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中国低档（低收入）女性性工作者艾滋病防治现状

研究报告

Research on HIV/AIDS Prevention and Intervention among

 Chinese Low-Tier (Low-Income) Female Sex Workers

中国性工作者机构网络平台

China Sex Worker Organization Network Forum(CSWONF)

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目 录

[1. 致谢 1](#_Toc371268983)

[2. 缩略语表 2](#_Toc371268984)

[3. 摘要 3](#_Toc371268985)

[4. 背景 7](#_Toc371268986)

[5. 本报告目的 8](#_Toc371268987)

[6. 方法和材料 9](#_Toc371268988)

[7. 中国从事商业性行为女性及低档女性性工作者称谓 10](#_Toc371268989)

[8. 低档女性性工作者的界定 12](#_Toc371268990)

[8.1 从女性性工作者招揽嫖客和交易的场所来界定 12](#_Toc371268991)

[8.2 从女性性工作者单次商业行为价钱来进行界定 13](#_Toc371268992)

[8.3 根据女性性工作者的收入来进行界定 13](#_Toc371268993)

[8.4 从女性性工作者的接客频率等方面来界定 14](#_Toc371268994)

[9. 低档女性性工作者的人群规模及特点 16](#_Toc371268995)

[9.1 低档女性性工作者规模估计 16](#_Toc371268996)

[9.2 社会人口方面的特点 16](#_Toc371268997)

[9.3 流动性 17](#_Toc371268998)

[9.4 低档女性性工作者的嫖客人群 17](#_Toc371268999)

[9.5 接客频率 17](#_Toc371269000)

[9.6 艾滋病知识的知晓率 18](#_Toc371269001)

[9.7 艾滋病病毒性病感染风险的自我认识 18](#_Toc371269002)

[9.8 低档女性性工作者的吸毒行为 18](#_Toc371269003)

[9.9 安全套使用 19](#_Toc371269004)

[9.10 性病感染率 20](#_Toc371269005)

[9.11 HIV感染率 21](#_Toc371269006)

[9.12 求医行为 21](#_Toc371269007)

[9.13 干预覆盖面和有关指标 21](#_Toc371269008)

[9.14 HIV检测情况 22](#_Toc371269009)

[9.15 低档女性性工作者的监测 22](#_Toc371269010)

[9.16 低档女性性工作者对HIV流行的影响和促进作用 23](#_Toc371269011)

[10. 国内外针对女性性工作者常见的HIV防治策略 25](#_Toc371269012)

[11. 我国针对低档女性性工作者的干预现状 32](#_Toc371269013)

[11.1 高危人群干预工作队（简称“高干队”） 32](#_Toc371269014)

[11.2 综合示范区项目 35](#_Toc371269015)

[11.3 全球基金艾滋病项目 36](#_Toc371269016)

[11.4 其它国际项目 38](#_Toc371269017)

[12. 中国为女性性工作者提供服务的CBO情况 41](#_Toc371269018)

[13. 低档女性性工作者HIV防治工作的挑战和建议 44](#_Toc371269019)

[13.1 差距分析 44](#_Toc371269020)

[13.2 困难和挑战 45](#_Toc371269021)

[13.3 建议 47](#_Toc371269022)

[13.3.1 关于低档女性性工作者的艾滋病防治 47](#_Toc371269023)

[13.3.2 关于服务于低档女性性工作者CBO的发展 53](#_Toc371269024)

[13.3.3 关于中国性工作者组织网络平台的发展 55](#_Toc371269025)

[14. 本报告的局限 58](#_Toc371269026)

[15. 附录 59](#_Toc371269027)

[15.1 附录1：访谈提纲（CBO成员） 59](#_Toc371269028)

[15.2 附录2：访谈提纲（目标人群） 61](#_Toc371269029)

[16. 参考文献 62](#_Toc371269030)

# 致谢

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# 缩略语表

AIDS 获得性免疫功能丧失综合症（艾滋病）

CBO 社区（会）组织

CSW 商业性工作/者

FSW 女性性工作者

HIV 艾滋病病毒

IDU 静脉吸毒/者

MSM 男男性接触者

NCAIDS 国家性病艾滋病预防控制中心

NGO 非政府组织

RCC 全球基金整合滚动项目

STI/STD 性传播感染/疾病

UNAIDS 联合国艾滋病规划署

UNFPA 联合国人口基金

VCT 自愿咨询检测

# 摘要

女性性工作者是艾滋病传播和感染的重要高危人群，然而在女性性工作者中，有一类被称为“低收入女性性工作者”或“低档女性性工作者”的亚人群这是高危人群中的高危人群，不同地方低档女性性工作者的组织方式会有所不同，但是通常包括街头女性性工作者、低档洗头房、路边店、低档旅馆、农村偏远地区等处的女性性工作者。她们每次性服务的单价较低、收入也较少，通常具有以下特点：年龄较大、已婚者居多、文化程度较低、流动性大、嫖客人群多为收入较低人群、接客频率和客人数目较大、艾滋病相关知识知晓率较低、艾滋病病毒性病感染风险的自我认识较差、吸毒行为比例高、安全套使用率低、性病感染率高、HIV感染率高、不正确的求医行为较多、接受干预包括HIV检测的比例较少。

总的来讲，同普通女性性工作者相比，低档女性性工作在与艾滋病防治密切相关的特点方面可以总结为“三多一少”：首先是感染风险多。由于她们文化水平低、自我保护意识低、艾滋病相关知识匮乏、艾滋病病毒感染风险的自我意识低、客人的安全套使用意愿较低、容易具有多种危险行为、她们自己的安全套使用率低等特点大大增加了她们感染艾滋病病毒的风险；其次就是她们传播艾滋病病毒的风险多。由于她们性病、艾滋病等感染率较高、感染后继续从事商业性行为的情况较多、客人的健康防范意识较差、同商业性伴以及固定性伴间的安全套使用率较低等因素导致她们在感染HIV后继续传播HIV的风险较多；再次，就是她们在感染HIV和性病后传播的人群数量多。多数低档女性性工作者的客人人数和商业性行为次数均多于普通女性性工作者，而且无保护的性行为次数和比例也较多，因此她们潜在感染的人群数量也较多；最后，就是低档女性性工作者接受干预的机会较少。由于她们流动较大、人群隐蔽、自我保护意识较强、不容易被接触到、当前的重视不够、干预覆盖面较低等原因，导致很多低档女性性工作者无法被常规的干预活动所覆盖。这“三多一少”是密切相关和相互影响的，总之，低档女性性工作者已经成为HIV传播的一个极其重要人群。

目前，我国针对低档女性性工作者的艾滋病防治工作方面还存在着较大的差距，包括针对低档女性性工作者方面的策略信息不足、干预覆盖面和干预力度远远不够、干预质量不足等。未来针对该人群的艾滋病防治工作也面临着多重的困难和挑战，如支持性环境建设、相应的防治队伍建设、防治能力欠缺，以及在实施具体干预工作时所面临的技术策略和措施方面的挑战。尤其是由于低档女性性工作者的自身特点导致针对她们开展艾滋病防治工作时非常困难，可以概括为“四难”：首先是发现难。很多低档女性工作场所通常没有明确的标志、流动性很强，组织形式比较隐蔽，难于被发现；其次是接触难。她们的自我保护意识非常强，难以取得她们的信任，一般需要较长时间和通过她们熟识的核心同伴才能逐步得获得她们的认可并开展干预；再次是干预难。她们比较分散、工作场所条件简陋或者是户外，有些干预措施和活动很难开展，例如，现场咨询和检测。另外，由于她们的赚钱意识较强，时间紧张，通常没有时间参加常规的干预活动；最后就是改变难。低档女性性工作者的脆弱性较大、经济弱势地位比较明显，安全性行为的采纳受到多种客观条件的制约，单纯依靠干预她们本身很难改变她们的危险行为，例如，绝大多数情况下，她们是否使用安全套取决于客人的意愿和经常受到金钱的驱使而无法采取安全性行为。

无论是国外还是国内，目前针对低档女性性工作者均没有一个系统的、有效的干预策略和措施，多数项目仍利用针对普通女性性工作者的干预方法来开展工作，然而，这些常规的措施在低档女性性工作者中很难发挥较好的效果。在我国针对低档女性性工作者的艾滋病防治工作存在着较大的差距：

1、女性性工作者HIV哨点监测数据不能真实反映低档女性女性性工作者人群中的实际情况。低档女性性工作者人群中调查研究的安全套使用率常常低于哨点监测结果，而HIV/STD患病率往往高于哨点监测结果。针对我国低档女性性工作者的整体情况有代表性的数据仍然缺乏。

2、在国家和项目层面上缺乏专门针对低档女性性工作者开展HIV防治干预工作的策略和指南。

3、对低档女性性工作者的HIV防治工作重视不够，投入不足。在前面提到的针对我国低档女性性工作者的几个主要大规模防治项目中，绝大多数的项目策略是针对普通女性性工作者的。

4、当前针对低档女性性工作者的HIV干预覆盖面和干预力度远远不够。目前，在我国针对女性性工作者开展的主要国内外大规模干预项目包括前面提到的高干队、综合示范区、各轮全球基金和个别的国际合作项目，而正在开展的项目只有第二轮综合示范区项目和全球基金RCC艾滋病项目。而通过这些项目的策略和活动干预到的大部分是普通女性性工作者，无法有效接触到低档女性性工作者，能够覆盖到的低档女性性工作者也只是少数，覆盖面非常有限。此外，专门针对低档女性性工作者的国际项目规模都很小，如USAID针对低档女性性工作者的项目仅仅局限在广西鹿寨市和云南个旧市等个别项目点，乐施会的低档女性性工作者干预项目也仅限于资助个别社区组织来开展的，总的来讲，目前我国针对低档女性性工作者的覆盖面仍然非常有限。高干队目前基本上不再提到了，国际项目即将结束，国家主导的只有综合示范区，而综合示范区里面对低档的干预非常有限，因此低档将面临严重的干预缺口。不仅针对低档女性性工作者的干预覆盖面非常有限，而且面临断档的危险。

5、为低档女性性工作者提供HIV干预服务的CBO组织需要进一步加强。目前能够为低档女性性工作者提供服务的CBO组织存在几方面的障碍，包括：CBO的数量严重不足，多数集中在城市地区；CBO的规模较小，可以覆盖的目标人群数量非常有限；CBO的能力不足，无法满足针对低档女性性工作者的干预需求；在大量国际项目和援助经费撤离中国的情况下面临着严重的经费短缺问题，尤其是针对低档女性性工作者的HIV防治经费面临断档的风险。

在一些国际项目的资助下中国的CBO在最近几年得到了很大的发展，为女性性工作者服务的CBO组织也取得了较大的进步，但是能够为低档女性性工作者提供服务的CBO情况仍然不容乐观。这些CBO数量非常有限，多数都是同时为各种女性性工作者提供服务，而为低档女性性工作者提供服务只是这些组织活动的一部分，对于很多CBO来说甚至是很少的一部分，并没有制定专门的计划或者付出特殊的努力去为低档女性性工作者提供服务。多数CBO集中在城市里面，在有低档女性性工作者的偏远农村地区几乎没有，规模较小，这些组织覆盖的低档女性性工作者数量较少。在这些组织中，除了由卫生专业人员负责管理和开展工作的个别组织，多数组织的业务能力非常欠缺，迫切需要提高。此外，经费不足是这些组织面临的最大挑战。不仅仅是针对低档女性性工作者的干预经费严重不足，多数组织的自身生存和发展经费也无法保障。

中国性工作者机构网络平台于2009年2月，12家从事性工作者干预的相关机构在云南昆明成立，目前共用14家成员组织，是国内性工作者组织的一个主要发声渠道。然而，该平台的生存和发展面临着严峻挑战，自从2012年开始就已经没有日常运转经费来源了，该平台唯一的工作人员工资也只能靠其它组织的资助来维持，该平台无法开展常规性活动，只能偶尔以平台的名义申请单独的研究调查等小额项目。

针对上述情况和当前现状，本报告作者就低档女性新工作者的艾滋病防治工作、为低档女性性工作者提供服务的CBO未来发展，以及中国性工作者机构网络平台的未来发展等方面提出以下建议：

关于低档女性性工作者的干预策略和方法方面的建议包括：1.加强对低档女性性工作者的监测工作；2.加强支持针对低档女性性工作者的应用性研究，包括干预策略、高危行为、人群规模、干预覆盖面等；3.起草制定如何在低档女性性工作者中开展HIV干预的技术性指南；4.从战略高度考虑，提高对低档女性性工作者中HIV防治的重视程度，加大政策上和经费上的支持力度；5.加强针对低档女性性工作的嫖客人群开展艾滋病防治干预工作；6.加大针对低档女性性工作者的男朋友和固定性伴的干预工作力度；7.加强低档女性性工作者中的咨询检测、阳性预防、关怀和治疗服务；8.加强为低档女性性工作者提供服务的社区组织的支持力度；9.针对低档女性性工作者的特殊需求和特点，在开展干预工作时需要作出特殊的技术考虑，详细的技术细节见后面原文。

关于服务于低档女性性工作者的CBO发展方面建议包括：1.CBO需要向专业化方向发展，需要高质量的参与；2.政府购买服务将是CBO可持续性发展的重要途径；3.专业技术能力和高质量服务是CBO可持续性发展的重要前提；4.特色服务和业务专长对于CBO可持续性发展将具有重要意义；5.建立公开透明的财务管理制度和体系；6.专业化人才队伍建设将是CBO可持续性发展的重要保证；7.做好随时进行注册的准备；8.积极寻求和建立外部的技术支持网络。

关于中国性工作者组织网络平台发展方面的建议包括：1.鉴于目前平台面临的经费困难，维持当前的运作模式是一个比较现实的选择；2.加强为成员提供服务的活动和努力；3.未来该平台可以考虑建立一个成员间的资源整合与信息分享和交流机制；4.条件允许的情况下考虑重新制定平台的战略规划，审阅和修订该平台于2010年制定的章程；5.可以考虑适当的扩大成员规模，增加平台成员的多样性，通过提供有吸引力的服务等方式来吸引更多成员加入；6.平台需要提升自身的技术力量和能力，争取借助专家和业务研究成果的力量逐步把自己塑造成为女性性工作者包括低档女性性工作者艾滋病防治领域的权威和标志性机构；7.未来平台的业务方向和战略定位可以考虑：（1）进一步加强为成员提供服务的意识和努力，设计和增加常规性的服务活动，提升平台的凝聚力和吸引力；（2）开展关于女性性工作者艾滋病防治和CBO相关的宏观倡导活动；（3）关注女性性工作者防治工作领域的最新科研动态和进展，通过科研活动和科研成果提升平台影响力和生存能力；（4）帮助成员建立统一的外部技术支持网络；（5）平台的融资渠道需要多样化发展。

# 背景

2011年我国估计的78万感染者中经性传播达到了63.9%，比2009年的59.0%增加了4.9个百分点，其中异性传播从2009年的44.3%上升为2011年的46.5%，在异性传播中，约1/4为配偶间性传播，3/4为非配偶间性传播。2011年估计的4.8万新发感染中，经性传播的构成比由2009年的75.7%上升到2011年的81.6%，其中，经异性传播占52.2%，比2009年的42.2%多10个百分点[1]，可见目前经异性途径传播和感染HIV仍然是我国艾滋病病毒流行的主要途径。而在异性导致的HIV传播和感染中，低档女性性工作者则发挥着至关重要的作用，对HIV流行的潜在影响和驱动明显。许多研究认为低档女性性工作者是传播和感染HIV的一个非常重要的高危人群，城市中的街头女性性工作者也往往是外来民工和本地居民艾滋病病毒感染的桥梁[2-5]。

目前，我国针对女性性工作者的干预工作主要集中在中高档女性性工作者人群，而针对低档女性性工作者的艾滋病防治工作面临着许多重大的困难和挑战，例如，总体上重视不够、投入的资源和经费非常有限、仍然缺乏有效的干预策略、覆盖面非常有限等。随着国际资助经费的大量停止和撤出，中国低档女性性工作者的艾滋病防治工作面临着更加严峻的缺口。

为此，在中国性工作者网络的协调和配合下，UNAIDS通过其亚太技术支持网络进行公开招标挑选和支持外部专家旨在全面分析中国低档女性工作者的艾滋病防治现状、了解当前为低档女性性工作者提供艾滋病防治服务的CBO情况，为我国制定针对低档女性性工作者的艾滋病防治策略提供参考建议和依据，同时也为中国性工作者组织网络平台以及服务于低档女性性工作者的CBO提出未来发展建议。

# 本报告目的

本报告主要有以下三个方面的具体目的：

1、分析当前中国低档女性工作者的现状，包括人群特点、危险行为等相关信息、艾滋病防治工作现状、困难和挑战，并提出针对中国低档女性新工作者的艾滋病防治工作建议；

2、了解当前为低档女性性工作者提供艾滋病防治服务的CBO情况，并提出其未来发展的建议；

3、分析了解中国性工作者组织网络平台情况，为其进一步发展提出建议。

# 方法和材料

本包括的内容主要基于大量的文献检索和收集其他相关现有资料进行阅读和总结。其中中文文献检索主要是在中国知网上进行的，文献检索的主要中文主题词包括：“低档”“低收入”“低价格”“女性性工作者”、 “女性性服务者”“性工作者”、“性服务女性”、 “性服务人员” “性服务小姐”、“暗娼”、 “卖淫女”、“低档暗娼”、“街头暗娼”、“场所暗娼”、 “HIV”“艾滋病”等检索词的单独或者不同组合，根据检索出来的文章名称进行筛选，最终查找出同本次研究内容相关的中文文章67篇；在[PubMed/MEDLINE](http://www.ncbi.nlm.nih.gov/pubmed/)进行英文检索的主题词包括：“female sex workers + HIV”、“low-income female sex workers”、“brothel-based female sex workers”、“direct female sex workers”、“street-based female sex workers”等。对检索出来的文献进行筛选后最终选取了30篇与本主题关系最为密切的英文文献作为参考。

除了通过网上检索发表的专业文献外，作者还访问了大量的国内外组织和政府机构等网站，同时检索和下载了许多相关文献。此外，UNAIDS北京办公室和UNFPA北京办公室也提供了相应的背景资料。为了进一步收集最近的一线资料和了解实际情况，作者还进行多次现场考察，就低档女性工作者的相关问题访谈了上海、山东和云南等地相关CBO工作人员和目标人群。

# 中国从事商业性行为女性及低档女性性工作者称谓

英文中对于提供商业性服务的女性一般称为“female sex workers”[6-15]，而在我国对于该类人群的称呼则随着社会的发展变化而有所不同，在不同性质的文章中也有所不同。早期时候多称为“妓女”、“娼妓”[16]；在90年代后期开始将提供性服务的女性称为“小姐”，直到现在仍被各方面人员广泛使用[17]；在中国疾病预防控制中心性病艾滋病预防控制中心网站上下载的中国遏制与防治艾滋病“十二五”行动计划中没有发现直接针对提供性服务女性的称呼，但是称呼性服务现象为“卖淫嫖娼”[18]，2005年6月我国出台的高危行为干预工作指导方案（试行）中称为“暗娼”[19]，2010年开始我国公安部门将“卖淫女”的称呼改为“失足妇女”[20-22]，这些称谓代表了我国官方文件中的称呼；在学术领域对于该人群的称呼多种多样，主要包括“暗娼”[2-5, 23-50]，其它的称呼包括“女性性工作者”[51, 52]、“性服务女性”[53, 54]、“性服务人员”[55]、“性服务小姐”[56]、“女性性服务者”[57-61]和“卖淫女”[62]等称呼。本文中则统一称呼普通提供商业性服务的女性为“女性性工作者”，缩略语为FSW。

研究发现，女性性工作者感染HIV的高危行为和风险并不是相同，该人群内部也包含了多种多样的亚人群分类，同普通女性性工作者相比，其中有一类女性性工作者具有更高的传播和感染艾滋病病毒的风险。国内外针对这一高风险女性性工作者群体的称谓多种多样，主要是针对这一群体所具备的某一特点来进行称呼的。通过在中国知网上检索发现，我国针对该类女性性工作者的称谓包括：“低价格女性性工作者[63]”、“街头暗娼”[2, 26, 30-34, 64-75]，俗称为“站桩鸡”[2]，有的地方针对这些“站桩鸡”也有其它地方俗称，如“毛线鸡”“米线鸡”等，在其它文献中的称呼还有“低档暗娼”[27, 28, 37, 41, 43, 45]。目前针对该类具有较高危险行为的暗娼尚缺乏一个统一称谓，为了写作方便和称谓简单，同时也为了与多数学者的称呼保持一致，本文中特指该类女性性工作者为“低档女性性工作者”， 在含义上包括了上面提到的一些列具有较高感染HIV风险的各类女性性工作者，不仅仅局限于在低档场所工作的女性性工作者。本文中判断其是否为“低档女性性工作者”的唯一标准就是同普通女性性工作者相比，低档女性性工作者具有更高传播和感染HIV的高危行为和风险。

同当地普通女性性工作者相比，哪些女性性工作者具有更高的感染HIV风险极大地取决于当地特定的经济文化背景和风俗习惯，因此在不同的国家会有所不同。例如，在国外的很多研究发现，具有感染艾滋病病毒较高风险的女性性工作者包括“street-based female sex workers”（同我们所说的街头女性性工作者）[8, 15, 76, 77]，也有的国家研究发现“brothel-based female sex workers”（在妓院里工作的女性性工作者）则具有较高的感染HIV风险[11]，此外还有“low-income female sex workers[78]”“direct sex workers” （直接的女性性工作者）[79]、“high frequency female sex workers”（即，高接客频率的女性性工作者）[80]。

# 低档女性性工作者的界定

关于如何界定不同类型的女性性工作者是否为低档女性性工作者，国内外不同研究和学者着眼点有所不同，总的来讲，均是强调低档女性性工作者的某一方面特征来界定该类人群，目前国内外学者主要是从以下四个方面来确定哪类女性性工作者具有更高的感染HIV风险，即，是否属于本文所指的“低档女性性工作者”。

## 从女性性工作者招揽嫖客和交易的场所来界定

以女性性工作者招揽嫖客的场所和接客地点区分出哪些属于低档女性性工作者是国内外比较普遍的做法。例如，我国的一些学者认为在街头、公园、广场以及居住在廉租房内从事商业性服务的女性属于低档女性性工作者[2]。根据文献研究发现，在我国不同地方从揽客场所来划分可以确定为低档女性性工作者的女性性工作者包括：

* 街头女性性工作者、站街女、站桩女[64, 81]
* 在小巷、公园、花园等露天场所等待和招揽嫖客或打毛线衣的女性[64]
* 在洗头房、路边店[82, 83]
* 发廊, 足疗馆[84]
* 按摩屋[52]
* “摸摸”舞厅[52]
* 出租房[69, 82]
* “陪吃点”(大排档、路边饭馆) [5]
* 小型洗浴中心[41]
* 农村女性性工作者[50]
* 低档旅馆[69]
* 城乡结合地带的女性性工作者[4]

用揽客场来界定是否需属于低档女性性工作者并不是绝对的，同时取决于当地的经济水平和风俗习惯，例如有些研究认为美容、美发、发廊、浴足、按摩店等处揽客工作的女性性工作者属于中档女性性工作者[5]，但是其他学者确认为是低档女性性工作者[52, 84]。此外，不同国家的情况也会有所不同，例如多数学者认为站街女、站桩女[64, 81]具有较高的感染HIV风险，而有的国家学者却发现同“night club sex worker”（夜总会女性性工作者）和“brothel-based female sex workers”（在妓院里工作的女性性工作者）相比，“street-based female sex workers”（同我们所说的街头女性性工作者）则具有较低的感染HIV风险[11, 85]。

总之，低档女性性工作者揽客场所的特点一般为无固定场所或者以场所的房屋、装修、室内设置情况、消费等情况认为该场所的档次在当地属于低档[50]，低档场所多分布在郊区或城中村且呈聚集分布[5]。低档场所分散、隐蔽、灵活性强, 为跟随市场或躲避公安打击而经常搬迁, 场所分布在县城偏僻、小的街道上, 或家庭窝点、废弃的厂房院落、在县城周边及公路沿线的小饭店或小商店等, 低档场所具有偏僻、分散、隐蔽、经常变迁, 女性性工作者流动性强的特点。一般在农村地区的低档场所中少数标识为娱乐服务场所, 多数低档场所无明确标识名称[50]。

用场所来界定低档女性性工作者的突出优点是有利于开展干预艾滋病防治干预工作，能够比较直观的根据场所的特点发现和找到这些低档女性性工作者并开展宣传和教育工作。因此，作者建议在实际工作中用场所来界定低档女性性工作者。

## 从女性性工作者单次商业行为价钱来进行界定

也有的学者根据女性性工作者单次性交易的价格分为高、中、低档, 其中交易价格最低的女性性工作者为低档女性性工作者[48, 67]。但是单次交易价钱的高低是相对的，在不同经济发展水平的地方具有极大的不同。例如，宗雪梅等人在河北省平山县等地开展的研究中将每次性交易收费在100元以上的为高档场所, 60~ 100 元的为中档场所, 60元以下的为低档场所[50]；李桂云等在大冶市开展的研究中认为每次交易交易价钱200元以上者为高档，中档50-200元，低档为20～50元[3]。实际女性性工作者揽客场所与每次交易价钱是密切相关的，因此，往往是将揽客场所与交易价钱相互结合来确定哪些女性性工作者属于低档女性性工作者。例如，梁剑晖等人在江门市开展的研究中规定：高档女性性工作者指工作场所在桑拿、大型宾馆、酒店、酒吧等，每次性交易价格在200 元以上者；中档女性性工作者指工作场所在美容、美发、发廊、浴足、按摩店等，每次性交易价格在50 ～200 元之间者；低档女性性工作者指工作场所为“站桩点”( 街头、河边、公园) 、“陪吃点”( 大排档、路边饭馆) 、出租屋等，每次性交易价格在50 元以下者[5]。

作者认为以女性性工作者单次交易价钱来界定低档女性性工作者也是一个比较好的方法，因为这样也能够容易的识别出她们并开展有针对性的干预工作。

## 根据女性性工作者的收入来进行界定

有国外的学者直接认为“low-income female sex workers”“低收入女性性工作者”具有较高的感染HIV危险，[78]，即属于我们所说的低档女性性工作者的范畴。但是直接用收入来定义低档女性性工作者的国外研究并不是很多，例如，用“low-income”与“female sex workers”等关键词的不同组合在PubMedline上基本搜索不到相关的文章。在中国也有用“低价格女性性工作者[63]”来界定低档女性性工作者的，尽管有很多学者调查研究过低档女性性工作者的收入[33, 81]，如，在云南的一个研究发现71.8%的街头女性性工作者月收入低于1500元[2]，但是直接用收入来界定低档女性性工作者的国内研究也不多见，用“低价格”、“低收入”与“暗娼”、 “女性性工作者”等关键词的不同组合在中国知网上也很难搜索到相关文章。

尽管多数研究发现低档女性性工作者的实际收入确实很低，但是用“低收入”来界定低档女性性工作者并不利于开展艾滋病防治工作，因为，如果不通过调查研究很难了解女性性工作者的收入，因而无法直观的识别低档女性性工作者并开展有针对性的艾滋病防治工作。

## 从女性性工作者的接客频率等方面来界定

在国外的一些研究项目中也有的学者根据女性性工作者接客频率的高低直接将女性性工作者称呼为高频女性性工作者（high frequency sex workers）和低频女性性工作者（low frequency sex workers），高频女性性工作者的接客频率要高于低频女性性工作者，低频女性性工作者主要包括路边女性性工作者和居住所接客的女性性工作者，高频女性性工作者则包括酒店女性性工作者[80]。高频女性性工作者具有较高的感染HIV和STD风险[23]，即属于本文所称的低档女性性工作者的范畴。如在孟加拉国的研究中发现，通过综合分析酒店女性性工作者和路边女性性工作者后发现路边女性性工作者的HIV和STD感染率却低于酒店女性性工作者，其中最主要的一个原因就是酒店女性性工作者的接客频率高于路边女性性工作者，而安全套使用率却低于路边女性性工作者[80]。因此，在该国的酒店女性性工作者（高频女性性工作者）则类似于我们所关注的低档女性性工作者。

此外，也有的国外学者将女性性工作者分为直接女性性工作者（direct sex workers）和间接女性性工作者 （indirect sex workers），其中直接女性性工作者主要是在一些明确为商业性行为的场所接客，如有些国家的妓院，其接客频率比间接女性性工作者的要高，但是其安全套使用频率也高于间接女性性工作者，综合分析后发现其HIV和STD感染率高于间接女性性工作者[79]，即直接女性性工作者为我们所关注的具有较高HIV感染风险的低档女性性工作者。

总之，无论从上述四个方面中的哪个方面来界定低档女性性工作者，关注的重点都是低档女性性工作者所具有的感染HIV的高危行为和风险。此外，我们需要注意的是，不同国家和地区经济水平和风俗文化有所不同，界定低档女性性工作者的着眼点和方法会有所差别，无法简单的对等比较。另外，不同的界定方法均是相对而言，都是同本地区其他类别的女性性工作者相比较而言的，因为只有这样才具有现实的艾滋病防治意义。而本报告主要针对中国的情况进行分析和总结。

# 低档女性性工作者的人群规模及特点

前文已经提到，低档女性性工作者之所以得到广泛的关注主要是因为相对于普通的女性性工作者而言，她们具有更高的传播和感染艾滋病病毒的风险，这些高风险同低档女性性工作者人群所具有的许多特点是密切相关的，而这些特点也在不同方面成为针对该类人群开展艾滋病预防和控制的主要障碍和挑战。国内外许多研究者发现，低档女性性工作者的具有下列特点。

## 低档女性性工作者规模估计

低档女性性工作者通常比较隐蔽，流动性强，尽管没有查到我国大范围低档女性性工作者人群规模估计的报道，但是在有一些学者在不同的地方针对当地低档女性性工作者的人群规模进行了估计和研究。总的来讲，低档女性性工作者的规模要比中高档女性性工作者的人群规模小[2]。陈远在云南做的一个研究估计甲乙两县街头女性性工作者分别占当地女性性工作者总数的21.8% 和31.6%[64]；2004 年在贵州兴义市和2005年在甘肃嘉峪关市运用普查法和枚举法估计当地流动女性性工作者估计值分别占当地女性性工作者总数的13.2%和16.3%[64, 86, 87]。2002年埃塞俄比亚Addis Ababa 市，对揽客聚集地街头性工作者清点人数值占当地性工作者总数的7.93%。柬埔寨Phnom Penh，街头性工作者则约占10.7%[64]；在江门市运用普查法估计该城区女性性工作者规模估计数为3668～4375人，其中低档女性性工作者人数估计为263人；中档女性性工作者人数估计为1072人；高档女性性工作者的95%可信区间估计人数为2333～3040人，高档女性性工作者比例高达61.4%～73.2%。学者认为该市中、低档女性性工作者比例较低可能与当地经济水平和产业结构有关[5]；在昆明市运用捕获-再捕获法估计该市城区街头女性性工作者人群基数为486人[68]；宗雪梅在农村地区开展的一项研究发现，一般来说, 每个县内有1～4家高档场所, 1～30家中档场所, 30～150家低档场所。一般低档场所规模较小, 每个场所1～5人的情况较多, 10人左右的情况很少[50]。

## 社会人口方面的特点

许多学者针对我国低档女性性工作者情况开展过调查研究，发现我国低档女性性工作者人群通常年龄较大，以中年为主[2, 67, 69, 72]，且档次越低其平均年龄越大[39]。如陈家群等人在宁波市街头女性性工作者人群的调查中发现该女性性工作者人群年龄偏大，平均年龄29.63 岁，以21~40岁为主，占72.08%[65]。低档女性性工作者人群的文化程度通常较低[2, 67, 69, 72]，有研究发现街头女性性工作者的文化程度偏以初中及以下者为主，占92.79%[65]；在贵州的调查显示54. 9%的街头女性性工作者为小学或文盲；在四川某市调查中发现街头女性性工作者中69.8%为小学文化程度以下；在云南摩梭地区站桩妇女曾受教育者更是寥寥无几；英国一项在Bristol 地区的调查也显示街头女性性工作者平均受教育年数显著低于当地的一般人群[67]，文化程度低,其安全套使用率通常也低[39]。低档女性性工作者中一般已婚者居多[38, 47, 55]，例如，在云南的一项调查中发现有56.2%的街头女性性工作者为在婚状态[2]，而另外一项在宁波开展的调查中发现街头女性性工作者中已婚者占69.47%[65]。

## 流动性

同宾馆、酒店及娱乐场所相比，低档女性性工作者的流动性较大[50, 69, 82]，研究发现低档女性性工作者的流动性较大，例如，在程晓莉等人在安徽省开展的一项调查中发现有29. 9% 的女性性工作者在当前工作场所活动时间在1个月之内的，有30. 8%的人为 1~ 3个月的，两者合计比例超过一半，流动性较强，流动周期在3个月以内[88]。而在上海的实地访谈中发现，在大城市里面，一般街头女性性工作者和公园里面的女性性工作者流动性不是很大，因为她们通常都要靠熟客做生意，而且街头女性性工作者通常都有自己固定的地盘，到一个新的地方要面临许多不确定性。但是足浴房等场所的低档女性性工作者流动性则很大，几乎每1-2个月都要换，那里的多数客人喜欢寻找新的面孔。

## 低档女性性工作者的嫖客人群

低档女性性工作者由于其每次商业性行为交易价格较低，而与其相对应的嫖客人群也多为经济状况较差，收入较低的人群为主，如老年人（或退休老年人）、进城打工者、人力工人(棒棒) 、建筑工人、农民居多[2, 71]。在性产业中，这部分人群的客人往往是低收入、年龄相对较大、社会地位相对较低的人群。而“老年客人”和低档女性性工作者两类人群都具有安全保护措施较差的行为特征，且随着年龄的增加，安全套使用率会逐渐降低，因此也极大地增加了传播和感染艾滋病病毒的风险[27]。

