Let’s talk about sex work in humanitarian settings: piloting a rights-based approach to working with refugee women selling sex in Kampala

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ABSTRACT: Although it is well known that refugees engage in sex work as a form of livelihood, stigma and silence around this issue persist within humanitarian circles. As a result, these refugees’ sexual and reproductive health and rights, and related vulnerabilities, remain overlooked. Their protection and health needs, which are significant, often go unmet at the field level. In 2016, the Women’s Refugee Commission and Reproductive Health Uganda partnered to pilot a peer-education intervention tailored to meet the needs of refugee women engaged in sex work in Kampala. Findings from the pilot project suggest the feasibility of adapting existing rights-based and evidence-informed interventions with sex workers to humanitarian contexts. Findings further demonstrate how taking a community empowerment approach can facilitate these refugees’ access to a range of critical information, services and support options – from information on how to use contraceptives, to referrals for friendly HIV testing and treatment, to peer counselling and protective peer networks.

Keywords: sex work, human rights, humanitarian response, HIV, peer-education, key population, community empowerment

“Before this training, I didn’t know that I couldn’t use a condom more than once.” (Congolese refugee woman, peer educator)

Introduction

Refugees around the world sell sex as a means of generating income, for themselves and for their families. They experience severe health and safety risks in the course of doing so, including exposure to HIV and sexual violence at the hands of clients and security agents. At the same time, these refugees’ health and protection needs, which are complex, largely go unmet at the field level. Stigma and silence around the topic of sex work in humanitarian contexts prevails, creating barriers to the development of much-needed dialogue, research and programming. To help bridge this gap, in 2016 the Women’s Refugee Commission (WRC) partnered with Reproductive Health Uganda (RHU) to pilot a peer-education approach to working with refugees selling sex in Kampala. Findings from the project suggest the feasibility of adapting existing evidence-based and rights-based interventions with sex workers to meet the needs of refugees who sell sex. Findings further demonstrate how doing so can facilitate these refugees’ access to critical information and services (i.e. related to their sexual health and rights), while empowering them to be advocates and agents of peer support within their communities.

Background

Refugees often have few livelihood options available to them. This is true for the millions of refugees who are in transit, fleeing war or other crises, and those who are living in situations of protracted displacement, either in refugee camps or, more commonly, in cities.
Where they have sought refuge, they face many barriers to employment. These barriers almost always operate in tandem and include legal restrictions on their right to work, language barriers and intersecting vectors of discrimination, based on class, gender, race, refugee status or disability. For the majority of refugee women – cisgender and transgender women – gender discrimination at household and community levels further blocks their access to safe and reliable employment.

Previous research conducted by the WRC underscored what many humanitarian actors already know, that sex work in humanitarian contexts is not uncommon. Those findings also brought to light the extent to which this topic remains stigmatized and unaddressed within humanitarian response.

The term “sex work” is not often used within humanitarian discourse or programming. Instead, the consensual selling of sex by adults is often deemed “survival sex”. It is framed as a negative coping strategy and cited as a justification for ancillary interventions, such as increased food aid or livelihood programming. Given the need for terminology that is non-judgemental, grounded on minimal assumptions, and inclusive of affected individuals’ diverse circumstances and perspectives, this article uses the term “sex work”. Since many forcibly displaced persons who sell sex do not self-identify as “sex workers”, we refer throughout to individuals as being “engaged in sex work”.

The health and protection needs of refugees engaged in sex work largely go unmet at the field level. This is due to a combination of factors, from refugees’ own fears of being judged or jailed to service providers’ personal beliefs around sex or sex work. Refugees who sell sex report not feeling comfortable disclosing it to service providers, including sexual and reproductive health (SRH) providers and gender-based violence (GBV) case managers. Individuals who disclose it feel stigmatized and discriminated against. They report service providers giving them information that reflects neither the realities of their situation nor their own priorities. For instance, they are sometimes referred to alternative livelihoods programmes (including those which are faith-based) without regard for their own decision-making processes or other types of assistance, such as information on safe sex practices, drop-in centres or peer support options. Operational guidance for working with refugees engaged in sex work is also very limited.

