Clinical and Support Services
Clinical and Support Services

1. Community Empowerment
2. Addressing Violence against Sex Workers
3. Community-led Services
4. Condom and Lubricant Programming
5. Clinical and Support Services
6. Programme Management and Organizational Capacity-building

- Starting, managing, monitoring and scaling up a programme—from both a centralized and community perspective
- Community mobilization and structural interventions
- Fundamental prevention, care and treatment interventions
What’s in this chapter?

This chapter discusses how to implement the recommended package of clinical services for sex workers. It describes key principles for designing and delivering services that are appropriate to the needs of sex workers (Section 5.1).

The services covered in this chapter are:
- voluntary HIV testing and counselling (Section 5.2)
- antiretroviral therapy (Section 5.3)
- treatment for tuberculosis (Section 5.4)
- additional services for sex workers who inject drugs (Section 5.5)
- sexually transmitted infection services (Section 5.6)
- sexual and reproductive health services (Section 5.7)
- mental health (Section 5.8).

The chapter also provides a list of resources and further reading (Section 5.9).
5 Clinical and Support Services

5.1 Operational principles for clinical and support services

Providing appropriate, accessible and acceptable clinical and support services for sex workers presents unique challenges because of the stigma and discrimination often faced in clinical settings. However, clinical services can be a focus for community empowerment if sex workers are involved in their design, implementation and monitoring.\(^1\) This also encourages uptake of services by sex workers.

It is essential to build trust between health-care providers and sex workers receiving services. This may be done, in part, by following these overarching principles:

1. **Voluntary and informed consent**: Sex workers have the right to decide on their own treatment and the right to refuse services. Health-care providers should explain all procedures and respect the sex worker’s choice if he or she refuses examination or treatment.

2. **Confidentiality**: Confidentiality of patient information, including clinical records and laboratory results, should always be maintained to protect the privacy of sex workers. Sex workers should be allowed to provide identifying information other than their official birth name (identification papers or biometric data should not be required). Continuity of services may be assured by assigning an enrolment number.

3. **Appropriate services**: Clinical services should be effective, of high quality, provided in a timely manner and address the needs of sex workers. Health services should be in line with international standards, current best practices and guidelines.

4. **Accessible services**: Clinical services should be offered at times and places convenient for sex workers. Where possible, services should be integrated or closely linked so that a broad range of health services can be accessed at a single visit (see Section 5.1.1).

5. **Acceptable services**: Health-care providers should be discreet, non-judgemental, non-stigmatizing and trained to address the special needs of sex workers.

6. **Affordable services**: Services should be free or affordable, bearing in mind the cost of transport and lost income opportunities for sex workers visiting a service provider.

Figure 5.1 shows how these principles may be put into practice through coordinated activities at each level of a prevention programme for HIV and sexually transmitted infections (STIs).

5.1.1 Service delivery and integration

Although different clinical services are divided into separate sections within this chapter, the goal of effective programme planning should be to create delivery models with the fewest barriers for people to access services. Clinical and nonclinical services are often complementary, and coordinating the two may also be appropriate. Approaches to make services more user-friendly include:

- co-locating interventions and cross-training providers
- involving the community in the development, promotion, delivery and monitoring of services
- training non-sex worker staff in a culture and duty of care towards sex workers
- taking steps to ensure that law enforcement activities do not interfere with sex workers’ access to services.

\(^1\) In most contexts in this tool, “community” refers to populations of sex workers rather than the broader geographic, social or cultural groupings of which they may be a part. Thus, “outreach to the community” means outreach to sex workers, “community-led interventions” are interventions led by sex workers, and “community members” are sex workers.
Figure 5.1 Illustrative multi-level approach to acceptable, accessible and respectful clinical services

Programme level | Programme role
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Central | • Development of guidelines and standard operating procedures
• Policy development for appropriate services and non-stigmatizing clinical environment
• Advocacy for affordable, confidential, respectful sex worker services
• Sex worker-specific pre-service training in health education institutions
• Modules for sex worker issues incorporated into relevant ongoing in-service trainings
• Work with professional bodies (i.e. nursing association, medical association) to incorporate relevant topics in routine communications with members
• Coordination with national programmes to ensure links between clinical services and to establish referral networks

State/Province | • Training and sensitization of clinic staff on sex worker issues in relevant state-/province-wide trainings; monitoring and supportive supervision of district-level clinic staff
• Training and sensitization of state-/province-level programme managers and health officials on sex worker issues in clinical care
• Advocacy for affordable, accessible, confidential, respectful sex worker services
• Coordination with state-level health officials and authorities on ongoing issues of accessibility and acceptability, quality assurance and ensuring functional referral system

District/County | • Training and sensitization of clinic staff on sex worker issues in relevant district-wide trainings; monitoring and supportive supervision of municipal-level clinic staff
• Advocacy for affordable, accessible, confidential, respectful sex worker services
• Coordination with district health officials and authorities on ongoing issues of accessibility and acceptability and ensuring functional referral system
• Ensuring participation in quality-assurance programmes and activities

Municipality/Sub-municipality | • Work with clinics to establish evening and weekend hours, mobile and fixed-time/fixed-location satellite services
• Work with clinics to ensure confidentiality of services
• Training and sensitization of staff at key referral clinics; monitoring quality of clinical services
• Regular meetings with staff at key referral clinics for feedback
• Campaigns to inform sex workers of their right to confidentiality and the right to refuse services
• Ensuring sex workers’ involvement in clinical services
• Ensuring effective links to community-based services as well as quality assurance

Frontline worker/Community | • Participation as trainers in clinical staff training and sensitization
• Ensuring sex workers’ involvement in clinical services
• Monitoring quality/respectfulness of clinical services
• Participation in regular meetings with clinical and community-based staff
5.2 Voluntary HIV testing and counselling

5.2.1 Introduction

Voluntary HIV testing and counselling (HTC) is an essential entry point to HIV prevention, and to care and life-sustaining treatment for people with HIV. By combining personalized counselling with knowledge of one’s HIV status, HTC can motivate behaviours to prevent HIV transmission, and persons living with HIV can access supportive counselling, treatment for opportunistic infections and antiretroviral therapy (ART).

Voluntary HTC services should be part of an integrated programme of HIV prevention, care and treatment, so that sex workers, their partners and their families have access to HTC as frequently as required, at times and locations that are convenient. Counselling and testing services should adhere to the “5 C’s” principles described below, and should be delivered respectfully and without coercion, judgement, stigma or discrimination.

Respondents to the values and preferences survey stressed that in order for ART to be more widely available to sex workers, more sex workers must know their HIV status. Respondents unanimously expressed disapproval of mandatory or coercive testing.

5.2.2 Types of HIV testing and counselling and delivery

HTC services may be provided in a variety of settings, including:

- mobile community outreach
- health facilities
- safe spaces (drop-in centres)
- bars, clubs and brothels
- homes or households.

Finger-prick blood sample or mouth swab are preferred collection methods. They can be performed by a trained community worker; these methods may also be more acceptable to people who have injected drugs and may have difficulty with venous blood access or have concerns about drug use disclosure.

