



**CHANGE**

CENTER FOR HEALTH  
AND GENDER EQUITY

## **ALL WOMEN, ALL RIGHTS, SEX WORKERS INCLUDED:**

U.S. FOREIGN ASSISTANCE AND  
THE SEXUAL AND REPRODUCTIVE HEALTH  
AND RIGHTS OF FEMALE SEX WORKERS

# ACKNOWLEDGEMENTS

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# ACRONYMS

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ANC	antenatal care
APLO	Anti-prostitution Loyalty Oath
ART	antiretroviral therapy
COPs/ROPs	Country Operational Plans/Regional Operational Plans
DMPA	Depot medroxyprogesterone acetate, commonly known as Depo-Provera, a long-acting injectable contraceptive
FSW	female sex worker
GBV	gender-based violence
HHS	U.S. Department of Health and Human Services
HIV	human immunodeficiency virus
HPV	human papillomavirus
HTC	HIV testing and counseling
IAC	International AIDS Conference
LARCs	long-acting reversible contraceptives
LINKAGES	Linkages across the continuum of HIV services for key populations affected by HIV
MSM	men who have sex with men
NGOs	non-governmental organizations
NSWP	Global Network of Sex Work Projects
OGAC	U.S. Office of the Global AIDS Coordinator
PAC	post-abortion care
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
PrEP	Pre-Exposure Prophylaxis
PWID	people who inject drugs
SRHR	sexual and reproductive health and rights
SRH	sexual and reproductive health
STIs	sexually transmitted infections
SWIT	Sex Worker Implementation Tool or <i>Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions</i>
TVPA	Trafficking Victims Protection Act
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHO	World Health Organization

# ABOUT THIS REPORT

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Female sex workers (FSWs) experience significant unmet sexual and reproductive health and rights (SRHR) needs related to family planning, safe pregnancy, gender-based violence (GBV), and HIV. FSWs continue to be framed by the international community largely in terms of their HIV risk as though it represents the full depth and breadth of their health needs. While rights-based HIV prevention, treatment, and care for FSWs is essential, the international community must acknowledge that FSWs are women with a range of SRHR needs and the same right to comprehensive, non-discriminatory healthcare services as women in the general population.\*

In recent years, emerging research and collaborative guidelines on programs for sex workers such as the *Sex Worker Implementation Tool* (SWIT)<sup>1</sup> have increased knowledge about evidence-based best practices to effectively address the HIV epidemic in FSWs, as well as promote their broader SRHR needs. The global movement for the decriminalization of sex work is also gaining momentum with growing recognition that promoting FSWs' fundamental human rights is necessary to end the HIV epidemic, including the rights to associate and organize, the right to equal protection of the law, the right to be free from violence, the rights to privacy and freedom from arbitrary interference, the right to health, and the right to work and free choice of employment.<sup>2</sup> The United States (U.S.) has also gradually intensified its global health programming and funding specific to FSWs. Some of its most recent projects suggest an encouraging shift toward recognition of the necessity of a human rights approach to FSWs and other key populations.<sup>†</sup>

Despite these areas of progress, significant challenges remain. Insufficient attention and resources are directed at the structural drivers of FSWs' HIV risk and poor SRHR outcomes, including criminalization, stigma, discrimination, and endemic violence. Moreover, the health and rights of FSWs are highly politicized, with resulting negative consequences for donor policies and programs.

The first section of this report aims to provide an overview of best practices around the SRHR of FSWs, including those related to HIV/AIDS, family planning, sexual health, maternal health, and gender-based violence, as well as highlight some of the most urgent knowledge gaps that should be addressed moving forward. The second section of this report assesses how U.S. foreign assistance can better conform with best practices to support the SRHR of FSWs, including both specific policies and more general programmatic approaches.

The report is based on a review of peer-reviewed articles, collaborative guidance and recommendations, and grey literature which examined the SRHR needs of FSWs. CHANGE also conducted semi-structured, not-for-attribution interviews with key informants, including U.S. officials, country-based implementers, researchers, sex workers, and sex worker advocates, service providers, and representatives from multilateral

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\* This report focuses on female sex workers (FSWs). For the purposes of this report, FSWs primarily means cisgender women sex workers. However, it is crucial to recognize the unmet sexual and reproductive health needs and extreme rights violations faced by transgender women engaged in sex work. There remains a tremendous research gap on the distinctive needs of transgender women sex workers—the limited data available demonstrate high levels of stigma, discrimination, violence, and elevated risk for HIV. For example, a 2008 systematic review and meta-analysis examining sex work and HIV status among transgender women found that as many as one in four transgender women sex workers is living with HIV (note that this review primarily included studies conducted in high-and middle-income countries). See Don Operario et al., *Sex Work and HIV Status Among Transgender Women: Systematic Review and Meta-Analysis*, 48 JAIDS 97, 102 (2008). To the extent that transgender people and sex workers constitute distinctive key populations, transgender women sex workers may be understood to experience intersectional forms of risk and vulnerability which require committed research, investment, and response. For a discussion of the health needs of transgender sex workers, see S.L. REISNER ET AL., TECHNICAL REPORT: THE GLOBAL HEALTH NEEDS OF TRANSGENDER POPULATIONS 19-28 (2013), available at [http://www.aidstar-two.org/upload/AIDSTAR-Two-Transgender-Technical-Report\\_FINAL\\_09-30-13.pdf](http://www.aidstar-two.org/upload/AIDSTAR-Two-Transgender-Technical-Report_FINAL_09-30-13.pdf); GLOBAL NETWORK OF SEX WORK PROJECTS, BRIEFING PAPER NO. 9: THE NEEDS AND RIGHTS OF TRANS SEX WORKERS (2014), available at <http://www.nswp.org/sites/nswp.org/files/Trans%20SWs.pdf>. Although CHANGE's mission centers on the health and rights of women and girls, which are the focal point of this report, many men also engage in sex work. They too experience a hugely diverse range of work settings, health needs and vulnerabilities. See GLOBAL NETWORK OF SEX WORK PROJECTS, BRIEFING PAPER NO. 8: THE NEEDS AND RIGHTS OF MALE SEX WORKERS (2014), available at <http://www.nswp.org/sites/nswp.org/files/Male%20SWs.pdf>.

† Key populations include men who have sex with men (MSM); people who inject drugs (PWID); sex workers; transgender people; and people in prisons and other closed settings.

organizations. Based on our review and these interviews, we identify priority areas where U.S. foreign assistance should be better harmonized with best practices and fundamental human rights principles in order to more effectively promote the health and rights of FSWs.

In a global context where sex work is almost universally criminalized and gross human rights abuses against sex workers are widespread, changes to U.S. foreign assistance are only one piece of what must be a larger collective response. However, the U.S. is well-positioned as both a funder of research and an international donor to promote a global health agenda that addresses FSWs' broader SRHR needs and priorities, along with an inclusionary, rights-based, community-empowerment paradigm.

## **The Health and Human Rights Framework**

It is well-established that “health is a fundamental human right indispensable for the exercise of other fundamental human rights.”<sup>3</sup> The health and human rights framework embraces the centrality of structural drivers of human well-being, including gender inequality, stigma, and discrimination. As with other fundamental rights, States have an affirmative obligation to respect, protect, and fulfill the right to health. Health facilities, goods, and services must also be available, accessible, acceptable, and of high quality. Additionally, communities should have the opportunity to participate in health-related decision-making at every level.<sup>4</sup>

The relationship is reciprocal—violations of core human rights are a clear driver of ill health. In the context of the HIV epidemic, it was observed early on that “individual and population vulnerability to disease, disability, and premature death is linked to the status of respect for human rights and dignity.”<sup>5</sup>

These principles are especially important for FSWs, a population which has often been targeted for coercive public health and social policies that fail to incorporate fundamental human rights principles, such as non-discrimination and equal treatment.

# EXECUTIVE SUMMARY

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The global response to the health of FSWs has focused principally on HIV, but it is vital to recognize that the disproportionate burden of HIV borne by FSWs occurs in tandem with significant unmet SRHR needs. Many FSWs face an unmet need for family planning, and programs often fail to account for FSWs' specific needs, frequently resulting in unintended pregnancy. Across diverse settings, a majority of FSWs will be mothers, yet linkages between HIV and antenatal care services for FSWs remain weak. High levels of unintended pregnancy lead many FSWs to resort to unsafe abortion, particularly in countries where abortion is legally restricted or otherwise inaccessible. Globally, GBV directed at FSWs is a severe problem negatively affecting FSWs' health and rights in a multitude of ways.

The past several years have witnessed a scaling up of international efforts to address the health and rights of FSWs, as well as an intensifying call for the decriminalization of sex work. While the U.S. has advanced its global health response to the needs of FSWs since the passage of the Global AIDS Act in 2003, policy and programmatic challenges remain and should be addressed to more effectively promote the health and rights of FSWs, including:

- the U.S. conflation of sex trafficking and voluntary sex work and the Anti-Prostitution Loyalty Oath (APLO), as well as the associated failure to prioritize community empowerment interventions;
- funding, research, and programmatic silos which reflect a failure to recognize the whole-woman health needs of FSWs;
- an ongoing emphasis on biomedical interventions to prevent HIV over broader SRHR interventions;
- disconnection from national programs and minimal country investment in FSWs, which results in lack of sustainability;
- restrictions on U.S. foreign assistance for abortion and abortion-related activities;
- limited access to SRHR services for adolescents who sell sex.

On the basis of the findings and analysis, the report concludes with concrete recommendations on ways in which the U.S. government can take action to support the SRHR of FSWs. CHANGE suggests a range of actions, including rescindment of National Security Presidential Directive-22 (NSPD-22) and clearer guidance on the APLO, more intensive promotion of integration across the full spectrum of FSWs' SRHR needs, particularly family planning and HIV, and a scale up of Pre-Exposure Prophylaxis (PrEP) and HIV Testing and Counseling (HTC) that is rights-respecting and inclusive of civil society. CHANGE hopes the recommendations will support efforts to advance sex workers' rights. Furthermore, the report's findings demonstrate that the U.S. government, and PEPFAR in particular, are poised to foster stronger integration between SRH and HIV services for FSWs.

