Implementing Comprehensive HIV/STI Programmes with Sex Workers
PRACTICAL APPROACHES FROM COLLABORATIVE INTERVENTIONS
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**Acronyms and abbreviations**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AfriCASO</td>
<td>African Council of AIDS Service Organizations</td>
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<tr>
<td>AIDS</td>
<td>Acquired immunodeficiency syndrome</td>
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<td>APCASO</td>
<td>Asia Pacific Council of AIDS Service Organizations</td>
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<td>APNSW</td>
<td>Asia Pacific Network of Sex Workers</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>BHESP</td>
<td>Bar Hostess Empowerment and Support Programme</td>
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<td>BOCONGO</td>
<td>Botswana Council of Non-Governmental Organizations</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<tr>
<td>CSO</td>
<td>Civil-society organization</td>
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<tr>
<td>DIFFER</td>
<td>Diagonal Interventions to Fast Forward Enhanced Reproductive Health</td>
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<tr>
<td>DOTS</td>
<td>Directly observed treatment—short course</td>
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<tr>
<td>GO</td>
<td>Governmental organization</td>
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<tr>
<td>GRADE</td>
<td>Grading of Recommendations, Assessment, Development and Evaluation</td>
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<td>HBV</td>
<td>Hepatitis B virus</td>
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<td>HCV</td>
<td>Hepatitis C virus</td>
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<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<tr>
<td>HOPS</td>
<td>Health Options Project Skopje</td>
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<td>HOYMAS</td>
<td>Health Options for Young Men on HIV, AIDS and STIs</td>
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<td>HPV</td>
<td>Human papilloma virus</td>
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<tr>
<td>HRT</td>
<td>Hormone replacement therapy</td>
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<tr>
<td>HTC</td>
<td>HIV testing and counselling</td>
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<td>IPT</td>
<td>Isoniazid preventive therapy</td>
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<tr>
<td>KASH</td>
<td>Keeping Alive Societies’ Hope</td>
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<td>KHPT</td>
<td>Karnataka Health Promotion Trust</td>
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<td>LDSS</td>
<td>Low dead space syringe</td>
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<td>LMIS</td>
<td>Logistics management information system</td>
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<td>NAAT</td>
<td>Nucleic acid amplification test</td>
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<td>NANGOF</td>
<td>Namibia NGO Forum</td>
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<tr>
<td>NASCOP</td>
<td>National AIDS &amp; STI Control Programme</td>
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<tr>
<td>NGO</td>
<td>Nongovernmental organization</td>
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<tr>
<td>NHOCAT</td>
<td>National Harmonized Organizational and Capacity Assessment Tool</td>
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<td>NSP</td>
<td>Needle and syringe programme</td>
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<td>NSWP</td>
<td>Global Network of Sex Work Projects</td>
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<td>NZPC</td>
<td>New Zealand Prostitutes Collective</td>
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<td>OST</td>
<td>Opioid substitution therapy</td>
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<tr>
<td>PADEF</td>
<td>Partnership Assessment and Development Framework</td>
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<td>PEP</td>
<td>Post-exposure prophylaxis</td>
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<td>PPT</td>
<td>Periodic presumptive treatment</td>
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<tr>
<td>PrEP</td>
<td>Pre-exposure prophylaxis</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>PWID</td>
<td>People who inject drugs</td>
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<td>SACA</td>
<td>State Agency for the Control of HIV/AIDS</td>
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<td>SANGRAM</td>
<td>Sampada Grameen Mahila Sanstha</td>
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<tr>
<td>SHARPER</td>
<td>Strengthening HIV and AIDS Response Partnership with Evidence-based Results</td>
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<td>SHiPS</td>
<td>Strengthening HIV Prevention Services</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>SWEAT</td>
<td>Sex Worker Education and Advocacy Task Force</td>
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<td>SWING</td>
<td>Service Workers in Group Foundation</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TOP</td>
<td>Targeted Outreach Program</td>
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<tr>
<td>UBRAF</td>
<td>Unified Budget, Results and Accountability Framework</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VAMP</td>
<td>Veshya Anyay Mukti Parishad</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>

Agency has two distinct meanings: 1) an organization; and 2) the choice, control and power that a sex worker has to act for her/himself. In chapters where “agency” is used with the second meaning, the definition is given in a footnote at the first occurrence.

