

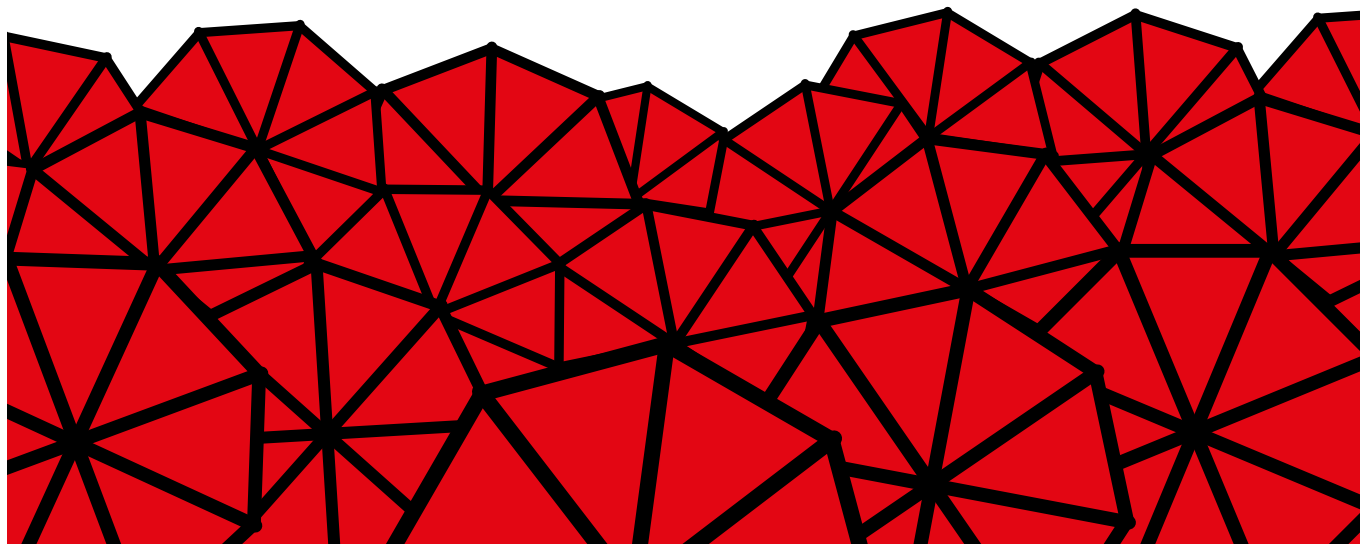


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**Global Network of Sex Work Projects**  
Promoting Health and Human Rights

**BRIEFING  
PAPER**

# **HIV and STI Testing and Treatment Policies**



# HIV and STI Testing and Treatment Policies

## Introduction

Globally, sex workers are disproportionately impacted by HIV, and face heightened risks of STI transmission.<sup>1</sup> Sex workers are twelve times more likely than the general population to be living with HIV.<sup>2</sup> There has been significant investment in researching and responding to the HIV epidemic worldwide, however, very little is targeted at HIV prevention and treatment programmes for sex workers. However, in the last five years, sex workers have been recognised as a key population for HIV programming given the disproportionate burden of HIV carried by female, male and transgender sex workers and their increased vulnerability as a result of criminalisation, violence, discrimination

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and stigma. Stigma has perpetuated the view that sex workers are ‘vectors of disease’ who must be controlled, often through aggressive surveillance, criminalisation and individual behaviour change.<sup>3</sup> A growing body of evidence from academics and the sex worker community have highlighted the role that structural barriers, among them, criminalisation of sex work, use of condoms as evidence of sex work, lack of appropriate health care, and lack of access to safe sex supplies, have in increasing sex workers’ vulnerability to HIV and STI transmission.<sup>4 5 6</sup> Reducing the risk of HIV and STIs for sex workers requires a response that mitigates the structural marginalisation of people in sex work and respects their human rights.

The most effective programming for managing HIV and STI transmission amongst sex worker populations are sex worker-led, implementing human rights-based community empowerment frameworks.<sup>7</sup> Rights-based approaches to managing the vulnerabilities associated with sex work have resulted in the reduction of HIV and STI transmission, and increased condom use.<sup>8</sup>

Significant strides have been made in combatting the global HIV epidemic as well as in developing accurate rapid STI testing and treatment in recent years. However, in many settings, sex workers lack access to prevention, treatment, care and support services, preventing them from benefitting from these advances. In low and middle-income countries sex workers continue to be at elevated risk, with HIV prevalence estimated to be as high as 37% in some regions.<sup>9</sup> In Sub-Saharan Africa, where the highest numbers of sex workers living with HIV are reported, only 60-percent of sex workers have received an HIV test in past 12 months.<sup>10</sup> Sex workers report difficulties accessing condoms and lubricants, and report unmet health needs in over 165 countries.<sup>11</sup> Funding for rights-based and sex worker-led HIV prevention

