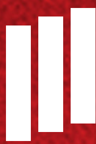


Women's Refugee Commission
Research. Rethink. Resolve.

Reproductive Health Uganda
RHU

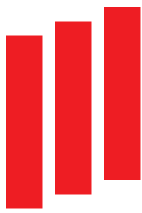
Working with Refugee Women Engaged in Sex Work:

Bringing a Peer Education Model and Mobile Clinics to Refugees in Cities

Kampala and Nakivale Settlement, Uganda
January - August 2016

Case Study: Strengthening Urban GBV Prevention & Response in Uganda

April 2017



Research. Rethink. Resolve.

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children and youth displaced by conflict and crisis. We research their needs, identify solutions and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

Acknowledgments

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Cover photo: Training facilitator discusses the rights of refugees engaged in sex work with peer educators. © RHU

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Background

Mitigating Urban Refugees' Risks of Gender-Based Violence

This case study emerged from a broader initiative of the Women's Refugee Commission (WRC) to build up the much–needed evidence base on best practices for strengthening gender-based violence (GBV) prevention and response in urban, rather than camp, contexts.

Previous research, conducted in various urban settings, underscored the importance of empowering urban refugee communities and individuals to take a leading role in not only designing GBV prevention efforts, but also tailoring them to the particular complexities (social, political, financial, infrastructural) of the city environments in which they live.[1] That research also emphasized the unique challenges and opportunities that exist for GBV prevention and response in urban settings. In turn, it signaled the need for significant structural changes to how humanitarian GBV programming is developed, financed, and implemented in order to be effective in this new "beyond camps" era.

In response to those early findings, WRC partnered with local organizations in different urban humanitarian settings throughout 2016, for the purpose of piloting GBV activities that would be at once innovative, community-driven, and responsive to the GBV risks experienced by a particularly at-risk, or hidden, urban refugee population.

Peer educators in Nakivale Refugee Settlement.

Pilot activities were highly localized. Yet they also adhered to three key tenets of a successful urban GBV response model: (1) proactively working with diverse local actors, governmental and nongovernmental; (2) mitigating GBV risks prioritized by communities themselves; and (3) targeted outreach and tailored programming to meet the particular needs of marginalized, hidden, and/or highly vulnerable populations.[2]

This case study outlines two pilot interventions implemented in Uganda by WRC's partner, Reproductive Health Uganda (RHU). They were:

1. Training refugee women engaged in sex work to be peer educators in Kampala and in the Nakivale Refugee Settlement. This intervention was designed to address information, service, and support gaps affecting these women. It took an evidence-informed and rights-based approach to working with these women, in order to strengthen their skills and capacity to mitigate GBV risks and otherwise improve their health and safety. A total of 80 women refugees were trained as peer educators: 50 women in Kampala and 30 women in Nakivale.
2. Bringing mobile clinics to refugee neighborhoods in Kampala. These clinics offered a wide array of health services, including GBV response services. They visited areas of the city that were designated by refugee community members as being particularly hard-to-reach places. They were also an opportunity to reach populations of refugees who are especially "hidden" or stigmatized and who might not otherwise travel to static sites in order to access services. Across the five sites, mobile clinic staff provided direct services to 3,244 urban refugees, the vast majority of whom were women and children.

Part 1: Training Refugee Women Engaged in Sex Work as Peer Educators

Violence, Stigma and Service Gaps

Many forcibly displaced persons engage in sex work, regularly or occasionally, as a means of earning income. Although this is widely known amongst humanitarian actors, little research and guidance exists for ensuring these refugees' protection and health needs are met.[3] Selling sex is heavily stigmatized, both within humanitarian response and amongst refugee communities. As a result, few refugees who do it have access to information, services and support relevant to their immediate health and safety; others lack access to services where they feel they are treated with dignity and their decisions or perspectives are respected.

In February 2016, the WRC published research findings related to GBV against refugees engaged in sex work. That report, Mean Streets: Refugees Engaged in Sex Work, set forth the diversity of perspectives and experiences of refugees who trade sex, as well as the diversity of services and support they seek. Whereas some of the refugees who were consulted for Mean Streets reported being primarily interested in finding alternative livelihood options, others were more concerned with learning about options for accessing peer support, safety training, condoms, how to use condoms, HIV/AIDS testing, and who they can call if they are arrested by police.

