Smart Girl
ឈ្លាសវៃចៀសសេវាសុខភាព

ប្រសិទ្ធI PRASIT

PROGRAM REVIEW

PROVIDING HIV/AIDS
PREVENTION AND CARE FOR

ENTERTAINMENT WORKERS

REPORTING PERIOD:
OCTOBER 2008 - JUNE 2010

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGMENTS

This mid-term review was conducted by FHI 360[1] Cambodia, funded by the United States Agency for International Development (USAID) under the PRASIT project. The study was conducted between August and December 2010 in 11 major Cambodian cities.

The research team at FHI 360 Cambodia, led by Dr. Kai-Lih Liu (Associate Director, Strategic Information (SI)), and FHI 360 Cambodia Prevention Units, led by Caroline Francis, would like to thank all stakeholders and partners who made this review possible. Dr. Kai-Lih Liu and Caroline Francis acted as Joint Principal Investigators for this study. Iwen Wang assisted in study design and protocol development. Ngor Somany designed ACASI/CASI format of all questionnaires. SMARTgirl Program Officers (Muth Sokunny and Seng Sopheap) assisted in field coordination. Prum Virak was responsible for data management and field coordination. Phou Maly led a field team of interviews (Ly Sreypeou, Lim Dany, Keo Serey, Cheom Bunthy, Yav Net) to conduct interviews with selected EWs, and MStyle Program Officers (Heng Koy and Chhoeung Sovannarith) conducted the Facilitator interviews. Qualitative data was contributed by Bou Amara, who conducted the in-depth interviews of entertainment workers as part of her master's degree in Health Social Science at Mahidol University, Thailand.

The final report was prepared by an external consultant, Kerry Richter and finalized by Nicky Jurgens (Technical Assistance Advisor, M&E, FHI 360), with input from Amy Weismann (Associate Director, Prevention and Mitigation, FHI 360).

The review team would like to extend their sincere appreciation to all the participants who took part in this mid-term review, without who the study would not have been possible.

1 FHI 360 - An organization created in July 2011 from the combined resources and expertise of Family Health International and the Academy for Educational Development

ABBREVIATIONS

ACASI	Audio Computer-Assisted Survey Instrument
BSS	Behavioral Sentinel Surveillance
C/PITC	Community / Peer Initiated Testing and Counseling
CASI	Computer-Assisted Survey Instrument
CUP	100% Condom Use Program
EW	Entertainment Worker
FP	Family Planning
HIV	Human Immuno-deficiency Virus
IA	Implementing Agency
MARP	Most At Risk Population
MDG	Millennium Development Goals
MSM	Men who have Sex with Men
NCHADS	National Centre for HIV/AIDS, Dermatology and STI Control
NECHR	National Ethics Committee for Health Research
NGO	Non Governmental Organization
NIPH	National Institute of Public Health
PPS	Probability Proportional to Size
PSI	Population Services International
PWID	People Who Inject Drugs
R1, R2 ETC.	Respondent to in-depth interview #1, #2 etc.
RH	Reproductive Health
SG	SMARTgirl
SSS	STI Sentinel Surveillance
STI	Sexually Transmitted Infection
TG	Transgender
VCCT	Voluntary and Confidential Counseling and Testing

EXECUTIVE SUMMARY

Cambodia continues to make significant gains in the fight against HIV, and FHI 360, through the USAID-PRASIT Project, has remained at the forefront of that battle with those most at risk. Through a host of innovative programs spanning outreach, research and technical assistance to government and NGOs, FHI 360 has set the pace for change.

As Cambodia's HIV epidemic continues to shrink, it remains vital that the most-at-risk populations (MARPs)—entertainment workers (EWs), men who have sex with men (MSM), and people who inject drugs (PWID)—remain a priority for prevention, particularly those who are hidden or hard to reach. In 2008 the Cambodian government introduced the Law on the Suppression of Human Trafficking which had a major impact specifically on the EW population in the country. Brothels and many other entertainment establishments (EE) were shut down, forcing these women to work in less visible locations and unsupported by any social or health-related services.

In response, the innovative, branded SMARTgirl program was developed by PRASIT. The project responds to the needs of high risk EWs, reaching them with strategic prevention and education messages, condom and lubricant supplies, as well as systematic health service referrals.

This mid-term review of SMARTgirl was conducted to gather data which, when triangulated with other sources, could be used to monitor program performance over the October 2008 – December 2010 period. Both quantitative and qualitative data was collected from EWs as well as peer facilitators and analysis was supported by existing programmatic data. The information gathered has been used to generate recommendations for the remaining 2 years of the initiative under PRASIT.

Overall, the results from the review were overwhelmingly encouraging and supportive of the SMARTgirl initiative. SMARTgirl is effective in reaching a significant proportion of EWs with the core package of HIV prevention education, information about prophylaxis and referrals to appropriate sexual health services through a variety of channels. The data also shows that SMARTgirl has been very successful in reaching its target group of higher risk EWs, with the drop-in services at the SMARTgirl Clubs being particularly appealing to this sub-group of EW.

Uptake of reproductive health care and modern or long acting methods of family planning is still relatively low amongst EWs and does not rank as a high priority in their life. Additionally EWs' condom use and risk perception is low when discussing sex with husbands or long term partners. If it is these relationships that are determined to be one of the current driving forces of the HIV epidemic in Cambodia, data from the review suggests much work is to be done in this area with both men and women involved in the entertainment sector.

Throughout 2011-2012, SMARTgirl will reach further, into venues such as massage parlors, night clubs, karaoke (KTV) and casinos to continue efforts to reach the most high risk EWs with recent innovations such as Community / Peer Initiated Testing and Counseling (C/PITC), a community-based rapid HIV test. SMARTgirl will also be putting a heavy focus on strengthening linkages between HIV and family planning services to increase the number of EW referred to and accessing contraceptive methods. One initiative may be to incorporate family planning into SMARTgirl Clubs. SMARTgirl will also continue to work with community stakeholders such as the police and other law enforcement agencies to build their capacity and knowledge of EWs and to make appropriate referral services for them.

The team at FHI 360 strives to continuously improve the effectiveness of the SMARTgirl program, and uses data, such as that from this mid-term review, to do so. Through strategic technical assistance, FHI 360 encourages local implementing agencies to do the same.

INTRODUCTION

Background

Cambodia has achieved dramatic success in reducing its national HIV prevalence since the 1990s. From an estimated peak of 2% in 1998, HIV prevalence among the general population has decreased to 0.9% in 2006 and was estimated to have dropped further to 0.7% by 2009 . As a result, Cambodia is one of the few countries in the world that has achieved its Millennium Development Goals (MDG) related to HIV. However, despite this success HIV prevalence remains unacceptably high amongst certain at-risk groups—entertainment workers (EWs), men who have sex with men (MSM), transgender individuals (TG), and people who inject drugs (PWID).

Despite the success of the 100% Condom Use Program (CUP) in reducing HIV prevalence among entertainment workers (EWs), the 2008 Law on the Suppression of Human Trafficking and the corresponding closure of entertainment establishments forced EWs to work in less visible locations. Since the 2008 law, there has been a significant shift of women working in brothels to those working in non-brothel based entertainment establishments. Many of these women do not sell sex or, even if they do have transactional sex, do not consider themselves to be sex workers. The CUP targets women working in brothels but misses the great majority of women working in the entertainment industry. In its 2007 report, the National Centre for HIV/AIDS, Dermatology and STI Control (NCHADS) reported 50% coverage among brothel-based EWs, but only 8% coverage among non-brothel based EWs. The 2008 law and the changing Cambodian socioeconomic context has hampered STI and HIV prevention efforts and made it difficult to ensure condom availability and accessibility, and led to the demand for new approaches to improving the sexual health of these vulnerable women.

Like other vulnerable groups, EWs have overlapping risks and mix with other populations. In the 2005 STI Sentinel Surveillance survey (SSS), 40% of MSM reported having sex with a female partner in the past year, with female EWs identified as the most common sexual partner. Drug use is also an emerging issue: the 2007 Behavioral Sentinel Surveillance (BSS, 2007) found 10% amphetamine (yama) use among brothel-based EWs. A 2006 study by Population Services International (PSI) found that up to 6% of female karaoke workers reported ever having injected drugs.

HIV prevention efforts among EWs have focused on their role in reducing personal risks for HIV, as well as contributing to risk reduction of their clients and partners. Emphasis has been placed on educating women in self-efficacy (e.g. condom negotiation techniques) instead of challenging gender norms that make women vulnerable in the first place. Cambodia is not unique in that it is men (husbands, sweethearts, regular partners and clients) who typically determine when, where and how sex will occur.

Programs for EWs have not consistently updated and rejuvenated messages, and materials and approaches have remained stagnant for almost ten years. Boredom is common among EWs, peers and outreach workers. While condom use is high with commercial transactions, almost one quarter of EWs report irregular condom use with regular partners and sweethearts. With around a third of all EWs reporting having had an abortion in the past year (BSS, 2007), family planning and reproductive health information and services are critical.

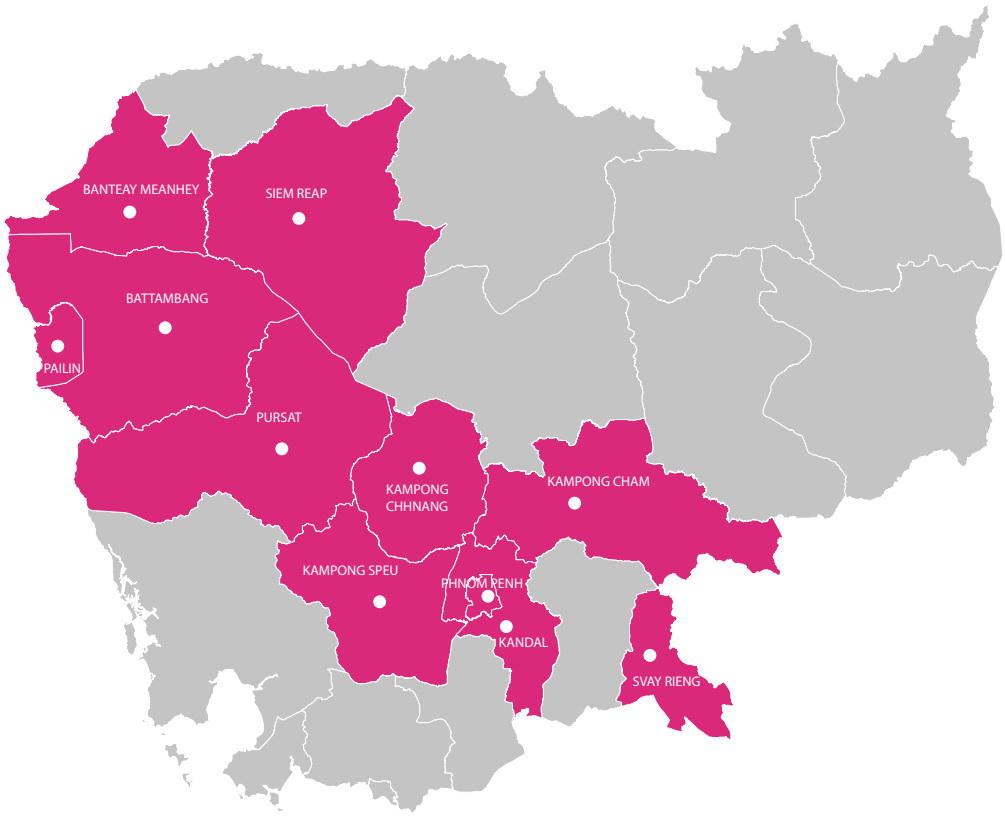
Reinvigorating HIV prevention for EW: the evolution of SMARTgirl

Recognizing that Cambodian and Vietnamese women working in the entertainment industry have made a tremendous contribution to HIV prevention in Cambodia but remain vulnerable to unplanned pregnancy, illicit drug use, STIs and HIV, under the PRASIT Project, FHI 360 Cambodia and its partners introduced the SMARTgirl HIV prevention and care program in October 2008. SMARTgirl aims to improve the sexual health and general well-being of EWs through an innovative, holistic, human rights based and branded, sexual health program.

The key programmatic strategies of SMARTgirl are as follows:

1. To implement targeted and branded behavior change approaches for subgroups of EWs that emphasize risk reduction and promote safer sexual practices.
2. To promote and increase access to health information, products and services among EWs.
3. To build a supportive environment for EW sexual health by mobilizing stakeholders such as entertainment establishment owners, police, healthcare providers and others.
4. To build the capacity of implementing agency staff, facilitators, volunteers and stakeholders to plan, coordinate, implement, manage and monitor the program.

FIGURE 1. SMARTgirl Geographic Coverage



The SMARTgirl program covers 11 cities throughout Cambodia: Phnom Penh, Kompong Cham, Battambang, Siem Reap, Banteay Meanchey, Kandal, Kompong Chhnang, Kompong Speu, Pursat, Pailin and Svey Rieng. Key program activities include the delivery of core services through individual and group level outreach conducted at a variety of venues where EWs work, including beer gardens, restaurants, karaoke bars, night clubs, massage parlors, guesthouses, brothels and in Svey Rieng outreach is also conducted in casinos. EWs fall into 3 distinct, but sometimes overlapping employment categories: fully employed by an establishment, freelance and street-based. Freelance EWs typically recruit clients to frequent certain bars, restaurants etc., from whom they get commission. The EW may also receive payment from the client for entertaining them, which may or may not include sex. Street-based EWs typically recruit clients for sex from street locations. EWs may participate in one or more of these activities to ensure sufficient income.

Through contact with SMARTgirl programs, EWs are provided with targeted HIV/STI/RH prevention education, condom and lubricant promotion and systematic health service referrals for HIV and STI screening. SMARTgirl Clubs have been established in 5 priority cities (Phnom Penh, Kompong Cham, Battambang, Siem Reap and Banteay Meanchey), where in addition to the services mentioned above, EWs

can obtain HIV VCCT (the Phnom Penh club also offers mobile STI testing once a month) as well as access information on non-health services including social safety net protection, occupational training and drug use treatment support. SMARTgirl clubs also offer EWs a safe space to relax, socialize and get manicures. The Clubs are staffed by a Club Manager, Outreach workers and volunteer Peer Facilitators, who are also supported by a team of peer educators. For the purpose of this review, the abovementioned individuals are collectively referred to as 'Facilitators'.

During this 2008-2010 reporting period, program activities were conducted via FHI 360's seven Implementing Agencies (IA): Cambodian Women for Peace and Development (CWPD), Khemera, Medecine de l'Espor Cambodge (MEC), Partners for Development (PFD), Phnom Srey Association for Development (PSAD), Sacrifice Families, Orphans and Development Association (SFODA), Agency for Technical Cooperation and Development - Pharmaciens Sans Frontieres (ACTED-PSF).

SMARTgirl stands apart from other programming among Cambodian and Vietnamese entertainment workers in several ways:

- A positive, non-stigmatizing and fun tone (the SMARTgirl brand) runs through all messaging, materials and interventions.
- Quarterly strategic behavioral communications themes and objectives form the basis of the targeted interventions. Each quarter, the SMARTgirl team use EW testimonials, monitoring data and other evidence to articulate specific communications objectives that form the basis of messaging and communications tools. These tools have been designed to raise awareness, increase service uptake and promote positive healthy behaviors in a way that resonates with and appeals to targeted service users. Recognizing that EWs are not a discrete population, PRASIT has harmonized quarterly messaging with its program for males who have sex with males (called "MStyle"), so that those who are most vulnerable to HIV receive consistent, relevant, clear and powerful messages through a number of different channels.
- A focus on building a network of dedicated supporters – SMARTgirls – that can act as inspirational role models for positive health.
- A stronger capacity building and M&E component, so that implementers are better trained, can more effectively collect and use data for program quality assurance and improvement, can build stronger partnerships for referrals and outreach, and can reach the targets set out for themselves as individuals, their organizations and the program as a whole.
- Linked response, that moves beyond a series of individual "projects" serving EWs to a "program" that promotes and builds partnerships with implementing agencies to respond to the short and long-term, diverse needs of Cambodian and Vietnamese women in the entertainment industry.

Above all, SMARTgirl is a flexible, innovative program that uses feedback from EWs and evidence to promote women's positive health and well-being in a complex, changing Cambodian society.

The SMARTgirl Review

This report describes the results of a mixed-method review of the SMARTgirl program over the October 2008 – December 2010 reporting period. The analysis conducted will help to monitor program performance over this period and generate programmatic recommendations for the remaining 2 years of the initiative.
A number of key assumptions underlie the development of the SMARTgirl program. These assumptions include the following:

1. EWs will identify with the SMARTgirl brand and the key messages of the program will resonate with them. Ultimately, EWs reached through the program will see themselves as "SMARTgirls" and will use words like "believable," "supportive," "fun," and "relevant" to describe the SMARTgirl program.

2. By linking the SMARTgirl (EW) and the MStyle (MSM) programs, FHI 360 and its partners will reach overlapping populations (e.g. TG, EWs with MSM partners, etc.) with powerful, consistent messaging.
3. The program's design—particularly its emphasis on quarterly communications themes, targeted messaging and comprehensive capacity building—means that outreach workers and peer facilitators are well trained; that program quality is consistent across geographic settings and across implementing agencies; and messages are retained by both those providing and receiving them.
4. EWs reached through SMARTgirl will be consistently receiving PRASIT's "core" package of prevention services at each contact. The core package consists of three components: (a) targeted education; (b) condoms/lubricant (promotion or provision, with an emphasis on social marketing); and (c) systematic health service referrals.

The SMARTgirl "brand" can be used as a social mobilization platform to link diverse groups of EWs across the country; to foster a more positive image of entertainment work and the women who work in this industry; and to support a more vocal group of women who advocate for positive health. The review aims to assess the validity of these key assumptions and answer particular programmatic questions, including:

1. What are the key characteristics of EWs reached by the SMARTgirl program?
2. What is the proportion of those who avail health services more than once in a particular reporting period compared to those who do not?
3. Are there differences in risk perception and risk reduction behaviors between EWs with different levels of exposure to the SMARTgirl program?
4. What are the key determinants that influence positive behaviors among EWs in the program?

Using the results of the quantitative and qualitative surveys conducted between August and November 2010 with project beneficiaries and program implementers, as well as regular program monitoring data, this mid-term review aims to assess the validity of program assumptions and answer these key programmatic questions, to identify strengths and weaknesses of the program and to generate programmatic recommendations for the future.

Review Objectives

The specific objectives of the review are to:

1. Profile the key characteristics of EWs exposed to the SMARTgirl program.
2. Establish a dose-response[2] association between exposure to the program and key behavioral determinants.
3. Assess the benefits of SMARTgirl program perceived by the members.
4. Assess the SMARTgirl program service access barriers and opportunities.
5. Assess SMARTgirl program implementers' capacity to deliver information, products and referrals.

