested that the true national burden of HIV infections may be as high as 6000. Data from the national registry as of June 2003 also indicates that 86% of infections have been sexually acquired, 63% of which from heterosexual exposures.

The Philippines has long had an active programme of registering entertainment establishments and their female employees (Guest Relation Officers or GROs in the local terminology) and requiring the latter to submit weekly or bi-monthly examinations in some areas for STI and health education classes. Data from these sources and also from HSS and BSS indicate that between the mid-1990s and 2002, there was a steady (neither significant increase nor decrease) rate of syphilis among all types of high-risk groups (registered and freelance sex workers, MSM and IDUs) and also a fairly high (50%-80%) level of knowledge of HIV prevention strategies. Less encouraging has been a consistently low and unchanged level of consistent condom use (< 30%) by these high-risk groups for the same period.

The 100% CUP was initiated in April 1999 by Program for Appropriate Technology in Health (PATH) as part of the AIDS surveillance and education project in eight sites in the Philippines, but the enforcement of “No condom - No sex” due to confounding factors is yet to be in place. Recently in January 2003, four additional cities expressed their interest to implement the 100% CUP in their locality where there are estimated to be 300 registered sex workers. This programme is seeking initially to increase communication and build consensus and commitment through a non-confrontational approach. There are extensive plans to expand the 100% CUP into other localities as soon as funding is available.

Mongolia

Mongolia has experienced very little impact from the HIV/AIDS pandemic. Only four cases of HIV infection through sexual exposure have been reported in Mongolia, one each in 1992, 1997, 2001 and 2003. Authorities in Mongolia, however, consider themselves to be vulnerable to HIV/AIDS because of a high level of mobility among the populations, the size of its young population (50% < 23 years old), poverty, low levels of education among the general population as well as their geographic proximity to neighbouring countries with a substantial HIV/AIDS epidemic. This latter concern is magnified by the realization that sex work in Mongolia most frequently involves traders and business people who travel widely, and the generally recognized high levels of STI among female sex workers (averaging 60% nationally).



The 100% CUP was initiated in Darkhan *aimag* (province) in mid-2002. Darkhan was chosen as the first site because of the cooperative environment among civil authorities and sex workers and because of STI rates, which are substantially higher than national averages including documentation of STI rates of 78% among sex workers. It is estimated that there are at least 300 sex workers in the province, the vast majority of whom are freelance. Because of the nature of sex work in Mongolia, the Darkhan 100% CUP equips the sex workers with “green cards” for several reasons: to encourage monthly STI check-ups at local STI clinics; to indicate their participation in the programme; and also to immunize them from police arrests for carrying condoms. The programme cooperates with NGOs (Darkhan Railway Women’s Association and Women’s Association Hope and Trust) that work with freelance sex workers in outreach activities. Initial assessment has already shown promising results. There has been documented a reduction in STI rates among sex workers in the first six months of the programme and the Darkhan Condom Social Marketing programme has shown a 15% increase in condom sales between 2002 and 2003.

Mongolia has plans to expand the 100% CUP to two additional sites in 2004 (Selenge and Dornod *aimags*) with support from WHO and the Global Fund. There is also hope to add four more sites in 2004 including Uvurkhangai and Orkhon *aimags* if resources are forthcoming. It is also the plan of the authorities to expand the programme by five sites a year between 2005 and 2007 for a total of 22 sites by the end of this period. Clients of sex workers such as prisoners and gold miners will also be part of the target group for intervention.

The Lao People’s Democratic Republic

HIV/AIDS has been a growing problem in the Lao People’s Democratic Republic. Cumulatively, between 1990 and 2003, there were 1089 HIV-infected persons, 590 AIDS cases and 452 deaths. 80% of HIV transmission in the Lao People’s Democratic Republic is believed by authorities to be from heterosexual exposures.

In July 2003, the Lao People’s Democratic Republic launched its first 100% CUP pilot site in Savannakhet province. The province was selected for participation due to the high HIV prevalence rates in the area, good political commitments and cooperative entertainment establishments. Sex workers (or “service women” as they are known locally) in the Lao People’s Democratic Republic are highly mobile and negotiate sex in a variety of places. Within Savannakhet, it was recognized that there were six nightclubs, seven hotels, 31 guesthouses and 38 restaurant/beer bars where sex is commonly negotiated. At this early stage of piloting, the 100% CUP in the Lao People’s Democratic Republic is still seeking to broaden political support and gain the cooperation of establishment owners to at least assure the availability of condoms at the sites.