Although early responses to the HIV epidemic recognized the need to engage with sex workers, they remain a neglected population in HIV response. Nonetheless, today there is a body of established good practices for working with sex workers to implement comprehensive HIV prevention programmes; one hallmark of these models is that they have been developed and implemented in collaboration with sex workers.

Most of this work has originated outside the humanitarian sector and remains unknown to humanitarian actors. This is a critical gap in humanitarian response, given the disproportionate burden of HIV infection, stigma and violence borne by persons who sell sex. Additionally, 92% of all HIV/AIDS deaths attributed to sex work occur among African women and countries with more than 50% of sex workers living with HIV are all in sub-Saharan Africa. That region is also a locus of the global refugee crisis: 4 of the top 10 countries hosting refugees are in sub-Saharan Africa. Working with refugees in sub-Saharan Africa who engage in sex work should be a primary concern.

Research on refugees who sell sex is scant, but that which exists suggests that they face a host of additional risk factors and access issues, compared to host community sex workers. Refugees who are engaged in sex work are targets of violence, including rape, sexual torture and robbery, because perpetrators can assume they are even less likely than host community sex workers to report it or have any recourse. Language barriers, stigma and a lack of mobility further constrict refugees’ access to critical information and services, including information about preventing HIV and other sexually transmitted infections (STIs) or any sex worker-friendly service providers, spaces or community supports that may be in the area. It is also important to note that compared to host community sex workers, refugees engaged in sex work hold specific rights and entitlements under international law and the protection mandate of the UN High Commissioner for Refugees (UNHCR), such as access to various forms of assistance and rights-respecting service provision.

*While this article focuses on refugees engaged in sex work, its discussion has relevance to working in rights-based and evidence-informed ways with other forcibly displaced persons engaging in sex work, such as those who are internally displaced.
Another complicating factor is that many refugees who are engaged in sex work do not identify as sex workers. They are unfamiliar with the term “sex worker”, or what it signals in terms of rights and access to resources. Refugees who sell sex also hold diverse views on it: some see it as a job, others do it to meet dire economic needs and want desperately to exit; others talk about it as the best of limited options or their only realistic option. Their reported motivations range from being able to earn enough money to meet basic needs (buy food, pay rent); to buying a smart phone; to being able to work at night so they can watch their children during the day. Some refugees report that this type of work allows them to earn more income while working fewer hours than other available jobs, like domestic work or farm or factory jobs; it also allows them to exercise more agency over when, where and how they work.

This diversity of perspectives is further complicated by the range of conditions in which refugees sell sex, from hotels in large cities to tents in refugee camps, in countries where sex work is criminalized and others where it is not. Such variance in conditions and normative/socio-legal environments calls for thoughtful, nuanced approaches that are tailored to each context and individual.

Simultaneously, all refugees who engage in sex work – whether they view it as a job or a survival tactic – share the same rights and should be entitled to the same range of services, information and support options. This is the central message of a recent Guidance Note. That Note expresses an urgent need for:

“minimum policies, protocols, and programming … to safeguard the basic rights of refugees engaged in sex work; to mitigate their exposure to violence and discrimination; to empower them to assert their rights; and to build service providers’ capacities to work with them.”

It argues that taking a rights-based and evidence-informed approach to working with these refugees requires leveraging established good practices from outside the humanitarian sector, adapting them as necessary for humanitarian contexts.

This was the impetus for a pilot project tailored to meet the needs of refugee women engaged in sex work in Kampala, Uganda, which we describe below.

Case study: adapting a peer-education model for refugee women engaged in sex work

Methods

RHU, an affiliate of the International Planned Parenthood Federation, has been providing integrated SRH and GBV services to sex workers in Kampala since 2008. The pillars of this work are a free night-time drop-in center for sex workers and a peer-education programme. Prior to the spring of 2016, RHU had never purposefully facilitated refugees’ inclusion in its sex worker programming or conducted a peer-education training with refugees.

RHU’s peer-education programme embodies community empowerment for working with individuals who sell sex. After completing a five-day training, the peer educators act as focal points and outreach coordinators for others engaged in sex work in their communities. They take ownership over designing and conducting activities, including: distributing condoms; hosting capacity-building and know-your-rights sessions; conducting peer counselling and support sessions (in groups or one-on-one); and providing referrals for individuals seeking friendly legal, SRH or GBV services.