To effectively achieve these objectives, this mid-term review documents the following findings:

- Background characteristics of SMARTgirl clients and program facilitators
- Success of the different SMARTgirl program channels
- Success of the delivery of the core service package
- Positive health knowledge and practices among EW—i.e. uptake of health services
- HIV risk behaviors among EW—including sexual risk behaviors, condom use and alcohol and drug associated risk behaviors

2 A dose-response relationship in this case describes the change in effect/behavior of EWs when exposed to different levels of SMARTgirl programming.

- Overlapping populations and the role of SMARTgirl and MStyle programs
- Stigma and gender-based violence faced by EW
- Identification with and perceptions of the SMARTgirl program

METHODOLOGY

Overview

The review of the SMARTgirl program was conducted between August and November 2010 by triangulating 1) existing program data; 2) quantitative questionnaire data, including face-to-face interviews with EW and program facilitators using the (Computer-Assisted Survey Instrument) CASI or Audio Computer-Assisted Survey Instrument (ACASI) technology; and 3) a qualitative survey of EWs. All study materials and protocols were reviewed and approved by National Institute of Public Health (NIPH) National Ethics Committee for Health Research (NECHR) in Cambodia.

Program data

FHI 360 Cambodia's monitoring and evaluation database (i.e. FHICAMIS) was used to analyze key indicator data collected from IAs working with EWs in the SMARTgirl program. Indicators were analyzed for the period of implementation of the SMARTgirl program, October 2008 – December 2010. The following core indicators were collected:

- Number of people reached through individual-level and group-level outreach;
- Number of contacts through individual-level and group-level outreach;
- Number of people registered at the SMARTgirl Clubs;
- Number of commodities (condoms and lubricants) distributed and socially marketed
- Number of referrals made to and collected from STI, VCCT, reproductive health/family planning and other key services; and
- Number of people reached through club or community-based events.

The program data are presented in graphical form and are used to provide information on program trends and to provide a cross-check with the survey data.

Questionnaires

QUANTITATIVE DATA: BEHAVIORAL AND PREVENTION COVERAGE SURVEY FOR EWS

A quantitative survey was conducted with a sample of EWs in the SMARTgirl program area and with all SMARTgirl outreach workers, peer facilitators and club managers. The methodology is described below.

SAMPLE SIZE AND SAMPLING STRATEGY

The most recent mapping of high risk entertainment venues compiled by IAs (who update their mapping on a quarterly basis) was used as a sampling frame. This sampling frame included the name and address of the venues, the type of establishment (i.e., restaurant, karaoke, beer garden/club, massage, and brothels), and the number of female staff.

A two-stage cluster sampling scheme stratified by city was used to select participants. The sampling frames from the six major program areas were combined together and sorted by city and then by the venue type (restaurant, karaoke, beer garden/club, massage, brothels etc.). The number of EWs selected for each city was determined proportionally to the total number of EWs in that city. A weight of 30% was added to the sample number to cover the non-response rate. Therefore, it was calculated that a total of 1043 (803*1.3) should be selected, with the aim of surveying at least 803 participants. Clusters were selected with probability-proportional-to-size (PPS), and a fixed number of participants (n=15) were randomly selected from each cluster at the second stage. The result was seven self-weighted and representative samples by city, and together, they represent the total target population in the program areas.

It was assumed that this would be a repeated survey since FHI 360 may conduct a similar survey in the future for the final project evaluation. Based on this assumption, the required sample size was computed using the following formula for repeated surveys:[3]

$$n = D\frac{\left[Z_{1-\alpha}\sqrt{2\bar{P}(1-\bar{P})} + Z_{1-\beta}\sqrt{P_1(1-P_1)+P_2(1-P_2)}\right]^2}{(P_2-P_1)^2}$$

D = design effect = 2

P_1 = estimated proportion at first survey (uptake of STI check-up in the past year) =0.32

P_2 = estimated proportion at second survey for the above indicator = 0.42

$\bar{P} = (P_1+P_2)/2 = (0.32+0.42)/2 = 0.37$

$Z_{1-\alpha} = 1.645$ ($\alpha = 0.05$, one-sided)

$Z_{1-\beta} = 0.84$ ($\beta = 0.80$)

Inflation factors include invalid answers (10%) and non-exposure to at least two interventions of the SMARTgirl program (30%) and are applied to the calculation of the required sample size. A required sample size of 803 EWs was calculated. A total of N=1,043 EWs were recruited in the survey: 485 from Phnom Penh, 30 from Pailin, 30 from Battambang, 80 from Poipet, 75 from Svay Sisophon, 175 from Siem Reap and 99 from Kampong Cham.

ELIGIBILITY

All those who met the following criteria were eligible for participation in the study:

- Khmer speaking
- Biological female
- Aged 17 years or above
- Self-identified as an EW or sex worker or working in entertainment establishments, such as massage parlors, bars, karaoke halls, beers gardens or restaurants, private homes etc. that are covered by the program.
- SMARTgirl outreach workers, peer leaders and club managers who are in charge of facilitating outreach contacts, making referrals and commodity social marketing or distribution.

QUESTIONNAIRE CONTENT

Survey questionnaires contained questions pertaining to the following:

- Socio-demographic characteristics
- Exposure to core program interventions including SMARTgirl clubs
- Access to condoms, lubricants and HIV information
- Health service referrals and health service uptake
- Sexual risk behaviours
- Alcohol and drug risk behaviours
- Identification with and perception of the SMARTgirl program

DATA COLLECTION

Local interviewers were recruited and trained to conduct face-to-face interviews and in discussing sensitive issues. Whilst IA staff were involved in introducing peers to the interviewers, to minimize bias, staff were not directly involved in the data collection process. IA facilitators approached potential participants before their working hours, generally between 10am and 3pm, and explained the study in detail to those who were willing to participate. The interviewers then obtained verbal informed consent and sent the participant to

3 Family Health International (2000). Behavioral Surveillance Surveys: Guidelines for Repeated Behavioral Surveys in Populations at Risk of HIV.

the interview site to conduct the interview in private. During the interview, no personal identifiers were recorded or written down in the field notes and all participants were assured of their confidentiality. Consenting participants were interviewed in private locations with only the interviewer and participant present. Survey data was collected through self-administered interviews using a CASI or where appropriate with the ACASI, which was administered with the help of the interviewers. After the interviews, participants received a mobile telephone calling card of $2 USD to compensate for their time and effort. In addition, they received condoms, lubricant, communications materials and STI/VCCT referral slips.

DATA MANAGEMENT AND ANALYSIS

Data analysis was conducted using STRATA 8.1. Descriptive statistics of all variables were computed. In addition, associations including possible dose-response relations between exposure to interventions and key behavioural variables were also examined. All survey-related documents and materials were stored in locked filing cabinets in the FHI 360 Cambodia office.

Qualitative data

Nine in-depth interviews were conducted with female entertainment workers participating in the SMARTgirl program. These included those who work in karaoke shops, massage parlors, beer gardens, and on the street, and who do not necessarily self-identify as sex workers. These interviews were conducted as part of a thesis for a master's degree in public health, which was approved by the Cambodia National Ethical Committee. The study was conducted independently from FHI 360 Cambodia, but the author granted FHI 360 the permission to use the results.

The interviewer built relationships with SMARTgirl Club members through volunteering at one of the clubs in Phnom Penh and participating in all activities for one month. In this way she gained the trust of some club members who were the first respondents for the interviews. Recruitment of respondents focused on selecting female entertainment workers who have worked in a wide range of entertainment venues. After selecting a few informants that the interviewer knew personally, the remaining informants were recruited using snowball sampling.[4]

Transcripts of the nine interviews were translated from Khmer to English. They were reviewed and coded by the author of this report according to topics of interest. The qualitative data is used to provide meaningful supportive detail on some of the key topics that were also covered in the EW quantitative survey.

Peer Facilitator Capacity Survey

SAMPLE SIZE AND SAMPLING STRATEGY

All SMARTgirl club managers, outreach workers and peer facilitators were recruited to participate in this survey.

ELIGIBILITY

All SMARTgirl club managers, outreach workers and peer facilitators who were in charge of facilitating outreach contacts, making referrals and condom social marketing or distribution were eligible for participation in this survey.

QUESTIONNAIRE CONTENT

The questionnaire contained relevant questions to elicit the following information about program facilitators:

1. Their understanding of SMARTgirl goals and objectives;
2. Their understanding of the prevention core package and whether they provided the core

4 A non-probability sampling technique where an existing study subject recruits future subjects from among their acquaintances..

package at the last contact;
3. Their retention of key quarterly messages;
4. Their reasons for becoming involved in SMARTgirl and whether or not they feel emotionally connected to the program;
5. Whether or not they have received referral incentives from the program; and
6. Their perceived benefits and challenges of the program.

DATA COLLECTION

Data collection took place between August and December 2010 in 7 Cambodian cities. Interviews were conducted using CASI, facilitated by MStyle program officers from FHI 360. These program officers were familiar with the SMARTgirl programmatic approach and were therefore able to administer the questionnaire and prompt respondents as needed. No personal identification information was recorded on the questionnaire. Interviews took place in a private room where only the interviewer and respondent were present. Verbal informed consent was obtained from the respondent and recorded on the CASI. Participation in the survey was voluntary and the respondent could choose not to answer any question s/he didn't want to. In total, 87 of the approximately 142 facilitators participated in the survey with 85 completing the survey, a 60% total response rate.

DATA MANAGEMENT AND ANALYSIS

Data analysis was conducted using STRATA 8.1. Descriptive statistics of all variables were computed. All survey-related documents and materials were stored in locked filing cabinets in the FHI 360 Cambodia office.

RESULTS

1.Background Characteristics of SMARTgirl clients and program facilitators

SMARTGIRLS

Figure 1.1 profiles the socio-demographic characteristics of EWs interviewed during the survey. Overall about two-thirds of the EWs in the sample were in their 20s, with 22% age 18-20 and 15% in their 30s. Just under half were single (never married); about 1 in 4 was married and about 1 in 3 formerly married. When asked about their living arrangements, 42% reported that they lived with family (parents, husband/children and/or other family members). A nearly equal proportion (37%) lived with friends. About 13% of the EWs lived alone, and 7% lived with a sweetheart or ta-ta.[5] Approximately half of the EWs sampled were migrants who came to live in Phnom Penh within the last 5 years.

FIGURE 1.1: Socio-demographics of EWs in the sample (N=1,057)

With regards to their educational background, 11% of the EWs reported they had no education, with three-quarters having had 7 years or less. Only 18% reported their literacy in Khmer is "good to excellent". About 1 in 4 had some English speaking ability and 6% some Vietnamese speaking ability. One in four reported that they own a mobile phone.

5 Slang for a wealthy man who supports a woman as his mistress.

TABLE 1.1: Profile of EWs by current and former jobs

	ALL RESPONDENTS
CURRENT JOBS	
Karaoke worker	45.3
Beer garden worker	23.5
Beer promoter	6.1
Bar worker	4.8
Freelance EW	4.2
Massage parlor worker	7.0
Brothel-based EW	5.2
Street-based EW	3.0
Unemployed	0.1
Other	0.8
TOTAL	100.0
(n)	(1054)
SECOND JOB	
None	79.6
Another EW job	11.7
Non-EW job	7.2
Student	1.5
TOTAL	100.0
(n)	(1048)
FORMER JOB	
Unemployed	18.5
EW	26.0
Non-EW	55.4
TOTAL	100.0
(n)	(1053)

The SMARTgirl program focuses on reaching non-brothel based EWs, particularly those working at entertainment establishments and as freelancers. As seen in Table 1.1, karaoke, beer garden, beer promoters and bar workers make up about 80% of the sample. The majority of EWs seemed to have one primary job with only 20% reporting a second EW-related job and 7% a non-EW related job.

The nine qualitative interviews provided rich background and insight into the diversity among women who work in the entertainment business. Several of them were freelance sex workers who have gained a substantial amount of independence; their clients reach them by phone and they meet them at a guest house for sex. One of the respondents solicited clients on the street and the others had a full-time job at a karaoke shop or restaurant, where they met clients.

Two of the women in this sample were HIV positive, one of whom no longer participated in sex work because she was afraid of passing the infection on to a client; the other said she used condoms consistently.

While all of the women interviewed reported they became an EW out of poverty, their situations ranged from being close to starvation, to making a choice to shift from lower-paying work to EW work because of the pay differential. Many became sex workers to support their children. Some examples of the reasons for entering into EW are highlighted below: To measure exposure to the SMARTgirl program, responses to four questions relating to SMARTgirl contact through outreach or SMARTgirl Clubs were analyzed:

R1: My parents ran away from home…they escaped from my village without any notice even to their own children. My mother had a huge debt; that's why she had to leave us. As the eldest daughter, I was responsible for raising all of my five younger siblings by myself.

R4: I saw other girls who worked in the entertainment place can earn lots of money; that's why I wanted to work in a place like them. I first started working as a waitress but I got too tired so I moved to work in a karaoke establishment. My life is not so difficult because I only have to earn money to support myself; I don't need to send anything to my parents.

R8: The salary I got from factory work was not sufficient to support me and my child. Finally I ended up working as a waitress in the hope that I would get a higher salary. Recently I have been earning extra tips from clients everyday so I can save my regular salary to buy some big items for the family.

1. Those who had never heard of SMARTgirl or had not been approached by an outreach worker in the past three months (no exposure);
2. Those who had been approached by an outreach worker more than one month and less than three months ago (some degree of exposure);
3. Those who had contact with an outreach worker in the past month (high degree of exposure); and
4. Those who were SMARTgirl Club members and said that they visited a SMARTgirl Club at least once a month (high degree of exposure).

Table 1.2 presents personal characteristic data of the sample by degree of exposure to SMARTgirl. Overall, 70% of the sample had a high degree of exposure: 25% visited SMARTgirl Clubs at least once a month and another 45% reported they had talked to an outreach worker in the past month. It should be noted that there is also often a high degree of overlap, where EWs meet SMARTgirl facilitators through outreach as well as by visiting a Club.

TABLE 1.2: Exposure to SMARTgirl by personal characteristics

	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month		TOTAL	(n)
			(3) SG outreach	(4) Visit SG Club		
TOTAL						
	15.9	14.1	44.6	25.4	100.0	1057
AGE GROUP						
18-20	22.3	10.9	44.1	22.7	100.0	229
21-24	18.2	10.1	45.2	26.5	100.0	347
25-29	9.3	17.8	43.9	29.0	100.0	321
30-34	15.5	17.2	45.7	21.6	100.0	116
35+	13.6	27.3	43.2	15.9	100.0	44
Median age	**23**	**26**	**24**	**24**		
X^2	*35.5 W/D.F/12P<.000*					
MARITAL STATUS						
Single	17.4	12.4	45.3	24.9	100.0	461
Married	13.7	14.9	38.8	32.5	100.0	255
Formerly married	15.7	15.7	47.6	21.1	100.0	332
X^2	*13.2 w/d.f. 6 p=.039*					
NUMBER OF CHILDREN						
None	16.7	11.6	45.4	26.4	100.0	606
One	16.0	15.6	43.3	25.1	100.0	275
Two	13.1	23.0	42.6	21.3	100.0	122
Three or more	13.7	13.7	47.1	25.5	100.0	51
X^2	*12.5 w/9 d.f. p=.188*					

	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month		TOTAL	(n)
			(3) SG outreach	(4) Visit SG Club		
LIVING ARRANGEMENTS						
With family	14.3	15.6	43.0	27.1	100.0	442
With sweetheart/ta-ta	10.1	14.5	47.8	27.5	100.0	69
With friends	16.4	13.4	49.6	20.7	100.0	397
Alone	20.9	11.9	35.1	32.1	100.0	134
Other	(-)	(-)	(-)	(-)	100.0	10
X^2	*21.6 w/12 d.f. p=.042*					
EDUCATIONAL ATTAINMENT						
None	17.2	21.6	48.3	12.9	100.0	116
1-4 years	12.5	17.5	46.1	23.9	100.0	297
5-7 years	16.8	13.3	41.8	28.0	100.0	368
8 years or more	17.6	8.5	44.9	29.0	100.0	272
Median years of education	**6**	**4**	**5**	**6**		
X^2	*27.2 w/9 d.f. p=.001*					
MIGRANT STATUS						
Lived in current location <5 years	16.4	12.7	43.8	27.2	100.0	489
Lived in current location 5+ years	15.5	15.3	45.2	23.9	100.0	568
X^2	*2.6 w/3 d.f. p=.450*					
KHMER LITERACY						
Good to excellent	15.4	15.0	44.8	24.7	100.0	861
Illiterate, poor or fair	17.6	10.4	43.0	29.0	100.0	193
X^2	*4.1 w/3 d.f. p=.251*					
ENGLISH ABILITY						
None	15.7	15.3	44.4	24.7	100.0	791
A little	17.0	10.8	45.7	26.5	100.0	223
Fair-good	15.4	10.3	38.5	35.9	100.0	39
X^2	*5.5 w/6 d.f. p=.478*					
VIETNAMESE ABILITY						
None	15.3	14.4	44.6	25.8	100.0	974
A little	15.2	8.7	43.5	32.6	100.0	46
Fair-good	38.1	14.3	47.6	-	100.0	21
X^2	*14.1 w/6 d.f. p=.028*					
OWN/ACCESS TO MOBILE PHONE						
No	20.8	13.8	40.4	25.0	100.0	260
Yes	14.2	14.2	45.9	25.7	100.0	795
X^2	*6.7 w/3 d.f. p=.082*					

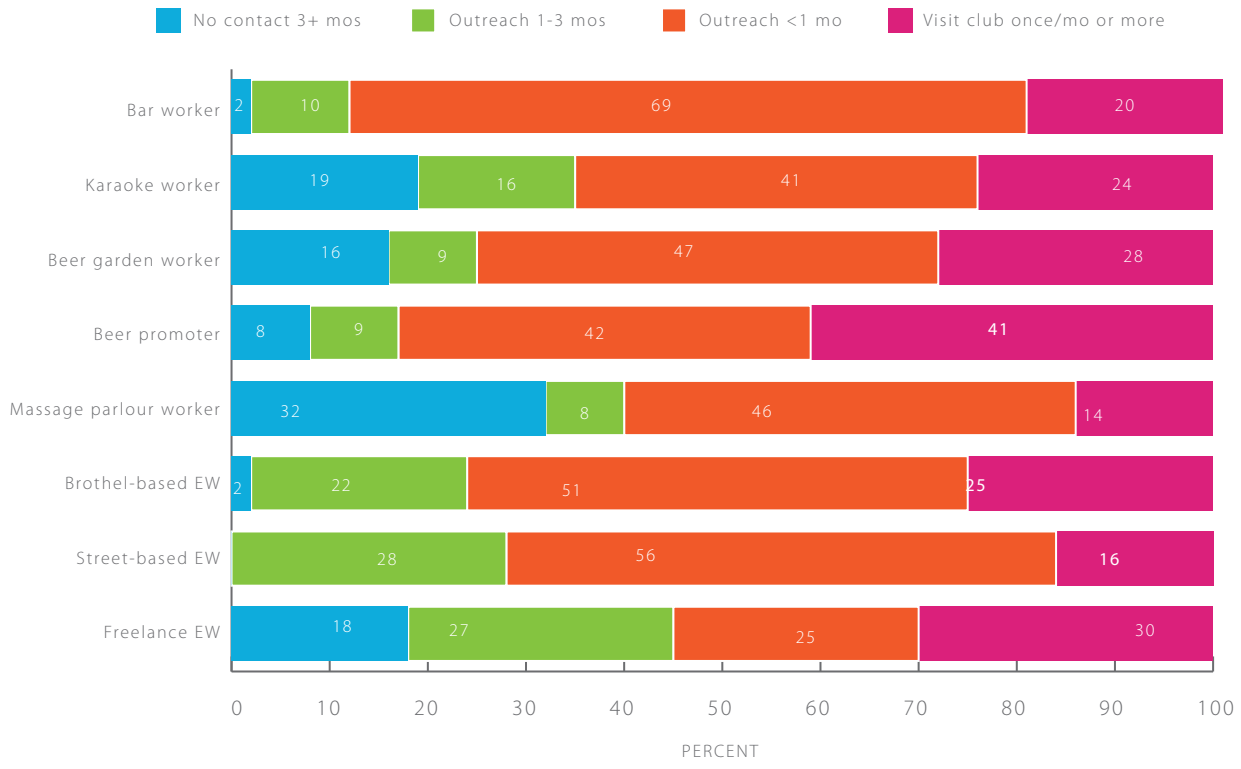
(-) Insufficient cases

The most frequent users of SMARTgirl Clubs were EWs in their 20s. When analyzing the data from the perspective of marital status, EWs who were married were most likely to be club members (33%), while EWs who were single or formerly married were most likely to have been exposed to SMARTgirl in the past month through an outreach worker.