Baseline information of selected STI and HIV prevalence and condom use among sex workers has been documented and indicates that the HIV infection rate among sex workers was 1% in 2001 and 2002, while infection rates of chlamydia and gonorrhoeae were 23.3% and 13% respectively. Only 14% of sex workers reported consistent use of condoms.



4 APPENDIX

Status of 100% CUP in selected countries in Asia

VIET NAM									
Sites	Date initiated	# of EEs	# of SWs	Level of activities					Results of evaluations: STI, HIV, condom use
				1	2	3	4	5	
Can Tho	2000	150	700	x	x	x	x		SW/HIV – 94' 1.02%; 95' 3.24%; 96' 2.75%; 97' 1.59%; 98' 6.11%; 99' 4.19%; 00' 1.75%; 01' 7.95%; 02' 10.99% CS – 500 000
Quang Ninh	2001	100	400	x	x	x	x		SW/HIV – 01' 1.74%; 02' 4.22% CS – 126 000
Ha Tay	2002	69	150	x	x	x	x		SW/HIV – 01' 1.88%; 02' 2.42% CS – 510 000
Dong Nai	2002	108	936	x	x	x	x		SW/HIV - 96' 0.53%; 97' 1.53%; 98' 0.81%; 99' 2.94%; 00' 0.97%; 01' 2.47%; 02' 0.82% CS – 353 000
Thanh Hoa	2003	100	400 but seasonal activity	x	x	x	x		SW/HIV - 94' 0%; 95' 0%; 96' 0%; 97' 0%; 98' 0%; 99' 0.49%; 00' 12.23%; 01' 25.49%; 02' 3.32% CS – 400 000
12 sites WB/ADB				x	x	x	x		
DFID/The Norwegian Agency for Development Cooperation (NORAD)									Not yet started
Future plans									
1) Inclusion of 100% CUP in the National Strategy for nationwide expansion									
2) Expanding the programme to 21 provinces with support from DFID/NORAD									
3) Solidifying multisectoral coordinating roles									
4) Increasing condom advertising, promotion and availability through social marketing									
5) Improving STI services and identifying the means to evaluate results in the programme									



- Sex workers are mainly indirect and there are no brothels as such and few street-based.
- ADB provinces are Lai Chau, Quang Tri, Dong Tap, An Giang and Kien Giang
- WB provinces are Soc Trang, Nghe An, Ha Tinh, Thanh Hoa, Binh Duong, Binh Phuoc and Long An

ABBREVIATION CODES					
Level of activities	Types of EEs		Sex workers	Results	
Level 1: Verbal indication of support	A: All types	K: Karaoke	FL: Freelance	CULS: Condom use/last sex	CT: Chlamydia
Level 2: Permitting condom posters in EEs	B: Brothel	H: Hotel	D: Direct	SW: Sex worker	SY: Syphilis
Level 3: Onsite education/outreach in EEs	BL: B-Like	M: Massage parlour	ID: Indirect	C: Client	NG: Gonorrhea
Level 4: Ensuring condom availability in EEs	BH: Bath house			CS: Condom Sales through social marketing	A: Any STI
Level 5: Ensuring "No Condoms – No Sex"					



CHINA									
Sites	Date initiated	# of EEs	# of SWs	Level of activities					Results of evaluations: STI, HIV, condom use
				1	2	3	4	5	
Huangpi (Wuhan)	06/2001	50-70 BL	4-500	x	x	x	x	x	SW/CULS: 10/01 - 60%, 10/02 - 88%; 09/03 - 94.5% SW/STI: 10/01 - CT 30%, SY 8%, NG 3%, HIV 0%; 10/02 - CT 16%, SY 1%, NG 0%, HIV 0%; 09/03 - CT 14%, SY 1%, NG 0%, HIV 0%
Jingjiang (Jiangsu)	06/2001	120 BH	1500-2000	x	x	x	x	x	SW/CULS: 12/01 - 55%; 11/02 - 91%; 06/03 - 14% SW/STI: 12/01 - CT 34%, HIV 0% 06/03 - CT 14%, HIV 0%
Danzhou (Hainan)	08/2002	231 H, M	1270	x	x	x	x		SW/CULS: 09/02 - 17% 11/03 - 65% SW/STI: 09/02 - CT 11%, SY 8%, NG 4%, HIV 0% 11/03 - CT 6.6%, SY 4%, NG 2.5%, HIV 0%
Lixian (Hunan)	07/2002	98 A	658	x	x	x	x		SW/CULS: 07/02 - 7%, 07/03 - 81%, 11/03 - 88% SW/STI: 07/02 - CT 12%, NG 5%, SY 0%, HIV 0%; 11/03 - CT 3.3%, NG 0%, SY 0%, HIV 0%
Future plans									
1) Finalize National guideline on 100% CUP									
2) Expand by integrating with existing projects supported by UNFPA/Family planning system, Future's Group, Swedish International Development Cooperation Agency (SIDA), European Union (EU), WB Health 9 and China CARES									
3) National Dissemination Seminar									
4) Build capacity through training									