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3 A global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations.
4 A safe space or drop-in centre is a place where sex workers may gather to relax, meet other community members and hold social events, meetings or training. See Chapter 3, Section 3.3, for details.
Comprehensive services with and for sex workers have been provided in Kenya for a number of years. Prevention education and condom distribution are provided in “hot spots” by outreach workers, most of whom are trained sex workers. HTC is provided in clinics as well as at outreach sites. All persons found to be HIV-positive are referred to a nearby clinic, although sex workers may choose alternate locations if they prefer, and they move from site to site as they choose. Clinics are open in the evenings and on Saturdays and offer comprehensive care including pre-ART care, prevention and treatment of opportunistic infections, support groups and long-term ART. Additional services, such as diagnosis and treatment of other STIs and cervical cancer screening are also available. These projects, located in all the major cities of Kenya, have advisory committees that include sex workers and advocates, and operate with the support of the Ministry of Health. As of June 2013, over 40,000 sex workers and family members had received services through these comprehensive programmes throughout the country.

### Box 5.1

**Case example: Comprehensive care with and for sex workers in Kenya**

Comprehensive services with and for sex workers have been provided in Kenya for a number of years. Prevention education and condom distribution are provided in “hot spots” by outreach workers, most of whom are trained sex workers. HTC is provided in clinics as well as at outreach sites. All persons found to be HIV-positive are referred to a nearby clinic, although sex workers may choose alternate locations if they prefer, and they move from site to site as they choose. Clinics are open in the evenings and on Saturdays and offer comprehensive care including pre-ART care, prevention and treatment of opportunistic infections, support groups and long-term ART. Additional services, such as diagnosis and treatment of other STIs and cervical cancer screening are also available. These projects, located in all the major cities of Kenya, have advisory committees that include sex workers and advocates, and operate with the support of the Ministry of Health. As of June 2013, over 40,000 sex workers and family members had received services through these comprehensive programmes throughout the country.

### 5.2.3 Essential activities for voluntary HTC services for sex workers

#### A. Preparation

Appropriate preparation for delivering HTC services includes building community awareness and demand, training providers, selecting locations and times to deliver services, and procuring supplies.

**Community awareness and building demand for voluntary HTC**

- Community members should be informed about the benefits of knowing one’s HIV status and about the availability of treatment if they are infected with HIV. Even with awareness-raising activities for the general public or key populations, sex workers may not know about services that are respectful of sex workers or provided by trained and qualified sex workers.
- As part of awareness-raising campaigns, sex workers should be informed of their right to confidentiality and consent and their right to refuse HIV testing if they choose.

**Training providers and community outreach workers**

- Training in HTC should follow national and international standards (see Section 5.9).
- Training for counsellors who will provide HTC to sex workers should include additional training on:
  - the duty to be respectful and non-judgemental
  - the specific needs of sex workers
  - the absolute requirement to maintain confidentiality, not only about HIV results, but also about any other information provided during the counselling session, including the sex worker’s engagement in sex work.

**Location and timing of services**

- Both the location and the timing of voluntary HTC services should be responsive to the needs and requests of sex workers. In some settings, this might mean providing services during evening hours or weekends, such as “moonlight HTC”, which has been provided in a number of countries.
- Community settings may be more attractive than health-care institutions.
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Procuring essential supplies
- Procurement of supplies to conduct HIV testing is usually done by the agency or organization providing the services.
- A programme serving sex workers that wishes to provide voluntary HTC on-site should work with local health authorities to obtain training and authorization to provide HTC, as well as the needed supplies.
- It may be helpful to obtain handouts or other informational material about the importance of HIV testing to distribute to sex workers.

Management
Refer to Chapter 6. For information specific to the management of voluntary HTC services, please refer to the WHO Handbook for improving HIV testing and counselling services.5

B. HTC service delivery

Pre-test information
- The pre-test session should focus on basic HIV information and information about the HIV testing process, and ensure that testing is voluntary.
- A risk assessment may be used to develop a risk reduction plan that is specific to the situation of the client. However, it is not necessary to investigate the sex worker’s behaviours, number of partners, injecting drug use and other information unless the client volunteers this information.

Post-test counselling
This counselling is provided when the test results are ready to be given to the client.
- Information about what is needed in the post-test counselling session may be found in the WHO publication Delivering HIV test results and messages for re-testing and counselling in adults.
- Sex workers who are found to have HIV infection should be offered immediate referral for long-term care and treatment at a clinic or hospital whose staff are respectful of sex workers. They should also receive counselling about how to avoid transmitting HIV to others.
- All people, including sex workers, who are found to be HIV-negative should be provided with risk-reduction information specific to their individual risks, given access to condoms and lubricant, and counselled on strategies to negotiate safer sex. (See also Chapter 4.)
- Mental health issues, such as anxiety and depression, should be assessed if the counsellor has been trained in these areas. Referral to a clinician with training in mental health may be helpful. (See also Section 5.8.)

Repeat testing
- Sex workers who test HIV-negative should be advised to return for repeat testing after four weeks. They should also seek re-testing at least annually. See Delivering HIV test results and messages for re-testing and counselling in adults for more detailed information on repeat testing for sex workers and others at high risk for HIV infection.
- Some programmes serving sex workers and others at high risk offer those who test negative repeat HTC at regular intervals. This repeat testing may be done every three months or whenever a sex worker requests it, and should be offered at least annually as recommended by WHO for persons at higher risk. Repeat HIV testing should also be offered whenever there is a new STI diagnosis.

5 Details on this and other WHO publications mentioned in this chapter may be found in Section 5.9.
Self-testing
Reports suggest that HIV rapid tests are being sold and used for self-testing in an increasing number of countries, and sex workers and their clients may be using HIV tests for self-testing. Guidance on self-testing will be issued by WHO by 2014. Key issues relating to self-testing among sex workers are:

• There are potential benefits and risks of self-testing. One benefit may be to make HIV testing acceptable to people who currently avoid HIV testing in facilities. People who could benefit from regular retesting may find self-testing more convenient than returning to a facility frequently. The risks of self-testing include operator error or mistakes, misinterpretation of results, and lack of confirmation of HIV-positive results. Lack of counselling may result in depression and lack of access to treatment among those who test HIV-positive.

• It is an abuse of HIV testing in any form—including self tests—for employers, brothel owners or clients to force a sex worker to be tested. Coercing a person to use a self-test does not constitute voluntary testing.

• Any person who tests HIV-positive on the basis of a self-test should be informed of the need for confirmatory testing at an HTC site, health facility or laboratory.

• All persons using self-tests, including sex workers, should be counselled that a negative test result is not a reason to stop using condoms, because persons recently exposed to HIV may have a negative result on self-testing but be infectious.

Partner and family testing
Voluntary testing of regular partners, spouses and family members is available in many settings. When a sex worker tests HIV-positive, it is often helpful to offer voluntary counselling and testing to members of the family or household. Sex workers living with HIV should be supported to disclose their results to trusted family members, and voluntary HTC should be available to their partners, children and other family members.

C. Follow-up
Prevention services
• All persons, including sex workers, regardless of HIV status, should be informed about prevention services, including condoms and lubricants (see Chapter 4).

• Male sex workers who have female sex partners should be informed about the protective effects of male circumcision and referred to voluntary medical male circumcision services. Potential side-effects and the waiting period prior to resuming sexual activity should be carefully explained. The protective effect of male circumcision for men who have sex with men remains unclear. (See resources in Section 5.9.)

Connection to care and supportive services
Every person who tests HIV-positive should be offered care, support and treatment that is respectful and acceptable. Programmes serving sex workers, especially when providing voluntary HTC, should take responsibility to ensure that those who are HIV-positive are empowered to:

• enroll in care at a site that is acceptable to them and respectful of them
• participate in community-led support groups
• return for all follow-up visits.
Programmes serving sex workers should take extra efforts to support links to care, such as identifying a trusted peer (or community outreach worker) to accompany HIV-positive sex workers to care, support and treatment services. However, this should only be done with the sex worker’s consent.