- 1 WHO, UNFPA, UNAIDS, NSWP, World Bank & UNDP, 2013, “Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions” available at [http://www.who.int/hiv/pub/sti/sex\\_worker\\_implementation/en/](http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/) (last accessed 5 December, 2015).
- 2 UNAIDS, 2014, “The Gap Report” available at <http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport> (last accessed 12 December, 2015).
- 3 Pamela Das and Richard Horton, “Bringing Sex Workers to the Centre of the HIV Response” *The Lancet*, 385 (2014), 3–4.
- 4 Michele R Decker et al., “Human Rights Violations against Sex Workers” *The Lancet*, 385 (2014) 186–199.
- 5 Kate Shannon et al., “Global Epidemiology of HIV among Female Sex Workers” *The Lancet*, 385 (2014) 55–71.
- 6 NSWP, 2013, “The Impact of Non-rights Based HIV Programming For Sex Workers Around the World” available at <http://www.nswp.org/resource/global-briefing-paper-the-impact-non-rights-based-hiv-programming-sex-workers-around-the-world> (last accessed 15 December, 2015)
- 7 WHO, UNFPA, UNAIDS, NSWP, World Bank & UNDP, “Implementing Comprehensive HIV/STI Programmes with Sex Workers”
- 8 Deanna Kerrigan et al., “A Community Empowerment Approach to the HIV Response among Sex Workers” *The Lancet*, 385 (2014) 172–185.
- 9 UNAIDS, The Gap Report
- 10 Lueddeke, “Towards an Integrative Post-2015 Sustainable Development Goal Framework” (Springer Publishing Company, 2015).
- 11 Ibid.

and treatment programmes remains disproportionately low, and there are significant political barriers to be overcome in achieving a change to this situation.<sup>12</sup>

This briefing paper explores sex workers' experiences of HIV and STI testing and treatment programmes from a global perspective. There is strong evidence for empowering sex workers through human rights-based approaches to HIV and STIs, with guidance<sup>13</sup> from the World Health Organization (WHO), United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS), NSW, the World Bank and the United Nations Development Programme (UNDP). However consultation with sex workers has indicated significant barriers to the implementation of sex worker-led programming. Rights-based approaches to HIV and STI testing and treatment for sex workers remain challenged by criminalisation of

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sex work, criminalisation and discrimination against people living with HIV (both generally and in occupational settings), and a lack of quality assurance and evaluation of programming for sex workers. There is a need for greater investment in appropriate, high-quality, rights-based services, and research led by sex workers in order to meet the specific needs of this population.

## Service Delivery for Sex Workers

Programmatic responses to HIV where sex workers take collective ownership have proven to be the most effective in reducing transmission.<sup>14</sup> Few HIV and STI testing and treatment programmes are sex worker-led, and many fail to include sex workers in the design, implementation, monitoring and evaluation of programmes. In many places, sex workers must choose to receive services from service providers who neither understand nor respect them, or go without health care. When sex workers do access HIV and STI testing and treatment, they face confidentiality violations and other breaches of their human rights.

## Mandatory Testing and Treatment

Mandatory HIV testing, in addition to being an abuse of human rights, puts sex workers at risk of increased violence and loss of income. Mandatory testing is often done in a way that fails to respect the confidentiality of sex workers. Those who test positive may have their status revealed to co-workers, clients and their community without their consent. Sex workers living with HIV report experiencing workplace discrimination, social exclusion, extortion, and violence from the police, clients, their communities and their families. Criminalisation of HIV non-disclosure, exposure and transmission increases stigma against people living with HIV and puts sex workers living with HIV at risk of prosecution. Sex workers who test positive or who refuse to participate in mandatory testing may be dismissed from their workplaces, and in places where selling sex is legal, they may be denied a license, resulting in further criminalisation. Sex workers are often expected to pay for mandatory testing, further marginalising those who cannot afford to pay.<sup>15</sup>

12 NSW, 2011, "PEPFAR and Sex Work" available at <http://www.nswp.org/resource/pepfar-and-sex-work> (last accessed 15 December, 2015)

13 WHO, UNFPA, UNAIDS, NSW, World Bank & UNDP, "Implementing Comprehensive HIV/STI Programmes with Sex Workers"

14 Kerrigan et al., "A Community Empowerment Approach to the HIV Response among Sex Workers."

15 AIDSUnited, 2015, "HIV Criminalization" available at <https://www.aidsunited.org/Primers%2C-Fact-Sheets%2C-0024-Toolkits/AIDSWatch-Fact-Sheets.aspx> (last accessed 15 December, 2015)

In some countries sex workers are subjected to mandatory testing after arrest.

*“A group of sex workers were rounded up by the police, forced to take an HIV test in the presence of the police and everybody else, and the results of the tests were announced publicly.”*

MALAWI SEX WORKER

In Mexico, an HIV test is required to get a permit to work as a sex worker, however in the event of a positive result, individuals are often barred from working. A sex worker in Mexico reports he was forced to take an HIV test, and subsequently denied access to ART. He eventually appealed to the National Commission of Rights in Mexico to obtain access to ART.