In March 2016, the WRC and RHU partnered to pilot a peer-education intervention with refugees engaging in sex work in Kampala. The main objective of the project was to train 50 refugees engaged in sex work to become peer educators and obtain their feedback about the programme. RHU would also work with the peer educators to adapt its existing training curriculum to better meet the needs and priorities of refugees.

An open invitation to refugees engaged in sex work was shared through RHU’s staff and client base, including to individuals accessing services at RHU’s free night-time clinic for sex workers. Eighty-two women registered for 50 available slots, prompting RHU to create selection criteria that would ensure diversity among the peer educators across nationalities, languages, and areas where they work or live within the city. All registrants were cisgender women, although this was not deliberate.

† The intervention was conceptualized by WRC and RHU and implemented by RHU.
‡ Research affirms that refugees of diverse sexual orientations, genders, ages and (dis)abilities sell sex as a form of income.
Peer educators were trained in two cohorts of 25 women grouped based on common language. At their option, the women were also offered SRH and GBV services, as well as HIV/STI testing and counselling.

The trainings covered various topics, including: human rights; SRH topics, e.g. family planning and prevention and treatment of HIV/STIs and other STIs; local laws related to sex work; GBV and safety in sex work; interacting with police and other law enforcement; peer counselling; parenting as a sex worker; life skills and action planning; community outreach; and individual and community advocacy.

RHU staff individually interviewed each participant during the training. Their interview tool was primarily qualitative and covered biodata, conditions under which they left their home country, entry into sex work, exposure to violence and from whom, access to SRH services, perspectives on the training content, and knowledge of and access to contraceptives as well as to various peer, financial and psychosocial supports. Interviews were conducted in French and Kiswahili. Data collected was transcribed and translated into English by trilingual RHU staff.

In June 2016, follow-up focus group discussions were held at RHU’s Bwaise clinic with 18 peer educators. An open-ended qualitative tool was used to facilitate discussions led by WRC and RHU staff and conducted in French and Kiswahili, with English translation. Data were transcribed in English. Questions asked for peer educators’ perspectives on both the training and their experiences as peer educators. WRC staff conducted individual interviews with members of RHU’s team to understand how working with the refugee peer educators compared with working with Ugandan sex workers. These interviews were conducted in English, with multilingual RHU team members.

Findings
A majority (79%) of the 50 peer educators were Congolese. Others had fled to Uganda from Rwanda (9%), Burundi (6%), South Sudan (3%) and Somalia (3%). A majority (80%) were 30 years of age or younger; 30% of those women were age 20 or younger.

Feedback from participants
Participants’ feedback on the trainings was overwhelmingly positive. When asked which topics were most useful to them, some cited legal advice, whereas others favoured safe sex and family planning.

One mother of five reflected:
“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.”

Another woman shared that she had previously been unaware that condoms are for single use:
“Before this training, I didn’t know that I couldn’t use a condom more than once.”

As peer educators, participants expressed strong commitments to helping their peers access the same information and address the service gaps they have experienced.

“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.”

“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.”

“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.”

“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 ….”

Respondents noted that peer-to-peer education is likely more effective than alternatives to outreach by, for example, public health actors, because they often have to work “in the shadows” and exercise discretion when discussing their experiences.

“Being an ambassador means we are serving the community… 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.”

Most of the peer educators (88%) reported doing sex work because of a lack of available alternatives that pay comparably. Nearly all reported that their work is “a secret”, something...
they must hide from their families, friends and community. Of those who were married, nearly all shared that their husbands do not know, and must not learn, that they sell sex. Aligning with previous research findings in Kampala and elsewhere, women shared their belief that they are more targeted for rape, beatings and robberies than Ugandan sex workers because attackers – namely clients and security agents – know they are even less likely to report violence because they are refugees.

Peer educators reported engaging in various risk mitigation strategies, including working in groups and sharing information about safe and unsafe places to work. They discussed regular violence they experience at the hands of police, clients and Ugandan sex workers who see them as “competition”, as well as tips for avoiding such confrontations.