To WRC and RHU's knowledge, this pilot was the first time peer education for women engaged in sex work has been integrated into humanitarian response in Uganda.

Humanitarian field staff consulted for Mean Streets revealed on their part a desire for operational guidance on how to best serve these refugees. They expressed a need for 'good practice guidance' that would at once reflect the diversity of refugees' needs, and be grounded in evidence and a rights-based approach to service provision. A follow-up resource, Working with Refugees Engaged in Sex Work: A Guidance Note for Humanitarians, was published in October 2016.[4] A key message of that guidance is the importance of integrating existing good practices for working with sex workers into humanitarian practice. A body of evidence- and rights-based practices does exit; many are a product of thoughtful collaboration between development or public health actors who work with 'key populations' and sex workers themselves. Yet few of these good practices have been implemented in or adapted for humanitarian settings, so they do not reach refugees who are engaged in sex work.

Adapting the Peer Education Model for Humanitarian Response

Since 2008, Reproductive Health Uganda (RHU) has been providing integrated SRH and GBV services to Ugandan sex workers. Core components of this work are a free nighttime clinic for sex workers and a peer educator program. Although a small number of refugees have participated in sex worker peer education trainings over the years, project RHU had never deliberately targeted refugees for inclusion or tailored content for refugees before this pilot.[5,6]

The pilot trained 50 refugee women engaged in sex work in Kampala to be peer educators. Feedback provided from participants during those trainings emphasized their relevance and timeliness for women living in refugee settlements outside of Kampala, so the pilot was subsequently expanded to the Nakivale Refugee Settlement. In Nakivale, RHU trained an additional 30 refugee women engaged in sex work to be peer educators. Although the pilot project has ended, these women are continuing to do community outreach and facilitate information sharing, SRH referrals, safe GBV identification and referral, and peer support in their active, ongoing role as trained peer educators.

The Peer Education Model

Peer education follows a community-empowerment approach for working with individuals engaged in transactional sex. As described in the 2013 Sex Worker Implementation Tool published by the World Health Organization et al.: "community empowerment

is more than a set of activities; it is an approach that should be integrated into all aspects of health and HIV programming. It is the cornerstone of a human-rights-based approach to HIV and sex work…"[7] Evidence from outside the humanitarian sector demonstrates the effectiveness of peer education and peer-led outreach and support in reducing HIV and GBV risks amongst persons doing sex work.[8,9]

Following established good practice in peer education training, the sessions conducted by RHU were holistic and participant-driven. They covered the following topics:

- Human rights and rights advocacy
- STI and HIV/AIDS testing, prevention, and continuum of care
- Family planning
- Life planning skills
- Parenting in sex work
- Safer sex in sex work
- Community mobilization
- Community outreach
- Condoms and condom distribution
- Gender Based Violence
- Violence in sex work
- Dealing with security and law enforcement
- Action planning

"Before the training, I didn't know I couldn't use a condom more than once."
– Peer educator, Kampala

Trainings were organized and coordinated by RHU staff members with prior experience working and conducting similar trainings with Ugandan sex workers. Based on previous experience, staff used a variety of activities and media to teach the curriculum, including focus group discussions, peer and expert presentations, videos and photo slideshows.

As discussed further below, RHU slightly modified its standard curriculum in order to tailor the trainings, which are usually done with Ugandan sex workers, to address the particular needs and risks facing refugees engaged in sex work.

RHU held two five-day trainings, with 25 participants in each cohort.

Refugee Women as Peer Educators

To launch the peer educator initiative with refugee women, RHU first got word of the project out through its networks, including through a handful of refugees currently accessing various services at RHU's health clinics, and by forming a new working relationship with a community based organization led by Congolese refugees called Bethesaida Community Church; the organization disseminated information about the project among Congolese refugees. Once 50 refugees had volunteered to become peer educators, RHU led them through a five-day training session. (Although all 50 were women, the project was not initially designed to cater exclusively to female sex workers.)

Trainings were holistic, covering a range of topics, including: human rights; SRH and family planning, including condom use; GBV prevention and response; testing and treatment for HIV/STIs; relevant local laws; tips for speaking with police if approached; peer counseling; safety and risk mitigation; parenting as a sex worker; community outreach; mobilization and advocacy.