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Mandatory HIV testing of sex workers is ineffective in reducing new HIV infections among sex workers or the general population, and is not an evidence- or rights-based practice.<sup>16</sup> Indeed, mandatory testing of sex workers can be considered counter-productive: it is expensive, does not reach intended groups, is inefficient and is a fundamental violation of their human rights. The mandatory testing of sex workers, especially in collusion with law

enforcement or by health providers, excludes sex workers as stakeholders in service provision, and lacks buy-in and trust from community members. Sex workers who are most marginalised and vulnerable to HIV transmission may avoid accessing health care, avoid working in legal sex work venues and move to more isolated work areas, to avoid being targeted for mandatory testing.

## Consent and Coercive Testing and Treatment

Sex workers have the right to voluntary, confidential testing and treatment, yet in the context of criminalisation and stigma sex workers are often subject to coercive testing and treatment.<sup>17</sup> Coercive HIV and STI testing occurs on a continuum. Beyond mandatory testing after arrest or as a condition of their work, sex workers may be tested or given treatment without their consent, denied access to other medical services if they refuse testing or treatment, be coerced into testing by health care workers or outreach workers, or be given incorrect or incomplete information to coerce them into agreeing to testing or treatment. Programmes that prioritise meeting targets over the rights of individual sex workers, or individual health care or outreach workers who have targets to meet or are being paid for each individual who is tested often fail to respect sex workers' right to informed consent and voluntary testing and treatment.

16 Elena Jeffreys, et al., “Mandatory Testing for HIV and Sexually Transmissible Infections among Sex Workers in Australia: A Barrier to HIV and STI Prevention” *World Journal of AIDS*, 2 (2012), 203–211

17 WHO, UNFPA, UNAIDS, NSWP, World Bank & UNDP, “Implementing Comprehensive HIV/STI Programmes with Sex Workers”

Many sex workers are forced to disclose the nature of their work in order to access affordable health care, which has tremendous risks given the stigma sex workers face. They are then often subject to coercive testing. In Indonesia, HIV treatment has been made available through the Strategic Use of Antiretroviral (SUFA) programme, however only key populations can access care through this programme. Many women do not want to self-identify as sex workers at primary health care centres close to their home, due to concerns about confidentiality, and therefore do not take advantage of the SUFA programme. Similarly, according to sex workers in the United States, doctors have undertaken testing for HIV and STIs without the consent of a patient or required that they get tested regularly. Often, sex workers are treated poorly by health care workers, are denied their basic right to informed consent, and are frequently unable to access complaints procedures.

## Periodic Presumptive Treatment and Syndromic Treatment

Periodic Presumptive Treatment (PPT) is a periodic anti-biotic treatment for STIs without screening, often in the absence of any symptoms, based on the assumption that sex workers are likely to have STIs. Syndromic treatment is the administration of a broad spectrum of anti-biotic treatments based on symptoms for STIs but without screening to confirm a specific infection.

PPT and syndromic treatment may be offered in places where testing is not readily available, or as a cost-saving measure, as anti-biotics are

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less expensive than screening. When PPT and syndromic treatment are used as a cost-saving measure it is typically implemented within a framework that views sex workers as less deserving of the same quality of health care as the general population.

PPT and syndromic treatment are not appropriate as long-term practices, and have negative outcomes that include increasing stigma and stereotypes that all sex workers have STIs, creating a false sense of security leading to clients resisting condom use, and negative health impacts, such as strain on the digestive and immune system and the development of treatment-resistant strains of STIs.

A 2012 NSWP survey of sex workers found that the risks of such programming outweigh the benefits to sex workers.<sup>18</sup> WHO recommends that PPT and syndromic treatment only be utilised as a temporary, short-term measure in emergency situations until comprehensive sexual health services are developed<sup>19</sup>.

18 NSWP, 2012, "WHO Community Consultation Report" – updated available at <http://www.nswp.org/resource/nswp-who-community-consultation-report-updated> (last accessed 15 December, 2015)

19 World Health Organization, 2008, "Periodic presumptive treatment for sexually transmitted infections" available at <http://www.who.int/reproductivehealth/publications/rtis/9789241597050/en/> (last accessed 15 December, 2015)

**...sex workers must have access to all relevant information in order to make informed decisions...**

If PPT and syndromic treatment are offered, sex workers must have access to all relevant information in order to make informed decisions, and programming must only be offered if its uptake is voluntary and not imposed as part of a coercive or mandatory public health scheme. The implementation of PPT and syndromic treatment should occur alongside a commitment to developing comprehensive health care services and accessible testing, with the meaningful involvement of sex workers in the development of programmes. However, the use of PPT often highlights discriminatory practices within health care whereby sex workers are seen as ‘less deserving’ of appropriate health care and are sometimes denied access to the most efficient treatment and care available to other members of the general public.

Innovative sex worker-led models should be considered to avoid situations where appropriate testing and treatment services are not readily accessible to sex workers. A sex worker in Nigeria reports that HIV and STI testing services have shifted to a home-based model, with services being provided by trained sex workers, with positive results.