The proportion of EWs who belong to a SMARTgirl Club increases with education - 29% of those with 8 or more years of education visited the clubs regularly, however, only 13% of those with no education do so and were more likely to have been reached by outreach workers. Migrant status, Khmer literacy or English ability didn't seem to have a significant impact on exposure, however, the small number of women in the sample with fair or good Vietnamese language skills had a low degree of exposure to the program; 38% were not reached at all, indicating that the program may be having difficulty in reaching Vietnamese EWs.

As previously mentioned, the SMARTgirl program focuses on reaching non-brothel based EWs, particularly those working at entertainment establishments and as freelancers. Figure 1.2 depicts the degree of exposure to the SMARTgirl program by current job. Massage parlor employees were far more likely than any other EWs to visit the clubs (over 40% said that they did so at least once a month) while freelancers and karaoke workers were least likely to visit the clubs regularly; however, they were the most likely to have had contact with an outreach worker in the past month. EWs with a second job also in the entertainment sector were more likely to visit the SMARTgirl Clubs frequently than those without a second job or another job outside of the entertainment world. When analyzing former jobs of EWs, outreach seems to be effective in reaching women who previously held jobs outside the entertainment sector or who were unemployed (50% and 41% respectively), but who now are an EW.

FIGURE 1.2: Exposure to SMARTgirl by current job



SMARTGIRL FACILITATORS

Nearly two-thirds of the SMARTgirl facilitators who participated in the review were peer facilitators/educators with one-third being outreach workers and the remaining 5% were SMARTgirl Club managers. Most of the facilitators had been working with the SMARTgirl program for more than a year with 20% working for more than two years. The majority (81%) said that they wanted to work with SMARTgirl to help EWs and help prevent HIV and over half said that they did so because they were EWs themselves. A significant proportion (45%) said that they wanted experience working for an NGO (two-thirds wanted to work for an NGO in the future), with only 20% saying that earning extra money was one of their motivations. About 58% of the facilitators interviewed said that they also worked as EWs. The remainder held a variety of other jobs and 25% had no other job.

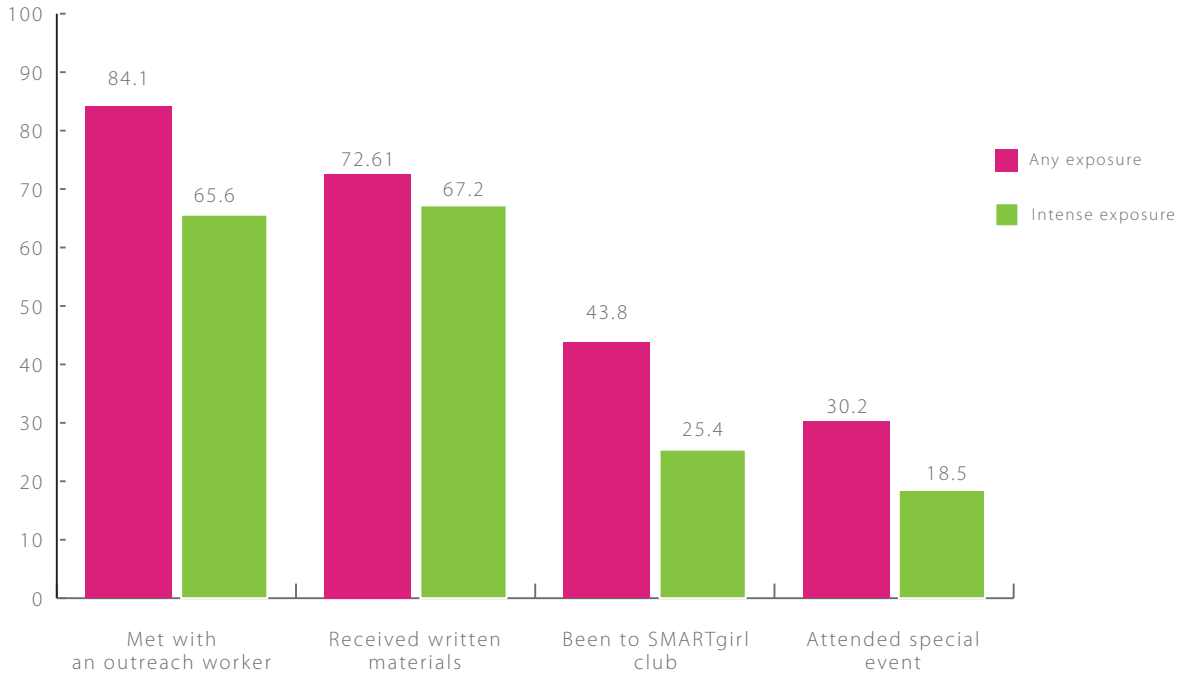
2.Success of SMARTgirl program channels in reaching EWs?

A key strategy of the SMART girl program is to use a variety of channels to reach EWs, to maintain program variety, ensure messages are reinforced, and to establish visibility of the SMARTgirl brand. Strategies to reach EWs include peer outreach, drop-in centers branded as SMARTgirl Clubs, special events sponsored by SMARTgirl, and strategic behavioral communications materials.

Nearly three-quarters of the EWs surveyed had received the SMARTgirl handbook, and approximately two-thirds had received promotional materials and/or other strategic communication materials. Nearly all EWs who received the promotional and strategic communication materials used them, while 76% of those who received the handbook used it.

Approximately half of all EWs who had heard of the SMARTgirl program are Club members, which translates to around 41% of all EWs surveyed. Non-members either cite busy lives (85%) or inaccessibility (26%) as their reasons for not joining. The most popular reason given for EWs to becoming a SMARTgirl member, was access to healthcare services (82%). Other reasons included meeting friends (38%); feeling welcomed and relaxed (38%); using club facilities (34%); and "the club is fun" (33%). Among SMARTgirl Club members, only 18% were carrying their membership card at the time of the interview.

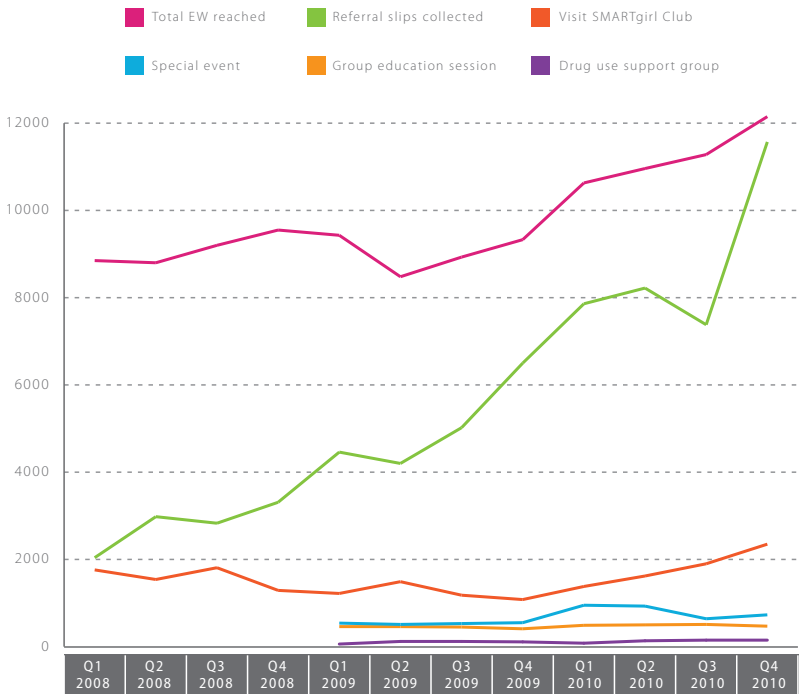
FIGURE 2.1: Reach of various channels to all EWs (n=1057)



Intense exposure = met with outreach worker in the past month; used written materials; go to SG club at least once a month; attended more than one special event.

Visits to SMARTgirl Clubs by members averaged around 1 visit per month. The most commonly attended activity, for both members and non-members, was group education sessions. Attendance at special events, use of beauty salon services and accessing STI/VCCT referral or services were the next most popular program activities. SMARTgirl Clubs and special events, while popular amongst members were not as effective in reaching as wide a range of EWs (Figure 2.1) as outreach. The relative numbers of EWs visiting a SMARTgirl Club, attending a group education session, a drug use support group or a special event reflect the proportions seen in the general monitoring data (Figure 2.2)—most EWs were reached through outreach rather than club visits.

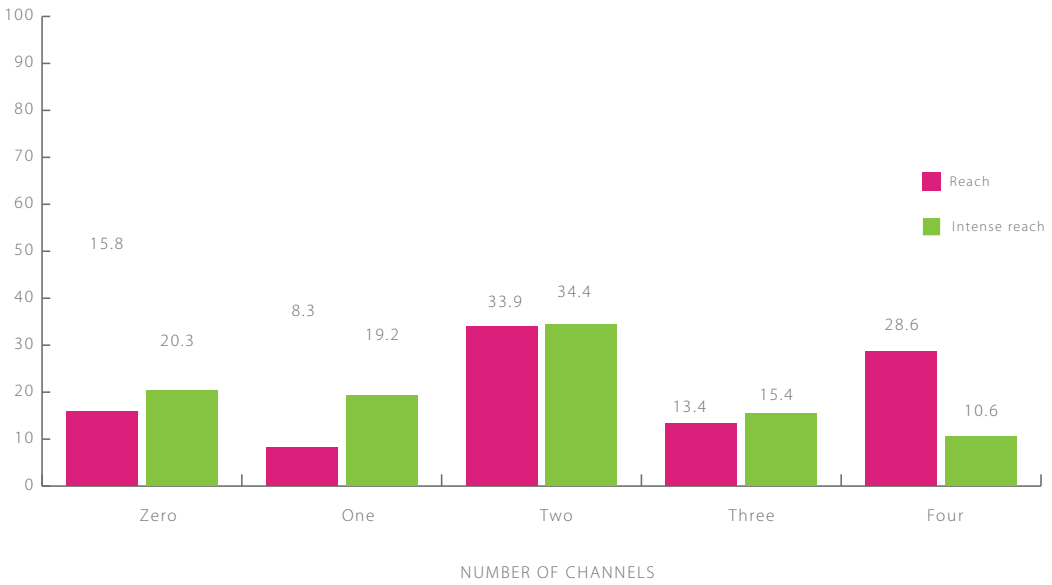
FIGURE 2.2: Program data on numbers of EWs reached by various channels



Total EWs reached = Number of EWs reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards.month; attended more than one special event.

The provision of written materials seemed to be an effective method of reaching the target group, with nearly three quarters of all surveyed EWs having received them. When analyzing the variety of program elements reaching EWs (outreach, written materials, clubs, events) the majority of EWs had been exposed to two or more, as is the intention of the program design (Figure 2.3).

FIGURE 2.3: Number of channels reached and intensity for all EWs



FACILITATOR INTERVIEWS

To ensure the information provided to EWs is consistent and correct, peer facilitators and educators were surveyed with regards to their knowledge of services and their level of activity in promoting them. The majority of SMARTgirl facilitators knew of at least two places for STI and VCCT referral (77%) and the vast majority agreed or strongly agreed that regular referrals are effective in increasing referral uptake (81%). More than half of the facilitators reported they had received one of the prizes at the quarterly draw for most referrals made, and 44% had received a prize more than once. Nearly all (98%) agreed that NGOs should collaborate or have MoUs between each other to facilitate a smooth referral process and therefore help reduce HIV amongst EWs. A large majority promoted SMARTgirl Clubs (86%) and did so at their last meeting with an EW (81%), including those not operated by their own NGO (81%).

3. Delivery of core services package

CORE PACKAGE

Core services include targeted HIV/STI/RH prevention education, condom and lubricant promotion and systematic health service referrals for HIV and STI screening. The core services package stands at the center of PRASIT's prevention programming and management efforts have concentrated on systematizing the delivery of the package and hence standardizing quality across sites. Outreach workers and SMARTgirl facilitators reach EWs through individual- and group-level outreach.

Table 3.1 examines whether respondents report having received this core package in the last two meetings with SMARTgirl facilitators. Out of all the services offered by SMARTgirl, the most frequently mentioned was health education and materials (86% in the last meeting and 88% in the second-to-last meeting) followed by health referral slips (70% and 80%) and condoms/lubricant (60% and 70%). Approximately half of the respondents received all 3 components of the core package the last time they met with SMARTgirl staff.

SOURCES OF HIV EDUCATION/INFORMATION

The data set out in Table 3.2 reveals whether SMARTgirl has become a key source of information for EWs on HIV and women's health issues. The vast majority (65%) reported SMARTgirl as their main source of information on HIV and similarly 62% relied on it as their main source of information on women's health. Access to this information was strongly associated with the degree of exposure to SMARTgirl; of those who had visited a SMARTgirl Club more than once a month, 86% reported it is their main source of information on HIV and 82% for women's health. Those with no exposure to SMARTgirl mainly obtained their information through the media (38%) and friends (30%). These findings show what an important service SMARTgirl provides to EWs in delivering vital information on HIV and women's health.

OBTAINING COMMODITIES

It has been shown above that the majority of EWs surveyed have been exposed to a wide variety of SMARTgirl services and materials, including the core package. However, it is important to assess whether this exposure translates into corresponding levels of knowledge and behavior.

Figure 3.1 presents monitoring data on number of condoms sold, number of condoms distributed free, the number of EWs attending STI services and the number attending VCCT services. The effect of a shift in program strategy is seen toward the end of 2008, as the program began prioritizing the social marketing of condoms; as the number of condoms sold increased, the distribution of free condoms declined.

TABLE 3.1: Materials, commodities and types of information provided at last two meetings with a SMARTgirl outreach worker

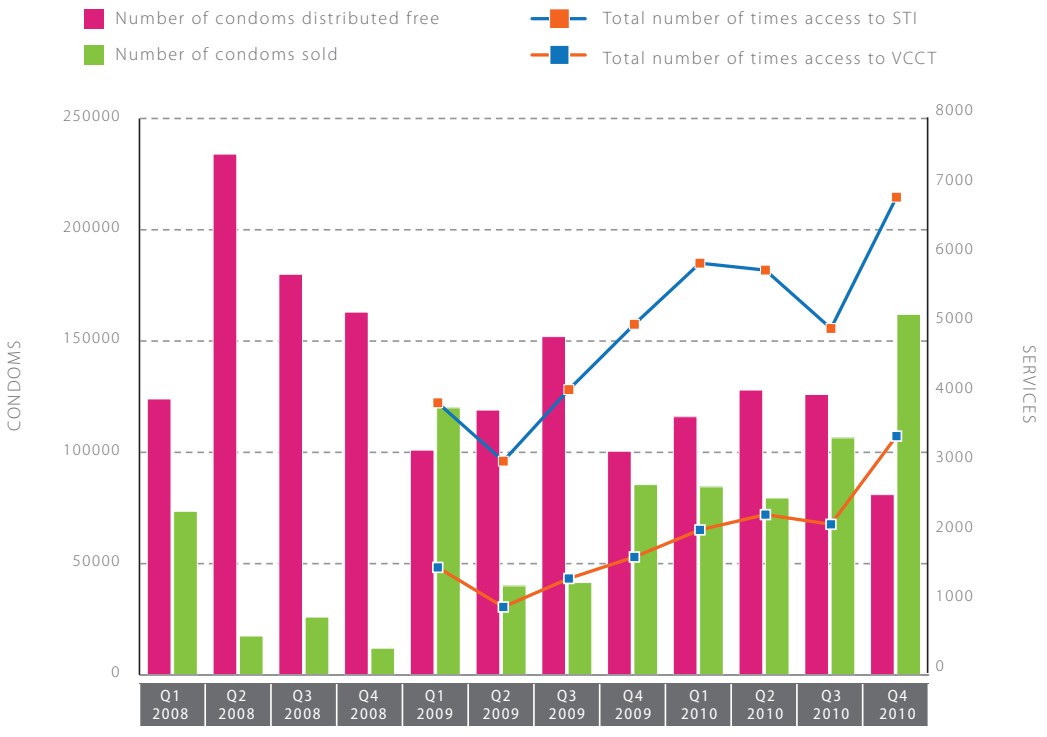
	Last meeting	2nd-to-last meeting
MATERIALS/COMMODITIES/TYPES OF INFORMATION PROVIDED (OF THOSE WHO MET WITH SG FACILITATOR PAST 3 MONTHS)[6]		
Health education material	85.7	87.7
Health referral slips	69.7	80.1
Condom/lube	60.0	70.3
Information about club	39.4	60.1
Information about drug services	36.8	56.8
Information about network	25.4	43.2
(n)	(856)	(815)
NUMBER OF MATERIALS/COMMODITIES/TYPES OF INFORMATION PROVIDED (OF THOSE WHO MET WITH SG FACILITATOR PAST 3 MONTHS)		
None	1.0	5.8
1	23.0	17.8
2	14.3	5.9
3	21.7	9.4
4	15.3	13.8
5	11.9	21.8
6	12.7	25.5
Total	100.0	100.0
(n)	(865)	(865)
Median number of materials provided	**3**	**4**
PERCENT WHO RECEIVED THE CORE PACKAGE OF SERVICES (OF THOSE WHO MET WITH SG FACILITATOR PAST 3 MONTHS)		
Percent who received the core package from either last meeting or 2nd-to-last meeting		63.3
(n)	(863)	(863)
NUMBER OF CORE MATERIALS/COMMODITIES/REFERRALS PROVIDED (OF THOSE WHO MET WITH SG FACILITATOR PAST 3 MONTHS)		
None	3.6	7.9
1	25.1	18.0
2	25.3	15.5
3	46.0	58.6
Total	100.0	100.0
(n)	(863)	(863)
Median number of core materials provided	**2**	**3**

