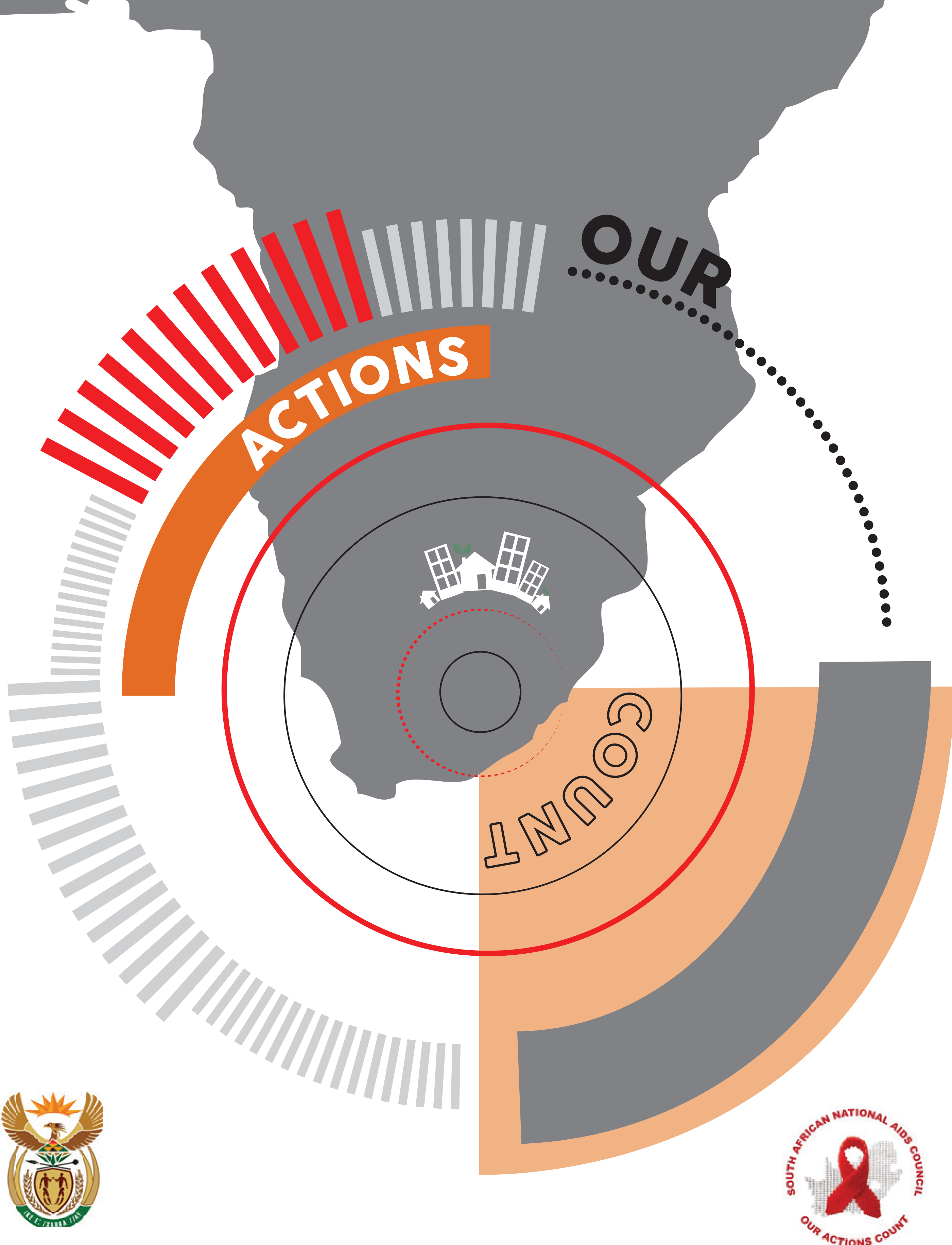


SOUTH AFRICAN NATIONAL AIDS COUNCIL
OUR ACTIONS COUNT

THE SOUTH AFRICAN NATIONAL SEX WORKER HIV PLAN

2016 | 2019

NACOSA
COLLECTIVELY TURNING THE TIDE ON HIV, AIDS AND TB

Sisonke
A movement for sex workers, by sex workers

sweat
Sex Workers Education & Advocacy Taskforce

SONKE GENDER JUSTICE
HIV/AIDS • GENDER EQUALITY • HUMAN RIGHTS

PHRU
IMPROVING LIFE THROUGH RESEARCH

RHI
WITS REPRODUCTIVE HEALTH & HIV INSTITUTE

IOM • OIM

UNFPA

ILO
International Labour Office

TB/HIV CARE ASSOCIATION
PROJECT INTEGRATE

fhi360
THE SCIENCE OF IMPROVING LIVES

WOMEN'S LEGAL CENTRE

SOUTH AFRICANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS
PEPFAR

UNAIDS

Table of Contents

Foreword	6
Preface	7
Executive Summary	8
Abbreviations and Acronyms	10
Glossary and Definitions	11
Section A:	
Strategic Approach to HIV Programming with Sex Workers	13
1 Introduction	13
1.1 Sex worker HIV programming in South Africa	14
1.2 Development of the plan	14
1.3 Goals, objectives and targets	14
1.4 Principles	15
2 Programme approach	16
2.1 Using a combination prevention approach	16
2.2 Using a peer educator-led approach	16
2.3 Theory of change	17
2.4 Determinants of HIV for sex workers	18
2.5 Target populations	19
Section B:	
Implementation Guide	20
1 Combination prevention interventions	20
Peer education package	20
Health care package	24
Psychosocial service package	29
Human rights package	33
Social capital building package	35
Economic empowerment package	37
2 Models of service delivery	39
3 Monitoring, Evaluation, Research, and Innovation	39
3.1 Indicators	39
3.2 Data sources and flow	43
3.3 Data use	43
3.4 Implementation considerations	43
4 Planning, coordination and management	43
4.1 Sustainability	45
5 Human and financial requirements	45
5.1 Costing and financing plan	45
6 References	46

Table of Figures

Figure 1: HIV prevalence among female sex workers	13
Figure 2: Theory of change	18
Figure 3: Provincial distribution of sex workers in South Africa	19
Figure 4: Distribution across rural and urban areas	19

The South African National Sex Worker HIV Plan, 2016-2019

Information in this document may be copied and distributed freely. It is requested that the document be referenced appropriately when used, and that the source is acknowledged.

Suggested citation: SANAC. The South African National Sex Worker HIV Plan, 2016-2019. Pretoria, South Africa: 2016.
Comments on this document can be emailed to kerry@sanac.org.za

The authors and publisher have made every effort to obtain permission for and to acknowledge and reference the use of copyright and academic material throughout this document. This work represents contributed material from various stakeholders, expert contributors, and community organisations. Should any infringement of copyright or referencing error have occurred, please contact the editor, and every effort will be made to rectify omissions or errors in the event of a reprint or new editions

Foreword

Sex workers have not received the same attention as the general population in our country response to HIV, tuberculosis (TB) and Sexually Transmitted Infections (STIs). A number of recent studies have shown that the sex worker community is at a substantially elevated risk of HIV and that prevalence rates in this community are among the highest in the world. It has also come to my attention through the SANAC Sex Worker Sector that there are many

> "The core package has been designed to encompass the multi-faceted lives of sex workers and it calls for the national coordination of a range of diverse responses to the social and structural barriers that confront sex workers on a daily basis.

human rights violations that limit the access of sex workers to much needed HIV care and prevention interventions, including condoms, psycho-social support and legal assistance. Prevalence research conducted in 2013 and 2014 shows that HIV prevalence among sex workers is 3 to 5 times higher than in the adult female population. Urgent steps are needed.

The launch and implementation of this, the South African National Sex Worker HIV Plan, shows that we are serious about combatting new infections in this population. The plan provides for a standardised minimum package of services to be implemented by all sectors, both within and outside of government. The core package has been designed to encompass the multi-faceted lives of sex workers and it calls for the national coordination of a range of diverse responses to the social and structural barriers that confront sex workers on a daily basis. In line with the evidence available, the plan is based on a peer-led approach which is key to reducing high-risk sexual practices among sex workers and their clients.

This Plan includes the provision of Pre-Exposure Prophylaxis (PrEP). PrEP affords sex workers a greater chance to stay negative. Now that the World Health Organization (WHO) has recommended the use of PrEP in populations with high incidence, and the Medicines Control Council has registed Truvada for this purpose, I am pleased to endorse the recommendation in this Plan to provide PrEP to sex workers.

The Plan also endorses the provision of Universal Test and Treat (UTT) for sex workers. This too has received the blessing of the National Department of Health, as part of our commitment to the UNAIDS-led campaign to reach the targets of '90-90-90' by 2020, and in line with World Health Organization (WHO) treatment guidelines. Both the provision of PrEP and UTT for sex workers have been approved by the SANAC Plenary in November 2015 where it was endorsed by government and civil society.

Dr PA Motsoaledi, MP
Minister of Health

Preface

The production of the National Sex Worker HIV Plan is a result of the work of many organisations and individuals over many years. It would not have been possible without the dedication of sex worker advocacy groups and the bravery of sex workers themselves.

This Plan has been the work of a wide range of government departments, NGOs, research organisations, the SANAC Sex Worker Sector and the SANAC Secretariat who worked together to establish consensus on all aspects of the Plan. All members of the Technical Working Group made a substantial contribution of time and effort. The Steering Committee consisting of Kholi Buthelezi (Sisonke), Thuli Khoza (SANAC Sex Worker Sector), Sally Shackleton (SWEAT), Connie Kganakga, Kerry Mangold, Lebowa Malaka (all SANAC Secretariat) must be acknowledged for their special efforts to keep the process on track when differences emerged in the TWG.

Nevilene Slingers and her team (SANAC Secretariat) and Marieta de Vos and her team (NACOSA) ensured that the Global Fund investments were secured. This will enable the core of the programme to scale up rapidly.

Special thanks go to Nosipho Vidima (SWEAT/Sisonke) who very ably co-chaired the TWG. The involvement of sex workers in every step of the development of this Plan is a testament to the Sisonke motto, 'Nothing about us, without us.'

Special thanks also go to the Minister of Health, Dr Aaron Motsoaledi and Dr Yogan Pillay, Deputy Director-General in the National Department of Health, for their leadership, guidance and encouragement during the development and launch of this Plan.

Dr Fareed Abdullah
Chairperson of the Technical Working Group
Chief Executive Officer
South African National AIDS Council

Executive Summary

Sex workers are self-identified male, female, and transgender adults selling sexual services for money. A 2013 rapid population size estimation study commissioned by SANAC reported that there are approximately 153 000 sex workers in South Africa. These workers are a highly marginalized group with high rates of HIV, TB, and STI incidence and prevalence. Prevalence is as high as 71.8% among female sex workers in Johannesburg – one of the very highest rates in the world. Sex workers face stigma and discrimination at every turn, including in the legal system and also when accessing health and social services. Provision of prevention and treatment interventions for sex workers is a key goal for the country as a whole in order to address the HIV epidemic and related mortality and morbidity.

> “Provision of prevention and treatment interventions for sex workers is a key goal for the country as a whole in order to address the HIV epidemic and related mortality and morbidity.

This document contains a three year plan to address this situation. The Plan aims to reach 70 000 sex workers over the next three years using a peer educator led approach. This will be achieved by recruiting 1 000 peer educators over the same period, in order to address the multiple drivers of HIV and opportunistic infections. Drivers include violence, including sexual violence and rape; lack of empowerment to negotiate condom use; legal barriers to accessing health and social services; stigma and discrimination; poverty and inequality; and the fragmentation of sex worker programmes.

This Plan sets out targets to ensure that at least 95% of sex workers use condoms with their clients and partners, that gender-based violence falls by 50%, and that the global targets of 90-90-90 are met for sex workers. The latter implies that 90% of sex workers know their HIV status, 90% of those testing positive are on antiretroviral treatment, and 90% of sex workers on ARVs are virally suppressed. These are ambitious targets, yet achievable with strong political and financial commitment, such as that already provided by the National Department of Health's High Transmission Area (HTA) Programme, the Global Fund and PEPFAR. There has been strong commitment already to scale up HIV-related sex worker services in South Africa since 2010 and this Plan builds upon existing projects.