The criminalisation of HIV, along with the mandatory testing of sex workers, coercive testing and treatment, and the use of periodic presumptive treatment (PPT) and syndromic treatment are ultimately indicative of failures in providing appropriate, rights-based services for sex workers. These approaches are associated with poor individual and public health outcomes.

## Sex Worker Inclusion and Provider Training

Globally, there is a lack of meaningful involvement of sex workers in the development of HIV and STI testing and treatment programmes and in their implementation. In Indonesia and Vietnam, sex workers are often included as volunteers, but are not compensated for their labour and lack avenues for input, feedback, or grievances. Sex workers experience stigma and discrimination from service providers.

*“The voices of sex workers are not heard because sex workers’ stigma and discrimination is so high so sex workers choose to be silent and hide.”*

INDONESIAN SEX WORKER

Key populations are not prioritised by service providers, and are often not included in national strategies to address HIV.<sup>20 21</sup> Services are, consequently, provided by staff who tend to hold many prejudices towards sex workers and are generally not appropriately trained or sensitised to work with the sex worker community. In Myanmar a lack of experience of recently graduated service providers contributes to the poor services and stigma and discrimination faced by sex workers when accessing health care.

20 Shannon Kowalski and Susana Fried, “Sex and the Global Fund” Health and Human Rights Journal, 2008.

21 Anna Forbes, “Sex Work, Criminalization, and HIV: Lessons from Advocacy History” BETA, 2010, 20–29.

**Sex workers should be involved in designing appropriate and accessible programmes, and in sensitising health care professionals who work with sex workers.**

Sex workers in Bangladesh report that there are few places for sex workers to go for voluntary counselling and testing in the country. The STI care facilities are perceived by sex workers as offering low-quality services provided by health care workers who discriminate against sex

workers. Sex workers are not considered to have a role to play in providing clinical services and are excluded from the design, implementation and monitoring of HIV and STI testing and treatment programmes. Sex workers should be involved in designing appropriate and accessible programmes, and in sensitising health care professionals who work with sex workers.

When sex workers are meaningfully involved in service provision, the experience of sex workers is positive. In Guyana, a partnership between the Guyana Sex Worker Coalition (GSWC) and the USAID-funded Advancing Partners and

Communities Project, was considered a 'sex worker-friendly' service and has been well attended by sex workers.

WHO and UNAIDS international guidelines emphasise the fundamental importance of confidentiality at all levels of HIV and STI services for sex workers, however sex workers report their privacy is frequently violated by health care workers.<sup>22 23</sup> Sex workers in Uganda, Nigeria, Kenya, Zimbabwe and South Africa shared the experience of having health care workers breach their right to confidentiality by disclosing the results of HIV and STI testing.

*"Health workers shout at sex workers in the presence of all other patients, disclose their health conditions to third parties without their consent, and publicly state that they would rather spend their energy, efforts and drugs on 'real people' and not sex workers."*

MALAWI SEX WORKER

*"I work on the street in Montego Bay and I don't trust the people at the clinic because they were the ones who made the status of one of the sex workers on the corner know. And that girl didn't trust anybody that works with the Ministry and she never went to clinic until it was too late she died."*

JAMAICA SEX WORKER

Criminalisation and stigma of sex work is the reason that many sex workers do not seek health care services, especially for HIV and STIs. Sex workers in a number of counties reported that in order to be treated for HIV and STIs, they must attend the clinic with a partner for both to receive treatment. This is a major barrier to treatment for sex workers who may be unable to identify or contact their clients, or who are not able to disclose their HIV status to clients for safety reasons. Such breaches of confidentiality serve to alienate sex workers from accessing sexual health services, and in turn continue to exacerbate the vulnerability of sex workers to HIV and STI transmission.

22 UNAIDS, 2006, "International Guidelines on HIV/AIDS and Human Rights 2006", Consolidated Version., available at <http://www.ohchr.org/EN/Issues/HIV/Pages/InternationalGuidelines.aspx> (last accessed 15 December, 2015).

23 UNAIDS, 2012, "UNAIDS Guidance Note on HIV and Sex Work" available at [http://www.unaids.org/en/resources/documents/2012/20120402\\_UNAIDS-guidance-note-HIV-sex-work](http://www.unaids.org/en/resources/documents/2012/20120402_UNAIDS-guidance-note-HIV-sex-work) (last accessed 15 December 2015)

### *Vignette: Cambodia*

The SmartGirl programme of FHI360 in Cambodia highlights the complexities of providing appropriate care, and dangers involved when sex workers are not included in the development and implementation of an HIV and STI testing and treatment initiative.

SmartGirl works on the concept of community-based testing. An HIV test is done by a member of the community, and if positive, follow-up confirmatory testing is done in a health facility. As SmartGirl is practiced, there are instances of lack of consent, lack of confidentiality, or both. SmartGirl staff arrive in venues where sex work takes place, such as bars or clubs. The owners of the establishments coerce all sex workers in their establishments to take the test. The women sit around a table and undergo rapid tests conducted by the SmartGirl staff one by one. It is virtually impossible for sex workers to refuse to be tested. Refusal may result in the assumption that the sex worker is HIV positive, resulting in the sex worker being fired or they may be fired for refusing. Some sex workers are simply not ready to have an HIV test but are coerced into testing.