Capacity-building: In Chapter 6, the term “organizational capacity-building” is used. However, “capacity development”, “organizational development” or a number of other terms would serve equally well.

Community: 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.

Community outreach worker: 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 may 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.

Implementing organization is an organization delivering a prevention intervention to sex workers. It may be a governmental, nongovernmental, community-based or community-led organization, and may work at a state, district or local level. Sometimes a nongovernmental organization provides services through sub-units at multiple locations within an urban area, and in this case, each of those sub-units may also be considered an implementing organization.

“Indoor” sex workers work in a variety of locations including their homes, brothels, guesthouses, bars, clubs and other indoor sex work venues.

Safe space (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.

Sex workers: “Female, male and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally” (UNAIDS Guidance note on HIV and sex work, updated 2012). Sex work may vary in the degree to which it is “formal” or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities. This publication does not address the sexual exploitation of children, i.e. people under 18 years of age.

Values and preferences survey: A global consultation was conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations. This consultation document, Female, Male and Transgender Sex Workers’ Perspectives on HIV & STI Prevention and Treatment Services, is referred to in this tool as the “values and preferences survey”.

Glossary
Introduction
Sex workers have been among the populations most affected by HIV since the beginning of the epidemic more than 30 years ago. In both concentrated and generalized epidemics, HIV prevalence is considerably higher among sex workers than in the general population. There are numerous reasons for this, including the type of work in which sex workers engage, unsafe working conditions, barriers to the negotiation of consistent condom use, and unequal access to appropriate health services. Sex workers often have little control over these factors because of social marginalization and the criminalization of sex work. Violence, alcohol and drug use in some settings also increase vulnerability and risk.

Much has changed in the response to HIV over the last three decades, especially in the areas of prevention, testing and treatment. What remains missing is a respectful and inclusive response to marginalized and vulnerable populations, including sex workers. This is seen in countless individual stories, as well as in discriminatory laws, regulations and policies, including those that prohibit non-citizen, migrant and mobile sex workers from receiving life-saving medications.

All sex workers have a fundamental human right to the highest attainable standard of health. Healthcare providers have an obligation to provide services to sex workers, regardless of the legal status of sex work and sex workers. Health workers, programme managers and national leaders should ensure that all sex workers have full, adequate and equal access to HIV prevention methods and commodities, and HIV testing services and HIV treatment, guided by the principle of health for all and human rights.

The purpose of this tool

In 2012 the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Network of Sex Work Projects (NSWP) developed a guidance document on Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries. This document, referred to in this publication as the “2012 Recommendations”, sets out technical recommendations on effective interventions for the prevention and treatment of HIV and other sexually transmitted infections (STIs) among sex workers. The recommendations are summarized following this Introduction.

Following the dissemination of the 2012 Recommendations, many parties expressed a need to know how to implement them. This publication responds to that need by offering practical advice on implementing HIV and STI programmes for sex workers. It contains examples of good practice from around the world that may support efforts in planning programmes and services, and describes issues that should be considered and how to overcome challenges.

This tool is the product of collaboration among sex workers, service providers, researchers, government officials and nongovernmental organizations (NGOs) from around the world, as well as United Nations agencies, and development partners from the United States. The tool is aligned with the 2012 Recommendations. It also refers to a global consultation conducted with sex workers by NSWP as part of the process of developing the 2012 Recommendations. This consultation document is referred to in this tool as the “values and preferences survey”.2

**Definition of sex workers**

Sex workers include “female, male and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally.”3 Sex work may vary in the degree to which it is “formal” or organized. It is important to note that sex work is consensual sex between adults, which takes many forms, and varies between and within countries and communities. This publication does not address the sexual exploitation of children, i.e. people under 18 years of age.