RHU staff, after comparing the stories of the refugee peer educators with those of Ugandan sex workers, concluded that refugee women engaged in sex work are more likely to experience sexual and physical violence than their host country counterparts, especially at the hands of clients and police. They also work for less money, and wage theft is common. As one RHU staff member put it,

“Refugee sex workers are more harassed by security and other local law agencies and in many cases reported that their monies and other belongings are grabbed by the security agencies; they are also more beaten and more raped, and sometimes told that they ‘came to kill Ugandans by infecting them with HIV’.”

Because sex work is criminalized in Uganda, attackers can do this with impunity by threatening to report the refugee women to police or other security agencies for selling sex. RHU staff further concluded that upon entering the trainings, the refugee women were comparatively less knowledgeable about a range of SRH and protection issues than Ugandan sex workers.

Peer educators expressed significant interest in learning about contraception and in having a friendly forum for asking questions; some had never before seen a demonstration of how to correctly use a male or female condom, although interest in the latter was especially dynamic. Most participants had never heard of the female condom, but expressed hope that it could be useful in offering 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.

HIV counselling and testing was offered on-site to all participants. Of the 50 peer educators, 15 (30%) were HIV positive. Only 2 knew their status before the training and the other 13 learned it during their training.

Implementation challenges

RHU staff encountered obstacles in facilitating the trainings, including tailoring content to participants’ needs and addressing their privacy concerns, especially their fear of being “found out” for selling sex.

Refugees in Uganda hail from a variety of countries and speak diverse languages and dialects. Language barriers “had never been part of [RHU’s] thinking before”, when it came to conducting trainings, so they had to adapt. RHU staff identified peer educators to serve as translators.

Considering language of instruction is now central to RHU’s recruiting of peer educators and assigning staff to work with them. The use of new translators also raised privacy concerns, however, so RHU staff stressed confidentiality as a right and an expectation, while putting mechanisms in place to safeguard educators’ identities. One RHU staff member shared:

“[T]he issues of confidentiality, and 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].”

Reflecting on refugees’ fears of being found out, another RHU staffer noted:

“Refugees who are doing sex work, first of all, they have fear. So even if they are experiencing violence, they are not able to report it. The violence against refugee sex workers is higher, because their vulnerability is higher. Because there is nobody to protect them. Ugandan sex workers, most of them know how to maneuver around, and to make a report without admitting to their communities and authorities 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 staff reported difficulty convincing refugees that RHU’s facilities and night-time clinic for sex workers could be safe spaces for them. RHU staff attributed this to fears the refugee women had of being discovered by police to be selling sex and of being stigmatized or ostracized by family and friends. Peer educators shared their intentions to leave sex work once they “get out of the refugee situation” and do not wish to be judged about their pasts.

Expansion to Nakivale Settlement

Based on the pilot project, in July 2016, WRC and RHU obtained additional funding to expand the peer educator training to Nakivale, six hours’ drive west of Kampala. After consulting with diverse stakeholders, including UNHCR and the settlement commandant, RHU staff trained 30 refugee women to be peer educators, using the training package adaptations used in Kampala. The women were Congolese (40%), Rwandan (30%), Burundian (20%) and Tanzanian (<1%). Of the 30 Nakivale peer educators, 7 (23.3%) were HIV positive; as with the HIV positive peer educators in Kampala, all are currently accessing antiretroviral therapy and related services (unpublished RHU project report, on file with the authors).

Limitations

Limitations of this research include sample size and sample bias. All participants were cisgender refugee women, serving male clientele, and all learned of the project through word of mouth. Language barriers meant that RHU staff had to follow up individually with some participants to verify information. RHU staff also provided feedback on the trainings, which created risks inherent in self-reported data. Data analysis was conducted by the authors manually.

Funding and practical limitations made it difficult to assess the impact of the peer-education trainings on individual and community levels beyond the June 2016 focus group discussion. Additional research is needed to assess how many additional refugees have been reached by the peer educators (in terms of network effects) and how information, resources and modes of support provided by the peer educators are continuing to impact individual and community well-being.