5.2.4 Quality assurance of services

In the design and development of voluntary HTC services, special attention should be paid to establishing effective and acceptable links to services, quality assurance of testing and appropriate testing strategies to confirm positive test results in line with national guidelines. See Section 5.9 for tools for quality assurance testing.

5.2.5 Voluntary HTC performed by community outreach workers and lay counsellors

Voluntary HTC may be more acceptable to sex workers when the testing and counselling are performed by a trusted peer, i.e. another sex worker. Adequate training, ongoing performance support and monitoring are essential for all staff performing HIV testing at the community level, including health workers, programme staff and community outreach workers. Community outreach workers are an effective part of the voluntary HTC workforce. Community outreach workers who provide HTC should receive certified training in line with national HTC guidelines. Opportunities for professional development and promotion to supervisory, management and leadership roles should always be available for community outreach workers.

Box 5.2  
Case example: Outreach to provide HIV testing and counselling in Ghana

Pro-Link, an NGO, provides HIV prevention services to sex workers in five regions of Ghana. One project site in a low-income area of the capital, Accra, serves a catchment area of approximately 90,000 residents. Outreach activities have identified at least 50 locations and brothels in the community, with an estimated 5,000 sex workers. Pro-Link has trained 54 community outreach workers, sponsors community support groups and savings clubs, and has operated a drop-in centre since 2008, staffed by outreach workers and a nurse who provides STI screening and treatment, voluntary HTC, and follow-up care for those living with HIV.

Miriama, a sex worker who has been trained in on-site HIV rapid testing, counselling and follow-up care, provides HTC outreach services at locations where women work, including on the rooftop of a brothel. When a sex worker tests HIV-positive, Miriama makes sure that the sex worker goes to a nearby clinic for confirmatory testing and enrolment in care and treatment, if needed. Miriama manages to create private spaces even where there are no walls, ensures confidentiality even with the brothel owner downstairs, and expresses an accepting and loving approach to the sex workers she serves, many of whom are very young.

6 In this tool, “community outreach worker” is used to mean a sex worker who conducts outreach to other sex workers, and who is not generally full-time staff of an HIV prevention intervention (full-time staff might be called “staff outreach workers” or also simply “outreach workers”). Community outreach workers may also be known by other terms, including “peer educators”, “peer outreach workers” or simply “outreach workers”. The terms “community” or “peer” should not, however, be understood or used to imply that they are less qualified or less capable than staff outreach workers.
5.3 Antiretroviral therapy

5.3.1 Introduction

**2012 Recommendations: Evidence-based Recommendation 6**

Use the 2013 WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection for sex workers living with HIV.

The increased availability of and access to ART has significantly decreased HIV-related illness as well as deaths due to HIV. Recent advances in HIV treatment, and the success of community advocacy for increased availability of affordable drugs, have resulted in substantial improvements in the quality of life of people living with HIV throughout the world. Although access in resource-limited settings is usually not as comprehensive as in industrialized countries, free or subsidized ART services are now widely available in many countries with high HIV prevalence.

The treatment principles and recommendations for antiretroviral drug (ARV) use by sex workers are the same ones applicable for all people with HIV infection. All sex workers with HIV and/or tuberculosis (TB) should have access to ART and to anti-TB drugs and services. In addition to the clinical benefit to the HIV-positive sex worker, providing ART has the potential to prevent HIV transmission by reducing viral load.

Sex workers may face greater challenges than the general population in accessing HIV care and treatment services and, once started on ART, to retention in care and adherence to treatment. This is often because of stigma and discrimination in health-care settings and the inflexibility and inconvenience of service provision. Other barriers to successful ART provision for sex workers include mobility, criminalization of sex work and uncertain immigration or legal status, which may prevent them from accessing free ART in settings where only country nationals are entitled to free medical care.

However, providing ART to sex workers is feasible and is as effective as in the general population. Programmes providing outreach or services to sex workers should ensure that sex workers know where to go for treatment and are supported in their access to ART and TB medications.

Respondents to the values and preferences survey supported the use of the same ART protocols as for other adults with HIV. The need for universally accessible treatment was emphasized, including access to treatment for migrants and those without legal documents.

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7 A global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations.
5.3.2 Essential definitions and prerequisites of ART services

The 2013 WHO Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infections outline recommendations on when to start ART and what to use.

- ART should be initiated in all HIV-positive individuals with CD4 count ≤500 cells/mm³ regardless of WHO clinical stage.
- As a priority, ART should be initiated in HIV-positive individuals with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and HIV-positive individuals with CD4 count ≤350 cells/mm³.
- ART should be offered to all HIV-positive individuals, regardless of WHO clinical stage or CD4 cell count, in the following situations:
  - individuals co-infected with HIV and active TB disease
  - individuals co-infected with HIV and hepatitis B virus (HBV) with evidence of severe chronic liver disease
  - pregnant and breastfeeding women with HIV
  - HIV-positive partners in serodiscordant couples, to reduce the risk of HIV transmission to uninfected partners
  - all HIV-positive children under 5 years old.

The guidelines also recommend:

- use of simplified, less toxic and more convenient antiretroviral regimens for first- and second-line treatment, preferably as fixed-dose combinations
- integration of ART in TB, antenatal and maternal and child health services, and in settings providing opioid substitution therapy (OST)
- decentralization of ART services. ART should be provided in peripheral health facilities, initiated by nurses and with maintenance support from community health workers
- the “Three I’s” for HIV/TB (intensified TB case-finding, isoniazid preventive therapy [IPT] and TB infection control), as outlined in the WHO policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders.

5.3.3 Specific considerations for sex workers on ART

The principles for ART use, including when to start and what to use, are the same for all people with HIV. Therefore the clinical management of HIV-positive sex workers should not differ from that of other populations, and there are no special requirements.

Sex workers in many countries report that they experience stigma, discrimination and a lack of respect when attending health-care facilities used by the general public. However, experience in some high HIV-burden countries, including Cambodia, Côte d’Ivoire, Kenya, Thailand and Zambia shows that ART services designed specifically for sex workers increase treatment uptake and adherence.
Understanding and addressing concerns about ART

Like many people, sex workers may have fears and concerns about ART, and outreach and support programmes should understand and address fears or misconceptions about the possible adverse effects of ARVs.

As ART is now recommended for people earlier in their infection, those with HIV who are asymptomatic require careful counselling to understand why it is beneficial to initiate ART before feeling unwell or having symptoms. The benefit of adhering to prescribed treatment and maintaining a suppressed viral load of HIV to support good health and prevent treatment failure, as well as the benefit of ART in reducing the risk of HIV transmission, should be fully discussed. This may happen over several sessions, if necessary, checking whether the sex worker understands the issues and answering any questions.

Knowledge of the current community understanding of ART issues is imperative so that programmes, clinicians, counsellors and outreach workers may address any concerns with accurate and appropriate information.

Box 5.3

Sex worker-specific ART services

There are several key clinical service delivery elements specific to sex workers that may make access to ART easier, more acceptable and more effective, and support adherence to ART and retention in care:

- flexible clinic hours (weekends, evenings)
- clinical services at sites located near places of work
- “no appointment needed” and drop-in services available
- “emergency” drug pickups available when running out of ARVs
- family-centred services for sex workers with children
- patient-held records for sex workers who may seek ART at different sites
- respectful and non-judgemental staff attitudes.