The Plan in this document is based upon six core packages of interventions, in turn based on WHO's 2014 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations which was adapted to the South African context. As part of these interventions, sex workers will be among the first in South Africa to receive Pre-Exposure Prophylaxis (PrEP) and Universal Test and Treat (UTT) services – the latest that HIV science has to offer to reduce incidence and negative health outcomes for key populations. The six are:

1. Peer education package
2. Health care package
3. Psychosocial service package
4. Human rights package
5. Social capital building package
6. Economic empowerment package

There are three tiers of service delivery outlined in the plan, with areas of high-density sex worker numbers (over 3,000 sex workers per district) requiring dedicated clinics offering sex worker services, and those of low density (less than 3,000 sex workers per district) relying on mobile services delivered at hotspots (such as brothels, hotels and clubs) with support from outreach teams.

The peer groups form the backbone of the planned response, yet fostering an enabling environment is also important, in order to decrease violence, stigma and discrimination. An enabling environment is one where various role-players, such as health and social workers, law enforcement officials, legal representatives and community members, help to improve sex workers' wellbeing. This includes moving towards legal reform in order to minimise the dangers involved where sex work goes unmonitored and unregulated.

In addition, this Plan requires coordination between various sectors of government, NGOs and donors. The SANAC Secretariat will play a coordination, resource mobilisation and advocacy role for this Plan, while government departments and NGOs will be responsible for implementation. Monitoring and Evaluation (M&E) will be done in real time, allowing inputs by peer educators as well as programme implementers. The Technical Working Group will play the role of providing ongoing technical guidance for the Plan, while sex worker organisations including Sisonke will be strengthened.

Section A of this document is primarily for policymakers, presenting the background to the Plan, including an introduction to the evidence, history and legal framework of sex work in South Africa, and the theoretical basis and principles of the formulation of the approach and the theory of change. Section B is for implementers of the plan, with practical guidance on the various packages and interventions, information on M&E, details of programme coordination, and a series of tables that summarise activities, special considerations, and responsibilities for all those involved in implementation.

Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Anti-retroviral
CI	Confidence Interval
CSO	Civil Society Organisation
CTOP	Choice of Termination of Pregnancy
DBE	Department of Basic Education
DSD	Department of Social Development
DOE	Department of Education
DOH	Department of Health
DOJ&CD	Department of Justice and Constitutional Development
EPWP	Expanded Public Works Programme
FSW	Female Sex Worker
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HTA	High Transmission Area
HTS	HIV Testing Services
IBBS	Integrated Biological and Behavioural Survey
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MMC	Medical Male Circumcision
NPA	National Prosecuting Authority
NSP	National Strategic Plan on HIV, STIs and TB, 2012-2016
PEP	Post-exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPT	Periodic Presumptive Treatment
PrEP	Pre-Exposure Prophylaxis
PSS	Psychosocial Support
RTM	Real Time Monitoring
SAHMS	South Africa Health Monitoring Survey
SANAC	South African National AIDS Council
SAPS	South African Police Service
SASSA	South African Social Security Agency
SBCC	Social and Behaviour Change Communication
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
TASP	Treatment as Prevention
TB	Tuberculosis
TCC	Thuthuzela Care Centre
TOP	Termination of Pregnancy
UCSF	University of California, San Francisco
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization

Glossary and Definitions

Collective identity refers to the shared sense of belonging to a group or social support network.

Combination HIV prevention is an approach that seeks to achieve maximum impact on preventing new HIV infections by combining biomedical, socio-behavioural and structural interventions that are human-rights based and evidence informed, in the context of a well-researched and understood local epidemic.

Gender-based violence refers to violence that is directed against a person on the basis of gender. It constitutes a breach of the fundamental rights to life, liberty, security, dignity, equality between men and women, non-discrimination, and physical and mental integrity.

HIV prevention refers to interventions and strategies designed to prevent the spread of HIV in South Africa. These are carried out at health facilities, in communities, and by individuals and groups.

Key populations are populations that are at a higher risk of HIV exposure or onward transmission. These include men who have sex with men, injecting drug users, sex workers and prisoners.

Men who have sex with men refers to males who have sex with males regardless of whether they have sex with women or have a personal or social gay or bisexual identity. This concept is inclusive of men who self-identify as heterosexual but have sex with other men.

Post-Exposure Prophylaxis refers to antiretroviral medicines that are taken after exposure or possible exposure to HIV. The exposure may be occupational, as in a needle-stick injury, or non-occupational, as in unprotected sex with a person living with the virus.

Prevention of Mother-To-Child Transmission refers to the four-pronged strategy to prevent new HIV infections in infants and keep mothers alive and families healthy. The four prongs are: halving HIV incidence in women; reducing the unmet need for family planning; providing antiretroviral prophylaxis to prevent HIV transmission during pregnancy, labour, delivery, and breastfeeding; and providing care, treatment, and support to mothers and their families.

Pre-Exposure Prophylaxis refers to antiretroviral medicines that are prescribed before exposure or possible exposure to HIV as a preventative measure.

Real-time monitoring refers to a programmatic data collection system that allows information to be viewed immediately after collection in an easily understood format that people can use in day-to-day decision making.

Sex worker refers to a consenting adult (18 years or older) male, female or transgendered person who works in different settings with the primary intention of exchanging money for sex. Sex workers in this programme include self-identified adult male, female and transgender sex workers who work in different settings.

Sex worker refers to a consenting adult (18 years or older) male, female or transgendered person who works in different settings with the primary intention of exchanging money for sex. Sex workers in this programme include self-identified adult male, female and transgender sex workers who work in different settings.

Sexual and reproductive health services refer to services for family planning, infertility services, prevention of unsafe abortion and post-abortion care, diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer and other gynecological morbidities, and the promotion of sexual health, including sexuality counselling.

Sexually Transmitted Infection refers to infections that are spread by the transfer of organisms from person to person during sexual contact. These include HIV, chlamydia trachomatis, and the human papillomavirus, which can cause cervical, penile, or anal cancer, genital herpes, cancroid, syphilis, and gonorrhea.

Social capital refers to the networks, norms, and social trust that facilitate cooperation for mutual benefit.

Transgender refers to a person with a gender identity that is different from his or her sex at birth; they may be male to female or female to male. They may also prefer not to conform to any gender binary, or to rather use gender-neutral references.

Section A:

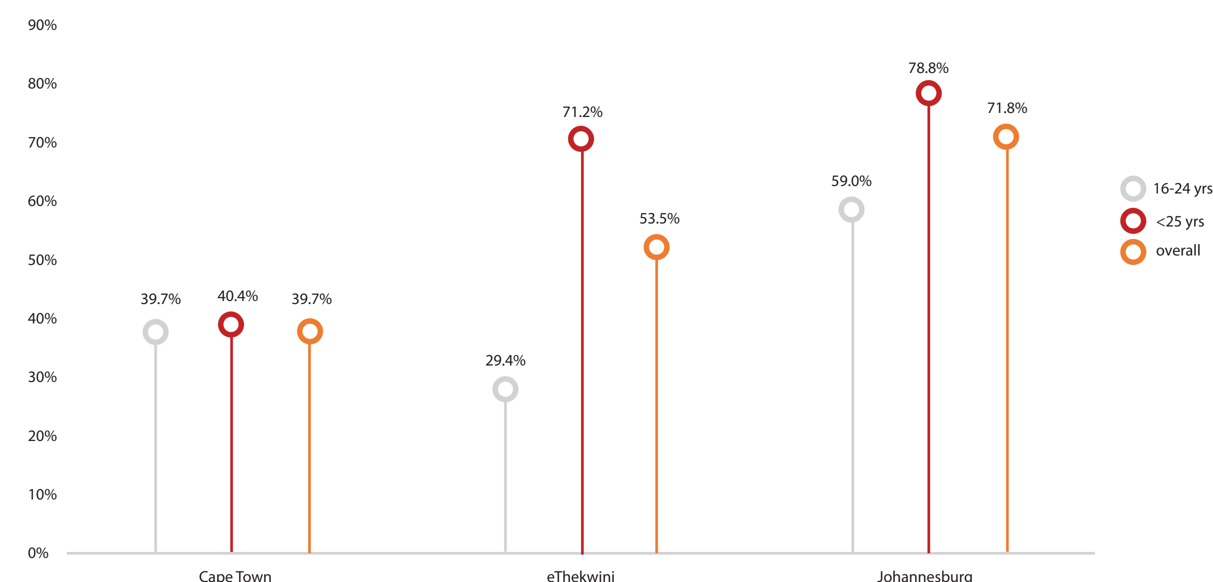
Strategic Approach to HIV Programming with Sex Workers

1 Introduction

Globally, HIV prevalence among sex workers and their clients is 10–20 times higher than among the general population[5]. Studies in South Africa suggest that the prevalence rate among female sex workers ranges from 40% to 88%, significantly higher than the 14.4% (95% CI 13.3–15.6) prevalence among adult women in the general population[4,6,7]. Modelled estimates of HIV incidence in female sex workers and their clients accounted for approximately 6% (IQR 5% - 8%) of heterosexual transmission in South Africa[8].

Earlier estimates of HIV prevalence from 2008 among female sex workers in South Africa were 59.8%[10]. More recent work undertaken by University of California, San Francisco (UCSF) show wide variations between the large cities of Cape Town, Durban and Johannesburg. The 'Integrated Biological and Behavioural Survey'[4] from 2014 estimated the prevalence of HIV among female sex workers at 71.8% in Johannesburg; 39.7% in Cape Town, and 53.5% in eThekweni (Figure 1). The same report observed marked differences in HIV prevalence among female sex workers 25 years and older compared to the 16-24 age group, confirming the urgency of focused intervention for sex workers from an early age. This data confirms that female sex workers carry an enormous burden of HIV disease.

Figure 1: HIV prevalence among female sex workers



The vast majority of sex workers have tested for HIV and more than three-quarters of HIV-positive female sex workers are aware of their status. Prevalence of syphilis among female sex workers in Johannesburg and Cape Town is among the highest measured in the southern African region. In addition, sex workers continue to experience intense stigma and discrimination, violence (including sexual assault) with little recourse to justice, legal barriers and constraints to accessing services[4].

1.1 Sex worker HIV programming in South Africa

Sex workers have generally been overlooked and underserved by health and social services in South Africa. From 2010 onwards, efforts have focused on scaling up health services for sex workers. More recently, there has been a substantial increase in the provision of programmes for sex workers. Programmes funded by the Global Fund, PEPFAR and the government reach as many as 35 000 to 40 000 sex workers. These programmes often overlap and report on different aspects of the sex worker services being delivered. Implemented interventions have resulted in best practices showing us how to (a) make the sex work context safer; (b) provide care and support services to sex workers, their clients, non-commercial sex partners, and children; and (c) empower sex workers to improve their own wellbeing and social capital. Different programmes focus on different aspects of the needs of sex workers. The aim of this Plan is to ensure that a minimum package of services including HIV prevention, treatment, psycho-social support, legal support and economic empowerment is made available to all sex workers. While services are available in some areas, there is limited national reach and retention on treatment is often a challenge, given that sex work is criminalised and sex workers are a highly mobile population.

1.2 Development of the plan

The National Strategic Plan on HIV, STIs and TB 2012 – 2016 (NSP) notes that sex workers need a comprehensive and nationally coordinated response. This should include HIV care, treatment, and prevention services that address exacerbating factors such as alcohol and substance use, as well as access to justice and legal protection to address violence and harassment of sex workers.

For these reasons, a coordinated national sex worker HIV prevention, care and treatment plan, which includes service delivery models that meet the needs of different contexts, and outlines a core package of services has been developed in this South African National Sex Worker HIV Plan (2016-2019).

1.3 Goals, objectives and targets

The goal of the South African National Sex Worker HIV Plan is to achieve a long and healthy life for all sex workers, their clients, non-commercial sex partners and children.
The aims of the South African National Sex Worker HIV Plan are to:

1. Reduce HIV, STI and TB incidence among sex workers;
2. Reduce HIV, STI and TB-related mortality among sex workers; and
3. Reduce human rights violations experienced by sex workers.

