

## **Sex Work - Key Facts and Figures**

- Over 75% of new HIV infections occur through sexual contact. Factors that increase the rate and efficiency of heterosexual HIV transmission include high rates of sexual partner change and the presence of other sexually transmitted infections (STIs).
- In many countries, sex workers are frequently exposed to HIV and other STIs. HIV prevalence as high as 60-90% are found in some places where sex workers have poor access to HIV prevention services.
- In commercial sex settings where condom use is inconsistent and access to effective STI treatment limited, half to two-thirds of women working as sex workers typically have a curable STI at any one time.
- Only 16% of sex workers are estimated to have access to HIV prevention services. Regardless of the region, poor access to services correlates with high STI and HIV prevalence.
- Early in epidemics, HIV and STI prevalence frequently rises rapidly among sex workers and their clients, especially where condom use is low and access to health care services poor. In the absence of effective interventions, clients transmit infection both to sex workers and to their regular partners, extending transmission into the general population.
- In the absence of effective interventions, high rates of transmission in commercial sex and drug injecting networks continue to drive HIV epidemics even after HIV has spread more widely in generalized epidemics.

### **Interventions in sex work settings**

- Successful prevention in commercial sex networks can avert multiple secondary infections and slow transmission through bridging populations into the general population.
- Where highly targeted interventions have been implemented with sex workers and clients on a large scale (for example in Thailand and Cambodia) increased condom use and declining HIV and STI trends among high risk and general population groups is documented.
- A number of activities are highly effective in preventing HIV transmission in commercial sex networks. These include several of the same activities - outreach, peer support, education and advocacy - that work for other vulnerable populations, as well as more specific interventions - condom promotion and STI control - that specifically address occupational risks.
- Availability of treatment provides an important incentive for people to make contact with HIV services. If, through integrating prevention and treatment, this leads to increased uptake and coverage of harm reduction services where HIV is spreading fastest, maximum impact on developing HIV epidemics can be achieved.

## **Snapshots of successful HIV prevention interventions with sex workers**

In the early 1990s, **Thailand** targeted HIV prevention with a '*100% condom use policy*' including communication, condom and STI interventions in commercial sex work settings. These interventions soon had impact on a national scale with fewer men reporting to have visited commercial sex workers, a rise in consistent condom use in commercial sex from 14% to over 80%, decrease of curable STI incidence by over 95% and decrease of HIV prevalence among sex workers and military recruits. During this period, HIV prevalence stabilized in the general population and eventually declined.

In **Cambodia**, interventions have targeted sex workers and their clients since 1994-5. A '*100% condom use policy*' in brothels was adopted, supported by widespread free condom availability through the public sector, an aggressive condom social marketing campaign, peer outreach, improved STI care, and social mobilization of sex workers. Sex workers report increasing levels of consistent condom use with clients and decreasing incidence of STIs. Recent HIV seroprevalence trends show 21-48% reductions in HIV-1 prevalence for these same groups between 1997 and 2000.

In Nairobi, **Kenya**, interventions with sex workers - including peer support, condom promotion and STI services - have been strengthened throughout the 1990s. During this period, HIV prevalence in the city declined, rates of curable STIs fell to low levels, and chancroid (once the major cause of genital ulcers) all but disappeared. HIV incidence, previously 25-50% among Nairobi sex workers, fell to 4% by end of the decade.

In Abidjan, **Cote d'Ivoire**, female sex workers attend Clinique de Confiance, for counselling and clinical examinations. From 1992 to 1998, there was a trend towards shorter duration of sex work, higher prices, and more condom use. Among sex workers attended the clinique for the first time, significant declines were found in the prevalence of HIV prevalence (from 89 to 32%), gonorrhoea (from 33 to 11%), genital ulcers (from 21 to 4%), and syphilis (from 21 to 2%).

Sex workers in Kolkata, **India** have organized themselves to address many social and health problems that they face. The Sonagachi project shows a dramatic 50-fold increase since 1992 in female sex workers who say they now always insist on condom use (from 1,1% to 50,4% always; 2,7% to 90,5% overall). Within the project, sex workers work as peer educators raising awareness among fellow workers as well as clients.

'Projet SIDA' in Kinshasa, **Democratic Republic of the Congo**, provision of STI care and condom promotion resulted in a major decline of HIV incidence among female sex workers. Over the life of the project, condom use increased (from 11% to 68%), STI prevalence declined significantly, and HIV incidence fell from 11.7 to 4.4 per 100 women-years.

In mining communities in **South Africa**, mobile clinical services linking outreach and clinical services reached sex workers and other women at high risk. After nine months reported condom use increased and rates of curable STIs fell to between 70% and 85% for women using the services. Among hostel-based miners living in the area of the intervention, prevalence of gonococcal/chlamydial infection fell by one third and genital ulcers by almost 80%.

An intervention in Angeles City, **Philippines** used a single round of presumptive treatment for sex workers to reduce STI prevalence, then attempted to improve routine prevention and screening services. Prevalence of gonorrhoea and chlamydia, measured one month later, fell from 58% to 41%.