## 接客频率

多数研究表明低档女性性工作者的接客频率较高[2, 82]，这不仅仅是界定低档女性性工作者的一个重要特征，同时也是其传播和感染HIV/STD的一个重要高危因素。性伙伴人数越多，感染一种或几种性病的危险性就越大[23]。如果女性性工作者工作时间延长，接客人数增多还会降低其安全套的使用率。如在多米尼加共和国的一项调查显示女性性工作者每周接客天数超过2天，安全套持续使用率显著降低，每天工作时间长，接客人数多，接客天数多，会增加女性性工作者感染HIV的脆弱性[52]。在我国的研究表明，低档女性性工作者的接客频率不等，有的调查中发现低档女性性工作者最近一日接客人数的中位数为2，最近一周接客人数的中位数为10[2]，还有的调查显示低档女性性工作者平均每日接客4-5个[69]；刘惠等人的调查显示低档女性性工作者最近1周接客数2~ 100 次, 平均16. 25 次[71]。在实际访谈中也发发现同样的结果，一位来自低档女性性工作者的同伴人员说，“由于低档女性性工作者的单次价钱较低，她们赚钱的主要策略就是‘走量’！”。

## 艾滋病知识的知晓率

多数研究显示低档女性性工作者的艾滋病相关知识知晓率显著低于当地的其他女性性工作者[29, 38, 44, 82]。如在云南的一次调查后中显示高档女性性工作者的艾滋病相关知识知晓率为98.9%，而低档女性性工作者的知晓率仅为75.0%[49]；在开远市的调查中显示高档女性性工作者的HIV知识得分为10.2，而低档女性性工作者的HIV知识得分仅为5.8[29]。

低档女性性工作者不仅艾滋病知识知晓率较低，而且在研究中也发现一些错误的预防方法被低层次娱乐场所女性性工作者传播并实践着, 如在访谈中得知, 有女性性工作者使用药液等定期冲洗等等。这些都是促进安全套使用的不利因素[83]。

有研究发现低档女性性工作者中艾滋病性病传播与预防相关知识通过卫生工作者获得的只有26.13%，主要是通过电视、宣传资料和广播而获得，这也提示我们今后在电视等媒体上要加强艾滋病性病预防方面的宣传教育[65]

## 艾滋病病毒性病感染风险的自我认识

大多数街头女性性工作者存在着不可能感染艾滋病或性病的侥幸心理，但对于艾滋病及其预防的知识还缺乏深入了解，她们普遍认为艾滋病离她们生活还远，并没有意识到要通过采取更加安全的行为来减少感染艾滋病的危险。如有研究发现，在调查的299名街头女性性工作者中，认为自己可能感染艾滋病的街头女性性工作者只占17.1%，而67.3%的人认为自己不可能染上性病[2, 32]；在淮安开展的一项研究表明，只有20.95%的女性性工作者担心自己现在或将来有可能感染上艾滋病病毒[55]。

## 低档女性性工作者的吸毒行为

研究中发现低档次性服务场所静脉吸毒的女性性工作者所占比例较高，国外也有研究发现低档次性服务场所吸食大麻的女性性工作者比例较高。一般认为女性性工作者一旦吸毒将难以继续留在中高档娱乐场所从事商业性性服务，这些女性性工作者为了获取毒资或毒品而进入低档次的性服务场所。而一旦女性性工作者开始吸毒，尤其是注射毒品则极大地增加了传播HIV到一般人群的风险[2, 23]。在我国云南的一项调查显示，当地低档女性性工作者中的吸毒比例占3.3%[2]。

## 安全套使用

低档女性性工作者中最重要的高危行为就是其安全套使用率较低，许多研究表明低档女性性工作者的安全套使用率要低于当地的高档女性性工作者[2, 44, 52, 55, 69, 84]，与宾馆、酒店及娱乐场所相比，低档女性性工作者高危行为的危险性最高[72]。我国哨点监测的数据显示，2010年女性性工作者最近一个月商业性行为坚持使用安全套的比例为67.8%，最近一次商业性行为安全套使用率为90.5%[1]，然而低档女性性工作者中的安全套使用率要远远低于国家监测数据。例如，研究发现每次性服务收费低于100元、每年收入低于1000元和低档场所的女性性工作者更容易发生无保户性行为[23]；广西柳州的研究中高档女性性工作者中最近一次商业性行为中安全套使用率为81.7%，而低档女性性工作者只有62.3% [82]；四川宜宾的研究中发现高档女性性工作者最近一次是商业性行为中安全套使用率为71.9%，而低档女性性工作者的安全套使用率仅有21.4%[84]；在淮安的研究中显示高档女性性工作者最近一次是商业性行为中安全套使用率为62.2%，而低档女性性工作者的安全套使用率仅有16.3%[55]；安徽的研究中发现在中高档场所和低档场所中女性性工作者与客人非保护性行为分别为 45.4%和 54.6%[23]。

在发生商业性行为是不使用安全套的一个最主要原因就是客人不愿意使用[26, 55, 65, 84]，如在云南的一项调查中发现街头女性性工作者中没有使用安全套的原因主要是客人不愿意使用，占76.9%[2]。低档女性性工作者中安全套使用率低的另外一个原因也同她们的保护意识以及经济上的考虑有关，如果客人多付钱，或者是对有些“干净”、帅气的客人不愿用，大多数街头女性性工作者也会同意不使用[65]，例如，在宁波的调查中发现不使用安全套坚决不交易和尝试说服顾客使用安全套的分别占26.13%和69.37%，实际上每次都使用安全套的只有53.15%[65]；安徽的研究中发现，“在最近30天中, 有没有过客人非常干净, 又愿意多给钱没有用套就做了”的问题中, 有40% 的女性性工作者回答有，显示她们可能会在使用安全套的成本和收入之间进行更多的利益权衡, 而导致其发生不安全性行为[88]。女性性工作者与关系密切的配偶间安全套使用频率低，尤其在与固定性伴发生关系时使用率偏低[83]。其原因是彼此之间己经有了信任感，所以女性性工作者与性伴关系越密切，安全套使用频率越低，如在云南的调查中发现最近一个月与固定性伴发生性关系时，仅有33.3%的街头女性性工作者每次都使用安全套有[2]；在安徽一个调查中发现中低档女性性工作者在近3个月与配偶或固定男友使用安全套的比例仅为48.5%[88]。

除了较低的安全套使用率外，低档女性性工作者中另外一个重要的危险因素是安全套的质量问题，由于她们收入较低，更倾向于购买使用便宜、低质量的安全套，因而很容易发生安全套破裂现象[83]，增加了传播和感染HIV的风险。如，在云南的调查中发现，有21.8%的街头女性性工作者报告最近一周发生过安全套破裂现象[2]。

## 性病感染率

很多研究表明低档女性性工作者通常性交易频繁，性病感染率也高于其他类型的女性性工作者[2, 69, 71, 72, 82, 84]，例如在广西柳州的一项调查中表明，高档女性性工作者中有性病症状的占42.9%，而低档女性性工作者中却高达65.9%，高档女性性工作者中梅毒感染率为1.4%，而低档女性性工作者的梅毒感染率则高达9.6%[82]；在刘芳等人在云南开展的调查中发现，街头女性性工作者中有25.8%的调查对象自述最近一年有过性病症状[2]；胡锦流等人在淮安市做的一项调查显示低档娱乐场所衣原体阳性率为35.3%，显著高于高档娱乐场所21.4% [55]。

低档女性性工作者中不仅普通的性病患病率，而且梅毒感染率也常常很高[39]。如，例如广西柳州的调查中表明，高档女性性工作者中梅毒感染率为1.4%，而低档女性性工作者的梅毒感染率则高达9.6%[82]；广东、海南等地研究显示高档女性性工作者梅毒患病率为1.29%~1. 64%，中、低档女性性工作者梅毒患病率却高达20. 0%~38. 2%[5]。同时，也有报到称经常光顾街头女性性工作者的嫖客感染性病的危险性显著高于经常光顾其他类女性性工作者的嫖客[26]。

研究提示性病与HIV感染之间存在着重要的协同关系，性病可以增加HIV 的传染性和易感性( 相对危险性可高达300倍)，是HIV 经性传播的重要危险因素[5]，尤其是梅毒作为一种溃疡性疾病，其对于HIV的感染和传播有着非常重要的促进作用[23]。

低档女性性工作者不仅仅各种性病患病率高，而且一旦感染上性病后，其传染性病的风险更要高于其他类型的女性性工作者，如调查发现，如果感染上性病后高档女性性工作者中有83.7%的人会停止提供性服务，但是低档女性性工作者中只有61.7%的人会停止提供性服务[55]；而另外一项调查中显示如果得了性病高档娱乐场所85%的人会停止提供性服务，远远高于低档娱乐场所的64.3%[84]。

## HIV感染率

总的来讲，我国女性性工作者人群中的感染率仍然较低多数监测哨点的数据显示女性性工作者中HIV感染率低于1%，而HIV检出率高于1%的哨点仅局限在云南、新疆、广西、四川和贵州5省吸毒较为严重的局部地区，这些地区通常存在着性途径和吸毒途径交叉感染的较高风险[1]，而低档女性性工作者中的HIV感染率则远高于女性性工作者中HIV平均感染水平。多数研究发现，低档女性性工作者中HIV的感染率要远远高于当地其他类型女性性工作者的HIV感染率，例如，在广西梧州的一次调查研究中发现，高档女性性工作者的HIV感染率为0，而低档女性性工作者中的HIV感染率为1.3%[81]；在广西柳州的一项调查中发现高档女性性工作者的HIV感染率为0.23%，而低档女性性工作者的HIV感染率为0.60%[82]；有的地方低档女性性工作者HIV检出率达到2.68%[2]；在大冶市的另外一次研究中发现中档女性性工作者中的HIV感染率为0（0/733）,而当地低档女性性工作者中的HIV感染率却高达3.45[3]。最近在广西针对7936名低档女性性工作者的一项调查研究显示，平均HIV感染率为1.9%。而不同类型低档女性性工作者间HIV感染率差别较大，其中，年龄大于40岁者HIV感染率为4.6%，文盲者HIV感染率为4.5%，离异/丧偶者HIV感染率为4.9%，没有固定场所者HIV感染率为4.0%，有吸毒行为者HIV感染率为6.4%。这些低档女性性工作者共来自全区51个市、县，而其中HIV感染率最高的县达到8.5%（5/59）[89]。可见，个别地区低档女性性工作者中HIV感染率已经达到非常高的程度了。

## 求医行为

如果出现性病症状，低档女性性工作者去正规综合医院性病门诊看病的比例很低，例如，在重庆开展的一项调查发现低档女性性工作者在出现性病相关症状后，其处理方式中47%为自己买药, 16%的低档女性性工作者到私人性病诊所就医，只有16%的人到正规医院就医治疗[71]；在云南的一项研究显示，出现性病症状时，低档女性性工作者中有26%的人到私人诊所就诊，25.5%选择自己买药治疗，另外还有1.3%的人不做任何处理[2]；在宁波开展的一项研究表明出现性病症状后，出现性病症状时有40%的低档女性性工作者会到私立医疗机构就诊，自已买药治疗的有26.67%[65]。

## 干预覆盖面和有关指标

中国遏制与防治艾滋病“十二五”行动计划中明确提出“高危行为人群有效干预措施覆盖率达到90%以上，接受艾滋病检测并知晓检测结果的比例达到70%以上；所有计划生育技术服务机构发放和推广使用安全套；95%的宾馆等公共场所摆放安全套或设置自动售套机；高危行为人群安全套使用率达到90%以上”[18]。因此，女性性工作者人群安全套使用率必须达到90%以上才能达到“十二五”行动计划的要求，而许多研究表明，目前低档女性性工作者中的安全套的使用率却远远低于这个指标要求[23, 55, 82, 84]。我国针对女性性工作者人群开展的干预项目虽然取得了很大的进展，但是女性性工作者中的干预覆盖面距离“十二五”行动计划的要求还有较大的差距，如2010年我国女性性工作者人群的干预覆盖面只有53.4%[1, 90]。我国当前开展的女性性工作者人群干预措施大多停留在娱乐场所女性性工作者层面，而针对低档女性性工作者的干预开展得较少，个别地区街头女性性工作者中的干预覆盖面远远低于平均水平，如陈远等人开展的一项研究表明，在云南某县街头女性性工作者中的干预覆盖面仅为28.4%[65]，无法起到控制性病/ 艾滋病传播的作用, 提高低档女性性工作者人群干预覆盖面和干预质量应成为当地的重点工作。[64]

## HIV检测情况

有研究表明最近一年做过艾滋病检测的女性性工作者更能坚持使用安全套[2]，但是低档女性性工作者中的HIV咨询检测覆盖面非常有限。例如，在安徽省阜南县的一项调查中发现仅有46.5%的低档女性性工作者调查对象接受过HIV自愿咨询检测服务[24]，在云南省对13个县（市）的街头女性性工作者的研究中显示，最近一年里，仅有49.8%的街头女性性工作者做过HIV检测[2]。

## 低档女性性工作者的监测

科学及时的检测低档女性性工作者人群中的高危行为和HIV感染情况对于指导我们制定有针对性的干预策略以及合理配置资源具有非常重要的指导意义。根据我国2009年下发的《2009年全国哨点监测实施方案》规定，原则上对女性性工作者人群的监测应在社区内发生高危行为的场所进行，或在女性性工作者监管场所内进行。其中要求设置社区监测哨点，根据当地女性性工作者危险行为状况，可将发生高危行为的场所分为高、中、低三个层次，低档次女性性工作者不得低于监测样本量的10%，来自中等层次场所的女性性工作者不低于40%[91]。由此可见，目前我国女性性工作者人群的哨点监测大部分都是针对场所从业的女性性工作者，而低档女性性工作者，如街头女性性工作者，由于其工作场所的隐蔽、分散以及流动性大等方面的原因，卫生人员不易接近该人群，经常成为监测工作的盲区[2]。这也说明了为什么低档女性性工作者人群中调查研究的安全套使用率会低于监测中的结果[23, 55, 84]，而HIV/STD患病率往往高于监测结果[1-3, 55, 82]。

## 低档女性性工作者对HIV流行的影响和促进作用

2011年我国估计的78万感染者中经性传播达到了63.9%，比2009年的59.0%增加了4.9个百分点，其中异性传播从2009年的44.3%上升为2011年的46.5%，在异性传播中，约1/4为配偶间性传播，3/4为非配偶间性传播。2011年估计的4.8万新发感染中，经性传播的构成比由2009年的75.7%上升到2011年的81.6%，其中，经异性传播占52.2%，比2009年的42.2%多10个百分点[1]，可见目前经异性途径传播和感染HIV仍然是我国艾滋病病毒流行的主要途径。而在异性导致的HIV传播和感染中，低档女性性工作者则发挥着至关重要的作用。她们具有较高的STD和HIV感染率，接客频率较高，安全套使用率低，自我保护意识较低，很容易发生不安全性行为，尤其是许多低档女性性工作者为已婚女性，同配偶和固定性伴间的安全套使用率更低，对HIV流行的潜在影响和驱动明显，许多研究认为低档女性性工作者是传播和感染HIV的一个非常重要的高危人群，城市中的街头女性性工作者也往往是外来民工和本地居民艾滋病病毒感染的桥梁[2-5]。例如，通过模型预测发现，未来多年内在孟加拉国异性商业性行为导致的新发感染将成为新发感染的最主要来源[80]。泰国的模型预测结果也显示未来新发感染的一个重要来源是夫妻间传播，而商业性行为则是导致该预测结果的主要原因之一[79]。



**图1 历年新报告HIV感染者AIDS病人传播途径构成[1]**

综上所述，同普通女性性工作者相比，低档女性性工作在与艾滋病防治密切相关的特点方面可以总结为“三多一少”：首先是感染风险多。由于她们文化水平低、自我保护意识低、艾滋病相关知识匮乏、艾滋病病毒感染风险的自我意识低、客人的安全套使用意愿较低、容易具有多种危险行为、她们自己的安全套使用率低等特点大大增加了她们感染艾滋病病毒的风险；其次就是她们传播艾滋病病毒的风险多。由于她们性病、艾滋病等感染率较高、感染后继续从事商业性行为的情况较多、客人的健康防范意识较差、同商业性伴以及固定性伴间的安全套使用率较低等因素导致她们在感染HIV后继续传播HIV的风险较多；再次，就是她们在感染HIV和性病后传播的人群数量多。多数低档女性性工作者的客人人数和商业性行为次数均多于普通女性性工作者，而且无保护的性行为次数和比例也较多，因此她们潜在感染的人群数量也较多；最后，就是低档女性性工作者接受干预的机会较少。由于她们流动较大、人群隐蔽、自我保护意识较强、不容易被接触到、当前的重视不够、干预覆盖面较低等原因，导致很多低档女性性工作者无法被常规的干预活动所覆盖。这“三多一少”是密切相关和相互影响的，总之，低档女性性工作者已经成为HIV传播的一个极其重要人群。

# 国内外针对女性性工作者常见的HIV防治策略

目前针对女性性工作者的干预措施很多，然而专门针对低档女性性工作者的特殊干预措施并不常见[69]，仍然缺乏针对低档女性性工作者的独特干预策略，不过许多研究表明针对一般女性性工作者的干预措施同样适用于低档女性性工作者，只要在实施过程中根据低档女性性工作者的不同特点进行适当的调整即可以起到较好的干预效果[2]。由UNFPA主编的“The HIV and Sex Work Collection-2012”一书对于国际上在女性性工作者（包括低档女性性工作者）中的HIV干预防治模式已经进行了充分的分析和总结，本章节内容主要借鉴或摘录该书中的核心要点与案例。国内外针对女性性工作者常见的干预措施包括：

1、同伴为基础的社区外展和宣传教育

“同伴教育”(Peer Education)指的是具有相同背景、共同经历、或有共同语盲的人们在一起分享信息、观念和行为技能，实现预期教育目标的教育形式和过程。在这样的过程中，同伴们可以讲述自己的经历和体会，交流信息与技能，唤起其他同伴的共鸣。而且在同伴教育过程中，信息传出者和信息接受者之间可以发生角色转换，是更为平等的信息交流过程[69]。过去多年来国内外许多成功的经验已经证明，同伴为基础的社区外展和宣传教育对于接触到女性性工作者人群并为她们提供HIV预防服务和建立信任关系极其重要。许多研究表明同伴教育可以有效的提高目标人群的知识、增加安全套使用和扩大干预的覆盖面[4, 92]。例如，在南昌市开展的研究表明，针对固定场所女性性工作者和无固定场所女性性工作者同时开展同伴教育、外展等宣传教育活动后进行调查评估，结果发现，无固定场所艾滋病相关知识知晓率由干预前2.4%上升到干预后的82.0%，固定场所艾滋病相关知识知晓率由干预前36.2%上升到干预后的98.0%；最近一次性行为时安全套的使用情况上，无固定场所组的安全套的使用率由14.3%上升至干预后的80.0%，固定场所组由66.8%上升至87.5%；干预前无固定场所组调查对象接受过预防艾滋病的服务的比例为19.0%，接受过同伴教育的比例为0.0%，最近一年做过艾滋病检测比例为0.0%，干预后分别上升至52.0%、32.0%和58.0%；干预前固定场所组的调查对象接受过安全套的宣传与发放、艾滋病咨询与检测的比例为97.0%，接受过同伴教育的比例为67.3%，最近一年做过艾滋病检测比例为41.7%，干预后分别上升至100.0%、90.5%和84.0%[4]。可见，有效的开展同伴宣传和外展不仅可以有效提高固定场所女性性工作者的艾滋病相关知识、安全套使用率和干预覆盖面，而且对于无固定场所低档女性性工作者同样有效，如果开展得好在某些方面的效果甚至更明显[39]。李娟等人在重庆低档女性性工作者中开展的研究也验证了同伴教育对于低档女性性工作者的效果，结果表明，同伴教育宣传员也作为女性性工作者获得艾滋病的相关知识的一个重要途径，低档女性性工作者人群中通过同伴教育干预前后同伴间交流增加，调查对象在艾滋病防治知、信、行方面有明显改善。知识知晓率从干预前的28%提高到70.5%；从未使用过安全套的比例从13%下降到4.5%；最近一次商业性行为安全套使用率从59%提高到75%；自愿进行艾滋病检测的人数比例从2%上升到18%，该作者认为在街头女性性工作者中同伴教育是值得推广的普及艾滋病相关知识，转变对待艾滋病相关态度和行为的有效干预方式[69]。

总之，同伴为基础的外展和教育活动在接触到目标人群，尤其是隐蔽的女性性工作者人群、影响目标人群的社区观念、改进求医行为、创造目标人群对服务的需求和获取这些服务的自信等方面均具有极其重要的意义[92]。国际经验表明，有效的同伴教育和外展具备以下特点[92]：

（1）制定较好的操作层面的微观计划，绘制高危人群场所分布图并估计每个场所的人群规模；

（2）制定有效的培训计划，定期培训外展同伴宣传员以确保她们具有正确的关于艾滋病、性病和生殖健康等知识，以及较好的人际交流技巧；

（3）利用有效的机制来管理和指导外展同伴，鼓励她们分享经验、挑战和寻找解决方案，确保外展工作能够的得到不断的改进和提高；

（4）把宣传教育整合到根据社区需求而开展的社会活动中；

（5）利用对现有服务的了解，以及社区组织、女性性工作者和卫生服务提供者间的密切合作关系最大化目标人群对HIV防治服务的利用；

（6）建立外展同伴激励机制，包括培训学习机会和职业发展机会等。

（7）对同伴外展人员进行能力建设对于扩大覆盖面和提高干预效果及其重要。能力建设的内容应不仅仅局限于有效的沟通交流和演示如何使用安全套，还要培训同伴如何动员和激励女性性工作者社区成员提高她们的健康和权利意识，培训同伴成为健康服务与女性性工作者社区间的桥梁。传统的课堂讲授培训是不够的，其他有效的能力建设方式包括各种非正式讨论、同伴间经验分享和学习等。

2、活动中心

创建女性性工作者人群社区活动中心作为一种有效的社区授权、宣传教育和获得卫生服务的策略，在整个亚太地区得到了广泛的应用。社区活动中心对于女性性工作者来讲是一个重要的社会资源，有助于促进社区的团结，在预防和减少她们暴露HIV的风险方面具有很多好处，例如，有时社区活动中心可能是她们可以聚在一起活动的唯一安全地方、可以同朋友及同伴互相交流、参与不同的学习活动和社会活动、休息和放松、洗澡或者生病的时候在这里可以得到照顾。此外，在社区活动中心可以开展多种多样的HIV预防相关活动，如，HIV宣传教育、生活技能培训、性和生殖健康培训、HIV咨询和检测、性病诊断和治疗服务、计划生育服务、提供安全套和润滑剂预防产品等服务[92]。

活动中心里面可以根据需要同时开展不同频率的活动，如，每日开展的活动、每周开展的活动、每月开展的活动和每年开展开展的活动。通常每日开展的活动包括：咨询检测、医疗转介服务、同伴外展宣传、电视和录像宣传、作为洗浴和打扮的场所、性病艾滋病和生殖健康宣传教育、安全套和润滑剂发放及展示等；每周的活动可以包括定期STI和生殖健康检查、社区聚会、常用的职业技能培训、经验分享和问题解决等；每月的活动可以包括生活技能培训和较大规模的社会聚会和活动等；每年的活动如每年的十二月一日世界艾滋病日活动。

3、安全套、润滑剂等的发放和社会市场营销

安全套推广始终是预防HIV通过性传播的一个非常重要措施，而且也被广泛证明是有效的干预措施。许多地方在发放男用安全套和润滑剂的同时，女用安全套也作为重要补充被广泛研究和推广。安全套和润滑剂等预防物品的发放通常被结合到其他的干预活动中，如同伴教育、外展宣传、咨询检测、性病服务、关怀治疗等。除了免费的安全套发放之外，有些组织和机构也采用安全套市场营销的方式推广使用安全套，这样不仅可以促进安全套的使用，同时也能够在一定程度上为社区组织获取可持续发展的资源。许多成功的案例表明安全套社会营销具具有以下积极的意义和效果：可以促进男性客人的安全套使用；有助于在性产业和更广的社区中构建使用安全套的支持性社会观念、是获得可负担的高质量安全套可持续性和具有较好成本效益的途径、能够为社会组织带来可以灵活支配的额外资源。

4、促进咨询和检测

高质量的咨询和检测服务对于目标人群及时接受HIV检测服务、了解感染状况、降低高危行为和采取保护措施具有重要的意义和效果。多方面的数据显示女性性工作者人群中HIV检测覆盖率较低，因此，在女性性工作者人群中加大投入力度，积极开展咨询和检测服务、扩大检测的覆盖面也是各国广泛采取的一种措施。减少和避免影响检测的不利因素对于扩大检测覆盖面具有重要的意义，例如，加强保密措施和创造非歧视的服务环境对于扩大女性性工作者中的咨询和检测服务具有非常积极的影响。

5、社区组织提供的快检服务

有研究表明，如果咨询人员不是来自女性性工作者社区的人员，她们通常不愿意接受咨询和检测服务。而社区小组人员更容易获得她们的信任，在服务态度、时间、地点等方面比较灵活，可以更好的满足女性性工作者的需求。尤其是提供快速HIV检测服务可以大大缩短获得结果的时间，减少流失率，能够有效扩大服务的覆盖面。在国内外有很多社会组织成功为女性性工作者提供HIV快速检测的优秀案例。

6、随访、关怀和治疗服务

及时针对需要治疗的阳性女性性工作者开展随访、关怀和治疗服务对于提高她们的生活质量，减少HIV的进一步传播具有重要的作用和意义。对于咨询检测中发现的阳性女性性工作者及时开展随访、关怀和治疗等服务也有助于提高她们接受检测服务的积极性。许多项目和组织还专门成立了阳性女性性工作者关怀组织，可以为她们提供一系列的随访和关怀服务，包括治疗转介、心理咨询、依从性咨询、家庭关怀、社区关怀和临终关怀等服务。为阳性女性性工作者获得友好可及的治疗和关怀服务发挥了重要的作用。

7、加强性病诊疗和生殖健康等服务

性病与HIV感染之间存在着重要的协同关系，性病可以增加HIV的传染性和易感性，是HIV经性传播的重要危险因素，尤其是梅毒等溃疡性疾病，其对于HIV的感染和传播有着非常重要的促进作用。因此，提供高质量、可负担和友好可及的性病服务也是女性性工作者中HIV防治的一项常见策略和做法。此外，女性性工作者还有许多其它方面的需求，尤其是生殖健康方面的需求也值得我们重点关注。例如，她们同固定性伴间的安全套使用率通常很低、具有较高的流产率和遭受性暴力的比例等。因此，在开展HIV预防服务时，同时针对女性性工作者的现实需求提供相应的生殖健康等服务不仅有助于提高她们接受HIV预防服务的兴趣，而且可以降低她们传播和感染HIV的脆弱性。这些服务包括避免意外怀孕、产前、分娩和产后关怀服务、母婴阻断治疗、计划生育以及全套的避孕服务等。HIV预防项目同性病服务、生殖健康服务相整合的成功案例很多，例如，缅甸的TOP项目和中国昆明百合社会组织开展的HIV预防项目在这方面均取得了很好的效果，充分例证这些项目不仅产生了较好的HIV预防结果，同时也发挥了较好的性病防治和生殖健康方面的积极效果。

8、通过有关信息交流技术开展宣传和教育

有些地区和国家发现，很多具有较高教育水平的年轻女性性工作者通过手机等渠道寻找客人，因此积极研究和利用相关的信息交流技术和渠道开展HIV宣传将会是一种潜在的有效措施，可以接触到一些更隐蔽和流动的女性性工作者。

9、社区参与和赋权

许多实践表明，不管采取什么样的干预措施，只有女性性工作者这个目标人群的充分参与才能取得较好的HIV防治效果。社区参与和赋权不仅仅限于招募目标人群作为同伴宣传员或外展人员参与HIV防治工作，而更广泛意义上的社区参与和赋权还包括：真正的提高女性性工作者的自身人权意识和地位、加强她们改进自身安全和健康的能力和意识、加强她们改善工作、生活环境和条件的能力等，从而改变她们的弱势地位，提高她们采取使用安全套等安全性行为方面的能力和意愿。很多项目，尤其是国际项目在这方面已经开拓了很好的策略和做法，如，通过有效同伴教育模式、多样化的宣传和社区动员活动解决女性性工作者在工作生活中面对的挑战；解决她们获得HIV、生殖健康和其它健康服务遇到的各种障碍，包括降低歧视和提高社区对相关服务的需求和获取这些服务的信心；提供法律援助等创新措施预防和减少针对女性性工作者的暴力等策略。此外，还包括促进各种服务于女性性工作者的社会组织的发展，如为这些组织提供各种必要的能力建设和高质量的技术支持活动，从而提高他们发展自身组织机构的能力、设计和实施各种有效干预项目的能力，以及提高她们发展女性性工作者社区的领导能力。

10、理财创收服务

尽管很多女性性工作者都希望能够赚很多钱，积累存款并逐渐变得富有，但是她们缺乏相应的知识和能力进行理财。因此，有些机构，如昆明的百合女性性工作者组织在针对低收入女性性工作者开展了有针对性的理财服务并取得了较高的效果。通过培训和加强女性性工作者的理财意识和能力，尤其是在追踪个人的收入、支出、储蓄和投资等方面的能力和策略。在百合社区组织的支持和帮助下许多女性性工作者还购买了基金等理财产品并取得了较好的收益。而更有趣的事她们还利用理财的意识和理念来推广使用安全套和采纳安全性行为，通过培训和宣传使女性性工作能够意识到，维持健康也是确保个人今后资金安全的一个非常重要方面。

此外，她们还培训女性性工作制作并销售一下手工艺品等创收的知识和技能，以及其它方面的职业技能培训。然而需要注意的是，这些活动虽然在一定程度上对于女性性工作者提高个人经济收入和生活保障方面起到了积极的促进作用，但是在实施的过程中也有很多现实的挑战，对于她们生活的影响很难起到实质性的转变，同时我们也不能寄希望于她们能够很容易的从事一个新的工作和行业。

11、减少和解决女性性工作者获取HIV预防服务的障碍

女性性工作者感染和传播HIV的风险受到许多因素的影响，由于她们社会地位较低，属于弱势群体，有许多因素提高了女性性工作者的脆弱性，如，客人暴力、人口拐卖、社会歧视等。这些因素防艾了女性性工作者对各种HIV预防服务的获得，降低了她们采取安全性行为的能力，针对这些因素开展的预防干预项目有助于减少女性性工作者的脆弱性，提高HIV的预防效果。当前有许多这方面的成功案例，尤其是国际上的成功案例，包括：旨在改变政策和社会观念，创造支持性的政策和社会环境的干预策略，如泰国的SWING组织和缅甸的TOP项目针对女性性工作者脆弱性的根本原因开展的干预策略；孟加拉国Durjoy Nari Sangha社会组织开展的预防和减少针对女性性工作者的各种暴力的干预策略；针对保护女性性工作者人权和法律方面的倡导、针对女性性工作者人口之拐卖等方面的倡导和法律援助等，如，泰国EMPOWER组织为女性性工作者开展人权和反人口拐卖等方面的倡导和法律援助等项目。

12、上述各种干预措施的综合运用和实施、转介网络

尽管从不同的领域来看，针对女性性工作者的干预可以分为不同的策略，不同的地区和组织也会有不同的干预侧重点，然而也有很多研究和实践表明，各种策略综合应用的干预方案会产生较好的HIV防治效果。在上海针对小型娱乐场所中低档女性性工作者开展的一项干预研究中通过多部门合作采取综合的HIV干预策略，包括：1）面对面宣传，由多部门成立的艾滋病高危人群干预队伍每月深入场所对女性性工作者开展面对面的宣传，包括现场问答、图片展示、角色扮演、播放视频、发放资料，宣传艾滋病预防知识和安全套劝说技巧等方式；2）安全套推广使用：在场所内免费发放安全套，在场所集中地区安装自动售套机；3）医疗转介服务：提供综合性医疗机构性病及妇科门诊转介服务。干预一年后的评估结果表明，干预组的艾滋病防治知识知晓率、最近一次性行为安全套使用率、近一个月与客人性行为时安全套从不使用率、正确就医认识率均与常规宣传干预组差异显著，总的来讲，干预组的女性性工作者人群中艾滋病防治知识知晓率明显提高，安全套使用状况改善，正确就医认识率显著高于常规宣传干预组[44]。刘惠等人于2009年在重庆专门针对街头低档女性性工作者的干预模式效果进行了评估研究，取得了较好的经验。结合目标人群文化程度低下、年龄偏大、敏感、戒备心理较强、获得知识的途径和能力有限等特点，针对性的开发出了“知情人提供线索，坚冰突破，小规模宣传，培养同伴教育宣传员，定期外展现场干预咨询交流相结合”的模式等，包括开展以咨询、谈心为主的流动宣传、同伴宣传、安全套推广等。外展干预过程中，注重宣传形式的多样化，发放以图片为主的宣传卡片、折页和画册，简明易懂，提供免费优质安全套，生殖健康知识手册，传授安全套质量鉴别和使用技巧、与嫖客交流的技巧，现场问题咨询等活动，同时发展同伴教育者展开宣传。经过三个月的干预后目标人群艾滋病知识知晓率显著提高，从干预前的28% 提高到71%；最近一次安全套使用率从干预前的59% 提高到75%，最近一个月安全套每次使用率从4%提高到26%[72]。2010年国家艾滋病防治社会动员项目资助的马鞍山市低档女性性工作者艾滋病及生殖道感染综合干预项目中，采取多种策略，综合开展深入访谈和咨询等宣传教育活动、同伴教育、安全套推广、每月一次性病专科医生、妇科临床医生巡诊及转介服务，提供性病、生殖道感染检查与艾滋病自愿咨询检测服务等，经过为期4个月的干预后进行评估。结果表明，干预后目标人群最近一次与嫖客安全套使用率从干预前的54.2%提高到77.5%；最近一个月与嫖客坚持每次使用安全套的比例从干预前的43.3%提高到干预后的55.0%；干预前低档女性性工作者生殖道自报有症状的人中就诊率为56.3%，干预后为74.6%，比干预前增加了18.3%[41]。