## I. INTRODUCTION: HUMAN RIGHTS, SRHR, AND THE SEX SECTOR

FSWs continue to bear a disproportionate burden of HIV/AIDS,<sup>6</sup> but also experience significant unmet SRHR needs related to family planning, safe pregnancy, and gender-based violence.<sup>7</sup> The causes of these poor health outcomes are diverse, but the centrality of structural factors such as criminalization and systemic human rights violations is well established.<sup>8</sup> Criminalization of sex work encourages stigma and discrimination against FSWs.<sup>9</sup> Such laws transform sex work into an illegitimate, criminal identity rather than a way of earning an economic livelihood.<sup>10</sup> Even without a criminal record, FSWs are viewed as “dirty,” immoral, and deserving of punishment, with negative consequences for healthcare, education, housing, and parental rights.<sup>11</sup>



Stigma and discrimination, together with criminalizing laws, operate to exclude FSWs from health systems, including access to critical preventive commodities, such as male and female condoms.<sup>12</sup> Many countries, including the U.S., continue to neglect FSWs in their national public health systems, with foreseeable shortcomings in knowledge about FSWs' disease burden and health needs.<sup>13</sup> To illustrate, between 2011 and 2015, an average of only 37 countries reported HIV prevalence among female sex workers to UNAIDS.<sup>14</sup> Moreover, few countries have public health programming specifically designed for FSWs and government investment in such programs is generally low.<sup>15</sup> UNAIDS estimated in 2012 that less than 1% of global funding for HIV prevention was spent on HIV and sex work.<sup>16</sup>

## Legal Regulation of Sex Work— What are the Options?

Sex work is governed by a variety of legal models, the most common of which is criminalization.

- **Criminalization:** The specific law will vary from setting to setting, but normally there will be a prohibition on the act of receiving money or goods in return for sex (i.e., being a sex worker); for providing money or goods in exchange for sex (i.e., being a client); and/or being connected with or otherwise profiting from the sex industry (e.g., being a “madam” in a brothel).
- **Partial criminalization:** Often referred to as the “Swedish model” or the “Nordic model” because of its adoption in Sweden and Norway, this approach decriminalizes the selling of sex but the purchasing of sex remains a crime.
- **Legalization:** Sex work is made formally legal, but is heavily regulated and treated differently than other forms of work. Typical requirements relate to permissible working areas, mandatory health checks, and registration—failure to comply can result in criminal sanction. Senegal and the Netherlands are examples of this model.
- **Decriminalization:** Criminal penalties for sex work are removed. Sex workers receive the same protections and recognition as workers in any other occupation. New Zealand fully decriminalized sex work in 2003.

Laws that criminalize sex work make FSWs disproportionately vulnerable to police harassment, violence, and human rights abuses.<sup>17</sup> Enforcement activities by police—including confiscation of condoms or use of condoms as evidence of illegal activity, arrest and detention, raids, displacement, extortion, and violence—encourage FSWs to move underground where they have less control over their working conditions, including condom negotiation and client screening, and are less able to access essential health services.<sup>18</sup> Not carrying condoms to avoid arrest has clear consequences for FSWs' ability to protect themselves while working. Negative interactions with the police also lead directly to negative health outcomes. One study demonstrated that having coerced sex with police to avoid trouble, giving gifts to police to avoid trouble, police confiscation of condoms, workplace raids, and arrest were all associated with STI symptoms, inconsistent condom use, acceptance of more money for unprotected sex, and client violence.<sup>19</sup> Paying bribes to the police threatens FSWs' economic security, thereby increasing pressure to engage in higher-paid, riskier sex. It is thus unsurprising that FSWs frequently avoid seeking the protection of police in response to abuse by clients and other non-state actors for fear of arrest or other mistreatment.<sup>20</sup> When directed at FSWs, rape and other forms of GBV are often not treated as criminal offenses, leading to a climate of impunity for clients and intimate partners alike.<sup>21</sup> This failure of



the State to respond to human rights violations perpetrated against FSWs is tantamount to a policy of tolerance for such abuses.<sup>22</sup> In a context where their occupation is criminalized, FSWs are also effectively hindered from organizing to form trade unions, promote their collective interests, or seek other essential labor protections.<sup>23</sup>

## **Amnesty International's Policy on the Decriminalization of Sex Work**

In May 2016, Amnesty International released a new policy that calls on States to “[r]epeal existing laws and refrain from introducing new laws that criminalize or penalize directly or in practice the consensual exchange of sexual services between adults for remuneration.”<sup>24</sup>

The policy followed months of intensive research across four very different settings: Argentina,<sup>25</sup> Hong Kong,<sup>26</sup> Norway,<sup>27</sup> and Papua New Guinea.<sup>28</sup> In each country, the legal status of sex work is slightly different, yet across the board, Amnesty International documented gross human rights violations perpetrated against sex workers. Amnesty International's findings demonstrated how these abuses are enabled by environments where sex work is criminalized. In response to these findings, as well as work done by major multilateral organizations such as WHO and UNAIDS, and extensive consultation with sex worker advocates and other stakeholders, Amnesty International embraced decriminalization as the most effective way for governments to protect, respect, and fulfill the rights of sex workers.

Countries that decriminalize sex work have experienced positive results. In 2003, New Zealand decriminalized sex work as part of what has been described as a shift from a “moralist approach” to a “health and human rights approach.”<sup>29</sup> In its report on the Prostitution Reform Act of 2003, which it released five years after the law's passage, the Prostitution Law Review Committee responsible for examining the impacts of the law concluded that it had a “marked effect in safeguarding the rights of sex workers to refuse particular clients and practices, chiefly by empowering sex workers through removing the illegality of their work.”<sup>30</sup> Other research has documented a dramatic positive shift in the relationship between sex workers and law enforcement in New Zealand following decriminalization: sex workers are now reporting violence and non-paying clients to police, who are enabled to more meaningfully support sex worker safety and rights.<sup>31</sup> Similarly, the state of New South Wales (NSW) in Australia has implemented a model that is largely decriminalized which has “improved human rights; removed police corruption; netted savings for the criminal justice system; and enhanced the surveillance, health promotion, and safety of the NSW industry.”<sup>32</sup> In neither setting have predictions about increased trafficking or a growth in the size of the sex industry come to pass.<sup>33</sup>

## What is sex work and why is it “work”?

The Joint United Nations Programme on AIDS (UNAIDS) defines a sex worker as an adult or young person eighteen years or older who receives money or goods in exchange for sexual services, either regularly or occasionally.

It is important to understand that there is great diversity in sex work. It may be brothel-based and highly organized or more informal and situated in public settings like parks or bars. Some sex workers are highly mobile whereas others work from home. Women enter sex work for a variety of reasons—it may be a full-time occupation or function to serve a specific economic need, e.g., healthcare costs for a child. Many women who sell sex will not self-identify as sex workers.<sup>34</sup>

Sex workers are entitled to the same rights and protections as other workers. The view that sex work is inherently exploitative denies the fundamental agency of sex workers—sex may be understood as a form of labor like any other form of labor. Criminalization of sex workers or their clients “negates the individual right to self-determination, autonomy, and agency” for sex workers. Criminalization nullifies sex workers’ control over their own bodies, directly impairs their free choice over how to make a living, and perpetuates prejudice and stigma.<sup>35</sup>

The dangers and human rights abuses that sex workers face result from criminalized settings in which they are rendered unable to enforce their rights or seek basic protections from the State. Sex workers need the same things that all workers need: access to healthcare, safe workplaces, and protection from labor abuse and exploitation. This is why UNAIDS, UNDP, UN Women, the ILO and people engaged in sex work all embrace the concept and terminology of sex work as “work.”

FSWs also confront a range of barriers from the health sector due to criminalization, including stigma and discrimination from providers. For instance, in a survey of more than 200 healthcare providers in Laos who offered STI services to FSWs, more than half expressed negative attitudes about FSWs.<sup>36</sup> Negative provider attitudes may result in a lack of confidentiality, e.g., regarding HIV status or engagement in sex work, forced treatment or testing, and denial of needed services.<sup>37</sup> Migrant FSWs, FSWs living with HIV, and FSWs who inject drugs frequently face even greater discrimination from healthcare providers. In response to poor treatment, FSWs may avoid seeking care altogether or may choose not to disclose that they are sex workers to healthcare providers, with clear implications for the quality and appropriateness of service delivery.<sup>38</sup> In addition to stigmatizing attitudes, many providers lack appropriate knowledge and training to meet the unique needs of FSWs.<sup>39</sup>

## **UN Rapporteur on the right of everyone to the highest attainable standard of health:**

“As with other criminalized practices, the sex-work sector invariably restructures itself so that those involved may evade punishment. In doing so, access to health services is impeded and occupational risk increases. Basic rights afforded to other workers are also denied to sex workers because of criminalization, as illegal work does not afford the protections that legal work requires, such as occupational health and safety standards.”<sup>40</sup>

While decriminalization of sex work is necessary for FSWs to fully realize their fundamental rights and is a precondition for an effective global HIV response, it should not be understood as a panacea. An enabling environment for FSWs also requires affirmative, rights-respecting laws to protect against discrimination and violence, and ensure other essential protections, including social, health, and financial services. National strategic health plans should recognize FSWs, and ensure that healthcare services to FSWs are available, accessible, acceptable, and of high quality based on the principles of non-discrimination and the right to health. Addressing police abuse and the barriers to accessing legal services in response to violations of FSWs’ rights requires systemic institutional change that does not occur overnight. Social and cultural norms that encourage GBV against FSWs and other key populations must be challenged. Finally, the promotion of community empowerment and partnerships between sex worker-led organizations, government, civil society, and local allies is a process that should be strengthened and sustained over time.<sup>41</sup>

## **II. THE HEALTH AND HUMAN RIGHTS OF FEMALE SEX WORKERS: WHAT DO WE KNOW?**

This section provides a summary of public health research on FSWs and HIV, family planning, safe pregnancy and maternal health, abortion, gender-based violence, substance use and harm reduction, and hard-to-reach populations.