6 Multiple responses possible, therefore responses may not add up to 100%.

TABLE 3.2: Main source of information on HIV and women's health issues by exposure to SMARTgirl

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
MAIN SOURCE OF INFORMAITON ABOUT HIV					
SMARTgirl program	65.3	0.6	72.3	74.7	85.5
Media (Newspaper, TV, Radio, Internet)	13.3	38.1	11.5	9.2	5.9
Friends	10.2	29.8	6.1	7.5	4.8
Other NGOs	5.9	14.3	7.4	4.5	2.2
Other	3.2	9.5	1.4	3.0	0.7
Do not know/ No response	2.1	7.7	1.4	1.1	0.7
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1051)	(168)	(148)	(466)	(269)
X^2		*389.4 w/15 d.f. p<.000*			
MAIN SOURCE OF INFORMATION ABOUT WOMEN'S HEALTH					
SMARTgirl program	61.5	0.6	62.2	71.3	82.1
Media (Newspaper, TV, Radio, Internet)	17.1	44	18.9	12.2	7.8
Friends	7.9	22.6	4.1	6	4.1
Other NGOs	6.1	14.9	7.4	3.9	3.7
Other	5.2	10.1	6.1	5.1	1.9
Do not know/ No response	2.2	7.7	1.4	1.5	0.4
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1051)	(168)	(148)	(466)	(269)
X^2		*345.5 w/15 d.f. p<.000*			

FIGURE 3.1: Monitoring data on condoms and VCCT and STI services



The SMARTgirl program was an important source for condoms for all respondents with some exposure to SMARTgirl (Table 3.3). More than 60% of EWs with exposure to SMARTgirl received condoms from SMARTgirl facilitators or clubs, but approximately 9% reported never getting condoms. EWs with no exposure to SMARTgirl were much more likely to say that they never get condoms (45%) or get them from pharmacies/ other retail (14%), other NGOs (12%), their workplace (11%) or their sexual partner (11%). These women were three times more likely to have to buy their condoms compared to EWs who had been in contact with the SMARTgirl program; 79% of EWs received condoms the last time they met with a SMARTgirl peer leader/outreach worker. Approximately half of the respondents had condoms and lubricant available at their workplace.

TABLE 3.3: Condom access of EWs by exposure to SMARTgirl

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
WHERE EW NORMALLY GET CONDOMS					
Never get	15.5	45.1	10.2	12.7	5.3
SMARTgirl facilitators	50.6	0.6	59.9	60.5	58.7
Non-SMARTgirl NGO/out-reach	6.5	11.7	8.8	4.7	5.3
Workplace	6.0	11.1	3.4	6.2	3.8
Store/pharmacy/retail outlet	5.9	14.2	6.8	4.5	2.7
SMARTgirl club	5.4	0.0	2.0	2.4	15.9
Sexual partner	3.9	10.5	2.0	3.4	1.9
Friends/sweetheart	1.6	2.5	1.4	1.3	1.9
Me-kar	0.8	0.6	1.4	0.9	0.4
Other	3.8	3.7	4.1	3.4	4.2
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1057)	(162)	(147)	(466)	(264)
X^2		*355.5 w/d.f. 27 p<.000*			

HEALTH SERVICE REFERRALS

The pattern for access to services closely follows that for condom sales, including the sharp upturn of both in the last quarter of 2010; the results of a strategy shift in the delivery of referral slips and targeted programming in social marketing. The number of EWs who accessed STI services is nearly twice that of VCCT and the gap remains relatively constant, perhaps in part due to the prevalence of STIs and their symptomatic nature when compared with HIV. However, overall the monitoring data collected by the SMARTgirl program between 2008 and 2010 shows promising results where the number of referral slips collected from health service partners steadily increased almost to the point of all EWs reached.

FACILITATOR INTERVIEWS

It is also important for program monitoring and evaluation to assess the level of knowledge SMARTgirl facilitators have about the delivery of core package components. Table 3.4 shows that nearly all (99%) facilitators reported health education and providing referrals (94%) as their main activities; a lesser percentage mentioned condom promotion and distribution (79%). Nearly three-quarters (73%) mentioned all three core activities. When asked what services must be provided during an EW meeting they reported

health education (98%), health referral (91%) and condoms (82%); 74% mentioned all three services. When asked what services they actually provided at their last meeting however, the percentages were slightly lower: 93% for health education, 88% for referral and 79% for condoms, with only 62% having provided the entire core package of services. SMARTgirl facilitators gave positive ratings to the SMARTgirl facilitator training, with 81% strongly agreeing that they felt more confident and better prepared after attending the training. About

TABLE 3.4: Knowledge of core services as reported by SMARTgirl facilitator

	PERCENT
MAIN ACTIVITIES PERFORMED AS SMARTGIRL FACILITATOR[7]	
Provide health education	98.8
Promote/give condoms/lube	79.4
Give health referrals	94.0
Sensitize govt/health workers, community	35.5
Manage club	15.5
Organize special/national events	22.6
Follow-up/feedback for outreach workers	2.2
Capacity building for facilitator	1.1
(n)	(84)
Percent who mention all three core activities	**72.9**
SERVICES THAT MUST BE PROVIDED WHEN MEETING EWS*	
Provide health education	97.6
Promote/give condoms/lube	82.4
Give health referrals	90.6
Sensitize govt/health workers, community	3.5
Manage club	3.5
Organize special/national events	5.9
Promote club	1.1
(n)	(85)
Percent who mention all three core activities	**74.1**
SERVICES PROVIDED LAST TIME THAT FACILITATOR MET AN EW*	
Provide health education	92.9
Promote/give condoms/lube	78.8
Give health referrals	88.2
Percent who mention all three core activities	**62.4**
NUMBER OF TRAINING SESSIONS ATTENDED	
1	7.1
2	7.1
3	4.8
4	14.3
5	4.8
6	11.9
7	17.9
8 or 9	32.2
Total	100.0
(n)	(85)
Median number of trainings	**6.5**

7 Multiple responses possible, therefore responses may not add up to 100%.

one-third of facilitators (32%) had attended 8 or 9 training sessions and the median number of trainings attended was 6.5. The data displayed in table 3.5 supports the assumption that the more trainings a SMARTgirl facilitator attended, the more aware they became of the content of the SMARTgirl core services, however, it does not seem to be translating into action; there is no correlation between the number of trainings attended and the provision of all three core services the last time they met with an EW.

TABLE 3.5: Perception and provision of core services of SMARTgirl facilitator by number of trainings attended

	Attended 1-5 training sessions	Attended 6-9 training sessions
Mention all three core services as main activities	59.4	80.8
X^2	**4.6 w/1 d.f. p=.033**	
Know all three core services that must be provided when meeting an EW	65.6	80.8
X^2	**2.4 w/1 d.f. p=.120**	
Say that they provided all three core services the last time they met an EW	62.5	63.5
X^2	**0.0 w/1 d.f. p.=929**	
(n)	(32)	(52)

4. Positive health knowledge and practices (i.e. service uptake)

KNOWLEDGE OF HEALTH SEEKING PRACTICES

Table 4.1 shows that approximately three-quarters of EWs surveyed acknowledged the recommendation for RH/FP services at least once a year, however, EWs who had been in contact with the SMARTgirl program were more likely than others to have visited RH/FP services in the past year, and to have visited multiple times. Thirty percent of EWs who had contact with a SMARTgirl facilitator in the past month and 44% who visited SMARTgirl Clubs accessed RH services two or more times per year, while only 14% of those with no exposure did so. Over 60% of those with high exposure who accessed RH services said that they did so at the encouragement of a SMARTgirl facilitator.

TABLE 4.1: Reproductive health service knowledge and use of RH/FP services by exposure to SMARTgirl

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
OPINION ON HOW MANY TIMES A WOMAN SHOULD VISIT RH/FP SERVICES IN A YEAR					
Four times a year	40.5	34.0	39.0	43.0	40.8
Twice a year	26.1	29.3	28.4	22.1	29.8
Once a year	7.2	9.5	8.5	6.5	6.3
When needing FP/RH products	15.5	19.0	8.5	15.7	16.9
Other	10.8	8.2	15.6	12.8	6.3
Total	100.0	100.0	100.0	100.0	100.0
(n)	(990)	(147)	(141)	(447)	(255)
X^2		*25.5 w/d.f. 12 p=.013*			

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
BEEN TO RH/FP SERVICES IN PAST YEAR					
No	52.2	73.6	52.7	54.5	35.1
Yes, once	15.8	12.3	12.8	15.2	20.5
Yes, twice	10.2	6.1	17.6	7.7	13.1
Yes, three or more times	21.7	8.0	16.9	22.5	31.3
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1045)	(163)	(148)	(466)	(268)
X^2		*345.5 w/15 d.f. p<.000*			
WHERE DID YOU GO FOR A CHECK-UP[8]					
Government health center	65.1	65.2	71.4	70	56.6
RHAC	37.1	28.3	35.7	32.4	45.7
Marie Stopes	13.1	2.2	11.4	11.7	18.5
Private clinic/pharmacy	12.2	21.7	12.9	10.8	11
Other	13.1	2.2	8.6	14.1	16.8
(n)	(502)	(46)	(70)	(213)	(173)
X^2		*345.5 w/15 d.f. p<.000*			
REASONS FOR GOING FOR A CHECK-UP					
To get RH/FP consultation	57.2	47.7	60	62.7	51.7
Encouraged by SMARTgirl facilitator	55.4	4.5	52.9	61.3	62.1
To get RH/FP products	54.6	52.3	64.3	54.7	51.1
For regular check-up	42.4	25	31.4	43.9	49.4
To get abortion	6.6	11.4	4.3	4.2	9.2
Other	2.2	13.6	1.4	0.9	1.1
(n)	(500)	(44)	(70)	(212)	(174)
REASONS FOR NOT GOING FOR A CHECK-UP					
No RH/FP problems	65.1	63.9	72.7	63.8	64.2
No need (use condoms)	14.8	9.2	10.1	17.3	18.9
Feeling shy of service providers	13.2	16.8	11.4	13.4	9.5
Can get FP products by myself	12.1	8.4	10.1	11.8	18.9
Scared to visit clinic	6.6	5.9	2.5	7.5	8.4
Service not open when I need it	6.0	3.4	10.1	7.1	3.2
No transportation assistance	1.3	0.0	2.5	1.2	2.1
SMARTgirl facilitator/OW did not encourage me	0.9	0.0	1.3	1.2	1.1
Health care providers do not treat me well	0.2	0.0	1.3	0.0	0.0
Other	7.1	7.6	12.7	6.7	3.2
(n)	(547)	(119)	(79)	(254)	(95)

8 Multiple responses possible, therefore responses may not add up to 100%.

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
CONTRACEPTIVE METHOD USED[9]					
Condom	77.7	74.3	86.4	82.8	68.1
Daily pill	19.7	21.6	12.3	15.0	28.7
Withdrawal	14.6	12.2	13.6	14.2	16.5
Injectables	8.0	2.7	2.5	6.0	15.4
IUD	4.1	1.4	0.0	4.1	6.9
Calendar (rhythm) method	3.4	1.4	3.7	4.9	2.1
Implants	3.1	0.0	0.0	2.6	6.4
Abortion	3.1	4.1	1.2	1.9	5.3
Female sterilization	3.0	1.4	2.5	1.9	5.3
Lactational amenorrhea	1.1	1.4	0.0	0.7	2.1
Emergency contraception pill	0.8	1.4	0.0	1.1	0.5
Other	0.3	1.4	1.2	0	0
(n)	(547)	(119)	(79)	(254)	(95)

HEALTH SEEKING PRACTICES

Overall, Government health centers were the most popular choice for RH care, but those with higher exposure to SMARTgirl were more likely to visit NGO clinics, such as RHAC and Marie Stopes. For those who had not been for a check-up in the past year, the most common reason given was not having had any RH/FP-related problems. Current use of a family planning method was strongly associated with exposure to SMARTgirl; 70% of those with high exposure reported they were using a method vs. 43% of those with no exposure. The most common method by far was condoms (78%), followed by 20% (or 28% of frequent SMARTgirl Club visitors) who were on the oral contraceptive pill. The majority (89%) of EWs also agree that it is important to use more than one form of contraception in order to prevent both pregnancy and HIV. Table 4.1 clearly shows that high exposure to SMARTgirl clubs in particular is successfully translating into a significantly enhanced level of decision making with regards to family planning; reflected in their use of longer term, non-negotiable methods.

Nineteen percent of EWs reported having had an abortion in the past year. Interestingly, 27% of frequent SMARTgirl Club visitors had an abortion in the past year, compared to 13% who had no exposure to the program. This may be in part due to the accurate information and appropriate referral services provided by SMARTgirl facilitators in the Clubs, which enables EWs to better make informed decisions.

The method of abortion was almost evenly split between surgical abortion (55%) and pills (47%). Fortunately only a few reported the use of massage, traditional herbs or "harmful activities". On average, 18% reported having had two or more abortions and again, those frequently visiting the Clubs were more likely (24%) to have had multiple abortions. EWs obtained abortions at a variety of places, most notably from private clinics (39%), pharmacies/drug stores (21%), Marie Stopes (13%) and government clinics (13%). Frequent club visitors were more likely to go to Marie Stopes (24%) or government clinics (17%) than those reached in the past month through outreach, who most often went to private clinics (41%).

9 Multiple responses possible, therefore responses may not add up to 100%.

Current recommendations suggest that high risk individuals (such as EWs) should be screened for STIs at least four times per year. The data displayed in Table 4.2 shows that about 80% of EWs with high exposure to SMARTgirl thought that screening should be conducted at least 4 times per year, including about half who suggested monthly or "every time she has unprotected sex". This group was also much more likely to have been screened in the past year (84%) and multiple times, compared to 41% of those with no exposure to SMARTgirl. Private clinics were by far the most popular place for screening (56%), followed by RHAC with 38% of EWs accessing their services. Only 1% of the respondents mentioned Government Health Center as one of their preferred STI screening outlets; the lack of confidentiality being the primary reason for not going there.

EWs who had been in contact with SMARTgirl within the past 3 months most commonly accessed STI screening after a discussion with an outreach worker or facilitator. This is in contrast to those without SMARTgirl contact who usually went to the clinic after they became symptomatic or because they had had risky behavior, such as unprotected sex.

TABLE 4.2: STI screening knowledge and experience of EWs by exposure to SMARTgirl

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
OPINION OF HOW MANY TIMES EWS SHOULD BE SCREENED FOR STIS IN ONE YEAR					
Every time she has unprotected sex	13.2	12.3	6.9	12.8	18.0
Monthly	35.4	35.2	38.6	35.1	34.1
Every quarter	29.3	27.8	30.3	30.4	27.7
Every 6 months	12.8	12.3	12.4	12.4	13.9
Once a year	3.3	2.5	3.4	3.3	3.7
Other	3.7	3.7	7.6	3.5	1.9
Don't know	2.4	6.2	0.7	2.6	0.7
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1035)	(162)	(145)	(461)	(267)
X^2		*34.0 w/d.f. 18 p=.013*			
HOW MANY TIMES SCREENED FOR STI IN PAST YEAR					
None	32.0	59.4	33.8	31.1	15.6
Once	14.1	12.7	16.9	14.4	13.0
Twice	13.2	9.7	12.8	9.9	21.2
3-4 times	18.2	9.7	16.9	18.2	24.2
5 or more times	22.5	8.5	19.6	26.4	26.0
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1048)	(165)	(148)	(466)	(269)
X^2		*112.9 w/d.f. 12 p<.000*			

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
WHERE USUALLY GO FOR STI SCREENING[10]					
Private clinic/pharmacy	56.0	43.4	67.3	63.4	44.5
RHAC	38.1	37.3	40.8	30.3	48.0
Government Family Health Clinics	17.7	13.4	12.2	18.4	20.3
Traditional healer	10.0	16.4	9.2	11.9	5.7
Marie Stopes	8.3	4.5	4.1	6.9	13.2
MEC	4.2		3.1	3.1	7.5
Government health center	1.0	-	-	0.6	2.2
Other	10.5	-	10.2	10.9	13.2
(n)	(712)	(67)	(98)	(320)	(227)
REASONS FOR NOT GOING TO GOVERNMENT OUTLET*					
The service is not confidential	29.4	24.1	19.0	25.4	37.3
I have to wait too long	27.0	34.5	42.9	23.9	22.9
The clinic is not open when I need it	15.2	17.2	4.8	11.3	20.5
The facilitator is not friendly to me	14.7	6.9	14.3	18.3	14.5
The service quality is not good	13.2	10.3	4.8	18.3	12.0
Other	22.1	20.7	23.8	26.8	18.1
(n)	(205)	(22)	(30)	(81)	(72)
WHY WENT FOR STI SCREENING[11]					
SMARTgirl facilitators/OWs encouraged me	64.3	3.0	69.4	69.6	72.9
Displayed STI symptoms	41.2	35.8	40.8	49.2	31.6
No symptoms but had risky behavior	40.1	61.2	39.8	36.7	38.7
Assisted with transportation to clinic	32.2	3.0	38.8	35.7	32.9
Wanted to get lottery prize	8.9	-	5.1	6.3	16.9
Other	1.4	4.5	2.0	0.9	0.9
(n)	(1037)	(163)	(146)	(464)	(266)

10, 11 Multiple responses possible, therefore responses may not add up to 100%.