# 我国针对低档女性性工作者的干预现状

## 高危人群干预工作队（简称“高干队”）

通过检索和查找公开发表的资料，并没有找到我国专门针对低档女性性工作者制定的干预策略和方案，只有针对所有女性性工作者人群（包括低档女性性工作者）开展的干预工作，其中包括我国于2004年6月制定的娱乐场所服务小姐预防艾滋病/性病干预工作指南[93]，该指南中的重点目标人群是娱乐服务场所重的女性性工作者人群。于2005年6月我国出台了高危行为干预工作指导方案（试行）文件，该方案中规定：各级卫生行政部门负责领导本行政区域高危行为干预工作，掌握工作进展情况，提供政策和经费支持；各级疾病预防控制机构负责制定工作计划和组织实施高危行为干预工作。该文件要求各地组建高危人群干预工作队，负责针对高危人群（包括女性性工作者人群）开展行为干预工作。由中国疾病预防控制中心负责组织全国高危人群干预工作队（简称“高干队”）的师资培训；收集、报告实施进展情况，组织经验交流和推广活动；对全国高危行为干预工作提供技术指导。高干队针中针对高危人群的主要干预策略（包括女性性工作者人群）摘录如下[19]：

1、小媒体宣传：在目标人群活动场所和社区，高危行为干预工作者采用直接培训目标人群和小组讨论的方式，对目标人群采用“面对面”培训、发放小媒体（如折页、张贴画、小画册、录像带、光盘等）等方式开展预防艾滋病知识的健教与宣传，提高目标人群防治知识知晓率和自我健康保护意识，并改变高危行为和求医行为。

2、同伴教育：在目标人群中选择态度积极并有影响力的人作为同伴教育者，进行预防知识强化培训，鼓励他们以适合该人群的方式，通过一对一或多个同伴之间的交流，宣传艾滋病、性病预防知识，传授正确使用安全套、拒绝危险性行为等技能。针对目标人群流动性大的特点，教育场所经营者和雇主支持和配合同伴教育者在场所内开展教育活动和发放宣传品。

3、外展服务：选择目标人群较为集中的地区，会同计生、妇联、红十字会等部门挑选有相应活动能力和干预技能的防治人员，深入到高危人群中提供妇女保健、生殖健康咨询、医疗转介等服务，或通过在营业性娱乐场所内及附近开设健康咨询门诊等方式，为高危人群提供宣传教育、咨询、医疗和安全套供应等干预服务。

4、安全套的推广与正确使用：拓宽安全套的销售渠道，以商业营销和社会营销等方式，支持、鼓励各类医疗卫生保健机构、药店、商店和超市销售优质安全套，在娱乐场所附近设立安全套自动售货机，提高安全套的可及性。通过有针对性的健康教育，教会目标人群正确使用安全套，促进目标人群每次性行为都全程正确地使用安全套。

5、规范性病诊疗服务和生殖健康服务：整顿规范性病诊疗市场、建立完善规范化性病门诊，改善性病服务质量，为目标人群提供包括性伴追踪、病症处理、咨询与健康教育相结合的规范化性病诊疗优质服务，做到早诊断、及时规范治疗，减少艾滋病、性病传播的危险。

6、有关场所干预：在性病诊所、自愿咨询检测点、美沙酮治疗门诊、针具交换项目点等均应放置预防艾滋病宣传品、播放宣传教育片、开通热线电话，提供免费咨询、医疗转介服务，并免费发放安全套。

高干队中明确提到:女性性工作者人群包括在各类娱乐场所、饭馆、旅店和街头等场所进行卖淫活动的妇女。而针对女性性工作者人群的干预工作参照我国于2004年6月制定的娱乐场所服务小姐预防艾滋病/性病干预工作指南具体实施。该指南中针对女性性工作者的主要干预策略和活动摘录如下[93]：

1、开展有针对性的艾滋病/ 性病健康教育

在娱乐场所服务小姐中开展形式多样的、与性病诊疗服务相结合的健康教育活动，提高她们对艾滋病/ 性病的知识知晓水平和自我健康保护意识，以及改变她们的求医行为。这些健康教育干预活动主要包括健康教育宣传员(或称外展工作人员)直接实施的宣传教育、同伴教育、和大众媒体宣传等。

（1）健康教育宣传员(或称外展工作人员)

根据各地的实际情况，在当地卫生、计生、妇联、红十字会等部门中挑选数名有工作能力和责任心的卫生专业人员作为健康教育宣传员，定期到辖区内的娱乐场所进行现场宣传教育和提供咨询服务。

（2）同伴教育宣传员

各地根据当地情况，从娱乐场所服务小姐中挑选数名服务小姐，培训她们作为同伴教育宣传员，在娱乐场所服务小姐中开展同伴教育活动。

（3）大众媒体宣传教育进一步扩大宣传教育的覆盖面

为了进一步扩大宣传教育覆盖面，创造良好的防治艾滋病、性病的舆论环境，该指南中还要求卫生部门密切配合宣传部门，利用电台广播、电视、报纸等宣传工具，大力宣传艾滋病/性病基本知识，适度扩大对一般人群的健康教育。在流动人口较多的大型厂矿企业、农贸商场、市场，或流动人口较集中的居住区，进行艾滋病一般知识的宣传教育，提高流动人口的健康意识，倡导健康的生活方式。

2、促进安全套的推广与正确使用

以商业营销和社会营销相结合的方式提高优质安全套的可及性和可获得性；通过有效的健康教育、外展干预和咨询服务，促进服务小姐每次性行为都全程、正确使用安全套。

3、提供规范的性病诊疗服务及生殖健康服务

整顿规范性病诊疗市场，改善性病服务质量，为服务小姐提供有效的、可接受的、可负担的规范性病诊疗服务及生殖健康服务。具体的干预策略和要求如下：

（1）性病诊疗与咨询服务人员提供性病知识和咨询

要求所有开展性病诊疗服务的机构都应该提供合格的艾滋病/性病咨询服务。候诊室里应该提供多种健康教育宣传材料，供病人候诊时翻阅。每个公立性病门诊至少有2－3名态度和蔼、不歧视、服务热情的中年女性医生，负责对女性病人进行性病诊治和咨询。建议门诊的医务工作人员同时可兼做健康教育宣传员，深入到娱乐场所中去，为服务小姐提供现场的艾滋病/ 性病知识宣传和咨询。这既增加了服务小姐与工作人员的进一步沟通和交流的机会，建立良好关系，又有利于解决服务小姐的实际问题，鼓励她们到门诊接受检查和治疗。

（2）改善性病诊疗服务

国家性病检查和治疗是针对娱乐场所服务小姐开展干预工作的重要组成部分。提供优质服务，做到早诊断、早治疗不仅可以及时解除她们的疾苦，同时也可以减少她们感染和传播性病/艾滋病的危险。该指南中要求性病诊疗的基本内容应该包括以下几个方面：

1）定期检查

由于服务小姐在短时间内与很多嫖客发生性行为，感染性病的危险性相对较高，定期检查可以及时发现，尽早治疗。

2）治疗现有感染

应该指导病人正确就医和规范治疗。遵照医嘱，足量、全程地接受治疗；告诉病人若不及时、彻底治疗，有可能导致更严重的后果，如：女性不孕症、盆腔炎等。

3）性伴通知与治疗

告诉病人，应通知性伴及时就诊。在性伴就诊有困难的情况下，可以通过病人带药的方法，帮助性伴接受同步诊治。

4）随访

对需要随访的病人，应该叮嘱她们能够按时到医院/门诊复诊。

5）坚持使用安全套

需要告诫病人，在完成疗程前及未治愈前应暂时停止性活动。如果不可避免，则需要坚持使用安全套。

6）艾滋病/ 性病、生殖健康咨询

在为病人治疗性病的同时，需要提供一对一的艾滋病/性病、生殖健康咨询服务。有条件的地方可在诊疗机构内开设咨询电话，安排具备咨询知识和技能的医护人员值班。咨询内容可见健康教育内容和性病诊疗内容。咨询员需要从求咨者的处境、心态出发，通过同情、理解和两者的互动，通过交谈帮助求咨者分析讨论他们所面临的问题，找出解决问题的办法，并帮助他们采取行动。诊疗机构内的工作人员要尊重、不歧视求咨者，并为求咨者保密。

## 综合示范区项目

我国的综合示范区项目到目前为止共实施了两轮，在2003-2008年期间我国建立了首轮的127个艾滋病综合防治示范区，在各级政府领导和有关部门的支持下，对于落实国家防治政策，探索适合当地实际情况的工作模式方面积累了大量的防治工作经验，起到了示范带头作用。为了进一步推广示范区工作经验，推动全国艾滋病综合防治工作深入开展，我国于2009年开始启动了第二轮示范区的工作，目前正在进行中。共确定了309个中央财政支持示范区，其中包括51个中央重点建设示范区，258个中央与省（区、市）共建示范区。

第二轮中与女性性工作者密切相关的目标有三个，包括艾滋病相关知识知晓率达90%以上；女性性工作者最近一次性行为中安全套使用率达到85%以上；梅毒年报告感染增长率控制在10%以下。示范区中涉及到女性性工作者的干预措施包括：在公共场所设置安全套发售设施、针对女性性工作者开展健康教育；安全套推广等工作；提供规范性病诊疗和转介服务；外展服务；培训同伴教育者，开展同伴教育；艾滋病的自愿咨询检测；鼓励和支持社会团体和民间组织开展针对女性性工作者的预防干预活动。

## 全球基金艾滋病项目

中国从2004年开始实施全球基金艾滋病项目，最早开始实施的是第三轮全球基金艾滋病项目，之后陆续成功申请到了第四轮、第五轮、第六轮、第八轮和全球基金RCC艾滋病项目。目前正在实施的只有全球基金RCC艾滋病项目。 中国全球基金RCC艾滋病项目，是通过全球基金滚动资金渠道申请到的整合滚动项目。项目本着统一规划和资源整合的原则，在整合了原有的第三轮、四轮、五轮、六轮和刚申请到的第八轮艾滋病项目的基础上，充分整合国家所有艾滋病防治资源，包括中央转移支付经费、省、市和县（区）级投入，以及其他国际合作项目的资金，在国家统一的规划和计划下开展实施艾滋病防治工作，项目地区为31个省（自治区、直辖市）。

在这几轮的全球基金艾滋病项目中，除了第八轮艾滋病项目[94]主要针对流动人口（已经整合到RCC项目中）外，其它各轮全球基金艾滋病项目都在不同程度上涉及到女性性工作者中的HIV防治活动。其中第三轮全球基金艾滋病项目[95]重点支持治疗和关怀活动，专门针对女性性工作者的HIV防治活动较少，包括行为改变交流、安全套推广和社会市场营销。

第四轮全球基金艾滋病项目[96]的主要目标为控制女性性工作者和注射吸毒人群等高危人群众中的HIV传播和流行，因此，专门针对女性性工作者的干预策略较多，包括：针对女性性工作者的IEC宣传、大众媒体宣传、成立社区妇女健康活动中心开展各种宣传和干预、外展和同伴宣传等行为改变交流、安全套推广和社会营销、咨询和检测、性病服务、生殖健康服务、治疗关怀、加强社会组织参与，此外还针对嫖客人群开展了一定的宣传和干预。

重点针对低流行地区经性途径传播HIV的预防，第五轮全球基金艾滋病项目[97]是中国第一个将MSM人群作为目标人群的大规模国际项目。除了MSM人群外，女性性工作者也是其目标人群之一，此外，该项目中还有很重要的一个内容就是资助CBO的参与。在该轮全球基金项目中同女性性工作者密切相关的干预策略包括：宣传教育、外展、同伴宣传、安全套推广、咨询和检测、性病服务、社区组织能力建设等。

第六轮全球基金艾滋病项目[98]主要目的为加强社区组织能力建设，促进其积极参与针对高危人群的HIV防治工作。目标人群中不仅包括女性性工作者，还包括她们的嫖客人群。此外，在该轮项目的申请书中也明确提出要重点关注街头女性性工作者和跨境女性女性性工作者等最弱势群体。第六轮全球基金针对女性性工作者开展的具体干预措施包括：支持建立和运作社区组织开展的女性性工作者社区健康活动中心，社区组织参与的同伴教育，外展干预，行为改变交流，包括女用安全套在内的安全套推广，性病咨询检测和治疗服务，CBO和当地疾病预防控制中心合作开展的咨询和检测服务（包括快检服务），以及加强社区组织的能力建设等。

全球基金RCC艾滋病项目[99]是目前唯一正在实施的全球基金艾滋病项目，其主要的目的是提高各种HIV预防干预服务全面可及和扩大覆盖面，女性性工作者是其目标人群之一，在项目书中也同时明确提出了对街头女性性工作者的重点关注。本轮全球基金的一个重要特点是资助了大量的社区组织参与中国的艾滋病防治工作。针对女性性工作者的主要干预策略包括：大众媒体宣传、外展和同伴宣传、安全套推广、HIV咨询和检测、性病诊断和治疗服务、阳性者的转介和随访、减少歧视、社区组织能力建设等。表1简单列出了在中国开展的各轮全球基金艾滋病项目的简单信息。

**表1 中国各轮全球基金艾滋病项目基本信息**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **项目名称** | **项目总目标** | **项目目标人群** | **项目周期** | **项目总经费** |
| **第三轮** | 加强中国中部地区以社区为基础的艾滋病综合治疗、关怀和预防项目 | 在中国中部7个省58个艾滋病高发贫困县减轻由艾滋病造成的影响，并控制艾滋病的传播。 | 上世纪90年代中、早期因既往有偿采供血而导致的艾滋病病毒感染者/病人及其家庭。 | 5年（2004年9月1日—2009年8月31日） | 97,888,170美元 |
| 第四轮 | 降低中国七省脆弱人群中艾滋病病毒的传播、减轻其影响项目 | 在中国中西部7个省（自治区）降低艾滋病病毒在注射吸毒人群和女性性工作者中的传播并减轻艾滋病所带来的影响。 | 女性性工作者、注射吸毒者、男男性行为者、流动人口 | 5年（2005年7月1日—2010年6月30日） | 63,742,277美元 |
| 第五轮 | 在中国预防新一轮的HIV感染项目 | 通过以控制性传播为主的艾滋病综合干预措施，遏制艾滋病在中国七个省（自治区、直辖市）高危和脆弱人群中的继续蔓延。 | 性工作者、男男性接触者和流动人群 | 5年（2006年7月1日—2011年6月30日） | 28,902,073美元 |
| 第六轮 | 鼓励、支持民间组织和非政府部门参加扩大中国艾滋病防治工作项目 | 利用并加强中国民间组织以及非政府组织的能力，通过利用民间组织的独特优势来填补现有艾滋病防治项目的缺口并扩展覆盖面，向最脆弱人群和难以接触的人群提供必要的预防、治疗以及其它支持性服务。 | 女性性工作者和嫖客、男男性行为者、静脉注射吸毒者、校外青少年和艾滋病病毒感染者/病人以及受艾滋病影响的儿童和孤儿。 | 5年（2008年1月1日—2012年12月31日） | 14,395,715美元 |
| 第八轮 | 在中国七省开展针对弱势流动人群的艾滋病预防与关怀服务项目 | 预防艾滋病的传播及降低艾滋病对弱势流动人群的影响。 | 流动人群中最弱势的群体 | 5年（2009年—2014年） | 61,413,199美元 |
| RCC | 中国全球基金艾滋病项目。 | 扩大中国艾滋病预防、治疗和关怀服务，促进高危人群及艾滋病病毒感染者和病人对艾滋病综合防治服务的全面可及。 | 女性性工作者、静脉吸毒人群、男男性行为人群、流动人口、艾滋病病毒感染者/病人（包括儿童）和孕妇。 | 六年（2010年1月－2013年9月） | 约5.09亿美元（上限经费） |

## 其它国际项目

除了前面提到的全球基金等大的国际项目外，在中国开展一些其他国际合作项目中也有涉及到女性性工作者开展干预活动的，如在美国国际发展署资助（USAID）下,由美国家庭健康国际驻华代表处（FHI360）和国际人口服务组织（PSI）在云南和广西开展的艾滋病防治合作项目，以及中国盖茨基金会艾滋病防治合作项目在中国开展的早期阶段资助过针对女性性工作者的动员检测活动。

在美国国际发展署资助下，美国家庭健康国际驻华代表处和国际人口服务组织针对女性性工作者开展的主要干预模式为综合性的预防、关怀和治疗模式[100]。在该模式中，针对高危人群（包括女性性工作者和嫖客）提供包含六项核心服务的综合服务包，具体包括：针对女性性工作者等高危人群干预的行为改变交流服务；针对女性性工作者等高危人群的性病防治服务；重点针对吸毒人群的降低危害服务；重点针对感染者和其家属的持续性预防、关怀、支持和治疗服务；针对女性性工作者等高危人群的安全套社会营销和安全套发放服务；针对女性性工作者等高危人群的艾滋病咨询检测服务（详见图2）。该模式中，除了提供综合服务包外，为了确保这六项核心服务能够取得较好的效果，还需要同时开展包含另外六项内容的支持性环境干预，包括：政策及倡导；社区动员；策略信息；能力建设；生计发展；减少污名和歧视。在鹿寨和个旧还单独针对低档女性性工作者制定并实施了专门的干预策略，但是规模和覆盖面非常有限。



**图2 USAID资助的艾滋病综合预防模式**

联合国人口基金（UNFPA）最近也更加关注低收入女性性工作者的干预，自从2012年以来，UNFPA继续与中国疾控中心性病艾滋病防治中心合作，在江西、海南和贵州的4个项目地区的城中村、出租屋、大桥下、树林边、公园、路边、农贸市场、胡同内等地方，针对流动的站街女、相对固定的“出租屋女”、“毛线女”、“板凳女”等低档女性性工作者开展有针对性的性病艾滋病干预，总共覆盖了约400名低档女性性工作者。这些妇女年龄以35-50多岁为主，文化程度低，自我保护意识普遍较低，安全套使用率低，客人多为民工、退休老年人等。目前，开展的主要干预措施包括：同伴教育、提供性病和生殖健康诊疗服务、社区干预。其中同伴教育活动的主要是由熟悉当地性工作者语言和文化的同伴开展，协同当地疾病预防控制中心或项目方开展活动。社区干预主要是通过社区居委会找到并接触“场所”（如出租屋、农贸市场等）内的性工作者，与其建立伙伴关系，开展安全套促进、支持同伴教育、开展性病艾滋病以及生殖健康知识宣传等活动。

此外，也有其它个别国际项目重点关注低档女性性工作者的艾滋病防治工作，例如，乐施会资助的山东胶州项目，但是这些项目的规模和覆盖面都非常有限。

# 中国为女性性工作者提供服务的CBO情况

在一些国际项目的资助下中国的CBO在最近几年得到了很大的发展，参与艾滋病防治工作的程度不断深入，无论是从参与的数量上还是从参与服务的质量上都有了很大的提高，尤其是为MSM人群提供服务的CBO组织得到了很大的发展和大量经费援助。为女性性工作者服务的CBO组织也取得了较大的进步。中国CBO的发展过程中国际合作项目发挥了巨大的作用，尤其是全球基金和盖茨基金会项目。例如，中盖艾滋病防治合作项目中给社会组织的经费总额占总预算的五分之二，有200多个社会组织通过中国性病艾滋病防治协会和中华预防医学会得到了中盖艾滋病项目经费的资助，其中绝大多数是为MSM人群服务的CBO。

全球基金中RCC艾滋病项目是目前正在实施的、也是对CBO资助力度最大的一轮全球基金项目。截止到2012年底全球基金RCC艾滋病项目为865家CBO（包括注射吸毒人群、男男性行为者、女性性工作者、感染者社会、反歧视和性别策略社会组织）提供了5978万元人民币的资助，其中有595（10.4%）万元的经费用来资助服务于女性性工作者的CBO。具体的资助情况见表2。

**表2 全球基金中RCC艾滋病项目资助的CBO情况（截止到2012年底）**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **目标人群分类** | **干预目标人群数** | **资助的项目数** | **CBO数目** | **全年经费（万元）** |
| CSW | 59,480 | 151 | 149 | 595 |
| MSM | 38,230 | 271 | 261 | 382 |
| IDU | 231,800 | 81 | 81 | 2,318 |
| PLWH | 73,029 | 353 | 348 | 2,410 |
| 反歧视 | （-） | 65 | 64 | 181 |
| 性别策略 | （-） | 27 | 27 | 92 |
| 合计 | 402,539 | 948 | 862 | 5,978 |

中国发展简报出版的2011年国内NGO名录共收集了699家国内组织，其中艾滋病领域的组织共有73家，但是仅有一家组织把女性性工作者的艾滋病防治工作工作作为其工作的主要领域和重要内容，没有一家组织是真正由女性性工作者组成的组织[101]。此外，全国艾滋病信息资源网络撰写的2012年中国艾滋病社会组织名录中共收集了967个全国社会组织信息，然而缺乏社会组织分类汇总信息。由于作者无法获得电子数据库，因此不能进行详细的定量分析关于低档女性性工作者的CBO情况，但是，通过阅读发现，里面真正由女性性工作者组成的CBO组织极其有限，从该名录中也无法获得这些组织是否开展低档女性性工作者的艾滋病防治工作[102]。

关于服务于低档女性性工作者的CBO信息情况，没有检索到公开发表的资料。但是在访谈中发现，由于针对低档女性性工作者的干预难度较大，不容易开展工作，经费来源较少，因而专门服务于低档女性性工作者的CBO非常有限，多数都是同时为各种女性性工作者提供服务，而为低档女性性工作者提供服务只是这些组织活动的一部分，对于很多CBO来说甚至是很少的一部分，并没有制定专门的计划或者付出特殊的努力去为低档女性性工作者提供服务。

2009年2月，12家从事性工作者干预的相关机构在云南昆明，推动产生了中国性工作者机构网络平台（以下简称网络平台），平台致力于扶持成员机构发展，改善性工作者职业健康环境。通过机构能力建设及倡导，信息、经验、知识的交流和分享等活动，以增强成员机构的综合能力，进而推动性工作者自我认同，减少歧视与伤害。这个平台，目前是国内性工作者组织的主要发声渠道。目前该平台共有14家成员组织，包括，云南瑞丽市妇女儿童发展中心、天津信爱文化传播有限公司、四川江油温馨家园、云南个旧苦草工作室、天津深蓝工作组、山东胶州市爱心健康咨询中心、青岛你我社会工作服务中心、北京折翼天使、云南昆明平行、上海心生、北京阳光之旅社区公益小组、沈阳爱之援助健康咨询服务中心、北京同行和广西浮萍工作室。这些成员中仅有4个组织主要为低档女性性工作者提供服务或者低档女性性工作者在她们的目标人群中占有较大比例。因此，相对于低档女性性工作者的干预需求来讲，这类CBO规模和发展情况远远不能满足实际需求，干预覆盖面极其有限，对于控制该人群中的HIV流行难以产生有效的影响。

总之，目前真正以女性性工作者为基础的组织很少，尤其是能够为低档女性性工作者提供服务的这类CBO数量更少，而且多数集中在城市里面，在有低档女性性工作者的偏远农村地区几乎没有；且这些组织的规模较小，覆盖的低档女性性工作者数量较少。在这些组织中，除了由卫生专业人员负责管理和开展工作的个别组织，多数组织的业务能力非常欠缺，迫切需要提高。此外，经费不足是这些组织面临的最大挑战。不仅仅是针对低档女性性工作者的干预经费严重不足，多数组织连自身生存和发展经费也无法保障。例如，在这些接受访谈的5家目标人群中包括低档女性性工作者的主要CBO中，到2013年底几乎所有这些组织针对低档女性性工作者的HIV干预经费都将停止，没有一家能够确定有可靠的经费来源，其中，有些组织连自身的生存经费也不能保障。

# 低档女性性工作者HIV防治工作的挑战和建议

## 差距分析

目前我国虽然针对女性性工作者开展了许多工作，包括政府经费直接资助的高干队和综合示范区项目，以及国际合作项目，如多轮的全球基金项目、美国国际发展署资助的项目等等，但是整体分析发现，其中针对低档女性性工作者的HIV干预工作仍然是一个被广泛忽视的领域，存在着以下方面的缺口和不足：

1、缺乏关于低档女性性工作者的策略信息。目前关于我国低档女性性工作者的整体信息非常缺乏，包括人群规模情况、干预情况、危险行为情况和HIV感染情况。导致信息缺乏的一个重要原因就是目前女性性工作者HIV哨点监测数据不能真实反映低档女性女性性工作者人群中的实际情况。尽管在我国的HIV哨点监测方案中规定，低档女性性工作者样本数量不得低于监测样本量的10%，然而实际工作中，由于我国女性性工作者人群的哨点监测大部分都是针对场所从业的女性性工作者，而低档女性性工作者，如街头女性性工作者，由于其工作场所的隐蔽、分散以及流动性大等方面的原因，卫生人员不易接近该人群，经常成为监测工作的盲区[2]。结果导致低档女性性工作者人群中调查研究的安全套使用率常常低于哨点监测结果，而HIV/STD患病率往往高于哨点监测结果。目前，虽然有许多学者开展过关于我国低档女性性工作者的人群规模、高危行为、HIV和STD等感染率方面的研究，但是这些研究数据均为局部地区的情况，针对我国低档女性性工作者的整体情况有代表性的数据仍然缺乏。

2、当前针对低档女性性工作者的HIV干预覆盖面和干预力度远远不够。目前，在我国针对女性性工作者开展的主要国内外大规模干预项目包括前面提到的高干队、综合示范区、各轮全球基金和个别的国际合作项目，而正在开展的项目只有第二轮综合示范区项目和全球基金RCC艾滋病项目。而通过这些项目的策略和活动干预到的大部分是普通女性性工作者，无法有效接触到低档女性性工作者，能够覆盖到的低档女性性工作者也只是少数，覆盖面非常有限。此外，专门针对低档女性性工作者的国际项目规模都很小，如USAID针对低档女性性工作者的项目仅仅局限在广西鹿寨市和云南个旧市等个别项目点，乐施会的低档女性性工作者干预项目也仅限于资助个别社区组织来开展的，总的来讲，目前我国针对低档女性性工作者的覆盖面仍然非常有限。高干队目前基本上不再提到了，国际项目即将结束，国家主导的只有综合示范区，而综合示范区里面对低档的干预非常有限，因此低档将面临严重的干预缺口。不仅针对低档女性性工作者的干预覆盖面非常有限，而且面临断档的危险。

3、针对低档女性性工作者的干预服务质量不够。作者在访谈和现场观察中发现，这些小组在针对低档女性性工作者的外展和同伴干预中仍然是简单的发放安全套、软化剂或者纸巾等其它物品，个别的外展人员能够同目标人群进行了泛泛的交流。干预形式单一，内容枯燥，缺乏针对性，可以看出这些小组缺乏有针对性的外展计划和制定有针对性的不同外展宣传话题。不仅小组的干预如此，其它一些较大国际和国内项目中在针对低档女性性工作者的干预服务质量方面也存在类似的问题，需要进一步加强。在国家和项目层面上缺乏专门针对低档女性性工作者开展HIV防治干预工作的策略和指南。在所有这些针对女性性工作者的干预项目中，开展的各种防治策略重点均是针对普通女性性工作者来制定的，在实施的过程中缺乏专门针对低档女性性工作者的有效干预策略和实施指南。虽然有些项目的实施策略中明确提出了关注低档女性性工作者的HIV防治，但是仅限于项目书中的关注而已，缺乏具体可操作的指导性策略和干预指南，相应的导致针对低档女性性工作者的防治工作也多数只能停留在计划书里面，而在实施过程中得到落实的专门针对低档女性性工作者的干预服务质量要求和策略活动的效果远远不够。

## 困难和挑战

1、支持性环境不利于针对低档女性性工作者的AIDS防治工作。

（1）对低档女性性工作者的HIV防治工作重视不够，投入不足。目前在我国尚没有从战略高度把低档女性性工作者作为一个单独的高危人群提出来，也没有专门针对低档女性工作者划拨出足够艾滋病防治经费。在前面提到的针对我国低档女性性工作者的几个主要大规模防治项目中，绝大多数的项目策略是针对普通女性性工作者的，如，场所内女性性工作者，而仅有第六轮全球基金和全球基金RCC艾滋病项目中专门提出了要关注街头等低档女性性工作者的HIV防治工作，但是，包括这两轮全球基金项目在内的前面提到的几个所有HIV防治项目中均没有提出专门针对低档女性工作者的干预指标要求，也没有单独列出专门经费用于低档女性性工作者的HIV防治工作，所有的实施策略也都是针对普通女性性工作者制定的，结果导致实际工作中绝大多数干预活动是针对容易开展干预工作的场所内女性性工作者实施的，项目当地大多数的低档女性性工作者也无法被这些常规的项目干预策略所接触到。

（2）目前的法律环境和低档女性性工作者的生存环境增加了对其干预的难度和感染HIV的脆弱性。在我国，性工作者仍然属于违法犯罪，是公安打击的重点。而低档女性性工作者更容易受到“严打”的影响，使她们变得更加隐蔽和不容易被干预到。同时，也使她们在针对自身的“性暴力”和违法犯罪中维护自身权利和利益的难度大大增加，缺乏这方面的意愿，进一步降低了她们采取安全性行为的能力和地位。

2、针对低档女性性工作者的艾滋病防治队伍和防治能力不足。

目前针对女性性工作者的艾滋病防治队伍仍然非常缺乏，而在防治能力和经验方面也面临着极大的不足，尤其是作为针对低档女性性工作者艾滋病防治队伍中极为重要的成员，为她们提供HIV干预服务的CBO组织发展和能力面临着巨大的挑战。前面已经提到，目前能够为低档女性性工作者提供服务的CBO组织存在几方面的障碍，包括：CBO的数量严重不足，多数集中在城市地区；CBO的规模较小，可以覆盖的目标人群数量非常有限；CBO的能力不足，无法满足针对低档女性性工作者的干预需求；在大量国际项目和援助经费撤离中国的情况下面临着严重的经费短缺问题，尤其是针对低档女性性工作者的HIV防治经费面临断档的风险。

3、策略和措施方面的困难和挑战。

（1）低档女性性工作者多数比较隐蔽，很多低档场所外面没有名称和缺少娱乐服务挂牌的标识，或者没有固定的场所，不像一些场所内的女性性工作者很容易找到。如公园内和街头站桩女性工作者，如果没有长时间的观察和了解，很难识别出她们。

（2）没有娱乐场所老板的组织，多数地方低档女性性工作者人群比较分散，在扩大干预覆盖面方面的难度较大，需要更多的同伴宣传员和外展人员开展工作，需要投入较多的人力、精力和时间。

（3）有些低档女性性工作者人群流动性较大、稳定性较差，在针对其开展艾滋病宣传教育、安全套推广及其他行为干预时难度较大，一方面不容易找到她们，另一方面目标人群接受干预的机会和频率也会较小，因而健康教育效果较差。和普通女性性工作者相比，如果达到同样的干预强度则需要更大的干预频率和投入，尤其是人员数量以及投入的时间和精力等。

（4）多数低档女性性工作者的自尊心强、防范意识高，很难接近她们，如果没有该人群中的内部知情者引荐或者经过长时间的接触很难获得她们的信任和开展干预工作。

（5）有些地区的低档女性性工作者关于艾滋病知识还比较匮乏，加上她们教育水平不高，自我感染HIV的风险意识较差，对艾滋病防治工作重视不够，接受艾滋病知识的积极性和主动性不强，极大的影响了艾滋病宣传教育等干预的效果。

（6）低档女性性工作者的经济上的弱势地位使其在采用安全性行为方面的地位同样弱势，更容易受到客人的影响。而她们的客人多数是低收入人群，而这部门人群的健康防范意识不高，另外还有很多是老年人群，由于年龄和身体条件的限制，这部分人群不仅安全套使用能力较差，而且安全套使用意愿也很低，因此针对低档女性性工作者的行为改变难度非常大，能够长期保持安全性行为的难度更大。

（7）多数低档女性性工作者的客人数量较多，每日接客频率较高，有很多女性性工作者反映，在实际交易的过程中如果她们坚持使用安全套则会有很多客人流失，这样对其收入的影响非常大。因此，单纯针对低档女性性工作者开展的干预工作对于促使其坚持使用安全套的效果有限。

（8）多数低档女性性工作者的收入较低，经济的弱势地位比较明显，更容易为赚钱而从事高危行为，他们不经感染上HIV和性病的危险大，而且传播HIV和性病的危险也非常大，许多研究表明，受到经济利益的驱使，如果感染上性病她们继续从事商业性行为的比例很高。在访谈中也发现同样的问题，有的访谈对象针对这个问题甚至说“……患病后更需要钱来治疗了，不管是否得病我们总要吃饭啊！”

