



**FEMALE, MALE AND TRANSGENDER  
SEX WORKERS' PERSPECTIVES  
ON HIV & STI  
PREVENTION AND TREATMENT SERVICES:  
a global sex worker consultation**

October 2011

The Global Network of Sex Work Projects (NSWP) exists to uphold the voice of sex workers globally and connect regional networks advocating for the rights of female, male, and transgender sex workers. It advocates for rights based health and social services, freedom from abuse and discrimination, and self-determination for sex workers.

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## **FEMALE, MALE AND TRANSGENDER SEX WORKERS' PERSPECTIVES ON HIV & STI PREVENTION AND TREATMENT SERVICES: a global civil society consultation**

October 2011

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"When I can work in safe and fair conditions,  
When I am free of discrimination,  
When I am free of labels like 'immoral' or 'victim',  
When I am free from unethical researchers,  
When I am free to do my job without harassment, violence or breaking the law,  
When sex work is recognized as work,  
When we have safety, unity, respect and our rights,  
When I am free to choose my own way,  
THEN I am free to protect myself and others from HIV."

EMPOWER THAILAND

Closing Ceremony XVth International AIDS Conference

Bangkok, Thailand, 11-16 July 2004

## **ABOUT THIS REPORT**

The World Health Organization (WHO) is developing guidelines for evidence-based interventions for the prevention and treatment of HIV and other sexually transmitted infections (STIs) in low- and middle-income countries. As a global partner to the WHO in this process, the Global Network of Sex Work Projects oversaw a civil society consultation of sex workers commissioned by the WHO to gather feedback on proposed guidelines. This report contains the findings from that consultation and was submitted to the WHO.

## **ACKNOWLEDGEMENTS**

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## BACKGROUND

In most low- and middle-income countries, sex workers are far more likely to be infected with HIV than the general population.<sup>1</sup> Prevalence-rates among sex workers vary greatly depending on context. For instance, 15% of female sex workers in Southern India; 14-31% in Ukraine; 1% in Egypt; 3.6% in the Dominican Republic<sup>2</sup> and 68% in Zambia<sup>3</sup> are living with HIV. There is comparatively little data available on HIV-prevalence-rates among male and transgender sex workers. However, a meta-analysis of 25 studies with over 6000 participants from 14 countries found that overall, transgender sex workers and male sex workers had higher prevalence rates than female sex workers and calculated them at 27.3% and 15.1% respectively.<sup>4</sup>

In inquiring into HIV-services for sex workers, the UN Independent Commission on AIDS in Asia found that:

In countries where there has been a significant investment in programs for sex workers, HIV infection rates have tended to be reduced, stabilized or remain low. Conversely, in countries where little attention has been paid to HIV prevention and treatment for sex workers, HIV infection rates remain high – in some countries as high as nearly 70%.<sup>5</sup>

Despite this, globally, less than 1% of global HIV-prevention funding is spent on sex work.<sup>6</sup> In 2010, UNAIDS calculated that, based on country progress reports, 51% of sex workers did not have access to prevention-services. However, many sex worker project and service-provision NGOs believe the proportion is much higher. In 2006, for instance, the International HIV/AIDS Alliance found that, according to their calculations, 84% of sex workers globally did not have access to HIV services.<sup>7</sup>

The high rates of HIV among sex workers are reflective not only of public health failures, but of the context of widespread and severe human rights abuses leveled against sex workers.<sup>8</sup> Indeed, contexts of criminalization, penalization and police repression of sex work preclude institutional redress and equal access to protection of the law when sex workers are subject to abuse.

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<sup>1</sup> The UNAIDS 2008 Report on the Global AIDS Epidemic.

<sup>2</sup> The UNAIDS 2010 Report on the Global AIDS Epidemic.

<sup>3</sup> The UNAIDS 2006 Report on the Global Aids Epidemic.

<sup>4</sup> Operario D, Soma T, Underhill K. 2008. "Sex work and HIV status among transgender women: systematic review and meta-analysis." *J Acquir Immune Defic Syndr.* May 1;48(1):97-103.