**How to use this tool**

This tool is designed for use by public-health officials and managers of HIV, AIDS and STI programmes; NGOs, including community and civil-society organizations; and health workers. It may also be of interest to international funding agencies, health policy-makers and advocates.

The authors recognize that the tool may not be read from cover to cover. However, the reader is urged to at least look over all six chapters rather than concentrating only on those that may be of most immediate interest, in order to understand how each contributes to the goal of comprehensive programmes for sex workers. Each chapter explicitly or implicitly addresses one or more of the 2012 Recommendations. The first three chapters describe approaches and principles to building programmes that are led by the sex worker community. These community-led approaches are themselves essential interventions. Chapters 4 and 5 describe how to implement the recommended health-care interventions for HIV prevention, treatment and care. Chapter 6 describes how to manage programmes and build the capacity of sex worker organizations. (See Figure 1.)

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2 _Female, Male and Transgender Sex Workers’ Perspectives on HIV & STI Prevention and Treatment Services_. Edinburgh, United Kingdom: Global Network of Sex Work Projects, 2011.

Figure 1. Structure of the tool

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
Chapter 1 Community Empowerment is the foundation of the tool. This chapter describes how empowerment of the sex worker community is both an intervention in itself, and also essential to effective planning, implementation and monitoring of all aspects of HIV and STI prevention, treatment and care.

Chapter 2 Addressing Violence against Sex Workers focuses on one of the most urgent needs of sex workers: to be protected from violence, discrimination, abuse and other forms of human-rights violation. The effectiveness of HIV/STI prevention interventions is often compromised when interventions to address violence are not implemented concurrently.

Chapter 3 Community-led services: Like community empowerment, a community-led approach to planning, delivering and monitoring services for sex workers is essential to make programmes more effective and sustainable. This chapter describes the principles of community-led services and shows how they are applied to outreach, safe spaces (drop-in centres) and programme oversight.

Chapter 4 Condom and Lubricant Programming presents a detailed description of how to plan and implement the provision of male and female condoms and lubricants, using the approaches outlined in the previous chapters. The chapter covers planning for and managing adequate supplies, multi-level promotion of the commodities, and creating an enabling environment.

Chapter 5 Clinical and Support Services presents detailed descriptions of fundamental prevention, treatment and care interventions, incorporating the approaches outlined in the previous chapters. The services described include voluntary HIV testing and counselling, antiretroviral therapy, treatment of STIs and co-infections, such as tuberculosis and viral hepatitis, and additional services, such as for sexual and reproductive health, harm reduction for sex workers who inject drugs, post-rape care and mental health.

Chapter 6 Programme Management and Organizational Capacity-Building provides practical guidance on planning, starting, scaling up, managing and monitoring an effective programme from two perspectives: (1) a large multi-site programme with centralized management and multiple implementing organizations, and (2) local community groups seeking to start or expand services.

What are the key elements of each chapter?
Each chapter begins with an introduction that defines the topic and explains why it is important. The introduction presents one or more of the 2012 Recommendations, where relevant, and in some chapters underlying principles are also presented. Interventions are described in detail, broken down into stages or steps, wherever possible, to make them easy to follow. Topics or points of particular interest are presented in text boxes. Case examples from programmes around the world are presented in shaded boxes. These examples do not describe an entire programme in detail, since numerous publications address common programmatic issues, but they highlight specific aspects related to sex worker programming that have worked well in their contexts. The purpose of the case examples is to illustrate how an issue or challenge has been addressed, and to inspire ideas about approaches that could work in the reader’s own context. The forms, charts, etc. presented from various programmes have the same purpose. Each chapter ends with a list of resources—tools, guidelines and other practical publications—that are available online; and further reading—journal articles and other publications—that provide a research or academic perspective on some of the points made in the chapters.
Navigating within and between chapters