Participants in the training were also, at their option,

Training facilitator discusses the rights of refugees engaged in sex work with peer educators.

provided access to SRH and GBV response services, including HIV/STI testing.

As peer educators, participants commit to being focal points and outreach coordinators for other refugees in their respective communities who are engaged in sex work. Peer educators take on independent activities in their communities, including capacity-building and information sharing amongst fellow refugees engaged in sex work. They also engage in condom distribution; organize information, safety, and know-your-rights sessions for their peers; conduct one-on-one peer mentoring and support; and provide referrals to peers seeking legal, SRH, GBV and/or other services.

Feedback on Being Trained as a Peer Educator: Refugee Women in Kampala

"I've been one of the beneficiaries of the training. I really liked how they trained us, and I've decided to bring out this information in my community."
- Peer educator, 24 yrs.

"The training was quite pleasant because I got to learn about many things I didn't know before…I talk to people about what I've learned. I try to reach people and talk to them about what I know. Yes, whenever it is possible, whenever I can have them with me, I give out condoms."
- Peer educator, 23 yrs.

"The training helps me to teach my sisters, who do the same work as me. As I am an HIV peer educator, it helps me so much."
- Peer educator, 29 yrs.

"We had a training for five days, where we learned many things. We were trained to be ambassadors. Now I interact with four groups of women, where I share information and show them how to use condoms and other information to protect them. So people know how to protect themselves….On top, we learned other skills as well, financial skills and savings activities"
- Peer educator, 39 yrs.

"I came [to Uganda] with my sister. We live together. We engage in sex work out of poverty, to afford the rent bill. I have seen this is putting our lives at risk. For any assistance, we welcome it."
- Peer educator, 24 yrs.

"I am thankful for the training. Now I can prevent having more children, because I have been trained. I am training my neighbors on family planning."
- Peer educator, 27 yrs, mother of five

"I was among those lucky people in the training. As a peer now, in the community, I am working with my fellows, to teach them what I learned."
- Peer educator, 32 yrs.

"Being an ambassador means we are serving the community, we take information to the community. Like where they can get services. And we can escort them, or go with them for referrals. We have groups who are forming, so you can meet ten people, and inform them, and they inform. It is like a chain."
- Peer educator

Challenges of Bringing the Peer Education Model to a Humanitarian Context

RHU staff encountered challenges in ensuring their peer education program would be accessible to refugees engaged in sex work, and tailored to meet their particular needs. These challenges were met through adapting traditional training methods and developing new ways and partners for conducting outreach.

Refugees engaged in sex work are especially hidden

RHU staff experienced difficulty tapping into a network of refugees engaged in sex work, because unlike with Ugandan sex workers, RHU staff did not know refugees' "hotspots" for working. Yet once RHU staff were able to identify a few refugees engaged in sex work who were interested in the training, news of and interest in it spread through word of mouth. RHU's new relationship with Bethesaida Community Church, noted above, also helped recruit volunteers. "We don't go out ourselves to mobilize refugees," an RHU staff person explained: "We really network with refugee

NGOs, and they help us to map out and mobilize… They know some of the sex workers in their community, so we got peer educators identified through them.

"Refugees are not as open about it…Some of them will not open up that they are doing sex work because they fear the law of Uganda…It is more secretive and hidden within the refugee community, there is more stigma around it."
- RHU staff, comparing serving refugee women engaged in sex work to Ugandan women

And then we use those peer educators to mobilize others." Mindful of church administrators' reluctance to discuss the training materials in depth, RHU staff worked with them to strike an appropriate balance that left everyone comfortable: "When it comes to our [services for refugees engaged in sex work], the church is not involved. They do the mobilization with peer educators, but we provide the services and information. This is an arrangement that works for us."
In addition, the regular commuting of some of the peer educators back and forth between Kampala and nearby refugee settlements resulted in word of the project traveling to the settlements—generating interest in having a peer educator training in the settlements long before the Nakivale phase of the pilot was developed. What is more, at least two of the refugees engaged in sex work who participated in the Kampala training were later discovered to be living in a nearby settlement but traveling to Kampala to work during the week; hence they started doing community outreach to other refugees engaged in sex work in the settlement—providing referrals to RHU and delivering information packages—as soon as they had finished their training in Kampala.