总之，针对低档女性性工作者的艾滋病防治不仅存在宏观政策环境、干预队伍和能力方面的挑战，还有低档女性性工作者自身特点而导致的“四难”：首先是发现难。很多低档女性工作场所通常没有明确的标志、流动性很强，组织形式比较隐蔽，难于被发现；其次是接触难。她们的自我保护意识非常强，难以取得她们的信任，一般需要较长时间和通过她们熟识的核心同伴才能逐步得获得她们的认可并开展干预；再次是干预难。她们比较分散、工作场所条件简陋或者是户外，有些干预措施和活动很难开展，例如，现场咨询和检测。另外，由于她们的赚钱意识较强，时间紧张，通常没有时间参加常规的干预活动；最后就是改变难。低档女性性工作者的脆弱性较大、经济弱势地位比较明显，安全性行为的采纳受到多种客观条件的制约，单纯依靠干预她们本身很难改变她们的危险行为，例如，绝大多数情况下，她们是否使用安全套取决于客人的意愿和经常受到金钱的驱使而无法采取安全性行为。

## 建议

### 关于低档女性性工作者的艾滋病防治

1、支持性环境建设

（1）提高对低档女性性工作者中HIV防治的重视，加大政策上和经费上的支持力度，把低档女性性工作者中的HIV干预防治做工作提升到一个战略性的高度来考虑。要把低档女性性工作者放在同IDU、MSM同等重要的地位来考虑，作为一个单独的高危人群来看待，针对该人群制定单独的指标要求、经费预算和干预实施方案。

（2）开展政策倡导工作，为警察等执法人员提供培训和交流，使他们充分认识到低档女性性工作者在传播和感染艾滋病方面的重要作用和意义，理解她们的生存环境，避免在执法过程中加大她们传播和感染艾滋病的脆弱性。同时，对于针对她们的性暴力等各种违法犯罪事情进行打击，在法律的框架内维护低档女性性工作者应当享有的权利。

2、加大针对低档女性性工作者的策略信息和研究工作。

（1）加强对低档女性性工作者的监测工作。在国家的HIV哨点监测系统内根据不同地区女性性工作者内HIV流行情况和人群规模估计，适当增设低档女性性工作者监测哨点，制定低档女性性工作者监测哨点的采样要求。有困难的地方可以在普通女性性工作者检测哨点中增加低档女性性工作者的样本比例，以便能够更好的反映出当地女性性工作者中HIV总体情况，能够及时监测低档女性性工作者人群中的高危行为和HIV感染情况。

（2）加强支持针对低档女性性工作者的应用性研究，包括干预策略、高危行为、人群规模、干预覆盖面等。目前有一些学者开展了关于针对低档女性性工作者有效开展HIV干预方面的研究，但是这些研究多数规模较小，缺乏系统性，针对低档女性性工作者的总体情况、有效干预策略和方法等方面的依据仍然比较缺乏，需要进一步加强。例如，有研究表明，关于不使用安全套的原因，男客们选择“熟悉、相信”的占47.1％，而妇女们同样的选择则超过半数（55.2％），学者从人类学的角度分析发现，作为文化基础的上述观念在性关系网络中不仅存在，也是影响或改变网络成员行为的重要因素，比如，“熟悉”和“相信”成为性行为保护措施如何选择的关键原因。该学者建议，如果能够通过社会网络分析找到低档女性性工作者的性关系网络中关键成员，并引导其发挥正向作用，将产生事半功倍的效果，对整个网络的健康行为将产生裨益[27]。我们如果能够进一步将类似的研究成果进行试点，创新地应用到实际工作中，对于探索针对低档女性性工作者的有效HIV干预策略将能够提供重要的科学依据。

3、大力资助和开展有针对性的干预策略和措施。

（1）起草制定如何在低档女性性工作者中开展HIV干预的技术性指南。目前缺乏一个在我国专门针对低档女性性工作者开展HIV干预的技术指南，大部分针对低档女性性工作者开展的干预活动仍然延续着针对普通女性性工作者的干预策略和方法，而这些常规的做法通常无法有效的接触到低档女性女性性工作者，不能切实满足她们的特殊需求。因此，有必要在广泛现场研究和实际工作经验的基础上，制定一个专门针对低档女性性工作者的有效干预指南。

（2）加强针对低档女性性工作的嫖客人群开展艾滋病防治干预工作。前面提到，低档女性性工作者经济上的弱势地位导致其在同客人进行安全套性行为谈判中同样处于弱势地位。许多研究表明，低档女性性工作者不使用安全套的原因中大部分来自于客人，因此，针对低档女性性工作的嫖客人群开展干预工作对于提高安全套使用率，预防HIV的传播具有重要的意义。

（3）加大针对低档女性性工作者的男朋友和固定性伴的干预工作力度。多数研究表明，低档女性性工作者同她们的男朋友或固定性伴安全套使用率远远低于商业性行为中的安全套使用率。而她们所谓的“男朋友”或者“固定性伴”中很多是经常光顾低档女性性工作者的嫖客人群，与这些固定性伴和男朋友的不安全性行为传播和感染艾滋病的风险非常大。因此，一方面需要加强针对低档女性性工作者在这方面的干预宣传和干预力度，另一方面也需要针对她们的固定性伴和男朋友开展干预工作。

（4）加强低档女性性工作者中的咨询检测、阳性预防、关怀和治疗服务。研究表明，低档女性性工作者在感染上性病后，为了赚钱通常会继续从事商业性行为。同时访谈中也发现，一些HIV阳性的低档女性性工作者为了生存也不会因此放弃商业性行为，而这些感染了STD/HIV的低档女性性工作者在发生商业性行为中也不能保证百分之百使用安全套，为HIV的传播发挥了极其重要的作用。目前，在我国的美沙酮维持治疗项目中有针对阳性IDU的重点考虑政策、在MSM人群中有很多CBO专门针对阳性者提供关怀和治疗服务，而在低档女性性工作者人群中，类似的工作和努力则非常有限。因此，应该加强低档女性性工作者的HIV咨询和检测工作，为HIV阳性的低档女性性工作者提供高质量的干预、关怀和治疗服务，促使其采取安全性行为，预防HIV的传播。

（5）加强为低档女性性工作者提供服务的社区组织的支持力度。在针对低档女性性工作者的干预中，CBO发挥了独特的作用，扮演着卫生工作者无法替代的角色，CBO具有工作时间灵活，同目标人群的文化相容性较强等特点，尤其在接触目标人群、取得她们的信任等方面均具有无法替代的优势。然而目前虽然我国在CBO参与方面取得了很大的进展，但主要集中在为其他人群提供服务的CBO，如MSM人群、IDU和普通女性性工作者人群。而针对为低档女性性工作者服务的CBO的支持和资助力度则远远不够，没有得到应有的重视。因此，下一步需要有针对性的加大这类CBO的支持和资助力度，包括能力建设、组织发展和经费支持等，从而让她们更好的为低档女性性工作者提供HIV防治服务。

（6）同普通女性性工作者相比，低档女性性工作者有许多特殊的需求和特点，针对低档女性性工作者开展干预工作时需要作出特殊的考虑，不能照搬传统的策略和做法，针对个别干预措施中的具体技术建议和考虑如下：

1）接触方式：虽然各地的低档女性性工作者组织形式和活动地点有所不同，但是总的来讲，低档女性性工作者隐蔽、分散、场地多变、流动性强，一些农村偏远地区的女性性工作者还地处偏僻，因此，针对女性性工作者开展干预工作最重要的一环，也是最为难开展的一环。有学者针对农村地区女性性工作者低档场所人群及场所特点, 依据这些场所、人群与社会其它部门、人群的关联性, 找准切入点, 在发现农村地区女性性工作者低档场所方面总结出了相关人物引见法、自我观察法、自身体验法、表明身份法和滚雪球法等5种方法[50]，摘录如下以供借鉴：

①相关人物引见法：主要是通过负责管理娱乐场所的相关政府部门职能部门的工作人员进行引见。与娱乐服务场所相关的政府职能部门主要有公安、工商、卫生监督部门, 通过访谈各相关部门的相关人员可以了解到有关的涉性活动的娱乐服务场所, 引见进入涉性场所、接触到场所老板、关键人物和女性性工作者, 帮助干预人员赢得她们的信任和支持。这种方法比较适合首次接触哪些有固定场所、而且有老板组织的低档女性新工作者。此法成败的关键在于取得老板的信任及合作, 老板了解到干预的目的及带给她们的益处后, 干预工作就会顺利开展; 同时还可以吸引合适的相关人物加入到干预队伍中。

②知情者引见：场所周围的居民、平时到场所经常逛的闲散人员, 与场所人员有业务关系者如销售安全套的送货商、到场所送饭、送矿泉水的相关业务员, 场所附近的诊所医生或综合医院相关科室的医生, 这些人对场所及女性性工作者的情况了解较多, 通过他们可确定场所、进入场所, 接触到老板和女性性工作者；租房中介人员, 了解附近居民房屋空闲及出租的整体情况, 也了解当地旅店的情况, 是外来人员入住本地的联络人员, 能够准确定位女性性工作者的场所。

③现场观察法：高危场所的分布依据消费人群的情况而定, 尤其是农村地区的低档场所频繁变迁, 但一定是跟随男性集中的场地和路线变动, 发现女性性工作者场所的重要方法是依据性需求市场的存在。在男性务工人群集中的工厂、矿场、码头、车站附近村庄、村边、乡镇、县城、县城周边以及长卡司机经过的公路沿线多设有高危场所；低档高危场所多设在服务场所, 少数设在娱乐场所, 或起名为保健按摩、洗浴桑拿、足疗按摩、美容、美发、纹身、路边饭店旅社、歌厅、健身房等；有些低档场所没有名称, 这些场所的主要特征是: 集中分布在男性集中的场地附近, 开门营业时间在下午、晚上至深夜, 房间彩灯或昏暗, 场所内女服务员多、小姐妆浓性感、休闲, 室内很少或没有相关的服务工具, 见不到正在做足疗、美发等服务的小姐。干预人员到相关场地观察到具有上述特征的场所可初步定为高危场所, 需要通过其它方法进一步核实确定。

④自身体验法：通过自我观察或知情者介绍待定的高危场所, 可以通过假扮司机或生意伙伴给客户或上司找小姐、假扮嫖客等方式直接进入高危场所, 询问是否提供性服务、性交易价格、是否用安全套、小姐的人数年龄等情况, 女性性工作者面对自己的客户会热情接待、回答上述问题, 依据回答内容确定高危场所。采用自身体验法需要想好充分的理由, 编好台词, 有比较熟练的表演技巧, 设计好脱身、离开场所的方法, 男性干预人员可假扮嫖客和司机, 女性干预人员可假扮帮忙的生意伙伴。

⑤表明身份法：干预人员直接进入高危场所, 从核心人物入手, 直接与老板和服务员对话, 表明干预人员的真实身份和干预工作的目的及方法, 说明干预工作的原则和对她们带来的益处。在一些艾滋病防治大众宣传工作比较深入、普及的地区, 各相关部门能够协调配合, 已有良好的社会氛围和群众基础的地区可采用此种方法。这种方法要求干预人员有熟练的干预技术和良好的心理素质, 以服务的方式进入场所, 以服务的心态与她们沟通, 充分了解她们的需求, 针对需求开展干预工作, 建立良好的信任关系, 用真诚打动她们。这种方法直接、见效快, 能够与高危人群建立长期良好的关系, 可了解到真实的深层次的信息, 传递完整的宣传干预信息, 适用于各类确定的、待定的高危场所。

⑥滚雪球法依据已接受干预的高危场所老板或女性性工作者提供的信息, 发现、确定其它高危场所和女性性工作者。这种方法信息准确可靠；对提供信息者给与适当奖励, 并可作为同伴宣传员和推荐新场所的同伴宣传员协助干预工作；受从众心理影响, 新发现的场所更容易接受、配合干预工作, 推进干预工作深入开展, 扩大干预覆盖面。

2）外展和同伴教育是针对低档女性性工作者一项重要干预策略，有研究表明同伴也是她们获得艾滋病知识的主要途径之一[57]。针对低档女性性工作者开展外展时，不能像固定场所那样一次可以接触到很多人，或者有时可以一起组织许多人一起开展外展活动。多数低档女性性工作者单独租房、站街或者是露天公园等公共场所，在进行外展或者同伴教育时只能一对一进行，一次接触到的目标人群非常有限，因此，为了达到一定的覆盖面，需要招募较多的针对低档女性工作者的外展和同伴人员；有些低档女性性工作者的流动性较大，为了达到一定的干预强度，需要加大外展或同伴教育的干预频率，例如提高到每月干预一次；由于低档女性性工作者的自我保护意识很强、警惕性高，有些低档女性性工作者是有家庭的兼职女性，对隐私等信息更是极其敏感，很难得到她们的信任，因此，开展外展或者同伴宣传的人员一定要来自低档女性性工作者的目标人群，最好是能够招募到来自不同类型的低档女性性工作者作为同伴宣传员，只有这样才能够接触到她们并取得她们的信任，有利于进一步开展行为干预工作；不同场所和类型的低档女性性工作者在流动性、自身特点等方面会有所不同，因此在实施外展和同伴教育时应该对她们进行细分，以便制定不同的针对性策略。在选择同伴教育宣传员时可以考虑因素包括[93]：本人自愿参加，愿意向同伴进行有关健康教育宣传；具有一定的文化水平和理解能力；在该人群中具有一定的影响力；有较强的责任心，有较好的应付特殊情况的能力；善于交流，具备一定的人际交往技巧和组织能力；针对外展人员和同伴需要提供有针对性的培训，包括如何说服客人使用安全套的能力；针对低档女性工作者的外展内容也需要有特殊考虑：例如，增强女性性工作者与“客人”交流并说服客人使用安全套的技巧是外展干预中极为重要的内容、培训她们用嘴戴安全套等有效方法，同时，由于她们的客人数量较大，往往会超出预期，应该鼓励她们每次外出从事商业性行为时需要多带些安全套等。

3）低档女性性工作者普遍受教育水平较低，此外，经常会有些关于防治HIV的错误认识在低档这些人群中流行，针对她们的艾滋病相关宣传材料应该通俗易懂，简单明了，针对性要强。条件允许的情况下，最好能够在实际评估的基础上开发出专门针对当地低档女性性工作者的艾滋病相关宣传材料。

4）低档女性性工作者由于客人较多，频率较大，因此她们更喜欢润滑剂比较多的安全套，这样可以减少对身体的损伤。此外，由于低档女性性工作者经济条件较差，客人数量较大，安全套的支出成本对于她们来讲也不容忽视，经常使用廉价质量差的安全套现象比较常见，因此能否获得免费的、适合她们需求的安全套对于提高安全套的使用率具有重要的意义[83]。也 有研究表明能够免费能到安全套的低档女性性工作者比不能免费得到安全套的低档女性性工作者更能坚持使用安全套[2]。

5）针对普通女性性工作者的社区健康活动中心需要提供有针对性的性病诊治、生殖健康或者其他身体检查等服务才能吸引低档女性性工作者前来接受服务。低档女性性工作者的时间安排比较紧张，虽然时间由自己安排，不想场所里面的性工作者由娱乐场所老板进行管理，但是她们却没有闲暇的时间外出参加活动。由于每日接客量大，只要有时间她们就会随时出去寻找或者等待客人，对于她们来讲，“时间就是金钱”，因此她们非常珍惜时间，很少有闲暇时间参加活动中心定期举办的各种宣传教育等活动，此外，她们对于距离和交通路费也比较敏感。而访谈中发现，也有很多低档女性性工作者定期去活动中心，她们最主要目的就是接受那里开展的免费健康体检、生殖健康服务或者性病诊治服务等，也有去活动中心是为了那里的免费洗浴。尤其是性病服务和健康体检对她们具有非常大的吸引力，在有的性病门诊（同时提供健康体检）甚至发现外展中能够接触到的低档女性性工作者人数比直接来门诊接受服务的人数要少。因此，针对低档女性性工作者的健康活动中心需要进行专门的设计和考虑才能够提高活动中心的利用率 ，一定要同性病服务、生殖健康服务或者健康体检等服务相结合，这样才能够对她们有一定的吸引力。

6）定期为低档女性性工作者提供咨询和检测服务，早期发现感染者并提供关怀和治疗服务对于防止低档女性性工作者中HIV的传播具有重要意义。但是在实施检测时需要做出一些特殊的考虑，例如，针对街头、公园等公共场所的低档女性性工作者很难开展现场快检，因为难以找到一个方便和能够保证隐私的场所。低档女性性工作者多数为流动人口，在提供日常的咨询检测服务同时，如果能够结合她们自身特点开展有针对性的动员检测服务会取得较好的效果，例如，在每年春节或其它重大节假日时她们回家之前提供检测、在她们结婚之前等特殊时候提供有针对性的咨询检测服务，一般会得到她们的支持和认可。此外，由于低档女性性工作者对隐私的特殊敏感性，在动员她们进行检测时需要做出特殊的说明和保证。

### 关于服务于低档女性性工作者CBO的发展

在针对低档女性性工作者的干预中，CBO具有重要的地位和作用，可以发挥卫生工作者无法替代的角色，例如，CBO具有工作时间灵活、同目标人群的文化相容性较强、可以接触到防范心理极强的低档女性性工作者、容易获得她们的信任并开展HIV防治工作等独特的优势。因此，作为CBO组织应该充分意识到自身应该扮演的角色，扬长避短，才能使本组织获得可持续性发展和壮大，才能在艾滋病防治工作中发挥应有的作用和做出最大的贡献。结合当前为低档女性性工作者提供服务的CBO发展现状和存在的挑战，针对CBO未来发展方面提出以下建议：

1、CBO需要向专业化方向发展，需要高质量的参与。CBO在中国得到了前所未有的发展和重视，他们的作用和贡献已经在一定程度上得到了政府的认可。然而，随着重视程度的增加，社会上对CBO的期望和要求也不断提高，他们需要承担的责任和义务也不断增加。未来CBO在HIV防治方面的参与不仅仅局限于最初的简单参与，而是需要更加专业化和高质量的参与。因此，CBO自身的组织发展也需要迫切适应新形势下的要求和挑战。对自身的组织发展和业务水平应该有一个长远和战略性规划，包括组织构架、人员队伍建设、专业能力、业务领域和财务管理等一系列领域的规划和加强。在为低档女性性工作者提供服务的CBO专业化发展方面尤其需要关注以下几点：

（1）专业化人才队伍建设将是CBO可持续性发展的重要保证。较高的CBO专业化程度将会更有利于可持续性发展，而专业化发展将极大地依赖于较高素质和能力的专业化人才队伍建设。包括高素质的工作人员招募和管理、志愿者招募和管理、员工薪酬奖励机制的制定实施等。如果单纯依赖于来自目标人群的CBO工作人员将会难以满足CBO的发展和实际工作需要，尤其是那些完全由来自低档女性性工作者组成的CBO组织将会面临更大的发展挑战。因此，CBO需要提前做好准备，考虑和制定相应的人才队伍建设计划。

（2）专业技术能力和高质量服务是CBO可持续性发展的重要前提。随着CBO的深入参与和对CBO重视程度的增加，未来对CBO的服务质量要求和产出标准将会逐步提高。而对CBO的资助经费将逐渐由国际援助转向中国政府的经费资助，以结果为导向的经费管理很可能是政府部门的一项重要考虑，必将向CBO要质量和要效果。因此，CBO应该有意识的积极提高自身专业技术能力，强化服务质量意识和提高服务质量，建立起对所使用经费负责的机制，关注经费的使用效果和质量，只有这样的CBO才能逐步得到认可和更多的经费资助，才能具有可持续性发展的潜力。

（3）特色服务和业务专长对于CBO可持续性发展将具有重要意义。随着不同领域CBO数量的不断壮大，优胜劣汰必将成为CBO发展所面临的一个必然选择。而目前为低档女性性工作者提供服务的CBO数量仍然有限，因此对于这些CBO将是一个重要的发展契机。这些CBO应该进一步加强自身为低档女性性工作者提供服务的业务能力，强化和突出自身的业务特长和专业化特点，不断探索创新的服务模式，例如，可以积极探索为低档女性性工作者提供HIV防治服务的有效模式、探索如何针对低档女性性工作者客人提供HIV防治服务的有效模式等，这样才能逐步树立本机构的技术领域权威和声望，有利于申请到更多的经费资助提供服务和进行组织发展建设。

2、政府购买服务将是CBO可持续性发展的重要途径。大量国际援助经费逐步停止和撤离中国，2013年底CBO将面临极其严峻的经费短缺和生存挑战。然而幸运的是中国政府已经承诺将由政府经费来弥补相应的CBO经费空缺，因此，未来CBO的可持续性发展将极大的依赖中国政府的资助。为此，CBO必须要未雨绸缪，积极的做好从国际经费援助的模式转向由中国政府资助的模式。不同的资助来源对于经费申请渠道、申请资格、管理方式和使用要求等方面均会有所不同，CBO一定要积极学习了解中国政府经费的申请要求和管理模式，提前做好准备。

3、建立公开透明的财务管理制度和体系。资金安全几乎是所有资助方首先关注的重点，一个完备的财务管理体系和制度对于获得资助方的信任和认可至关重要，对于成功申请到项目经费甚至起到一票否决的作用，同时对于确保项目经费的合理使用和成本效益也具有重要意义。因此，CBO应该积极建立和加强本组织的财务管理体系和能力，确保公开透明，符合各种资助方的要求。

4、做好随时进行注册的准备。未来CBO的可持续性发展将在极大程度上取决于中国政府的经费资助情况，因此，CBO需要提前做好准备，详细了解中国政府经费的申请要求和管理规定。虽然目前我国尚未出台关于未来CBO经费申请和管理的相关规定，但是根据以往情况分析，中国政府经费的管理对于资金安全要求很高，通常需要具有合法的银行账户，专款专用，拥有合法身份很可能是CBO申请政府经费的一个重要优势或者要求。虽然注册不一定是获得合法银行账户的唯一选择，但是可以预见，中国政府对CBO民政注册将会持有更加开放和支持的态度，如果能够通过注册拥有一个合法的CBO身份和地位，对于组织的发展将会起到积极的促进作用。

5、积极寻求和建立外部的技术支持网络。随着社会对CBO的关注不断增加，CBO参与HIV防治工作的服务质量将成为关注的重点。在提高服务质量方面单纯依靠CBO自身的努力和能力是远远不够的，根据国际项目的经验表明，可靠的外部技术支持对于改进项目的实施效果和确保服务质量具有重要的意义。因此，如果CBO能够通过各种途径和努力寻求和建立一个有效的外部技术支持途径和渠道，其必将成为本组织的独特优势，对组织的长远发展必将发挥积极作用。

### 关于中国性工作者组织网络平台的发展

目前中国性工作者机构网络平台是国内性工作者组织的一个主要发声渠道，该平台的存在对于扶持成员机构发展，改善性工作者职业健康环境，政策倡导等方面具有积极的作用和意义。

目前该平台的生存和发展存在严峻的挑战，首先面临的最大挑战，也是最核心的挑战就是运转经费。自从2012年开始就已经没有日常运转经费来源了，该平台唯一的工作人员工资也只能靠其它组织的资助来维持，该平台无法开展常规性活动，只能偶尔以平台的名义申请单独的研究调查等小额项目。此外，由于没有经费资助，平台也无法保证足够的人员投入来开展相应活动和提供服务，形成了恶性循环。考虑到平台目前的发展现状和现实困难，本文作者针对平台的未来发展方向提出以下建议：

1、鉴于目前平台面临的经费困难，维持当前的运作模式是一个比较现实的选择，即，只保留一人兼职负责平台的相关事务，围绕平台的需求和所关注的技术领域申请相应的经费为特定的活动提供支持。

2、为了维持和提升平台的凝聚力和更好的为平台成员提供服务，在目前人员非常有限的情况下，平台可以考虑适当的定期开展一些人力投入不需要太多的活动，例如，定期检索并与成员分享有关国内外关于女性性工作和艾滋病等方面的最新动态、各种项目招投标信息、政策法规、技术指南、研究成果等。此外，在为成员提供服务时，应该考虑根据不同成员的能力水平和发展现状提供一些有针对性的个性化服务。

3、未来该平台可以考虑建立一个成员间的资源整合与信息分享机制。目前平台拥有的资源非常有限，但是很多平台成员具有较多的资源，因此，可以考虑在成员之间建立一个可以相互分享和利用彼此资源和信息的渠道，这样既在一定程度上环节了平台资源短缺的矛盾，同时也为成员提供了一个扩大其自身影响和为其它成员提供服务的机会。建立该机制时应该考虑如何增加一些激励措施来鼓励成员积极支持和参与资源整合与信息分享机制。这些可供分享的资源和信息可以包括：可以提供培训的师资资源、资助一些小范围调查研究的经费、各种关于女性性工作和艾滋病等方面的最新动态、项目招投标、政策法规、技术指南、研究成果、项目实施和进展等信息、成员间的需求与合作方面的信息等。

4、目前该平台的战略规划是2010制定的一个两年发展规划，随着最近几年国内艾滋病防治工作环境和形式的发展变化，该战略规划已经过时，不能为平台的发展提供指导，实际上平台目前没有战略规划。因此，在条件允许的情况下，可以考虑制定平台新的战略规划，结合最新的艾滋病防治形势，以便为平台的未来发展提供现实可行的指导作用。同时考虑审阅和修订该平台于2010年制定的章程。

5、目前平台只有14个成员组织，在规模方面还算不上较大，可以考虑适当的扩大成员规模，增加平台成员的多样性，通过提供有吸引力的服务等方式来吸引更多成员加入。这样有助于提升平台的影响力和知名度，建立代表性更强更广泛的平台，可以更大范围的共享资源和信息，可以更好的整合与利用成员的资源和力量提供各种服务。

6、在对外提升平台的国际和国内影响力和声誉方面，平台需要提升自身的技术力量和能力，争取借助专家和业务研究成果的力量逐步把自己塑造成为女性性工作者包括低档女性性工作者艾滋病防治领域的权威和标志性机构。平台应该尽可能的申请经费来组织相关专家开展有关防治策略、方法、技术指南、倡导等方面的前沿研究并及时发布和分享研究成果，提升平台的影响力和声誉。尤其是在逐步把自己塑造成一个中国女性性工作者的最大发声平台方面需要投入更多的努力。

7、未来平台的业务方向和战略定位可以考虑以下方面：

（1）进一步加强为成员提供服务的意识和努力，设计和增加常规性的服务活动，提升平台的凝聚力和吸引力，主要包括：通过多种渠道分享各种信息服务；能力建设服务，尤其是刚刚成立的女性性工作者组织提供能力建设和技术指导服务；机构发展支持服务；融资信息与合作等方面的支持服务等；平台应该进一步发挥国际网络的优势为成员提供国际经验、研究动态、经费资助等方面的信息和支持。

（2）关于女性性工作者艾滋病防治和CBO相关的宏观倡导，具体包括：优先防治和需要特殊关注的技术领域；为女性性工作者提供服务的CBO生存发展环境；宏观的政策法规、弱势保护和群体援助等。

（3）关注女性性工作者防治工作领域的最新科研动态和进展。科研能力和科研成果无疑是提升平台影响力和生存能力的最佳途径，但是不一定要求平台人员本身一定具备这样的能力，平台可以利用自身的国际网络优势和平台国内影响优势组织协调专家、申请经费、与成员合作等途径合作开展各种前言的科研项目和活动，分享研究成果，提升平台的影响力和筹资发展能力。

（4）帮助成员建立统一的外部技术支持网络和提供能力建设机会。未来对CBO的要求和期望也越来越高，对CBO服务质量的关注会越来越多。然而单纯依靠CBO本身来提高服务质量是远远不够的，如果能够利用平台的国内外网络优势和影响力，帮助所有成员建立一个统一的外部技术支持和能力建设机制与网络不仅能够提升平台的影响力和贡献，而且可以满足成员的需求和提升她们的业务能力，有助于平台和成员的可持续性发展。

（5）平台的融资渠道需要多样化，可以考虑以下几个方面的尝试：

1）依靠平台自身的力量和影响力独立申请国际项目资助；

2）利用自身的国内外联系网络渠道广泛获取各种项目招投标信息，确定研究方面和成员组织联合申请经费，这样既可以发挥平台的宏观影响力和网络优势，又可以发挥成员机构的一手现场经验和实体组织的优势；

3）利用平台的信息优势和国内外网络优势，在国际资助方和成员单位之间发挥桥梁和纽带作用，充当协调组织的角色，协助资助方和成员单位实施方共同完成项目的执行；

4）通过为成员单位提供个性化服务和综合性服务收取必要的服务费用或者会员费用等途径获取平台的运作经费。

# 本报告的局限

首先，本报告主要依赖于公开可以获得的文献资料和项目报告等资料进行分析和总结，然而，在这方面可以获得的具有足够细节信息的资料非常有限，很多重要资料和信息都无法得到。几乎所有资助女性性工作者的项目中，低档女性性工作者均不是一个独立的目标人群，因此，涉及到低档女性性工作者的信息几乎没有，如，关于针对低档女性性工作者的覆盖面和相关产出指标、关于干预低档女性新工作者的具体实施情况和困难等信息。

其次，CBO相关定量信息非常缺乏，尤其关于低档女性性工作者CBO的信息几乎没有，因此本报告中涉计到的相关问题无法进行较深入的定量分析和评估，如CBO提供服务的覆盖面、服务质量和效果等方面的数据。

再次，多数项目都有很多内部资料和研究成果没有被公开发表或者无法通过公开渠道获得，即使作者拥有这些资料也无法使用，因此，在一定上影响了本报告对最新资料的全面利用。

最后，同样由于很多项目没有公开的最终报告和项目执行细节情况，因此，本报告中并不能穷尽其它在国内开展的针对低档女性性工作者的艾滋病防治项目和经费援助，只是挑选了一些最具有代表性和规模较大的项目作为参考。

# 附录

## 附录1：访谈提纲（CBO成员）

|  |  |  |
| --- | --- | --- |
| **编号** | **问题** | **回答** |
| 1 | 您认为低档女性女性工作者在哪些方面同其他小姐有明显的不同的特点（例如，服务场所、居住场所、老板管理、服务方式、收费情况、收入情况、客人情况、安全套使用情况、个人文化经济背景等情况）？ |  |
| 2 | 她们主要在哪些场所做生意？为什么？客人都是哪些人群？经常在什么时间做生意？ |  |
| 3 | 她们安全套使用情况如何？在使用安全套方面有哪些障碍（个人方面、客人方面、其它方面）？怎样才能保坚持每次是使用安全套？坚持使用安全套的困难是什么？是否有过安全套破裂的情况？她们的安全套一般从哪里获得的？ |  |
| 4 | 你们组织目前针对低档女性性工作者开展了哪些工作？针对低档女性性工作者提供这些服务时有什么特殊的考虑吗？她们的主要需求是什么？在开展工作的是如何进行督导和评估的？收集哪些资料？如何收集和利用的？ |  |
| 5 | 你们认为针对低档女性性工作者开展干预工作的要点是什么？难点是什么？有什么经验教训吗？ |  |
| 6 | 在针对低档女性性工作者开展艾滋病防治工作方面，你认为社区组织有哪些不可替代的优势和作用？如何更好的发挥社区组织的作用？ |  |
| 7 | 曾经和目前正在接受的资金来源、资金数量、未来一年预期的经费需求、来源和数量、缺口等情况如何？针对低档女性小姐的干预经费主要来自哪里？ |  |
| 8 | 你们在开展低档女性性工作者艾滋病防治工作中有哪些困难？未来需要哪些帮助？ |  |
| 9 | 中国性工作者组织网络曾经提供过哪些帮助？可以进一步发挥哪些作用？你们需要她们提供什么样的支持？你们组织对于这个平台的发展起到了什么作用？对平台的发展如何进一步发挥你们组织的作用和贡献？ |  |
| 10 | 中国在针对低档女性性工作者的艾滋病防治方面，你们有哪些建议？ |  |
| 11 | 你们组织的未来发展方面存在哪些困难和挑战？你认为你们组织的能力如何？在能力建设方面有哪些不足和需求？未来的组织发展方面需要哪些帮助？ |  |

## 附录2：访谈提纲（目标人群）

|  |  |  |
| --- | --- | --- |
| **编号** | **问题** | **回答** |
| 1 | 您认为低档女性女性工作者在哪些方面同其他小姐有明显的不同的特点（例如，服务场所、居住场所、老板管理、服务方式、收费情况、收入情况、客人情况、安全套使用情况、个人文化经济背景等情况）？ |  |
| 2 | 你们主要在哪些场所做生意？为什么？客人都是哪些人群？经常在什么时间做生意？ |  |
| 3 | 你们安全套使用情况如何？在使用安全套方面有哪些障碍（个人方面、客人方面、其它方面）？怎样才能保坚持每次是使用安全套？坚持使用安全套的困难是什么？是否有过安全套破裂的情况？她们的安全套一般从哪里获得的？ |  |
| 4 | 你们劝说过客人使用安全套吗？怎么劝说的？有什么困难？他们一般用吗？为什么？ |  |
| 5 | 过去一年你们接受过哪些艾滋病防治服务？哪些组织提供的？你们觉得这些服务如何？在获得这些服务方面有什么困难吗（干预、检测咨询、治疗关怀等）？如何改进这些服务？ |  |
| 6 | 你们认为针对低档女性性工作者开展干预工作的要点是什么？难点是什么？有什么经验教训吗？ |  |
| 7 | 在针对低档女性性工作者开展艾滋病防治工作方面，你认为社区组织有哪些不可替代的优势和作用？如何更好的发挥社区组织的作用？ |  |
| 8 | 你们认为在开展低档女性性工作者艾滋病防治工作中有哪些困难？你们最关注什么？有哪些主要的需求？ |  |
| 9 | 中国在针对低档女性性工作者的艾滋病防治方面，你们有哪些建议？ |  |

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English Part

英文部分

Table of Content

[1. Acknowledgements 1](#_Toc371272766)