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Although the rapid screening test results are given individually, confidentiality is not assured. Those who are positive are given the opportunity to take free transport to the health centre for confirmatory testing. Other workers may see a co-worker take the free transport to the health centre. The workers also often compare results in informal conversations later. In either of these two situations there is a possibility that an individual's HIV status may be disclosed. Female sex workers known to a local sex worker collective have quit establishments when they learn their HIV status to avoid being fired.

Women who undergo confirmatory testing are paid \$2.50 and the SmartGirl staff are paid \$2.50 for each test they conduct regardless of the HIV status of the sex worker. SmartGirl staff are working against targets. Local sex workers did not participate in the planning of the SmartGirl programme but members have been invited to SmartGirl report meetings in which it has been reported that 2 to 3% of women sex workers test positive.

The SmartGirl testing programme can be contrasted with the support given by a local sex worker-led initiative to Cambodian sex workers who want to undergo testing. A team leader or community coordinator can be approached by a sex worker at any time. The risks and benefits of testing are explained to her and transport to a voluntary counselling and testing site is arranged. No money changes hands.



## Access to Prevention, Commodities and Treatment

Globally, sex workers indicate that access to condoms and lubricants are a priority. Many sex workers report lack of access to condoms

**Where sex work is criminalised, police will often seize condoms as evidence of sex work.**

and lubricants in workplaces, or that they are expensive if available. Where sex work is criminalised, police will often seize condoms as evidence of sex work.<sup>24</sup> In New Zealand, where sex work has been decriminalised, sex workers are able to procure and use condoms without fear of arrest or harassment, as well as hold clients accountable for using condoms through the criminal justice system.<sup>25</sup>

In addition to condoms and lubricants, sex workers have considered other biomedical interventions to reduce HIV transmission, including pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and treatment as prevention (TasP).

PrEP and PEP are the use of antiretroviral therapy (ART) by individuals who do not have HIV, to prevent HIV infection. PrEP is taken daily, often for an extended period of time, prior to potential exposure. PEP is taken immediately (or as soon as possible) after an exposure for a limited amount of time. TasP recognises that the use of antiretroviral therapy (ART) can be effective in reducing the risk of transmission of HIV, by lowering the viral load of individuals living with HIV.

The use of PrEP and PEP must not undermine condom use or reduce access to treatment for sex workers living with HIV.<sup>26</sup> Given the stigma faced by sex workers, many will only seek access to PEP after a sexual assault, and may not seek it out after other exposures at work.

In 2014, NSWP conducted a global consultation on the use of PrEP and early treatment. Issues raised by sex workers who took part in the consultation included concerns that targeting sex workers as a key population for PrEP might lead to an increase in mandatory testing (as testing is a precondition for receiving PrEP) and other rights violations; that it might lead to an increase in clients pressurising them for unprotected sex; that there would be additional pressure on budgets allocated to condom programming; that the police would use possession of Truvada (PrEP medication) as evidence of sex work; and that stigma and discrimination against sex workers would increase. Sex workers also raised a key concern about the ethics of providing ARVs to HIV-negative individuals when there are still so many HIV-positive sex workers who are not able to access treatment and need life-saving medication. Sex workers were also concerned that PrEP does not prevent unwanted pregnancy or exposure to other STIs, and that there are already significant treatment coverage gaps for existing medications in many areas.<sup>27</sup>

24 Human Rights Watch, 2012, "Sex Workers at Risk" available at <https://www.hrw.org/report/2012/07/19/sex-workers-risk-condoms-evidence-prostitution-four-us-cities> (last accessed 15 December, 2015).

25 New Zealand Ministry of Justice, 2008, "Report of the Prostitution Law Review Committee on the Operation of the Prostitution Reform Act 2003" available at <http://www.justice.govt.nz/policy/commercial-property-and-regulatory/prostitution/prostitution-law-review-committee/publications/plrc-report> (last accessed 15 December, 2015).

26 NSWP, 2014, "Global Consultation: PrEP and Early Treatment as HIV Prevention Strategies" available at <http://www.nswp.org/resource/global-consultation-prep-and-early-treatment-hiv-prevention-strategies> (last accessed 15 December, 2015).

27 Ibid.

**Where PrEP and early treatment programmes are developed, sex workers must be meaningfully involved in all levels of policy and programmatic discussions...**

Where PrEP and early treatment programmes are developed, sex workers must be meaningfully involved in all levels of policy and programmatic discussions, including in the design, implementation and monitoring of these programmes. Appropriate programming includes ensuring that the strategies are accessible and sustainable, that sex workers have access to accurate knowledge and information, ensuring all trials and data collection methods used are ethical, and promoting and expanding community-based services, in particular sex worker-led HIV testing and treatment services.<sup>28</sup>

PrEP, PEP and other biomedical interventions have a place in the global fight to end HIV. However, these will fail if implemented at the expense of supporting and empowering sex workers and other key populations to take ownership of their health needs, and if they are not implemented within a rights-based framework. The risks to the individual and to sex worker communities' long-term efforts to reduce prevalence through the full decriminalisation of sex work<sup>29</sup>, community empowerment, and barriers to effective and appropriate implementation must be recognised. Sex workers must be fully engaged in this growing debate.