ABBREVIATION CODES					
Level of activities	Types of EEs		Sex workers	Results	
Level 1: Verbal indication of support	A: All Types	K: Karaoke	FL: Freelance	CULS: Condom	CT: Chlamydia
Level 2: Permitting condom posters in EEs	B: Brothel	H: Hote	D: Direct	use/last sex	SY: Syphilis
Level 3: Onsite education/outreach in EEs	BL: Brothel-like	M: Massage parlour	ID: Indirect	SW: Sex worker	NG: Gonorrhea
Level 4: Ensuring condom availability in EEs	BH: Bath house			C: Client	A: Any STI
Level 5: Ensuring "No Condoms – No Sex"					



MYANMAR									
Sites	Date initiated	# of EEs *	# of SWs *	Level of activities*					Results of evaluations: STI, HIV, condom use
				1	2	3	4	5	
Four pilot Townships	03/01								Tachileik data: SW/CULS: 2001 60%; 2002 70%; 2003 90%
Townships 1-11	11/02								
Townships 1-43	2003								
Implementing townships funding: 15 UNAIDS; 18 WHO; 10 UNFPA; 3 UNDP; 12 FHAM									
Future plans									
1) Expand the 100% TCP to the rest of the 100 priority townships jointly identified by Ministry of Health and UN organizations in 2001 plus 12 townships from Yangon and Mandalay Divisions from 2004 to 2005									
2) Expand to the remaining of 324 townships all over the country from 2006 to 2008									

* information not available

ABBREVIATION CODES					
Level of activities	Types of EEs		Sex workers	Results	
Level 1: Verbal indication of support	A: All types	K: Karaoke	FL: Freelance	CULS: Condom use/last sex	CT: Chlamydia
Level 2: Permitting condom posters in EEs	B: Brothel	H: Hotel	D: Direct	SW: Sex worker	SY: Syphilis
Level 3: Onsite education/outreach in EEs	BL: Brothel-like		ID: Indirect	C: Client	NG: Gonorrhoea
Level 4: Ensuring condom availability in EEs	BH: Bath house				A: Any STI
Level 5: Ensuring "No Condoms – No Sex"					



PHILIPPINES									
Sites	Date initiated	# of EEs *	# of SWs *	Level of activities					Results of evaluations: STI, HIV, condom use (2002)
				1	2	3	4	5	
Angeles	1999						x	x	FLSY - 11%, RFSY - <5%, HIV - >1%, CCU - 22%
General Santos	1999					x			FL/DSFSY - 1%, RFSY - 3%, MSMSY - 2%, HIV - >1%, CCU - 23%
Quezon	1999						x		FLSY - 4%, RFSY - 3%, MSMSY - 3%, HIV - >1%, CCU - 31%
Iloilo	1999						x		FLSY - 11%, RFSY - 1%, HIV - >1%, CCU - 13%
Zamboanga City	1999						x		FLSY - 6%, RFSY - 1%, MSMSY - 16%, HIV - <1%, CCU - 33%
Baguio						x			FLSY - 1%, RFSY - 0.3%, MSM - 2%, HIV - >1%, CCU - 7%
Pasay	1999						x		FLSY - 0.4%, RFSY - 0.3% HIV - >1%, CCU - 39%
Cebu	1999						x		FLSY - 18%, RFSY - 1%, MSMSY - 8%, IDUSY - 6%, HIV - >1%, CCU - 12%
Cagayan de Oro						x			FL/RFSY - 1%, HIV - >1%, CCU - 15%
Davao	1999						x		FLSY - 3%, HIV - >1%, CCU - 30%
Laoag City	2003			x					
San Fernando	2003			x					
Urdaneta	2003			x					
Dagupan	2003			x					
Future plans									
1) Expand the 100% CUP into other localities as soon as funding is available									