HIV counseling and testing took place as part of the peer educator training.

Language barriers

Refugees in Uganda hail from a variety of countries of origin and speak diverse languages and local dialects. This presented a new challenge for conducting the peer educator trainings and working with the peer educators. Although language barriers "had never been part of [their] thinking before," RHU staff began strategically identifying peer educators who could serve as translators and/or designated focal points for particular neighborhoods where less commonly known dialects are spoken. Consideration of language is now one of RHU's early priorities in recruiting peer educators and assigning staff to work with them. That different translators are being used also raised privacy concerns, however, so it became especially important to underscore confidentiality as a right and as an expectation, both of the peer educators (vis-à-vis RHU staff and hired translators) and of the individuals with whom peer educators will engage in their communities.

RHU grouped participants into two training sessions, each lasting five days. Participants were grouped partly based on languages, so that Kinyabwisha/Kinyarwanda was the main language of instruction for the first group, and Kiswahili was the main language of instruction for the second group. RHU staff noted that although peer educators from different nationalities were supportive of each other, almost no peer educator was willing or able to conduct outreach to refugees engaged in sex work from other nationalities: "This is because, while all of them know their situation as vulnerable women refugees, there is the big factor of language differences."

"Compared to the Ugandan [sex workers] I see, for refugees it can be less of a job and more for survival."
- RHU staff

Facilitating access to services and resources for refugee women who are afraid of being "found out" to be selling sex

RHU staff cited several reasons why speaking with some refugee women engaged in sex work proved more challenging than holding similar conversations with Ugandan women. "Some of them are [religious]," one staff member explained, "so they don't want to talk about condoms or family planning methods" and their pre-existing knowledge of sexual health is more limited than host community counterparts: "Some of them think that you can use a condom several times," one RHU staff member observed. To accommodate these factors, staff facilitating the trainings got creative in using stories and different language to impart information, and learned to come to the trainings with fewer assumptions about participants' existing knowledge of, familiarity with, or openness to discussing certain topics.

> *"Refugees who are doing sex work, first of all they have fear. So even if they are having violence, they are not able to report it. The violence for refugee sex workers is higher, because their vulnerability is higher. Because there is nobody to protect them. Ugandan sex workers, more of them know how to maneuver around, and to make a report without admitting to the sex work. They also know where they can go [safely] to get services. But the refugees, where will they go? When you are a refugee, clients take advantage."*
> *- RHU peer educator program coordinator*

Another staff person shared that with refugee women in particular, it is difficult to convince them that RHU's sex worker-friendly services are safe for them, because they are afraid of being discovered by police to be doing an illegal activity.

In response, RHU staff worked with peer educators to prioritize confidentiality throughout the training, and put mechanisms in place to safeguard peer educators' identities. Reflecting on working with refugees, RHU staff observed that "the issues of confidentiality, and

> *"They are probably the best in partnering for mobilization and services delivery…They know all refugee issues in Kampala and have a strong network…They however also need training in GBV, SRH, and HIV as community leaders."*
> *- RHU staff, reflecting on the benefits of working with a refugee-led CBO to identify hard-to-reach and/or marginalized urban refugees*

> *"As we work more with refugees doing sex work, we identify those that have better language understanding…So even among those refugees you can identify people with different backgrounds who can be community liaisons who can help us with programming."*
> *- RHU staff*

protection of the rights of each individual refugee, was found to have been the most important for the refugees, as many had relatives they never wished to know their business and no other provider was practically handling [their need for services]."

RHU staff also noted that, compared to their experience working with Ugandan sex workers, the refugee women "were less willing to disclose that they do sex work" out of fear that it would negatively affect their marriages or social relationships. A number of peer educators shared that they plan to leave sex work once they "get out of the refugee situation" and they do not wish for anyone to judge them for their past.