<sup>5</sup> *Redefining AIDS in Asia: Crafting an Effective Response.* Report of the Independent Commission on AIDS in Asia. 2008.

<sup>6</sup> UNFPA Media Fact Sheet on Sex Work and HIV, July 2010.

<sup>7</sup> International Aids Alliance. *Global Review.* 2006.

<sup>8</sup> UNAIDS Guidance Note on HIV and Sex Work, 2009.

Furthermore, despite the available evidence in support of rights-based health interventions with sex workers<sup>9</sup>, a number of governments have undertaken HIV-interventions that, rather than empower sex workers, actively infringe upon their rights through such measures as mandatory or forced testing; public disclosure of test results; and police repression of sex workers under the pretext of “fighting HIV”, “fighting trafficking” or “fighting sexual exploitation”. The resulting widespread violence against sex workers by state and non-state actors, unjust and unsafe working conditions and frequent discrimination have created important obstacles to prevention and treatment and fueled HIV transmission.

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<sup>9</sup> See the most recent results of sex work HIV-interventions based on community mobilization as a key component in UNAIDS 2010 Report on the Global AIDS Epidemic.

## METHODOLOGY

Sex workers were contacted through regional sex worker networks, sex worker groups and sex work projects. The majority of interviewees were part local or national groups that were not direct members of the NSWP but were affiliated with regional networks that were part of the NSWP. A few organizations were direct members while others were in no way connected to the NSWP.

Interviews were done in person, over the phone or on a few occasions when neither of these was possible, over e-mail. All interviews were based on a lengthy semi-structured questionnaire that was conducted in English, French, Spanish, Russian, Indonesian and, with the assistance of translators that sex workers had selected, into a plethora of other languages. An interview protocol was developed to ensure uniformity of interviews across the research team. Despite the efforts made at uniformity, sex workers at times had differing interpretations of the interventions being described in line with their contextual references for public health and law enforcement practices. Interviews were conducted between July 25, 2011 and September 17, 2011.

### BALANCING REPRESENTATION

Interviews took place in 33 countries across 6 regions. Over 50 sex workers participated. In most countries, only one sex worker responded. However, in Jamaica and Mexico, two sex workers were interviewed. In Thailand, Cambodia and Bolivia, sex workers chose to answer the questionnaire in a group and report their collective answers. Even when only one sex worker responded, they generally did so based on the collective experience of sex workers in their locale. In the case of Argentina, the respondent is both director of the national female sex worker organization and of Redtralsex, the Latin American female sex worker network; she therefore responded both in reference to her country context and to other country contexts she was familiar with.

In each region, researchers sought to represent gender diversity by ensuring the participation of male and transgender sex workers. One limitation of this consultation is that no male sex workers serving a female clientele were reached. Although respondents' HIV status is not indicated in this report, according to GIPA principles, at least one sex worker in each region consulted was HIV-positive.

In the table below, a star indicates that there were at least that number of participants of a given gender per region, but the exact number is unknown because of a collective response.



### Respondents by Region and Gender

	Africa	Asia	Caribbean	CEE/CA	Latin America	Western Europe
MSW	1	1	2	1	1	
TSW	2	5	1	1	1	1
FSW	5	11*	4	2	6*	1

#### Interviews were done in the following countries:

**Africa:** Botswana, Cameroon, Congo (DRC), Kenya, Mali, South Africa, Uganda, Zimbabwe.

**Asia:** Cambodia, Fiji, India, Indonesia, Malaysia, Papua New Guinea, Timor Leste, Thailand.

**Caribbean:** Antigua and Barbuda, Dominican Republic, Grenada, Jamaica, Saint Lucia, and Trinidad.

**CEE/CA:** Bulgaria, Macedonia, Serbia, and Ukraine.

**Latin America:** Argentina, Bolivia, Guatemala, Mexico, Peru.

**Western Europe:** France, Sweden

#### Sex Industry Sectors Represented

Sex workers covered a very wide range of sectors of the industry. Frequently, respondents had experience in a number of different sectors in the industry. Listed are the sectors sex workers identified having worked in in each region.