[2. Abbreviations 2](#_Toc371272767)

[3. Abstract 3](#_Toc371272768)

[4. Background 8](#_Toc371272769)

[5. Purposes of This Report 9](#_Toc371272770)

[6. Method and Materials 10](#_Toc371272771)

[7. The Name for *Females Providing Commercial Sex Service and Low-Tier Female Sex Workers* in China 11](#_Toc371272772)

[8. Definition of Low-Tier Female Sex Workers 13](#_Toc371272773)

[8.1 Define by the Location Where Female Sex Workers (FSWs) Solicit Clients and Provide Service 13](#_Toc371272774)

[8.2 Define by the Price per Commercial Service Provided by Female Sex Workers 14](#_Toc371272775)

[8.3 Define by Female Sex Workers’ Income 15](#_Toc371272776)

[8.4 Define by Female Sex Workers’ Frequency of Serving Clients, etc. 15](#_Toc371272777)

[9. Low-Tier Female Sex Workers’ Population Size and Features 17](#_Toc371272778)

[9.1 Low-Tier Female Sex Workers’ Population Size Estimation 17](#_Toc371272779)

[9.2 Social Demographic Features 17](#_Toc371272780)

[9.3 Mobility 18](#_Toc371272781)

[9.4 Low-Tier Female Sex Workers’ Clients 18](#_Toc371272782)

[9.5 Frequency of Serving Clients 19](#_Toc371272783)

[9.6 Awareness Rate of HIV/AIDS Knowledge 19](#_Toc371272784)

[9.7 Self-Cognition of HIV Infection Risk 19](#_Toc371272785)

[9.8 Low-Tier Female Sex Workers’ Drug-Use Behavior 20](#_Toc371272786)

[9.9 Condom Use 20](#_Toc371272787)

[9.10 Infection Rate of STDs 21](#_Toc371272788)

[9.11 Infection Rate of HIV 22](#_Toc371272789)

[9.12 Health-Seeking Behavior 23](#_Toc371272790)

[9.13 Intervention Coverage and Related Indexes 23](#_Toc371272791)

[9.14 Situation of HIV Testing 23](#_Toc371272792)

[9.15 Monitoring Low-Tier Female Sex Workers 24](#_Toc371272793)

[9.16 Low-Tier Female Sex Workers’ Impacts on HIV Prevalence 24](#_Toc371272794)

[10. Common HIV Prevention and Intervention Strategies for Female Sex Workers in China and Abroad 27](#_Toc371272795)

[11. Current Intervention Situation among Low-Tier Female Sex Workers in China 35](#_Toc371272796)

[11.1 High Risk Group Intervention Team 35](#_Toc371272797)

[11.2 Comprehensive Demonstration Area Project 39](#_Toc371272798)

[11.3 Global Fund HIV/AIDS Projects 40](#_Toc371272799)

[11.4 Other International Projects 42](#_Toc371272800)

[12. Situation of Community-Based Organizations (CBOs) Providing Services for Female Sex Workers in China 45](#_Toc371272801)

[13. Challenges and Suggestions of HIV Prevention Work among Low-Tier Female Sex Workers 48](#_Toc371272802)

[13.1 Gap Analysis 48](#_Toc371272803)

[13.2 Difficulties and Challenges 49](#_Toc371272804)

[13.3 Suggestions 52](#_Toc371272805)

[13.3.1 HIV/AIDS Prevention among Low-Tier Female Sex Workers 52](#_Toc371272806)

[13.3.2 Development of Community-Based Organizations (CBOs) Providing Services for Low-Tier Female Sex Workers 58](#_Toc371272807)

[13.3.3 Development of China Sex Worker Organization Network Forum (CSWONF) 60](#_Toc371272808)

[14. Limits of This Report 64](#_Toc371272809)

[15. Appendix 65](#_Toc371272810)

[15.1 Appendix 1: Interview Outline (CBO Members) 65](#_Toc371272811)

[15.2 Appendix 2: Interview Outline (Target Group) 67](#_Toc371272812)

[16. References 68](#_Toc371272813)

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2. Abbreviations

AIDS Acquired Immune Deficiency Syndrome

CBO Community-Based Organization

CSW Commercial Sex Work/Worker

CSWONF China Sex Worker Organization Network Forum

FSW Female Sex Worker

HIV Human Immunodeficiency Virus

IDU Injected Drug User

MSM Man who has Sex with Man

NCAIDS National Center for AIDS/STD Control and Prevention

NGO Non-Governmental Organization

RCC Global Fund Rolling Continuation Channel

STI/STD Sexually Transmitted Infection/Disease

UNAIDS Joint United Nations Programme on HIV/AIDS

UNFPA United Nations Fund for Population Activities

VCT Voluntary Consulting and Testing

3. Abstract

Female Sex Workers (FSWs) are high risk group of HIV/AIDS transmission and infection. “Low-income female sex workers” or “low-tier female sex workers” are especially at high risk, comparing to other female sex workers. Low-tier FSWs have different organization forms in different places. But usually it includes street-based FSWs, and FSWs of low-tier barbershops, roadside parlors, low-tier motels, rural or remote areas, etc. These FSWs have relatively low service price, and low income. They are usually old aged, mostly married, less educated, very mobile. Their clients usually have low income. These FSWs serve clients more frequently and serve larger number of clients. Their knowledge about HIV/AIDS is low. They lack of the awareness of HIV infection risk. More of them are using drug. Their condom-use rate is low. Their infection rate of STDs and HIV/AIDS is high. They have more wrong health-seeking behaviors. They accept fewer interventions including HIV testing.

Generally speaking, comparing to regular FSWs, the features of low-tier FSWs related to HIV/AIDS prevention and intervention can be concluded into “Three *More*’s and One *Fewer*”. Firstly, these FSWs’ infection risks are *more*. They have lower education level, lower self-protection awareness, less HIV/AIDS knowledge, lower awareness of HIV infection risk, lower condom-use willingness among their clients, more risk behaviors, lower condom-use rate among themselves, etc., which all tremendously increase their HIV infection risk. Secondly, these FSWs’ HIV transmission risks are *more*. They have higher infection rate of STDs and HIV/AIDS, more instances of still continuing commercial sexual behavior after infection, lower health protection awareness among clients, lower condom use rate with both commercial sexual partner and regular sexual partner, which give them more risks of continuing the HIV transmission after being infected of HIV. Thirdly, the groups transmitted by these FSWs after their infection of HIV and STDs are *more*. Most low-tier FSWs’ client amount and commercial sexual behavior amount are more than regular FSWs, and the amount and percentage of their unprotected sexual behavior are more, so the potential groups being infected by these FSWs are more. Lastly, these low-tier FSWs have *fewer* opportunities to receive the intervention. They are very mobile, invisible, more conscious of self-protection, not easy to be reached. Their risks are not being emphasized now, and the intervention coverage range is low. These all make many low-tier FSWs not covered by routine intervention activities. This “Three *More*’s and One *Fewer*” is closely related and interacted. Therefore, low-tier FSWs have been a vital group of HIV transmission.

Nowadays, HIV/AIDS prevention and intervention work among low-tier FSWs in China has lots of disadvantages, including lack of strategy information on low-tier FSWs, not enough intervention coverage and strength, low intervention quality, etc. HIV/AIDS prevention and intervention work for this group in the future will also be confronted with multiple difficulties and challenges, such as constructing supportive environment, building intervention teams accordingly, lack of intervention capability, and challenges of technical strategy and measure in implementing specific intervention work. Especially low-tier FSWs’ own features make the HIV/AIDS prevention and intervention work among them very difficult, which can be summarized as “Four *Difficulties*”. Firstly, these FSWs are *difficult* to find. Many low-tier female sex work establishments do not have a clear sign. They are very mobile, and their organizing form is relatively hidden. So they are hard to find. Secondly, it is *difficult* to communicate with these FSWs. Their self-protection consciousness is very strong, so it is hard to gain their trust. It takes a long time to gradually gain their trust and conduct the intervention through their familiar core peers. Thirdly, it is *difficult* to conduct intervention among these FSWs. They are scattered, and their establishments are plain or even outside. So some intervention measures and activities are very hard to implement, such as on-site consulting and testing. In addition, they are more willing to make money, and do not have much spare time, so they do not have time to attend routine intervention activities. Lastly, it is *difficult* to change their behavior. Low-tier FSWs are more vulnerable, and their economical disadvantage status is obvious. So their acceptance of safe sexual behavior is restricted by multiple conditions, and it is hard to change their risk behavior through intervention solely on themselves. For example, in most conditions, their condom use depends on clients’ willingness, and these FSWs usually disregard safe sexual behavior driven by money.

Either in China or in other countries, there is no systematic, effective intervention strategy and measure for low-tier FSWs. Most projects still use the intervention measures for regular FSWs to conduct their work. But these conventional measures are very difficult to have good effect on low tier FSWs. In China, HIV/AIDS prevention and intervention work among low-tier FSWs has lots of disadvantages:

1. FSW HIV sentinel point monitoring data cannot reflect low-tier FSWs’ real status. Low-tier FSWs’ condom use rates from investigations and studies are usually lower than the sentinel point monitoring results, but HIV/STD infection rates are often higher than the sentinel point monitoring results. We still lack representative data for the overall situation of low-tier FSWs in China.

2. There is no strategy or guidance specialized for HIV prevention and intervention among low-tier FSWs on the country and project levels.

3. Neither enough emphasis nor enough investment is placed on HIV prevention and intervention among low-tier FSWs. As mentioned above, most strategies in several major large-scale intervention projects for low-tier FSWs in China are originally for regular FSWs.

4. Current HIV intervention coverage and strength among low-tier FSWs is far from enough. National and international major large-scale intervention projects for FSWs include high risk group intervention team, comprehensive demonstration area, every round of Global Fund and other international collaborative projects, and on-going Round 2 comprehensive demonstration area and Global Fund RCC HIV/AIDS projects. The strategies and activities in these projects can only intervene in mostly regular FSWs, and cannot effectively reach low-tier FSWs. Even those low-tier FSWs who do be covered are minor, and the coverage is very limited. In addition, the scale of international projects specialized for low-tier FSWs is very small. For example, USAID projects for low-tier FSWs are only limited to individual project point Guangxi Luzhai, Yunnan Gejiu, etc. Oxfam projects for low-tier FSWs are also limited to individual community-based organization. In sum, current coverage for low-tier FSWs in China is very limited. High risk group intervention team is not mentioned anymore, and international projects are going to end. Only comprehensive demonstration area is led by the government. But the fund for low-tier FSWs in comprehensive demonstration area is very limited. So low-tier FSWs are faced with severe intervention gap. Not only is the coverage for low-tier FSWs very limited, but also the intervention for them is likely to be sold out.

5. CBOs providing HIV intervention services for low-tier FSWs need to be further improved. Currently CBOs who can provide services for low-tier FSWs have several obstacles, including: the amount of CBOs is far from enough, and most of them concentrate in the urban area; CBOs’ scale is relatively small, and the number of target groups that they cover is very limited; CBOs’ capabilities are not enough, which cannot satisfy low-tier FSW intervention demand; With lots of international projects and funding dropped out of China, CBOs will be faced with severe shortage of funds, especially the risk of HIV intervention fund for low-tier FSWs being sold out.

With the fund of some international projects, CBOs in China have developed a lot in recent years. CBOs targeting FSWs have also made great progress. But the situation of CBOs targeting low-tier FSWs is not optimistic. The number of these CBOs is very limited. Most of them are providing service for all tiers of FSWs, and providing service for low-tier FSWs is only part (a small part for many CBOs) of their activities: they did not make specialized design or good efforts to provide service for low-tier FSWs. Most CBOs concentrate in the urban area, and there is almost no CBO in the remote rural area with low-tier FSWs. They have small scale, and cover relatively few low-tier FSWs. In these organizations, except for individual organization which is taken charge by health professionals, most organizations lack capabilities and need improvements. In addition, shortage of funds is the largest challenge that these organizations are faced with. Not only is intervention fund for low-tier FSWs extremely insufficient, most organizations cannot guarantee their own survival and development funds.

China Sex Worker Organization Network Forum (CSWONF) is founded by 12 organizations being engaged in sex worker intervention, in Kunming, Yunnan, in February 2009. Now CSWONF has 14 member organizations. It is an important voicing channel for sex worker organizations in China. However, CSWONF’s survival and development are faced with severe challenges. It has had no source for routine operating expenses since 2012. The salary of the only staff in CSWONF can only be funded by other organization. CSWONF cannot operate routine activities, so it only occasionally applies for micro-projects of separate investigation or study in the name of CSWONF.

Given the above conditions and current situation, the author would like to provide the following suggestions for HIV/AIDS prevention and intervention among low-tiers FSWs, the future development of CBOs targeting low-tier FSWs, the future development of CSWONF, etc.:

The suggestions for intervention strategies and measures for low-tier FSW are: 1. Strengthen the low-tier FSW monitoring work. 2. Strengthen supporting applied research on low-tier FSWs, including intervention strategy, high risk behavior, group scale, intervention coverage, etc. 3. Draft technical guidance about how to launch HIV intervention among low-tier FSWs. 4. Enhance the attention degree of HIV prevention and intervention among low-tier FSWs, and strengthen the political and financial support. 5. Reinforce HIV/AIDS prevention and intervention work targeting clients of low-tier FSWs. 6. Increase intervention strength targeting low-tier FSWs’ boyfriend and regular sexual partners. 7. Enhance consulting and testing, positive prevention, care and treatment service for low-tier FSWs. 8. Enhance the support for CBOs targeting low-tier FSWs. 9. Given low-tier FSWs’ special needs and features, make special technical considerations in the intervention work; please see technical details later in the paper.

The suggestions for the development of CBOs targeting low-tier FSWs are: 1. CBOs need to develop to the direction of professionalism, and need high-quality involvement. 2. Government buying service will be an important approach for CBO’s sustainable development. 3. Professional technical capabilities and high-quality service are an important premise of CBO’s sustainable development. 4. Characteristic service and professional skills will be of significance to CBO’s sustainable development. 5. Build an open and transparent financial management system. 6. Professional team building will afford an important guarantee for CBO’s sustainable development. 7. Be prepared to register in any time. 8. Actively search and build outside technical support network.

The suggestions for the development of CSWONF are: 1. In view of CSWONF’s shortage of funds, maintaining current operating model is a realistic choice. 2. Enhance activities and efforts of providing service for members. 3. In the future, CSWONF should consider building a system of resource integration and information share and communication among members. 4. If conditions permit, consider re-making CSWONF’s strategy plan, reviewing and revising CSWONF regulations made in 2010. 5. Consider augmenting member size, increasing member’s diversity, and attracting more members by providing attractive services and so on. 6. CSWONF should improve its own technical capabilities, try to gradually shape itself as an authoritative and representative organization of HIV/AIDS prevention and intervention among FSWs including low-tier FSWs, based on experts’ and its own research results. 7. The future operation direction and strategy plan of CSWONF can be: (1) further enhancing the awareness and efforts of providing service for members, designing and increasing routine service activities, to promote CSWONF’s cohesion and attraction; (2) implement macro-advocacy activities about HIV prevention and intervention among FSWs, and CBOs; (3) Pay attention to the latest academic trend and progress in FSW intervention area, and improve CSWONF’s influence and survival abilities by academic activities and publications; (4) Help members build a unified outside technical support network; (5) CSWONF’s financial channels need diverse development.

4. Background

In 2011, 63.9% of the estimated 780,000 infected persons in China were infected through sexual transmission, which was 4.9 percentages more than the 59.0% in 2009. Heterosexual transmission increased from 44.3% in 2009 to 46.5% in 2011. Among heterosexual transmission, about 1/4 was spousal sexual transmission, 3/4 was non-spousal sexual transmission. Among the estimated 48,000 newly infected persons in 2011, sexual transmission increased from 75.7% in 2009 to 81.6% in 2011, in which heterosexual transmission was 52.2%: 10 percentages more than 42.2% in 2009 [1]. Heterosexual HIV transmission and infection is still the principle pathway of HIV prevalence in China. In heterosexual HIV transmission and infection, low-tier female sex workers (FSWs) are playing the most important role; and their potential impact on and driving of HIV prevalence is obvious. Plenty of research finds that low-tier FSWs are an important high risk group of HIV transmission and infection. Street-based FSWs in the urban area are usually the HIV transmission bridge for migrant workers and local residents [2-5].

The intervention targeting FSWs in China now is mostly concentrating on middle or upper tier FSWs, while HIV/AIDS prevention and intervention for low-tier FSWs is faced with many severe difficulties and challenges, such as not enough attention in general, very limited resources and funds invested, lack of effective intervention strategies, very limited coverage, etc. With lots of international funds stopped and dropped out of China, HIV/AIDS prevention and intervention for low-tier FSWs in China is confronted with more severe gap.

With the coordination and cooperation of China Sex Worker Organization Network Forum (CSWONF), UNAIDS through Technical Support Facility for Asia Pacific (TSF) selected and supported outside experts by open bid, in order to fully analyze the current situation of HIV/AIDS prevention and intervention for low-tier FSWs in China, and understand the current situation of CBOs who are providing HIV/AIDS prevention and intervention service for low-tier FSWs, which will provide reference proposals and foundations for making strategies of HIV/AIDS prevention and intervention among low-tier FSWs in China, and propose future development suggestions for CSWONF and CBOs targeting low-tier FSWs.

5. Purposes of This Report

This report has three purposes:

1. To analyze the current situation of low-tier FSWs in China, including group features, high risk behaviors, etc.; the current situation, difficulties and challenges of HIV/AIDS prevention and intervention; and then propose suggestions for HIV/AIDS prevention and intervention among low-tier FSWs in China.

2. To understand the situation of CBOs who are providing HIV/AIDS prevention and intervention service for low-tier FSWs, and then propose future development suggestions.

3. To analyze and understand the situation of China Sex Worker Organization Network Forum (CSWONF), and propose suggestions for its further development.

6. Method and Materials

This report is mainly based on reading and summarizing the large amount of literature search and other related materials collection. Chinese literature search was mainly done on China National Knowledge Infrastructure (CNKI). Major Chinese keywords used in literature search are individual keyword or different combination of keywords: “low tier”, “low income”, “low price”, “female sex worker”, “female sex service provider”, “sex worker”, “sex service female”, “sex service personal”, “sex service miss (xiao.jie)”, “unlicensed prostitute (an.chang)”, “prostitute (mai.ying.nv)”, “low-tier prostitute”, “street-based prostitute”, “brothel-based prostitute”, “HIV”, “AIDS”, etc. After screening article titles of the search results, the author confirmed 67 Chinese articles related to this research. The English keywords the author used in PubMed/MEDLINE are: “female sex workers + HIV”, “low-income female sex workers”, “brothel-based female sex workers”, “direct female sex workers”, “street-based female sex workers”, etc. After screening the search results, the author selected 30 most-related English articles for reference.

Besides online searching for academic literature, the author also visited large amount of websites of national and international organizations and government, and searched and downloaded plenty of related literature. In addition, UNAIDS Beijing Office and UNFPA Beijing Office also provided related background materials. To collect the latest first-hand materials and understand the real situation, the author conducted several field observations, and interviewed CBO staff in Shanghai, Shandong, Yunnan, etc., and the targeted group, concerning questions related to low-tier FSWs.

7. The Name for *Females Providing Commercial Sex Service and Low-Tier Female Sex Workers* in China

In English literature, females providing commercial sex service are usually called “female sex workers” [6-15]. In China, the name for this group is changing according to the society’s development and change, and it is also different in articles of different characteristics. In the early period, it was mostly called “prostitute (ji.nv)”, “whore (chang.ji)” [16]. In late 90s, females providing sex service began to be called “miss (xiao.jie)”, and it has been widely used by different kinds of people till now [17]. In the “Twelfth Five” Action Plan of HIV/AIDS Prevention and Intervention in China which was downloaded from the website of National Center for AIDS/STD Control and Prevention, China CDC, the author did not find how the females providing sex service were directly called, but the phenomenon of sex service is called “prostitution and whoring (mai.ying piao.chang)” [18]. In June 2005, the Guidance Scheme for High risk group intervention Work (for Trial Implementation) called it “unlicensed prostitute (an.chang)” [19]. In 2010, the public security ministry changed the name of “prostitute (mai.ying nv)” to “women taking a wrong step (shi.zu fu.nv)” [20-22]. These names represent what have been called in government documents in China. In academic area, the names for this group are diverse, including “unlicensed prostitute (an.chang)” [2-5, 23-50], “female sex workers” [51, 52], “sex service females” [53, 54], “sex service personal” [55], “sex service miss (xing.fu.wu xiao.jie)” [56], “female sex service provider” [57-61] and “prostitute (mai.ying nv)” [62], etc. In this paper, females providing commercial sex service will be called “female sex workers”, whose abbreviation is FSW.

According to the research, female sex workers’ high risk behaviors and risks of HIV infection are diverse. There are multiple sub-groups in this group. Comparing to regular FSWs, one type of FSWs are at higher risk of transmitting and infected with HIV. The names for this high risk FSWs in China and abroad varies, but are mainly called according to this group’s certain feature. Through the search on CNKI, the names for this type of FSWs in China are: “low-price female sex workers” [63], “street-based prostitute (jie.tou an.chang)” [2, 26, 30-34, 64-75], commonly referred as “standing chicken (zhan.zhuang ji)”[2]. Other places have different names for “standing chicken”, such as “woolen-yarn chicken (mao.xian ji)”, “rice-noodle chicken (mi.xian ji)”, etc. In other literature, it is called “low-tier prostitute (di.dang an.chang)” [27, 28, 37, 41, 43, 45]. There is no unified name for this type of high risk prostitutes. For writing convenience and simplifying name, and maintaining consistence with most scholars, this type of female sex workers in this paper will be called “low-tier female sex workers”, which includes some female sex workers with high HIV infection risk listed above, but is not limited to female sex workers working in low-tier establishments. In this paper, the only standard used to determine whether it is “low-tier female sex worker” is low-tier female sex worker has high risk behavior and higher risk of transmitting and infected with HIV, comparing to regular female sex worker.

Comparing to local regular FSWs, which type of FSWs having higher risk of HIV infection largely depend on local economical and cultural background and customs, so it will be different in different countries. For example, plenty of research in other countries finds that FSWs with higher risk of HIV infection includes “street-based female sex workers” [8, 15, 76, 77], “brothel-based female sex workers” [11], “low-income female sex workers” [78], “direct sex workers” [79], “high frequency female sex workers” [80].

8. Definition of Low-Tier Female Sex Workers

About how to define whether different types of female sex workers are low-tier female sex workers, different research and scholars in China and abroad have different points of view. Generally speaking, most of them emphasize using certain feature of low-tier FSWs to define this group. Scholars in China and abroad use the following four aspects to determine which type of FSWs has higher risk of HIV infection, in other words, belongs to “low-tier FSWs” in this paper.

#### 8.1 Define by the Location Where Female Sex Workers (FSWs) Solicit Clients and Provide Service

Defining low-tier FSWs by the location where FSWs solicit clients and provide service is a popular method in China and abroad. For example, some scholars in China consider that the females providing commercial sex service on the street, in the park, square, and rent room belong to low-tier FSWs [2]. According to literature research, FSWs in China who can be defined as low-tier FSWs by location for client solicitation include:

* Street-based female sex workers, street walkers (*zhan.jie nv*), standing females (*zhan.zhuang nv*) [64, 81]
* Females who are waiting for and soliciting clients or doing knitting work in the open space (lane, park, garden, etc.) [64]
* Head-washing parlors, roadside parlors [82, 83]
* Barbershops, foot-therapy parlors [84]
* Massage parlors [52]
* “Touch Touch (*mo.mo*)” dance hall [52]
* Rent room [69, 82]
* “Accompany-to-eat spots (*pei.chi dian*)” (sidewalk snack booths, roadside restaurants) [5]
* Small-scale bathhouses [41]
* Rural female sex workers [50]
* Low-tier motels [69]
* Female sex workers in the combination area of city and countryside [4]

It is not necessarily the case to define low-tier FSWs only by location of client solicitation, because it is also determined by local economical level and customs. For example, some research consider that FSWs who solicit clients in beauty parlors, barbershops, foot-therapy parlors, massage parlors, etc. should belong to middle-tier FSWs [5], But other scholars think these FSWs should belong to low-tier FSWs [52, 84]. In addition, the situation in different countries will also be different. For instance, most scholars think street walkers (*zhan.jie nv*) and standing females (*zhan.zhuang nv*) [64, 81] have higher risk of HIV infection, but other scholars find that comparing to “night club sex worker” and “brothel-based female sex workers”, “street-based female sex workers” have lower risk of HIV infection [11, 85].

In a word, the features of the location where low-tier FSWs solicit clients are that it has no fixed location, or it is considered as low tier according to its room, decoration, arrangement, consuming level, etc. [50], and it usually concentrates in suburbs or villages within the city [5]. Low-tier establishments are scattered, hidden, and flexible. They move a lot to follow the market or avoid the police crackdown. These establishments are distributed on small remote streets of country towns, or family homes, disposed factory courtyards, small restaurants or small shops in the surrounding area of country towns and on highway traverses, etc. Low-tier establishments’ features include remote, scattered, hidden, mobile, and their female sex workers moving a lot. A few low-tier establishments in the rural area are marked as entertainment service, but most of these establishments have no clear sign [50].

The outstanding advantage of defining low-tier FSWs by location is to favor HIV/AIDS prevention and intervention work: to visually find these low-tier FSWs by location features and then conduct propaganda and education work. Therefore, the author recommends using location to define low-tier FSWs in practical work.

#### 8.2 Define by the Price per Commercial Service Provided by Female Sex Workers

Some scholars categorized FSWs into high, middle, low tier FSWs, according to FSWs’ price per commercial service; FSWs with lowest service price are low-tier FSWs [48, 67]. But the service price is relatively high or low, and it is very different in places of different economical development. For example, the research conducted by Xuemei Zong et al. in Pingshan, Hebei defines establishments with the unit service price of more than 100 Yuan as high tier, those with 60 to 100 Yuan as middle tier, those with less than 60 Yuan as low tier [50]. In the research done in Daye City, Guiyun Li et al. consider those with more than 200 Yuan unit service price as high tier, 50 to 200 Yuan as middle tier, 20 to 50 Yuan as low [3]. In fact the location where FSWs solicit their clients is closely related to the unit service price. So it is usually the combination of solicitation location and service price that determines which FSWs are low-tier FSWs. For instance, Jianhun Liang et al. define in their research in Jiangmen City: high-tier FSWs work in sauna, large-scale hotels, pubs, bars, etc., and their unit service price is more than 200 Yuan; middle-tier FSWs work in beauty parlors, barbershops, foot-therapy parlors, massage parlors, etc. and their unit service price is 50 to 200 Yuan; low-tier FSWs work at “standing spots (*zhan.zhuang dian*)” (street, riverside, park), “accompany-to-eat spots (*pei.chi dian*)” (sidewalk snack booth, roadside restaurant), rent room, etc., and their unit service price is less than 50 Yuan [5].

The author thinks defining low-tier FSWs by unit service price is also a good method: these FSWs can be easily recognized by this method, and then we can conduct targeting intervention work.

#### 8.3 Define by Female Sex Workers’ Income

Research abroad shows that “low-income female sex workers”, defined as low-tier FSWs in this report, have higher risk of HIV infection [78]. But there is not much research abroad which defines low-tier FSWs by income, for example, there is no related article showing up if using different combination of the keywords “low-income” and “female sex workers” and so on to search on PubMed/Medline. There is research in China using “low-income female sex workers [63]” to define low-tier female sex workers. Although many scholars investigated on low-tier FSWs’ income [33, 81], for example, a study in Yunnan found that 71.8% street-based FSWs had less than 1500 Yuan income per month [2], yet it is still rare to directly use income to define low-tier female sex workers in the research in China. Using different combination of the keywords “low price”, “low income” and “prostitute”, “female sex workers”, etc. to search on CNKI is also difficult to get related articles.

Though much research found that low-tier FSWs’ real income was very low, using “low income” to define low-tier FSWs does not favor HIV/AIDS prevention and intervention work. It is hard to know female sex workers’ income if not through investigations and studies, which makes not possible visual recognizing of low-tier FSWs, and then conducting the targeting HIV/AIDS prevention and intervention work.

#### 8.4 Define by Female Sex Workers’ Frequency of Serving Clients, etc.

In some research projects abroad, a scholar divides female sex workers into high frequency sex workers and low frequency sex workers, according to sex workers’ frequency of serving clients. High frequency sex workers’ frequency of serving clients is higher than low frequency sex workers’, where low frequency sex workers include roadside sex workers and home-based sex workers, and high frequency sex workers include hotel-based sex workers [80]. High frequency FSWs, defined as low-tier FSWs in this paper, have higher risk of HIV and STD infection [23]. The research in Bangladesh found that roadside FSWs’ infection rate of HIV and STD is actually lower than hotel-based FSWs’, through comprehensive analysis of hotel-based FSWs and roadside FSWs. The main reason of this is that hotel-based FSWs’ frequency of serving clients is higher than roadside FSWs’, but its condom use rate is lower than roadside FSWs’ [80]. Therefore, hotel-based FSWs (high frequency FSWs) in Bangladesh are similar to low-tier FSWs whom we are concerning.

In addition, a scholar abroad divides FSWs into direct sex workers and indirect sex workers. Direct FSWs serve clients in some establishments with obvious commercial sex behavior, such as national brothels. Direct FSWs’ frequency of serving clients is higher than indirect FSWs, but their condom use rate is higher than indirect FSWs. Through comprehensive analysis, the scholar found that direct FSWs’ infection rate of HIV and STD was higher than indirect FSWs [79], where direct FSWs are defined as low-tier FSWs with higher risk of HIV infection in this report.

In Sum, no matter using which of the above four aspects to define low-tier FSWs, the main focus is always the feature of high risk behavior and risk of HIV infection among low-tier FSWs. In addition, we should be aware that different countries and places have different economical levels and customs. The points of view and methods to define low-tier FSWs will be different, so it cannot be simply compared correspondently. Different defining methods are relative. Only if compared with other categories of FSWs in the same area, it will have real meanings of HIV/AIDS prevention and intervention. This report mainly analyzes and summarizes the situation in China.

9. Low-Tier Female Sex Workers’ Population Size and Features

As mentioned earlier, the reason that low-tier FSWs are widely concerned is that comparing to regular FSWs, low-tier FSWs have higher risk of transmitting and infected with HIV. The high risk is closely connected to the features of low-tier FSWs, and these features in many ways become main obstacles and challenges to conduct HIV/AIDS prevention and intervention for this group. Researchers in China and abroad find low-tier FSWs have the following features.

#### 9.1 Low-Tier Female Sex Workers’ Population Size Estimation

Low-tier FSWs are hidden and mobile. Although the author has not found any report on group size estimation of low-tier FSWs over a wider area in China, some scholars have done estimation and research on the population size of local low-tier FSWs in different places. Generally, low-tier FSWs’ population size is smaller than middle and upper-tier FSWs’ [2]. Yuan Chen estimated in a study in Yunnan that street-based FSWs of County Town A and B were respectively 21.8% and 31.6% of all local FSWs [64]. The research in Xingyi City of Guizhou in 2004 and in Jiayuguan City of Gansu in 2005 estimated local mobile FSWs were respectively 13.2% and 16.3% of all local FSWs, using census and enumeration methods [64, 86, 87]. In Addis Ababa City of Ethiopia in 2002, street-based sex workers were 7.93% of all local sex workers, by counting these sex workers at the area where they solicited clients. In Phnom Penh of Cambodia, street-based sex workers were 10.7% [64]. In Jiangmen City, by using census method, estimation of FSWs was 3668 to 4375 in its urban area, in which low-tier FSWs were estimated to be 263, middle-tier FSWs were 1072, and upper-tier FSWs’ 95% confidence interval was 2333 to 3040 with percentage of 61.4% to 73.2%. The scholar believed that the relatively low percentage of middle and low-tier FSWs could be related to local economical level and industry structure [5]. In Kunming City, by using the capture-recapture method, street-based FSWs in its urban area were estimated to be 486 [68]. Xuemei Zong found in a study conducted in the rural area that in each county town, there were 1 to 4 upper-tier establishments, 1 to 30 middle-tier establishments, and 30 to 150 low-tier establishments. Usually low-tier establishments had a small size: most low-tier establishments had 1 to 5 sex workers, while only few establishments had about 10 sex workers [50].

#### 9.2 Social Demographic Features

Many scholars have done research on low-tier FSWs in China, and found that low-tier FSWs in China are usually relatively older, mainly middle-aged [2, 67, 69, 72], and the lower the tier, the older the age [39]. For example, Jiaqun Chen et al. found in the investigation of street-based FSWs in Ningbo City that these FSWs were relatively older, whose average age was 29.63, and who were mainly 21 to 40 years old, 72.08% [65]. Low-tier FSWs’ education level was often lower [2, 67, 69, 72]. A study found that the education level of street-based FSWs was mainly junior middle school and lower, 92.79% [65]. An investigation in Guizhou showed that 54.9% of street-based FSWs were primary-school level or illiterate. An investigation in a city of Sichuan found that 69.8% of street-based FSWs had lower than primary-school education level. In Mosuo area of Yunnan, there were very few standing women who had been educated. An investigation in Bristol area of the United Kingdom also showed that the length of education of street-based FSWs was significantly lower than the local general population [67]. The lower the education level, the lower the condom use rate [39]. More low-tier FSWs were married [38, 47, 55]. For instance, an investigation in Yunnan found that 56.2% of street-based FSWs were married [2]; another investigation in Ningbo City found that 69.47% of street-based FSWs were married [65].