### **HIV/AIDS**

Though FSWs continue to bear a disproportionate burden of HIV in both concentrated and generalized epidemic settings,<sup>‡</sup> there are still significant gaps in knowledge about their experience with HIV prevention, treatment, and care. In many settings, FSWs encounter numerous barriers, whether in accessing voluntary, confidential testing or adhering to antiretroviral therapy (ART) following a diagnosis of HIV.<sup>42</sup>

#### ***HIV Prevention***

FSWs’ risk of HIV occurs at multiple levels, including individual biologic and behavioral, network, community, social, and environmental. Effective prevention interventions will target these intersecting drivers of risk by including combinations of biomedical, behavioral, and structural approaches.<sup>43</sup>

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<sup>‡</sup> A generalized epidemic is characterized by an HIV prevalence that is consistently greater than 1% in pregnant women attending antenatal clinics. An epidemic is concentrated when HIV is confined mainly to one or more high risk groups (such as MSM or PWID) and prevalence is less than 1% in the general population.

- Core Prevention Activities

Core recommendations for HIV prevention in FSWs include voluntary HIV testing and counseling (HTC) in community and clinical settings, correct and consistent condom use, and screening and management of sexually transmitted infections (STIs).<sup>44</sup> Peer interventions, sexual risk reduction, and condom promotion are also effective at reducing HIV risk.<sup>45</sup>

HTC is essential to prevention efforts and is the gateway point to care, yet many FSWs remain unaware of their status.<sup>46</sup> FSWs face the same challenges to accessing HTC as people in the general population; however, they also confront barriers unique to sex work, including pervasive provider stigma and discrimination, as well as forced or coercive testing which violates their rights to informed consent and bodily integrity.<sup>47</sup> Where there are laws that criminalize HIV non-disclosure, exposure, and transmission, FSWs may avoid testing because a positive result will create risk of arrest and prosecution.<sup>48</sup> Strategies to improve HTC uptake must account for the specific needs of the FSW population and the particular context.<sup>49</sup> In its 2015 *Consolidated Guidelines on HIV Testing Services*, the World Health Organization (WHO) stresses that community-based HIV testing services are often a critical way of increasing access for populations who would otherwise avoid seeking care, including FSWs.<sup>50</sup> These services should be offered in settings that are acceptable, convenient, and responsive to FSWs' experiences—for example, a mobile clinic or night clinic may facilitate better access to sexual health services for FSWs due to the nature of their work.<sup>51</sup>

Historically, a major focus of HIV prevention efforts among FSWs has been on increasing the use of condoms,<sup>52</sup> though sex workers exhibit the highest levels of reported condom use in the world.<sup>53</sup> While it is essential that condoms and condom-compatible lubricants are widely promoted and freely available to FSWs,<sup>54</sup> promotion alone does not go far enough. Condom promotion efforts need to address sex-worker specific barriers to consistent condom use, such as client refusal<sup>55</sup> or more money for unprotected intercourse.<sup>56</sup> Additionally, structural drivers of condom non-use must be considered. For instance, condoms are confiscated as evidence of criminal conduct and destroyed by police across many settings.<sup>57</sup> Research has shown that FSWs who move away from main streets because of police pressure and zoning restrictions can consequently experience increased risk of being pressured into unprotected sex with a client.<sup>58</sup>

Much of the attention to STIs among FSWs has been on account of STIs increasing the efficiency of HIV transmission, with far less emphasis on the role of STIs in producing high levels of general reproductive morbidity.<sup>59</sup> There remains insufficient attention to the unmet need for routine gynecological care among FSWs. A recent systematic review of facility-based sexual and reproductive services for FSWs in Africa revealed that only 3 of the 54 projects assessed offered access to cervical cancer screening and treatment.<sup>60</sup> Yet, multiple studies document the high burden of human papillomavirus (HPV) experienced by FSWs relative to women in the general population,<sup>61</sup> including persistent infection with high-risk strains, the main cause of cervical cancer.<sup>62</sup> Another important health issue is bacterial vaginosis, a common type of infection associated with vaginal douching or washing.<sup>63</sup> It is often highly prevalent among FSWs and is linked to pre-term delivery, pelvic inflammatory disease, and other STIs, including HIV.<sup>64</sup> Better integration of services to address these essential health needs is necessary.

- Post-Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP)

FSWs experience high levels of sexual violence—the estimated prevalence is 33-72% globally<sup>65</sup>—but there is surprisingly little published research on the availability or uptake of Post-Exposure Prophylaxis (PEP) for

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§ In 2014, the most recent year that UNAIDS has data available, 44 countries provided information on FSWs specifically. In that year, an overall average of 53% of FSWs in the countries submitting data had received an HIV test in the last 12 months and were aware of their status, but this masks tremendous regional and country-level variation. For instance, in Afghanistan, less than 6% of FSWs knew their status from a recent HIV test, whereas over 70% did in Kenya. See [aidsinfo.unaids.org](http://aidsinfo.unaids.org).

FSWs. PEP is the use of antiretroviral (ARV) medicine after potential exposure to HIV to prevent infection. Barriers to uptake for FSWs include perceived side effects of antiretroviral medications, lack of knowledge about PEP, and stigma.<sup>66</sup> A recent study of FSWs in Nairobi found that despite its free availability, the highest-risk FSWs were less likely to have heard of PEP, access PEP, or complete the full course of therapy once initiated.<sup>67</sup> In a 2014 systematic review of facility-based sexual and reproductive services for FSWs in Africa, not one site specifically mentioned provision of PEP.<sup>68</sup> There is thus an urgent need for more research on access, uptake, and adherence to PEP for FSWs.

Pre-Exposure Prophylaxis (PrEP), the daily use of ARV drugs by an HIV-negative person who is at high risk to prevent infection, is a promising tool for FSWs.<sup>69</sup> However, of the major PrEP trials to date, few have specifically described the inclusion of FSWs. Previous research has confirmed the potentially high acceptability of PrEP among FSWs,<sup>70</sup> but a global consultation conducted in 2014, which included more than 400 participants from 40 countries, demonstrated high levels of skepticism. Many sex workers indicated they would be unwilling to adopt PrEP as prevention, in part due to concerns about how it could detract from a comprehensive human rights-based approach, as well as its accessibility and sustainability.<sup>71</sup> The exclusion of FSWs from most of the research on PrEP to date highlights the need for a concerted effort to explore the distinctive structural challenges faced by FSWs in PrEP uptake and use, including provider stigma, fear of disclosure to other FSWs and clients, fear of the authorities, lack of social support, substance use, mobility, and risk compensation.<sup>72</sup> In 2015, WHO released updated recommendations on PrEP for individuals at substantial risk of HIV infection,\*\* a classification which includes some but not all FSWs.<sup>73</sup> WHO is also currently underway with several implementation studies on PrEP to examine its feasibility, several of which include sex workers.

### • The Emergence of other Woman-Controlled Prevention Methods

Microbicides are biomedical products that are being designed to prevent HIV infection by killing or disabling the virus. They can take many forms, including a topical gel, vaginal ring, or other kind of insert. The female condom is a method of barrier contraception that a woman can insert into her vagina before sex which can prevent both pregnancy and HIV.

There is currently no commercially available microbicide or vaginal gel to prevent infection with HIV, but modeling suggests that even a low-to-moderately effective microbicide would have a significant impact on HIV among FSWs<sup>74</sup> and some research has also shown the acceptability of microbicides for FSWs.<sup>75</sup> In 2016, results from two large studies demonstrated that a monthly vaginal ring containing the ARV drug dapivirine reduces the risk of HIV infection in women by about 30%.††<sup>76</sup> These results are exciting because a vaginal ring avoids many of the difficulties with adherence that undermine the effectiveness of topical gels—it can provide stable, long-acting protection over the course of an entire month, much like using a vaginal ring for contraception.<sup>77</sup> At the same time, intravaginal rings are discreet and woman-controlled and can therefore be critical in situations where it is not possible to negotiate condom use. The International Partnership for Microbicides plans to seek regulatory approval for the monthly dapivirine ring in 2017 and is in the process of developing a three-month ring. Ring technologies, which require minimal monitoring and do not require action before or after sex as some of the gels do, may be especially useful for FSWs. These technologies also protect against HIV infections with non-client partners but still preserve the option of pregnancy, which is a valuable benefit.<sup>78</sup> As the dapivirine ring is rolled out, more research will be needed about its use specifically with FSWs. Additionally, there should be more consideration of the future of rectal microbicides and their usefulness for FSWs—these clinical trials are in relatively early stages but have primarily focused on MSM and transgender women, though we know that in some settings, FSWs engage in high levels of anal sex.<sup>79</sup>

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\*\* Substantial risk is defined as greater than 3% incidence of HIV infection in the absence of PrEP.

†† 31% in the Ring Study and 27% in ASPIRE trial. Although there were somewhat different outcomes according to age level, this is likely related in part to adherence. In the ASPIRE trial, which included over 2,500 women from Malawi, Uganda, Zimbabwe, and South Africa, 6% of the baseline sample reported transactional sex in the previous year. See Thesla-Palanee Phillips et al., *Characteristics of Women Enrolled into a Randomized Clinical Trial of Dapivirine Vaginal Ring for HIV-1 Prevention*, 10 PLOS ONE 1, 7 (2015).