Sex workers in the United States of America, a high-income country where ART is accessible, report difficulty with medical adherence given the stigma of HIV and fear of being identified as being HIV positive if the medication is found. HIV medication has been used by law enforcement to justify the arrest and prosecution of sex workers living with HIV under laws that criminalise HIV non-disclosure, exposure and transmission.

*“Sex workers are very mobile, but often miss taking their antiretroviral treatment when they have been arrested and locked up by the police.”<sup>30</sup>*

USA SEX WORKER

Sex workers in middle and low-income countries face additional challenges in accessing HIV treatment. The most effective ART treatments are often not available due to high cost and many countries experience stock out of ART. In some countries, such as Indonesia, key populations, including sex workers, have been prioritised for treatment. However, in other countries, sex workers of all genders report being denied treatment. In Malawi, sex workers are seen as an ‘undeserving criminal population’, and health workers are reluctant to provide ART to sex workers living with HIV. Health care workers may assume that sex work is inherently risky, that sex workers are undeserving of treatment, or that sex workers living with HIV ‘deserve’ any negative health impacts. These assumptions are given precedent over the needs of sex workers in clinical decision-making, resulting in sex workers’ right to essential treatment being violated.

Expenditure in HIV and STI prevention should be considered an investment that will deliver returns.<sup>31</sup> Sex workers must be prioritised in such investments.

28 Ibid.

29 Chris Beyrer et al., “An Action Agenda for HIV and Sex Workers” *The Lancet*, 385 (2014) 287–301.

30 Best Practices Policy Project, 2015, “Nothing About Us, Without Us: HIV/AIDS-related Community and Policy Organising for US Sex Workers” available at <http://www.bestpracticespolicy.org/nothing-about-us-without-us/> (last accessed 15 December, 2015)

31 UNAIDS, 2012, “Investing for Results: Results for People” available at [http://www.unaids.org/en/resources/documents/2012/20120604\\_investing\\_for\\_results](http://www.unaids.org/en/resources/documents/2012/20120604_investing_for_results) (last accessed 15 December

## Funding

Funding is a crucial aspect of the development and implementation of rights-based and sex worker-led programmes. Services for sex workers are historically underfunded, with significant barriers to funding right-based programmes given anti-prostitution policies, criminalisation, stigma and discrimination.<sup>32,33</sup> According to UNAIDS, less than 1% of global HIV prevention spending in 2008 was allocated to programmes targeting sex workers.<sup>34</sup>

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International donors, which include bi-lateral government donors such as USAID and UN agencies, and global funding mechanisms such as The Global Fund, create an environment of services that are not consistently funded and are vulnerable to economic recession and changes in funding

priorities.<sup>35</sup> Additionally, sex workers report donors often come with ready-made programmes, indicating a lack of ownership or meaningful involvement of sex workers.

International donors have been forced to intervene given a lack of response from national and local governments to provide HIV and STIs programmes for key populations, including sex workers. Despite being a key population, sex workers are frequently excluded from national strategic plans addressing sexual health and HIV, resulting in a lack of funding for services. In Côte d'Ivoire, the National Strategic Plan on Key Populations was adopted in 2014, to protect the human rights of people living with HIV. However this plan does not specifically address sex workers or highlight their rights despite strong advocacy by the sex worker community. Sex workers in the United States of America also advocated for inclusion without success.<sup>36</sup> Without governments being willing to prioritise sex workers as a key population, sex workers will continue to lack access to appropriate HIV and STI testing and treatment services. Additionally, governments' reluctance to be inclusive of sex workers has a global impact. PEPFAR which has allocated nearly six billion dollars to HIV prevention globally since 2003, has required international USAID grant recipients to endorse the 'Anti-prostitution pledge'<sup>37</sup>. Other governments, such as Sweden also endorse anti-prostitution policies. Such policies have resulted in many effective programmes not receiving funding with devastating impact upon vulnerable sex worker communities.

In countries that deliver health care through a national health system, migrant and transgender sex workers are often excluded and marginalised. Sex workers in Romania indicated that access to health care services, including HIV treatment, can be limited by lack of identity documents. Due to these barriers, migrant and transgender sex workers are more likely to avoid state health and social services. Transgender individuals systematically face challenges to access state identification. There are high cost associated with name and gender change, in countries where these changes are possible. For transgender sex workers who are not able to change their name or gender marker, they may experience high levels of stigma and discrimination for having identification that does not match their appearance, and may be denied services, or have their identification confiscated. Similarly, migrant sex workers are often unable to access treatment within national health systems, due to their lack of legal status within the country.