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
REASONS FOR NOT GETTING STI SCREENING*					
No STI symptoms	76.2	74.2	77.1	78.2	73.2
Scared to visit clinic	16.2	10.3	18.8	18.3	19.5
Service not open when I need it	7.0	5.2	8.3	9.2	2.4
No risky behavior	5.2	5.2	2.1	6.3	4.9
Can get medicine and treat myself	4.6	7.2	4.2	2.1	7.3
No transportation assistance	2.1	3.1	4.2	0.7	2.4
SMARTgirl facilitator/OW did not encourage me	1.8	-	2.1	-	12.2
Health care providers do not treat me well	0.9	2.1	-	0.7	-
Other	9.5	9.3	8.3	11.3	4.9
(n)	(328)	(97)	(48)	(142)	(41)

The data in Table 4.3 displays information about EW's knowledge and practice with regards to HIV screening. Current recommendations suggest that high risk individuals (such as EWs) should be tested for HIV every 6 months. The vast majority of EWs said that they thought that EWs should go for testing at least twice per year, with the most popular answer being every quarter. Overall, 68% of all EWs surveyed had been tested for HIV in the past year—83% of those with high exposure compared to 43% of those with no exposure to SMARTgirl. In addition, EWs with high exposure to SMARTgirl were more likely to have been tested multiple times in the past year. "Risky behavior" was the main reason given for accessing an HIV test (66%) and SMARTgirl Club frequenters were particularly likely to report they were encouraged by SMARTgirl facilitators (74%). The most common reasons provided for not accessing HIV was the lack of AIDS symptoms (55%) and/or they had not engaged in risky behavior (39%), however, 93% of the EW surveyed believe women should be tested for STIs and HIV even if she uses condoms consistently. Private clinics were the most frequently mentioned place for testing (56%), but those with high exposure to SMARTgirl were more likely to mention a variety of other avenues. As with STI screening, only a small percentage (9%) of respondents went to a government health center and the reasons for not going were again the lack of confidentiality as well as a long wait.

FACILITATOR INTERVIEWS

When questioned on their thoughts and practices about healthcare for EWs, the majority of SMARTgirl facilitators thought EWs should be screened monthly for STIs (61%) and between 2-4 times per year for HIV (94%). Nearly all SMARTgirl facilitators agreed that an EW should be retested later if she were tested less than three months after risky behavior (99%).

Most SMARTgirl facilitators agreed that reproductive health education for EWs is important (78%) and agreed that women should use a second form of contraception in addition to condoms (75%). Nearly all (94%) could name two places to get an abortion and all (100%) agreed that abortion can be very dangerous if not done in a safe place.

TABLE 4.3: HIV testing knowledge and experience of EWs by exposure to SMARTgirl

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
OPINION OF HOW MANY TIMES EWS SHOULD BE SCREENED FOR HIV IN ONE YEAR					
Every time she has unprotected sex	15.7	18.2	11.6	12.7	21.7
Monthly	16.8	16.4	15.1	15.1	20.9
Every quarter	35.8	31.4	41.1	41.6	25.5
Every 6 months	24.5	23.3	24.0	23.9	26.6
Once a year	4.3	5.7	4.8	4.2	3.4
Other	2.9	5.0	3.4	2.6	1.9
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1025)	(159)	(146)	(457)	(263)
X^2		*34.1 w/d.f. 15 p=.003*			
HOW MANY TIMES SCREENED FOR HIV IN PAST YEAR					
None	32.1	56.8	27.7	33.5	17.1
Once	18.4	16.7	18.2	17.2	21.6
Twice	21.3	13.0	29.1	20.0	24.2
3-4 times	19.0	6.8	17.6	19.8	25.7
5 or more times	9.3	6.8	7.4	9.5	11.5
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1044)	(162)	(148)	(465)	(269)
X^2		*34.1 w/d.f. 15 p=.003*			
WHERE USUALLY GO FOR HIV SCREENING[12]					
Private clinic/pharmacy	55.6	50.0	65.4	62.0	43.9
RHAC	34.4	23.0	34.6	28.9	45.7
Government VCCT Clinics	17.8	20.3	11.2	16.9	21.5
Government health center	9.1	17.6	7.5	9.7	6.3
Marie Stopes	7.2	1.4	5.6	5.8	11.7
MEC	4.5		1.9	3.9	8.1
Other	8.0	1.4	7.5	7.8	10.8
(n)	(712)	(67)	(98)	(320)	(227)
REASONS FOR NOT GOING TO GOVERNMENT VCCT OUTLET*					
The service is not confidential	33.3	23.8	14.8	30.4	44.2
I have to wait too long	27.2	23.8	22.2	34.2	23.3
The facilitator is not friendly to me	16.0	4.8	22.2	15.2	17.4
The clinic is not open when I need it	15.5	14.3	14.8	12.7	18.6
The service quality is not good	12.2	9.5	11.1	17.7	8.1
Other	21.1	23.8	29.6	25.3	14.0
(n)	(213)	(21)	(27)	(79)	(86)

12 Multiple responses possible, therefore responses may not add up to 100%.

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
WHY WENT FOR HIV TEST[13]					
No symptoms but had risky behavior	65.9	64.2	67.0	73.3	55.5
SMARTgirl facilitator/OW encouraged me	56.1	4.5	58.5	54.1	73.6
Assisted with transportation to VCCT site	30.0	3.0	33.0	33.6	31.8
Wanted to get lottery prize	9.6	0.0	6.6	5.5	19.6
Displayed AIDS symptoms	3.7	6.0	2.8	2.9	4.5
Other	9.1	25.4	9.4	8.8	4.5
(n)	(700)	(67)	(106)	(307)	(220)
REASONS FOR NOT GETTING HIV SCREENING*					
No AIDS symptoms	54.6	54.3	55.0	54.3	55.8
No risky behavior	39.0	43.5	47.5	34.4	37.2
Scared to visit VCCT site/get needle	19.0	17.4	22.5	18.5	20.9
I am afraid of getting result	10.1	9.8	10.0	10.6	9.3
Service not open when I need it	6.4	6.5	7.5	6.6	4.7
I can get medicine and treat by myself	1.8	2.2	-	0.7	7.0
No transportation assistance	1.2	2.2	5.0	0.0	0.0
SMARTgirl facilitator/OW did not encourage me	0.9	-	-	2.0	-
Health care providers do not treat me well	0.6	-	-	-	4.7
Other	11.3	8.7	12.5	13.9	7.0
(n)	(326)	(92)	(40)	(151)	(43)

5. HIV Risk and behaviors

An important part of the SMARTgirl program is to raise EWs' awareness of the risks they face, to empower them to reduce these risks, and to provide them with a support network.

SEXUAL PROFILE AND CONDOM USE

Nearly a third of all the EWs surveyed felt it was risky to carry condoms and lubricant; the risk being that people will think of them as a "bad woman". The EWs were also concerned that a family member or partner would find them (36%) or that the police would find them (27%) and arrest or harass them as a result (although only 4% of EW reported ever having being arrested or harassed by police for carrying condoms).

One respondent from the qualitative review had been arrested by the police, and reported that SMARTgirl had empowered her to handle the situation:

13 Multiple responses possible, therefore responses may not add up to 100%.

R6: Once the police arrested me they used very abusive language. They said, "Pouk Mi Ngeng (an extremely impolite word to call women instead of their name) why do you do this job?" I responded "Hey! Pou (Uncle) you called us Mi Ngeng which is very rude - you should remember that you also have a mom, sisters or a daughter so you should pay respect to women. You wear a powerful uniform (police uniform) but you should not use this power to abuse others. You are a literate person you should have used better words than this". That policeman was very angry with me and he attempted to slap me in the face. I warned him, "Ok you make a strike to slap me and we will see the result!" He screamed at me, "Oh! Just because you have the support of NGOs to be on your side you think you shouldn't be afraid of the police, right?"

Overall, 87% of the EWs surveyed knew their HIV status; 2% were positive, 81% negative and 4% did not want to divulge their status. The remainder did not know their status but 91% felt that their risk for HIV infection was low, 48% of whom reported it was "very unlikely" that they were at risk of HIV infection. Knowledge of consistent condom use as a prevention method was fairly high (83%) with a much lower percentage able to name other risk reduction methods: regular HIV testing (44%), regular STI screening (37%) and reducing the number of sexual partners (37%). Only about half of the EWs were able to name two ways to reduce risk. EWs with higher exposure to SMARTgirl were much more likely to mention HIV testing and STI screening, and to be able to name two ways; while only 34% of respondents with no exposure to SMARTgirl were able to name two methods of risk reduction.

Several of the EWs surveyed shared their personal experiences on HIV risks and condom use negotiation:

R7: I never allow any client to sleep with me without a condom. Even some clients look gentle and nice to me but I can't guarantee if he has done anything with other girls in the past. I convince them using soft language. I also clarify with them that I have not been alone recently, I have had many partners too so they should protect themselves. I speak to them, 'You have a wife and children so you should love yourself more than me; if you love me more than yourself you will be hurt one day,' I told them like that. They said no problem.

R1: There was a client who didn't want to use a condom at all. He beat me up and pulled my hair hard saying, "I won't use it! I spend so much money why do I need to use a condom?" He jumped on me and held tightly to both of my hands. It was very painful. I kicked him in the groin so he would get off. He was very hurt I guess but he still jumped on me again until I felt too exhausted and let it be. I felt so worried after that, I went to do a blood test (HIV testing); the result was negative - I was so happy!

Q: In that violent case it seems it is really hard for you to negotiate!

R1: R1: Yes exactly, it is very difficult! Our negotiation strategy using sweet tone such as, "Bong (sweet term for calling man) please use a condom - I will make you feel good…" such a strategy doesn't work at all in this situation!

10, 11 Multiple responses possible, therefore responses may not add up to 100%.

Approximately 18% of EWs reported they had never had sex as shown in Table 5.1. The proportion is closer to 30% amongst those who are not familiar with SMARTgirl, which again confirms that SMARTgirl is reaching the appropriate target of EWs with higher risk. The majority of EWs had sex before the age of 20, with a median age of 19.6.[14] The EWs interviewed were most likely to have recently had sex with a client (38%), compared to a sweetheart (31%) or spouse (24%).

TABLE 5.1: Sexual health risks faced by EWs

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
AGE AT FIRST SEXUAL EXPERIENCE					
Never	17.7	29.3	14.3	16.6	14.1
Less than 18	19.1	17.7	23.1	19.7	16.8
18, 19	34.1	29.9	36.1	33.7	36.3
20-24	24.0	18.9	21.1	26.0	25.2
25+	2.9	1.8	4.1	3.1	2.7
Don't remember	2.2	2.4	1.4	0.9	5.0
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1030)	(164)	(147)	(457)	(262)
X^2		*36.9 w/d.f. 15 p=.001*			
PERCENT WHO HAVE SEXUAL PARTNER BY TYPE					
Husband	23.7	22.6	24.8	19.7	30.5
Sweetheart	31.0	22.0	27.5	32.5	36.1
Tata	10.7	3.0	9.4	12.7	12.6
Client	37.6	31.0	41.6	40.1	34.9
(n)	(1057)	(168)	(149)	(471)	(269)
PERCENT WHO ALWAYS USE CONDOMS WITH SEXUAL PARTNER BY TYPE (OF THOSE WHO HAVE THAT TYPE OF PARTNER)*					
Husband	14.0	6.9	6.3	14.1	21.3
Regular partner	51.2	45.9	44.9	55.7	48.0
Client	90.3	87.5	87.1	92.6	89.1
REASONS FOR NOT USING CONDOMS WITH HUSBAND*					
We trust each other	65.4	72.2	67.6	62.5	64.2
Married couples don't use condoms	36.4	47.2	35.3	35.0	32.8
My husband refuses to use condoms	26.3	27.8	32.4	27.5	20.9
It shows my devotion to our relationship	17.1	11.1	14.7	18.8	19.4
It feels better without condoms	17.1	2.8	23.5	21.3	16.4
There is no risk of HIV transmission	17.1	2.8	17.6	21.3	19.4
Condoms are not available	4.1	2.8	2.9	6.3	3.0
Other	6.0	.0	8.8	8.8	4.5
(n)	(217)	(36)	(34)	(80)	(67)

14 Median age at first sex is calculated using life table methods, so that the experience of those who have not yet had sex is included in the calculation.

15 Multiple responses possible, therefore responses may not add up to 100%.

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
REASONS FOR NOT USING CONDOMS WITH REGULAR PARTNER[16]					
We trust each other	65.5	57.9	73.1	70.4	56.9
We are in an intimate relationship	48.0	52.6	53.8	40.7	54.9
My partner refuses to use condoms	33.9	10.5	46.2	39.5	27.5
There is no risk for HIV transmission	28.2	21.1	26.9	34.6	21.6
It shows my devotion to our relationship	16.9	15.8	19.2	16.0	17.6
It feels better without condoms	14.1	15.8	0.0	19.8	11.8
Condoms are not available	7.3	5.3	7.7	7.4	7.8
Other	11.3	5.3	3.8	14.8	11.8
(n)	(177)	(19)	(26)	(81)	(51)

Of EWs who are married, few reported consistent use of condoms with their husband (14%), but the percentage was somewhat higher for those with high exposure to SMARTgirl. About half reported always using condoms with regular partners and nearly all (90%) always use condoms with paying clients. When asked why they do not use condoms with their husband or regular partners, "trust" was the main answer given (66%), along with other statements about the intimacy and devotion of the relationship. About one-third, however, reported their husband or regular partner refuses to use condoms. A substantial proportion also reported that there is no risk of HIV transmission with their husband (17%) or regular partner (28%). There is little variance in these answers with respect to exposure to SMARTgirl.

This EW described her thought process about who she uses condoms with:

R5: I use a condom with every client. (But) I can't use a condom when I sleep with my partner because then I don't feel close to him. Ordinary couples don't normally use condoms. When I am with my partner I feel that we are the true husband and wife; it is not like a client that gives me money after sleeping with me. When my loved partner uses a condom with me I feel upset (she laughs).

The series of graphs shown in Figures 5.1a to 5.3b give a sense of the types of sexual risk that may expose EWs to HIV and provides strong evidence that SMARTgirl is reaching its target audience of high risk EW through appropriate service interventions. For example, Figure 5.1a shows that 38% of the sexual partners of EWs surveyed were paying clients. The program is also shown to be effectively reaching EWs who have multiple clients and/or a sweetheart or tata, and other potentially high risk EWs.

Nearly 60% of the EWs reported either not having had sex or having had sex with only 1 person in the past 3 months, whereas at the opposite end of the spectrum, 11% reported having had 30 partners or more. EWs who reported to have had 30 or more partners also had high exposure to SMARTgirl, though those with 1-3 partners were the most likely to visit SMARTgirl Clubs. Outreach efforts appear to be reaching approximately half of those with multiple partners.
Figure 5.3a shows results concerning safe sex behavior compared to the number of partners and displays

16 Multiple responses possible, therefore responses may not add up to 100%.

FIGURE 5.1a: Percentage distribution of EWs by type of partner in the past 3 months

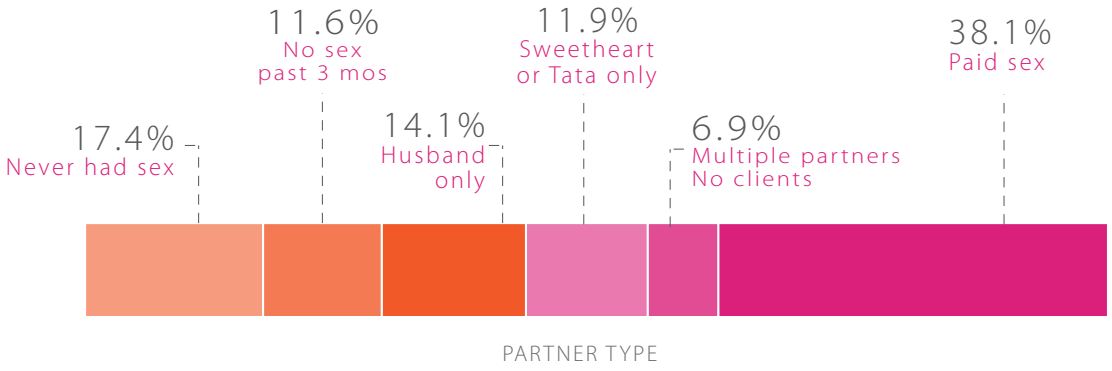


FIGURE 5.1b: Exposure to SMARTgirl by type of partners in the past 3 months

(X^2=38.6 w/15 d.f. p=.00)

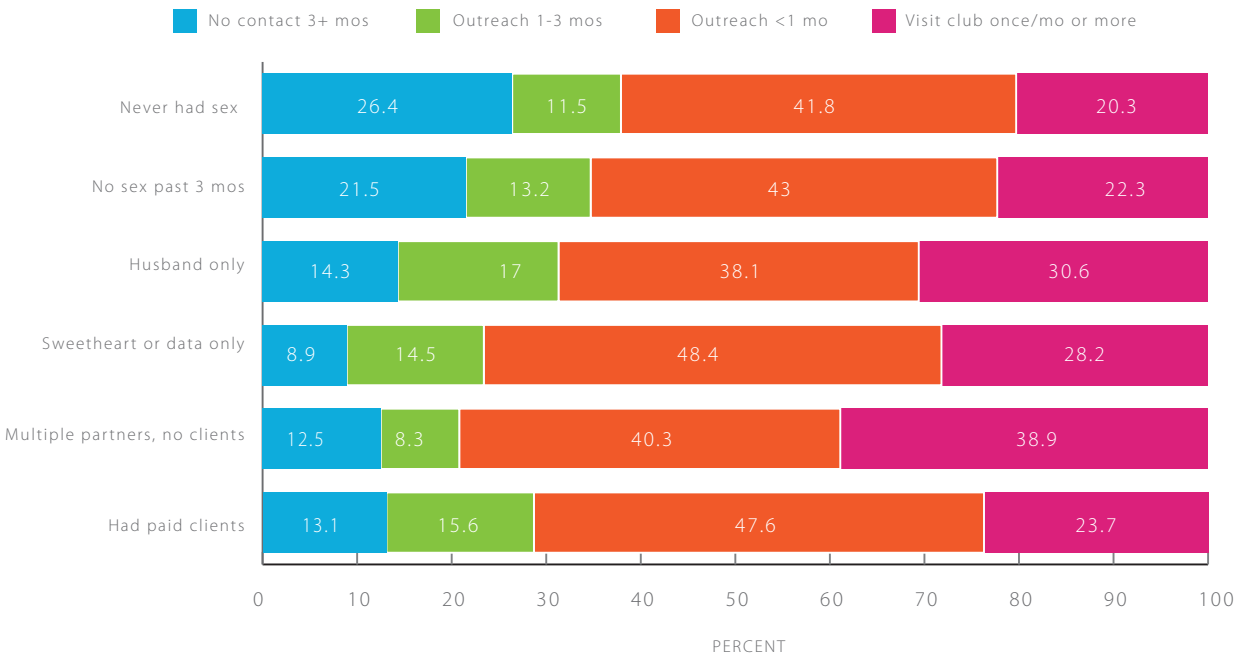


FIGURE 5.2a: Percentage distribution of EWs by number of partners in the past 3 months