Tailoring the trainings for refugees

To ensure that content and delivery of the peer education training modules would be relevant to refugees engaged in sex work, and address their particular vulnerabilities and concerns, RHU worked with participants to modify slightly its standard training package. Issues related to refugee rights were integrated into training materials, including discussions of the UN Convention on the Rights of Refugees, UNHCR's protection mandate, and refugees' rights in Uganda, from laws around identity documentation to their ability to access public health and other services. RHU also allotted time to facilitate a discussion

"Addressing gaps in their information, this was an adjustment for us. Identifying particular myths within refugee communities around family planning and doing sex work. So we modified the training as we gave it."
- Peer education training facilitator

amongst participants about their backgrounds, so they could share their individual stories of why and how they fled their countries of origin to arrive in Uganda.

Participants also wanted to know whether, and how, being arrested for doing sex work could be used against them in their petitions for resettlement. This underscored the importance of tailoring information to meet the particular needs of refugees who are engaged in sex work, and understanding how their rights as refugees interacted with their rights as persons engaged in sex work. During the training sessions, it also emerged that not all participants had officially registered with UNHCR. This prompted RHU staff to make sure all peer educators understood the importance of registering with UNHCR and how to go about it.

In Kampala, demand for peer educator trainings exceeded what had been budgeted to achieve. While the trainings were capped at 50 participants, 32 more had registered to attend. RHU responded by establishing selection criteria and explaining that even those who were not trained to be peer educators would benefit from the project.

Expanding the Peer Educator Training to Nakivale Settlement

In discussions with peer educators in Kampala, it came to light that many of the peer educators actually live full-time in one of the refugee settlements located outside of the city. According to these women, sex work is not only a common form of earning income in the camps, but also a highly stigmatized one that is conducted in secret. It is also very risky, as women experience rape, sexual assault, and other types of GBV in the course of doing this work; they also have little information about critical aspects of related sexual and reproductive health concerns, and little access to friendly services or peer support.

In light of this finding, WRC and RHU expanded the peer educator program to Nakivale settlement, about six hours west of Kampala. With an additional $5,000, RHU staff traveled to the Nakivale, where they conducted the five-day peer education training. As in Kampala, training materials were tailored for refugees engaged in sex work. Ultimately 30 refugee women who self-identified as selling sex as a form of income participated in the training and agreed to serve as peer educators in their communities. The women's nationalities were diverse: 40% Congolese, 30% Rwandan, 20% Burundian, <1% Tanzanian. Training facilitators used two languages in all sessions. The sessions were conducted in the evening, which was determined to be most convenient for a majority of participants.

"When you do programming with refugees doing sex work, it is better to support them to know their rights, and to know the implications of some of their actions. These are all risk mitigation strategies… make sure they get all the information, so they can be safe and advocate for themselves."
- RHU staff

Before carrying out the training, RHU coordinated and met with various stakeholders involved in operating the Nakivale settlement. This included representatives from the Office of the Prime Minister who oversee humanitarian assistance within Uganda, as well as the settlement Commandant and UNHCR regional and settlement focal points. Support was also provided by Medical Teams International, which runs health programs in Nakivale, in the form of helping to identify both an appropriate venue for the peer educator training and potential participants. Stakeholders also asked, before the training, whether it would be possible to increase the number of participants to 100, or at least 50, given demonstrated need.

Short of expanding the project, stakeholders urged RHU to be "more aggressive and look for more resources" in order to replicate and scale up the peer educator initiative,

to "at least 100 more peers" in Nakivale. They further underscored a need for RHU to reach out to the "many more people" in other settlements as well—especially women—who are selling sex as an income generating activity, in a variety of conditions and circumstances.

Many of the same trends identified amongst peer educators in Kampala were present among the peer educators trained in Nakivale. A majority of the peer educators (all women) shared that they do sex work in order to survive and/or because of a lack of alternative options that would pay comparably. Many reported feeling that they must keep their sex work a secret, including from their husbands. They reported feeling as though because of their refugee status, they are at a higher risk of violence, including rape, by clients and security agents.

Condom use in particular was a topic that garnered significant interest and positive feedback from participants. Discussion of the female condom was especially robust: most participants had never heard of it, but shared that it could be very useful since it would offer protection with clients who refuse to use a male condom—disputes over which were frequently cited, by the peer educators, as a catalyst for GBV by clients. RHU staff had brought boxes of condoms to the training, and each peer educator, at their option, ultimately took home between 400 and 1000 condoms for their personal use and for distribution to peers.