#### 9.3 Mobility

Comparing to hotel, pub, and entertainment establishments, low-tier FSWs are more mobile [50, 69, 82]. Research found that low-tier FSWs were more mobile. For example, Xiaoli Chen et al. found in an investigation in Anhui Province that 29.9% of FSWs had worked in current establishment for less than 1 month, 30.8% for 1 to 3 months; which summed up to more than a half, very mobile, and the mobility cycle was less than 3 months [88]. The field interview in Shanghai showed that in a big city, street-based FSWs and FSWs in the park were often not very mobile. Because their business usually relied on regular clients and street-based FSWs usually had their own fixed spot. They would have to be faced with lots of uncertainty if they had chosen to move a new spot. But low-tier FSWs in establishments such as foot-therapy parlor were very mobile. They would change an establishment every 1 to 2 months. Most of their clients liked looking for a new face.

#### 9.4 Low-Tier Female Sex Workers’ Clients

Due to their low price of commercial sex service, low-tier FSWs’ clients are mainly in bad economic condition and have lower income, such as old people (or retired old people), immigrant workers, physical labor workers (*bang.bang*), peasants [2, 71]. In the sex industry, these FSWs’ clients are usually low-income, old aged, and in low social status. “Old clients” and low-tier FSWs both have poor safety protection measures in their behaviors. The older they are, the lower their condom use rate is. It will greatly increase their risk of HIV transmission and infection [27].

#### 9.5 Frequency of Serving Clients

Many studies showed that low-tier FSWs had higher frequency to serve clients [2, 82]. This is not only an important feature to define low-tier FSWs, but also an important high risk factor of their transmitting and infected with HIV/STD. The more sexual partners are, the higher the risk of infected with one or more STDs [23]. If FSWs work for more time, and serve more clients, their condom use rate will be lower. For example, an investigation in Dominican Republic showed that if a FSW had worked for more than 2 days a week, their condom use rate would be significantly lower. Longer work time, more clients served, more days serving clients, would increase FSWs’ vulnerability of HIV infection [52]. Research in China showed that low-tier FSWs varied in the frequency of serving clients. An investigation found that the median of low-tier FSWs’ frequency of serving clients was 2 in a day, and 10 in a week [2]. Another investigation showed that low-tier FSWs had served averagely 4 to 5 clients in a day [69]. The study of Hui Liu et al. showed that low-tier FSWS had served 2 to 100 clients in a week, average 16.25 [71]. The field interview also showed similar findings. A peer educator of low-tier FSWs said: “Since low-tier FSWs’ unit service price is low, their strategy to make money is ‘quantity (*zou.liang*)’!”

#### 9.6 Awareness Rate of HIV/AIDS Knowledge

Many studies showed that low-tier FSWs’ awareness rate of HIV/AIDS knowledge was significantly lower than other local FSWs [29, 38, 44, 82]. For instance, an investigation in Yunnan showed that high-tier FSWs’ awareness rate of HIV/AIDS knowledge was 98.9%, and low-tier FSWs’ awareness rate was only 75.0% [49]. An investigation in Kaiyuan City showed that high-tier FSWs’ HIV knowledge score was 10.2, and low-tier FSWs’ HIV knowledge score was only 5.8 [29].

Besides low awareness of HIV/AIDS knowledge among low-tier FSWs, research also found that some wrong prevention methods were disseminated and practiced by low-tier FSWs. For example, the interview showed that some FSWs used liquid medicine etc. for regular washing. These are all unfavorable factors to promote condom use [83].

Research found that only 26.13% of low-tier FSWs received HIV/STD transmission and prevention knowledge from health workers, and most of them gained the knowledge from TV, publicity materials, and radio. This reminds us of reinforcing communication and education of HIV/STD prevention in the media such as TV [65].

#### 9.7 Self-Cognition of HIV Infection Risk

Most street-based FSWs have a fluke mind that they will not be infected with HIV/STD. They lack a deep understanding of HIV/AIDS prevention knowledge. They think HIV/AIDS is far away from their lives, and have not realized that it is necessary to conduct safer behaviors to reduce the risk of HIV infection. For example, research found that among 299 street-based FSWs, only 17.1% of them thought it was possible for them to be infected with HIV, and 67.3% thought they would never get infected with STDs [2, 32]. A study in Huai’an City showed that only 20.95% of FSWs were worrying that they were or would be infected with HIV [55].

#### 9.8 Low-Tier Female Sex Workers’ Drug-Use Behavior

Research found that in low-tier establishments, the percentage of FSWs using drug injection was higher. Research abroad also found that in low-tier establishments, the percentage of FSWs using marijuana was higher. It is generally acknowledged that once FSWs begin to use drug, it will be hard for them to stay in middle and upper-tier entertainment establishments to provide commercial sex service. These FSWs will enter low-tier sex service establishments to earn money for drug. Once FSWs start to use drug, especially drug injection, it will greatly increase the risk of transmitting HIV to general population [2, 23]. An investigation in Yunnan of China showed that 3.3% of local low-tier FSWs used drug [2].

#### 9.9 Condom Use

The most important high risk behavior among low-tier FSWs is low condom use rate. Much research showed that low-tier FSWs’ condom use rate was lower than local high-tier FSWs [2, 44, 52, 55, 69, 84]. Comparing to hotel, pub, and entertainment establishments, low-tier FSWs’ high risk behaviors were the most risky [72]. According the monitoring data of sentinel points in China, the rate of FSWs insisting using condoms during commercial sex behaviors in the last month in 2010 was 67.8%, and the condom use rate in the last commercial sex behavior was 90.5% [1]. However, the condom use rate among low-tier FSWs is far lower than the national monitoring data. For example, research found that FSWs in low-tier establishments and whose unit sex service price was lower than 100 Yuan and annual income was less than 1000 Yuan were more likely to have unprotected sex behavior [23]. The study in Liuzhou City of Guangxi showed that the condom use rate of high-tier FSWs in the last commercial sex behavior was 81.7%, while that of low-tier FSWs was only 62.3% [82]. Research in Yibin City of Sichuan found that the condom use rate of high-tier FSWs in the last commercial sex behavior was 71.9%, while the condom use rate of low-tier FSWs was only 21.4% [84]. Research in Huai’an City showed that the condom use rate of high-tier FSWs in the last commercial sex behavior was 62.2%, while the condom use rate of low-tier FSWs was only 16.3% [55]. Research in Anhui found that FSWs having unprotected sex behavior in middle and high-tier establishments and low-tier establishments was 45.5% and 54.6% respectively [23].

One of the most important reasons not to use condom during commercial sex behavior is that clients are not willing to use [26, 55, 65, 84]. An investigation in Yunnan found that street-based FSWs not using condoms was mainly because clients were not willing to use, whose percentage was 76.9% [2]. Another reason of low condom use rate among low-tier FSWs is related to their awareness of conservation and economic consideration. If clients pay more, or some “clean” and handsome clients do not want to use, most street-based FSWs will agree not to use [65]. For example, an investigation in Ningbo City found that 26.13% would refuse to provide service without condom, 69.37% would try to convince clients to use condoms, but actually only 53.15% would use condoms every time [65]. Research in Anhui found that for the question “In the last 30 days, have you not used condoms if clients are very clean and also willing to pay more?”, 40% of FSWs answered yes, which showed that they had considered more balance of benefits between the cost and income of using condoms, which led to their unsafe sex behavior [88]. Condom use rate between FSWs and their close partners is low, especially lower when having sex with regular partners [83]. It is because they trust each other, the closer the relationship between FSWs and sex partners, the lower the condom use rate. For instance, an investigation in Yunnan found that only 33.3% street-based FSWs used condoms every time when they were having sex with regular sex partners in the last month [2]. An investigation in Anhui found that the condom use rate between middle and low-tier FSWs and their spouses or regular boyfriends in the last 3 months was only 48.5% [88].

Besides low condom use rate, another important factor among low-tier FSWs is the quality of condoms. Due to their low income, they incline to buy cheap and low-quality condoms, which may be very easy to be broken [83], and increase the risk of HIV transmission and infection. For example, an investigation in Yunnan found that 21.8% of street-based FSWs reported that there were condoms broken in the last week [2].

#### 9.10 Infection Rate of STDs

Much research showed that low-tier FSWs frequently provide sex service, and their infection rate of STD was higher than other tiers of FSWs [2, 69, 71, 72, 82, 84]. For example, an investigation in Liuzhou City of Guangxi showed that 42.9% of high tier FSWs had STD symptoms, while it was 65.9% among low-tier FSWs; 1.4% of high tier FSWs were infected with syphilis, while 9.6% of low-tier FSWs were infected with syphilis [82]. Fang Liu et al. found in an investigation in Yunnan that 25.8% of street-based FSWs accounted in their own words that they had STD symptoms in the last year [2]. Jinliu Hu et al. found in an investigation in Huai’an City that the rate of Chlamydia positive in low-tier entertainment establishments was 35.3%, significantly higher than 21.4% in high-tier entertainment establishments [55].

Not only regular STD infection rate, but also syphilis infection rate among low-tier FSWs are usually very high [39]. For example, an investigation in Liuzhou City of Guangxi showed that 1.4% of high tier FSWs were infected with syphilis, while 9.6% of low-tier FSWs were infected with syphilis [82]. Research in Guangdong and Hainan etc. showed that 1.29% to 1.64% of high-tier FSWs were infected with syphilis, while 20.0% to 38.2% of low-tier FSWs were infected with syphilis [5]. In the mean time, the risk of STD infection among clients of street-based FSWs was significantly higher than that among clients of other tiers of FSWs [26].

Research shows that there was an important correlation between STD infection and HIV infection. STD will increase HIV’s infection and vulnerability (the risk will be as high as 300 times), and is an important risk factor of HIV sexual transmission [5]. Especially syphilis, as an ulcer disease, plays an very important promotion role for HIV infection and transmission [23].

Not only low-tier FSWs have high STD infection rate, but also is their risk of STD transmission much higher than other tiers of FSWs once they are infected with STD. For example, research found that after being infected with STD, 83.7% of high-tier FSWs would stop providing sex service, but only 61.7% of low-tier FSWs would stop providing sex service [55]. Another investigation showed that after being infected with STD, 85% of FSWs in high-tier entertainment establishments would stop providing sex service, far higher than 64.3% in low-tier entertainment establishments [84].

#### 9.11 Infection Rate of HIV

Generally speaking, the infection rate among FSWs in China is relatively low. Most monitoring data of sentinel points showed that HIV infection rate among FSWs was lower than 1%, and the sentinel points where HIV infection rates were higher than 1% were limited to severe drug use areas of Yunnan, Xinjiang, Guangxi, Sichuan, and Guizhou. These areas have high risk of cross infection of sexual transmission and drug use transmission [1]. HIV infection rate among low-tier FSWs is much higher than the average HIV infection rate among FSWs. Most research found that HIV infection rate among low-tier FSWs was far higher than that of other tiers of local FSWs. For example, an investigation in Wuzhou City of Guangxi found that HIV infection rate of high-tier FSWs was 0, while HIV infection rate of low-tier FSWs was 1.3% [81]. An investigation in Liuzhou City of Guangxi found that HIV infection rate of high-tier FSWs was 0.23%, while HIV infection rate of low-tier FSWs was 0.60% [82]. In another place, HIV infection rate of low-tier FSWs was 2.68% [2]. Another study in Daye City found that HIV infection rate of middle-tier FSWs was 0 (0/733), while HIV infection rate of local low-tier FSWs was as high as 3.45 [3]. A recent investigation on 7936 low-tier FSWs in Guangxi showed that the average HIV infection rate was 1.9%. HIV infection rates varied among different types of low-tier FSWs, in which HIV infection rate of more than 40 years old FSWs was 4.6%, HIV infection rate of illiterate FSWs was 4.5%, HIV infection rate of divorced or widowed FSWs was 4.9%, HIV infection rate of FSWs without regular establishments was 4.0%, and HIV infection rate of drug-use FSWs was 6.4%. These low-tier FSWs came from 51 cities or counties of the district, and the county with the highest HIV infection rate was 8.5% (5/59) [89]. It shows that HIV infection rate among low-tier FSWs in certain area is really very high.

#### 9.12 Health-Seeking Behavior

If having STD symptoms, the rate of low-tier FSWs going to a STD clinic of proper general hospital is very low. For example, an investigation in Chongqing found that if having STD symptoms, 47% of low-tier FSWs would buy medicine to treat themselves, 16% would go to a private STD clinic, only 16% would go to a proper hospital [71]. A study in Yunnan showed that when having STD symptoms, 26% of low-tier FSWs would go to a private clinic, 25.5% would buy medicine to treat themselves, and 1.3% would do nothing [2]. A study in Ningbo City showed that when or after having STD symptoms, 40% of low-tier FSWs would go to a private medical institution, and 26.67% would buy medicine to treat themselves [65].

#### 9.13 Intervention Coverage and Related Indexes

*The “Twelfth Five” Action Plan of HIV/AIDS Prevention and Intervention in China* specifies that “the coverage of effective intervention measures for groups of high risk behavior should be more than 90%, and the rate of HIV testing and knowing the testing result should be more than 70%; all family planning technical service organizations distribute and promote using condoms; 95% of public areas such as hotels put condoms or set automatic machine for condom sale; condom use rate among groups of high risk behavior should be more than 90%” [18]. Therefore, only if condom use rate among FSWs is more than 90%, will it achieve the requirement of the “Twelfth Five” Action Plan. But many studies showed that condom use rate among low-tier FSWs was far lower than this index requirement [23, 55, 82, 84]. Although intervention projects for FSWs in China have made big progress, yet the intervention coverage of FSWs has a big gap comparing to the requirement of the “Twelfth Five” Action Plan. For example, the intervention coverage of FSWs in China in 2010 was only 53.4% [1, 90]. The intervention measures for FSWs in China mainly stay in the level of FSWs in entertainment establishments, while intervention for low-tier FSWs is conducted less. The intervention coverage of street-based FSWs in certain area is far lower than the average level. For instance, Yuan Chen et al. found in a study that the intervention coverage of street-based FSWs in a county of Yunnan was only 28.4% [65], which cannot play the role of controlling STD/HIV transmission. Increasing low-tier FSWs’ intervention coverage and intervention quality becomes the major task locally [64].

#### 9.14 Situation of HIV Testing

Research showed that FSWs who had HIV testing in the last year would insist more on using condoms [2], but HIV consulting and testing coverage of low-tier FSWs is very limited. For example, an investigation in Fu’nan County of Anhui found that only 46.5% of low-tier FSWs had received HIV voluntary consulting and testing service [24]. Research on street-based FSWs in 13 counties/cities of Yunnan showed that only 49.8% of street-based FSWs had HIV testing in the last year [2].

#### 9.15 Monitoring Low-Tier Female Sex Workers

Scientific and timely testing of high risk behavior and HIV infection among low-tier FSWs is of directive significance for us to formulate targeted intervention strategy and rational resource deployment. According to “*2009 National Sentinel Point Monitoring Implement Proposal”* which was issued in China in 2009, in principle FSWs monitoring should be conducted in establishments with high risk behaviors, or in FSW supervision institutions. It requires setting community monitoring sentinel points. According to the situation of local FSWs’ risk behaviors, establishments with high risk behaviors can be divided into three levels: high, middle, and low. Low-tier FSWs should not be lower than 10% of monitoring sample quantity, and FSWs of middle-tier establishments should not be lower than 40% [91]. From this, current FSWs’ sentinel point monitoring in China mainly targets FSWs working in establishments, but low-tier FSWs such as street-based FSWs usually become monitoring work’s blind zone. Health workers are not easy to reach low-tier FSWs because low-tier FSWs’ establishments are hidden, scattered, and mobile, etc. [2]. This also proves that why condom use rate of low-tier FSWs in research is lower than monitoring result [23, 55, 84], but HIV/STD infection rate is usually higher than monitoring result [1-3, 55, 82].

#### 9.16 Low-Tier Female Sex Workers’ Impacts on HIV Prevalence

In 2011, among estimated 780,000 infectors in China, sexual transmission was 63.9%, increasing 4.9 percentages from 59.0% in 2009, in which heterosexual transmission increased from 44.3% in 2009 to 46.5% in 2011. In heterosexual transmission, about 1/4 was spousal sexual transmission, and 3/4 was non-spousal sexual transmission. Among estimated 48,000 new infectors in 2011, sexual transmission increased from 75.7% in 2009 to 81.6% in 2011, in which heterosexual transmission was 52.2%, increasing 10 percentages from 42.2% in 2009 [1]. It is clear that heterosexual transmission and infection of HIV is still the main pathway of HIV prevalence in China. In heterosexual HIV transmission and infection, low-tier FSWs play a very important role. They have high STD and HIV infection rate, high frequency of serving clients, low self-protection awareness, and are easier to have unsafe sex behavior. Especially many low-tier FSWs are married, and their condom use rate with their spouse and regular sex partners is lower, which potentially impacts and obviously promotes HIV prevalence. Many studies showed that low-tier FSWs are a very important high risk group of HIV transmission and infection, and street-based FSWs in the urban area are usually the bridge of HIV infection for immigrant workers and local residents [2-5]. For example, through model prediction, new infection through commercial heterosexual behavior would become the most important source of new infections in Bangladesh in future years [80]. Model prediction result in Thailand also showed that an important source of future new infection was spousal transmission, while commercial sex behavior was one of the main reasons leading to this prediction result [79].



**Figure 1: Routes of Transmission of Newly Reported HIV Infectors and AIDS Patients Over Years [1]**

In sum, comparing to regular FSWs, comparing the features of low-tier FSWs related to HIV/AIDS prevention and intervention can be concluded into “Three *More*’s and One *Fewer*”. Firstly, these FSWs’ infection risks are *more*. They have lower education level, lower self-protection awareness, less HIV/AIDS knowledge, lower awareness of HIV infection risk, lower condom-use willingness among their clients, more risk behaviors, lower condom-use rate among themselves, etc., which all tremendously increase their HIV infection risk. Secondly, these FSWs’ HIV transmission risks are *more*. They have higher infection rate of STDs and HIV/AIDS, more instances of still continuing commercial sexual behavior after infection, lower health protection awareness among clients, lower condom use rate with both commercial sexual partner and regular sexual partner, which give them more risks of continuing the HIV transmission after being infected of HIV. Thirdly, the groups transmitted by these FSWs after their infection of HIV and STDs are *more*. Most low-tier FSWs’ client amount and commercial sexual behavior amount are more than regular FSWs, and the amount and percentage of their unprotected sexual behavior are more, so the potential groups being infected by these FSWs are more. Lastly, these low-tier FSWs have *fewer* opportunities to receive the intervention. They are very mobile, invisible, more conscious of self-protection, not easy to be reached. Their risks are not being emphasized now, and the intervention coverage range is low. These all make many low-tier FSWs not covered by routine intervention activities. This “Three *More*’s and One *Fewer*” is closely related and interacted. Therefore, low-tier FSWs have been a vital group of HIV transmission.

10. Common HIV Prevention and Intervention Strategies for Female Sex Workers in China and Abroad

Nowadays there are many intervention measures for FSWs, but special intervention measures for low-tier FSWs are not common [69], special intervention strategies for low-tier FSWs are still in need. Many studies showed that intervention measures for regular FSWs also worked for low-tier FSWs; If being properly adjusted in the implement process according to different features of low-titer FSWs, these measures would have good intervention effects [2]. The HIV and Sex Work Collection- 2012 edited by UNFPA has provided sufficient analysis and summary on international HIV prevention and intervention models among FSWs (including low-tier FSWs). This section’s content mainly refers to or excerpts key points and cases in this book. The usual intervention measures for FSWs in China and abroad include:

1. Peer-Based Community Outreach and Propaganda Education

“Peer Education” means the education form and processes that people with the same background, same experience, or same language share information, ideas, and behavior skills together, to achieve the expected education goal. During this process, peers can express their own experience and lessons, exchange information and skills, to evoke sympathy of other peers. Moreover, in the process of peer education, information deliverer and information receptor may exchange their roles, which is a more equal process of information communication [69]. Plenty of successful experience for the past years in China and abroad has proved that, peer-based community outreach and propaganda education is extremely important to provide HIV prevention service and establish trust among targeted FSWs. Many studies showed that peer education can effectively increase target group’s knowledge, increase condom use rate, and broaden intervention coverage [4, 92]. For example, research in Nanchang City showed that through investigation evaluation after conducting propaganda education such as peer education and outreach among FSWs with and without fixed establishments, the result showed that HIV-related knowledge awareness level among non-fixed establishments increased from 2.4% before the intervention to 82.0% after the intervention, and HIV-related knowledge awareness level among fixed establishments increased from 36.2% before intervention to 98.0% after the intervention. About the condom use in the last sex behavior, condom use rate in non-fixed establishments increased from 14.3% to 80.0% after then intervention, and that in fixed establishments increased from 66.8% to 87.5%. Before the intervention, in non-fixed establishments the rate of FSWs received HIV service was 19.0%, the rate of these FSWs received peer education was 0.0%, the rate of these FSWs received HIV testing in the last year was 0.0%; after the intervention, these rates increased to 52.0%, 32.0%, and 58.0% respectively. Before the intervention, in fixed establishments the rate of FSWs received condom education and distribution, HIV consulting and testing was 97.0%, the rate of these FSWs received peer education was 67.3%, the rate of these FSWs received HIV testing in the last year was 41.7%; after the intervention, these rates increased to 100.0%, 90.5%, and 84.0% respectively [4]. Effective peer education and outreach can not only effectively increase HIV related knowledge, condom use rate, and intervention coverage for FSWs with fixed establishments, but also works for low-tier FSWs without fixed establishments; if being conducted well, its effects in some aspects would be more obvious [39]. Juan Li et al. also proved the effect of peer education on low-tier FSWs in the research on low-tier FSWs in Chongqing City; the results showed that peer educator was an important pathway for FSWs to receive HIV-related knowledge. After the peer education, low-tier FSWs communicated more with each other, and improved their knowledge, information, behavior related to HIV prevention. Knowledge awareness rate increased from 28% before the intervention to 70.5%; the rate of having never used condom decreased from 13% to 4.5%; condom use rate in the last commercial sex behavior increased from 59% to 75%; the rate of voluntary HIV testing increased from 2% to 18%. Juan Li et al. thought peer education among street-based FSWs was an effective intervention method worth popularizing, to publicize HIV-related knowledge, and change HIV-related attitude and behavior [69].

To sum, peer-based outreach and education activities are of extremely important significance in the aspects of getting in touch with target group, especially hidden FSWs, influencing community ideology of target group, improving health-seeking behavior, establishing target group’s confidence in service needing and receiving [92]. According to international experience, effective peer education and outreach have the following characteristics [92]:

(1) Formulate good micro plan of operating level, draw distribution map of high risk group establishments, and estimate group size of each establishment.

(2) Formulate effective training plan, regularly train outreach peer educators, to make sure that they have correct knowledge of HIV, STD, and reproductive health, etc., and good interpersonal communication skills.

(3) Use effective system to manage and supervise outreach peers, encourage them to share experience, challenges, and seek solutions, to make sure that outreach work will be improved and enhanced continuously.

(4) Integrate propaganda education into social activities catering to community needs.

(5) Based on the knowledge of current service, and close cooperation relationship between CBOs, FSWs, and health service providers, maximize target group’s use of HIV prevention service.

(6) Establish outreach peers’ excitation mechanism, including opportunities of training and education, and career development, etc.

(7) Capacity construction for outreach peers is very important to broaden coverage and increase intervention effect. Capacity construction should not be limited to effective communication and demonstration of how to use condoms, but should also include training peers how to mobilize and encourage FSWs to increase their health and rights awareness, and to become the bridge between health service and FSWs community. Traditional classroom lecture training is not enough. Other effective capacity construction methods include informal and formal discussion, experience sharing and learning between peers, etc.

2. Activity Center

Establishment of FSWs community activity center is an effective strategy for effective community empowerment, propaganda education, and receiving health service. It has been broadly applied in the whole Asian Pacific area. Community activity center is an important social resource for FSWs. It helps improve community unity, and has many advantages in the aspect of prevention and reducing the risk of exposing to HIV. For example, community activity center may be the only safe place for them to get together, and here they can communicate with friends and peers, participate in different learning activities and social activities, rest and relax, take a shower, or taken care of while being sick. In addition, diverse HIV prevention activities can be conducted in the community activity center, for example, HIV propaganda education, life skills training, sex and reproductive health training, HIV consulting and testing, STD diagnosis and treatment service, family planning service, providing condoms and lubricant products, etc. [92]

Activities of different frequencies can be simultaneously conducted in the activity center according to needs, for example, daily activities, weekly activities, monthly activities, and yearly activities. Usually daily activities include consulting and testing, medical referral service, peer outreach propaganda, TV and video propaganda, place for shower and make-up, STD/HIV and reproductive health propaganda education, condom and lubricant distribution and exhibition, etc. Weekly activities include regular STI and reproductive health check-up, community gathering, often used occupational skills trainings, experience sharing, and problem solving, etc. Monthly activities include life skills trainings, and large-scale social gathering and activities, etc. Yearly activities include World AIDS Day activity on December 1.

3. Distribution and Social Marketing of Condom, Lubricant, etc.

Condom promotion has always been a very important measure, and also proved to be an effective intervention measure, to prevent HIV via sexual transmission. In the mean time of distributing male condoms, female condoms as an important complement are broadly studied and promoted in many places. Distribution of prevention products such as condoms and lubricant is usually combined with other intervention activities, such as peer education, outreach propaganda, STD service, caring treatment, etc. Except free condom distribution, some organizations and institutions also promote condom use through condom marketing, which can promote condom use, and also gain sustainable resources for CBOs to some degree. Many successful cases showed that condom social marketing had the following positive meanings and effects: improving male clients’ condom use, establishing condom use supportive social ideology in sex industry and broader community, being a sustainable pathway to get affordable high-quality condoms and having good cost benefit, bringing flexible extra resources for social organizations.

4. Promote Consulting and Testing

High-quality consulting and testing service has important meanings and effects for target group to timely receive HIV testing service, know infection status, reduce high risk behavior, and adopt protection measures. Multiple data showed that HIV testing coverage among FSWs was relatively low. Therefore, increasing investment strength, actively conducting consulting and testing service, broadening testing coverage among FSWs are also a measure broadly adopted by various countries. Reducing and avoiding adverse factors impacting testing has of important significance for broadening testing coverage. For example, enhancing confidentiality measures and creating non-discriminating service environment have very positive influence on broadening FSWs’ consulting and testing service.

5. Quick Testing Service Provided by CBOs

Research showed that if consulting personal was not from the FSWs community, FSWs were usually not willing to receive consulting and testing service. But community team members are easier to gain their trust, more flexible in the aspects of service attitude, time, location, etc., which better satisfies FSWs’ needs. Especially quick HIV testing service can greatly shorten the time of getting results, decrease the rate of losing FSWs, and effectively broaden service coverage. Many social organizations in China and abroad have great cases of successfully providing HIV quick testing for FSWs.

6. Regular Follow-Up Visits, Caring and Treatment Service

Timely regular follow-up visits, caring and treatment service for positive FSWs needing treatment have important effects and meanings for improving their life qualities, and reducing HIV further transmission. It is found in the consulting and testing that timely regular follow-up visits, caring and treatment service for positive FSWs will help increase their enthusiasm of receiving testing service. Many projects and organizations established positive FSWs caring organizations, providing a series of regular follow-up visits and caring service for them, including treatment referral, psychological consulting, compliance consulting, family care, community care, and terminal care, etc. It plays an important role for positive FSWs receiving friendly and accessible treatment and caring service.

7. Enhance Services of STD Diagnosis and Treatment, and Reproductive Health, etc.

STD and HIV infection have important correlations. STD can increase HIV infection and vulnerability, is an important risk factor of HIV sexual transmission. Especially ulcer diseases such as syphilis can greatly facilitate HIV infection and transmission. Therefore, providing high-quality, affordable, friendly and accessible STD service is also a regular strategy and method of HIV prevention among FSWs. In addition, FSWs also have other needs, especially needs related to reproductive health are worth our attention. For example, their condom use rate with regular sex partners is usually very low, and the rate of abortion and sex violence is relatively high, etc. So while conducting HIV prevention service, providing services of reproductive health and so on according to FSWs’ practical needs can not only increase their interest of receiving HIV prevention service, but also reduce their vulnerability of HIV transmission and infection. These services include avoiding accidental pregnancy, caring service for ante partum, labor, and post partum, interruption of mother and infant treatment, family planning, and contraception service, etc. There are many successful cases combining HIV prevention projects with STD services and reproductive health services. For example, TOP project in Burma and HIV prevention project conducted by Kunming Lily/bai.he social organization of China have achieved good results. These projects not only have good HIV intervention results, but also have positive effects in STD prevention and treatment and reproductive health.

8. Propaganda and Education through Information Communication Technology

Some areas and countries found that many young FSWs with high education level searched for clients through mobile phone, etc. So using related information communication technology and channels to conduct HIV propaganda will be a potential effective measure, which may get in touch with some more hidden and mobile FSWs.

9. Community Involvement and Empowerment

Many practices showed that no matter using what kind of intervention measures, only if FSWs were fully involved would it get good HIV prevention and intervention effects. Community involvement and empowerment is not limited to recruiting target group as peer propagandist or outreach personal to participate in HIV prevention work; broader community involvement and empowerment also includes: really increasing FSWs’ human rights awareness and status, enhancing their capability and awareness of improving their safety and health, reinforcing their capabilities to improve their work and living environment and conditions, etc., so as to change their weak position, to improve their capabilities and willingness to adopt safe sex behavior such as using condoms. Many projects, especially international projects, have explored very good strategies and ways in this aspect. For example, use effective peer education model, diverse propaganda and community mobilization activities, to solve FSWs’ challenges in their work and lives; to remove diverse barriers that they encounter when they receive HIV, reproductive health and other health services, including reduce discrimination, and improve community’s confidence in needing related services and receiving these services; to provide creative measures such as legal assistance to prevent and reduce violence on FSWs. In addition, it also includes facilitating the development of social organizations serving FSWs. For instance, provide various necessary capability construction and high-quality technical support activities for these organizations, to improve their capabilities to develop their own organizations, design and implement various effective intervention projects, and to improve their leadership capability to develop FSWs’ community.

10. Financing and Earning Service

Although many FSWs wish to earn plenty of money, accumulate money saving, and gradually become rich, yet they lack relevant knowledge and capabilities to manage their money. Therefore, some organizations, such as Kunming Lily/bai.he FSW organization, conducted pointed financing services for low-income FSWs, and made good results. It trained and enhanced FSWs’ financing awareness and capabilities, especially the capabilities and strategies of tracking personal income, expenses, savings, and investments, etc. With the support and help of Lily CBO, many FSWs also bought financing products such as funds, and made good profits. What was more interesting was that using financing awareness and ideas, they promoted condom use and adopted safe sex behavior; trainings and propaganda made FSWs realize that maintaining health was a very important factor to ensure personal future fund security.

In addition, they trained FSWs’ knowledge and skills of earning money, such as making and selling hand crafts, and other occupational skills trainings. What needs to be aware of is, these activities did play a positive role in FSWs improving personal economic income and living guarantee to certain degree, but encountered many practical challenges in the implementation process: these activities could not fundamentally change their lives, and we could not hope that these FSWs could easily undertake a new job and industry.

11. Reduce and Remove Barriers of FSWs Receiving HIV Prevention Services

FSWs’ risk of HIV infection and transmission is influenced by many factors. They have lower social status, and are a disadvantage group. Many factors increase FSWs’ vulnerability, for example, client violence, trafficking, social discrimination, etc. These factors hinder FSWs receiving various HIV prevention services, and lower their capability to adopt safe sex behavior. Prevention and intervention projects targeting these factors help reduce FSWs’ vulnerability, and increase HIV prevention effects. There are many successful cases, especially international successful cases, including: intervention strategies aiming at changing policies and social ideology, and creating supportive policies and social environment. For example, intervention strategies targeting fundamental reasons of FSWs’ vulnerability by SWING organization in Thailand and TOP project in Burma; intervention strategies of preventing and reducing various violence on FSWs by Durjoy Nari Sangha social organization in Bangladesh. Advocate protecting FSWs’ human rights and legislation, advocacy and legal assistance for FSWs’ trafficking, etc., for example, projects of advocating and legal assistance of human rights and anti-trafficking of FSWs by EMPOWER organization in Thailand.