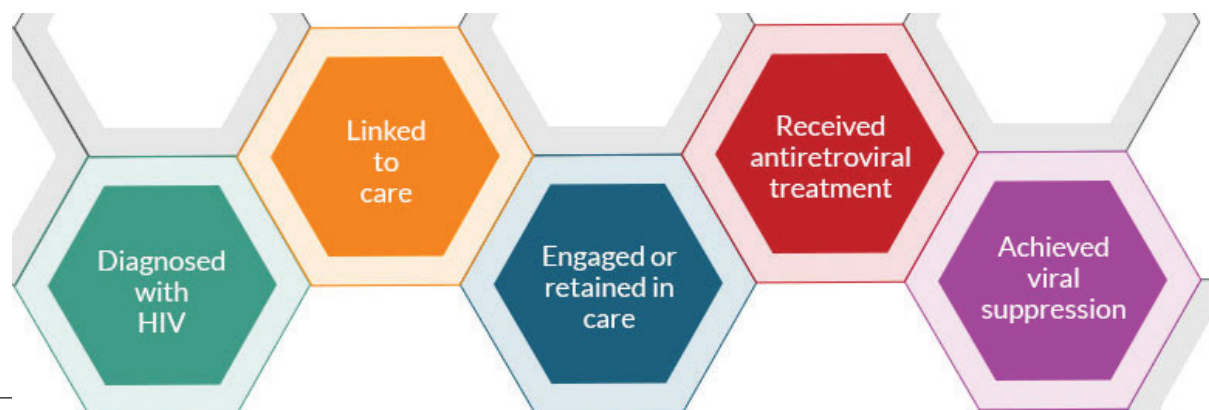


Given the numerous barriers to FSWs' consistent use of the male condom, the female condom offers real promise as the only woman-controlled method of dual protection that is currently available. In more than one study, the majority of FSWs sampled have preferred the female condom to the male condom.<sup>80</sup> There is also fairly strong evidence to suggest that programs which promote both male and female condoms among FSWs may be more successful at reducing unprotected sex than male condoms alone.<sup>81</sup> In at least one study, peer promotion of female condoms was just as effective as more intensive, clinic-based counseling.<sup>82</sup> Provision of female condoms to FSWs can also be highly cost-effective.<sup>83</sup> However, female condoms generally remain inaccessible or too expensive for many FSWs.<sup>84</sup>

- **Community Empowerment**

There is increasing support for the effectiveness of community empowerment approaches to promote the health and rights of sex workers.<sup>85</sup> In the community empowerment model, sex workers take ownership of the interventions that are designed to impact their lives. Sex worker-led interventions succeed because sex workers are best situated to identify their own needs, perspectives, and priorities.<sup>86</sup> Community empowerment forms the bedrock of the SWIT, as both an intervention in itself but also as a means of ensuring the effective planning, monitoring, and evaluation of HIV/STI interventions generally.<sup>87</sup> UNAIDS identifies community empowerment as being “at the heart of a human rights-based approach to HIV and sex work”<sup>88</sup> and enhancement of community empowerment among sex workers is also one of the evidence-based recommendations in WHO et al's *Prevention and Treatment Recommendations*.<sup>89</sup> Recent modeling has demonstrated that empowerment-based interventions can have a significant impact in both concentrated and generalized epidemic settings.<sup>90</sup>

### **The HIV Care Cascade**



From: [www.avert.org](http://www.avert.org)

A cascade framework is a helpful way of understanding the continuum of HIV services, from identifying and reaching FSWs with HTC to sustaining them on lifesaving treatment once diagnosed. While HIV prevention constitutes the essential first step of the cascade framework, the remainder of the continuum depicts the step-by-step process of a person being diagnosed as HIV-positive to receiving treatment and ultimately being virally suppressed (i.e., having a low amount of HIV in the body).<sup>91</sup> The extent to which FSWs successfully engage in the HIV care cascade has received considerably less attention than HIV prevention. Research suggests that FSWs can achieve ART uptake, attrition, and adherence outcomes comparable to those seen among women in the general population.<sup>92</sup> Yet, accessibility remains a serious problem for FSWs across many settings.<sup>93</sup> For instance, a majority of FSWs living with HIV who were eligible for treatment in a recent study in Cameroon were not accessing ART.<sup>94</sup> Unaffordability and frequent stock outs in many countries,<sup>95</sup> which encourage FSWs to modify their dosage in order to conserve medication, lead to compromised treatment effectiveness.<sup>96</sup> The lack of adequate access to ART results in preventable HIV-related mortality, which may be much higher among FSWs than in the general population of women.<sup>97</sup>

FSWs may face other barriers to the uptake of ART even when it is freely available, including fear of disclosure due to stigma and discrimination, lack of family support, negative experiences with healthcare providers, inadequate counseling and outreach by government health workers and non-governmental organization (NGO), and lack of knowledge about ART.<sup>98</sup> One study of Zimbabwean FSWs described how many considered “public humiliation” an integral part of the process when seeking ART.<sup>99</sup> Once on treatment, evidence on adherence is mixed, with some researchers documenting positive results. Encouragingly, a 2014 systematic review yielded a pooled estimate of treatment adherence among FSWs in low- and middle-income countries of 76%.<sup>100</sup> Yet, multiple studies also underscore the need to address psychosocial, economic, clinical, and structural barriers to FSWs’ continuum of HIV care.<sup>101</sup> Even when uptake of and adherence to therapy are strong, it is still beneficial to offer ongoing education and free condoms to address high-risk sexual behaviors.<sup>102</sup>

On the whole, far too little is known about HIV care cascade outcomes among FSWs. Priority areas for further research include the potential of peer support for ART adherence<sup>103</sup> and the significant role that GBV may play as a barrier for treatment continuity among FSWs. Violence has been associated with interruptions in care for women living with HIV in the general population.<sup>104</sup> ART should also not eclipse other essential prevention activities that target structural drivers of HIV, such as community empowerment. More broadly, rights-based approaches and supportive legal environments, including decriminalization of sex work, are essential to ensure FSWs’ equitable access to ART.<sup>105</sup>

## Family Planning and Contraceptive Services

Among FSWs who do not wish to become pregnant, unintended pregnancy may be understood as an occupational health risk of sex work.<sup>‡‡106</sup> Inadequate access to contraception leads to a high burden of unintended pregnancy and poor reproductive health outcomes, including risk of maternal morbidity and mortality. For FSWs who choose to terminate an unplanned pregnancy, accessing safe and legal abortion may be a serious challenge.<sup>107</sup> Although not especially well-documented, evidence suggests that FSWs tend to have greater unmet need for family planning than women in the general population.<sup>108</sup> Other studies have similarly found that FSWs with intimate or non-paying partners may be at higher risk of unintended pregnancy and STIs.<sup>109</sup> These findings spotlight a key issue for FSWs when it comes to their family planning and contraceptive needs, which is that they may have divergent goals with different partners. However, given the stigma directed at FSWs and the overwhelming emphasis on HIV/STI prevention, the complexity of their sexual and fertility goals has gone largely overlooked.

While FSWs have unique family planning and contraceptive needs related to their work, they also have the same fundamental right to freely decide whether, when, and under what conditions to have children. As with women engaged in other kinds of work, already having children or the desire to become pregnant impact FSWs’ decisions about contraception. For example, FSWs who are already mothers may be more likely to use hormonal contraception and have greater confidence to negotiate condom use with clients, but simultaneously less confidence to request protection with non-paying partners.<sup>110</sup> Some research has shown that the use of non-barrier modern contraceptive methods leads to less consistent condom use with both clients and steady partners.<sup>111</sup> However, the interaction between FSWs’ condom use and other methods of contraception is not well understood, as it implicates a range of factors, including condom negotiation, risk perception, and reproductive intentions.

FSWs often report limited access to or knowledge of available contraceptive methods, especially younger FSWs.<sup>112</sup> Reliance on condoms alone as a dual protection method for pregnancy and HIV/STI prevention is

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‡‡ An occupational health risk is a hazard that arises from the workplace or working conditions. For instance, exposure to hazardous workplace noise levels with inadequate protection may lead to hearing loss, which is an occupational hazard. Similarly, unintended pregnancy and HIV/STIs are occupational hazards of sex work—the elevated risk for those outcomes happens in the course of working. Since decriminalizing sex work in 2003, New Zealand has produced *A Guide to Occupational Health Safety in the New Zealand Sex Industry*, which addresses precisely these kinds of risks.



common,<sup>113</sup> though in some settings the use of long-acting reversible contraceptives (LARCs) or hormonal contraception may also be quite high.<sup>114</sup> Reliance on condoms alone as a method of pregnancy prevention presents particular concerns among FSWs. Moreover, some research has shown that FSWs remain in need even with dual method use because of incorrect and inconsistent use of condoms, but also pills or other coitally dependent methods.<sup>115</sup> Male condoms have a method failure rate of 18% with typical use among the general population<sup>116</sup> which is likely higher among FSWs because of their greater number of sexual contacts. Additionally, FSWs face a host of barriers to correct and consistent condom usage, highlighted above, including client violence and refusal, as well as financial incentives for unprotected sex.<sup>117</sup> The SWIT, recognizing that many FSWs may use condoms less consistently with regular partners than with clients, advises a highly effective contraceptive method for pregnancy prevention, and the male or female condom for HIV and STI prevention.<sup>118</sup> It also refers to emergency contraception (EC) and the importance of its availability to FSWs. There is scant research on FSWs' knowledge or attitudes toward EC, but in at least one study, only a third of women had ever heard of it.<sup>119</sup> Contraceptive counseling for FSWs should address the optimal options for preventing pregnancy *and* STIs with *all* partners, taking pregnancy intentions into account. It should also consider acceptability of condoms with intimate or non-paying partners, especially in settings where condoms are stigmatized or associated with HIV/STIs.<sup>120</sup>

FSWs' critical need for comprehensive family planning is well-documented, but less well understood is what works programmatically.<sup>121</sup> Programming and research moving forward should focus on effective service delivery models that are responsive to FSWs' unique needs around dual protection and clients versus intimate partners while respecting their fundamental right to decide whether and when to have children.

## Safe Pregnancy and Maternal Health

In many settings, FSWs are often mothers and experience high incidence of pregnancy, yet their pregnancy intentions, antenatal care (ANC), birth, and postpartum outcomes have been almost completely unaddressed. Women in sex work often report being a primary financial provider because of abandonment by partners or having left a partner due to abuse, and the need for financial earnings to support their children.<sup>122</sup> To ignore motherhood is to ignore a crucial domain of many FSWs' lives with negative implications for their health and well-being.<sup>123</sup>

### FSWs and motherhood

Nearly 90% of a sample of 457 Kenyan FSWs from three Nairobi townships and four rural towns had dependent children.<sup>124</sup> Of 850 FSWs sampled in Andhra Pradesh, India, 90% reported having children, and the majority of women were the sole providers in their household.<sup>125</sup>

Unintended pregnancy leads to health risks for both mother and infant.<sup>126</sup> Due to poor engagement of FSWs in the HIV prevention and care cascade, many FSWs desiring to become pregnant are HIV-positive, yet remain unaware of their status, creating risk of transmission to both partners and children.<sup>127</sup> Though FSWs often choose to continue working during pregnancy,<sup>128</sup> an unacceptable proportion of them are not provided HIV testing when accessing ANC.<sup>129</sup> Some studies have shown that FSWs with a prior history of giving birth have subsequently *higher* odds of unintended pregnancy,<sup>130</sup> which shows a deep disconnect. Family planning should be a standard part of the ANC and/or post-partum care that women receive which enables them to safely space or limit subsequent pregnancies. The data suggest that FSWs are falling through the cracks—either they are not accessing care during and after their pregnancies, or the care they do access fails to include adequate family planning. While FSWs may be living in settings where healthcare infrastructure is already weak and risk of maternal morbidity and mortality is generally high, they also encounter additional barriers to accessing ANC

because of stigma and discrimination. Moreover, ANC services are typically not tailored to FSWs' particular needs.<sup>131</sup> For instance, there is some evidence of an association between sexual violence and miscarriage/stillbirth among FSWs.<sup>132</sup> Given the high levels of sexual violence experienced by FSWs across many settings and the fact that many will continue working during pregnancy, this is an example of an overlooked need that must be addressed by ANC services for FSWs.