The objectives of the South African National Sex Worker HIV Plan are as follows:

1. To reduce the risk of HIV in sex workers and clients of sex workers through the consistent use of condoms, the reduction of risk behaviours and the creation of an environment for sex work that is safe for sex workers and clients;
2. To provide services to sex workers through a peer educator led programme, which includes the supply and distribution of condoms and lubricant, information and education and risk reduction interventions in creative spaces or drop-in centers throughout the country;
3. To provide health care services to sex workers (e.g. Sexually Transmitted Infection (STI) screening, diagnosis and treatment, HIV testing, early antiretroviral treatment, Pre-Exposure Prophylaxis (PrEP), Post-Exposure Prophylaxis (PEP), pregnancy testing, contraception, and termination of pregnancy services as per the national guidelines;
4. To provide psychosocial services for sex workers (e.g., places of safety, psychological and social support, harm reduction, alcohol, drugs and addiction services, social security services, social work services, stigma reduction programmes);
5. To ensure the development and implementation of effective mechanisms to deal with human rights abuses and violence from non-commercial sex partners, clients, police and health care providers, sensitisation of police and prosecuting authorities and legal and paralegal support;
6. To offer programmes for skills development and income generation for sex workers to address the social and economic factors that pressure many women into sex work;
7. To foster an enabling social, economic, legal and health system, and to remove the structural drivers of HIV to ensure that sex workers, their clients, non-commercial sex partners and children realise optimal health and wellbeing and to advocate for law reform; and
8. To support the strengthening of representative sex worker organisations such as Sisonke – the national sex workers movement.

The targets of the Plan are:

1. To reach 70 000 sex workers with a core package of services;
2. To recruit 1 000 peer educators;
3. To ensure that 95% of sex workers use condoms with their clients;
4. To provide PrEP for 3 000 sex workers (this target will be reviewed once the uptake is assessed in the first year);
5. To ensure that 90% of sex workers reached are tested for HIV and know their status;
6. To ensure that 90% of sex workers who test positive are on ART;
7. To ensure that 90% of sex workers on ART are virally suppressed;
8. To reduce instances of violence against sex workers by 50%.

More detail on these targets as well as other indicators for this Plan are included in Table 7 in Section B.

1.4 Principles

Several principles underpin the NSP, and provincial and sectoral implementation plans. These should also be applied equally to the South African National Sex Worker HIV Plan. Key principles are as follows:

- **Rights-based –** Strategies must be rooted firmly in the protection and promotion of human and legal rights, including prioritising gender equality and gender rights.
- **Evidence-based –** Initiatives should be based upon evidence and implementation should focus on the achievement of well-formulated objectives and targets.
- **Multi-sectoral –** All implementers should leverage the comparative advantage of various sectors and forging strategic partnerships for synergy.
- **Leadership and accountability –** True engagement at all levels can only be achieved through advocacy, ownership, empowerment, communication, and coordination.

2 Programme approach

2.1 Using a combination prevention approach

Evidence from the literature indicates that effective HIV prevention, care and treatment packages for sex workers, their clients, non-commercial sex partners, and children should include combinations of biomedical, behavioural and social, and structural interventions tailored to local contexts. The approach should be led and implemented by sex worker peers with the support of health, social, legal and human rights, social capital and economic empowerment services[8]. The Plan in this document outlines a combination of HIV prevention, care and treatment packages which are rights-based, evidence-informed, and community-owned, to reduce HIV and STI transmission among sex workers in South Africa.

2.2 Using a peer educator-led approach

A peer educator led approach, similar to that used in the Avahan programme in India, is adopted here due to the difficulty in accessing sex workers. The approach utilises peer educators to identify high-risk individuals among their social network. Peer educators provide psychosocial support and information that help improve their ability to reduce high risk behaviour. Interventions such as condom negotiation skills, regular STI screenings, and participation in self-help programmes, are used[19,20].

Peer educators are the backbone upon which service provision is implemented and facilitated, and through whom the community is enabled to access services. A strong collaboration between all service providers ensures they are effectively enabled to support a peer educator-led model, accommodate the mobility of the population, and can meet the aims and objectives set out by the Plan. A peer-educator led model includes the opinions of sex workers, allows organisations to access sex workers effectively, and facilitates health seeking and safer sexual behaviours. Improved agency and mobilisation among sex workers and sensitisation of health and social workers facilitates better access to health and social services. The South African National Sex Worker HIV Plan promotes the values of equality, dignity and non-discrimination for sex workers in addressing social and structural barriers to health care and human rights protection and services[21].

"Peer educators are the backbone upon which service provision is implemented and facilitated, and through whom the community is enabled to access services. A strong collaboration between all service providers ensures they are effectively enabled to support a peer educator-led model, accommodate the mobility of the population, and can meet the aims and objectives set out by the Plan.

Guiding principles for a peer educator-led approach

1. ***Peer educators must be current or former sex workers***
   This ensures that the context and complexities of the sex work industry are understood, and community social networks can be accessed.

2. ***Peer educators should be representative of the local sex worker population***
   This is in respect to gender, ethnicity, nationality, age, setting, and language.

3. ***There should be adequate training and development opportunities for peer educators***
   Peer educators should be provided with guidance, support, training, development, and promotion opportunities for career pathing.

4. ***Peer educators should decide for themselves to remain or exit the sex work industry***
   Peer educators should be given the freedom to remain in or leave the sex work industry without prejudice.

5. ***There should be an adequate ratio of peer educators to sex workers and supervisors***
   The Global Fund's sex worker programme in South Africa has demonstrated that a ratio of 1 peer educator: 60 sex workers is effective.

Adapted from SWEAT's guidelines[1]

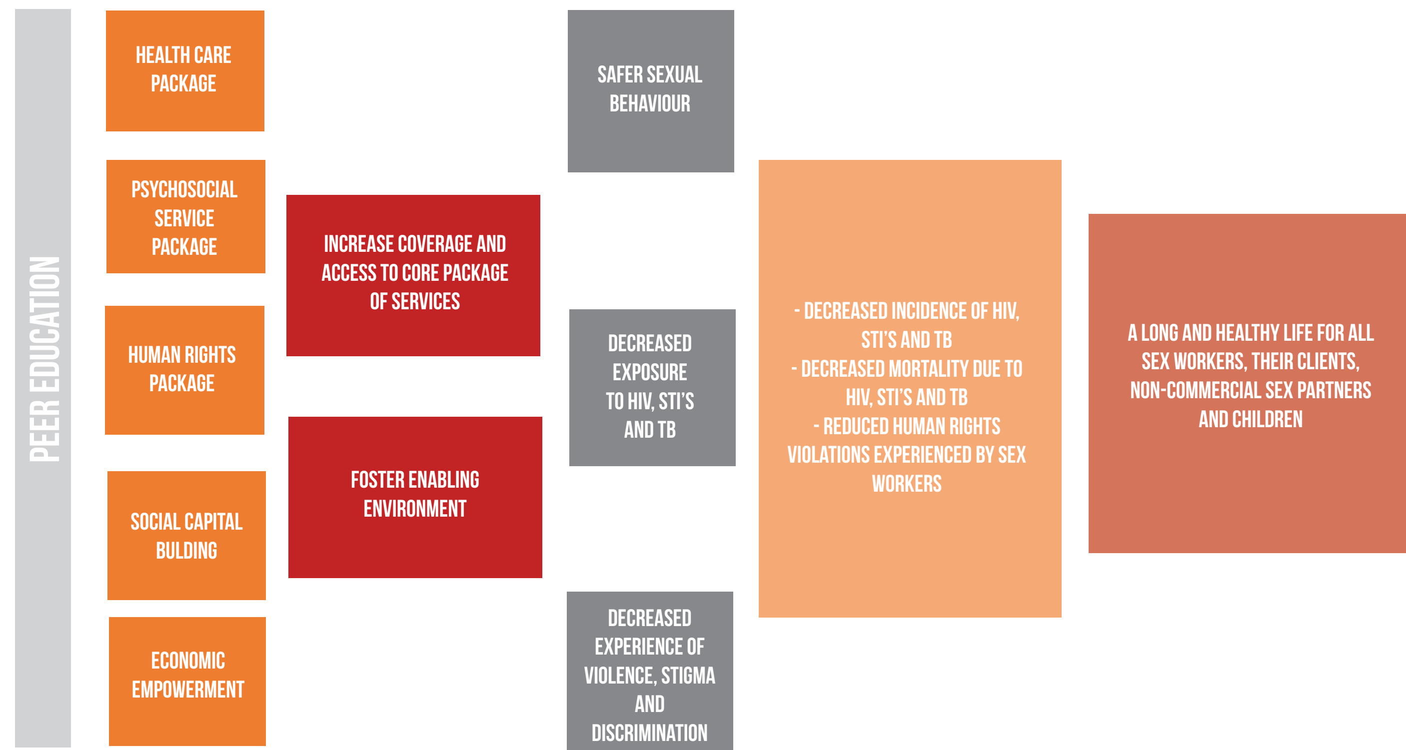
2.3 Theory of change

Figure 2 shows that peer educators are the foundation of the South African National Sex Worker HIV Plan. Peer educators are responsible for supporting and facilitating the delivery of a comprehensive packages of services.

Improved programme coverage and greater access to commodities and services, such as condoms and lubricants, and substance use interventions, decrease sex worker exposure to HIV, STIs and TB by encouraging safer sexual behaviour.

The idea behind these interventions is to foster an enabling environment. An enabling environment is one where various role-players, such as health and social workers, law enforcement officials, legal representatives and community members, help to improve sex workers' wellbeing. An enabling environment results in decreased violence and a reduction in stigma and discrimination. Additionally, it allows sex workers to protect themselves, their clients, non-commercial sex partners and children from HIV infections and facilitates their access to care and treatment, to reduce HIV incidence and HIV-related mortality.

Figure 2: Theory of change



2.4 Determinants of HIV for sex workers

Sex workers in South Africa are vulnerable to a range of factors that predispose them to HIV and STIs. These include biomedical, behavioural and social and structural factors. From a biomedical perspective, sex workers have a large number of sex partners and engage in frequent sex. The high prevalence of untreated STIs in sex workers also increases their risk of HIV acquisition.

Social context and risky behaviour contribute considerably to the vulnerability of sex workers. Unequal power relations between sex workers and their clients and non-paying sex partners impact on safer sex practices. For example, inconsistent condom use is exacerbated by the imbalance of power between sex workers and clients, negatively affecting sex workers' ability to insist on consistent condom use. Other behavioural practices influencing HIV risk include damaging vaginal practices such as douching, and low uptake of and adherence to anti-retroviral treatment (ART). In addition, many sex workers use alcohol and substances and are exposed to high levels of violence.

Social and structural factors intensifying sex workers' vulnerability to HIV infection include criminalisation of sex work, sex worker mobility, and low education levels. Social marginalisation of sex workers and the prejudice and discrimination that they are subjected to contribute to poor health outcomes. Despite a recent scale up in programmes for sex workers, coverage of sex worker-focused HIV and health services, and access to female condoms and lubrication, are limited.

The Sexual Offences Act criminalises sex work in South Africa[13]. Several studies worldwide have documented the detrimental effect of applying criminal law to the sex industry. Evidence shows that criminalisation drives sex workers underground and away from health, legal and other supportive services[14]. Criminalisation increases stigma and creates obstacles to accessing programmes[15] and reduces sex worker power, rendering them vulnerable to violence, human rights violations[11] and corruption[16].

2.5 Target populations

A 2013 rapid population size estimation study commissioned by SANAC reported that there are approximately 153 000 sex workers in South Africa. Female sex workers (FSWs) comprised the majority (138 000), followed by male (7 000) and transgender sex workers (6 000)[2,3]. The South Africa Health Monitoring Survey (SAHMS) included a size estimation of female sex workers in three cities in South Africa. The study reported 7 697 female sex workers in Johannesburg, 6 500 in Cape Town and 9 323 in Durban[4].

The 2013 SANAC study indicated that the number of sex workers varied by province (Figure 3), with the highest concentration of sex workers in Gauteng (22%), KwaZulu-Natal (16%) and the Western Cape (11%)[2]. Large urban cities attracted larger numbers of sex workers (51%), while only 12% were located in rural areas[2] (Figure 4). Sex workers often work in hotspots around mines, military zones, harbours, and along transport routes.