32 Fried and Kowalski-Morton, "Sex and the Global Fund"

33 Kerrigan et al., "A Community Empowerment Approach to the HIV Response among Sex Workers"

34 UNAIDS, 2012, "UNAIDS Guidance Note on HIV and Sex Work" (updated April 2012) available at [http://www.unaids.org/en/resources/documents/2012/20120402\\_UNAIDS-guidance-note-HIV-sex-work](http://www.unaids.org/en/resources/documents/2012/20120402_UNAIDS-guidance-note-HIV-sex-work) (last accessed 15 December, 2015)

35 "Retreat of international donors and neglect of national governments threatens harm reduction services," NAM Aidsmap available at <http://www.aidsmap.com/Retreat-of-international-donors-and-neglect-of-national-governments-threatens-harm-reduction-services/page/3007921/> (last accessed 15 December, 2015)

36 Best Practices Policy Project, "Nothing About Us, Without Us: HIV/AIDS-related Community and Policy Organising for US Sex Workers"

37 NSWP, "PEPFAR and Sex Work"

Despite recommendations by WHO for free or affordable health services, the funding environment often places the burden on sex workers to pay for testing and treatment, even in the case of mandatory testing. While sex workers are an economically diverse population globally, there are significant links between poverty and sex work. However, in many countries where services are available to sex workers, they are often expected to pay for these services. In Mexico, sex workers have to pay a high price for mandatory testing and treatment services. The SUFA programme in Indonesia provides services to sex workers for free, however it requires an initial registration fee and charges for viral load testing. Such costs create further barriers to sex workers accessing HIV and STI testing and treatment.

## Legal Considerations and Protections for Sex Workers

Scientific modelling has demonstrated that full decriminalisation of sex work, including sex workers, clients and third parties<sup>38</sup>, could prevent 33–46% of all new HIV infections within the next decade.<sup>39</sup> Full decriminalisation of sex work is recommended by UNAIDS, The Global Commission on HIV and the Law, Human Rights Watch and Amnesty

International to ensure the protection of sex workers' human rights, including their right to the highest attainable standard of health care. Despite these recommendations, sex work continues to be targeted through legislation that directly or indirectly criminalises or legally oppresses sex workers, their clients and third parties. Many of the laws that are applied to sex workers are vague and open to interpretation by the police and courts, such laws are often used by the police to harass, threaten, rape and extort money from sex workers. Both direct and indirect criminalisation have devastating effects on sex workers access to HIV and STI testing and treatment.<sup>40</sup> Additionally,

legislation intended to prevent the trafficking of persons for the purposes of sexual exploitation often conflates human trafficking and sex work, putting sex workers at greater risk for violence and HIV transmission.<sup>41</sup>

The criminalisation of sex workers is associated with an increased vulnerability to violence and health risks.<sup>42</sup> Sex workers in the United States and Cote d'Ivoire report that on arrest, they frequently experience sexual assault by law enforcement, often without condoms, as well as the seizure of condoms, ART, cell phones, money and other valuables. Repealing criminal sanctions against sex workers, their clients and third parties holds great promise for enabling sex workers to negotiate safer work conditions and access quality health care.

**Many of the laws that are applied to sex workers are vague and open to interpretation by the police and courts, such laws are often used by the police to harass, threaten, rape and extort money from sex workers.**

38 The term 'third parties' includes managers, brothel keepers, receptionists, maids, drivers, landlords, hotels who rent rooms to sex workers and anyone else who is seen as facilitating sex work.

39 Chris Beyrer et al., "An Action Agenda for HIV and Sex Workers" *The Lancet*, 385 (2014) 287–301.

40 Global Commission on HIV and the Law, 2012, "HIV and the Law: Rights, risk and health" available at <http://www.hivlawcommission.org/index.php/report> (last accessed 15 December, 2015)

41 Das and Horton, "Bringing Sex Workers to the Centre of the HIV Response"

42 UNDP, UNFPA, APNSW & SANGRAM, 2015, "The Right(s) Evidence: Sex Work, Violence and HIV in Asia" available at [http://www.asia-pacific.undp.org/content/rbap/en/home/library/democratic\\_governance/hiv\\_aids/the-right-s--evidence--sex-work--violence-and-hiv-in-asia--a-mul.html](http://www.asia-pacific.undp.org/content/rbap/en/home/library/democratic_governance/hiv_aids/the-right-s--evidence--sex-work--violence-and-hiv-in-asia--a-mul.html) (Last accessed 20 December 2015)

## Monitoring and Evaluation of Services

Globally, sex workers face high levels of stigma, discrimination and barriers when accessing services and justice.<sup>43</sup> A sex worker from Côte d'Ivoire reported challenges in accessing HIV and STI treatment in

**Globally, sex workers face high levels of stigma, discrimination and barriers when accessing services and justice.**

hospitals. If they are identified as sex workers by health care workers, they often are treated poorly and may experience significant delays in receiving treatment. Sex workers who can afford to access treatment at costly private clinics choose to, while those who cannot may not access care. Sex workers who experience discrimination often have no access to a system for filing complaints or grievances. Few programmes have a system in

place to ensure that services are acceptable and provided in a way that respects the human rights of sex workers.