ANC should be a good entry point for FSWs to access other essential care, including HTC and services to prevent mother-to-child transmission (PMTCT).<sup>133</sup> However, data about FSWs' uptake of PMTCT is limited. This is potentially due in part to the fact that FSWs will often choose not to disclose their work in healthcare settings, especially when healthcare is run by the government, because they anticipate that this will result in poor treatment.<sup>134</sup> Additionally, many FSWs remain unaware of methods to prevent vertical transmission of HIV from themselves to their children.<sup>135</sup> FSWs in Tanzania have described how ANC clinic staff will assume that a sex worker is HIV-positive and refer her to HIV clinical services without any further assessment of her needs as a seeker of antenatal care.<sup>136</sup> HIV-related stigma is also a major barrier to uptake of PMTCT generally.<sup>137</sup> Women living with HIV who are pregnant or who wish to become pregnant face discrimination and mistreatment in healthcare settings, including the withholding of information about all the options on terminating or continuing a pregnancy safely or insisting that a woman undergo sterilization as a condition of obtaining ART. The situation is even graver for FSWs living with HIV, who face converging discrimination and stigma and potentially even more constrained choice.<sup>138</sup> To date, there is very little literature on FSWs' facility-based childbearing experiences. Although there is robust documentation of stigma and discrimination against FSWs in healthcare settings, the focus is on seeking care for GBV, STIs, and HIV.<sup>139</sup> The data would suggest negative childbearing experiences in facilities, but as in other contexts, FSWs will probably avoid disclosure of their work if possible. This is a significant gap that requires further research.

An overarching challenge is that services remain highly segregated in many settings. There may be little connection between reproductive health services, including family planning and PMTCT, which are ordinarily directed at the general population of women, and targeted HIV/STI prevention services directed at FSWs.<sup>140</sup>

## Safe Abortion and Post-Abortion Care

Safe abortion access is an important service for FSWs, who report high rates of pregnancy termination, regardless of abortion's legal status.<sup>141</sup> Levels of pregnancy termination among FSWs may be significantly higher than among women who do not sell sex—surveys reveal reported levels of prior pregnancy termination between 50% and 90%, even in highly restrictive legal settings.<sup>142</sup> Unsurprisingly, evidence suggests that the amount of time a woman spends in sex work and how many clients she has are associated with her number of lifetime abortions.<sup>143</sup>

Abortion remains legally restricted or otherwise inaccessible throughout many countries of the world, leaving women to resort to unsafe methods of termination. Where abortion is difficult to access because of restrictive legal regimes, the high burden of unintended pregnancy among FSWs means that many will seek out unsafe abortion with resulting risk of maternal morbidity and mortality.<sup>144</sup> In one study of FSWs in Côte d'Ivoire, where abortion is legal only in cases of threat to the mother's life, fully a third of women reporting a prior abortion had experienced complications, ranging from hemorrhage to infertility.<sup>145</sup>

FSWs' access to post-abortion care (PAC) is an area that has received little attention, though the provision of PAC presents a critical opportunity for contraceptive counseling, especially for the many FSWs experiencing repeat unintended pregnancies. On the whole, even where abortion is legal without restriction as to reason, FSWs will likely face barriers to accessing care as a result of stigma and discrimination in healthcare settings.<sup>146</sup>

The SWIT and UNAIDS both recognize access to safe abortion and post-abortion care as part of the basic package of SRH services for sex workers.<sup>147</sup> Where legally permitted, linkage to safe abortion should be

fully integrated into other services around HIV/STI, family planning and antenatal care. Where illegal, FSWs should be advised about the risks of informal abortion methods and how to pursue alternative options safely (e.g., obtaining misoprostol from a pharmacy in order to self-induce pregnancy termination).<sup>148</sup> Regardless of abortion's legal status, FSWs should have access to comprehensive post-abortion care.

## Gender-Based Violence

Violence committed against FSWs is pervasive across all settings and is perpetrated by a range of actors, including police, clients, and intimate partners. Most of the research on GBV and FSWs has focused on clients or police, but husbands and other non-paying intimate partners also perpetrate violence, the harms of which should not be ignored.<sup>149</sup> For example, a 2016 study among a large sample of Indian FSWs documented that among those women who were married (22%), more than a fifth reported physical or sexual violence by their husbands in the previous six months.<sup>150</sup> Other studies from diverse settings have documented levels of GBV against FSWs by stable or emotional partners exceeding 50%.<sup>151</sup>

GBV is associated with a range of adverse health outcomes for FSWs, including increased risk for HIV<sup>152</sup> and other STIs.<sup>153</sup> To illustrate, recent modeling suggests that reducing the prevalence of GBV against FSWs in Kenya by 30% while holding all other conditions constant could result in a 25% reduction in cumulative HIV infections among FSWs over just five years.<sup>154</sup> It is well-documented that FSWs subject to violence are at increased risk of unprotected sex due to inconsistent condom use, client condom refusal, as well as condom failure and breakage.<sup>155</sup> FSWs also frequently face the implicit threat of client violence or the threat to withhold payment as methods of obtaining unprotected or otherwise coerced sex (e.g., higher risk anal sex).<sup>156</sup> Violence impedes FSWs from accessing essential HIV prevention and other health services.<sup>157</sup> As with women in the general population,<sup>158</sup> sexual violence is associated with negative pregnancy outcomes for FSWs, including increased risk of unplanned pregnancy,<sup>159</sup> pregnancy loss,<sup>160</sup> and recurrent abortion.<sup>161</sup> Importantly, there has been increasing attention to the psychological impacts of GBV among FSWs, with studies demonstrating an association between GBV and attempted suicide,<sup>162</sup> as well as a generally high prevalence of mental disorders, such as depression and post-traumatic stress disorder (PTSD).<sup>163</sup>

Despite the burden of sexual violence among FSWs, there is little research on other forms of obstetric and reproductive morbidity associated with GBV in the sex work context. For instance, traumatic gynecological fistula and genital injury have been reported in association with high levels of conflict-related sexual violence in Democratic Republic of Congo and elsewhere.<sup>164</sup> In a 2012 sample of approximately 1,500 FSWs in Kampala, Uganda, nearly 20% reported experiencing rape three or more times in the preceding six months.<sup>165</sup> With such high prevalence of GBV across settings, the relative sparseness of data about broader effects related to maternal health, birth outcomes, or subsequent substance use among FSWs who have survived sexual violence constitutes a serious gap. GBV against FSWs also interacts synergistically with a variety of other factors, including mobility<sup>166</sup> and economic insecurity,<sup>167</sup> to augment risk of HIV. However, the legal environment may be the most important driver of patterns of violence against FSWs. There is persistent evidence of an independent link between policing practices—including arrest, violence and coercion—and elevated rates of violence against FSWs.<sup>168</sup>

GBV in the context of sex work must be understood as a manifestation of gender inequality, stigma, discrimination, and as a violation of the fundamental human rights of FSWs.<sup>169</sup> Consistent with a recognition of these macrostructural factors, the SWIT, the UNAIDS 2014 guidance note on services for sex workers, and public health research all stress the need for comprehensive approaches to GBV against FSWs.<sup>170</sup> Addressing upstream factors—for example, by training FSWs about laws relating to their human rights and transforming punitive social norms that marginalize FSWs—is as essential as interventions at the healthcare level. Interventions that target the police have shown effectiveness in multiple settings at reducing violence directed at FSWs.<sup>171</sup> GBV services should be fully integrated into all programming for FSWs, including HIV prevention, treatment, and care, as well as other healthcare services. Healthcare providers should be trained to offer the full range of medical, legal, and psychosocial services for FSWs who experience GBV,<sup>172</sup> including comprehensive post-rape care.

## Substance Use and Harm Reduction

Substance use, gender-based violence, and risk for HIV and other STIs are closely related and should not be addressed in isolation.<sup>173</sup> People who inject drugs (PWID) are classified as a separate key population in the global HIV response, but in the lived experience of many women, the risks associated with sex work and injection drug use converge. Substance use, including injection drugs and other illicit substances, as well as alcohol abuse among FSWs has been associated with a variety of negative outcomes: STIs, sexual violence and unprotected sex,<sup>174</sup> poor mental health,<sup>175</sup> accepting more money for unprotected sex,<sup>176</sup> low contraceptive usage and high lifetime burden of unintended pregnancy,<sup>177</sup> adverse pregnancy outcomes,<sup>178</sup> police sexual coercion,<sup>179</sup> compromised ART adherence,<sup>180</sup> and overall elevated risk of GBV.<sup>181</sup> Many of these relationships may be considered reciprocal—for example, an FSW who confronts client violence may have less control over her environment and be less able to use safe injection practices.<sup>182</sup>

Injection drug use also remains a significant driver of HIV risk among FSWs in a variety of settings, especially in Eastern Europe and Central Asia.<sup>183</sup> Policing practices, which have such clear impacts on condom negotiation and sex worker safety, also play a significant role in the health of FSWs who inject drugs.<sup>184</sup> Where drug use is criminalized, FSWs may avoid carrying injection equipment for fear of arrest. Women who sell sex and inject drugs are “vastly overrepresented” in prison populations.<sup>185</sup> The correctional environment also presents enhanced risk for HIV infection, including through sexual violence perpetrated by male guards and the use of shared injection equipment among inmates.<sup>186</sup>

Programs directed at FSWs or at people who inject drugs are rarely tailored to provide services to women who inject drugs **and** sell sex.<sup>187</sup> The SWIT recommends that FSWs be provided the same comprehensive package of services described in the WHO/UNODC/UNAIDS 2012 *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, including opioid substitution therapy (OST) and needle and syringe programs (NSP).<sup>188</sup> More research is needed that investigates the complex interplay between sex work and substance use, as it is not straightforward. Given the centrality of structural drivers of risk produced by legal environments that criminalize both sex work and injecting drug use, community empowerment interventions which include FSWs who inject drugs should be prioritized.