Figure 3: Provincial distribution of sex workers in South Africa

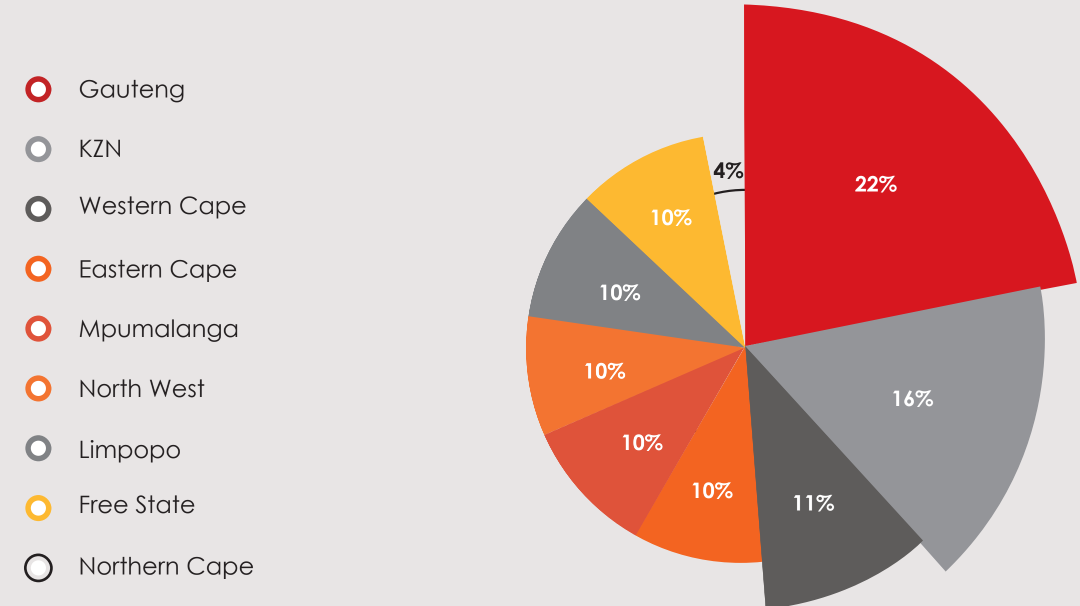


Figure 4: Distribution across rural and urban areas

Sex workers operating in some settings may be at particularly high risk of infection. For example, sex workers located at truck stops along national highways may be significantly more vulnerable than those working in brothels[64]. Globally, transgender and male sex workers are at high risk of contracting HIV[9,10]. However, there is limited data on HIV prevalence and risk behaviours among transgender and male sex workers populations in the African region[11]. The current Plan includes female, male and transgender sex workers that deliver indoor (brothels, hotels, clubs) or outdoor (street-based, truck-based) services.

Section B:

Implementation Guide

1 Combination prevention interventions

The South African National Sex Worker HIV Plan recommends 6 packages of interventions, based on WHO's 2014 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations[22] and adapted to the South African context. As noted earlier, strong peer education is the backbone of the approach recommended here. The approach also takes into account new developments such as PrEP and early treatment.

This following guide centers around six core packages of service:

1. Peer education package
2. Health care package
3. Psychosocial service package
4. Human rights package
5. Social capital building package
6. Economic empowerment package

Peer education package

Peer education forms the backbone of the Plan. The peer education package comprises seven different components discussed below.

1.1 Condoms and lubricants

Peer educators will assist with distribution of male and female condoms and lubricants to sex workers. It is also important that the distribution of condoms and lubricant are accompanied by information and condom and lubricant use demonstrations, and that sex workers are taught condom negotiation skills to enable them to negotiate condom use with their clients as well as their non-commercial sexual partners.

1.2 Social and behaviour change communication

Social and behaviour change communication (SBCC) encompasses a broad range of activities and approaches which focus on the individual, community, and environmental influences on behaviour and social change. Communication comprises "the art and practice of informing, influencing, and motivating individuals, communities, institutional and public audiences about important health and development issues"[23].

Peer educators will be responsible for relaying HIV, STI and TB prevention, care and treatment messages to sex workers and their clients and promoting health seeking behaviours to sex workers. Messaging will include consistent condom use as part of dual protection against HIV acquisition and unwanted pregnancy, PrEP, as well as adherence to treatment for HIV, STIs and TB. Peer educators will utilise different approaches to do so including one-on-one communication, risk reduction interventions and small group interventions. In addition, they will distribute information, education and communication (IEC) materials.

1.3 HIV testing services (HTS)

HTS is an entry point into treatment and care programmes, positive living and promotion of HIV prevention. Specially trained peer educators can conduct rapid HIV testing to sex workers, their non-commercial sex partners and potentially their clients. They would be responsible for educating sex workers about HIV, STIs and TB and referring them to clinical services where needed. Confidentiality and consent must be maintained and carefully considered in this context.

1.4 Linkage to care (peer navigation)

Peer educators will help sex workers access health services to increase uptake of PrEP and treatment for HIV, STIs and TB. Peer educators will be trained in adherence support to assist sex workers to adhere to their medication, whether this is for HIV, STIs or TB. This will allow them to facilitate and monitor linkage to care, do home visits and be able to refer sex workers to adherence clubs, and support in establishing these support mechanisms as well.

In addition, peer educators will provide referral to other services such as gender-based violence and substance use. Peer educators will link sex workers to legal services, safe houses and assist them in accessing social grants where appropriate.

1.5 Social mobilisation

Peer educators will mobilise sex workers through a variety of methods. One way to do this is to promote collective identity. Collective identity mobilisation is described as the formation of boundaries differentiating movement actors from outsiders; the establishment of consciousness that infuses meaning into group identification; and the negotiation of identity where it is made visible and politicised to the outside world[24].

This collective identity can find concrete expression in the formation of sex worker collectives such as Sisonke in South Africa. Sex worker collectives are an important mechanism for sex workers to develop solutions to the issues they face as a group, and to advocate for their rights as sex workers as well as their human rights[21]. Social mobilisation is discussed further in package 5: Social capital building.

1.6 Psychosocial support

Peer educators will support the implementation of the psychosocial service package. This includes supporting and counselling sex workers experiencing stigma and discrimination, those experiencing violence and those using substances, as well as referring them to professional services where required. Psychosocial support is discussed in further detail in the package 3: psychosocial service package.

1.7 Human rights support and access to justice

Peer educators will promote rights and justice literacy among their peers and facilitate access to legal services where necessary. Peer educators who are trained as paralegals will support other sex workers with legal issues, promote human rights and access to justice. Peer educators will also provide legal support to sex workers reporting sexual violence and other forms of abuse. In addition, peer educators are responsible for providing legal literacy services. This is discussed in further detail in package 4: Human rights package.

See Table 1 for more details on specific activities, implementation considerations and responsibilities.

TABLE 1: PEER EDUCATION: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partners
1.1 Condoms and lubricants	1.1.1Peer educators to distribute male and female condoms and lubricants through outreach, at safe spaces, sex work locations and in risk reduction workshops	• Availability of male and female condoms and lubricants	Peer Educators
	1.1.2 Peer educators to promote, educate and demonstrate correct and consistent condom use and build skills to negotiate condom use		
1.2 Social and behaviour change communication	1.2.1 Peer educators to distribute IEC material through outreach, at sex work locations, at safe spaces and in risk reduction workshops	• Standard messaging to be provided • Availability of IEC materials • Communication channel dependent on funding • Standardised training in health communication skills and HIV is needed.	Peer Educators
	1.2.2 Peer educators to undertake one-on-one or small group level communication on HIV, broader sexual health, human rights and psychosocial topics		
	1.2.3 Peer educators to conduct risk reduction workshops on HIV, broader sexual health, human rights and psychosocial topics		
	1.2.4 Peer educators to conduct small group interventions on HIV, broader sexual health, human rights and psychosocial topics		
1.3 HIV testing services	1.3.1 Peer educators to promote HTS, STI and TB screening and regular pap smears	• Peer educators must have good knowledge of available health services to refer peers to	Peer Educators
	1.3.2 Trained peer educators to conduct HTS with sex workers	• Standardised training especially in counselling skills needed	
		• HTS should not overshadow other peer educator responsibilities	
1.4 Linkage to care	1.4.1 Peer educators to link sex workers to health care services	• Linkage to sex worker sensitised services wherever possible	Peer Educators
		• Follow up should be routinely undertaken to confirm successful client confirmed linkage	
	1.4.2 Peer educators to support adherence to ART, PrEP, Prevention of mother-to-child transmission (PMTCT), STI and TB treatment	•Peer educators should be trained in appropriate adherence support	
	1.4.3 Peer educators to link sex workers to other services such as Thuthuzela Care Centers (TCC), safe houses, substance use, harm reduction, SASSA grants, legal aid centres, DSD and others	• Peer educators need to map local services and build relationships with community-based organisations	

TABLE 1: PEER EDUCATION: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partners
1.5 Social mobilisation	1.5.1 Peer educators to promote collective identity of sex workers	• Sensitivity towards male, female and transgender sex worker identities	Peer Educators
	1.5.2 Peer educators to promote membership of sex worker collective such as Sisonke	•Membership should be voluntary	
1.6 Psychosocial support	1.6.1 Peer educators to support implementation of the psychosocial service package	• Peer educators should be trained in psychosocial support provision and referral	Peer Educators
1.7 Human rights support and access to justice	1.7.1 Peer educators to provide paralegal support	• Specialised peer educators trained as paralegals	Peer Educators
	1.7.2 Peer educators to provide legal literacy services for sex workers, clients, health care providers, social workers and law enforcement officials	• Legal literacy services tailored to each target audience and addressing pre-existing attitudes and beliefs	

Health care package

The health care package comprises the following interventions: prevention; HTS; TB screening; HIV, TB and viral hepatitis treatment and care; and sexual and reproductive health (SRH) services.

2.1 Prevention

Prevention comprises condom use, ARV-related prevention – including PMTCT, PrEP and PEP -- and medical male circumcision (MMC) for male partners and male sex workers.

The impact of consistent condom use on reducing HIV infections is well documented, with a systematic review concluding that self-reported consistent use of condoms results in 80% reduction in HIV incidence[25]. Increasing the availability and use of male and female condoms, together with condom-compatible lubricant, remains a critical component of the health care package for sex workers. However, it is important that innovative distribution channels are used in order to ensure that barriers such as the opening and closing times of clinics, hostile attitudes of providers and law enforcers, lack of lubricants or female condoms, unavailability of services at places where sex workers operate and the cost of condoms in shops[26] are mitigated.

PrEP for HIV negative sex workers is recommended. The detailed guidelines on the method of delivery of PrEP will be issued by the National Department of Health. The provision of PrEP must be delivered in the context of comprehensive combination HIV prevention (including condom use) and accompanied by ongoing adherence support and regular HIV testing.

PEP is currently provided to those sex workers who are eligible, and must continue to be made available at all health facilities. PEP for rape survivors is more easily available than for other reasons (e.g. burst condom). This must be addressed to improve the uptake of PEP.

A number of studies have demonstrated the effectiveness of MMC on reducing the risk of female-to-male HIV transmission[27,28,29]. Male and transgender sex workers, as well as the male sexual partners of female sex workers, must be offered MMC.

2.2 HIV testing services and TB screening

HTS is the essential first step in enabling people to know their status and obtain HIV prevention, treatment and care services. For those who test negative, HTS provides an opportunity to put those at risk for HIV in contact with primary prevention programmes and to encourage retesting[30].

HTS for sex workers must focus on WHO's 5 Cs: consent, confidentiality, counselling, correct results and linkage to care – particularly consent and confidentiality[22]. HIV testing among sex workers should follow nationally validated testing algorithms.

Due to the high HIV prevalence, HIV-negative sex workers should be encouraged to test regularly – at least once every three months. Health care workers will be sensitised to offer sex workers HTS services. In addition, peer educators will provide HTS services during their outreach activities *(see Table 1)*.

2.3 HIV and TB treatment

The SAHMS survey revealed that ART uptake among sex workers who had previously been diagnosed with HIV was low and geographically distinct. ART coverage was reported at 45.3% in Cape Town, 35.9% in Durban and 23.4% in Johannesburg. Sex workers and other key populations often test late and there is a frequent failure in the linkages from HTS to care and assessment for ART[33]. Thus, many sex workers start treatment when already significantly immunocompromised. Recent evidence has demonstrated the efficacy of starting treatment early[34]. Early initiation of treatment for all sex workers testing HIV positive and regardless of CD4 count, is included in the health care package of the South African National Sex Worker HIV Plan. For sex workers on treatment, adherence support and ongoing counselling is critical. Early treatment will increase the coverage for ART in sex workers.