**Africa:** Street, bars.

**Asia:** Brothels, bars, street, massage parlours, home, hostels, and mobile (“any where where sex work is possible...which means anywhere.”).

**Caribbean:** Street, massage parlour, “tour guide”.

**Europe:** Street, apartment, strip club, mobile (“out-call”), massage parlour.

**Latin America:** Street, brothels, apartments, mobile (“out-call”), massage parlour, *whiskerías*.

## SUMMARY OF FINDINGS

Sex workers identified the following barriers to accessing HIV and STI related services: criminalization, penalization and repression of sex work, same-sex activity and gender expression; mandatory testing; discrimination and mistreatment within the health sector; exclusion of male and transgender sex workers; inappropriate and inadequate services; and funds diverted to programs that have no evidence-base.

Sex workers identified the following necessary steps to improve access to HIV and STI prevention and treatment: decriminalization, depenalization and non-repressive policy; HIV interventions in line with human rights standards; collective empowerment; recognition of sex work as work; comprehensive programs; and sex worker-led strategies.

Sex workers unanimously supported: condom promotion for sex workers; periodic voluntary screening for STIs; voluntary counseling and testing; and ARV treatment according to guidelines that apply to the general adult population.

Sex worker strongly supported: condom promotion for clients.

Sex workers strongly rejected: mandatory testing, periodic presumptive treatment for STIs (PPT) and provider-initiated testing.

## CONTEXT

### LEGAL CONTEXTS

Legal framework varied greatly across, and even within, the countries surveyed. Some countries criminalized or penalized sex workers, clients and third parties involved in the sex industry<sup>10</sup>. Others had a framework of partial criminalization (for example, of third parties and clients as in Sweden or of third parties and sex workers as in many Asian countries). Some countries had a mix of regulation (for example mandatory testing or zones) and partial criminalization. In these cases, partial criminalization was of third parties (as in Cambodia) and/or of particular sex workers (for example sex workers living with HIV, migrant sex workers, unlicensed sex workers as in Mexico) and/or of particular clients (for example clients in brothels as in Guatemala)). In most countries, there was a substantial gulf between the written law and its application. This was particularly the case when there was poor rule of law and widespread police and government corruption.

In some countries, laws against sex work were specifically gendered and applied only to “common prostitutes” (understood to be women) or “immoral women”. In other cases, they were gender-neutral, though in practice, often applied in a gendered way.

A number of countries had laws against same-sex behaviour that were used to criminalize male sex workers having sex with men as well as many transgender sex workers. Laws against cross-dressing, vagrancy offenses, immigration offenses, drug laws and trafficking laws were also often used to repress sex workers.

In countries with a mix of regulation and criminalization, sex workers could be penalized or criminalized for working outside of a given zone, not submitting to regular mandatory testing or being HIV-positive.

In many countries, police routinely subjected sex workers to unlawful arrest, extortion or and abuse.

### HUMAN RIGHTS CONTEXTS

Sex workers identified unlawful detention, police extortion, and physical and sexual violence by police as among the most common human rights abuses. In many cases, this contributed to impunity for other common human rights abuses that were cited such as: killings, death threats, physical and sexual violence by aggressors (including organized violence to enforce extortion).

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<sup>10</sup> This term generally refers to brothel-owners; managers; support, cleaning and security staff. However, in a number of contexts laws against third-parties who profit from or facilitate prostitution are used against sex workers working together and can be used against sex workers’ family members.

Sex workers cited laws they experienced as discriminatory as human rights abuses such as laws criminalizing sex work, gender expression and same-sex activity and laws enforcing mandatory testing and forbidding HIV-positive sex workers from working legally.

Sex workers also cited discrimination in many facets of their lives from difficulty opening a bank account; evictions from homes or neighborhoods; children being unable to go to school; rejection by health staff at hospitals; and impunity for violence against them.