Additional considerations when providing ART for sex workers may include:

- Drug treatment services available in the same or nearby location.
- Potential co-morbidities, such as cervical cancer, other STIs, HBV and hepatitis C (HCV).
- Addressing social vulnerabilities, including injecting drug use, other substance use, and violence that may affect access to treatment, adherence and retention, and lack of continuity of care and treatment interruptions (due to imprisonment, migration).
- All programmes referring sex workers to clinical sites providing ART should ensure that these services adhere to international standards of care outlined in this tool as well as address other key support, care and social services.
- Contraception and antenatal care services (including prevention of mother-to-child transmission for HIV-positive pregnant women) should also be available, and links to services supported, where needed.
- In order to meet the needs of mobile sex workers, health providers should also be flexible in interpreting national guidelines on the quantities of drugs to dispense at one time.
- The range of clinical support services for sex workers should be tailored to address the specific needs of male, female and transgender sex workers.
• Migrant sex workers and sex workers without documentation may experience significant barriers to accessing ART services. Programmes serving sex workers should be as flexible as possible to achieve the goal of universal access to care and treatment.

Integrated or “one-stop-shop” services may be one of the best ways of providing a fully comprehensive range of HIV and related health services. This may be possible in some settings where a number of services are available, such as voluntary HTC, clinical services including ART and treatment of HIV-related infections, contraception, antenatal services, cervical screening, legal advice, condoms, vaccinations, STI and viral hepatitis screening.

Community support for ART
Additional community elements that could be provided in parallel with formal clinical services to improve ART and health care for sex workers include:

• **trained community outreach workers** to accompany sex workers to clinics to receive ART. This should be provided only if the sex worker wants it. Community outreach workers should be trained to understand and respect the confidentiality of the sex worker receiving treatment.

• **community support and empowerment groups** for HIV-positive sex workers.

• **community committees** to monitor service delivery, and feedback loops to ensure appropriate, accessible and high-quality treatment.

• **community safe spaces (drop-in centres).**

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**Box 5.4**

**Case example: Managing care and treatment for male sex workers in Kenya**

Health Options for Young Men on HIV, AIDS and STIs (HOYMAS—www.hoymas.org) started in 2009 as a support group for male sex workers in Nairobi, Kenya. It now provides services for more than 1,200 male sex workers, more than half of whom are living with HIV. HOYMAS is owned, led and designed by the community. It provides a comprehensive range of HIV and health services in a safe space, with a nurse on site to help with daily issues of prevention, care and treatment. Services include:

• **A place to rest** for people on ART

• **Medicine storage**—men who do not have a safe place to store their ARVs may keep them at the centre and collect them when needed

• **Nutritional support** for those with HIV, and in particular to help those taking ARVs

• **Peer support** (“my brother’s keeper” programme)

• **Home visits** to sick members

• **Referrals** for other services, e.g. legal and post-violence support

• **Distribution outlet** for condoms and lubricants and information and education communication materials

HOYMAS also networks with government-managed health services to sensitize health workers to the clinical needs of men who have sex with men and male sex workers. HOYMAS’ community outreach workers liaise between the centre and five district hospitals and provide training to health workers on men who have sex with men and HIV issues.
Treatment literacy

Treatment of AIDS and other conditions, such as hepatitis, is continually changing, and it is important for sex workers to be up-to-date with recent developments so they can be fully informed and involved in their treatment. Sex worker-led treatment literacy programmes help sex workers stay informed about and understand issues relating to their treatment.

**Box 5.5**

**Case example: Sex worker treatment literacy in Asia**

The Asia Pacific Network of Sex Workers (APNSW) integrates sex worker-specific issues into the Treatment Literacy and Advocacy training conducted by the International Treatment Preparedness Coalition and Asia Catalyst. There is a dual focus on treatment literacy and advocacy. The real-life impact of side-effects of ARVs is examined and the reluctance of sex workers to start ART is discussed. The sessions explore how best to integrate adherence into the sex workers’ working environment, e.g. for those who work in bars or work irregular hours.

The sex worker-specific workshops aim to form better relationships across at-risk populations, i.e. between sex worker groups and other groups. APNSW also takes a high profile in treatment activism, especially around threats to access to generic medicines.

Pre-exposure prophylaxis

The 2012 Recommendations do not include guidance on the use of pre-exposure prophylaxis (PrEP) for sex workers. Separate guidance, issued in 2012 by WHO, on PrEP for HIV-serodiscordant couples, men and transgender women who have sex with men at high risk of HIV, encourages countries that wish to introduce PrEP for these particular groups to consider doing so through demonstration projects to ascertain its acceptability and how best to deliver it safely and effectively. It is recognized that adherence to PrEP is key to its effectiveness as a prevention strategy and that it may offer an additional HIV prevention option for some people who choose to use it.

5.4 Tuberculosis and sex workers

The 2012 Recommendations do not include a specific recommendation on TB. Diagnosis, prevention and treatment of TB in sex workers should follow national and international guidelines for treatment of TB in adults. The current global policy and guidelines on HIV-associated TB, at the time of printing, are:

- **WHO Policy on collaborative TB/HIV activities: guidelines for national programmes and other stakeholders** (2012)
- **WHO Guidelines for intensified tuberculosis case-finding and isoniazid preventive therapy for people living with HIV in resource-constrained settings** (2011)

People living with HIV are around 30 times more likely to develop TB than those who are HIV-negative, and they are at increased risk of dying from TB. People who use drugs and people with a history of incarceration are also at increased risk of developing TB, regardless of HIV status. While there are limited data on the association between TB and sex work, sex workers living with HIV, sex workers who inject drugs, and sex workers exposed to poor, cramped working and living conditions, including brothels or prisons, are at increased risk of developing TB, including multidrug-resistant TB.
The 2012 WHO TB/HIV policy recommends a 12-point package of interventions known as the collaborative TB/HIV activities. The aim of the package is to: establish and strengthen mechanisms for delivering integrated TB and HIV services; reduce the burden of TB among those living with HIV, which includes intensified case-finding, IPT and infection control (also known as the “Three I’s for HIV/TB”); and reduce the burden of HIV in TB patients. It recommends that all people living with HIV, including sex workers, should be screened regularly for the following four symptoms: current cough, fever, weight loss and night sweats. If they do not report any one of the four symptoms, active TB may be reasonably excluded and they should be offered IPT for at least six months. Those reporting one or more symptoms should be evaluated for TB and other conditions. If TB is suspected, WHO-approved molecular tests, such as Xpert MTB/RIF (a rapid automated test that looks for resistance to RIF), are recommended as the primary diagnostic test for TB in anyone living with HIV or at risk of drug-resistant TB.

Early ART significantly reduces the risk of mortality from HIV-associated TB. Given that TB is one of the most common AIDS-defining illnesses, WHO recommends that all TB patients, including sex workers, be offered HTC as a priority if their HIV status is not already known. If an individual is found to be living with both TB and HIV, WHO recommends that they should be started on ART as soon as possible, irrespective of CD4 count.

Programmes or community outreach services for sex workers are ideally placed to carry out TB screening and to support sex workers throughout the cycle of care, from TB prevention through diagnosis and treatment. They also play a vital role in training sex workers to recognise TB symptoms and understand TB transmission, as well as the importance of infection control and cough etiquette to reduce TB transmission. In addition, they can help sex workers identify nearby health facilities for diagnosis and initiation of treatment of active or latent TB, as necessary.