The peer educators also impressed upon RHU staff that within Nakivale, the need for non-stigmatizing access to services, information, and support for refugees engaged in sex work is high—and far exceeded what the current training was able to provide.

As in Kampala, HIV/STI testing and counseling was offered on-site to all peer educators. Of the 30 participants, 24 volunteered for testing; the remaining six did not because they already knew their serostatus as HIV positive. Out of the 24 who were tested, one was found to be HIV positive. (Hence 23.3% of the peer educators trained in Nakivale are HIV positive; all are currently accessing ART and related services.)

All 30 peer educators in Nakivale are participating in ongoing activities related to mobilization, services delivery, and providing other forms of support to peers, both in and outside of Nakivale. Most reported being mobile and traveling regularly between Nakivale and various nearby cities and towns in order to work.

It is important to note that the majority of peer educators, in both location, shared that they are only selling sex because doing so is one of their only options—sometimes their only option—for earning enough income to support themselves and/or their families. They regard doing sex work as essential to their survival. Some expressed a wish to have an alternative form of livelihood that paid them a comparable wage. Other peer educators reported viewing sex work as a job, and a few shared that they did it prior to leaving their home countries as well. Comparing the perspectives of the refugee peer educators to those of Ugandan sex workers, RHU staff shared that the latter are, in their experience, more likely to view selling sex as their regular job. For this reason, it is incumbent upon humanitarian responders to strengthen livelihoods programming for urban refugees, and ensure that refugees engaged in sex work have access to a range of effective programs and services for securing alternative employment that is safe and pays a living wage.[10]

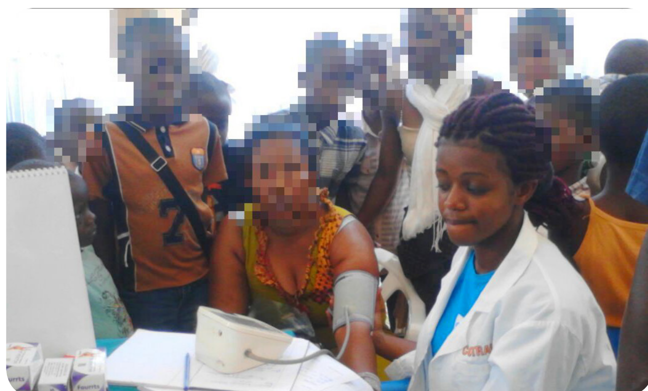
Female condom demostration with peer educators in Nakivale.

Part 2: Bringing Mobile outreach clinics to refugee neighborhoods: *Meeting refugees where they live can expand access to health and GBV services for refugees living in cities*

Another component of the pilot project was to provide health and GBV services directly to refugees living dispersed across Kampala. With the assistance of the Peer Educators, RHU identified five neighborhoods across the city with large refugee populations.

RHU sent its mobile outreach team typically used to target hard-to-reach Ugandan communities to these areas. A total of six visits to these neighborhoods were conducted, with 200-300 urban refugees. Over the course of a day, RHU's health and social services team provided diverse services to refugee men, women, and children. Team members included clinicians, nurses, a midwife, laboratory technologists, social workers and psychosocial counselors, data clerks, and peer educators. Among the services provided were:

- General clinical services/primary healthcare
- Respiratory tract infections
- Malnutrition
- Injuries
- GBV response, including post-rape examinations and psychosocial support for survivors
- SRH, STI/HIV testing and treatment
- Referrals to specialized service providers and clinics



RHU's mobile clinic visits a refugee neighborhood in Kampala.

Many of those served reported being unable to access alternative services for various reasons, including distance, transportation costs, discrimination, and language barriers. Across the five sites, RHU provided direct health and GBV services to 3,244 urban refugees, mostly women and children.

Mobile clinics: A safer, less stigmatizing way to reach refugees engaged in sex work

Although RHU's mobile clinic visits were designed to serve all refugees living in hard-to-reach neighborhoods, they proved especially useful for providing services to refugees engaged in sex work who would otherwise not be accessing SRH or GBV services for various reasons, including stigma. Of the 3,244 urban refugees served during the five mobile clinic visits, 923 were women who reported selling sex currently or previously as a form of income, regularly or on occasion.