Sex workers organise against injustices in health care. A hospital in Machala, Ecuador, was discriminating against sex workers and failing to provide appropriate confirmatory HIV testing. Sex workers and people living with HIV organised a protest demanding legal protections for the rights of sex workers and people living with HIV in health care settings. However, in spite of legal protections being put in place, stigma and discrimination continues. Just as sex workers are excluded from the development and implementation of programming, they are excluded from monitoring and evaluation processes. Meaningful involvement of sex workers is key to the successful implementation of HIV and STI testing and treatment programmes, including in the monitoring and evaluation of health services provided for sex workers.<sup>44</sup>

*“There are still certain practices of violations of rights in comprehensive care, the delivery of drugs, and the issue of confidentiality.”*

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## Research

Research on sex work, especially the vulnerabilities of sex workers to HIV and STIs, is dominated by a focus on the individual, with scant attention to the impact that structural factors have on risk factors.<sup>45</sup> More research is needed to provide a better understanding of both behavioural and structural barriers and their impact upon sex workers access to HIV and STI prevention and treatment services.

The diversity within the sex worker community is rarely represented within research and data collection. Male sex workers and transgender sex workers often get defined in data collection as ‘men who have sex with men (MSM)’ and their experiences and needs as sex workers forgotten. Migrant sex workers face similar issues as they are often defined as victims of human trafficking, and their experiences denied and their needs invisibilised.<sup>46 47</sup>

Sex work research should be developed and implemented with the meaningful involvement of sex workers and sex worker-led organisations to ensure community ownership and encourage the translation of these findings into appropriate, impactful service delivery.<sup>48</sup>

43 Kathleen N. Deering, et al., “A systematic review of the correlates of violence against sex workers” *American journal of public health* 104, (2014): e42–e54.

44 Sharon Weir et al., “Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men who have Sex with Men, and Transgender People” *MEASURE Evaluation*, (2012)

45 Shannon et al., “Global Epidemiology of HIV among Female Sex Workers”

46 Laura Agustin, “The disappearing of a migration category: migrants who sell sex” *Journal of ethnic and migration studies* 32, (2006) 29–47.

47 Beyrer et al., “An Action Agenda for HIV and Sex Workers”

48 S. Mikael Jansson et al., “In for the Long Haul: Knowledge Translation Between Academic and Nonprofit Organizations” *Qual Health Res.* (2010)131–143.

## Conclusion and Recommendations

Globally sex workers carry a disproportionate burden of HIV and other STIs. Lack of rights-based testing and treatment policies and lack access to acceptable, sex worker-led testing and treatment services increases the vulnerability of all sex workers. Sex workers must be included at every stage of programme planning, implementation, monitoring and evaluation, to ensure that programmes are effective and respect the needs and rights of sex workers.

The following recommendations are made to policy makers and programmers:

- End mandatory and coercive HIV and STI testing and treatment of all people, including for those who have recently been charged or detained because of involvement in sex work.
- End the practice of using condoms and ARVs as evidence of sex work or HIV status, whilst advocating for the full decriminalisation of sex work, HIV non-disclosure, exposure and transmission.
- All testing and treatment programmes must be confidential and prioritise the needs and well-being of individual sex workers over meeting targets.
- Periodic presumptive treatment (PPT) should only be implemented as an emergency, short-term measure where STI screening is unavailable and while comprehensive sexual health services are being developed. Where implemented PPT must be voluntary, with full and informed consent.
- Syndromic treatment should only be implemented where STI screening is unavailable and while comprehensive sexual health services, including screening, are being developed.
- Pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), and early treatment as prevention (TasP) strategies must be voluntary, and both the benefits and harms, including concerns about effective and appropriate implementation, must be addressed.
- Sex workers living with HIV must have equitable access to effective and affordable antiretroviral therapy, including if they are detained or incarcerated.
- Sex worker-led organisations must be funded in order to ensure that sex workers are included in the planning and implementation of testing and treatment programmes.
- All programmes must have an accessible complaints and grievance process – both formal (confidential) and informal (anonymous).
- Transgender sex workers and male sex workers should not be conflated as ‘men who have sex with men (MSM)’ in data and research about sex workers.
- Sex workers who do not have access to documentation or identification, such as migrant or transgender sex workers, must be able to access testing and treatment.
- Community-led, participatory research is needed to better understand the structural barriers faced by sex workers in accessing health services.

The Global Network of Sex Work Projects uses a methodology that ensures the grassroots voices of sex workers and sex worker-led organisations are heard. The briefing papers document issues faced by sex workers at local, national, and regional levels while identifying global trends.

The NSWP Secretariat manages the production of briefing papers and conducts consultations among its members to document evidence. To do this, NSWP contracts:

- Global Consultants to undertake desk research, coordinate and collate inputs from Regional Consultants and draft the global briefing papers.
- Regional Consultants to coordinate inputs from National Key Informants and draft regional reports, including case studies.
- National Key Informants, identified by the regional networks, to gather information and document case studies.



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Together with almost 100 local and international organisations we have united to reach 1 mission: achieving universal access to HIV/STI prevention, treatment, care and support for key populations, including sex workers, LGBT people and people who use drugs.

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