Ideally, the co-treatment of TB and HIV, as well as other co-morbidities such as drug dependence, should be made available at the same time and place. TB clinic staff should be trained on the need for respectful approaches to sex workers. Similar to ART, adherence is crucial for persons receiving TB treatment and prophylaxis, and health workers, counsellors, and community members serving sex workers should provide encouragement to sex workers receiving treatment for active or latent TB to ensure adherence.

Case example: HIV and undiagnosed TB

Many people living with HIV also have TB and need careful diagnosis, including for extra-pulmonary TB. Daisy, a sex worker advocate in Uganda, was on ART for more than eight years but still had severe spinal pain. In her own words, “I’d lost hope, and almost wanted to commit suicide, the pain was so bad.” Clinicians first told her that she had back pain because of her sex work, and then that her pain was psychosomatic, and referred her to a psychiatrist. Neither the psychiatrist nor physiotherapy helped.

Finally, after suffering with severe pain for more than two years, additional diagnostics were done and it was found that Daisy had TB of the spine. Because her TB was untreated for so long, her spine is damaged and could collapse, causing paralysis. She is now on TB drugs and wears a corset to prevent further spinal damage.
5.5 Additional services for sex workers who inject drugs

5.5.1 Introduction

In some regions of the world there is a substantial overlap between communities of people who inject drugs and sex workers. HIV transmission through injecting drug use accounts for 10% of the world’s new infections, and in some countries is the primary route of transmission. The prevalence of HIV among sex workers who inject drugs tends to be significantly higher than among those who do not inject. This vulnerability may be greater in females who inject drugs, due to gender inequalities and injecting practices. Therefore, when considering HIV prevention among sex workers, attention should be paid to ensuring that those sex workers who inject any kind of drugs have access to the services they need to keep themselves safe from the danger of acquiring or transmitting HIV, viral hepatitis and other bloodborne infections.

Sex workers who inject drugs, including those who are HIV-positive, should have full access to a comprehensive package of integrated HIV prevention, support, treatment and care services, as well as access to support and voluntary treatment for drug dependence should they want it.

The WHO/UNODC/UNAIDS Technical Guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users—2012 revision sets out nine key interventions that have proven efficacy in reducing HIV transmission among people who inject drugs. Seven of these interventions are already covered in other parts of this tool, and only the remaining two are exclusive to injecting behaviour: opioid substitution therapy (OST) and needle and syringe programmes (NSPs). These two interventions specifically reduce transmission among people who inject drugs and should be prioritized in a comprehensive HIV prevention package for sex workers who inject drugs. Only about half of the countries that report injecting drug use have also implemented OST and/or NSP. In countries where these services do not exist it is essential to support advocacy activities and community-led outreach services.

5.5.2 Opioid substitution therapy

There is overwhelming evidence gathered over 30 years that methadone substitution therapy is highly efficient, cost-effective and safe and has many collateral benefits in terms of stabilizing and improving the quality of life of people who are dependent on opioids. Some countries have started using buprenorphine with similar results. While OST is designed to treat opioid dependence, it has proven highly effective in preventing transmission of HIV and other bloodborne viruses through the sharing of injecting equipment, and in supporting adherence to the treatment of HIV and other health problems.

OST may be delivered in a wide range of settings and has been shown to be most effective when:
- dosage is adequate and individualized, based on the expressed needs of the user
- access to treatment is fast, easy and local, without overburdening bureaucracy
Clinical and Support Services

- take-home doses are available so that users do not have to attend the service daily
- the service is mobile and can be transferred to another location, should the user require it
- the service is integrated with a range of other support and care services, including NSPs.

OST and NSPs should not be treated as mutually exclusive, and accessing NSPs while enrolled in an OST programme should never be used as evidence by service providers that a person is no longer suitable for the OST programme.

5.5.3 Needle and syringe programmes

NSPs are cheap, easy to establish and have proven to be highly effective in reducing HIV transmission among people who inject drugs without increasing injecting behaviour. NSPs are best delivered at the community level and are an important point of first contact with people who inject drugs who are reluctant to use other services for fear of discrimination or abuse. The most effective NSPs:

- are community-led, with community members trained to deliver the service, including first aid
- are located close to where people who use drugs are
- are mobile and adaptable to the changing patterns of the drug-using scene
- offer a range of needle and syringe sizes (including those with low dead space between needle and syringe) and other essential injecting equipment, without any restrictions on the number of needles
- offer a range of other support and care services, such as legal aid, nutrition, family and housing advice, as well as health maintenance, like vein care and abscess avoidance and care
- offer overdose prevention, either by ensuring all staff are trained in overdose revival techniques or by providing naloxone to people who inject drugs and their families and community members.

5.5.4 Other considerations

Up to 90% of people who inject drugs in some countries are infected with HCV. NSPs should also provide other injecting equipment, such as cookers, swabs and bleach in order to prevent HCV. There is evidence that providing low dead space syringes (LDSS—which are designed to reduce the amount of blood remaining in the syringe after completely pushing down the plunger) reduces the risk of HIV and HCV transmission. NSPs should therefore provide LDSS in addition to other syringes appropriate for local needs.

Because injecting drug use is criminalized in many countries, and NSPs are generally highly visible, it is essential for those considering the establishment of such services to engage at a very early stage with the police and the wider community in order to gain their support.

Injecting equipment may also be shared by other communities, such as transgender women, who may use it for breast augmentation or hormonal therapy. It is essential to ensure that these people have access to the range of services they require to keep themselves safe.

It is also important that any service in contact with people who inject offer HBV vaccination (see Section 5.6.2, part D).
5.6 STI services

5.6.1 Introduction

**2012 Recommendations: Evidence-based Recommendation 3**

Offer periodic screening for asymptomatic STIs to female sex workers.

Screening and treatment of sex workers for STIs is important to prevent the acquisition and transmission of infections and to reduce reproductive health complications, such as pelvic inflammatory diseases, infertility and congenital infections.

Provision of basic HIV and STI clinical services is an essential component of a comprehensive package of services for sex workers and should be a priority in sex worker interventions. All sex workers should have access to acceptable, effective and high-quality STI services. These should be human rights-based, confidential, accessed voluntarily and without coercion, and provided after informed consent. Well-trained and non-judgemental health-care providers build trust and confidence among sex workers, who should be involved in service provision and not be seen as passive recipients of services.

An STI services package consists of case management for both symptomatic and asymptomatic STIs. Comprehensive STI case management also includes the promotion and provision of condom use, support for compliance with treatment, risk reduction counselling and partner management. Once established and scaled up, services may be expanded in scope to meet the broader health needs of sex workers.

Respondents to the values and preferences survey⁸ expressed unanimous support for periodic voluntary screening for STIs.

5.6.2 STI services for sex workers

Regular screening for asymptomatic infections among sex workers using laboratory tests is cost-effective given the high rates of STIs, and can reduce STI prevalence over time. It is therefore essential to invest in STI screening. Where laboratory diagnosis is available, laboratories should be staffed by qualified personnel with adequate training to perform technically demanding procedures, with quality assurance systems in place.

Absence of laboratory tests should not be a barrier to screening sex workers for STIs. A regular STI check-up is an opportunity to reinforce prevention and address other health needs. The check-up may consist of probing for symptoms of STIs and checking for signs of cervical and ano-rectal infections, including speculum and proctoscopic examination.