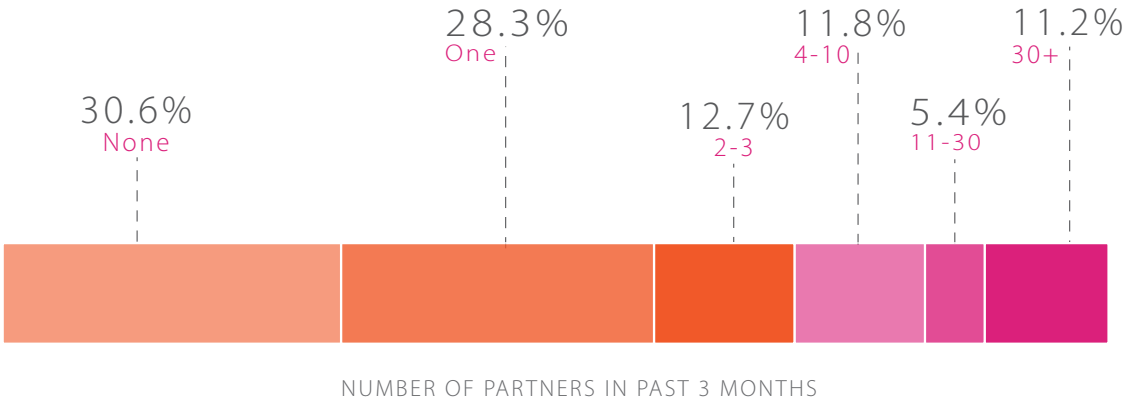
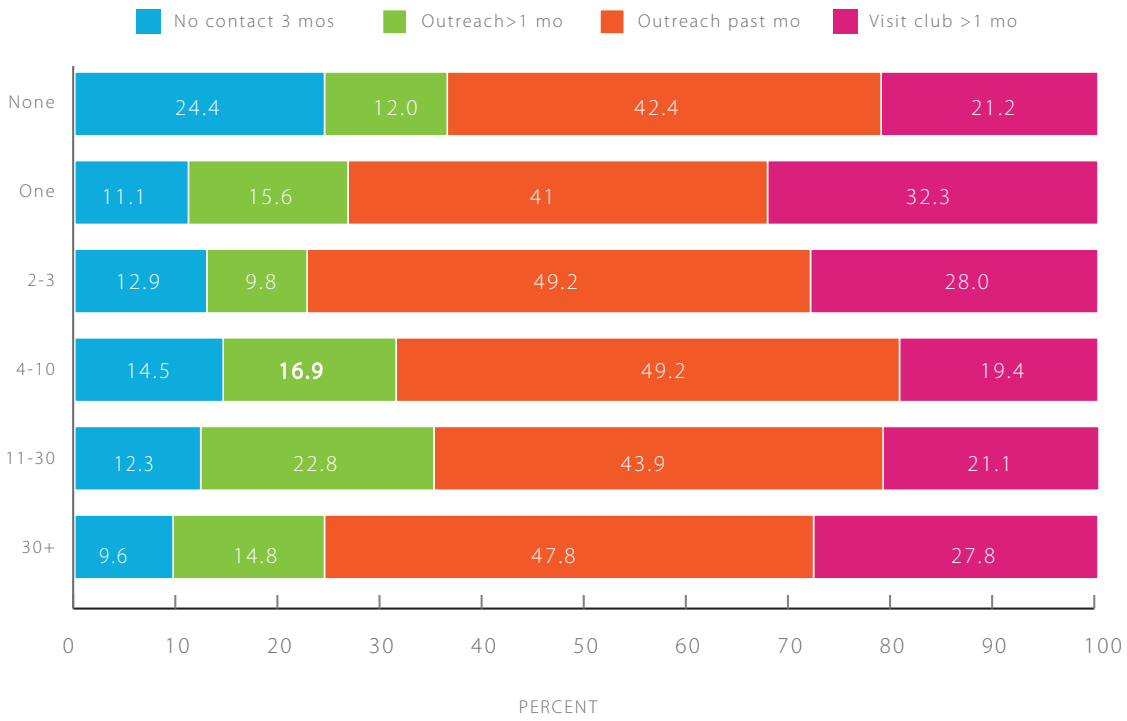


FIGURE 5.2b: Exposure to SMARTgirl by number of partners in the past 3 months
(X^2=40.3 w/15 d.f. p=.00)



a fairly even response rate. Only 6% were monogamous and reported they always used condoms, while 19% were monogamous and did not always use condoms. By contrast, of those with multiple partners 26% reported always using condoms, while 19% did not. Figure 5.3b shows that amongst EWs who reported being sexually active, there is no significant relationship between behavior and condom usage.

ALCOHOL AND DRUG USE

FIGURE 5.3a: Percentage distribution of EWs by level of risk

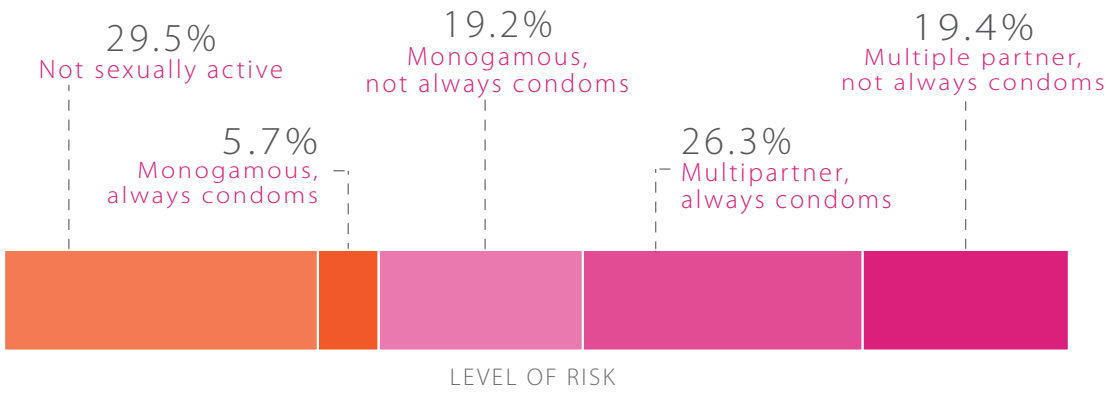
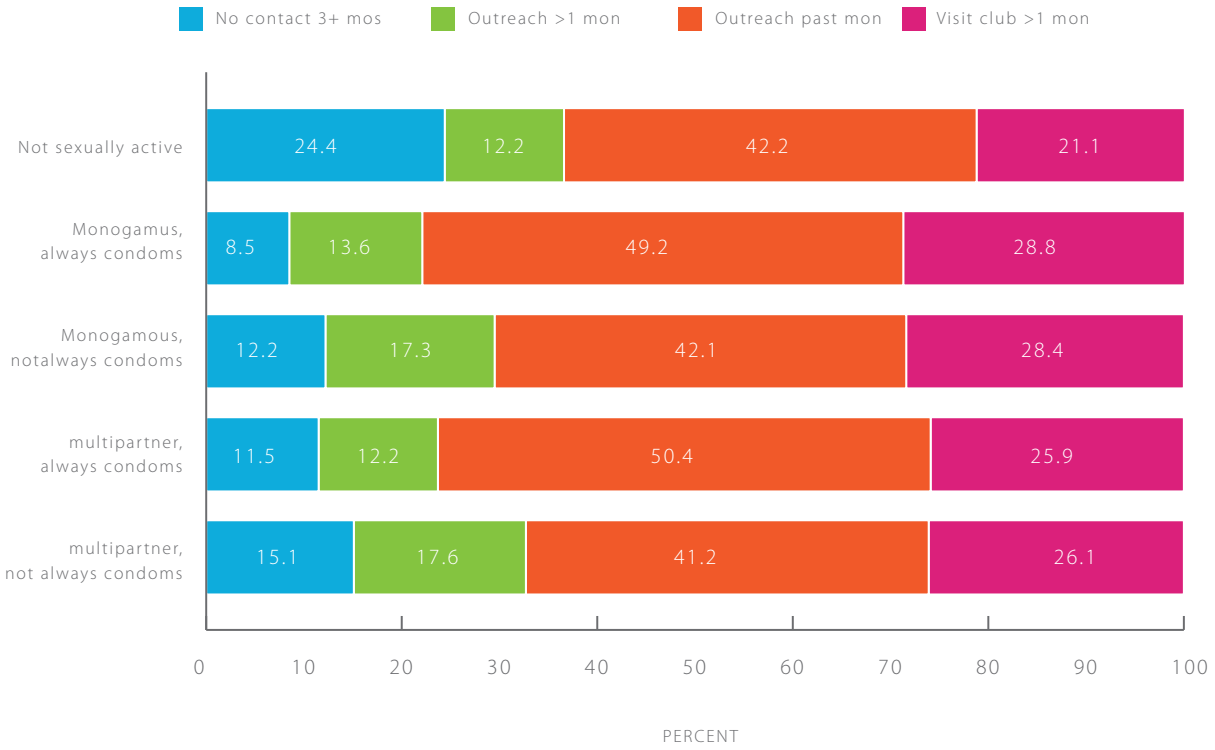


FIGURE 5.3b: Exposure to SMARTgirl by level of risk

(X^2=32.1 w/12 d.f. p=.00)



Alcohol and drug use can increase the risk of HIV, as those who drink and/or use drugs may be more likely to make poor choices and be less likely to protect themselves or use condoms consistently. Drinking is often an essential part of the job for EWs as they need to encourage customers to drink the brand of beer or alcohol that they are promoting. Many EWs said they drink or take drugs to dull their experience of servicing clients.

R6: When I started to use drugs it gave me motivation to earn more money; I have courage to approach clients on the street and easily accept clients.

When I started, I left my son at the orphanage and I rented a room for 20,000 Riels/month. I worked as a Beer Girl at that time. I got heavily drunk every day. Whenever I got home I would always vomit all over my room.

A third of all EWs reported that they drank every day, with another 25% reporting that they drank nearly every day. Moreover, 34% reported that they were required to drink with their customers. The respondents were often coerced into drinking more than they wanted to: 16% report this happening quite often and 68% report it happening sometimes or occasionally. Interestingly, however, most EWs did not agree that they got more clients, became more interested in sex, or that they would forget to use condoms when drinking alcohol. A slight majority did report that they enjoyed their jobs more when drinking (53%). Only a small percentage (9%) reported needing help with reducing the impact of alcohol on their health.

Nearly all EWs thought that it was easy to get drugs on the job and about one in four reported they had received offers of drugs at their workplace; EWs who visited SMARTgirl Clubs frequently were slightly more likely to say that this was the case. About an equal proportion reported that they knew where to get drugs with dealers being the most frequently mentioned source (11%), followed by friends (9%). If drugs were offered to the EWs, it was usually by customers (10%) or friends (8%).

R8: There are people who work in this bar and use drug; they know how to access the drugs and then they started to convince other women to use drugs like them. It costs about $5 per tablet. A drug user needs to take 1 tablet each time to get high. Once the drug is absorbed they become happy and start to enjoy themselves. I observed girls who use drugs—they live in a very small room and there is nothing in their room except a bed and a fan because they spend all their money on drugs. When they came to visit my house they criticize me for all the stuff I have, such as TV, electric cook pots and so on. Drugs are a waste of money. If I fall into using drugs with them I may need to sell all of my things like they have done to pay for drugs.

The EW's drug of choice was to smoke methamphetamine or amphetamines. Of those that had used drugs in the past 6 months, 75% thought they could work better or longer when using drugs, 71% enjoyed their jobs more and 69% believed they could get more clients. However, only 3% used drugs before or after sex, but 8% said that they had exchanged drugs for sex. No respondents reported having injected drugs.

FACILITATOR INTERVIEWS

SMARTgirl facilitators' knowledge of the risks that EWs face and their own risk reduction behavior were also assessed in the review. When asked what EWs could do to reduce their risk nearly all suggested EWs should use condoms consistently and correctly; 58% mentioned they should get tested for HIV and know their status; but only 31% mentioned partner reduction or reducing the use of alcohol and drugs (6%). Three-quarters of the facilitators knew of at least two risk-reducing methods. Nearly all facilitators knew that it is important to be screened regularly for HIV and STIs and EWs should be re-tested within three months of risky behavior if they initially test negative. All SMARTgirl facilitators were able to name two ways that methamphetamines destroy physical attractiveness and 95% could name more than two ways.

When asked about their own sexual health, 61% reported condom use compared to 11% who did not use condoms with their partners. Nearly two-thirds were using a contraception method, with 53% reporting use of condoms and 18% using the contraceptive pill; 34% reported using nothing at all. Three-quarters of facilitators had been screened for STIs and for HIV in the past year and 32% had obtained RH/FP services.

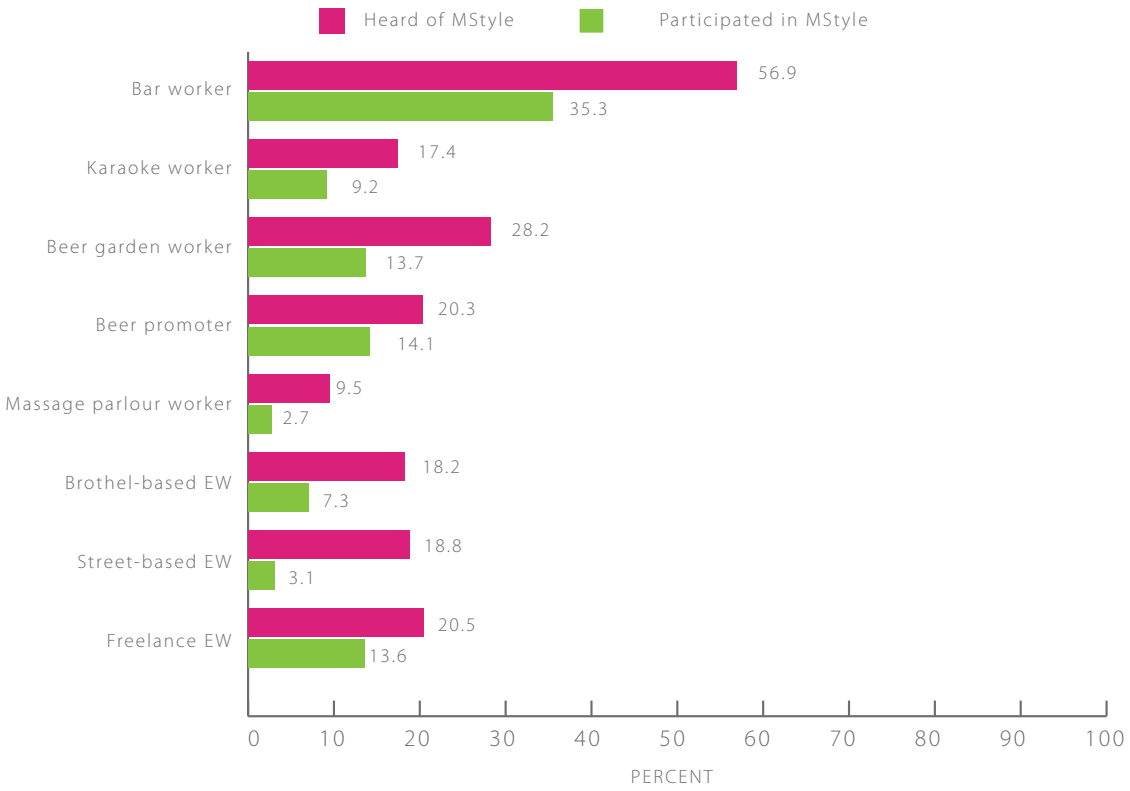
6. Overlapping populations - SMARTgirls and MStyle

PRASIT's MStyle program has been designed to promote HIV prevention for MSM through a number of channels, and includes some cross-promotional activities with SMARTgirl. The survey asked both EWs and SMARTgirl facilitators whether they were aware of the MStyle program - while only 22% of EWs surveyed had heard of the program, 94% of facilitators were aware of it. Although only 12% of EWs reported ever having participated in MStyle activities, this may include a large proportion of the transgender EWs. As seen in Table 6.1, awareness of MStyle was closely related to EWs' participation in SMARTgirl: 35% of those who visited a SMARTgirl Club regularly were aware of MStyle and 23% had participated in an MStyle activity. In addition, a high percentage (57%) of bar workers knew about MStyle and approximately one-third had participated in their activities (Figure 6.1). Among SMARTgirl facilitators, 42% reported their fellow facilitators sometimes talked about MStyle and/or used MStyle materials.

TABLE 6.1: Awareness of the MStyle program among EWs by exposure to SMARTgirl

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
EVER HEARD OF MSTYLE					
No	78.4	91.7	79.9	81.1	64.7
Yes	21.6	8.3	20.1	18.9	35.3
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1057)	(168)	(149)	(471)	(269)
X^2		*49.6 w/3 d.f. p<.000*			
EVER PARTICIPATED IN MSTYLE ACTIVITY					
No	88.7	99.4	91.3	91.1	76.6
Yes	11.3	0.6	8.7	8.9	23.4
Total	100.0	100.0	100.0	100.0	100.0
(n)	(1048)	(167)	(147)	(466)	(268)
X^2		*62.5 w/3 d.f. p<.000*			

FIGURE 6.1: Awareness and participation in MStyle among EWs by current job



7. Stigma and gender-based violence

Although not all entertainment workers are sex workers, they are placed in the same category by most of Cambodian society; in Khmer there is no separate term to distinguish entertainment workers from sex workers. EWs are seen as being "bad women" who are not marriageable, and who damage the reputation of "good" virginal Khmer women with traditional values.[17] This stigmatization affects HIV prevention for EWs in several ways. EWs may feel uncomfortable seeking reproductive health services, STI screening and treatment, and VCCT, as they feel they will be treated badly by health care professionals. They may also be afraid to carry condoms, as police may use this as evidence to arrest them for carrying out sex work. Cambodia's 2008 sex trafficking law has led to frequent arrests of sex workers and reports of police harassment and abuse.

17 Bou Amara. (2010). Being a "Smart Girl": constructing the new image for female entertainment workers, Phnom Penh, Cambodia (Master's thesis). Mahidol University, Salaya, Thailand.

Several of the women who were interviewed discussed how stigmatization affected them.

R3: Women who work in entertainment places, even if we are innocent, the clients still devalue us. It is like the proverb saying that 'one fish that stinks will alter the fresh fish in the same basket.'…Elderly people look at me as a non-Khmer woman. Actually, my job is very high dignity…other women should understand that I am also a woman like them.

R4: The discrimination against karaoke girls occurs not only among ordinary people but clients also… they never respect women. They regard women as their toys. They need hugs, kisses, slow dances and so on. Whenever I go out with clients the women who work in the same place with me gossip and stigmatize me… working here I have to confront discrimination made by clients, the outside world as well as my own colleagues. I don't want any of my (hometown) villagers know about my job because I worry my parents will lose face and feel ashamed.