Sex workers will be supported with follow up CD4 testing, viral load testing and ART adherence programmes offered by health care facilities and supported by peer educators to ensure regular monitoring and follow up (see Table 3). Viral suppression is associated with better health outcomes and protects against transmission to partners and babies.

In order for the Prevention of Mother-to-Child Transmission of HIV (PMTCT), all pregnant sex workers should have the same access to PMTCT services and follow the same guidelines as women in the general population[22].

2.4 Prevention and management of TB and viral hepatitis

An essential part of HIV treatment and care is the management of opportunistic infections such as TB and viral hepatitis[22]. Despite being preventable and curable, TB is the leading cause of HIV-associated mortality[22]. In order to address this, sex workers with TB should be managed in line with national guidelines[35]. HIV is also underdiagnosed in people with TB, so HTS for sex workers with TB and ART for those testing HIV positive, regardless of CD4 count, are important. In additional, non-commercial sex partners and children of sex workers with TB should be screened for TB and placed on treatment if needed.

It is recommended that sex workers who have not been vaccinated against Hepatitis B are tested and immunised.

2.5 Sexual and reproductive health services

In terms of STIs, syndromic management works well for sex workers with symptoms[36] and is based on standardised national algorithms. Periodic Presumptive Treatment (PPT) of STIs for sex workers involves giving antibiotic treatment for relevant bacterial or parasitic STIs. There is a good rationale for administering PPT in situations where the prevalence of STIs (especially chancroid) is high and sex workers have poor or inadequate access to health services[37].

Sex workers must be offered contraception (including dual protection) as well as access to emergency contraception and Choice of Termination of Pregnancy (CTOP). Pap smears must be made available to female sex workers on an annual basis to promote screening for cervical cancer. Table 2 outlines the service available in the healthcare package, to be provided predominantly by provincial Departments of Health and partners.

"Early initiation of treatment for all sex workers testing HIV positive and regardless of CD4 count, is included in the health care package of the South African National Sex Worker HIV Plan. For sex workers on treatment, adherence support and ongoing counselling is critical. Early treatment will increase the coverage for ART in sex workers.

TABLE 2: HEALTH CARE PACKAGE: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partner
2.1 Comprehensive condom and lubricant programming	2.1.1 Distribute male and female condoms and lubricant through health care facilities, at sex work locations and other innovative secondary distribution sites	• Provide a variety of colours and scents to prevent 'condom fatigue'	DOH; NGOs
2.2 ARV-related prevention - PrEP	2.2.1. Offer PrEP to all sex workers testing HIV negative	• Adherence support to be provided by peer educators (see Table 2), community health workers	DOH; NGOs
2.3 ARV-related prevention - PEP	2.3.1 a Offer PEP to eligible sex workers after possible exposure to HIV	• HIV risk assessment and counselling specific to HIV and PEP is needed	DOH; NGOs
2.4 Medical male circumcision (MMC)	2.4 Offer MMC to male and transgender sex workers and male sex partners of female sex workers	• Peer educators to provide counselling for continued condom use • Peer educators (Table 2) to drive demand creation for MMC	DOH; NGOs
2.5 HCT and TB screening	2.5.1 Encourage routine voluntary HTS in both the community and clinical settings at least 3 monthly for those testing HIV negative 2.5. 2 Undertake targeted HCT with clients and non-commercial sex partners	• Quality of pre-post counselling important • HIV services should be available during non-clinic hours, during outreach, at sex work locations and using a variety of delivery platforms • HIV services should be available in settings where men congregate such as at truck stops, taverns, mining hostels	DOH; NGOs
2.6 Early antiretroviral treatment	2.6.1 Offer early treatment to all sex workers testing HIV positive, irrespective of CD4 count	• Availability of access to (same day) CD4 testing • Adherence support to be provided by peer educators (see Table 2) and sensitised clinical staff • Pre-packaged drugs improve adherence	DOH, NGOs

TABLE 2: HEALTH CARE PACKAGE: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

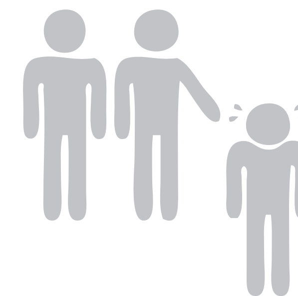
Component	Specific activities	Implementation considerations	Responsible partner
2.7 Prevention of mother-to-child transmission of HIV	2.7 Initiate all pregnant and breastfeeding sex workers living with HIV on ART regardless of CD4 count as per the current NDOH guidelines	• Pregnancy testing at clinic visits • Adherence support to be provided by peer educators (see Table 2)	DOH; NGOs
2.8 Tuberculosis	2.8.1 Manage sex workers with TB in line with national TB management guidelines 2.8.2 Offer routine HIV testing to all sex workers with suspected and diagnosed TB, and TB testing for all with any symptoms 2.8.3 Initiate ART in all sex workers with HIV and active TB disease regardless of CD4 cell count in line with current guidelines 2.8.4 Screen non-paying sexual partners and children of sex workers with TB for TB symptoms	• Adherence support to be provided by peer educators (see Table 2) and clinical staff	DOH
2.9 Viral hepatitis	2.9.1 Immunise eligible sex workers for Hepatitis B (eligibility: not already infected and not immune)	• Requires screening to diagnose exposure	DOH; NGOs
2.10 Sexually transmitted infection prevention, screening and treatment	2.10.1 Manage symptomatic sex workers syndromically in line with national STI management guidelines 2.10.2 Offer PPT for asymptomatic STIs to female sex workers 2.10.3 Offer STI treatment for non-paying sex partners of sex workers diagnosed with an STI	• Many STIs are asymptomatic in females • STI screening should be offered at each visit with a health care worker • If evidence for PTT for male and transgender sex workers becomes available, PTT should also be offered to them. • Sex workers may not want to disclose their STI diagnosis to their non-commercial sex partners	DOH DOH DOH

TABLE 2: HEALTH CARE PACKAGE: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partner
2.11	2.11.1 Offer female sex workers contraceptive options including dual protection 2.11.2 Offer female sex workers emergency contraceptives if needed	• Awareness of availability of family planning services	DOH
2.12 Safe termination of pregnancy and post- termination of pregnancy care	2.12.1 Offer termination of pregnancy to pregnant sex workers with unplanned/unwanted pregnancies	• Safe termination of pregnancy may not always be available at the primary health care level – refer where necessary	DOH
2.13 Pap smear	2.13.1 Offer annual pap smear to sex workers 2.13.2 Refer positive results for appropriate cervical cancer treatment	• HIV positive female sex workers are at heightened risk for developing cervical cancer	DOH

Psychosocial service package

Given the hostile environment in which sex work often takes place, a number of factors, both internal to sex workers, and external in their environments, have an impact on sex workers' psychosocial well-being[38]. Psychosocial support is conventionally offered by psychologists and social workers, but can also include the care and support offered by health care workers, peer educators, family members, lay counselors, friends, neighbours, and other community members[39]. It also includes interventions for family members of sex workers where applicable. The following sub-sections outline important components of psychosocial services to be provided to sex workers:



3.1 Stigma and discrimination

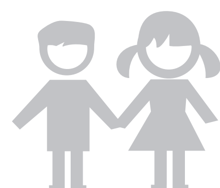
Addressing stigma and discrimination are central components of the psychosocial support package. WHO recommends that governments establish laws to protect against discrimination, violence, and other rights violations to help sex workers realise their human rights and reduce their vulnerability to HIV, STIs and the impact of AIDS[41]. Also helpful is the development of support groups for victims of violence and creation of safe spaces for sex workers to disclose their HIV status. These efforts must be complemented with competency and sensitisation training to health and social workers. Training should also be expanded to law enforcement officials, other service providers, and the community.

3.2 Violence against sex workers

Sex workers experience high levels of physical violence, sexual violence including rape[38] and intimate partner violence[21]. Often, this is a direct manifestation of the criminalised environment and the stigma and discrimination surrounding sex work[42]. Violence increases the likelihood of future risky sexual behaviour such as inconsistent condom use or lack of condom use, increased risk of STI and HIV infection[21], and unwanted pregnancy. Violence and lack of control over one's life means that sex workers may give lower priority to their health needs than to more immediate concerns such as safety and survival[8].

Efforts to eliminate violence towards sex workers must include the review of restrictive criminal laws and the involvement of sensitised law enforcement agencies, the judiciary and health services[5]. At an individual level, educational

strategies can help reduce violence experienced by sex worker by providing safety tips and creating awareness of legal protection options and support to access these[5]. At a local level, norms around violence will be addressed. At a community level, working with the police services will endeavor to reduce police violence and ensure that they take reports of violence from sex workers seriously[5]. An important first step is sex work sensitisation training for police officers and other security personnel.



3.3 Child protection for the sexual exploitation of children

Individuals selling sex who are under the age of 18 are considered by law to be sexually exploited. The physical effects of child prostitution include: HIV infection, vaginal trauma, pain, anger, depression, Post-Traumatic Stress Disorder (PTSD), insomnia and sexual and reproductive health problems. Exploited young children must only be reunited with their families by child protection services when this is in the best interest of the child.

3.4 Counselling support

Psychosocial stress is associated with poor mental health outcomes (e.g., anxiety, depression, substance use etc.)[39]. People with mental health problems have been shown to be at greater risk of HIV infection[39]. Counselling will be offered to sex workers who experience psychosocial stress as part of this package. Linkages to psychological assistance will be provided to sex workers to improve coping skills, self-efficacy and self-esteem.

3.5 Alcohol and drugs

High alcohol consumption is associated with higher HIV prevalence, higher exposure to sexual violence, mental health and increased morbidity and mortality[44]. Alcohol and other drugs are employed in some sex work settings to lower inhibitions and give sex workers the courage to approach clients[45]. Some sex workers develop drug and alcohol dependency and use sex work to support dependency or addiction. In addition to affecting sexual decision-making and judgement, alcohol and drug use can hamper condom negotiation skills and general health. Educating sex workers about the risks of alcohol and substance use as well as providing brief screening, harm reduction counselling and referral to services for those who need it are an important component of the psychosocial support package.

Activities are outlined in the table on the next pages.

TABLE 3: PSYCHOSOCIAL SERVICE PACKAGE: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partner
3.1 Stigma and discrimination	3.1.1 Establish support groups (violence, trauma, parenting, community issues, internal stigma) for sex workers	• Peer educators and sensitised NGO staff to facilitate groups • Support needs to be available after normal working hours	DSD SANAC Secretariat NGOs
	3.1.2 Establish support groups to help sex workers disclose their status to non-paying sex partners.	• Peer educators and sensitised NGO staff can facilitate these groups • Support needs to be available after normal working hours	DSD NGOs
	3.1.3 Provide sensitisation training to reduce stigma and discrimination in health and social services	• This could be expanded and adapted for other service providers	DSD, DOH
3. 2 Violence against sex workers	3.2.1 Ensure timely access to post-sexual assault care, including provision of ongoing counselling for survivors, trauma containment, emergency contraception, PEP for HIV and other STIs and other psychosocial care and support, as well as referrals to police and legal services	• Capacity of social workers • Peer educators to assist with linkage to care for violence (see Table 2)	DSD
	3.2.2 Support and strengthen referral to victim empowerment centers which assist building self-esteem and self-efficacy to empower sex workers to leave abusive relationships	• The choice ultimately lies with the sex worker	DSD
	3.2.3 Create safe spaces for meetings and for those subject to domestic or police violence (safe houses, half way houses) and other violence	• Peer educators to use existing forums for safe spaces	DSD
3.3 Child protection for the sexual exploitation of children	3.3.1 Provide diversion programmes to children engaged in sex work	• Build on existing diversion programmes	DSD
	3.3.2 Provide referrals for educational opportunities to children engaged in sex work	• Building on existing educational opportunities	DSD; DBE

TABLE 3: PSYCHOSOCIAL SERVICE PACKAGE: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partner
	3.3.3 Link with a social worker to provide family reunification programmes for young people sexually exploited, their families and communities	• Requires specialised training • Reunification to only take place if this is in the best interest of the child	DSD
	3.3.4 Provide child protection services for children being sexually exploited	• Build on existing child protection programmes	DSD
3.4 Counselling support	3.4.1 Provide ongoing counselling and referrals through lay counsellors and social workers for sex workers and their children suffering psychosocial stress	• Case-loads of social workers • Train peer educators to conduct lay counselling and trauma containment (see table 1)	DSD
	3.4.2 Improve linkages for psychiatric or serious psychological health concerns	• Number of specialised facilities and staff (capacity)	DSD
	3.4.3 Develop and implement coping skills training	• Availability of training materials	DSD
3.5 Alcohol and drug use	3.5.1 Peer educators and health care workers to provide routine screening for substance use issues	• Training in administering screening tools (questionnaires) • Training on harm reduction counselling principles	NGOs
	3.5.2 Provide evidence-based interventions, including referral to specialist support services	• Linkages between referrals and access to services	DSD

Human rights package

The South African Constitution protects people in South Africa from discrimination and safeguards their basic human rights. However, sex workers remain vulnerable to abuses including violence and exploitation by clients as well as pimps, and secondary victimisation by the police. Sex workers may also face discrimination when accessing services, such as health care, psychosocial services and legal support. The following issues must therefore be addressed.