 Provision of effective services to sex workers with STI symptoms should be a priority for STI services. Symptomatic STI patients may be aware they are infected and are more likely to seek care. In resource-poor settings where reliable STI testing is not feasible, WHO has recommended a syndromic approach (locally adapted) to manage symptomatic infections.

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⁸ A global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations.
STI services/interventions should be designed, organized and implemented at scale. Achieving high coverage, ensuring quality services and linking or integrating to HIV, sexual and reproductive health (SRH) and other services requires systematic, standardized approaches. A phased approach to scaling up services, moving from externally led services to community-led ones, is illustrated in Figure 5.2.

A. Designing STI services

Assess current STI services
When mapping sex worker communities before establishing an intervention (see Chapter 6, Section 6.2.6, part A), data on the quality of STI services, current use of services, their acceptability and accessibility should also be collected. This information may be used to determine the demand for STI services and develop a plan to improve existing services or establish new ones.

Define essential STI service package and other services for sex workers
STI services for sex workers should meet basic standards of quantity and quality. The national programme should lead the development of STI guidelines and operational standards and define the essential STI and other service package in consultation with technical experts, implementers and sex workers. These guidelines and standards will be the basis for implementation, training, supervision and monitoring.

The basic STI service package includes:
- syndromic case management for patients with symptoms
- screening and treatment of asymptomatic STIs:
  - syphilis screening
  - gonorrhoea and chlamydia screening
  - routine STI check-ups
  - referrals to voluntary HTC.

It is important that the STI service package be linked or integrated with HIV, SRH and primary care, when appropriate and feasible.

Since sex workers have a higher risk of STIs and their risk factors differ from those of the general population, STI management flowcharts specific to sex workers should be developed. Examples of these guidelines and standards are the Avahan India AIDS Initiative’s Clinic Operational Guidelines and Standards and the Government of Kenya’s National Guidelines for HIV/STI Programs for Sex Workers.

Organize STI services
A functioning management structure is important to implement and scale up STI and SRH services efficiently. It is important to specify roles and responsibilities at the different levels of the clinical services structure (see Figure 5.3). Communication and coordination mechanisms should be identified, and technical support and supervision at the different levels of care clearly articulated.
Figure 5.2 Scale-up of STI services for/with sex workers

- **Community-led**
  - Increasing Community Engagement
    - Services by sex workers
      - Scale up programme scope
        - Sustainability
        - Integrate with government systems
      - Scale up intensity
        - Maintain high coverage
        - Quality and effectiveness
        - Addressing other needs
    - Services with sex workers
      - Scale up infrastructure
        - Start-up
      - Scale up coverage
        - Sustainability
        - Integrate with government systems
    - Services for sex workers
      - Scale up programme scope
        - Sex workers as clinic managers
        - Integrated clinical services
      - Scale up intensity
        - Quality assurance of clinics
        - STI committee
        - Sex worker training and involvement in clinic operation
        - SRH services
        - HIV testing and counselling and HIV/opportunistic infection care
        - Clinic referral mechanisms
      - Scale up coverage
        - Training
        - Monitoring tools
        - Quarterly supervision
        - Standardized STI services
        - Coordination with community members and outreach team
  - Externally-led
B. Implementing and managing STI services

**Set up STI services**

Establish STI services that are accessible and acceptable for sex workers based on available resources and capacity. STI services should be respectful and non-judgemental, and should address sex workers’ particular needs.

In establishing clinical services, consider the factors listed in Table 5.1 to balance access with cost.

**Establish STI health care-seeking behaviour as a community norm**

It is essential that sex workers be aware of the symptoms of STIs and be encouraged to seek care promptly, and to seek regular STI screening. Linking STI services to outreach and community services helps achieve this.

Coordination with sex worker-led outreach is essential to promote STI services and support clinic follow-up. At the same time, provision of STI services reinforces condom promotion and education by community outreach workers. Clinic staff should develop strong communication with community outreach workers. Improving communication and referrals increases the overall prevention effect.
<table>
<thead>
<tr>
<th>Type of clinic</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stand-alone (often NGO-run)</td>
<td>• Full-time services in fixed location; ideal where there is a high concentration of sex workers (e.g. red-light district) and a large number of sex workers (&gt; 500) • Dedicated staff required</td>
<td>• Technically efficient • Comprehensive services may be provided; mix of clinical and educational interventions is possible • Flexible to address needs of sex workers • Possibility of linking to safe space (drop-in centre) • Involvement of sex workers is possible</td>
<td>• May be costly if few sex workers access the clinic • Possibility of stigma associated with clinic • May be difficult to sustain</td>
</tr>
<tr>
<td>Outreach clinics (often NGO-run)</td>
<td>• Satellite clinics (fixed location), mobile vans, health camps • Part-time clinics • Operate at fixed time in fixed locations • Ideal for reaching hard-to-reach sex workers and for providing services to smaller numbers of sex workers • Dedicated staff required</td>
<td>• May reach hard-to-reach sex workers • Acceptable and accessible • Cost-effective if accessing hard-to-reach sex workers</td>
<td>• Provision of comprehensive services for sex workers may not be possible • Quality of services may be variable</td>
</tr>
<tr>
<td>Preferred service providers (private)</td>
<td>• Services provided by trained private providers identified by sex workers. (It is essential that private practitioners be trained to provide effective STI services to sex workers based on national guidelines.)</td>
<td>• Acceptable to sex workers • May be cost-effective for a small number of sex workers • Sustainable</td>
<td>• Comprehensive services may not be provided (e.g. educational and counselling services) • Quality monitoring and reporting may not be possible</td>
</tr>
<tr>
<td>Government-owned clinics</td>
<td>• Government clinics, either stand-alone STI clinics or integrated with other services e.g. SRH, HIV, primary care</td>
<td>• Sustainable • Provision of technically efficient services if staff are well trained and facilities are available</td>
<td>• May not be acceptable and accessible to sex workers; strong links with NGO- and community-led outreach services are needed</td>
</tr>
</tbody>
</table>
Address structural barriers to accessibility and acceptability of services
Consider the activities depicted in Figure 5.4.

**Figure 5.4** How programmes improve accessibility and acceptability of STI clinic services

**Convenient clinic time and locations; services provided discreetly**

In Mozambique, night clinics were established. In South Africa, STI treatment is taken directly to sex work venues. In Kenya and Ethiopia, STI services are located in commercial buildings that are accessible as well as non-stigmatizing. In China, outreach services have been provided in a gay sauna.

**Address barriers with gatekeepers**

Advocate with brothel owners so that they are supportive of sex workers visiting the clinic, and advocate with the police to stop raids so that sex workers are not forced to work in places where they are harder to reach with services.

**Affordable and free services**

Free services for sex workers are provided in Brazil and Thailand. Senegal provides insurance schemes for STI laboratory tests.

**Promote STI clinic services**

- Health providers, outreach workers and programme managers should be convinced of the importance of STI clinic services.
- Create a positive expectation—STI services as an opportunity to promote wellness (e.g. at a clinic in Mysore, India, STI screening is promoted as regular health-care maintenance rather than for STI treatment).
- Understand sex workers’ attitudes and beliefs about STI services; brainstorm solutions with them to address low access and poor uptake of services.
- Demystify and promote STI services by educating sex workers, to address misconceptions and dispel fears.
- Motivate sex workers to come to the clinic (e.g. in Nicaragua, vouchers were distributed to sex workers for free STI services in selected NGO and private clinics; in Cambodia, sex workers are called “smart girls” because they take care of their health).