R7: I understand that Khmer women are given high dignity but this only applies to rich women, not to poor women like me. However, I think that although I do this job, it comes from my own efforts - I don't beg anyone for survival. I have talked openly to other people that, 'as we are born to be a woman, it is very sinful if we don't use our thing [vagina]. But if we give it to someone who needs it, we will earn merit!'…Although I am a sex worker I still have my own value; if we are strong and value ourselves highly no man dare abuse us.

While most (76%) of the EWs interviewed for the quantitative survey did not feel afraid of being seen when going for VCCT or STI screening, 70% said that they did feel stigmatized and/or discriminated against for being an EW, with 41% strongly agreeing with this statement (Table 7.1). Less than two out of three EWs (64%) said that their families knew that they worked as an EW. Many SMARTgirl facilitators agreed that it is important for people to accept that EWs are not morally inferior, although a third disagreed (33%).

TABLE 7.1: Perceptions of stigma of EWs by exposure to SMARTgirl

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
OPINION ON WHETHER EXPERIENCE STIGMA/ DISCRIMINATION AS RESULT OF BEING AN EW					
Strongly agree	78.4	91.7	79.9	81.1	64.7
Agree	21.6	8.3	20.1	18.9	35.3
Disagree	78.4	91.7	79.9	81.1	64.7
Strongly disagree	21.6	8.3	20.1	18.9	35.3
Don't know	100.0	100.0	100.0	100.0	100.0
Total	(1057)	(168)	(149)	(471)	(269)
(n)	(1035)	(162)	(147)	(459)	(267)
X^2		*16.2 w/d.f. 12 p=.182*			

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
WHETHER FAMILY KNOWS WHERE THEY WORK OR WHAT THEY DO					
Yes	63.7	58.4	62.8	61.5	69.7
No	36.3	41.6	37.2	38.5	30.3
Total	100.0	100.0	100.0	100.0	100.0
(n)	(712)	(67)	(98)	(320)	(227)
X^2		*7.0 w/d.f. 3 p=.071*			

Previous research in Cambodia has documented the considerable risks that EWs face with regard to violence, including rape and gang rape, by clients. Globally, sex workers who experience violence have been found to be significantly more likely to face HIV and reproductive health risks.[18] In the qualitative interviews, several instances of violence were reported.

R1: I have a friend who was invited to sleep with a youngster and he also invited me. I told my friend to go first and I will go later. Once I got there I saw my friend already in a terrible condition. Those men had spilt their sperm all over my friend's body, face and mouth and they left her without giving her any money…her vagina was covered by blood. There were about three men.

R4: A few days ago a client kicked a [karaoke] room operator hard. The owner did nothing; they let the clients walk out peacefully. Another time there was a client who was very aggressive. He got drunk somewhere else before he came here. I did something little that he didn't like, and so he broke the glasses and wine bottle immediately. I was so scared and it was very difficult to deal with him. The owner asked him to pay for the glasses but did not ask anything from me.

R6: One time a client rode me to a quiet place which was very far from my workplace. When I was on his motorbike I kept asking him where he's taking me to but he kept saying that it is not too far; just a little bit farther. I was so afraid but I could not jump off from his motorbike as it was too dangerous; I may have died and left my kids behind. Finally, when we arrived at the place there were another eight guys. However, only two of them had sex with me, the rest of them feel sympathy on me so didn't have sex with me. I tried to beg them. I showed them my breast (there was some milk coming out) and told them that I just newly delivered a baby so please save my life for my baby. One of them attempted to have sex with me without condom but I wouldn't let him. He kicked me hard but his friend stopped him and gave him a condom so he agreed to use it.

While the survey did not ask EWs about violence they experienced from clients, they were asked whether they were able to refuse sex if their partners refused to use condoms and whether they ever experienced violence from partners for suggesting condom use (Table 7.2). The answers varied by partner; about half reported they could refuse sex with their husband or regular partners, however, 22% and 18% respectively never suggested condom use with husbands or regular partners. EWs with high exposure to SMARTgirl reported to be considerably more empowered to negotiate/refuse sex than those who had not had any recent contact with SMARTgirl. This result displays an important aspect of the program: building EW self-esteem. Seventy two percent (72%) of EWs believed they could refuse sex with clients if they did not use

18 Richter, K. & Bobin, N. (2002). Sweetheart relationships in Cambodia: love, sex and condoms in the time of HIV. Phnom Penh: Population Services International; Beattie, T.S.H. et al. (2010). Violence against female sex workers in Karnataka state, south India: impact on health, and reductions in violence following an intervention program. BMC Public Health 10:476. doi:10.1186/1471-2458-10-476; Swain, S.N., Saggurti, N., Battala, M., Verma, R. K., & Jain, A.K. (2011). Experience of violence and adverse reproductive health outcomes, HIV risks among mobile female sex workers in India. BMC Public Health, 11:357, doi:10.1186/1471-2458-11-357.

a condom and only 3% never suggested condoms in the first place. Not surprisingly, EWs were more likely to experience violence from a client (55%) when negotiating condom use, although a fair proportion still reported abuse from husbands and regular partners (26% and 31% respectively) when suggesting they use a condom.

TABLE 7.2: Experiences with partner violence of EWs by exposure to SMARTgirl

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
ABLE TO REFUSE SEX IF HUSBAND REFUSES CONDOM USE					
Yes	49.8	27.5	50.0	51.5	57.3
No	50.2	72.5	50.0	48.5	42.7
Total	100.0	100.0	100.0	100.0	100.0
(n)	(271)	(40)	(36)	(99)	(96)
X^2		*10.2 w/d.f. 3 p=.017*			
EVER EXPERIENCED ANGER OR VIOLENCE FROM HUSBAND BY SUGGESTING CONDOM USE					
Never suggest condom use	22.0	22.5	18.9	26.3	18.6
Yes	26.0	22.5	29.7	22.2	29.9
No	52.0	55.0	51.4	51.5	51.5
Total	100.0	100.0	100.0	100.0	100.0
(n)	(273)	(40)	(37)	(99)	(97)
X^2		*3.1 w/d.f. 6 p=.798*			
ABLE TO REFUSE SEX IF REGULAR PARTNER REFUSES CONDOM USE					
Yes	54.7	31.6	40.7	54.9	70.6
No	45.3	68.4	59.3	45.1	29.4
Total	100.0	100.0	100.0	100.0	100.0
(n)	(179)	(19)	(27)	(82)	(51)
X^2		*11.4 w/d.f. 3 p=.010*			
EVER EXPERIENCED ANGER OR VIOLENCE FROM REGULAR PARTNER BY SUGGESTING CONDOM USE					
Never suggest condom use	18.1	31.6	11.1	18.8	15.7
Yes	31.1	21.1	29.6	32.5	33.3
No	50.8	47.4	59.3	48.8	51.0
Total	100.0	100.0	100.0	100.0	100.0
(n)	(177)	(19)	(27)	(80)	(51)
X^2		*4.1 w/d.f. 6 p=.666*			
ABLE TO REFUSE SEX IF CLIENT REFUSES CONDOM USE					
Yes	73.2	-	-	-	-
No	26.8	-	-	-	-
Total	100.0	-	-	-	-
(n)	(41)	(8)	(8)	(13)	(12)
X^2		*1.2 w/d.f. 3 p=.750*			

	All Respondents	(1) No contact with SG past 3 mos	(2) Contact with SG outreach 1-3 mos	Contact past month	
				(3) SG outreach	(4) Visit SG Club
EVER EXPERIENCED ANGER OR VIOLENCE FROM CLIENT BY SUGGESTING CONDOM USE					
Never suggest condom use	2.5	-	-	-	-
Yes	55.0	-	-	-	-
No	42.5	-	-	-	-
Total	100.0	-	-	-	-
(n)	(40)	(8)	(8)	(13)	(11)
X^2		*1.2 w/d.f. 3 p=.750*			
WHERE/WHOM DO YOU ASK FOR HELP IF PHYSICALLY OR EMOTIONALLY ABUSED BY CLIENTS OR OTHER MEN					
Employer	29.2	37.7	23.8	29.7	26.0
Police	28.2	30.2	26.5	27.7	28.6
NGOs	24.2	10.5	26.5	25.1	29.8
Friends	9.9	11.1	10.2	10.3	8.4
Family	7.0	8.6	10.2	6.1	5.7
Do not know	1.6	1.9	2.7	1.1	1.5
	100.0	100.0	100.0	100.0	100.0
X^2		*30.1 w/d.f. 15 p=.012*			
WHO DO YOU TALK TO WHEN YOU NEED SUPPORT[19]					
Friends	53.0	42.8	57.4	53.9	55.2
NGO/SMARTgirl outreach	44.3	9.6	38.5	49.6	59.7
Family	42.2	37.2	39.4	50.0	42.2
Neighbors/work colleagues	39.7	34.3	37.8	43.9	36.6
No one	3.0	4.8	4.7	2.8	1.1
Other	0.7	0.6	0.7	0.9	0.4
(n)	(1044)	(166)	(148)	(462)	(268)

One of the SMARTgirl program's main goals is to serve as a support network and source of information for EWs who experience violence. When asked where they would go for help if they experienced violence, their "employer" was the top answer (29%), closely followed by police (28%) and NGOs (24%). Those with higher exposure to SMARTgirl were most likely to mention NGOs (30%). When asked who they talk to when needing support, "friends" was the number one answer (53%), with NGOs/SMARTgirl second and most popular amongst those who frequently visit SMARTgirl Clubs.

19 Multiple response possible, responses do not sum to 100%.

8. Identification with and perceptions of SMARTgirl

Several respondents discussed how they became SMARTgirl peer facilitators, and how developing skills in teaching other EWs about prevention gave them confidence.

R1: I don't rely on my peer facilitator salary and I don't care about the money either. The most important thing I wanted is knowledge… once I joined the organization and I had the chance to conduct outreach sessions, the participants called me 'teacher'. I was so excited!

Others talked about their perceptions of being a SMARTgirl:

R5: I see a girl who is good at negotiating with clients. When clients attempt to put their hands on her private parts, she has tactics to avoid this situation by inviting clients to dance or take their hands away by talking to clients in sweet ways so as not to make them angry.

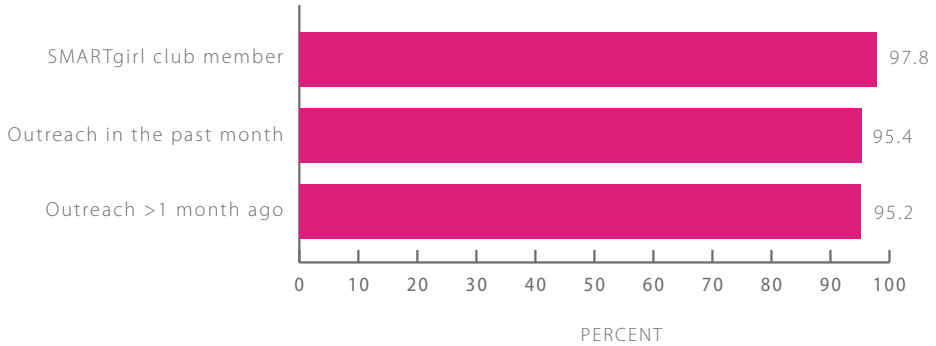
R6: Frankly, since there are NGOs working to support women who are involved in this kind of work, we have more freedom and confidence to challenge [the police]. In case we are arrested we can contact the NGOs to come and help us out. That's why I don't hesitate to join with any NGOs.

R7: Since I have joined with the NGO I feel more empowered. Previously I was weak, I allowed clients to do whatever they wished to me. But now it is different, the clients cannot just do anything to me. If I don't allow them to touch my body they can't do it. The most important thing is we have to be strong.

IDENTIFICATION WITH SMARTGIRL

The survey explored EWs' and SMARTgirl facilitators' attitudes and conceptualization of the program in several ways. EWs were asked whether they identified themselves as a SMARTgirl; as seen in Figure 8.1, the answer was overwhelmingly "yes" regardless of the extent of exposure to SMARTgirl programs. This indicates that the program has an extremely positive image among EWs. Facilitators were also asked about their identification with the program by rating four statements about the SMARTgirl program. The results were extremely positive with the vast majority of facilitators feeling proud to be part of SMARTgirl, feeling that they have personally contributed to SMARTgirl's success and they also reported talking about SMARTgirl outside of work. Facilitators also agreed that they should act as a positive role model for SMARTgirls.

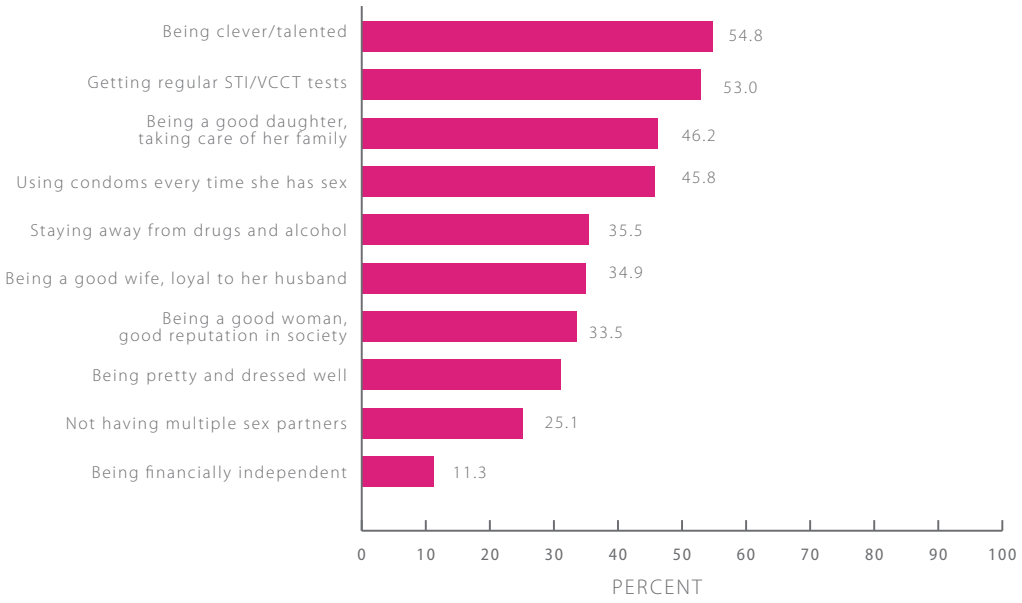
FIGURE 8.1: Percent of EWs who say they identify themselves as a SMARTgirl by exposure to the program



PERCEPTIONS OF SMARTGIRL

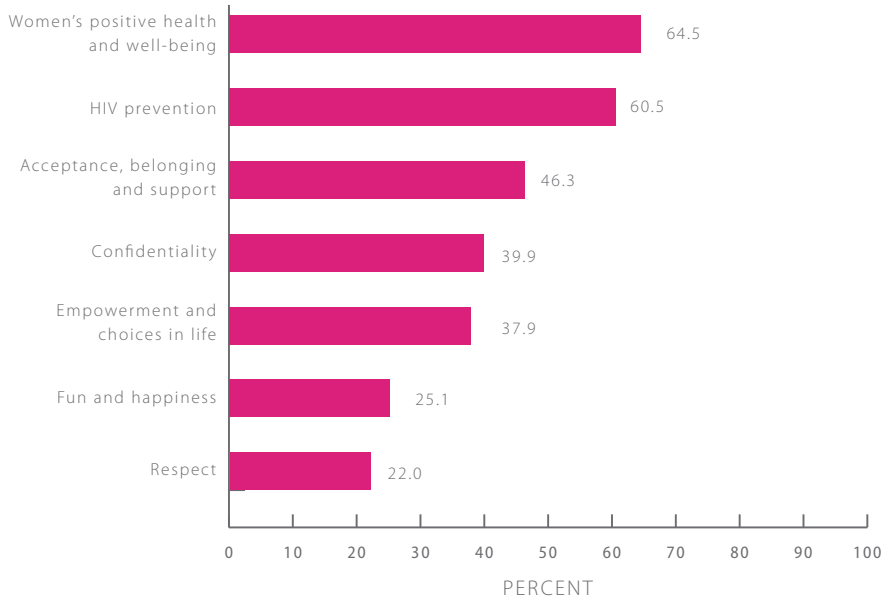
When asked what they thought a SMARTgirl was, the most popular response amongst EWs was "being clever and talented", closely followed by "getting regular STI and VCCT tests" (Figure 8.2). Other popular responses included "being a good daughter and taking care of the family" as well as "using condoms every time she has sex". The majority of SMARTgirl facilitators thought that a SMARTgirl was someone who is "positive and supports EWs", but there was also a significant number who thought it meant being "clever and talented".

FIGURE 8.2: EW opinions on what a SMARTgirl is (percentage "yes")



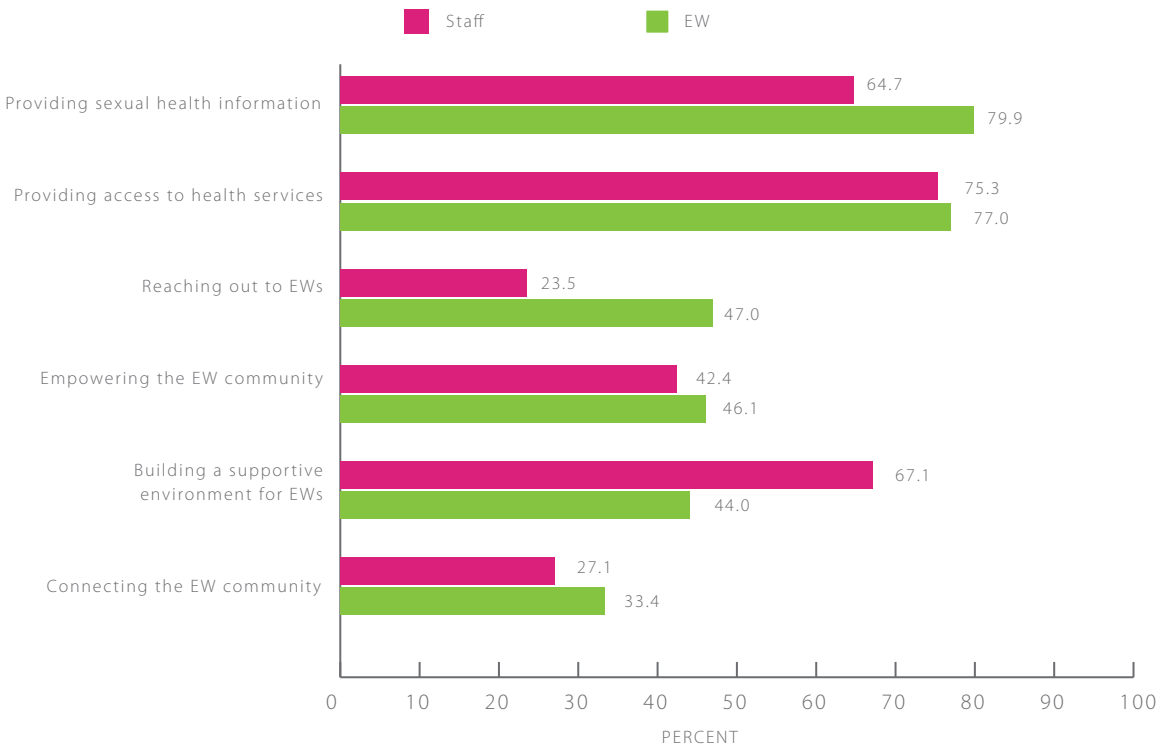
EWs were also asked their opinion about how to describe SMARTgirl (Figure 8.3); the majority agreed that it was about "women's health and well-being" (65%) and "HIV prevention" (61%). These messages resonated with EWs much more than "fun and happiness" (25%) or "respect" (22%).