Hence one benefit of bringing mobile clinics to refugee neighborhoods, and offering holistic services to the whole community, is that it provides cover for refugees who are engaged in sex work to access tailored services–without them having to visit a clinic for sex workers. Where mobile clinics are open to everybody in the community and offer a range of services, they reduce stigma and safety risks, including risks related to having to take secret trips to health or GBV clinics. For women who reported having to hide the fact they do sex work from their husbands, or fearing their neighbors would discover they sell sex, the mobile clinics made it possible for them to get the health and GBV services they needed. As one RHU staffer put it: "Many of these women had never accessed SRH or GBV services before. Even when there were some opportunities to access services, they could not due to stigma and discrimination."

> *"If you try to target [refugees engaged in sex work], they cannot come. And some are married, so their husbands won't allow them. So you have to be open to all refugees."*
> *- RHU Outreach Worker*

Of the 923 women who identified as currently or previously engaging in sex work, 88 were found to be HIV positive and were referred for ART related services. Amongst those who were referred, 23 women were already aware of their serostatus but were not accessing treatment; 65 women did not previously know they were HIV positive.

Refugee women engaged in sex work by nationality	Mobile clinic site #1	Site #2	Site #3	Site #4	Site #5	Total
Congolese	34	89	91	56	42	312
Rwandan	17	102	65	26	47	257
Burundian	3	21	45	41	32	142
Somali	0	11	43	34	2	90
South Sudanese	2	5	6	16	5	34
Other	16	13	24	21	14	88
Total	72	241	274	194	142	923

Recording the nationality and neighborhood of refugee women engaged in sex work enables RHU to make sure sufficient and accessible SRH and GBV services are made available, including referrals, peer educator outreach, condom distribution, safety trainings, and language translators.

Conclusion

Regarding the peer education intervention, expanding its peer educator program to refugee women was a new experience for RHU. RHU now has procedures in place to ensure staff engage refugee communities, as well as the Ugandan communities RHU has traditionally served. In Kampala and other cities where RHU works with persons involved in sex work, RHU now takes steps to include refugees engaged in sex work as beneficiaries, starting from the earliest planning stage of any given intervention.

Demand for the peer educator program was higher than RHU could meet. “The main and first request” made by peer educators and by representatives of Bethesaida Community Church about the project was to “train more peer educators and reach out to more refugees doing sex work.” This reflects the high unmet demand for services—SRH, GBV, safety trainings, condom distribution, peer support, etc.—by female refugees engaged in sex work in Kampala and settlements like Nakivale. During the trainings, peer educators expressed a strong desire for services near the places where they work, and for more peer educator trainings to be conducted.

Comparing their experience of working with refugee women engaged in sex work, to previous experience working with Ugandan sex workers, RHU staff concluded that the refugee women were more secretive about the fact that they sell sex as a form of income. They were more concerned about being “found out” by their husbands and other community members, and sought access to discrete, confidential services, information, and support. Protecting confidentiality was therefore critical in working with refugees engaged in sex work—both the peer educators and the individuals who accessed services through RHU’s mobile clinic visits.

Peer educators reported engaging in various risk mitigation strategies, including working in groups and sharing information about safe and unsafe places to work. They shared information about regular violence they experience at the hands of police, clients, and Ugandan sex workers who see them as “competition.” These reports, combined with information gathered during the mobile clinic visits, led RHU staff to conclude that on the whole, refugee women engaged in sex work experience more violence than their Ugandan counterparts. They work for less money, and are more likely to experience physical violence, wage theft, and exploitation from security agents than Ugandan sex workers. They are subjected to beatings, robberies, and rape in the course of selling sex. And because sex work is criminalized in Uganda, their attackers can do this with impunity by threatening to report them (the refugee women) to police or other security agencies for selling sex in the first place. RHU staff further found that the refugees were, comparatively, less knowledgeable about a range of SRH and protection issues—from condom use, to safety strategies, to HIV/STI testing, to ways of reporting GBV to authorities.

Throughout the course of the project, RHU staff engaged regularly with a variety of stakeholders,

including from UNHCR, the Office of the Prime Minister, Nakivale camp managers, refugee women engaged in sex work, and a refugee-led CBO.
There was overwhelming consensus amongst these actors that many more refugees engaged in sex work—mostly women, but also men—stand to benefit from the peer educator model and mobile outreach programs. In short, demand for these two project components, the peer educator training and the mobile clinics, far outstripped supply.