Some sex workers also spoke of the lack of application of protective laws such as worker health and safety laws, non-discrimination laws and social security laws to sex workers.

### **ACCESS TO HEALTH SERVICES**

Sex workers were often highly dependent on a few NGOs to obtain HIV-prevention materials, although a few received them through state-run clinics. Respondents frequently reported that prevention materials and information were difficult to access and inadequate. Sex workers reported a lack of information on prevention-strategies relevant to their work contexts; insufficient materials and insufficient quantities of available materials.

Sex workers generally had to attend state-run clinics, or if they could afford to, private clinics for testing and treatment. In a few contexts, sex workers could attend clinics specifically for sex workers, though this did not always guarantee that health personnel were non-discriminatory. Ill-treatment was particularly a problem when sex workers had to attend such clinics under mandatory testing regimes.

Some sex workers spoke favourably of clinics for sex workers in brothel areas (India) and for sex workers as well as people in a given neighborhood (Argentina) that had been successful due to sex worker-leadership in their implementation. Some sex workers hoped instead for respectful, quality and confidential treatment so they could attend clinics like anyone else.

In parts of Asia and Africa, many sex workers self-medicated with antibiotics or other medication they could purchase on the street in order to evade ill-treatment and discrimination from health care workers and/or because health care was unaffordable.

More information on the barriers sex workers faced to accessing health services is described in the next section.

## PRINCIPAL ISSUES

### BARRIERS TO PREVENTION AND TREATMENT

#### **Criminalisation/Repression**

Punitive laws and policies against selling sex, buying sex or brothel-keeping made it difficult for sex workers across many countries and regions to keep condoms on them or their premises for fear they would be used by police as evidence of prostitution and lead to arrest, extortion or abuse.

Punitive laws and policies against sex work often displaced sex workers to more dangerous and isolated areas, made them fear being identified as sex workers or made brothels more reticent to allow outreach workers in, and in so doing cut sex workers off from essential health and social services. In three different countries, many sex workers feared attending government-run clinics to get any kind of health service given that the governments were simultaneously cracking down on sex workers through purported “anti-trafficking” laws and campaigns. Similarly, laws against same-sex activity and gender expression drove male and transgender sex workers underground and away from services and exposed them to institutionally sanctioned abuse.

In some contexts, detention in police stations, prisons and forced rehabilitation centers represented major disruptions to individuals’ lives, lack of access to treatment and to HIV-prevention materials.

#### **Mandatory Testing**

Mandatory testing regimes led sex workers who tested positive - or feared they might - to work in more hidden areas or to migrate to other areas. This compromised their access to health and social services and placed them in less safe and more isolated working conditions.

#### **Discrimination and Mistreatment Within The Health Sector**

Discrimination by health care personnel was a frequent and major obstacle to health care services. Often, sex workers faced multiple levels of discrimination related to not only their sex work but also their HIV-status, drug use, migrant status, sexual orientation or gender identity.

Policy contexts in which health workers collaborated with police or brothel ownership to enforce coercive measures against sex workers created fear and mistrust of health personnel and significant obstacles to sex workers accessing even basic health services.

In some countries, undocumented or illegal migrants were unable to access health services or treatment.

#### **Exclusion of Male and Transgender Sex Workers**

Male and transgender sex workers faced specific barriers to prevention and treatment: the first and most fundamental of which was recognition of their existence and specific health care needs within HIV strategies and services.

Male and transgender sex workers faced multiple forms of discrimination when accessing health services. They also faced a widespread lack of information, education and counseling addressing male or transgender sex work and a lack of relevant prevention materials (for example, lubricant and clean syringes for hormone injections).

Transgender sex workers who could not obtain identity cards respectful of their chosen gender identity found it difficult to access even the most basic health care or social services.

### **Inappropriate and Inadequate Services**

Available STI and HIV services were often closed during hours when sex workers could frequent them, located in inconvenient areas, and unable to provide specific and pertinent information about safer sex work, safer gender transitioning, safer drug use or safer sex between men.