4.1 Supportive legislation and policies, including law reform

Criminalisation of sex work has been shown to drive sex workers underground and away from services, increasing stigma and creating obstacles to accessing programmes and, to reduce sex workers' power, rendering them vulnerable to violence, risky sexual behaviours, human rights violations, poor condom negotiation[48,49], mental health stresses[50] and corruption[14,51-53]. One study found that decriminalisation of sex work would have the greatest effect on the course of HIV epidemics across all settings, averting 33% to 46% of HIV infections [among female sex workers and their clients] in the next decade[54]. It is therefore important to secure political commitment for the decriminalisation of sex work to achieve public health goals and to safeguard human rights.

This programme will also work with SAPS to eliminate the practice of using possession of condoms, lubricant, ART, or other legal commodities as evidence of sex work and grounds for confiscation or arrest. Police officers often use public by-laws and other regulations to harass sex workers without following required procedures. This creates a hostile and violent environment for sex workers[55]. Studies from Cape Town found that municipal by-laws relating to loitering or creating a public disturbance are often employed to arrest sex workers[56].

4.2 Legal literacy and services

Supportive legislation and policies, including legal reform, may take time to realise. In addition, any changes to legislation or policy will not be effective without supportive activities being run in parallel. Supportive activities within the legal and human rights package will include: legal literacy on the human rights of sex workers; and sensitisation training of service providers and capacity strengthening to better document, report and prosecute perpetrators of abuse or discrimination.

Activities are outlined in the table below.

TABLE 4: HUMAN RIGHTS PACKAGE: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partner
4.1 Supportive legislation and policies, including law reform	4.1.1 Secure a commitment for decriminalisation of sex work which enables access to services	• Sex workers empowered to participate actively in public processes/discussions about law reform	DOJ&CD
	4.1.2 Eliminate the police practice of using possession of condoms, lubricant, ARVs or any other legal commodity as evidence of sex work and grounds for confiscation or arrest	• High level political commitment needed	SAPS
4.2 Legal literacy and services	4.2.1 Develop programmes to provide legal literacy and legal services to sex workers their clients and non-paying sex partners so that they know their rights and applicable laws and can receive support from the justice system when aggrieved	• All organisations offering services to sex workers should be trained to recognise human rights violations and to refer appropriately	NGOs
	4.2.2 Document cases of abuse to map trends, inform service delivery and law reform, and support potential litigation to safeguard sex worker human rights and seek justice	• Local referral mechanisms must be documented and distributed	NPA; DOH; DSD; SAPS; NGOs; SANAC Secretariat
	4.2.3 Sensitise and educate health care providers, social workers and law enforcement officials (including community policing forums and private security) on non-discrimination and sex workers' right to quality and non-coercive care, confidentiality and consent	• Specific sensitisation around HIV status, gender identity, selected occupation and nationality. • Ensure rights and policy violations are responded to in both the health and policing structures and that rights violators are held accountable	NPA; DOH; DSD; SAPS; NGOs
	4.2.4 Provide paralegal services and referrals	• Paralegals should be sex workers or ex-sex workers (see peer education section)	NGOs
	4.2.5 Assign specific officers within each police station to liaise with a sex worker complainant (or organisation providing assistance)	• Liaison officers will need to undergo sensitisation training • Liaison officers will be responsible for ensuring an investigation takes place, that evidence is gathered and liaise with organisations who can potentially provide access to witnesses • This activity will need to be rolled out in a stepwise approach, starting with priority stations	SAPS
	4.2.6 Distribution of an up to date National Sex Worker Friendly Services Directory	• The database will need to be updated on a continual basis. • Online directory with mobi-site	NGOs

Social capital building package

Collective identity mobilisation and community empowerment are effective ways to build the social capital of sex workers. The South African National Sex Worker HIV Plan will provide support to, and facilitate, sex worker-led initiatives to build a collective identity.

5.1 Collective identity mobilisation

5.2 Sex workers who lack collective identity – or a shared sense of belonging to a group or their own social support networks – are more vulnerable to HIV infection[5]. Without a sense of collective identity, competition between sex workers may arise, resulting in increased risk of human rights violations, risky sexual behaviour and abuse. Peer support and community mobilisation can facilitate social cohesion, mutual support, and development of self-help groups and networks between sex worker groups[5].

Community empowerment

Community empowerment as it applies to sex workers is considered "a structural intervention which seeks to address and alter social, political and material conditions surrounding sex work in a given setting"[57]. Research has demonstrated that community empowerment-based HIV prevention is associated with significant improvements across HIV outcomes in sex workers[58,59].

India's Sonagachi project, which employed a number of strategies to restructure sex workers' risk, has been promoted as an example of community interventions that empower sex workers[60]. It has been recognised by UNAIDS as a best practice model for its use of a community development approach to empower sex workers to take individual and collective action to reduce vulnerability to ill-health[61]. As part of its community empowerment approach, Sonagachi established a sex worker collective focused on promoting and protecting sex workers' human and labour rights, cultivated savings and business cooperatives formed and led by sex workers, and has fought for the reduction of stigma and discrimination and social inclusion of sex workers at both the community and policy levels[60].

"Research has demonstrated that community empowerment-based HIV prevention is associated with significant improvements across HIV outcomes in sex workers[58,59].

TABLE 5: SOCIAL CAPITAL BUILDING: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partner
5.1 Collective identity mobilisation	5.1.1 Develop and implement the South African National Sex Worker HIV Plan and implement this programme using a sex worker informed and designed national programme name and brand	• National branding of a programme that is informed by sex workers can enable sex workers to identify with a common brand and build a collective identity	SANAC Secretariat DOH
	5.1.2 Build in-group affiliation of sex workers with the South African National Sex Worker HIV Plan	• Leverage the SANAC sex work sector	SANAC Sex Work Sector
	5.1.3 Promote membership of sex worker organisations	• Build on and strengthen existing sex work collectives such as Sisonke	SANAC Sex Work Sector Sisonke
5.2. Community empowerment	5.2.1 Build capacity of sex worker collectives to enable active engagement in programme roll-out	• Sex worker collectives will require financial and human resources to be effective in their role	SANAC Secretariat
	5.2.2 Consultation in respect of policy and research	• Sex workers and sex worker organisations must be meaningfully consulted in the review and revision of policies related to this programme and with respect to research on sex work and sex workers	SANAC Secretariat
	5.2.3 Empower sex workers to take an active role in programme implementation, monitoring and evaluation	• Align with the M&E framework of this Plan • Preferred data collection methodology using a real time data system that can be utilised by sex workers themselves on their mobile devices	SANAC Secretariat Sex Worker collectives

Economic empowerment package

Income inequality, lack of alternate means of income generation, and poverty and gender inequalities contribute to entry into sex work[5]. Research has shown that on average, female sex workers in South Africa are responsible for four child or adult dependents, while male and transgender sex workers are responsible for two child or adult dependents[62]. In the same study only one fifth of female sex workers, 3.7% of male sex workers and no transgender sex worker participants reported that their non-commercial sex partners provided financial assistance to them[62].

Sex work remains a pragmatic means of earning a living for many in South Africa for a number of reasons: high unemployment rates, the fact that entering sex work requires no formal qualifications, and the pressing need to provide for dependents, often without the support of a spouse. Sex workers are often economically vulnerable, which can restrict their ability to negotiate for safe sex, discuss fidelity with their partners, or leave risky relationships[63].

Economic empowerment of sex workers is essential. What this means is that sex workers should be accorded the same rights as all other informal workers to safe and fair working conditions, with ongoing skills training, access to bank accounts and fair credit programmes, and the same potential to support their families and plan for their future as all other members of the wider community[21].

6.1 Skills Building

Skills development is a crucial component for the economic empowerment of sex workers. The development of skills includes providing skills building workshops on how to improve their skills as peer educators, to manage their financial affairs and to develop a skill set that will enable them to leave sex work should they choose to.

6.2 Career pathing

Studies have shown that many sex workers have indicated that they would like to have a clear path for career development. Career pathing will entail identifying those sex workers who would like to progress, and providing skills to allow them to fill roles including but not exclusive to: peer educators, trainers, paralegals and lay counsellors. Staff who train sex workers should be sensitised and open to learn from the sex workers as well as serve as mentors[21].

6.3 Educational improvement

In South Africa, low levels of education are one of the social/structural factors which increases sex worker vulnerability to HIV infection. Education for women is critical for mitigating the vulnerability of sex workers, expanding their life choices, reducing risk and promoting resilience[5]. Sex workers who wish to further their education should be provided with adequate resources to do so. This will include facilitating linkage to Adult Basic Education and Training (ABET), bursary schemes and scholarships to attend educational institutions.

6.4 Participate in Co-ops

Evidence suggests that sex workers who have few alternative sources of income are at higher risk of HIV infection and more vulnerable to violence. Participation in co-operatives or "co-ops" is an option for sex workers to either earn additional income or for those who wish to stop sex work. A co-op is an independent association of individuals who voluntarily cooperate for their mutual social, economic, and cultural benefit. Economic empowerment activities, such as educational workshops on how to establish and participate in successful co-ops, can create access to additional forms of income generation.

TABLE 6: ECONOMIC EMPOWERMENT: ACTIVITIES, IMPLEMENTATION CONSIDERATIONS AND RESPONSIBILITIES

Component	Specific activities	Implementation considerations	Responsible partner
6.1 Skills Building	6.1.1 Provide skills building workshops on financial management and entrepreneurship	• Include sessions on budgeting and savings as well as how to start your own business in the formal or informal sectors • Skills building should be equally appropriate for sex workers wanting to remain in sex work and those wanting to move out of the sector	SANAC Secretariat; NGOs
6.2 Career Pathing	6.2.1 Career pathing workshops for paralegals, peer educators, peer educator trainers, and lay counsellors	• Standardised training • Tailoring for each career path will be needed	NGOs
6.3 Educational Improvement	6.3.1 Facilitate access to ABET 6.3.2 Facilitate access to opportunities to complete secondary schooling, access scholarships and bursaries	• Educational opportunities dependent on funding	DBE; DHET; NGOs
6.4 Participate in co-ops	6.4.1 Conduct educational workshops on how to develop and participate in successful co-ops 6.4.2 Facilitate linkages to existing co-ops in the same geographic area	• Availability of materials • Availability of funding	NGOs; Development partners DoSBD

2 Models of service delivery

To stabilise and reverse HIV and STI epidemics on a national scale, effective interventions need to reach saturation levels of coverage – ideally 90% in areas where sex work takes place[5]. However, as described earlier in this document, prevalence of sex work differs by province, locality (urban vs rural) and by type of hotspot e.g. trucking route or mining area. Different models of service delivery are therefore needed to deliver the package of services.