**Increase clinic acceptability**

- Create a welcoming atmosphere in the clinic (e.g. rearrange the clinic set-up to create a friendly environment and to ensure confidentiality and privacy).
- Build a strong patient–provider relationship and treat all patients with respect.
- Maintain confidentiality (e.g. develop a clinic confidentiality policy, train health-care providers on confidentiality).
- Ensure that health-care providers are well trained and non-judgemental.

**Periodically reassess clinic acceptability**

In some STI clinics in India, community clinic oversight committees are established to support the management of the clinic, monitor service quality and identify acceptable and appropriate providers for STI services.
Involve sex workers and community outreach workers in clinic operations
Sex workers are capable of engaging at many levels of STI clinic operations, including management. Involvement of sex workers increases the sense of ownership and makes the clinic more acceptable and sustainable. STI services should promote meaningful participation of sex workers. Clinics should formalize sex worker involvement by specifying how sex workers may be involved in developing, managing and monitoring services.

Professional development should be an integral part of community empowerment, allowing sex workers to learn and be mentored to provide clinical services. Sex workers involved in the clinic operations should be trained to undertake their tasks, should maintain confidentiality and should be remunerated for their work.

Box 5.7
Case example: Community involvement in clinic operations in Uganda and India
In Uganda, sex workers supported government clinics in taking steps to make the services more acceptable to community members, and became involved in clinic operations.

In Mysore, India, sex workers have undergone formal training in nursing. Twelve sex workers who have completed their degree are now employed as nurses at the clinic.

Provide an appropriate and high-quality STI service package
Providing high-quality services encourages STI patients to seek care regularly. Figure 5.5 shows the factors that ensure quality in STI services.

Figure 5.5 Ensuring high-quality STI services
Link and integrate services
The majority of programmes providing services to sex workers focus on HIV and other STIs. However, sex workers and their families have the same needs for primary health care as anyone else. Sex workers may also experience problems associated with alcohol and drug use.

Programmes should work to provide a full range of health and social services. These should be accessible on site or by referral, without fear of discrimination. Services may be added incrementally based on sex workers’ priorities, the feasibility of providing services, and alternative solutions. HIV, SRH, HBV immunization, TB, and drug and alcohol dependency treatment are discussed in other sections of this tool.

Sex workers whose HIV, SRH and other health issues cannot be met or managed appropriately by the programme’s services should be referred to other facilities. Referral networks should be established depending on anticipated needs (see Figure 5.6). Clinics should compile a referral list of recommended providers, including names, addresses, telephone numbers and operating hours. Whenever necessary (e.g. due to perceived barriers to accessing services), accompanied referral should be considered.

Figure 5.6 STI referral network
Clinical and Support Services

Addressing the needs of male and transgender sex workers

Male and transgender sex workers need gender-specific interventions and services. Some male sex workers are heterosexual or bisexual while others identify as gay (homosexual). WHO guidelines for the Prevention and treatment of HIV and other sexually transmitted infections STIs among men who have sex with men and transgender people (2011) recommend the following:

- Men who have sex with men and transgender people with symptomatic STIs should seek and be offered syndromic management and treatment (in line with existing WHO guidance).
- Offer periodic testing for asymptomatic urethral and rectal N. gonorrhoeae and C. trachomatis infections, using nucleic acid amplification test (NAAT) rather than culture.
- Offer periodic serological testing for asymptomatic syphilis infection.
- Men who have sex with men and transgender people should be included in catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage (in line with existing WHO guidance).

It is essential to involve male and transgender sex workers in designing, implementing and monitoring STI services. In any setting, clinic standards should be adapted to ensure that gender-specific and appropriate services are provided. The model of service delivery depends on the specific context and on inputs from the male and transgender sex workers. In some settings, services for female sex workers may be adapted to provide services for male and transgender sex workers (e.g. offering services at specified times so that female, male and transgender sex workers may be seen separately at the same clinic). In some settings, clinics for men who have sex with men have provided services for male and transgender sex workers; in others, dedicated services for the sex workers have been established.

C. Periodic presumptive treatment

2012 Recommendations: Evidence-based Recommendation 4

Offer sex workers, in settings with high prevalence and limited clinical services, periodic presumptive treatment (PPT) for asymptomatic STIs.

The 2012 Recommendations state that:

1. PPT should be implemented only as a short-term measure in settings where STI prevalence is high, e.g. >15% prevalence of N. gonorrhoeae and/or C. trachomatis infection.
2. PPT for gonorrhoea and chlamydial infection should always be free, voluntary and confidential, and include counselling and informed consent.
3. PPT for gonorrhoea and chlamydial infection should only be offered as part of comprehensive sexual health services (including community empowerment, condom programming, STI screening, STI treatment and care) and while HIV/STI services are being further developed.
4. There should be ongoing monitoring of the possible benefits and harm that sex workers could experience from being offered PPT.
Clinical and Support Services

Related operational considerations include:

- the use of single-dose combination antibiotics for high cure rates
- enhanced condom promotion, including ensuring quality and accessibility to reduce rates of re-infection
- enhanced sex worker-led outreach to increase knowledge, coverage and use of services
- enhanced support for safer working conditions to increase opportunities for condom negotiation
- use of PPT as an emergency response only with these other components to reinforce STI control and HIV prevention with sex workers and their clients
- phasing out of PPT as soon as possible, e.g. after six months, even if prevalence has not declined, as other measures should by then be in place to maintain control.

The values and preferences survey concluded that the potential risks of PPT to sex workers outweigh the potential benefits. Sex workers reported harmful consequences from the introduction and use of PPT, and ongoing monitoring of the possible harm that sex workers could experience from PPT was requested. There was unanimous agreement from the values and preferences survey, and from participants at the related validation meeting, that PPT should only be offered when sex workers have access to all relevant information, including about side-effects, and only when uptake is voluntary and not imposed as part of a coercive or mandatory public-health effort.

D. Viral hepatitis

**2012 Recommendations: Evidence-based Recommendation 8**

Include sex workers as targets of catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage.

HBV is transmitted between people by contact with the blood or other body fluids of an infected person. Sexual contact and injecting drug use also transmit the virus. Risky sexual practices and sex work are associated with HBV infection in different regions of the world. Fortunately, highly effective vaccines against the virus are available. WHO recommends three doses of the vaccine for complete immunization and protection against potential HBV infection. WHO has also published *Guidance on prevention of viral hepatitis B and C among people who inject drugs*.

Like HBV, HCV is transmitted through contact with the blood or other body fluids of an infected person. Most HCV infections occur through the use of contaminated injection equipment among persons who inject drugs or in medical settings. HCV can also be transmitted by sexual contact, and the group at greatest risk is HIV-infected men who have sex with men. There is no vaccine to prevent HCV infection, but it can be cured with treatment. WHO is developing guidance for HCV treatment, and has published *Guidance on prevention of viral hepatitis B and C among people who inject drugs*. 
5.7 Addressing the sexual and reproductive health needs of sex workers

5.7.1 Introduction

Sex workers of all genders have SRH needs and the same reproductive health rights. SRH needs are often overlooked; it is important to expand clinical services beyond STIs and HIV to address them. Making SRH services available on-site or by referral allows for sex workers’ broader needs to be attended to and increases their confidence and participation in the programme. The following SRH services should be considered:

- family planning and contraceptive counselling
- safe pregnancy
- abortion and post-abortion care
- reproductive tract cancer screening (e.g. cervical, ano-rectal and prostatic cancers)
- counselling on hormone use and referral to other gender enhancement practices for transgender sex workers.