When services narrowly addressed HIV and STIs, sex workers were unable to get the support to address many of their social determinants of HIV-risk such as working conditions, homelessness, police repression and human rights abuses.

Prevention-materials and HIV and STI treatment were often insufficiently available or unaffordable. In some cases, they were inappropriate, such as written materials handed out to sex workers with low literacy levels.

### **Funds Diverted to Programmes with No Evidence-Base**

Sex workers were frustrated with the large sums of money allotted to programs that had no evidence-base for diminishing HIV among sex workers (or for diminishing sex work) such as “exiting” or “rehabilitation” programs for sex workers. As one respondent said: “Enough with the sewing machines! We need better working conditions.”

## **THE NEED FOR A COMPREHENSIVE RIGHTS-BASED APPROACH**

### **Decriminalization & Non-Repressive Policy**

Sex workers spoke at length of the need to change what one respondent called “both unwritten and written laws on sex work”; to repeal punitive laws and policies that contradicted public health objectives and human rights standards.

A number of sex workers stated that efforts to address HIV would consistently fall short if they neglected to address the criminalization of sex work, of same-sex activity and of gender expression.

### **HIV Interventions in Line with Human Rights Standards**

Sex workers affirmed the need for governments to repeal HIV-related law and policy measures that contributed to greater rights abuses through mandatory or forced testing, public disclosure of results or arrest of HIV-positive sex workers.

Sex workers underlined the importance of ensuring that as voluntary testing was increased, it remained truly voluntary. Furthermore, respondents underscored the importance of ensuring that sex workers had access to the highest attainable standard of health care and safeguarding against this right being curtailed due to a desire not to spend more money on sex workers' health.

### **Collective Empowerment**

Collective empowerment was seen as an absolutely necessary component to improving working conditions for sex workers; redressing abuse and developing sex worker-led strategies for health and rights interventions. In response to questions about how to support sex workers in protecting their health, respondents frequently alluded to the connections between individual and collective rights and power over working and living conditions. One respondent referred to this interplay as “improving sex workers' bargaining position” to enforce condom use and other safety precautions.

### **Recognition of Sex Work as Work**

Many of the impediments sex workers faced to protecting their health and safety were the result of unsafe and unjust working conditions. Many respondents pointed out that until governments and international bodies recognize sex work as work, it will be impossible to address the labour issues that frequently underpin sex workers' vulnerability to HIV.

### **Comprehensive Programmes**

Sex workers affirmed the importance of supporting programs that did not deal exclusively and narrowly with HIV and STIs but holistically addressed sex workers' needs. In some cases this referred to the need to address “human rights, health rights, legal rights,” in order to address sex workers' vulnerabilities to HIV.

In other places this meant addressing issues of working conditions, homelessness, conjugal violence, gender transition and migration as part of addressing access to prevention and treatment.

**Sex Worker-Led Strategies**

Sex worker repeatedly affirmed the necessity of meaningful partnerships between governments and sex workers within the planning, implementing and evaluating of HIV and STI prevention and treatment initiatives.

The results of this consultation highlight how in different locales, sex workers' needs, issues and priorities are vastly different. Sex workers are the best placed, in their varying contexts, to help design successful health strategies for their milieu and communities.



## THEMES SPECIFIC TO HIV and STI PREVENTION and TREATMENT SERVICES

### 1. COLLECTIVE EMPOWERMENT

Respondents unanimously supported collective empowerment of sex workers as a necessary component of strategies to address HIV and sex work.

Many respondents identified an important interplay between individual and collective empowerment. Individuals asserting more power over their living and working conditions can inform collective interventions to address systemic abuses or exclusions. As one respondent described this dynamic: “The benefit is that sex workers get [...] information, become brave to fight for their rights to health, become empowered to form their own organisations”. Conversely, the power of a collective behind them can make it possible for sex workers to address individual instances of abuse or exclusion.