## Hard-to-Reach Populations

Certain populations of FSWs are especially difficult to reach with conventional HIV programming, including migrant FSWs and women who do not necessarily identify as FSWs. Adolescents who sell sex are a generally overlooked population in both research and programming due to legal and policy environments that classify them as trafficked. However, evidence suggests that across diverse settings, 20-40% of FSWs enter commercial sex as adolescents.<sup>189</sup> Earlier entry into commercial sex elevates risk of violence and HIV<sup>190</sup> and young people who sell sex or engage in transactional sex may face greater difficulty accessing treatment and prevention services.<sup>191</sup> In some settings, they are more likely than their older counterparts to use substances during sex;<sup>192</sup> other research reveals low rates of consistent condom use, significant unmet need for contraception, high levels of abortion, and poor sexual and reproductive health knowledge.<sup>193</sup> Fear of interactions with the police or other forms of state institutionalization discourage many adolescents who sell sex or engage in transactional sex from accessing HIV or other sexual and reproductive health services.<sup>§§194</sup> Including them in studies or intervention trials is also extremely challenging given the ethical constraints on research with vulnerable minors.<sup>195</sup> These challenges call for more nuanced approaches to meet the SRHR needs of adolescents, combined with continuing efforts to prevent adolescent entry into selling sex.

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§§ UNICEF, UNFPA, and WHO define adolescent as a person aged 10-19 years. The Convention on the Rights of the Child (CRC), the most widely ratified human rights treaty in the world, defines a child as a person under 18 years of age. Many young people begin selling sex during this age span under a range of circumstances. CHANGE recognizes that girls and adolescents under 18 years of age cannot consent to engage in sex work and that all children have a right to be protected from sexual exploitation and abuse, consistent with the CRC and prevailing international consensus.



Mobile or migrant FSWs may be at risk of poorer SRH outcomes relative to non-migrant FSWs.<sup>196</sup> These findings suggest that FSWs who are mobile face uniquely heightened risk requiring expanded efforts to ensure they have access to violence prevention and comprehensive HIV services. Additionally, more research is needed on the experiences of refugee women who sell sex, as crisis and humanitarian settings present distinctive hazards.

Some women who irregularly sell sex may not self-identify as sex workers, yet have certain sexual and reproductive health needs because of these activities. There is very little literature on the needs of these women or how programs may be designed to identify them in ways that are non-stigmatizing.

FSWs experience a range of challenges in fully realizing their sexual and reproductive health and rights. FSWs have particular or more complex SRHR needs than women who do not sell sex—for instance, contraceptive counseling which adequately responds to different kinds of sexual partnerships. FSWs also face additional or more powerful barriers to accessing SRHR services including provider stigma or factors like working hours and mobility. Finally, FSWs may experience limited capacity or opportunity to demand SRHR services, particularly in criminalized contexts where their work is not recognized as a legitimate form of labor.<sup>197</sup>

### III. THE GLOBAL RESPONSE TO THE HEALTH AND RIGHTS OF FEMALE SEX WORKERS

It has been a decade since the Office of the High Commissioner for Human Rights (OHCHR) and UNAIDS jointly recommended that States address the negative human rights impacts of criminalization of sex work and its obstruction of the global HIV response:

“With regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of decriminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients.”<sup>198</sup>

Since then, a number of key multilateral organizations have added their voices to the movement supporting decriminalization of sex work, including: the WHO,<sup>199</sup> UNAIDS,<sup>200</sup> the United Nations Population Fund (UNFPA) and the United Nations Development Programme (UNDP).<sup>201</sup> In 2012, the Global Commission on HIV and the Law unequivocally called on governments, civil society, and international bodies to “decriminalise private and consensual adult sexual behaviours, including same-sex sexual acts and voluntary sex work.”<sup>202</sup> In the past several years, leading human rights organizations such as Amnesty International and Human Rights Watch,<sup>203</sup> along with a host of civil society organizations,<sup>204</sup> including the Center for Health and Gender Equity<sup>205</sup> have pushed for decriminalization.

#### 2016 Commission on the Status of Women

In response to a resolution by the Commission on the Status of Women (CSW), the UN Secretary General submitted a report on women, girls, and HIV at CSW’s 60th session in 2016. The report assessed the response of Member States to HIV and the extent to which those actions have been in accordance with the Beijing Declaration and Platform for Action, as well as the Programme of Action of the International Conference on Population and Development (ICPD). The resulting report points to the disproportionate burden of HIV borne by sex workers, acknowledges the role of stigma, discrimination, and violence, and affirms that “[c]ountries that criminalize key populations deter female sex workers and women who inject drugs from seeking critical HIV health services.”<sup>206</sup>

These developments build on several decades of growing awareness that criminalizing environments marginalize FSWs. It was 1992 when the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) Committee observed in General Recommendation 19 that sex workers “are especially vulnerable to violence because their status, which may be unlawful, marginalizes them.”<sup>207</sup> However, the growing call for decriminalization has evolved alongside a global health response that has largely conceptualized FSWs as vectors of disease with minimal consideration of their broader health needs as women or their rights as workers.<sup>208</sup> Most public health research and interventions have framed sex workers as a hazard to the public at large,<sup>209</sup> ignoring how FSWs are “highly vulnerable because of environmental and structural barriers that prevent them from accessing prevention services and having control over their activities.”<sup>210</sup> This framework is oriented around individual behavior with insufficient consideration of the harmful role of structural factors such as criminalization, gender-based violence, and economic insecurity, as well as the need for community empowerment approaches.

With the advent of ART and the shift to generalized epidemics in many settings, key populations, including FSWs, were deprioritized. It is only fairly recently, with evidence showing that FSWs experience a heightened HIV burden even in generalized epidemics, that there has been a resurgence of attention from the global community and growing international consensus that we will never reach zero by 2030 if we leave FSWs behind.<sup>\*\*\*</sup> As Stefan Baral and colleagues describe in their 2012 systematic review, even in generalized HIV epidemics in sub-Saharan Africa, FSWs have 12-times increased odds of living with HIV as compared to all women.<sup>211</sup> Nevertheless, the global response has largely failed to include the voices of sex worker-led organizations, which are best situated to identify the needs of FSWs and to deliver services that are empowering and genuinely responsive to structural determinants of risk, e.g., police abuse and societal discrimination.<sup>212</sup> Sex worker-led organizations are underfunded<sup>213</sup> and, due to stigma and marginalization, have faced formidable barriers to participation in important agenda-setting processes. For instance, the most recent 2014 International AIDS Conference (IAC) received criticism for its failure to meaningfully include both sex workers and drug users.<sup>214</sup> Similarly, U.S. travel restrictions prevented many sex workers from attending IAC 2012 held in Washington, D.C.<sup>†††</sup>

Despite these challenges, sex workers’ rights activists have organized to “protest against [their] exclusion and demand respect for their human rights.”<sup>215</sup> For instance, several sex workers’ rights organizations joined forces to co-host the Sex Worker Freedom Festival in Kolkata, India as an alternative to IAC 2012. The Festival brought together advocates from more than 40 countries and was a landmark event in the global sex workers’ rights movement.<sup>216</sup> The Global Network of Sex Work Projects (NSWP), formed in 1990 as an alliance of activists working on sex worker advocacy around the world and now including more than 237 organizations from over 70 countries,<sup>217</sup> has played an important role in a variety of international forums and conferences.<sup>218</sup> NSWP has also contributed to several important guidance instruments of the past five years, including the SWIT in 2013, which additionally brought together WHO, UNFPA, UNAIDS, World Bank, and UNDP, to develop a tool for implementing programs for and with sex workers. This was preceded by WHO et al’s 2012 *Prevention and Treatment Recommendations*, which includes recommendations on community empowerment and harm reduction, as well as specifically endorsing decriminalization of sex work.<sup>219</sup>

The emergence of these tools suggests a growing recognition of the specific needs of FSWs and a burgeoning commitment to their inclusion in the HIV response. This commitment is also reflected in the high-level planning of some important funders. For example in 2014, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) released its *Key Populations Action Plan: 2014-2017*, which details various objectives, one of which is to support meaningful participation of key populations at every level of implementation of Global Fund financing.<sup>220</sup> One way in which that objective has been carried out is the requirement that key populations be

\*\*\* In September 2015, world leaders committed to the Sustainable Development Goals (SDGs), which contain the following target under Goal 3: “By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.”

††† To apply for a non-immigrant visa to the United States, a person must disclose whether they have been “engaged in prostitution” within the past ten years. If so, the visa may be denied. Similarly, drug abuse or drug addiction are grounds for inadmissibility under the Immigration and Nationality Act.

included in all Country Coordinating Mechanisms (CCMs), effective January 1, 2015.<sup>221</sup> Another pivotal event in 2014 was the release of *The Lancet's* special issue on HIV and sex work, which brought structural drivers of HIV risk and the role of criminalization to the fore. Together, these developments suggest some progress around the health and rights of FSWs. However, broader SRHR needs such as safe pregnancy and comprehensive family planning for FSWs remain on the periphery of the global response.

## IV. U.S. FOREIGN POLICY, SEX WORK, AND HUMAN RIGHTS

The United States is the largest funder and implementer of global health programs worldwide.<sup>222</sup> The small portion of U.S. global health money that finds its way to FSWs is primarily through the HIV funding stream. The Fiscal Year 2016 Omnibus Appropriations Bill included about \$10.2 billion in global health funding, 55% of which is dedicated to HIV.<sup>223</sup> The majority of HIV funding is channeled through the President's Emergency Plan for AIDS Relief (PEPFAR), which is managed by the State Department's Office of the Global AIDS Coordinator (OGAC). OGAC transfers funds to various additional implementing agencies, including the U.S. Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), and the Peace Corps. The U.S. also contributes money to various multilateral organizations as part of its global HIV efforts, including the Global Fund, UNAIDS, and the International AIDS Vaccine Initiative (IAVI).