Case example: Government provision of SRH services to sex workers

Diagonal Interventions to Fast Forward Enhanced Reproductive Health (DIFFER), an initiative in India, Kenya, Mozambique and South Africa funded by the European Commission, is exploring a “diagonal” strategy, incorporating health-systems strengthening (a horizontal approach) with more targeted outreach to sex workers (a vertical approach) to define STI and broader SRH services. Models for delivery of services to meet the needs of sex workers and women include:

- government SRH services with special hours or spaces for sex worker services
- government SRH services with outreach and mobile or satellite sex worker services
- better coordination and two-way referral between services for sex workers run by community-based organizations or NGOs and government SRH services.

Hormonal therapy for transgender sex workers

There is currently no consensus on the safest and most effective dosing regimens for hormonal therapy for gender transition. Several centres have developed guidance on the use of hormones. Transgender people use hormonal therapy for its feminizing (estrogen) or masculinizing (testosterone) effects. This is usually done through advice from their friends or from information on the Internet. High doses are usually administered, and these have potentially serious side-effects. High doses of estrogen may result in an increased risk of thromboembolism and other outcomes such as liver dysfunction, breast cancer, coronary artery disease, cerebrovascular disease and headaches.

A qualified practitioner should be consulted when considering hormonal therapy, and people on hormonal therapy need access to medical monitoring.
5.7.2 Family planning and contraceptive counselling

The basic steps in effective family planning and contraceptive counselling for sex workers are:

• Provide counselling to determine the sex worker’s pregnancy intention.
• Discuss available methods of contraception, including dual method protection.
• Determine medical eligibility for the desired family planning method.
• Provide or prescribe the family planning method.
• Promote and provide condoms.

Sex workers may use condoms less consistently with regular partners than with their clients. Many sex workers therefore need dual method protection against pregnancy as well as against STIs and HIV. This may be achieved by using a highly effective contraceptive method for pregnancy prevention, and the male or female condom for STI and HIV prevention.

The following information should be provided so that sex workers may make an informed, voluntary choice of contraceptive methods:

• relative effectiveness of each method
• correct use of the method
• how it works
• common side-effects
• health risks and benefits
• signs and symptoms that would necessitate a return to the clinic
• return to fertility after discontinuing the contraceptive method.

Emergency contraception

Emergency contraception may be provided to a woman who has had unprotected vaginal sex, is not currently using a contraceptive method and is not pregnant. It should be provided as soon as possible after unprotected sex, ideally within 72 hours, with a limit of 120 hours. (Effectiveness is reduced beyond 72 hours.) Emergency contraception should be accessible to sex workers and the frequency of its use should be monitored.

*Note:* Since emergency contraception is not completely effective in preventing pregnancy and might not be efficient if used frequently, it is important to encourage sex workers to use a long-term family planning method.

Safe pregnancy

If a sex worker plans to become pregnant, she should be provided with information about safe pregnancy, including regular antenatal care, HIV and STI prevention and testing, appropriate nutrition and safe delivery.

Abortion and post-abortion care

Where abortion is legal, links to safe abortion services should be established. Where it is illegal, sex workers should be informed about the risks of informal abortion methods. Sex workers should have access to appropriate post-abortion care to reduce related morbidity and mortality, and care for post-abortion complications should be provided. Sex workers should be counselled on family planning to prevent future unwanted pregnancies.
5.7.3 Cervical cancer screening

Human papilloma virus (HPV) is an STI that can cause cervical cancer. Cervical cancer screening promotes early detection of precancerous and cancerous cervical lesions and prevents serious morbidity and mortality. Information and services for cervical cancer screening and treatment should be provided to sex workers.

It is recommended that cervical screening be performed for every woman aged 30–49 at least once in her lifetime. Screening may be done through visual inspection with acetic acid (vinegar), conventional Pap smear or HPV testing. Pre-cancerous and cancerous lesions should be treated immediately.

Women who are HIV-positive should be screened for cervical cancer regardless of age. Priority should be given to maximizing coverage of the risk age group and to ensuring complete follow-up of women with abnormal screening test results.

5.7.4 Screening for other cancers

Screening for breast cancer, ano-rectal and prostate cancer should be part of routine care, and links to treatment services should be provided.

5.7.5 Clinical care for survivors of sexual assault

Where possible, clinical care for survivors of sexual assault should be linked with community-led responses to violence (see Chapter 2, Section 2.2.6).

- Offer first-line support to survivors of sexual assault by any perpetrator.
- Take a complete history to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe, including genitalia).
- Offer emergency contraception to women presenting within five days of sexual assault, and ideally as soon as possible after the assault to maximize effectiveness.
- Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making with the survivor to determine whether HIV PEP is appropriate.
- Survivors of sexual assault should be offered prophylaxis for:
  - chlamydia
  - gonorrhoea
  - trichomonas
  - syphilis, depending on the prevalence.
  - The choice of drug and regimens should follow national guidelines.
- Hepatitis B vaccination without hepatitis B immunoglobulin should be offered as per national guidelines.
- Psychological support and care should be offered, including coping strategies for dealing with severe stress.

Interventions up to three months post-trauma

- Continue to offer support and care.
- If the survivor has mental health problems, provide evidence-based mental health services that are accessible, available and follow the WHO mhGAP Intervention Guide.
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**Intervention from three months post-trauma**

- Assess for mental health problems and manage according to *mhGAP*.
- If survivor has post-traumatic stress disorder, arrange for appropriate therapy.

**5.8 Mental health**

Mental well-being makes up an integral part of any individual’s capacity to lead a fulfilling life. Mental health and overall well-being are influenced not only by individual attributes, but also by the social circumstances in which people find themselves and the environment in which they live. Sex workers may be particularly vulnerable to mental health problems, because of poverty, criminalization, marginalization, discrimination or violence.

Poor mental health may be a barrier to seeking testing or treatment for HIV, and to continuing in care for those who are HIV-positive. Programmes should monitor for and address the obstacles to mental health created by HIV service providers who are unskilled in recognizing mental health problems or who actively stigmatize sex workers with such problems.

The WHO *mhGAP Intervention Guide* provides guidance in evidence-based interventions to identify and manage a number of priority conditions, including depression, psychosis, bipolar disorders, alcohol-use disorders, drug-use disorders, self-harm, suicidal ideation and other emotional or medically unexplained conditions.

**5.9 Resources and further reading**

**WHO guidance relevant to voluntary HIV testing and counselling**

WHO has issued guidance on HIV testing services since 1988, soon after the first tests were developed. The most recent guidance documents are:


   http://www.who.int/ihr/training/laboratory_quality/en/index.html

**WHO guidance relevant to pre-exposure prophylaxis**

   http://www.who.int/hiv/pub/guidance_prep/en/

**WHO guidance relevant to tuberculosis**


**WHO guidance relevant to injecting drug use**


   http://www.who.int/substance_abuse/activities/assist/en/


**Guidance relevant to male medical circumcision**


**Guidance relevant to sexually transmitted infections**


Clinical and Support Services


8. Clinic Operational Guidelines & Standards: Comprehensive STI Services for Sex Workers in Avahan-Supported Clinics in India. New Delhi: Family Health International [no date]. https://www.indiahiv.org/SitePages/PublicationType.aspx?keyid=18


Sexual and reproductive health


Mental health


Operational tools


Other resources


Further reading