Collective empowerment projects were cited as among the few to address in a long-term and sustainable way the rights violations, state repression and systemic discrimination that place sex workers at important risks, including health risks. Furthermore, by addressing sex workers' power over their living and working conditions, collective empowerment projects were highlighted as among the few to look at sex workers' lives holistically and in so doing to engage with issues such as migration, education, resistance to violence, mental health, relationships and self-representation.

Many respondents specified that supporting the collective empowerment of sex workers needed to be understood as necessarily including supporting sex workers' self-determination and self-organizing through sex worker led organisations or where these do not exist, spaces where sex workers can meet and in their own space, share information and build community.

Many respondents also identified the importance of recognizing sex workers as equal partners in designing, implementing and monitoring laws, policies, programs and interventions that are directed at them. Furthermore, when government bodies, transnational bodies, INGOs and NGOs meaningfully engage with sex workers as equal partners, this can often project a social recognition of sex workers as worthy of inclusion and equality more broadly. It was noted that sex workers are better able to assume such partnerships, when they have been supported to self-organize. One respondent expressed that the flip side of this is that “when support for collective empowerment is absent, we are not given equal recognition.”

Some respondents specified that one way collective empowerment should be included in strategies on HIV and sex work is by reallocating existing resources for HIV-prevention in commercial sex from large INGOs with no rights-based programming to sex worker-run organizations. For some respondents, an added benefit of sex worker-run services was that they were more likely to relevantly address the specific barriers and opportunities sex workers faced in protecting their health. As one respondent explained: “the large majority of HIV-prevention funds in our region go to large NGOs [with no sex worker leadership]. It is impossible for them to have the same kind of impact that we would have if funding went to sex worker-run initiatives.”

A further consideration identified by some respondents was that of all the possible interventions to include in a strategy on HIV and sex work, collective empowerment is the one that most clearly “has no disadvantages”.

## **2. CONDOM PROMOTION**

Respondents unanimously supported condom promotion and distribution to sex workers.

### **Enabling Conditions**

Respondents emphasized the importance of condom promotion strategies being peer-led (not just peer-implemented) in order for them to be relevant and thus effective. Some respondents stressed the importance of advice about condoms linked to advice about working conditions and the negotiation of commercial transactions rather than generic information.

Some respondents expressed concern that if condom-promotion was not part of a broader project supported by governments to increase sex workers’ power over their working conditions and living conditions, it would fail to be effective. In particular, laws against the sale of sex, the purchase of sex, or brothel-keeping meant that in many countries, sex workers and brothel owners feared keeping condoms on them, lest they be a tip off to police and lead to arrest, extortion or abuse.

Some respondents hoped for condom promotion to occur within the general population or specifically to men in order for clients to be reached. Some respondents supported condom-promotion to clients in sex work venues, while others had experienced such initiatives and felt that they had stigmatized condoms as associated with sex work or “bad sex”.

### **Male Condoms, Female Condoms & Lubricant**

All sex workers wished for greater availability of male condoms, particularly in sex work sites. Some sex workers still encountered barriers to accessing sufficient male condoms. One respondent commented that: “Not enough condoms and lube are distributed. For example, the Global Fund only allows for 128 condoms per worker!”

A couple of respondents reported that access was currently a problem, due to stock-outs of male condoms at NGOs that provided them to sex workers and even pharmacies. In one country with a mandatory-testing regime, sex workers complained that government clinics refused to give out condoms to sex workers who tested HIV-positive as they could no longer work legally under the legal regime in that country.

A couple of respondents spoke of the poor quality or unpleasant smell of the male condoms that were available for free. They felt that greater variety in sizes, brands and types of condoms (i.e. flavoured, lubricated, non-lubricated) that could be used for different work situations would make them more appealing to sex workers.

Female condoms were generally unavailable or too expensive to be affordable. A number of female sex workers in Africa and Asia spoke of wishing they could access them because they felt

safer with them. One male sex worker spoke of male and transgender sex workers preferring female condoms as more pleasurable. Other respondents found female condoms of little interest.