12. Comprehensive Using and Implementing of the Above Intervention Measures, and Referral Network

Although in different fields, intervention for FSWs can be divided into different strategies, and different areas and organizations have different intervention focuses, yet many studies and practices showed that intervention programs with comprehensive application of various strategies would have good HIV prevention effects. In Shanghai, an intervention study for middle and low-tier FSWs in small-scale entertainment establishments applied comprehensive HIV intervention strategy through cooperation of multiple divisions, including: 1) Face-to-face propaganda: HIV high risk group intervention team established by multiple divisions conducted face-to-face propaganda for FSWs in establishments every month, including question and answer, picture exhibition, role play, video play, materials distribution, HIV/AIDS prevention knowledge education, condom use negotiation skills, etc. 2) Condom use promotion: distributed free condoms in establishments, installed automatic condom-sale machine in establishment concentration area. 3) Medical referral services: provided services of medical referral to STD and gynecology clinics of comprehensive medical institutions. The evaluation results of the intervention after a year showed that, the intervention team’s HIV/AIDS knowledge awareness level, condom use rate of the last sex behavior, the rate of never using condoms with clients for the last month, correct health-seeking awareness rate were all significantly different from those of regular propaganda intervention team. In all, among FSWs in the intervention team, HIV/AIDS prevention knowledge awareness level increased significantly, condom use state improved, health-seeking awareness rate was significantly higher than that of regular propaganda intervention team [44]. Hui Liu et al. evaluated the effects of the intervention model for street-based low-tier FSWs in Chongqing in 2009, and gained good experience. According to target group’s features such as low education level, old age, sensitive, strong precautions, limited pathway and capability to gain knowledge, they developed “insider providing clues, breakthrough, small-scale propaganda, nourishing peer education propagandist, regular outreach intervention and consulting communication” model etc., including mobile propaganda focusing on consulting and heart-to-heart talk, peer education, condom promotion, etc. In the outreach intervention, emphasized diversity of propaganda styles, distributed propaganda cards, foldouts, and painting albums mainly with pictures, simple and easy to understand, provided free good-quality condoms and booklets of reproductive health knowledge, introduced condom quality screening and using skills, skills to communicate with clients, questions and consulting, etc. and developed peer educators to conduct propaganda. After three months’ intervention, target group’s HIV/AIDS knowledge awareness rate significantly increased, from 28% before the intervention to 71%; condom use rate in the last sex behavior increased from 59% before the intervention to 75%; condom use rate in the last month increased from 4% to 26% [72]. In the HIV/AIDS and reproductive tract infection comprehensive intervention project for low-tier FSWs in Ma’anshan City funded by national HIV/AIDS prevention and intervention social mobilization project in 2010, used various strategies, conducted propaganda education activities such as in-depth interview and consulting, peer education, condom promotion, monthly travel-around treatment and medical referral services to STD doctors and gynecologists, STD and reproductive tract infection check-up and HIV/AIDS VCT services, etc. and evaluated after four-month intervention. The results showed that after the intervention, target group’s condom use rate in the last sex behavior with clients increased from 54.2% before the intervention to 77.5%; the rate of using condoms with clients every time in the last month increased from 43.3% before the intervention to 55.0% after the intervention; the outpatient rate of low-tier FSWs with self-reported symptoms of reproductive tract increased from 56.3% before the intervention to 74.6% after the intervention, increased 18.3% [41].

11. Current Intervention Situation among Low-Tier Female Sex Workers in China

#### 11.1 High Risk Group Intervention Team

The author did not find intervention strategies and plans specialized for low-tier FSWs in China through searching for materials on record. There was only intervention work for all FSWs (including low-tier FSWs), including the Guidance for HIV/STD Prevention and Intervention Work among Service Misses (fu.wu xiao.jie) in Entertainment Establishments formulated in June 2004 in China [93], while the main target group in this guidance was female sex workers in entertainment service establishments. In June 2005, the Guidance Proposal for High Risk Behavior Intervention Work (Trial Implementation) came into being in China. This proposal provided that: all levels of administrative departments of public health took charge of leading high risk behavior intervention work in their administrative area, handling work development situation, providing policy and financial support; all levels of disease control and prevention systems took charge of formulating work plan and organizing implementation of high risk behavior intervention work. This proposal required all places to establish high risk group intervention teams, to take charge of behavior intervention work for high risk groups (including FSWs). China Center for Disease Control took charge of organizing faculty trainings for high risk group intervention teams; collecting, reporting implementation development, organizing experience sharing and publicizing activities; providing technical guidance for high risk behavior intervention work. Excerpts of high risk group intervention teams’ main intervention strategies for high risk groups (including FSWs) are as follows [19]:

1. Little Media Propaganda: In establishments and communities of target group, high risk behavior intervention workers adopt the method of direct training of target group and group discussion, use “face-to-face” trainings, little media (such as foldouts, posters, little painting albums, videotapes, video disks) distribution, etc., to conduct HIV/AIDS prevention and intervention knowledge education and propaganda, to improve target group’s prevention knowledge awareness level and self-health protection awareness, and change high risk behavior and health seeking behavior.

2. Peer Education: Choose influential persons with positive attitude in the target group to become peer educators, hold prevention knowledge reinforcement trainings, encourage them to use a suitable style for this group, through one-on-one or multiple peers’ communication, to publicize HIV/STD prevention knowledge, to introduce how to use condoms correctly and refuse unsafe sex behavior, etc. Based on target group’s feature of high mobility, educate establishment operators and bosses to support and coordinate peer educators to conduct education activities and distribute propaganda products in establishments.

3. Outreach Services: Choose the area where target group gathers, coordinate with family planning, women’s federation, red cross, etc. to select intervention personal with relevant activity capability and intervention skills, penetrate into high risk group to provide services of women’s health, reproductive health consulting, medical referral, etc., or through establishing health consulting clinic in or near for-profit entertainment establishments, provide intervention services of propaganda education, consulting, medical and condom supply and so on for high risk group.

4. Condom Promotion and Correct Use: Broaden condom marketing channel, use commercial marketing and social marketing and so on, support and encourage various medical and health care institutions, pharmacies, shops, and supermarkets to sell good-quality condoms, install automatic condom-sale machines near entertainment establishments, improve condom accessibility. Through pointed health education, teach target group to use condoms correctly, and promote target group to correctly use condoms in the whole process of every sex behavior.

5. Normative STD Diagnosis and Treatment Services and Reproductive Health Services: Rectify and standardize STD diagnosis and treatment market, establish and improve normative STD clinics, improve STD service quality, provide normative STD diagnosis and treatment good-quality services including sex partner tracking, disease symptom handling, and consulting and health education for target group, to achieve early diagnosis and timely normative treatment, and to reduce risk of HIV/STD transmission.

6. Relevant Establishment Intervention: In STD clinics, VCT spots, methadone treatment clinics, needle exchange project spots, and so on, place HIV/AIDS prevention propaganda products, play propaganda education video, open hotline, provide free consulting and medical referral services, and distribute condoms for free.

High risk group intervention team mentioned that: FSWs included women conducting prostitution in various entertainment establishments, restaurants, motels, and street, etc. Intervention work for FSWs referred to the Guidance for HIV/STD Prevention and Intervention Work among Service Misses (fu.wu xiao.jie) in Entertainment Establishments formulated in China in June 2004. Excerpts of main intervention strategies and activities for FSWs in this guidance are as follows [93]:

1. Conduct Pointed HIV/STD Health Education

Conduct various forms of education health activities combined with STD diagnosis and treatment services among entertainment service misses, improve their HIV/STD knowledge awareness level and self-health protection awareness, and change their health seeking behavior. These health education intervention activities mainly include propaganda education implemented by health education propagandists (outreach personal), peer education, and media propaganda, etc.

(1) Health Education Propagandist (Outreach Personal)

According to every area’s real situation, select several health professionals with working capability and responsibility as health education propagandist from local divisions such as health, family planning, women’s federation, Red Cross.

(2) Peer Education Propagandist

According to local situation, every area selects several service misses from entertainment establishments, trains them to be peer education propagandists, and conduct peer education activities among service misses in entertainment establishments.

(3) Media Propaganda Education Further Broaden the Coverage of Propaganda Education

To further broaden propaganda education coverage, create good public opinion environment for HIV/STD prevention and intervention. This guidance also requires health division to closely coordinate with propaganda division, use radio, TV, newspaper, etc. to conduct vigorous propaganda for HIV/STD basic knowledge, and properly broaden health education for general population. In big-scale industrial enterprises and farmer’s markets with plenty of migrant population, or residence areas where migrant population gathers, conduct propaganda education of HIV basic knowledge, improve migrant population’s health awareness, and promote healthy life style.

2. Promote Condom Use and Correct Use

Improve good-quality condoms’ accessibility and procurability in the way that combining commercial marketing and social marketing; use effective health education, outreach intervention, and consulting services, to promote service misses to correctly use condoms during the whole process of every sex behavior.

3. Provide Normative STD Diagnosis and Treatment Services and Reproductive Health Services

Rectify and standardize STD diagnosis and treatment market, improve STD service quality, provide effective, acceptable, affordable, normative STD diagnosis and treatment services and reproductive health services for service misses. The detail intervention strategies and requirements are as follows:

(1) STD Diagnosis and Treatment, and Consulting Service Personal Provide STD Knowledge and Consulting

All institutions with STD diagnosis and treatment services should provide qualified HIV/STD consulting services. Provide various health education propaganda materials in the waiting room, for patients to look over while waiting. Every public STD clinic should have at least 2 to 3 friendly, non-judgmental, enthusiastic middle-aged female doctors, taking charge of female patients’ STD diagnosis and treatment and consulting. Medical professionals in the clinic can also be health education propagandists, penetrating into entertainment establishments, providing HIV/STD knowledge propaganda and consulting for service misses. This will increase opportunities of further communication between service misses and personal, construct good relationship, and be good for solving service misses’ practical problems, and encouraging them to go to the clinic to receive check-up and treatment.

(2) Improve STD Diagnosis and Treatment Services

National STD check-up and treatment is an important part of the intervention work among service misses in entertainment establishments. Provide good-quality services; early diagnosis and early treatment can not only relieve their sufferings timely, but also reduce their risk of STD/HIV infection and transmission. This guidance also requires the following aspects as the basic content of STD diagnosis and treatment:

1) Regular Check-Up

Since service misses have sex behavior with multiple clients in a short time, their risk of STD infection is relatively high. Regular check-up can find the disease in time, and treat it early.

2) Treat Current Infection

Guide patients to be hospitalized correctly and have normative treatment. Follow doctor’s advices; receive the treatment in full dose and completely; tell patients that if not treated timely and thoroughly, it may lead to more severe consequence, such as female infertility, pelvic inflammation, etc.

3) Sex Partner Inform and Treatment

Tell patients that they should inform sex partner to see a doctor in time. If sex partner is not able to see a doctor, patients can bring medicine for their sex partner and help their sex partner to receive simultaneous diagnosis and treatment.

4) Regular Follow-Up Visits

For the patients who need regular follow-up visits, warn them to come to hospital/clinic to do return visits on time.

5) Insist Using Condoms

Caution patients to temporarily stop sex activities before completing the period of treatment and before being cured. If not avoidable, insist using condoms.

6) HIV/STD and Reproductive Health Consulting

While treating STD for patients, provide one-on-one HIV/STD and reproductive health consulting services. Open a consulting line in diagnosis and treatment institutions if possible, and arrange medical professionals with consulting knowledge and skills to be on duty. Consulting contents can refer to health education contents and STD diagnosis and treatment contents. Consulting personal need to start with patients’ situation and mind-set, through sympathy, understanding and their interaction, use conversations to help them analyze and discuss the problems they are faced with, find solutions to problems, and help them take action. Personnel in the diagnosis and treatment institutions should respect, not discriminate patients, and keep secrets for them.

#### 11.2 Comprehensive Demonstration Area Project

Comprehensive demonstration area project in China has been implemented for two rounds. In 2003 to 2008, 127 HIV/AIDS comprehensive demonstration areas were established for the first round in China. Under the support of government leaders and relevant departments at all levels, plenty of prevention working experience was accumulated in the aspects of implementing national prevention policies and exploring suitable working models according to local practical situation, which played the demonstration and leading role. To further popularize demonstration areas’ working experience and promote carrying out national HIV/AIDS comprehensive intervention work, the second round work of demonstration areas were launched in China in 2009, and is still going on. 309 demonstration areas funded by the state revenue were established, including 51 demonstration areas of the state priority and 258 demonstration areas co-constructed by the state and provinces/ districts/ cities.

In the second round, there are three purposes closely related to FSWs, including HIV/AIDS knowledge awareness level to achieve more than 90%; FSWs’ condom use rate in the last sex behavior to achieve more than 85%; syphilis infection increasing rate in annual report to be lower than 10%. Intervention measures related to FSWs in demonstration areas include: installing condom distribution and sale facilities in public places; conducting health education for FSWs; condom promotion; providing normative STD diagnosis and treatment and medical referral services; outreach service; training peer educator, and conducting peer education; HIV/AIDS VCT; encouraging and supporting social groups and non-governmental organizations to conduct intervention activities among FSWs.

#### 11.3 Global Fund HIV/AIDS Projects

Global Fund HIV/AIDS projects were launched in China in 2004. Round 3 of Global Fund HIV/AIDS projects was implemented the earliest, and then Round 4, Round 5, Round 6, Round 8, and RCC HIV/AIDS project of Global Fund. RCC HIV/AIDS project of Global Fund is the only one that is still running. RCC HIV/AIDS project of Global Fund in China is the integrated rolling project which is applied from Global Fund rolling continuation channel. Based on the integration of the Round 3, Round 4, Round 5, Round 6, and newly applied Round 8 HIV/AIDS projects, RCC applies the principle of unified planning and integrated resources, to thoroughly integrate all national HIV/AIDS prevention and intervention resources, including the state transferring funds, provinces/ cities/ counties/ districts investing, and other international collaborative projects’ funds, to conduct HIV/AIDS prevention and intervention work under national unified planning. The project location is 31 provinces/ autonomous regions/ directly governed city regions.

In these rounds of Global Fund HIV/AIDS projects, except Round 8 HIV/AIDS project [94] targeting migrant population (already integrated into RCC project), other rounds of Global Fund HIV/AIDS projects were involved with HIV prevention and intervention activities among FSWs to some degree. Round 3 Global Fund HIV/AIDS project [95] focused on supporting treatment and caring activities; there were not many HIV prevention activities specialized for FSWs, including behavior change communication, condom promotion, and social marketing.

The main purpose of Round 4 Global Fund HIV/AIDS project [96] was to control HIV transmission and prevalence among high risk groups such as FSWs and injection drug users. Therefore, there were many intervention strategies for FSWs, including:　IEC propaganda for FSWs, media propaganda, establishing community women’s health center to conduct various propaganda and intervention, behavior change communication such as outreach and peer education, condom promotion and social marketing, consulting and testing, STD services, reproductive health services, treatment and caring, enhancing social organizations’ involvement, and propaganda and intervention for clients.

Focusing on sexually transmitted HIV prevention in low-prevalence areas, Round 5 Global Fund HIV/AIDS projects [97] was the first large-scale international project targeting MSM in China. Except MSM, FSWs were also one of its target groups. Another important feature of this project was sponsoring CBO’s involvement. Intervention strategies closely related to FSWs in this round of Global Fund project were: propaganda education, outreach, peer propaganda, condom promotion, consulting and testing, STD services, CBOs’ capability building, etc.

The main purpose of Round 6 Global Fund HIV/AIDS project [98] was to reinforce CBOs’ capability building, and to facilitate their active involvement in HIV prevention work among high risk groups. Target groups not only include FSWs, but also their clients. In addition, the application statement of this round of project also pointed out that the focus would be the most disadvantaged groups such as street-based FSWs and transnational FSWs. Intervention measures for FSWs in Round 6 Global Fund included: supporting establishment and operation of FSWs community health activity center conducted by CBOs, CBOs involved peer education, outreach intervention, behavior change communication, condom promotion including female condoms, STD consulting and testing and treatment services, consulting and testing services (including quick testing service) collaborated by CBO and local CDC, and reinforcing CBOs’ capability building, etc.

RCC HIV/AIDS project of Global Fund [99] is the only one Global Fund HIV/AIDS project that is still running. Its main purpose is to increase accessibility and broaden coverage of various HIV prevention and intervention services. FSWs are one of its target groups. Its project statement also pointed out its focus on street-based FSWs. An important feature of this round Global Fund is sponsoring lots of CBOs to get involved in HIV/AIDS prevention and intervention work in China. Main intervention strategies for FSWs include: media propaganda, outreach and peer propaganda, condom promotion, HIV consulting and testing, STD diagnosis and treatment services, positive patients’ referral and regular follow-up visits, reducing discrimination, CBOs’ capability building, etc. Table 1 lists some information of rounds of Global Fund HIV/AIDS projects in China.

**Table 1: Basic Information of Rounds of Global Fund HIV/AIDS Projects in China**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Project Title** | **Project General Objective** | **Project Target Group** | **Project Period** | **Project Budget** |
| **Round 3** | Enhancing community –based HIV/AIDS comprehensive treatment, caring and prevention in Middle China | Reduce impacts caused by HIV/AIDS and control HIV/AIDS transmission in 58 high HIV/AIDS incidence poor counties of 7 provinces in China. | HIV infectors/patients and their families, due to paid blood donation in early and middle 1990s | 5 years (Sep 1, 2004 – Aug 31, 2009) | US$ 97,888,170 |
| Round 4 | Reducing HIV transmission and its impacts among vulnerable groups of 7 provinces in China | Reduce HIV transmission among IDU and FSWs and reduce its impacts in 7 provinces/ autonomous regions of China. | FSWs, IDU, MSM, migrant population | 5 years (Jul 1, 2005 – Jun 30, 2010) | US$ 63,742,277 |
| Round 5 | Preventing a new round of HIV infection in China | Through sexually transmitted HIV/AIDS comprehensive intervention measures, control HIV/AIDS continuing prevalence among high risk and vulnerable groups of 7 provinces/ autonomous regions/ directly governed city regions in China. | Sex workers, MSM, migrant population | 5 years (Jul 1, 2006 – Jun 30, 2011) | US$ 28,902,073 |
| Round 6 | Encouraging and supporting grass-rooted organizations and non-governmental organizations to participate in HIV/AIDS prevention and intervention work in China | Use and enhance capabilities of grass-rooted organizations and non-governmental organizations in China. Use grass-rooted organizations’ unique advantages to fill in gaps of current HIV/AIDS prevention and intervention projects, and to broaden coverage, providing necessary prevention, treatment, and other supportive services for the most vulnerable groups and hard-to-reach population. | FSWs and clients, MSM, IDU, out-campus youths, HIV infectors/ patients, and children and orphans impacted by HIV/AIDS | 5 years (Jan 1, 2008 – Dec 31, 2012) | US$ 14,395,715 |
| Round 8 | HIV/AIDS prevention and intervention and caring services for disadvantaged migrant groups in 7 provinces of China | Prevent HIV/AIDS transmission and reduce HIV/AIDS impacts on disadvantaged migrant groups. | Most disadvantaged groups of migrant population | 5 years (2009 – 2014) | US$ 61,413,199 |
| RCC | China Global Fund HIV/AIDS project | Broaden HIV/AIDS prevention and intervention, treatment and caring services in China, and facilitate full accessibility of HIV/AIDS comprehensive prevention and intervention services for high risk groups and HIV infectors and patients. | FSWs, IDU, MSM, migrant population, HIV infectors/ patients (including children) and pregnant women | 6 years (Jan 2010 – Sep 2013) | About US$ 0.509 billion (upper limit budget) |

#### 11.4 Other International Projects

Except big international projects such as Global Fund mentioned above, there are also other international projects in China involved in intervention work among FSWs. For example, HIV/AIDS prevention and intervention collaborative project in Yunnan and Guangxi conducted by Family Health International (FHI) 360 and Population Services International (PSI) and funded by U.S. Agency for International Development (USAID); mobilizing testing activities for FSWs funded by China and Gates Foundation HIV/AIDS prevention and intervention collaborative project during its early operation stage in China.

The main intervention model for FSWs funded by USAID and organized by FHI 360 and PSI is integrated prevention, caring and treatment model [100]. In this model, integrated service package including six core services is provided for high risk groups (including FSWs and clients). It includes: behavior change communication service for intervention among high risk groups such as FSWs; STD prevention and treatment service for high risk groups such as FSWs; harm reduction service mainly targeting drug users; durative prevention, caring, support, and treatment service mainly targeting infectors and their families; condom social marketing and condom distribution service for high risk groups such as FSWs; HIV/AIDS consulting and testing service for high risk groups such as FSWs (see Figure 2). In this model, except integrated service package, there is also supportive environment intervention including additional six contents to make sure the six core services achieve good effects. It includes: policy advocacy; community mobilization; strategy information; capability building; living development; reducing stigma and discrimination. There were also specialized intervention strategies formulated and conducted for low-tier FSWs in Luzhai City and Gejiu City, but its scale and coverage were very limited.



**Figure 2: Integrated HIV/AIDS Prevention and Intervention Model Funded by USAID**

UNFPA has also cared more about intervention among low-income FSWs recently. Since 2012, UNFPA have collaborated with National Center for AIDS/STD Control and Prevention (NCAIDS) of China CDC, conducting HIV/STD intervention targeting low-tier FSWs such as mobile street-walkers, relatively fixed “rent room women”, “yarn women”, “bench women” in villages within the city, rent rooms, under bridges, woods, parks, roadside, farmer’s markets, alleys, etc. of 4 project locations of Jiangxi, Hainan, and Guizhou. About 400 low-tier FSWs were covered. These women were mostly 35 to more than 50 years old, had low education level, low self-protection awareness, low condom use rate, served more migrant workers and retired old people, etc. Main intervention measures include: peer education, STD and reproductive health diagnosis and treatment services, community intervention. Peer education activities were mainly conducted by peers who knew local sex workers’ knowledge and culture, cooperating with local CDC or project parties. Community intervention were mainly finding and getting in touch with sex workers in “establishments” (such as rent room, farmers’ market) through community residents’ committee, to establish fellowship, and conduct activities such as condom promotion, peer education, STD/HIV and reproductive health knowledge propaganda.

In addition, other international projects also paid attention to HIV prevention work among low-tier FSWs, for example, Shandong Jiaozhou project funded by Oxfam. But these projects’ scale and coverage were very limited.

12. Situation of Community-Based Organizations (CBOs) Providing Services for Female Sex Workers in China

Funded by some international projects, CBOs in China have developed a lot in recent years. The degree that they get involved in HIV prevention work is deeper, and both quantity and quality of their involvement have greatly increased, especially CBOs working for MSM have developed a lot and received a large quantity of financial aids. CBOs working for FSWs have also progressed. International collaborative projects, especially projects of Global Fund and Gates Foundation, play a big role in the development of CBOs in China. For example, the fund given by China and Gates Foundation HIV/AIDS prevention and intervention collaborative project to social organizations was two fifths of its general budget. More than 200 social organizations, mostly CBOs working for MSM, received fund from China and Gates Foundation HIV/AIDS project through Chinese Association of STD and AIDS Prevention and Control and Chinese Preventive Medicine Association (CPMA).

Currently running RCC HIV/AIDS project of Global Fund has put most funding efforts to CBOs among all rounds of Global Fund projects. Until the end of 2012, RCC HIV/AIDS project of Global Fund had provided RMB 59,780,000 Yuan funding for 865 CBOs (including IDU, MSM, FSWs, infectors’ community, anti-discrimination and gender strategy social organizations), of which RMB 5,950,000 Yuan funding (10.4%) was used for CBOs working for FSWs (see Table 2).

**Table 2: Situation of CBOs Funded by Global Fund RCC HIV/AIDS Projects (till the end of 2012)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Target Group** | **Number of Population Covered** | **Number of Projects Funded** | **Number of CBOs** | **Annual Funding (RMB ten thousand Yuan)** |
| CSW | 59,480 | 151 | 149 | 595 |
| MSM | 38,230 | 271 | 261 | 382 |
| IDU | 231,800 | 81 | 81 | 2,318 |
| PLWH | 73,029 | 353 | 348 | 2,410 |
| Anti-Discrimination | (-) | 65 | 64 | 181 |
| Gender Strategy | (-) | 27 | 27 | 92 |
| Total | 402,539 | 948 | 862 | 5,978 |

*2011 China NGO Directory* published by China Development Brief collected 699 organizations in China, 73 of which were HIV/AIDS organizations, and only one organization put HIV/AIDS prevention and intervention work as its main working area and important content, and no organization was really run by FSWs [101]. In addition, *2012 China HIV/AIDS Social Organization Directory* written by China HIV/AIDS Information Network (CHAIN) collected 967 social organizations’ information, but lacked subtotal information of social organizations. Since the author could not get its digital database, detail quantitative analysis of CBOs for low-tier FSWs could not be done. But through reading, the author found that CBOs really constituted of FSWs were extremely limited. From this directory, the author could not know whether these organizations had conducted HIV/AIDS prevention and intervention work among low-tier FSWs [102].

No open published materials about CBOs serving low-tier FSWs were found. But the interview found that intervention among low-tier FSWs was relatively difficult, it was not easy to conduct work and its funding resources were relatively few, so CBOs specially serving low-tier FSWs were very limited. Most organizations worked for all tiers of FSWs, and providing services for low-tier FSWs was only part of these organizations’ activities. For many CBOs, it was even a very small part, and they did not formulate special plan or put special efforts to provide services for low-tier FSWs.

In February 2009, 12 organizations conducting intervention work among sex workers founded China Sex Worker Organization Network Forum (CSWONF) in Kunming City of Yunnan. CSWONF commits to support member organizations’ development, and to improve sex workers’ occupational health environment. Through activities such as organization capability building and advocacy, information, experience, knowledge communication and sharing, it promotes sex workers’ self identity, and reduces discrimination and harm. CSWONF is the main voicing channel for sex workers’ organizations in China. Now CSWONF has 14 member organizations, including: Yunnan Ruili Women and Children Development Center, Tianjin *Xin’ai* Cultural Transmission Company, Sichuan Jiangyou *Wenxin Jiayuan*, Yunnan Gejiu *Kucao* Studio, Tianjin *Shenlan* Working Team, Shandong Jiaozhou *Ai’xin* Health Consulting Center, Qingdao *Ni’wo* Social Work Service Center, Beijing *Zheyi Tianshi*, Yunan Kunming Parallel, Shanghai CSW& MSM Center, Beijing *Yangguang zhi Lv* Community Commonweal Team, Shenyang *Ai zhi Yuanzhu* Health Consulting Service Center, Beijing *Tongxing*, Guangxi *Fuping* Studio. Only 4 organizations among these members were providing services for low-tier FSWs, or low-tier FSWs were large portions of their target groups. Therefore, according to low-tier FSWs’ intervention needs, these CBOs’ scale and development could not satisfy the real needs, and their intervention coverage was extremely limited, which could not have effective influence on controlling the HIV prevalence among this group.

In sum, there are very few organizations really based on FSWs; especially CBOs providing services for low-tier FSWs are even fewer, and most of them concentrate in the urban area, almost no CBO for low-tier FSWs exists in remote rural area. These organizations have small scale, and cover relatively few low-tier FSWs. In these organizations, except individual organization managed and operated by health professionals, most organizations’ professional abilities are deficient, and need urgent improvement. In addition, lack of funding is the largest challenge that these organizations are faced with. Not only are intervention funds for low-tier FSWs severely deficient, but also most organizations cannot guarantee their own survival and development funds. For example, among interviewed 5 CBOs whose target groups include low-tier FSWs, almost all these organizations’ HIV intervention funding for low-tier FSWs will stop in the end of 2013, and no one is sure there will be reliable funding resource, and some organizations cannot even guarantee their own survival funding.

13. Challenges and Suggestions of HIV Prevention Work among Low-Tier Female Sex Workers

#### 13.1 Gap Analysis

Much work has been conducted among FSWs in China, including high risk group intervention team and comprehensive demonstration area project directly funded by the government, and international collaborative projects such as rounds of Global Fund projects and projects funded by USAID. But general analysis showed that HIV prevention work for low-tier FSWs is still a field being broadly ignored. It has the following gaps and disadvantages:

1. Lack strategy information about low-tier FSWs. There is very few information about low-tier FSWs in China, including population scale, intervention situation, high risk behavior, and HIV infection. An important reason for deficient information is that FSWs’ HIV sentinel point monitoring data cannot reflect the real situation of low-tier FSWs. Although the HIV sentinel point monitoring plan in China stipulates that low-tier FSWs’ sample should not be lower than 10% of all monitoring samples, yet in practical work, most sentinel points for FSWs target FSWs working in establishments; and low-tier FSWs such as street-based FSWs become the blind area of monitoring work because these FSWs’ working places are hidden, scattered, and very mobile, health staff is not easy to get in touch with these FSWs [2]. It makes that low-tier FSWs’ condom use rates in investigations and studies are usually lower than the sentinel point monitoring results, while HIV/STD infection rates are often higher than sentinel point monitoring results. Many scholars have done research on Chinese low-tier FSWs’ population scale, high risk behavior, HIV/STD infection, etc., but this research data is usually the situation of some areas, and the data for the general representative situation of low-tier FSWs in China is still lacking.

2. HIV intervention coverage and intervention strength for low-tier FSWs are far from enough. Main large-scale national and international intervention projects for FSWs in China include high risk group intervention team, comprehensive demonstration area, rounds of Global Fund, and other international collaborative projects mentioned above, while the only running projects now are the second round of comprehensive demonstration area project and Global Fund RCC HIV/AIDS project. These projects’ strategies and activities mostly cover regular FSWs, and cannot effectively reach low-tier FSWS. Even the low-tier FSWs that they do cover are very few, and their coverage is very limited. In addition, international projects for low-tier FSWs have very small scale, for example, projects for low-tier FSWs funded by USAID were only in Luzhai City of Guangxi, Gejiu City of Yunnan, etc., and intervention projects for low-tier FSWs funded by Oxfam were only conducted certain individual CBOs. In sum, the coverage for low-tier FSWs in China is still very limited. High risk group intervention team is not mentioned anymore, and international projects are going to end. The government is only supporting comprehensive demonstration area, whose budget for low-tier FSWs is very limited. So low-tier FSWs are faced with severe intervention gap. Not only does low-tier FSWs intervention have very limited coverage, but it is also faced with the risk of sold-out.

3. Intervention service quality for low-tier FSWs is not enough. The author found in the interview and field observation that in outreach and peer intervention for low-tier FSWs, these organizations only simply distributed condoms, lubricant plasticizer, or tissues, and individual outreach personal only communicated broadly with target group. Intervention’s style was single, content was boring, and it lacked focalization, which showed that these organizations lacked targeted outreach plans and targeted outreach propaganda topics. Not only are these organizations so, but also other large international and national projects have similar problems in the aspect of intervention service quality for low-tier FSWs, and need to improve. There are no strategy and guidance for HIV prevention and intervention work among low-tier FSWs in China in the level of the state and project. Among all these intervention projects for FSWs, the intervention strategies all focus on regular FSWs, and they lack effective intervention strategy and operation guidance specialized for low-tier FSWs during the implementation. Although some projects’ operation strategies mentioned HIV prevention and intervention among low-tier FSWs, yet they were only limited to the project statement, and did not have specific operational strategy and intervention guidance. Accordingly, prevention and intervention work for low-tier FSWs mostly only showed in the plan, and the effects of carried-out intervention service quality and strategic activities specialized for low-tier FSWs were far from enough during the implementation.

#### 13.2 Difficulties and Challenges

1. The environment does not facilitate AIDS prevention and intervention work for low-tier FSWs.

(1) There is not enough emphasis and investment on HIV prevention and intervention work among low-tier FSWs. Low-tier FSWs have not been proposed as an individual high risk group in the strategy level in China, and there is not enough HIV/AIDS prevention and intervention funding specially for low-tier FSWs. In the main large-scale prevention and intervention projects for low-tier FSWs in China as mentioned above, most project strategies are for regular FSWs such as FSWs in establishments. Only Round 6 of Global Fund and Global Fund RCC HIV/AIDS project specially proposed to pay attention to HIV prevention and intervention work among low-tier FSWs such as street-walkers. But all these HIV prevention and intervention projects including these two rounds of Global Fund did not mention special intervention index requirements for low-tier FSWs, or list special funding for HIV prevention and intervention work among low-tier FSWs. All these implemented strategies were formulated for regular FSWs, which led most intervention activities to be conducted for easy-to-conduct FSWs in establishments in practical work. Most low-tier FSWs in the project locations could not be reached by these regular project intervention strategies.

(2) Current legal environment and low-tier FSWs’ living environment increase intervention difficulty level and vulnerability of HIV infection. In China, sex work is still illegal and a crime, and is the focus of the police strike. Low-tier FSWs are easier to be influenced by “strike-hard”, which makes them become more invisible and not easy to be intervened. Meanwhile, it makes more difficult their defending rights and benefits when facing “sex violence” and crimes, and not willing to do this, which further decrease their status and capability to adopt safe sex behavior.

2. Teams and capabilities of HIV/AIDS prevention and intervention for low-tier FSWs are not enough.

HIV/AIDS prevention and intervention teams are still very deficient, and their intervention capabilities and experience are also extremely inadequate. Especially as the important member of the team of HIV/AIDS prevention and intervention for low-tier FSWs, CBOs providing HIV intervention services for them are also faced with great challenge in organizational development and capabilities. As mentioned above, CBOs providing services for low-tier FSWs have the following obstacles, including: the amount of CBOs is severely insufficient, and most of them concentrate in the urban area; CBOs have relatively small scale, and can cover very limited target group; CBOs’ capabilities are not enough, which cannot satisfy intervention demands of low-tier FSWs; in the condition of large international projects and aid funding dropped out of China, CBOs will face severe funding shortage, especially HIV prevention and intervention funding for low-tier FSWs will face the risk of sold-out.

3. Difficulties and challenges in aspects of strategies and measures.

(1) Low-tier FSWs are mostly invisible, and many low-tier establishments have no sign or lack the sign of entertainment service, or have no fixed location, not like FSWs in some establishments to be found easily. For FSWs in parks and street-walkers, it is very difficult to recognize them if not through long-time observation and understanding.

(2) Without organization of entertainment establishments’ bosses, low-tier FSWs in most places are relatively scattered. So it is difficult to broaden intervention coverage. It needs more peer propagandists and outreach personnel to conduct work, and needs more manpower, energy and time.

(3) Some low-tier FSWs are very mobile and not stable. It is difficult to conduct HIV/AIDS propaganda education, condom promotion and other behavior intervention, because it is not easy to find them, and their opportunities and frequencies of receiving intervention are relatively small. So the effects of health education are poor. Comparing to regular FSWs, it needs bigger intervention frequency and investment to achieve the same intervention strength, especially the amount of personnel and invested time and energy, etc.

(4) Most low-tier FSWs have high self-esteem and strong pre-caution, so it is very difficult to get in touch with them. It is difficult to get their trust and conduct intervention work without the introduction of insider of this group or long-time contact.

(5) Low-tier FSWs in some places have relatively poor HIV/AIDS knowledge. Low education level, poor risk awareness of HIV infection, not enough emphasis on HIV/AIDS prevention and intervention work, not strong enthusiasm and initiative of receiving HIV/AIDS knowledge, greatly influence effects of intervention such as HIV/AIDS propaganda education.