This Plan will utilise a 3-tiered delivery approach, supported by peer educators, based on the density of sex workers in a given area:

1. **Tier 1 (low density areas: <500 sex workers per district)** – Mobile services delivered at hotspots (brothels, hotels and clubs) and on streets where sex workers operate, supported by outreach teams

1.1 Outreach teams consist of sex worker peer educators and clinical staff (as necessary)

1.1.1 Peer educators receive a monthly stipend in line with ward-based teams

1.1.2 Peer educators are trained in: HTS, prevention methods, sexual and reproductive health, basic packages of care, condom negotiation skills

1.2 Prevention, screening and treatment are delivered at the hotspots

2. **Tier 2 (high density areas > 3000 sex workers per district**) – Dedicated key population clinics offering dedicated sex worker services

2.1 Flexible hours to accommodate sex worker activities and risk

2.2 Emergency PEP; family planning; emergency contraception; rape services

3. **Tier 3 (moderate density 500 – 3000 sex workers per district)** – combination of mobile services; fixed clinic services and outreach teams

3 Monitoring, evaluation, research, and innovation

The process of active monitoring and reporting the Plan above will involve a structured and coordinated system that aligns NGO reporting with the public reporting systems and which is bought into by all stakeholders, including the coordination body and sex workers themselves.

3.1 Indicators

Reporting against a set list of indicators in the programme will assist the country to evaluate the implementation, outcomes and impact of the South African National Sex Worker HIV Plan. Core indicators will assist the SANAC Secretariat to assess the state of progress at any given time during the programme while contributing to a better understanding of the response.

The indicators described below are aligned with the theory of change described in Section 2.3 in Section A above, the outcomes of the packages of services described in Section B, as well as existing national and international indicators (the National Strategic Plan for HIV, STIs and TB, 2012-2016 (NSP), DORA, the Global Fund and PEPFAR).

TABLE 7: M&E FRAMEWORK

	Indicator	Definition	Source document	Baseline	Target	Data source	Frequency of measurement	Comment
Decreased incidence of HIV, STIs and TB	Incidence of HIV in sex workers	Percentage of sex workers on the programme who are newly infected with HIV in a given year	NSP	TBD	TBD	Modelled, estimated, or laboratory measures	Annually	Year 1 programmatic data to be used as baseline data and targets to be set
	Prevalence of HIV in sex workers	Percentage of sex workers on the programme infected with HIV at a given point in time	NSP	Cape Town: 39.7% Durban: 53.5% Johannesburg: 71.8%	Cape Town: TBD Durban: TBD Johannesburg: TBD	IBBS	Every three years	N/A
	Prevalence of syphilis in sex workers	Percentage of sex workers diagnosed with syphilis at a given point in time	-	Cape Town: 19.6% Durban: 3.3% Johannesburg: 16.2%	Cape Town: TBD Durban: TBD Johannesburg: TBD	Programme data	Annually	N/A
	Incidence of TB in sex workers	Percentage of sex workers with a new or relapse case of TB (all forms) in a given year	NSP	TBD	TBD	Programme data	Annually	Year 1 programmatic data to be used as baseline data and targets to be set
Decreased mortality due to HIV, STIs and TB	Mortality of sex workers on the programme	Number of HIV positive sex workers on the programme who die	-	TBD	TBD	Programme data	Annually	As no prior data are available the first year's data will be used as a baseline
Safer sexual behaviour	Condom use among sex workers with clients	Percentage sex workers reporting condom use at last sex with a client	-	Cape Town: 89.4% Durban: 84.5% Johannesburg: 76.4%	Cape Town: 95% Durban: 95% Johannesburg: 95%	Programme data	Every three years	
	Condom use among sex workers with non commercial sex partners	Percentage sex workers reporting condom use at last sex with a non commercial sex partner	-	Cape Town: 13.6% Durban: 8.9% Johannesburg: 34.5%	Cape Town: 27.2% Durban: 17.8% Johannesburg: 69%	IBBS	Every three years	Target is to double the use of condoms at last sex with non-commercial sex partner

[1]Source document refers to a national guideline, reporting system, strategy or other document where this indicator required to be reported on

TABLE 7: M&E FRAMEWORK

	Indicator	Definition	Source document	Baseline	Target	Data source	Frequency of measurement	Comment
Decreased exposure to HIV, STIs and TB	Percentage of HIV positive sex workers who are on ART	Percentage of sex workers who tested HIV positive and are on ART	-	Cape Town: 45.3% Durban: 35.9% Johannesburg: 23.4%	90%	Programme data	Annually	
	Percentage of HIV positive sex workers on treatment who are virally suppressed	Percentage of sex workers virally suppressed 12 months after initiation of ART	-	-	90%	Programme data	Annually	
	Percentage of HIV negative sex workers on PrEP	Percentage of HIV negative sex workers who have been prescribed and are adherent on PrEP, as per national guidelines	-	TBD	3000	Programme data	Annually	
Experience of violence, stigma and discrimination	Prevalence of violence against sex workers	Percentage of sex workers who have experienced any form of violence in the preceding year	-	Cape Town: 47.3% Durban: 14.1% Johannesburg: 50.9%	Cape Town: 23.7% Durban: 7.1% Johannesburg: 25.5%	IBBS	Every three years	
Increase coverage and access to core package of services	Number of male condoms	Total number of male condoms distributed in a specified period of time to sex workers	DORA		11,8 million	Programme data	Quarterly	

TABLE 7: M&E FRAMEWORK

	Indicator	Definition	Source document	Baseline	Target	Data source	Frequency of measurement	Comment
Increase coverage and access to core package of services	Number of female condoms distributed	Total number of female condoms distributed in a specified period of time to sex workers		N/A	3,9 million	Programme data	Quarterly	
	Number of lubricants distributed	Total number of lubricants distributed in a specified period of time to sex workers	-	TBD	TBD	Programme data	Quarterly	
	Percentage of sex workers who received an HIV test in the past year and know their result	Number and percentage of sex workers who are tested for HIV in the past 12 months and know their results	Global Fund DORA	Cape Town: 71.2% Durban: 50.7% Johannesburg: 46.2%	90%	Programme data	Quarterly	
Programmatic indicators	Number sex workers reached	Total number of sex workers reached with a minimum core package of services	DORA	N/A	NDoH: 20 000 Global Fund: 40 000 PEPFAR: 10 000	Programme data	Quarterly	
	Number of peer educators	Number of peer educators trained by the programme	Global Fund	N/A	NDoH: 313 Global Fund: 625 PEPFAR: 156	Programme data	Quarterly	

3.2 Data sources and flow

The above indicators have been selected for monitoring the South African National Sex Worker HIV Plan. Wherever possible indicators will be collected using routine data sources. The other indicators would be obtained from non-routine sources to generate the required information.

Data flow for routine data collection

The proposed flow of data is from the implementing organisations through to the SANAC Secretariat which is responsible for the coordination of the Plan. Data will then flow upwards to the South African Government to be used for policy and strategic decisions.

This flow mirrors the funding and organisational model of the programme and data flowing in this way will avoid duplication and developing parallel systems.

3.3 Data use

Information generated must reach all those who need the information to facilitate decision-making that would strengthen the response and improve the performance of the organisations and institutions. Dissemination is an active and systematic process to ensure that all implementers in all sectors, provinces and stakeholders receive the information that they would need, timeously and in a practical format for decision making. An annual report on the South African National Sex Worker Plan will therefore be produced and disseminated.

3.4 Implementation considerations

To aid in effective and accurate programme reporting, a real time monitoring system will be introduced.

Real Time Monitoring System

The objective of a real time monitoring (RTM) system is a programme-centred, geographic focused real time data capture system for local level programme improvement and real time decision making to improve access to services by sex workers. The RTM platform should provide M&E functionality including key South African National Sex Worker HIV Plan indicators, alerts based on target thresholds and integration with existing information systems for monitoring sex worker HIV programmes.

The RTM system ensures continuity of care through information sharing between service providers. Data can be viewed on a real time basis or across periods of time basis in order to monitor performance. Data can be viewed on a location or by targets against coverage.

Implementing partners should utilise mobile phones equipped with the RTM application, a SIM card providing free data usage of the application, and training on the systems functionality. A mass campaign is suggested to provide all sex workers using the services with an enabled mobile phone.

4 Planning, coordination and management

National government departments will provide the leadership role for the South African National Sex Worker HIV Plan in terms of providing policy and strategic guidance.

The SANAC Secretariat will play a coordination, resource mobilisation and advocacy role for this plan, which is closely aligned to the goals and objectives of the NSP.

The National Sex Worker Technical Working Group will play the role of providing ongoing technical guidance for the South African National Sex Worker HIV Plan.

The SANAC Secretariat will be responsible for strategic information management including size estimation, coordination of a research agenda, programmatic and impact evaluations, real time monitoring, quality improvement and innovative financing options such as the Social Impact Bond. The SANAC Secretariat should also link the work across multiple government departments at the national and provincial level and advocate for the optimisation of all aspects of the national sex worker programme within and outside government.

The National Sex Worker Technical Working Group (re-established by SANAC on the 13th August 2015) will play the role of providing ongoing technical guidance for the South African National Sex Worker HIV Plan. This group includes representatives of government departments (including representation from the DoH's High Transmission Area (HTA) programme), the SANAC Secretariat, implementation organisations (with representation from Global Fund and PEPFAR partners), development partners, researchers and the civil society sex work sector. The role of this group includes maximising synergies between different partners as well as providing the opportunity for sex worker voices to inform programme design, implementation, and adaptation and monitoring.

Through a grant making system, awards will be made by the Global Fund, PEPFAR and South African national government departments and the SANAC Secretariat to various recipients, partners and programmes for the implementation of the Plan.

Component	Members	Role & Responsibility
Funding Mechanisms	DOH, DSD, DOJ&CD, PEPFAR, SANAC Secretariat, Global Fund and other government departments and donors	Mobilise and provide funding and technical leadership to local level organisations for the implementation of the South African National Sex Worker HIV Plan
Global Fund Principal Recipient and PEPFAR	Global Fund and PEPFAR contracting partners	Manage and disburse funds to local organisations for the implementation of the Plan. The role includes the coordination and management of programme design and reporting and building the capacity of the local organisations to ensure effective implementation of the programme. They facilitate networking, mobilisation and capacity building of sub-recipients to provide appropriate, evidence-informed programmes.
Sub recipient/ Sub-primes/Partners/ Programmes	Implementing Partners	Implement the South African National Sex Worker HIV Plan, adapted to the local context. Ensure standards, quality and coverage of services. Engage with district and where appropriate provincial AIDS structures.

4.1 Sustainability

In order for the South African National Sex Worker HIV Plan to be sustainable key activities are required to take place. These include the capacity strengthening of government departments, the capacity building of implementers, supporting community mobilisation around sex work, alignment of the programme within an existing system and sustaining and monitoring commitment to the plan and creating an evidence base for effective, efficient and accessible services for sex workers in South Africa. Capacity strengthening is an enabler for the implementation of this Plan and as such funds should be mobilised for this activity.

5 Human and financial requirements

Mobilisation of additional resources is essential if South Africa is to implement the South African National Sex Worker HIV Plan at scale to sufficiently reduce HIV prevalence in this community. Additional resources will be needed above what South Africa has sought in its Global Fund proposal, the PEPFAR-funded sex worker programmes, as well as the National Department of Health HIV and AIDS Conditional Grant funding.

The SANAC Secretariat will lead processes to identify potential donors to finance full implementation of the South African National Sex Worker HIV Plan. This will include advocacy with donors on financial resource needs and with National Treasury. SANAC Secretariat will also facilitate processes for development of multi-agency joint funding proposals.

5.1 Costing and financing plan

The SANAC Secretariat will commission a costed implementation plan and also estimate the medium to long term costs for the full scale up of the South African National Sex Worker Plan. This will inform the prioritisation of the package for implementation.