* information not available



ABBREVIATION CODES					
Level of activities	Types of EEs		Sex workers	Results	
Level 1: Verbal indication of support	A: All Types	K: Karaoke H: Hotel	FL: Freelance	CULS: Condom use/last sex	CT: Chlymadia SY: Syphilis NG: Gonorrhea T: Trichomoniasis A: Any STI
Level 2: Permitting condom posters in EEs	B: Brothel BL: Brothel-like		D: Direct ID: Indirect	CS: Condom sales	
Level 3: Onsite education/outreach in EEs	BH: Bath house		RF: Registered female	SW: Sex worker	
Level 4: Ensuring condom availability in EEs			MSM: Men having sex with men	C: Client	
Level 5: Ensuring "No Condoms – No Sex"			IDU: Injecting drug user DSF: Deep-sea fishermen	CCU: consistent condom use during sex last three months	



MONGOLIA									
Sites	Date initiated	# of EEs	# of SWs	Level of activities					Results of evaluations: STI, HIV, condom use
				1	2	3	4	5	
Darkhan aimag	07/02	none	>300 FL	na	na	na	na	na	SW/STI: 2002 – SY 7.7%, NG, 7.1%, T 11.2%; 2003 – SY 7.3%, NG 6.9%, T 6.2% CS: increase 15% between 2002-2003
Future plans									
1) Expand to Selenge, Orkhon, Uvurkhangai and Dornod in 2004									
2) Add five aimags each year between 2005 - 2007									

ABBREVIATION CODES					
Level of activities	Types of EEs		Sex workers	Results	
Level 1: Verbal indication of support	A: All types	K: Karaoke	FL: Freelance	CULS: Condom use/last sex	CT: Chlamydia
Level 2: Permitting condom posters in EEs	B: Brothel	H: Hotel	D: Direct	CS: Condom sales	SY: Syphilis
Level 3: Onsite education/outreach in EEs	BL: Brothel-like		ID: Indirect	SW: Sex worker	NG: Gonorrhea
Level 4: Ensuring condom availability in EEs	BH: Bath house			C: Client	T: Trichomoniasis
Level 5: Ensuring "No Condoms – No Sex"					A: Any STI



LAO PEOPLE'S DEMOCRATIC REPUBLIC									
Sites	Date initiated	# of EEs	# of SWs	EE Level of activities					Results of evaluations: STI, HIV, condom use
				1	2	3	4	5	
Savannakhet Province	7/18/03	6 NC	146	x				x	SW/HIV - 1% 2001/2002
		7 H	*						SW/CT - 23.3% 2001/2002
		31 GS	*						SW/NG - 13% 2001/2002
		38 BB	*						CCCU - 14 %
Future plans									
1) Plan to add two more Provinces by 2005									

* information not available

ABBREVIATION CODES					
Level of activities	Types of EEs		Sex workers	Results	
Level 1: Verbal indication of support	A: All types	K: Karaoke	FL: Freelance	CCCU: Consistent client condom use	CT: Chlamydia
Level 2: Permitting condom posters in EEs	B: Brothel	H: Hotel	D: Direct		SY: Syphilis
Level 3: Onsite education/outreach in EEs	BL: Brothel-like		ID: Indirect	CULS: Condom use/last sex	NG: Gonorrhea
Level 4: Ensuring condom availability in EEs	NC: Night club			SW: Sex worker	A: Any STI
Level 5: Ensuring "No Condoms – No Sex"	GS: Guest house			C: Client	
	BB: Beer bar				



TERMS USED IN 100% CUP

1. direct sex establishment - a place where sex is the primary service for sale and often takes place on site, e.g. brothels.
2. indirect sex establishment - a place where sexual services are offered/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.
3. sex workers - classified by the type of establishments: “direct sex workers” for direct sex establishments and “indirect sex workers” for indirect sex establishments.
4. freelance sex worker - someone who works relatively independently and is not formally involved with an “establishment”. This may be a streetwalker or a student who sometimes visits a hotel or bar to meet prospective clients. Some of these women are probably working for someone else, i.e. a pimp, or are in a network of organized prostitution. Their “managers”, however, are often unapparent and/or inaccessible.