(6) Economic disadvantage status of low-tier FSWs makes them also disadvantaged in adopting safe sex behavior, and easier to be influenced by clients. Their clients are mostly low-income population, and this population does not have high health protection awareness. Many clients are old people. Restricted by their age and physical qualifications, these clients are poor to use condoms, and have low willingness to use condoms, which make low-tier FSWs’ behavior change very difficult and keeping long-time safe sex behavior harder.

(7) Most low-tier FSWs’ clients are of big quantity, and they serve clients frequently every day. Many FSWs said that if they insisted using condoms, they would lose many clients, which influenced a lot for their income. Therefore, intervention work focusing solely on insisting low-tier FSWs using condoms has very limited effects.

(8) Most low-tier FSWs have low income, and their economic disadvantage status is relatively obvious, so they are easier to conduct high risk behavior to earn money. Not only do they have big risk of HIV/STD infection, but also they have very big risk of HIV/STD transmission. Many studies showed that driven by economic benefits, the rate of their continuing commercial sex behavior after STD infection is very high. The interview also found the same problem: a FSW said when talking about this: “…After getting sick, we are in more need of money to treat it. No matter being sick or not, we need to feed ourselves!”

In sum, HIV/AIDS prevention and intervention among low-tier FSWs does not only face challenges in macro-policy, intervention team and capabilities, but also face “Four *Difficulties*” led by low-tier FSWs’ own features: Firstly, these FSWs are *difficult* to find. Many low-tier female sex work establishments do not have a clear sign. They are very mobile, and their organizing form is relatively hidden. So they are hard to find. Secondly, it is *difficult* to communicate with these FSWs. Their self-protection consciousness is very strong, so it is hard to gain their trust. It takes a long time to gradually gain their trust and conduct the intervention through their familiar core peers. Thirdly, it is *difficult* to conduct intervention among these FSWs. They are scattered, and their establishments are plain or even outside. So some intervention measures and activities are very hard to implement, such as on-site consulting and testing. In addition, they are more willing to make money, and do not have much spare time, so they do not have time to attend routine intervention activities. Lastly, it is *difficult* to change their behavior. Low-tier FSWs are more vulnerable, and their economical disadvantage status is obvious. So their acceptance of safe sexual behavior is restricted by multiple conditions, and it is hard to change their risk behavior through intervention solely on themselves. For example, in most conditions, their condom use depends on clients’ willingness, and these FSWs usually disregard safe sexual behavior driven by money.

#### 13.3 Suggestions

#### 13.3.1 HIV/AIDS Prevention among Low-Tier Female Sex Workers

1. Build supportive environment.

(1) Improve low-tier FSWs’ emphasis on HIV prevention and intervention, increase support strength in policy and funding, and promote HIV intervention and prevention work among low-tier FSWs to a strategic level to consider. Consider low-tier FSWs as important as IDU, MSM, etc., treat them as an individual high risk group, to formulate specialized index requirements, funding budget, intervention implementation proposal for this group.

(2) Conduct policy advocacy work. Provide trainings and communication for law enforcers such as the police, to make them fully realize the low-tier FSWs’ important role and meaning in the aspects of HIV/AIDS transmission and infection, and understand their living environment, to avoid increase their vulnerability of HIV/AIDS transmission and infection in the law enforcement. Meanwhile, strike various illegal crimes targeting low-tier FSWs’ sexual violence etc., and protect low-tier FSWs’ rights in the law framework.

2. Increase strategic information and research work on low-tier FSWs.

(1) Reinforce monitoring work for low-tier FSWs. In national HIV sentinel point monitoring system, estimate FSWs’ HIV prevalence status and population scale according to different areas. Properly increase monitoring sentinel points for low-tier FSWs, and formulate sampling requirements for low-tier FSWs’ monitoring sentinel points. In difficult areas, increase low-tier FSWs’ sampling portions in regular FSWs’ monitoring sentinel points, to better reflect local FSWs’ HIV status, and timely monitor low-tier FSWs’ high risk behavior and HIV infection.

(2) Reinforce supporting applied research on low-tier FSWs, including intervention strategies, high risk behavior, group population scale, intervention coverage, etc. Some scholars have conducted studies on effectively conducting HIV intervention among low-tier FSWs, but these studies mostly had small scale, and lacked systematic. Facts on low-tier FSWs’ general situation, effective intervention strategies and methods, etc. are still relatively deficient, and need further improvement. For example, research showed that about reasons for not using condoms, 47.1% clients chose “familiar, trust”, while more than half (55.2%) women chose the same choice; the scholar analyzed from anthropological perspective that the above perception as the base of culture not only existed in sexual relationship network, but also influenced or changed important factors of network members’ behaviors, for instance, “familiar” and “trust” became crucial reasons for how to choose sexual behavior protection measures. The scholar suggested that if using social network to analyze and find low-tier FSWs’ key members in their sexual relationship network, and direct them to play a positive role, it will achieve maximum results with little efforts, and facilitate healthy behavior in the whole network [27]. If we can further apply similar research findings to experimental units, and creatively apply them to practical work, it will provide important scientific basis for exploring effective HIV intervention strategies for low-tier FSWs.

3. Vigorously fund and conduct targeted intervention strategies and measures.

(1) Draft and formulate technique guidance on how to conduct HIV intervention among low-tier FSWs. There is no technique guidance on HIV intervention specialized for low-tier FSWs in China. Most intervention activities for low-tier FSWs still use intervention strategies and methods for regular FSWs, but these regular ways usually cannot effectively reach low-tier FSWs, and cannot practically satisfy their special needs. Therefore, it is necessary to formulate an effective intervention guidance specialized for low-tier FSWs based on broad field study and practical operating experience.

(2) Strengthen conducting HIV/AIDS prevention and intervention work for low-tier FSWs’ clients. As mentioned above, low-tier FSWs’ disadvantaged economic status makes them also disadvantaged when negotiating sex behavior with condoms with clients. Many studies showed that most reasons of FSWs not using condoms come from clients. Therefore, conducting intervention work for low-tier FSWs’ clients has important meaning for increasing condom use rate and preventing HIV transmission.

(3) Increase intervention strength targeting low-tier FSWs’ boyfriends and regular sex partners. Many studies showed that low-tier FSWs’ condom use rate with their boyfriends or regular sex partners were far lower than condom use rate during commercial sex behavior. Many of their so-called “boyfriends” or “regular sex partners” were clients who regularly patronized low-tier FSWs. Unsafe sex behavior with these regular sex partners and boyfriends had very high risk of HIV transmission and infection. Therefore, on the one hand, need to reinforce low-tier FSWs’ intervention propaganda and intervention strength in this aspect; on the other hand, also need to conduct intervention work for their regular sex partners and boyfriends.

(4) Strengthen low-tier FSWs’ consulting and testing, positive prevention, caring and treatment services. Research showed that after infected with STD, low-tier FSWs would usually continue commercial sex behavior to earn money. Meanwhile, the interview also found that some HIV positive low-tier FSWs would not give up commercial sex behavior in order to survive. But these low-tier FSWs infected with STD/HIV could not guarantee using condoms 100% during commercial sex behavior, which played an extremely important role in HIV transmission. There are focusing consideration policies for positive IDUs in methadone maintenance treatment projects in China, and many CBOs provide caring and treatment services for positive MSMs. But there are very limited similar work and efforts for low-tier FSWs. Therefore, should reinforce HIV consulting and testing work for low-tier FSWs, provide high-quality intervention, caring and treatment services for HIV positive low-tier FSWs, and encourage them to adopt safe sex behavior, and prevent HIV transmission.

(5) Reinforce support strength for CBOs providing services for low-tier FSWs. In the intervention for low-tier FSWs, CBOs play a unique role, which cannot be replaced by health professionals. CBOs have flexible business hour, and strong compatibility with target group’s culture, especially have irreplaceable advantages in the aspects of reaching target group and getting their trust, etc. Although CBOs’ involvement has progressed a lot in China, yet it is mainly focusing on CBOs providing services for other groups, such as MSM, IDU, and regular FSWs. The support and funding strength for CBOs providing services for low-tier FSWs is far from enough, and it does not get relevant attention. Therefore, the next step should be increasing support and funding strength for these CBOs, including capability building, organizational development, and funding support, etc., to make them better provide HIV prevention and intervention services for low-tier FSWs.

(6) Comparing to regular FSWs, low-tier FSWs have many special needs and features. Need to make special considerations when conducting intervention work among low-tier FSWs, and cannot use traditional strategies and methods. The detail technique suggestions and considerations for intervention measures are as follows:

1) Means of contact: Although there are different low-tier FSWs’ organizational forms and activities locations in different places, yet in sum, low-tier FSWs are hidden, scattered, establishment changeable, very mobile, and some FSWs in rural remote areas are remote. Therefore, the most important step of conducting intervention work for FSWs is also the most difficult-to-conduct step. Using FSWs’ and establishments’ features in low-tier establishments in the rural area, and connections between these establishments and group and other social departments and group, to find breakthrough points; the scholar summarized introduction by interrelated people method, self observation method, self experiencing method, identity showing method, snow ball method for finding low-tier establishments of FSWs in the rural area [50]. Excerpts are as follows for reference:

①Introduction by interrelated people method: mainly introduce by relevant government staffs who are taking charge of managing entertainment establishments. Functional government departments related to entertainment service establishments are mostly public security, industry and commerce, health supervision departments. Interviewing relevant staff of these departments will get the information of entertainment service establishments with sex activities, being introduced to enter establishments with sex, get in touch with establishments’ bosses, key persons, and FSWs, and help intervention personnel win their trust and support. This method fits for newly touched low-tier FSWs with fixed establishments and organized by bosses. The key to success is to gain bosses’ trust and cooperation. After bosses know about intervention’s purposes and benefits for them, intervention work will be conducted smoothly; meanwhile it will attract suitable relevant persons to get involved in the intervention team.

②Introduction by insider: residents around establishments, people often wandering around establishments, people doing business with establishment members such as condom sale delivery people, meal delivery people, mineral spring water delivery people, clinic/hospital doctors near establishments. These people know more about FSWs and establishments. They can help identify establishments and enter establishments, get in touch with bosses and FSWs. Rental agency staff, to know the general situation of nearby residence house’s vacancy and rent. Know local motels’ situation, which is the connection of floating people staying here, and accurately locate FSWs’ establishments.

③Field observation method: High risk establishments’ distribution depends on consuming groups’ situation. Especially low-tier establishments in rural area move a lot, but surely follow male-concentration areas and routes. The important method to find FSWs’ establishments is according to sex demand market existence. High risk establishments are usually in male workers-concentration factories, ore yards, and wharfs, near bus stations, peripheries of villages, towns, counties, and along the highway where truck drivers pass by. Low-tier high risk establishments are mostly in service establishments, and a few are in entertainment establishments, or named as healthcare massage, bath and sauna, foot therapy and massage, beauty parlor, hairdressing, tattoo, roadside restaurants and motels, singing halls, gyms, etc. Some low-tier establishments have no name, and their main features are: concentrating near where males concentrate, opening in the afternoon, night to midnight, colorful lights or dusky in the room, more female waitresses in establishments, heavy make-up sexy misses, leisure, very few or no service tools in the room, no sight of misses who are doing foot therapy or hairdressing services. Intervention personnel can roughly confirm high risk establishments if observing establishments with the above features in the field, and need to further confirm using other methods.

④Self experiencing method: Through self observation or insider introduction of undetermined high risk establishments. Disguise as driver or business partner to find FSWs for customer or boss, or as client to enter high risk establishment directly, and ask if they provide sex service, the price of sex service, whether to use condoms, and FSWs’ amount and ages, etc. FSWs will enthusiastically receive their clients and answer the above questions. Confirm high risk establishments based on their answers. Using self experiencing method needs to think through enough reasons, rehearse lines, have proficient performing skills, design methods to escape and leave the establishment. Male intervention personnel can disguise as clients or drivers, while female intervention personnel can disguise as helping business partners.

⑤Identity showing method: Intervention personnel can directly enter high risk establishments, starting from key persons, have a conversation with the boss and waiters, show intervention personnel’s real identity and intervention work’s purposes and methods, and explain intervention work’s principles and benefits for them. In some areas of in-depth and popular HIV/AIDS prevention and intervention propaganda, all relevant departments can coordinate and cooperate, and there are good social environment and mass foundation to adopt this method. This method requires intervention personnel to have proficient intervention technique and good psychological quality, enter establishments by providing services, communicate with them with service mind, fully understand their needs, conduct intervention work according to their needs, construct good trust relationship, and move them by honesty. This method is direct, and has quick effects. It can establish good long-time relationship with high risk group, get real in-depth information, and pass on full propaganda intervention information. It is suitable for all kinds of confirmed or undetermined high risk establishments.

⑥Snow ball method: According to the information provided by high risk establishments’ bosses or FSWs who have accepted intervention, find and confirm other high risk establishments and FSWs. This method’s information is accurate and reliable. Give proper rewards to information providers, and ask them to be peer propagandist and recommend new establishments’ peer propagandist to cooperate with the intervention work. Influenced by follow-the-crowd psychology, new found establishments are easier to accept and cooperate with intervention work, facilitate intervention work’s further implementation, and broaden intervention coverage.

2) Outreach and peer education is an important intervention strategy for low-tier FSWs. Research showed that peers were also one of the main pathways for them to receive HIV/AIDS knowledge [57]. When conducting outreach for low-tier FSWs, it cannot reach many people once like in fixed establishments, or organize many people to conduct outreach activities together sometimes. Many low-tier FSWs rent a room separately or are street based, or work at public places such as open-air parks. When conducting outreach or peer education, can only do one-on-one, and target group reached once is very limited. Therefore, need to recruit more outreach and peer educators for low-tier FSWs. Some low-tier FSWs are very mobile, which needs to increase outreach or peer education’s intervention frequency to reach certain intervention strength. For example, increasing intervention frequency to once a month. Low-tier FSWs have very strong self-protection awareness and high pre-caution. Some low-tier FSWs are part-time women with a family, so they are extremely sensitive to privacy and it is hard to get their trust. Therefore, outreach or peer propaganda personnel must come from target group of low-tier FSWs. It is best to recruit different types of low-tier FSWs as peer propagandists, so to reach them and get their trust, and facilitate next intervention work. Low-tier FSWs in different establishments and with different types are different in aspects of mobility, features, etc. Need to distinguish them when conducting outreach and peer education, and formulate different targeted strategies. Factors needed to consider when selecting peer education propagandists include [93]: voluntarily participating, and willing to conduct health education propaganda for peers; have certain education level and understanding ability; have some influence among this group; have strong responsibility, and good capability to deal with special situation; good at communication, and have certain interpersonal skills and organizing ability. Need to provide targeted trainings for outreach personnel and peers, including capability of how to persuade clients to use condoms. Need to have special consideration for the intervention content for low-tier FSWs: for example, the skill of increasing communication between FSWs and “clients” and persuading clients to use condom is an extremely important content of outreach intervention. Train them to use mouth to put on condoms, etc. Meanwhile, since their clients have relatively large quantity, and usually exceed their expectation, should encourage them to bring more condoms when going out to conduct commercial sex behaviors, etc.

3) Low-tier FSWs usually have relatively low education level, and some wrong knowledge of HIV intervention is popular in these low-tier FSWs. HIV/AIDS propaganda materials for them should be simple and easy to understand, short and sweet, with strong points. If condition allows, it is best to develop HIV/AIDS propaganda materials specialized for local low-tier FSWs based on practical evaluation.

4) Due to more clients and higher frequency, low-tier FSWs prefer condoms with more lubricant, which will reduce harm to their body. In addition, low-tier FSWs have poor economic status, and more clients, so the cost of condoms cannot be ignored by them. Using cheap low-quality condoms is popular among them. So whether they can get free condoms suitable for their needs is very important for increasing condom use rate [83]. Research showed that low-tier FSWs who can get free condoms could insist more on using condoms than low-tier FSWs who cannot get free condoms [2].

5) Community health activity center for regular FSWs need to provide targeted STD diagnosis and treatment, reproductive health or other health check-up services to attract low-tier FSWs to come here to receive services. Low-tier FSWs have tight time arrangement. Although their time arrangement is up to themselves, not like sex workers in establishments being managed by establishments’ bosses, yet they do not have spare time to go out and participate in activities. They serve large amount of clients every day. Once they have time, they will go out to search or wait for clients. For them, “time is money”, so they cherish time very much, and have little spare time to participate in various propaganda education activities regularly held at activity center. In addition, they are very sensitive to distance and transportation cost. The interview showed that many low-tier FSWs regularly went to activity center, and their main purposes were to receive free health check-up, reproductive health services or STD diagnosis and treatment services, etc., or to get free shower there. Especially STD services and health check-up possess considerable attraction for them. In some STD clinic (also providing health check-up), it is found that low-tier FSWs reached in outreach are fewer than those coming to clinic to receive services. Therefore, health activity center for low-tier FSWs need to have special design and consideration to improve activity center’s utility rate. It must combine with STD services, reproductive health services or health check-up, so as to attract low-tier FSWs to some degree.

6) Regularly provide consulting and testing service for low-tier FSWs. Early finding infectors and providing caring and treatment service is important for preventing HIV transmission among low-tier FSWs. But it needs to make some special considerations when providing testing. For example, it is very difficult to conduct on-site quick testing for low-tier FSWs in public space such as street or park, because it is hard to find a convenient and private place. Low-tier FSWs mostly are migrant population. When providing routine consulting and testing service, targeted mobilizing testing services combined with their own features will obtain good effects. For example, provide testing before they go back home for spring festival or other important holidays; provide targeted consulting and testing service for their special moments such as before getting married. These will get their support and approval. In addition, due to low-tier FSWs’ special sensitivity to privacy, we need to make special statement and guaranty when mobilizing them to get tested.

#### 13.3.2 Development of Community-Based Organizations (CBOs) Providing Services for Low-Tier Female Sex Workers

In the intervention among low-tier FSWs, CBOs have an important position and role, and can play the role that health professionals cannot replace. For example, CBOs have flexible business hour, stronger compatibility with target group’s culture, can reach low-tier FSWs with very strong pre-caution, and get their trusts and conduct HIV prevention and intervention work among them, etc. Therefore, CBOs should be aware of their own role, maximize favorable factors and minimize unfavorable ones, so that CBOs can get sustainable development and become more powerful, and play the supposed role and make the largest contribution in HIV/AIDS prevention and intervention work. Given the development status and challenges of CBOs providing services for low-tier FSWs, the author proposes the following suggestions for CBOs’ future development:

1. CBOs need to develop toward professionalism, and need high-quality involvement. CBOs have made unprecedented progress and attention in China. Their role and contribution are recognized by the government to some degree. However, with the increasing attention, the society’s expectations and requirements for CBOs are higher and more, and CBOs’ responsibilities and duties become more. In the future HIV prevention and intervention, CBOs need not only to simply participate, but also to participate professionally and with high quality. Therefore, CBOs’ organizational development is faced with requirements and challenges urgently adjusting to the new trends. There should be a long-time and strategic planning for its organizational development and operating capability, including planning and reinforcing organizational structure, staff team building, professional capability, operating area, financing management, etc. Pay attention to the following points in the professional development of CBOs providing services for low-tier FSWs:

(1) Professional qualified personnel team building will guarantee CBOs’ sustainable development. High professionalism of CBOs will more favor sustainable development, and professional development will greatly rely on team building of personnel with high quality and capability. It includes: recruitment and management of high-quality personnel, recruitment and management of volunteers, formulation and implementation of staff’s compensation and reward mechanism, etc. Solely relying on CBO staff from target group is difficult to satisfy CBO’s development and practical job demand, especially those CBOs constituting entirely of low-tier FSWs will be faced with larger development challenges. Therefore, CBOs need to pre-prepare, and consider and formulate relevant qualified personnel team building plan.

(2) Professional technique capability and high-quality services are important premises for CBOs’ sustainable development. With CBOs’ in-depth involvement and increasing attention on CBOs, service quality requirements and output standards for CBOs in the future will gradually increase. Funding for CBOs will gradually transfer from international aids to the government’s funding. Result-oriented funding management is the government’s important consideration, so the government will surely ask CBOs for quality and effects. Therefore, CBOs should be aware of actively improving their own professional technique capabilities, strengthening awareness of service quality and improving service quality, establishing a system in charge of all used funding, paying attention to effects and quality of funding use, so that CBOs can be gradually recognized and get more funding, and have the potential of sustainable development.

(3) Characteristic services and specialized skills have important meaning for CBO’s sustainable development. With more and more CBOs in various areas, survival of the fittest will be an inevitable choice faced by CBOs’ development. Now there are very few CBOs providing low-tier FSWs, so it is an important development opportunity for these CBOs. These CBOs should further reinforce their professional ability of providing services for low-tier FSWs, strengthen and excel at their professional skills and professionalism, and continuously explore creative service models. For example, actively explore effective models of HIV prevention and intervention services for low-tier FSWs, explore how to provide effective models of HIV prevention and intervention services for low-tier FSWs’ clients, to gradually establish these CBOs’ authority and reputation in the technique area, and to help apply for more funding to provide services and build organizational development.

2. Government buying services will be an important pathway for CBOs’ sustainable development. Large amount of international aid funding gradually ends and drops out of China. In the end of 2013, CBOs will be faced with extremely severe funding vacancies and survival challenges. Fortunately, the Chinese government has promised that it will compensate CBOs’ funding vacancies with government funding. Therefore, CBOs’ sustainable development in the future will largely rely on the Chinese government’s aids. CBOs need to prepare beforehand, actively preparing to transfer from international funding model to government funding model. Different funding resources have different funding application channels, application qualifications, management styles and operating requirements, etc. CBOs need to actively learn the application requirements and management models of the government funding, to prepare early.

3. Establish an open and transparent financing management system. Fund security is a focal point that almost all funding agencies firstly pay attention to. A complete financing management system is very important to gain funding agencies’ trust and approval, and even plays the veto-by-one-vote role in successful funding application, and is also important for making sure reasonable operation and cost effectiveness of project funding. Therefore, CBOs should actively establish and reinforce their financing management system and capability, ensuring open and transparency, to achieve various funding agencies’ requirements.

4. Get ready for registration any time. CBOs’ sustainable development in the future will largely depend on the Chinese government’s funding aid situation. So CBOs need to prepare early, and learn more about application requirements and management regulations of the Chinese government’s funding. Although there is no relevant regulations on CBOs’ future funding application and management in China, yet based on previous experience, the Chinese government has very high standard for fund security. It usually requires a legitimate bank account, special money for special use, and having a legitimate status will probably be an important advantage or requirement of CBOs applying for government funding. Registration may not be the only choice of getting a legitimate bank account, but it is predicable that the government will have more open and support attitude on CBOs’ civil administration registration. Getting a legitimate CBO status through registration will facilitate the organization’s development.

5. Actively seek for and establish external technique support network. With increasing societal attention on CBOs, the service quality of CBOs’ HIV prevention and intervention work will be the focus. It is far from enough to rely solely on CBOs’ own efforts and capabilities to improve their service quality. According to international projects’ experience, reliable external technique support has important meaning for improving projects’ implementing effects and making sure service quality. Therefore, if CBO can seek for and establish an effective external technique support channel in various ways and efforts, it will surely be this organization’s unique advantage, and plays a positive role in the organization’s long-time development.

#### 13.3.3 Development of China Sex Worker Organization Network Forum (CSWONF)

Now CSWONF is the main voicing channel for sex worker organizations in China. CSWONF plays a positive role in supporting member organizations’ development, improving sex workers’ occupational health environment, policy advocacy, etc.

CSWONF has severe challenges in its survival and development. The biggest and most crucial challenge is operating expenses. Since 2012, CSWONF have had no resource for daily operating expenses. The salary of CSWONF’s only staff can only be maintained by other organization’s support. CSWONF cannot conduct routine activities, and can only occasionally apply for micro-projects such as individual investigations in the name of CSWONF. In addition, without funding, CSWONF cannot guarantee enough manpower input to conduct relevant activities and provide services, which forms a vicious cycle. Given CSWONF’s current development status and practical difficulties, the author proposes the following suggestions for CSWONF’s future development direction:

1. Given CSWONF’s funding difficulty, maintaining current operating model is a practical choice. In other words, keep one person to part-time take charge of CSWONF’s business, focusing on CSWONF’s needs and concerning technique area to apply relevant funding to support specific activities.

2. To maintain and improve CSWONF’s cohesion and to better provide services for members, CSWONF can consider properly and regularly conducting some activities without too much manpower, given its very limited manpower now. For example, regularly search and share with members the latest news, project applications, policies and laws, technique guidance, research findings on FSW and HIV/AIDS. In addition, when providing services for members, consider providing targeted personalized services according to different members’ capability levels and development statuses.

3. CSWONF should consider building a resource-integration and information-sharing system among members. CSWONF’s resources are very limited now, but many members have lots of resources. Building a channel to share and use each other’s resources and information among members, can relieve the contradiction of CSWONF’s resource lacking to some degree, and also provide an opportunity for members to broaden their own influences and provide services for other members. Consider how to add some excitation measures to encourage members to actively support and participate in the resource-integration and information-sharing system when building this system. These resources and information to be shared include: faculty resources for trainings; funding for small-scale investigations; the latest news, project applications, policies and laws, technique guidance, research findings, project implementation and development on FSW and HIV/AIDS; information on members’ needs and cooperation.

4. CSWONF’s latest strategy planning is a two-year development planning formulated in 2010. With the development and change of HIV/AIDS prevention and intervention working environment and styles in recent years in China, this strategy planning is out dated, and cannot provide guidance for CSWONF’s development. So technically CSWONF has no strategy planning now. If condition allows, consider formulating CSWONF’s new strategy planning, combined with the latest HIV/AIDS prevention and intervention trends, to provide practical and feasible guidance for CSWONF’s future development. Meanwhile consider reviewing and revising CSWONF’s regulations formulated in 2010.

5. Now CSWONF has 14 member organizations, whose scale is not large. Consider properly broadening member’s scale, increasing member’s diversity, and attracting more members to join by providing attractive services and so on. This will help increase CSWONF’s influence and reputation, construct CSWONF with stronger and broader representative, share resources and information more broadly, and better integrate and use members’ resources and power to provide various services.

6. To increase CSWONF’s international and national influence and reputation, CSWONF need to increase its own technique power and capabilities, using experts and research findings to gradually fashion itself as authoritative and significant organization in the area of HIV/AIDS prevention and intervention among FSWs including low-tier FSWs. CSWONF should apply more funding to organize experts to conduct cutting-edge research on prevention strategies, methods, technique guidance, advocacy, etc. and timely publish and share research findings, to increase CSWONF’s influence and reputation. Put more efforts on forming CSWONF to be a Chinese FSWs’ largest voicing forum.

7. CSWONF’s operating direction and strategy locating should consider the following aspects:

(1) Further reinforce awareness and efforts of providing services for members, design and increase routine service activities, increase CSWONF’s cohesion and attraction, including: sharing various information services through various channels; capability building services, especially providing capability building and technique guidance services for newly founded FSWs’ organizations; organization development support services; financing information and cooperation support services; providing information and support of international experience, research news, funding and so on for members based on CSWONF’s international network advantage.

(2) Macro-advocacy on HIV/AIDS prevention and intervention among FSWs and CBOs, including: prevention and intervention and technique areas needing special attention as the priority; survival and development environment for CBOs providing services for FSWs; macro-policies and laws, disadvantage group protection and group assistance, etc.

(3) Pay attention to the latest research news and development in the area of prevention among FSWs. Research capability and research findings are the best way to increase CSWONF’s influence and survival capability. This does not require CSWONF staff to have this kind of capability, but CSWONF can use its own international network advantage and national influence advantage, to organize and coordinate experts, apply funding, cooperate with members, to conduct various cutting-edge research projects and activities, share research findings, increase CSWONF’s influence and financing development capabilities.

(4) Help members to construct unified external technique support network and provide capability building opportunities. Requirements and expectations for CBOs in the future will be higher and higher, and attention on CBOs’ service quality will be more and more. It is not enough to rely solely on CBOs to increase their service quality. Use CSWONF’s international and national network advantages and influence, to help all members build unified external technique support and capability building system and network. This will help CSWONF increase its influence and contribution, and satisfy members’ needs and increase their operating capabilities, and favor CSWONF and its members’ sustainable development.

(5) CSWONF needs to have diverse financing channels, and can consider making the following attempts:

1) Independently apply for international project funding based on CSWONF’s own power and influence.

2) Based on its international and national connecting network channels, broadly obtain diverse project application information, and apply for funding on research and cooperate with member organizations. This can show CSWONF’s macro-influence and networking advantage, and also show member organizations’ first-hand field experience and entity organization’s advantage.

3) Based on CSWONF’s information advantage and international and national networking advantage, play the role of bridge and ligament between international funding agencies and member organizations; as a coordinating organization, coordinate with funding agencies and member organizations to complete the project’s implementation together.

4) Collect necessary service fee or membership fee for personalized services for member organizations, to obtain CSWONF’s operating expenses.

14. Limits of This Report

Firstly, this report mainly relies on analysis and summary of publicly available literature materials and project reports, etc. while there were very limited available materials with enough detail information, and many important materials and information could not be obtained. Low-tier FSWs were not an independent target group in almost every project on FSWS. So there was almost no information about low-tier FSWs, such as low-tier FSWs’ coverage and relevant output index, specific implementation performance and difficulties of low-tier FSWs’ intervention.

Secondly, there considerably lacks quantitative information of CBOs, especially there was almost no information of CBOs for low-tier FSWs. In-depth quantitative analysis and evaluation could not be done for relevant questions in this report, such as CBOs’ service coverage, service quality and effects.

Thirdly, most projects have many internal materials and research findings that are not open published or cannot be obtained through open channel. Even if the author has these materials, the author still cannot use them. It to some degree influences the full utilization of the latest materials in this report

Lastly, many projects do not have open final reports or project operation details, so this report cannot fully cover other HIV/AIDS prevention and intervention projects and funding aids for low-tier FSWs in China, and only selects some most representative and large-scale projects for reference.

15. Appendix

#### 15.1 Appendix 1: Interview Outline (CBO Members)

|  |  |  |
| --- | --- | --- |
| **N.O.** | **Question** | **Answer** |
| 1 | In what aspects do you think low-tier FSWs have obvious different features from other FSWs (for example, working place, living place, boss management, service style, service price, income, clients, condom use, personal cultural economic background, etc.)? |  |
| 2 | Where do they mostly do business? Why? What kind of clients do they have? At what time do they usually do business? |  |
| 3 | How is their condom use? What obstacles do they have when using condoms (personal, client, or else)? How to make sure that they use condom every time? What are the difficulties to insist using condoms? Any situation of condoms being broken? Where do they usually get condoms? |  |
| 4 | What work has your organization conducted for low-tier FSWs? What special considerations does your organization have when providing these services for low-tier FSWs? What are their main needs? How does your organization do monitoring and evaluation when conducting work? What materials does your organization collect? How to collect and use these?  |  |
| 5 | What do you think are the main points for conducting intervention work for low-tier FSWs? What are the difficulties? What experience or lessons have you learn?  |  |
| 6 | What irreplaceable advantages and roles do you think CBOs have when conducting HIV/AIDS prevention and intervention work for low-tier FSWs? How to better play CBO’s roles?  |  |
| 7 | How are previous and current fund resources and funding quantities; expected fund needs, resources, quantities, and gaps in the coming year, etc.? Where do funds for intervention among low-tier FSWs come from? |  |
| 8 | What difficulties have you had when conducting HIV/AIDS prevention and intervention work among low-tier FSWs? What help will you need in the future? |  |
| 9 | What help has CSWONF given? What role can CSWONF further play? What kind of support do you need CSWONF to provide? What role does your organization play in CSWONF’s development? What role and contribution will your organization further play for CSWONF’s development? |  |
| 10 | What suggestions do you have for HIV/AIDS prevention and intervention among low-tier FSWs in China?  |  |
| 11 | What difficulties and challenges does your organization have in its future development? How do you think of your organization’s capability? What are the disadvantages and needs in capability building? What help does your organization need in future organizational development? |  |

#### 15.2 Appendix 2: Interview Outline (Target Group)

|  |  |  |
| --- | --- | --- |
| **N.O.** | **Question** | **Answer** |
| 1 | In what aspects do you think low-tier FSWs have obvious different features from other FSWs (for example, working place, living place, boss management, service style, service price, income, clients, condom use, personal cultural economic background, etc.)? |  |
| 2 | Where do you mostly do business? Why? What kind of clients do you have? At what time do you usually do business? |  |
| 3 | How is your condom use? What obstacles do you have when using condoms (personal, client, or else)? How to make sure that you use condom every time? What are the difficulties to insist using condoms? Any situation of condoms being broken? Where do you usually get condoms? |  |
| 4 | Have you ever persuaded clients to use condoms? How did you persuade them? What difficulties did you have? Do they usually use condoms? Why? |  |
| 5 | What HIV/AIDS prevention and intervention services did you receive in the past year? Which organizations provided them? How do you think of these services? Any difficulties to receive these services (intervention, testing and consulting, treatment and caring, etc.)? How to improve these services? |  |
| 6 | What do you think are the main points for conducting intervention work for low-tier FSWs? What are the difficulties? Any experience or lessons? |  |
| 7 | What irreplaceable advantages and roles do you think CBOs play when conducting HIV/AIDS prevention and intervention work among low-tier FSWs? How to better play CBO’s roles?  |  |
| 8 | What do you think are the difficulties when conducting HIV/AIDS prevention and intervention work among low-tier FSWs? What do you care most? What are your main needs? |  |
| 9 | What suggestions do you have for HIV/AIDS prevention and intervention among low-tier FSWs in China?  |  |

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