References

1. SWEAT. Guidelines for employing sex worker peer educators.
2. SWEAT. Sex Workers In South Africa: A Rapid Population Size Estimation Study. Cape Town, South Africa: SWEAT, 2013.
3. Konstant TL, Rangasami J, Stacey MJ, Stewart ML, Nogoduka C. Estimating the number of sex workers in South Africa: rapid population size estimation. AIDS Behav. 2015 Feb;19 Suppl 1:S3-15. PubMed PMID: 25582921. Epub 2015/01/15. eng.
4. USCF. ANOVA. WRHI. South Africa Health Monitoring Study (SAHMS), The Integrated Biological and Behavioural Survey among Female Sex Workers. South Africa San Francisco: UCSF, 2014.
5. WHO. Preventing HIV among sex workers in sub-Saharan Africa. Geneva: WHO, 2011.
6. MAC AIDS Fund. MAC AIDS Prevention of Mother to Child Transmission Needs of Female Sex Workers Study Brief. 2015.
7. Shisana O RT, Simbayi LC, Zuma K, Jooste S, Zungu N, Labadarios D, Onoya D et al. South African National HIV Prevalence, Incidence and Behaviour Survey,
2012. . Cape Town: HSRC Press: 2014.
8. Bekker L, et al. Combination HIV prevention for female sex workers: what is the evidence? . The Lancet. 2014.
9. Setswe G WN, Cloete A, Mabaso M, Jooste S, Ntsepe Y, Sigida S, Msweli S, Mlobeli R and the Technical Advisory Committee. Programmatic mapping and size estimation of key populations: Sex Workers (male and female), Men who have Sex with Men, People Who Inject Drugs and Transgender People. Cape Town: NACOSA, 2015.
10. Operario D, Soma, T. & Underhill, K.,. Sex work and HIV status among transgender women: systematic review and meta-analysis. . J Acquir Immune Defic Syndr,. 2008; 48, :97-103.
11. Scorgie F, Chersich MF, Ntaganira I, Gerbase A, Lule F, Lo YR. Socio-demographic characteristics and behavioral risk factors of female sex workers in sub-saharan Africa: a systematic review. AIDS and behavior. 2012 May;16(4):920-33. PubMed PMID: 21750918. Epub 2011/07/14. eng.
12. National Department of Health . National Antenatal Sentinel HIV & Syphilis Prevalence Survey in South Africa. 2011.
13. National South African Government :The Presidency. Criminal Law Sexual Offences and Related Matters Amendment Act. Pretoria, South Africa: 2007.
14. Gable L, Gostin LO, Hodge JG. HIV/AIDS, Reproductive and Sexual Health, and the Law. American Journal of Public Health. 2008 06/03/accepted;98(10):1779-86. PubMed PMID: PMC2636460.
15. UNAIDS. UNAIDS Advisory Group on HIV and Sex Work The UNAIDS Advisory Group on HIV and Sex Work 72 Newhaven Road, Edinburgh EH6 5QG, Scotland 2011.
16. Harcourt C, Donovan B. The many faces of sex work. Sexually Transmitted Infections. 2005;81(3):201-6. PubMed PMID: PMC1744977.
17. National Planning Commision: The Presidency. National Development Plan 2030. Pretoria, South Africa: 2012.
18. UNDP. Sex Work And The Law In Asia And The Pacific: Laws, hiV and human rights in the context of sex work UNDP Asia-Pacific Regional Centre United Nations Service Building, 3rd Floor Rajdamnern Nok Avenue, Bangkok 10200, Thailand: United Nations Development Programme, 2012.
19. Bill & Melinda Gates Foundation Avahan-The India Aids Initiative : The Business Of Hiv Prevention At Scale. New Delhi, India. : Bill & Melinda Gates Foundation, 2008.
20. Bill & Melinda Gates Foundation . Managing HIV Prevention from the Ground Up: Avahan's Experience with Peer Led Outreach at Scale in India. New Delhi: 2009.
21. WHO UNPF, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, The World Bank. Implementing Comprehensive HIV/STI Programmes With Sex Workers Practical Approaches from Collaborative Interventions. Geneva: World Health Organization, 2013.
22. WHO. Consolidated Guidelines On HIV Prevention, Diagnosis, Treatment And Care For Key Population. Geneva , Switzerland 2014.
23. 2013 C-C. C-Change Final Report Washington DC: C-Change/FHI 3602013 [cited 2015]. Available from: www.c-changeproject.org/sites/default/files/C-Change-Final-Report.March2013.pdf.
24. Taylor V WN. Collective identities in social movement communities: lesbian feminist mobilization. In: Morris A, Mueller C, editors. Frontiers in social movement theory. . New Haven, CT: 1992.
25. Weller S, Davis K. Condom effectiveness in reducing heterosexual HIV transmission. Cochrane Database Syst Rev. 2002 (1):CD003255. PubMed PMID: 11869658. Epub 2002/03/01. eng.
26. Gilmour E, Karim SS, Fourie HJ. Availability of condoms in urban and rural areas of KwaZulu-Natal, South Africa. Sex Transm Dis. 2000 Jul;27(6):353-7. PubMed PMID: 10907912. Epub 2000/07/25. eng.
27. Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A. Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial. PLoS Med. 2005;2(11):e298.
28. Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, et al. Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. Lancet. 2007 Feb 24;369(9562):643-56. PubMed PMID: 17321310. Epub 2007/02/27. eng.
29. Gray RH, Kigozi G, Serwadda D, Makumbi F, Watya S, Nalugoda F, et al. Male circumcision for HIV prevention in men in Rakai, Uganda: a randomised trial. The Lancet.369(9562):657-66.
30. WHO. Consolidated guidelines on general HIV care and the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. . Geneva: World Health Organisation, 2013.
31. Cawley C, Wringe A, Slaymaker E, Todd J, Michael D, Kumugola Y, et al. The impact of voluntary counselling and testing services on sexual behaviour change and HIV incidence: observations from a cohort study in rural Tanzania. BMC Infect Dis. 2014;14:159. PubMed PMID: 24655360. Pubmed Central PMCID: PMC3994406. Epub 2014/03/25. eng.
32. Scott-Sheldon LA, Carey MP, Carey KB, Cain D, Simbayi LC, Mehlomakhulu V, et al. HIV testing is associated with increased knowledge and reductions in sexual risk behaviours among men in Cape Town, South Africa. Afr J AIDS Res. 2013 Dec;12(4):195-201. PubMed PMID: 25871481. Pubmed Central PMCID: PMC4520431. Epub 2013/12/01. eng.
33. WHO. Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC policy framework. Geneva: World Health Organization, 2012.
34. Initiation of Antiretroviral Therapy in Early Asymptomatic HIV Infection. New England Journal of Medicine. 2015;373(9):795-807. PubMed PMID: 26192873.
35. Department of Health. National Tuberculosis Management Guidelines 2014. Pretoria: 2014.
36. Mukenge-Tshibaka L, Alary M, Lowndes CM, Van Dyck E, Guedou A, Geraldo N, et al. Syndromic versus laboratory-based diagnosis of cervical infections among female sex workers in Benin: implications of nonattendance for return visits. Sex Transm Dis. 2002 Jun;29(6):324-30. PubMed PMID: 12035021. Epub 2002/05/30. eng.
37. Steen R, Dallabetta G. Sexually transmitted infection control with sex workers: regular screening and presumptive treatment augment efforts to reduce risk and vulnerability. Reprod Health Matters. 2003 Nov;11(22):74-90. PubMed PMID: 14708399. Epub 2004/01/08. eng.
38. South African National AIDS Council. National Strategic Plan for HIV Prevention Care And Treatment for Sex Workers. Pretoria, South Africa 2013.
39. National Department of Health. Operational Guidelines for HIV, STIs and TB Programmes for Key Populations in South Africa. South Afric: 2012.
40. Pauw I, Brener L. 'You are just whores—you can't be raped': barriers to safer sex practices among women street sex workers in Cape Town. Culture, Health & Sexuality. 2003 2003/01/01;5(6):465-81.
41. WHO. Prevention And Treatment Of HIV and Other Sexually Transmitted Infectionsfor Sex Workersin Low- And Middle-Income Countries Recommendations For A Public Health Approach. Geneva Switzerland: 2012.
42. Department of Gender Women and Health . Violence Against Women And Hiv/Aids: Critical Intersections. Violence Against Sex Workers And Hiv Prevention. Geneva: World Health Organization; 2005.
43. United Nations . UN Convention on the rights of the child. Geneva 1989.
44. WHO. Alcohol Use and Sexual Risk Behaviour: A Cross-Cultural Study in Eight Countries Geneva: 2005.
45. Wechsberg WM, Luseno, W. K., Lam, W. K. K., Parry, C. D. H., & Morojele, N. K.,. Substance use, sexual risk, and violence: HIV prevention intervention with sex workers in Pretoria. AIDS and Behavior. 2006;10(2):131–7.

References

46. Jewkes et al . Understanding Men's Health and the use of violence: interface of rape and HIV in South Africa. Medical Research Council. 2009.
47. Dunkle KL, Jewkes R. Effective HIV prevention requires gender□transformative work with men. Sexually Transmitted Infections. 2007;83(3):173-4. PubMed PMID: PMC2659081.
48. Blankenship K, And Koester, S. Criminal law, policing policy, and HIV risk in female street sex workers and injection drug users. Journal of Law, Medicine and Ethics 2002;30(4):550.
49. Ahmed A, Kaplan M, Symington A, Kismodi E. Criminalising consensual sexual behaviour in the context of HIV: Consequences, evidence, and leadership. Global Public Health. 2011 2011/12/01;6(sup3):S357-S69.
50. Seib C. The health of female sex workers from three industry sectors in Queensland, Australia Social Science & Medicine 2009;68, (3):476-7.
51. Scorgie F, Nakato D, Harper E, Richter M, Maseko S, Nare P, et al. 'We are despised in the hospitals': sex workers' experiences of accessing health care in four African countries. Culture, Health & Sexuality. 2013 2013/04/01;15(4):450-65.
52. Scorgie F, Vasey K, Harper E, Richter M, Nare P, Maseko S, et al. Human rights abuses and collective resilience among sex workers in four African countries: a qualitative study. Globalization and Health. 2013 07/26 11/27/received 06/25/accepted;9:33-. PubMed PMID: PMC3750273.
53. Harcourt CD, B . The many faces of sex work. Sex Transm Infect, 81, 201-206. 81. 2005:201-6.
54. Shannon K SSA, Goldenberg SM, Duff P, Mwangi P, Rusakova M, et al. Global epidemiology of HIV among female sex workers: influence of structural determinants. Lancet. 2014.
55. Secretariat . Global Commission on HIV and the Law . The Global Commission on HIV and the Law - risks, rights and health. Geneva: UNDP; 2012.
56. Fick N. Sex workers experiences with the local law enforcement in South Africa. Research for sex work. 2005 June 2005:4 - 8.
57. Evans C, Jana S, Lambert H. What makes a structural intervention? Reducing vulnerability to HIV in community settings, with particular reference to sex work. Glob Public Health. 2010;5(5):449-61. PubMed PMID: 19507079. Epub 2009/06/10. eng.
58. Jana S, Basu I, Rotheram-Borus MJ, Newman PA. The Sonagachi Project: a sustainable community intervention program. AIDS Educ Prev. 2004 Oct;16(5):405-14. PubMed PMID: 15491952. Epub 2004/10/20. eng.
59. Kerrigan DL, Fonner VA, Stromdahl S, Kennedy CE. Community empowerment among female sex workers is an effective HIV prevention intervention: a systematic review of the peer-reviewed evidence from low- and middle-income countries. AIDS Behav. 2013 Jul;17(6):1926-40. PubMed PMID: 23539185. Epub 2013/03/30. eng.
60. Swendeman D, Basu I, Das S, Jana S, Rotheram-Borus MJ. Empowering sex workers in India to reduce vulnerability to HIV and sexually transmitted diseases. Soc Sci Med. 2009 Oct;69(8):1157-66. PubMed PMID: 19716639. Pubmed Central PMCID: PMC2824563. Epub 2009/09/01. eng.
61. Bandyopadhyay N, Ray, K., Bannerjee, A., Jana, S., Saha, A., Kerrigan, D., Sharma Mahendra, V. . Operationalizing An Effective Community Development Intervention For Reducing Hiv Vulnerability In Female Sex Work: Lessons Learned From The Sonagachi Project In Kolkata, India. In: Horizons PC, editor.
62. Richter ML, Chersich M, Temmerman M, Luchters S. Characteristics, sexual behaviour and risk factors of female, male and transgender sex workers in South Africa. South African medical journal = Suid-Afrikaanse tydskrif vir geneeskunde. 2013 Apr;103(4):246-51. PubMed PMID: 23547701.
63. International Labour Organisation. Project on Economic Empowerment and HIV Vulnerability Reduction along Transport Corridors in Southern Africa, Corridor Economic Empowerment Innovative Fund Concept and Design. 2013.
64. UCSF and ANOVA. Long Distance Truck Drivers / Female Sex Workers. IBBS Factsheet. 2014.

Notes

Notes

OUR ACTIONS COUNT