Although each chapter is subdivided to make it easier to find and use information, the reader is urged not to view the various services and interventions described in a chapter as separate and independent of one another. In the same way, the content areas of each chapter are also linked and should not be considered in isolation. Cross-referencing is provided in each chapter to assist the reader in making these connections.
Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries

The 2012 Recommendations include technical, evidence-based recommendations following the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodology, as well as recommendations for good practice. The evidence-based recommendations are supported not only by scientific evidence but also by the real-life experience of sex workers around the world. The good practice recommendations are overarching principles derived from common sense, ethics and human-rights principles. These recommendations are not based on scientific evidence and did not go through a formal GRADE process, but were informed by the experience of sex workers and should be strongly promoted in all interventions with sex workers.

Good practice recommendations

1. All countries should work toward decriminalization of sex work and elimination of the unjust application of non-criminal laws and regulations against sex workers.

2. Governments should establish antidiscrimination and other rights-respecting laws to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realize their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Antidiscrimination laws and regulations should guarantee sex workers’ right to social, health and financial services.

3. Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.

4. Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker-led organizations.

Evidence-based recommendations

1. Offer a package of interventions to enhance community empowerment among sex workers.

2. Promote correct and consistent condom use among sex workers and their clients.

3. Offer periodic screening for asymptomatic STIs to female sex workers.

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

5. Offer voluntary HIV testing and counselling to sex workers.

6. Use the current WHO recommendations on the use of antiretroviral therapy (ART) for HIV-positive general populations for sex workers (and refer to the latest ones published in 2013, i.e. begin ART below a CD4 count of 500).

7. Use the current WHO recommendations on harm reduction for sex workers who inject drugs (in particular needle and syringe programme and opioid substitution therapy).

8. Include sex workers as targets of catch-up hepatitis B immunization strategies in settings where infant immunization has not reached full coverage.
Principles for implementing comprehensive HIV and STI programmes with sex workers

Several principles underlie the 2012 Recommendations and the operational guidance given in this publication. These principles are described in the 2012 Recommendations (pp.37–8) and are articulated in more detail in this tool. They may be summarized as follows:

- **Community empowerment** is the process whereby sex workers are empowered and supported to address for themselves the structural constraints to health, human rights and well-being that they face, and improve their access to services to reduce the risk of acquiring HIV. Community empowerment is an essential approach that underlies all the interventions and programme components described in this tool, and is inseparable from them.

- **Community participation and leadership** in the design, implementation, monitoring and evaluation of programmes are also essential. Participation and leadership help to build trust with those whom programmes are intended to serve, make programmes more comprehensive and more responsive to sex workers’ needs, and create more enabling environments for HIV prevention and sex work.

- Programmes should **address structural barriers**. Sex workers have detailed knowledge of the legal, social, cultural and institutional constraints that block their access to services and deny them their rights. Their participation is essential in strategizing to overcome these barriers.

- Programmes must **operate at multiple levels**, from the front line to the national policy arena. Programmers should take into account how and where operational and policy decisions are made about funding, health care, social benefits, education, law enforcement or media coverage. All of these areas affect HIV prevention programmes as well as the lives of sex workers. Programmes and the communities they serve must be part of the decision-making process. Sex workers can participate and offer leadership at all levels.

- Programmes should be **holistic**—considering the full range of sex workers’ service needs—and **complementary**—finding ways to coordinate and integrate service delivery—as far as possible, to make them more accessible and effective for sex workers, and to build strong referral links to other service providers. This includes clinical and non-clinical services, which should not be seen as separate realms.

- Although based on the 2012 Recommendations for sex workers in low- and middle-income countries, the principles that underlie this tool, and the operational approaches it presents, are no less **relevant to high-income countries** and should be seen as a minimum global standard.