Within the last several years, there has been an increase in dedicated U.S. programming for key populations, including FSWs, but the sums of money involved are negligible within the global health budget as a whole. Moreover, funding to FSWs and key populations more generally is difficult to track with any degree of precision. LINKAGES, a recent five-year cooperative agreement funded by PEPFAR and USAID and implemented in partnership with 20 countries by FHI 360,<sup>†††</sup> is an unusual example of a highly visible initiative specifically directed at key populations.<sup>224</sup> More typically, and like many global health programs, most programming for FSWs is episodic: it is implemented through a variety of agencies and sub-partners, for varied durations and in diverse settings, often with minimal publicly available documentation of process or results.

Since the U.S. is a major donor to global health and HIV in particular, the U.S. strategy and position on FSWs have significant implications throughout the world. In countries receiving PEPFAR funds, national governments tend to prioritize what PEPFAR prioritizes in their national HIV responses. U.S. restrictions, such as the Anti-Prostitution Loyalty Oath (APLO), which requires organizations receiving U.S. HIV funds to formally pledge their opposition to prostitution and sex trafficking,<sup>225</sup> have had documented negative impacts on service delivery for FSWs.<sup>226</sup> The U.S. stance on sex work continues to influence national policies toward FSWs with far-reaching implications for their health and rights, as well as the effectiveness of the global HIV response.<sup>227</sup>

### The U.S. Anti-Prostitution Position and the APLO

The Anti-Prostitution Loyalty Oath (APLO) remains part of the law authorizing PEPFAR. Included in the original Global AIDS Act of 2003 and subsequent reauthorizations, the APLO requires that any organization receiving funds under the Act pledge its organization-wide opposition to “prostitution and sex trafficking,”<sup>228</sup> though it does not apply to the Global Fund, the International AIDS Vaccine Initiative, nor any UN agency. Congressional findings at the time of the law's passage state that “[p]rostitution and other sexual victimization are degrading to women and children and it should be the policy of the United States to eradicate such practices.”<sup>229</sup> The U.S. government's conflation of trafficking with voluntary sex work—along with the mandate to abolish both—is an important reason why the APLO remains law, well after public health research, human rights organizations, and sex workers themselves have articulated the harms of this approach.

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††† FHI 360 is partnered with Pact, IntraHealth and the University of North Carolina at Chapel Hill in its implementation of LINKAGES.



Prior to the passage of the Global AIDS Act, the 2000 Trafficking Victims Protection Act (TVPA) established the Department of State's Office to Monitor and Combat Trafficking in Persons (TIP Office), which oversees the U.S. government's efforts to combat trafficking.<sup>230</sup> This was followed by President Bush's issuance of National Security Presidential Directive-22 (NSPD-22) in 2002, which expresses the official conflation of sex work and trafficking:

"Our policy is based on an abolitionist approach to trafficking in persons, and our efforts must involve a comprehensive attack on such trafficking, which is a modern day form of slavery. In this regard, the United States Government opposes prostitution and any related activities . . . These activities are inherently harmful and dehumanizing. The United States Government's position is that these activities should not be regulated as a legitimate form of work for any human being."<sup>231</sup>

The U.S. has aggressively promoted this vision through funding and diplomatic measures such as the annual *Trafficking in Persons Report*, which grades countries into tiers based on their compliance with "minimum standards" outlined in the TVPA.<sup>232</sup> Countries receiving a poor ranking may jeopardize their diplomatic relations with, and non-humanitarian aid from, the U.S. The rankings incentivize the passage of heavy-handed anti-trafficking legislation, which often include provisions on sex work, along with scale up of so-called "raid and rescue" operations.<sup>233</sup> To illustrate, Thailand's Suppression of Human Trafficking Act BE 2551, lauded as "progress" by the 2008 *Trafficking in Person Report*,<sup>234</sup> has been sharply criticized by sex worker advocates. Empower Foundation, a sex-worker led organization promoting the human rights of sex workers in Thailand, has documented how the law "makes it impossible for sex workers to take a pro-active role in addressing human trafficking in our industry."<sup>235</sup> The law has also led to a range of other rights violations, including forcible detention for women classified as trafficked and mandatory medical procedures.<sup>236</sup>

Non-governmental organizations (NGOs) such as the International Justice Mission, a faith-based anti-slavery organization, have received millions of dollars from the U.S. government in support of brothel raids to "rescue" women in the sex industry.<sup>237</sup> On-the-ground experience demonstrates that this model negatively impacts sex workers' lives and disrupts the delivery of crucial HIV services.<sup>238</sup> In 2005, WHO expressed concern about the ways in which "rescue raids of sex establishments have exacerbated violence against sex workers and compromised their safety."<sup>239</sup>

## The Harms of Raid and Rescue and Data Gaps in the Trafficking Debate

The “raid and rescue” approach refers to a process by which brothels or other sex establishments are raided, typically by law enforcement or NGO personnel, so that women and girls may be “rescued” from the commercial sex industry. Raid and rescue is predicated on the assumption that most (if not all) women in the sex industry are trafficked or otherwise coerced in some way. However, rigorous data to support this proposition are generally lacking. As Ronald Weitzer writes, “[i]n no area of the social sciences has ideology contaminated knowledge more pervasively than in writings on the sex industry . . . . Much of this work has been done by writers who regard the sex industry as a despicable institution and who are active in campaigns to abolish it.”<sup>240</sup> Moreover, doubt has been cast on figures cited by the U.S. about the magnitude of the trafficking problem.<sup>241</sup> As a response to trafficking, the raid and rescue approach produces a range of harms:<sup>242</sup>

- 1) The raids drive clients away. This does not stop sex work, rather it shifts sex work underground, where sex workers have less control over working conditions and are more vulnerable to client violence. Raids disrupt systems of self-governance and safety established by sex worker collectives.
- 2) The raids directly interfere with the well-recognized public health principle that the collectivization of sex workers reduces HIV risk.
- 3) The arrest and detention of sex workers in jails and rehabilitation homes disrupts HIV care and also exposes sex workers to additional risk.
- 4) It is extensively documented that State agents are perpetrators of violence against FSWs across all settings. Nevertheless, the raid, rescue, and rehabilitation model relies heavily on the police.
- 5) The conflation of sex work and trafficking negates the innovative and empowering work that sex workers themselves are doing to fight trafficking—this has special importance for adolescents.

Relying on NSPD-22, the TIP Office continues to categorically reject the use of the terms “sex work” or “sex worker” because those terms conflict with the position in the Presidential Directive that prostitution is not a legitimate form of work. This position persists, despite the U.S. government adopting “sex work(er)” across virtually every other agency in its global health response, including more broadly within the Department of State, USAID, and the U.S. Department of Health and Human Services (HHS). Both Secretary Kerry and former Secretary of State Clinton have acknowledged sex workers.<sup>243</sup> Recognizing sex workers as a key population within the global HIV response is essential to the legitimacy of U.S. participation in a range of international fora, as well as its cooperation with multilateral organizations such as UNAIDS and WHO.

The legacy of the U.S. conflation of sex trafficking and voluntary sex work denies the self-determination and autonomy of FSWs, hampers interagency collaboration, and fundamentally compromises the U.S. global HIV response. In U.S. law and guidelines, sex trafficking and sex work are both understood as fundamentally exploitative and the resulting goal becomes abolition of both as a form of modern day slavery.<sup>244</sup> This is well demonstrated by language in a 2004 *Seattle Times* editorial by John Miller, former director of the TIP Office:

“The worldwide fights against AIDS and slavery are both worthwhile, uphill battles. However, well-intentioned people seeking to limit the spread of AIDS in at-risk populations, especially in the commercial sex industry, often ignore a larger challenge—helping to free the slaves of that industry.”<sup>245</sup>

The editorial went on to question the Gates Foundation’s support for an Indian sex workers’ union and its distribution of condoms to FSWs because such an approach risks “ignoring the plight of captives.”<sup>246</sup> Casting all women engaged in sex work as trafficked captives obscures the complexities of migration, economic marginalization, and exploitative labor that women confront across a range of sectors—such as agriculture, factory labor, and domestic housework—while simultaneously denying FSWs’ agency to make decisions about their bodies and livelihoods. This is not to ignore the reality that some women and girls are trafficked for the purposes of sex and that some women do choose sex work due in part to extreme poverty and gender inequality. However, responding to these problems through harsher criminal laws, punitive border control measures, or morality-driven conditions attached to U.S. foreign assistance has not proven effective. The emphasis on a criminal approach makes it difficult for victims of trafficking to escape being classified as illegal migrants and subsequently deported.<sup>247</sup> It also undermines sex workers’ rights and conflicts with evidence-based public health programming.