RHU is currently seeking supplemental financial support that would enable its staff to provide much needed services and support for refugees engaged in sex work in Kampala and other urban centers throughout Uganda that are in close proximity to refugee settlements. Similarly, RHU is committed, with the requisite funding, to continuing to bring critical services and support to refugees engaged in sex work in Nakivale and other settlements.

Peer educator training session, Kampala.

For other providers who are interested in adapting the peer education model for humanitarian contexts, it is important to emphasize that RHU had previous experience working with Ugandan sex workers. This enabled RHU to share critical lessons learned through that work with refugee peer educators. It is therefore recommended that others who are interested in working with refugees engaged in sex work collaborate with host community sex workers first, or at least consult with them, so that their local knowledge—safety tips, safe referrals, etc.—can be shared with refugee communities.

RHU is also seeking funding to continue sending its mobile clinics to refugee neighborhoods outside of Kampala. These mobile clinics proved to be a critical entry point for SRH and GBV services for more hidden, stigmatized, and marginalized individuals, including refugees engaged in sex work.

Through its mobile service delivery to refugee neighborhoods in Kampala, RHU reached 3,244 refugees—mostly women—who self-identified as selling sexual services currently or in the past. Many of these women shared that the mobile clinics enabled them to access information and services they would not otherwise feel comfortable accessing, or be able to access. This suggests that an important entry point for reaching refugees engaged in sex work can be through mobile yet multi-faceted service provision open to all refugees. As one RHU staff member reflected: “It is important that we provide a range of services, so [refugees engaged in sex work] can come without having to self-identify as doing sex work. We serve everybody, to reduce the stigma of them coming.”

Endnotes

1. See WRC. 2016. Mean Streets: Preventing and Responding to Urban Refugees' Risks of Gender-Based Violence
2. More information on WRC's work in this area can be accessed at WRC's GBV & Urban Settings homepage, https://www.womensrefugeecommission.org/gbv/urban-settings.
3. While the pilot intervention discussed herein focused on working with refugee women engaged in sex work, learning from it has relevance to working with men and transgender refugees who also sell sex, as well as other forcibly displaced persons engaged in sex work, such as those who are internally displaced (IDPs).
4. WRC and OGERA. 2016. Working with Refugees Engaged in Sex Work: A Guidance Note for Humanitarians.
5. Numerous barriers prevent refugees in Kampala from participating in activities, or accessing services, that are designed for the host community. For refugees doing sex work in Kampala, a combination of language barriers, lack of information, stigma and discrimination against refugees, and market tensions with Ugandan sex workers have impeded their access to services and networks available to local sex workers. See WRC. 2016. Mean Streets: Refugees Engaged in Sex Work.
6. From 2012 to 2015, RHU implemented an SRH/HIV intervention with Ugandan sex workers in Kampala. Although refugees were not purposively targeted for inclusion, RHU estimates that of the 2,200 individuals served by that initiative who self-identified as doing sex work, around 400 were refugees.
7. World Health Organization et. al. 2013. Implementing Comprehensive HIV/STI Programmes for Sex Workers: Practical Approaches from Collaborative Interventions (also known as the Sex Worker Implementation Tool or SWIT)
8. For a list of empirical studies on the effectiveness of peer education and other peer-led interventions in promoting the health and safety of persons doing sex work, see id. at 72 ("Resources and further reading"). See also Working with Refugees Engaged in Sex Work: Guidance for Practitioners, supra note 4 at Annex B (listing evaluations of peer-led interventions in various countries and contexts).
9. "HIV prevention among sex workers (such as peer-led education and control of sexually transmitted infections) are more effective and sustainable when conducted within a community empowerment framework. From Kenya to Ukraine, Brazil to Thailand, India to the Dominican Republic, investment in community-led organizations of sex workers has resulted in improved reach, access, service quality, service uptake, condom use and engagement by sex workers in national policies and programmes"). Id. at 5.
10. See Working with Refugees Engaged in Sex Work: A Guidance Notefor Practitioners, supra note at 4.

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