Respondents emphasized the need for lubricant distribution to accompany condom promotion. In many locales, lacking lubricant, sex workers improvised with oil-based liquids that lead to condom breakage. As one respondent put it: “Giving out condoms without lubricant is like giving out canoes without a paddle.”

Lubricant was particularly important for sex workers providing anal sex (for sex workers of all genders but particularly for MSM and transgender sex workers). Sex workers also spoke of the importance of lubricant in reference to vaginal sex, particularly if they were experiencing vaginal dryness due to drug use, menopause or physical fatigue. Respondents in Africa and Caribbean spoke of the importance of providing lube because it was difficult to purchase given the widespread stigmatizing of lube as for “bad sex” or “gay sex”. In one context where homophobic violence was widespread and severe, a respondent underscored the importance of understanding how the associations of lubricant with gay sex could prove an insurmountable obstacle to purchasing it.

### **3. PERIODIC VOLUNTARY SCREENING FOR STIs**

Respondents expressed unanimous support for periodic voluntary screening for STIs. A great emphasis was placed on the need for screening to be truly voluntary; for STI treatment to be affordable and accessible; for medical staff to respect confidentiality and be non-discriminatory. Respondents wished STI-testing would be made truly accessible to sex workers by reaching outside of urban centres and using outreach vehicles that were tied to peer-driven projects or operating next to sex work sites; and being trained and equipped to offer services to male and trans sex workers. (In some African countries, it was greatly appreciated as a concept, but diverged from common practice whereby STI diagnoses are almost entirely syndromic for the general population due to cost).

One respondent expressed concern that such an intervention must safeguard against STI results being shared with brothel-owners or managers and leading to labour abuses (unfair dismissal, enforcement of unsafe sex, etc.).

### **4. PERIODIC PRESUMPTIVE TREATMENT OF STIs (PPT)**

Respondents expressed overwhelming disapproval of PPT. Respondents most commonly cited “the violation to sex workers’ rights” and the stigmatizing effect of furthering public perception that “all sex workers are sick” as objections. A number of respondents felt that such interventions could give both sex workers and clients a false sense of security and make condom use more difficult to enforce. One respondent replied: “Sex workers deserve the highest standard of health care not some inadequate minimum package. Here antibiotics are available over the counter and sex workers treat themselves symptomatically. Resistance is a problem in our country already.”

Many cited resistance, strain on the immune system, digestive tract and vaginal health as important side effects. One respondent expressed alarm that such measures “could lead to sex workers and

clients becoming reservoirs of resistant strains” creating a long-term obstacle to fighting HIV among a most-at-risk group. One respondent had experienced PPT in the 1980s when it was widely practiced in Peru (and mandatory) and had had negative health consequences, including experiencing a resistant strain of an STI.

Of the few sex workers who supported PPT, all interpreted it as voluntary and most interpreted it as an adjunct to (not a substitute for) voluntary screening whereby they could get free antibiotics when they chose not to screen (Indeed, most interpreted it as very similar or the same to how sex workers in their countries currently self-medicated with over-the-counter or black-market antibiotics). Of note, those who expressed support for PPT were strongly against non-voluntary interventions of any kind. Two respondents further qualified that it was only appropriate as a temporary measure if there was an important STI outbreak and no tests were available.

## **5. MANDATORY TESTING**

Respondents expressed overwhelming disapproval of mandatory testing. Respondents’ interpretation of mandatory testing varied. One respondent was uncertain but did express concern that it would result in discrimination against people living with HIV given laws criminalizing HIV-positive people who practice safe sex but do not disclose their status. Another respondent was open to the possibility under a legal framework recognizing sex work as work but was strongly opposed to legal penalties for sex workers who did not test.

Those who lived under mandatory testing in Latin America and Asia expressed unanimous disapproval. Such testing often was reported to lead to HIV-positive sex workers having to work underground or in a different part of the country as to go undetected by law enforcement. In some countries, mandatory tests were expensive and workers could not choose their health personnel even if they were facing discrimination or inadequate care. Mandatory testing was reported across many countries to be used by police as a threat to increase extortion and control over sex workers.