Discussion

Findings from the pilot project illustrate how a field-tested, rights-based intervention – previously implemented only with host community sex workers – can be adapted for a humanitarian context and tailored to meet the needs of refugees. The project suggests the potential benefits of peer-education as an intervention for bridging service and information gaps experienced by refugees engaged in sex work, and ultimately improving their health and protection outcomes. It signals further potential advantages, including cost-effectiveness, of partnerships between humanitarian actors and local organizations working with host community sex workers. Since these service providers may not be sensitized in providing services to refugees, their knowledge of and capacity to work with refugees, and within humanitarian contexts, will likely need to be strengthened.

Given poor data on refugees who sell sex and the conditions under which they sell it, the humanitarian community currently lacks objective indicators of how common it is, as well as these refugees’ risks and needs. The research available speaks to how these refugees have been excluded from humanitarians’ conceptions of “persons of concern”. The issue of sex work in humanitarian contexts has been downplayed and pathologized as a negative coping strategy without reflection on how to meet needs in accordance with humanitarian and human rights principles. Righting this wrong requires decisive shifts in policy and practice. Affirming that refugees engaged in sex work are entitled to rights-based, evidence-informed and nondiscriminatory service provision is the first step. What must follow are commitments to: develop and implement inclusion strategies; adapt community empowerment approaches to working with sex workers in humanitarian contexts; build appropriate networks of referral pathways; and build staff skills and capacities to work with – not on – these refugees.

Humanitarian actors should not move forward without consulting and collaborating with non-humanitarian experts, including sex worker-led organizations and health actors working with sex workers. This will help ensure that existing knowledge and good practices are leveraged, while unintended consequences are minimized. These actors may also be able to assist humanitarians in identifying context-specific entry points for working with these refugees. As was the case in Kampala, there may be opportunities to expand existing
community empowerment-based approaches to target or be inclusive of refugees.

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Résumé
Même si l’on sait que les réfugiés pratiquent le commerce du sexe comme moyen de subsistance, la stigmatisation et le silence autour de cette

Resumen
Aunque es bien sabido que los refugiados participan en trabajo sexual como un medio de subsistencia, el estigma y silencio en torno a este

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question perdurent dans les cercles humanitaires. Par conséquent, la santé et les droits sexuels et génésiques de ces réfugiés, et les vulnérabilités s’y rapportant, restent négligés. Leurs besoins en protection et soins de santé, qui sont importants, ne sont pas satisfaits au niveau du terrain. En 2016, la Women’s Refugee Commission et Reproductive Health Uganda se sont associés pour mettre en œuvre une intervention pilote d’éducation par les pairs taillée sur mesure pour répondre aux besoins des réfugiées pratiquant le commerce du sexe à Kampala. Les conclusions du projet pilote indiquent la possibilité d’adapter aux contextes humanitaires les interventions existantes basées sur les droits et guidées par des données concrètes avec les professionnels du sexe. Les résultats montrent aussi comment l’adoption d’une approche d’autonomisation communautaire peut faciliter l’accès de ces réfugiés à un éventail d’options de soutien, d’informations et de services essentiels, depuis des renseignements sur la manière d’utiliser les contraceptifs et des aiguillages vers des services conviviaux de dépistage et traitement du VIH, jusqu’à des conseils entre pairs et des réseaux de protection par les pairs.

tema persisten en los ámbitos humanitarios. Por consiguiente, se hace caso omiso de la salud y los derechos sexuales y reproductivos, y vulnerabilidades relacionadas, de estos refugiados. Su protección y necesidades de salud, que son significativas, no son satisfechas a nivel de campo. En el año 2016, la Comisión de Mujeres Refugiadas y Reproductive Health Uganda se aliaron para pilotear una intervención de educación de pares adaptada para atender las necesidades de los refugiados que participan en trabajo sexual en Kampala. Los hallazgos del proyecto piloto indican la viabilidad de adaptar las intervenciones actuales con trabajadores sexuales, basadas en derechos y evidencias, conforme a los contextos humanitarios. Además, los hallazgos demuestran cómo la aplicación de la estrategia de empoderamiento comunitario puede facilitar el acceso de estos refugiados a una variedad de información, servicios y opciones de apoyo fundamentales: desde información sobre cómo utilizar métodos anticonceptivos, hasta referencias a servicios amigables de pruebas y tratamiento del VIH, hasta consejería de pares y redes protectoras de pares.