FIGURE 8.3: EW opinions on words used to describe SMARTgirl (percentage "yes")



Both facilitators and EWs were asked about the strengths of the SMARTgirl program (Figure 8.4). EWs overwhelmingly replied that the provision of sexual health information was the main strength, followed closely by supporting access to health services. While SMARTgirl facilitators also believed the main strength of the program revolved around health care referrals and access, they were more likely to relate to less tangible programmatic aspects, such as the supportive environment for EWs.

FIGURE 8.4: EW and facilitator opinions on the strengths of the SMARTgirl program



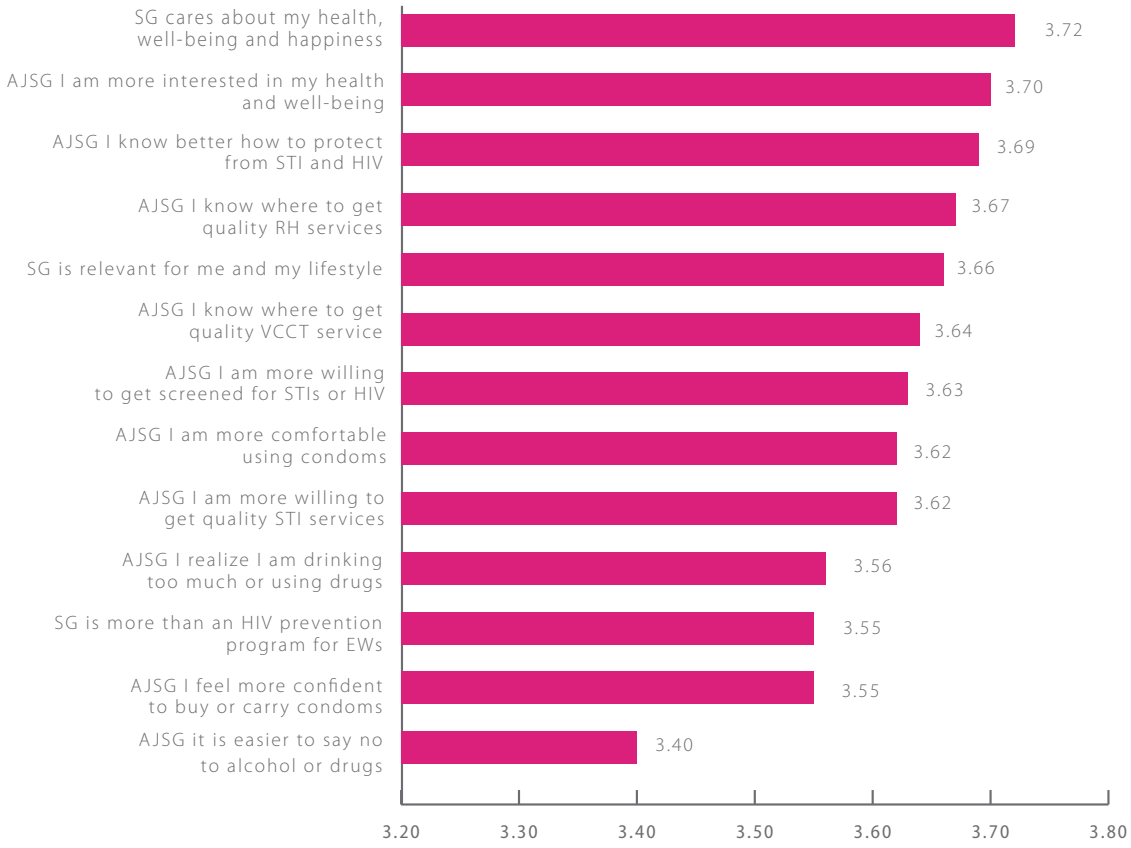
To further explore perceptions about the SMARTgirl program for EWs, an analysis of the principal components was conducted using responses to the questions on opinions of what a SMARTgirl is, words used to describe SMARTgirl and the strengths of the program. Principal components analysis is useful for reducing a large number of question items into a smaller number of constructs. The resulting factors represent correlations between the individual question items. As seen in Table 8.1, three underlying factors emerged from the analysis. The first, representing "support", includes items about the SMARTgirl program connecting the EW community, providing support and empowerment. It also includes consistent condom use, staying away from alcohol and drugs and not having multiple sex partners. The second factor, representing "health", contains items about the SMARTgirl program's health services, health information and well-being. This factor also includes being "clever and talented". Finally the "women's roles" factor includes the items about being a good wife, a good woman and a good daughter. The items that make up the three factors were tested for reliability as a scale; the Cronbach's alpha statistic shown in the last row of the table measures the internal consistency of the scale. Normally a value of 0.7 is required to establish that the scale is measuring an underlying construct. Both the "support" and "health" scales have a Cronbach's alpha of 0.8 or more, while the "family" scale is at 0.62, which leaves it questionable. While preliminary analysis finds that these scales do not vary by level of exposure to SMARTgirl, they will be used as independent variables in future multivariate analysis of factors affecting HIV prevention behavior. In this way they may reveal which of the SMARTgirl messages have been most effective in communicating the importance of HIV prevention.

TABLE 8.1: Factor loadings for EW perceptions of the SMARTgirl program

	SUPPORT	HEALTH	WOMEN'S ROLES
Q304D SMARTgirl does a good job of connecting the EW community	0.647		
Q304C SMARTgirl does a good job of building a supportive environment for EWs	0.644		
Q304E SMARTgirl does a good job of empowering the EW community	0.642		
Q304F SMARTgirl does a good job of reaching out to EWs	0.626		
Q303F When I think about the SMARTgirl Program I think about confidentiality	0.613		
Q303D When I think about the SMARTgirl Program I think about acceptance, belonging and support	0.571		
Q303E When I think about the SMARTgirl Program I think about respect	0.521		
Q303C When I think about the SMARTgirl Program I think about empowerment and choices in life	0.515		
Q302G I think that SMARTgirl means using condoms every time she has sex	0.479		
Q302J I think that SMARTgirl means staying away from drugs and alcohol	0.446		
Q302I SMARTgirl is not having multiple sex partners	0.402		
Q304A SMARTgirl does a good job of providing sexual health information		0.722	
Q304B SMARTgirl does a good job of providing access to health services		0.696	
Q303G When I think about the SMARTgirl Program I think about positive health and well-being of women		***0.658***	
Q303A When I think about the SMARTgirl Program I think about HIV prevention		0.641	
Q302H I think that SMARTgirl means having regular STI/ VCCT screening		0.556	
Q302E I think that SMARTgirl means being clever or talented		0.476	
Q302D I think that SMARTgirl means being a good wife or loyal to her husband			0.666
Q302B I think that SMARTgirl means being a good woman or having a good reputation in the society			0.638
Q302C I think that SMARTgirl means being financially independent			0.637
Q302A I think that SMARTgirl means being a good daughter or taking care of her family			0.585
Cronbach's alpha	**.87**	**.80**	**.62**

EWs were also asked whether they agreed or disagreed with a series of statements about how the SMARTgirl program had affected them. As seen in Figure 8.5, EWs tended to agree with nearly all of the statements, with the most identifiable ones being that "SMARTgirl cares about my well-being and happiness". Statements about interest in and knowledge about HIV/STI prevention and services also resonated with the respondents. The lowest scoring statement was "I find it easier to say no to alcohol or drugs", which may not have been applicable for many respondents.

FIGURE 8.5: Mean scale responses for perspectives on SMARTgirl (AJSG = After joining SMARTgirl; scale ranges from 1=strongly disagree to 4 = strongly agree)



Finally, the SMARTgirl facilitators were asked for their opinions on what the SMARTgirl program does well and what it needs to improve. Over 90% agreed with the objective of the SMARTgirl program and said that the goal of SMARTgirl is to improve the sexual health of EWs. Seventy three percent (73%) thought the program empowers EWs and 69% thought it helped them to prevent HIV. The facilitators thought that the multi-faceted approach to SMARTgirl helps it stand out and makes SMARTgirl special. The fact that they provide more than just HIV information also seems to be important; branding did not seem to be as significant a factor to the facilitators.

CONCLUSIONS AND PROGRAMMATIC RECOMMENDATIONS

Conclusions

FHI 360 and its partners introduced the SMARTgirl, an innovative, holistic, human rights based and HIV prevention and care program with the aim of improving the sexual health and general wellbeing of EWs . This review of the program found that it is effective in reaching a large percentage of EWs with information about HIV prevention and sexual health services through a variety of channels. The review also revealed important information about the staff and peer facilitators who were directly serving the EWs; knowledge levels about program activities, services and related information was high as were motivation levels to conduct the work they carry out.

SMARTGIRLS:

The majority of EWs reached through SMARTgirl were in their 20's, single, had limited education and had migrated to Phnom Penh within the last 5 years. All EWs surveyed became an EW for financial reasons; to supplement salary from another job, or simply to relieve themselves and their children from starvation. These factors and more imply that SMARTgirl is reaching their proposed target group of high risk EWs and the data reveals that over 70% of these women had a high degree of exposure to the program.

Well over half the SMARTgirl peer facilitators interviewed were EWs themselves and were motivated to carry out the work in order to prevent HIV amongst their peers. Nearly half aspired to eventually work for an NGO full time.

REACH OF SMARTGIRL:

Nearly all of the Entertainment Workers interviewed had heard of the SMARTgirl program. The data shows that SMARTgirl is especially successful in reaching its target group of non-brothel based EWs, 70% of whom have been heavily involved with SMARTgirl, either through joining SMARTgirl Club activities or through meetings with outreach workers. Outreach was highlighted in the review as the most important avenue for connecting with EWs; however, when analyzing all the variables the SMARTgirl Clubs seemed to consistently be most popular with the highest risk groups of EWs.

Peer facilitators were questioned about their knowledge of and referral to EW-friendly health services to ensure EWs were being reached with the appropriate information. The vast majority of SMARTgirl facilitators knew of at least two appropriate referral services and agreed that providing referrals directly correlates with service uptake by EWs.

CORE PACKAGE:

The SMARTgirl program aims to provide all EWs with a core package of services, which is comprised of targeted prevention education, condom and lubricant and systematic health service referrals. A high proportion of EWs accessed at least one of these services, but only about half received the full package. SMARTgirl remains an important source of HIV/STI/RH prevention education as well as condoms for EWs; more than half said that they normally get their information and condoms from SMARTgirl facilitators and this naturally increases with the level of interaction they have with the program. The data reflect similar results related to knowledge and practice of visiting RH/FP services, STI screening and HIV testing and counseling. While a high percentage of EWs reported using condoms, significantly few reported use of a different or second form of contraception, suggesting that perhaps more information and education could be provided to EWs about the benefits of long acting contraceptives in association with a secondary HIV/STI prevention method. This is especially poignant when up to a third of all EWs reported having had an abortion. EWs who were in contact with the SMARTgirl program were more likely to have had an abortion, suggesting that, as intended, SMARTgirl is reaching those EWs most at-risk and providing them with the information and education they need and can use.

As mentioned above only about half of the EWs interviewed reported to having received all three components of the core package last time they met with a SMARTgirl facilitator. Interviews with the facilitators revealed that approximately two-thirds provided the core package during their last meeting with an EW. Therefore, it can be concluded that although the majority of facilitators knew they should deliver the core package, they may need to be reminded about the importance and relevance of providing all these services during every meeting with an EW. In addition, facilitators could improve the message they are purveying to EWs about why a set of core services is being offered and the benefits around accepting the complete package. Facilitators appreciated the trainings that were provided throughout the reporting period and felt more confident as a result; more frequent, detailed trainings could possibly be provided to ensure all SMARTgirl facilitators are kept well informed and motivated to carry out their work.

HEALTH KNOWLEDGE AND PRACTICE

A high proportion of EWs interviewed knew that they should be tested for HIV at least two times per year; a slightly lower proportion, but still relatively high, knew that they should be tested for STIs at least 4 times per year. There was significant, positive correlation between the level of exposure to SMARTgirl and levels of knowledge and access to HIV and STI services which is a very encouraging outcome for the program; EWs consistently reported having accessed HIV or STI services after a meeting with and encouragement from a SMARTgirl facilitator.

The interviews also revealed that SMARTgirl facilitators' knowledge about HIV risk and appropriate services was very high; however, when questioned about STI testing and services, knowledge levels dropped. This finding will feed into recommendations for areas of training and capacity building for SMARTgirl facilitators.

HIV RISK:

In general, many EWs did not perceive themselves to be at great risk for HIV, believing that their knowledge of condom use, monogamy and trust may keep them safe. When talking about condom negotiation, SMARTgirl was praised for giving EWs the courage and tools to facilitate safe sex with paying clients. Although 90% of EWs said that they insisted upon condom use with a client, only 14% of married women could say the same for their husbands. If it is these relationships that are determined to be one of the current driving forces of the HIV epidemic in Cambodia, much work is to be done in this area with both men and women.

It has been well documented that drugs and alcohol can lead to risky decision-making and ultimately to STI and/or HIV infection. Not only did a fair proportion of EWs report to drinking on the job, many said that it was essential to promoting the product they were hired to sell. The majority also explained that they enjoyed their job more if they had been drinking or taking drugs. Unfortunately, when working in establishments or other environments where drugs and alcohol are heavily prevalent, violence, particularly gender based violence, is common. The reports from EWs during the review substantiate this claim and link it to a high degree of stigma and discrimination facing EWs in Cambodia.

When questioned about their own HIV risk and prevention practices, SMARTgirl facilitators' high level of knowledge translated into good practice with relatively high levels of condom use, and screening for both HIV and STIs.

OVERLAPPING POPULATIONS:

Less than a quarter of the EWs interviewed were aware of the MStyle program, the majority of who were regular visitors to SMARTgirl Clubs. Nearly all SMARTgirl facilitators knew about MStyle, but it seems they might not recognize the relevance in promoting their activities.

STIGMA AND GENDER-BASED VIOLENCE:

Reflecting society's general feeling about EWs and sex workers, a high proportion of EWs felt stigmatized as a result of the work they carried out. Fortunately, though, these feelings of being discriminated did not deter the majority from accessing HIV and STI screening services. The review did not directly address violence experienced by EWs, but when discussing condom negotiation, over half of the EWs interviewed reported some level of violent behavior from a client when condom use was suggested and a fair proportion reported abuse at the hands of their husbands or regular partners. The review revealed that EWs were well aware of the supportive services available to them when a victim of abuse.

The majority of SMARTgirl facilitators agreed with the statement that it is important for people to accept that EWs are not morally inferior, but a fair few disagreed. It is not clear, however, whether this is a reflection of or by EWs, since half of the facilitators interviewed were EWs themselves. Regardless, staff training on the impact of discrimination and EW empowerment may be beneficial.

SMARTGIRL BRAND:

Identification with and perceptions of the SMARTgirl program were overwhelmingly positive and the vast majority of respondents identified with the program. Multivariate analysis of perceptions, of both EWs and facilitators, of the program revealed two main factors to be statistically significant: 1) support, including connecting the EW community, providing support for condom use and avoiding alcohol/drugs, and empowerment; and 2) health, including SMARTgirl's health services, health information and messages about well-being.

Programmatic Recommendations

As a result of this review and on-going programmatic strategizing, the SMARTgirl program could further improve its services for EWs by considering the following recommendations:

Build capacity of staff

- Provide more regular or a series of themed trainings to all SMARTgirl facilitators. Topics should include, but not be limited to: core package delivery, health and social service referral guide, HIV and STI 101, implications of drug and alcohol use and appropriate support response, impact of discrimination, gender-based violence, building self-esteem;
- Organize field visits to all referral sites to improve facilitator knowledge and reference of key referral sites.

Increase appeal of and access to SMARTgirl Clubs

- Make Club members eligible to become SMARTgirl representatives and attend provincial or national meetings related to health and welfare of EWs, including HIV, STI and FP issues on behalf of the EW community;
- Improve variety and quality of activities in the SMARTgirl Clubs pertinent to EWs (e.g., make-up, hairdressing, literacy/basic education sessions);
- Provide an incentive to become a SMARTgirl member (e.g., card holders may be able to get discounts at certain venues through a private partnership deal with local vendors);
- Provide additional services, such as a money saving scheme.

Ensure provision of Core Services

- Reinforce accountability for facilitators to provide the core package of services to EWs;
- Strengthen linkages with and increased referrals to EW-friendly health services, such as NGO-based clinics through MoUs.

Address risk of EW partners

- Adapt condom negotiation skills building sessions to address importance of condom use with sweethearts and/or regular partners;
- Strengthen linkages with and direct referrals to EW-friendly social services dealing with gender-based violence issues.

Increase emphasis on Family Planning

- Increase number of referrals being made to Family Planning services;
- Encourage EWs to access VCT, STI and FP services all in one visit; however, this also may involve capacity building at the health service provider level to ensure EWs are supported to access each individual service;
- Train facilitators to build their capacity and knowledge about FP and the benefits of Condom Plus Family Planning;
- Integrate FP services into SMARTgirl Clubs.

Address concurrent issues

- Design and develop drug and/or alcohol user group sessions, utilizing a harm reduction approach.

Create an Enabling Environment

- Design and implement a partnership project with the police and other law enforcement agencies to build their understanding of the rights of EWs as members of the public, and ultimately to reduce arrest rates, EW's fear of law enforcement officials, and harassment by police.

To continue as well as expand the coverage of the SMARTgirl program, PRASIT was to franchise the brand to the IAs. This would entail the IA securing funding from alternative (i.e., non USG) source(s) for continuation of the program, but would have an MoU with FHI 360 Cambodia to provide technical assistance when required or deemed necessary. This plan will be piloted in the following reporting period with at least 2 existing IAs (CWPD & ACTED-PSF).