## **6. PROVIDER-INITIATED TESTING**

Respondents expressed overwhelming disapproval of this practice. A few respondents in Southern Africa were in favor. One respondent had experienced population-wide provider-initiated STI testing in the past (prior to being a sex worker) and expressed grave concern with how it overlapped with laws on mandatory notification of partners and laws in her country allowing the detention of HIV-positive people who authorities believe are not notifying their partners of their status, even if they are engaging in protected or low-risk activity.

## **7. VOLUNTARY COUNSELING AND TESTING FOR HIV (VCT)**

Respondents unanimously supported VCT. As with other clinical practices, they said that voluntary STI-testing must encompass confidentiality, accessibility and respectful service.

A number of respondents in Asia and Africa expressed concern that, as one respondent put it “Voluntary Counseling and Testing” had actually become “Virtually Compulsory Testing”. One respondent in Asia expressed great concern that “indicators of intervention programs based around number of sex workers tested are leading to more mandatory testing.” An African respondent echoed this concern and cited an NGO subjecting sex workers to coercive testing. Yet another respondent replied that:

“Testing is not voluntary in practice as a side effect of the 100% Condom Use Policy that has encouraged a system of pseudo mandatory testing where women must show a recent HIV test to collect their earnings and also on demand by police working in cooperation with Public Health. Migrant sex workers are under the same system of forced testing yet have no access to treatment.”

Many respondents expressed concern that “counseling” often consisted of rote messages that were rarely relevant to the barriers sex workers faced in their personal and work lives to preventing HIV transmission or taking care of their health. A respondent commented that “Counseling is simply a routine set of questions that lead to a HIV test, rather than a discussion to help sex workers decide whether to have a test or not.”

A number of respondents expressed concern at how new laws criminalizing non-disclosure of HIV status (even during protected interactions) were an obstacle to testing.

## **8. ANTI-RETRO VIRAL TREATMENT (ARVs)**

Respondents overwhelmingly supported for the same ARV treatment protocols as for other adults. A great emphasis was placed on the need for universally accessible treatment- including for undocumented migrants (either domestic migrants, as in the Former Soviet Union countries, or transnational migrants). With all but one exception, sex workers rejected targeting sex workers as priorities for receiving “treatment as prevention” in favour of universal access to ARVs and health care for HIV-positive people.

Many respondents stressed that for ARVs to be more available to sex workers, more sex workers must know their status. In order for this to occur, there must be less discrimination from health care personnel are more sex worker-led and empowerment-based projects that provide testing. A number of African respondents cited the need for nutritional counseling and the need for harm-reduction based alcohol counseling as necessary to improve ARV access.

Sex workers faced a number of barriers in taking their ARVs regularly such as fearing discrimination if people learned of their status, needing to hide their pills from clients when traveling with them (in their trucks, for example), the distance to clinics and frequent ARV stock-outs. In some countries in Asia a further problem is that a person’s CD-4 count has to be as low as 250-300 to get ARVs yet the person still has to be healthy enough to tolerate them in order to access them.

A number of sex workers said that HIV-positive sex workers need more than medication: they need comprehensive support, care and advocacy. However, one respondent explained: “There is no social support within the government or Global Fund planning for sex workers with HIV.”

## CONCLUSION

A few major themes emerge in sex workers' responses. The first is the need to stop harmful laws, policies and practices that either contribute to HIV-transmission or impede successful prevention and treatment.

The second is the need to scale-up successful interventions and to make them more relevant and accessible by involving sex worker-leadership.

The third is the need to see HIV and STI outside of a medical vacuum: to consider the important weight of obstacles such as human rights abuses, state repression, poor working conditions and discrimination and yet, to also see the remarkable possibilities presented by decriminalization, collective empowerment, rights-based programs and comprehensive strategies.