In 2013, UN Women, the UN body dedicated to gender equality and the empowerment of women, observed that the “conflation of consensual sex work and sex trafficking leads to inappropriate responses that fail to assist sex workers and victims of trafficking in realizing their rights. Furthermore, failing to distinguish between these groups infringes on sex workers’ right to health and self-determination and can impede efforts to prevent and prosecute trafficking.”<sup>248</sup>

Beyond the specific influence of the TIP Office, the APLO continues to conflate sex work and trafficking, and is the most damaging departure from best practice to promote the health and rights of FSWs. The 2003 Global AIDS Act contains two key provisions, which outline requirements on how PEPFAR funds may be used: Section 7631(e) stipulates that no funds “may be used to promote or advocate the legalization or practice of prostitution or sex trafficking.”<sup>249</sup> Section 7631(f) requires that recipient organizations actually have a policy explicitly opposing prostitution and sex trafficking (but not other forms of trafficking).<sup>250</sup> The U.S. government has interpreted these requirements expansively to prohibit activities deemed “inconsistent” with a policy opposing prostitution and sex trafficking, such as a grantee advocating for the legalization of prostitution using their own resources.<sup>251</sup>

Although both HHS and USAID have issued additional guidance on how the policy requirement should be interpreted,<sup>§§§</sup> grantee organizations remain deeply uncertain of what is permitted under the APLO. The uncertainty creates a chilling effect. Organizations have discontinued services for sex workers for fear of jeopardizing their overall funding, which may support a large portfolio of HIV/AIDS services for diverse populations. Interviews conducted for this report also brought to light how organizations feel unable to support efforts at decriminalization, despite their awareness of its necessity from a human rights and public health perspective. In this respect, the APLO directly interferes with national-level movements around the health and rights of FSWs. Human rights standards, public health evidence, accepted principles of harm reduction, and emergent legal norms all support advocacy for decriminalization. PEPFAR’s own 2015 *Technical Considerations* acknowledges that “[p]unitive laws against sex work, drug use, and consensual same sex sexual relations create a hostile environment for [key populations] and their providers where the needs of [key populations] are often ignored. This situation requires review of legal policies and practices with stakeholders

with meaningful engagement of [key population] groups to ensure that [key populations] may access lifesaving health services, including HIV prevention, care and treatment . . . ”<sup>252</sup>

Alternatively, the APLO can encourage organizations engaged in highly effective HIV prevention and advocacy efforts to decline U.S. funding because they reject the application of an anti-prostitution litmus test as stigmatizing and inherently marginalizing of FSWs, an already hard-to-reach population.<sup>253</sup> From a clinical perspective, the APLO forces healthcare providers to violate the basic tenets of non-judgmental and non-discriminatory care. Most importantly, sex worker-led organizations are effectively walled out and isolated from U.S. HIV efforts. This is critical because globally, HIV funding is the primary source of support for programming around the human rights of sex workers.<sup>254</sup> Moreover, access to resources and access to decision-making go hand in hand. Consulting with sex workers is not the same as truly supporting a sex worker-led process, and it is untenable to expect a sex worker-led organization to pledge its opposition to sex work. The APLO stymies support for sex worker empowerment and collectivization, both of which are essential to reducing the risk of HIV and promoting rights-based strategies to address the structural and social constraints to FSWs’ health.<sup>255</sup>

In 2013, following several years of litigation, the U.S. Supreme Court held that the APLO violates the U.S. Constitution since it requires funding recipients to “pledge allegiance to the Government’s policy of eradicating prostitution.”<sup>256</sup> This ruling applies only to U.S. NGOs and their foreign affiliates; the APLO is not unconstitutional when applied to foreign NGOs.<sup>257</sup> In 2015, the Open Society Foundations brought the case back to court in an effort to compel the U.S. government to comply with the earlier decision.<sup>258</sup> The court stressed that USAID and other funding agencies must provide clear and explicit exceptions to the APLO for U.S. NGOs and their foreign affiliates in all official communications, including RFPs, solicitations, and any government guidance, and encouraged USAID to adopt the simpler exception language used by HHS.<sup>259</sup> Although USAID had issued an Acquisition and Assistance Policy Directive (AAPD) in 2014, which clarified that the exception applies for all U.S.-based organizations,<sup>260</sup> plaintiffs argued that the language remained very unclear and still deterred their affiliates from applying for grants. HHS is now in the process of drafting new regulations to reflect the court decisions. Nevertheless, the pledge requirement continues to apply to overseas NGOs and a lack of clear guidance on what kinds of activities are prohibited as “inconsistent” under the policy continues to foster confusion.\*\*\*\*

The APLO politicizes the health of sex workers, frustrates U.S. credibility, and has no place in a public health program intended to fight HIV. The dissonance between the pledge and the fundamental rights of sex workers is condemned again and again by actors on the ground who witness firsthand its damaging impacts. Moreover, the APLO fails even on its own terms. If the end goal is the abolition of prostitution, imposing ideological conditions on FSWs while completely failing to address the structural drivers of sex work and the needs of women who are already in sex work is not the solution.

## Community Empowerment and Structural Interventions

While the effectiveness of community empowerment approaches is well established<sup>261</sup> and imperative from a human rights perspective, it remains underutilized in U.S. programming. Enhancing community empowerment among sex workers is a standalone, evidence-based, technical recommendation by WHO, NSWP and others,<sup>262</sup> and it has worked in large-scale programs like Avahan, Sonagachi, Pragati and Ashodaya, which are widely

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§§§ In 2010, HHS issued guidance that all recipients of funds must “agree” that they are opposed to the practices of sex work and sex trafficking, a change from the previous guidance which required that grantees of PEPFAR monies additionally “certify” their independence from any organization that engages in activities inconsistent with a policy opposing sex work. *See* 75 FR 18760; USAID provided a subsequent Acquisition and Assistance Policy Directive (AAPD) in 2014, which clarified that the requirement may be met by signing a statement in the award that the recipient is opposed to the practices of prostitution and sex trafficking (as opposed to demonstrating an affirmative separate organizational policy).

\*\*\*\* Refer to Annex IV for a more detailed timeline of the APLO litigation, which was initiated with multiple suits in 2005. The Annex also includes the current language being used to exempt U.S.-based NGOs from the APLO.

celebrated, well-described interventions from South Asia.<sup>263</sup> Yet the APLO, and more general U.S. resistance to recognition of sex work as an occupation, discourage support for community empowerment and structural interventions to address the needs of FSWs. This is because approaches that empower women to organize, articulate, and advance their own interests are antithetical to a worldview which conceptualizes them as either moral failures in an illegitimate line of work or exploited trafficking victims who need rescuing.

As part of its Human Rights Action Agenda, unveiled in the 2014 report *PEPFAR 3.0*, PEPFAR called attention to how “[v]arious forms of stigma and discrimination as well as harmful laws and policies reduce access to essential health services, and undermine efforts toward effective responses to HIV/AIDS.”<sup>264</sup> Its corresponding goals are to expand access to non-discriminatory HIV prevention, treatment and care for all people and increase civil society capacity to advocate for and create enabling environments.<sup>265</sup> However, current U.S. policy operates in a way that largely excludes FSWs from the benefits of these efforts because powerful structural drivers of HIV risk, such as sex worker stigma and criminalizing laws,<sup>266</sup> are not targeted for change. Rather, interventions for FSWs continue to emphasize a limited biomedical and behavioral focus. This is reflected in the indicators PEPFAR uses and its narrow focus on access to services as the most important issue for FSWs.<sup>†††</sup> Peer-led outreach is an approach that PEPFAR and USAID ostensibly encourage. However, in practice, programs designed around evidence-based benchmarks and protocols may inhibit the ability of peer-educators to speak candidly about sex, violence, and collective rights.

Newer U.S. mechanisms like LINKAGES demonstrate a stronger U.S. commitment to rights-based and community empowerment approaches for FSWs, but more is needed. Lack of indicators and technical guidance could signal to the countries where PEPFAR works that the community empowerment approach is not a U.S. priority.

## Funding, Research, and Programmatic Silos

Interviews conducted for this report underscored how sexual and reproductive health remain on the margins as a priority for HIV donors. This is perhaps even more pronounced with respect to FSWs because they have historically been framed strictly in terms of their vulnerability to HIV. There is similar difficulty in garnering the interest of family planning and reproductive health funders in the particular needs of FSWs. These highly delineated funding streams are then reflected in research and project priorities. Recent research has begun to incrementally expand the HIV agenda for FSWs to include topics such as ANC<sup>267</sup> or fertility intentions,<sup>268</sup> but the focus generally remains highly biomedical and on outcomes such as HTC uptake, reported condom usage, or viral suppression.

There is often a lack of integration between HIV and SRH in programs for FSWs. The SWIT and recent guidance from UNAIDS have drawn increasing attention to reproductive health, but these are guidance tools, not policy. PEPFAR’s *Technical Considerations* for the 2015 Country Operational Plans instruct that “[s]pecific efforts to link key populations, especially female sex workers (FSW) and women who inject drugs (WWID), and their partners to HTC and relevant PMTCT, care and treatment, and family planning services should be a priority.”<sup>269</sup> This echoes recommendations made in the *Technical Considerations* of the preceding three years,<sup>270</sup> some of which also address the specific need for linkages to user-friendly PEP and post-rape care for key populations, given their heightened risk for GBV.<sup>271</sup> In this respect, integration is a formal policy for PEPFAR, especially as it concerns family planning. Nevertheless, various difficulties persist: PEPFAR’s Monitoring, Evaluation and Reporting (MER) indicators are fragmented and narrow. There is an FP/HIV integration indicator, but it assesses the percentage of HIV service delivery points supported by PEPFAR that offer family planning services. It is very difficult to glean how FSWs are accessing family planning services based on this indicator, to say nothing of how those services are tailored to their particular needs. Another difficulty is

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††† For example, see former Global AIDS Coordinator Eric Goosby’s 2010 comments: “We want to care for every sex worker out there. If a sex worker comes to any of our facilities, that person will be embraced and followed for the duration of their life on anti-retrovirals. If there are examples of anybody being turned away . . . we would be on that like a laser.” See, IRIN/PLUS News, *Straight Talk With Eric Goosby*, Head of PEPFAR, July 26, 2010, <http://www.irinnews.org/printreport.aspx?reportid=89965>.



inadequate training and sensitization of clinicians, many of whom remain unaware that they can provide family planning directly to FSWs rather than referring them elsewhere or who simply do not view FSWs as women entitled to services such as ANC.

One of the greatest challenges in meeting the whole-woman health needs of FSWs at the programmatic level is insufficient attention to how their needs may be different from women who do not sell sex. For example, several recent meta-analyses have suggested that the long-acting injectable contraceptive DMPA may modestly increase risk of HIV infection<sup>272</sup> and some studies conducted specifically among FSWs have found a stronger association between use of DMPA and HIV acquisition.<sup>273</sup> These findings raise important questions about how best to weigh the risks and benefits of a long-acting, highly effective contraceptive for FSWs whose risk of HIV is already elevated due to a range of factors. At the same time, there is disregard for how FSWs' needs are the same as women who do not sell sex. FSWs need to be screened for cervical cancer and be counseled on all of their contraceptive options. Addressing the gap on both sides—FSWs' unique needs as a result of their occupational health risks as well as the full range of their SRHR needs as women—necessitates concerted action to dismantle the structural barriers and stigma that thwart the full realization of FSWs' sexual and reproductive health and rights.

## **The Race to Test and START and the Promise of PrEP**

Initiatives like 90-90-90,<sup>\*\*\*\*</sup> coupled with a persistent biomedical emphasis, make it even less likely that the broader sexual and reproductive health needs of FSWs will be addressed. Instead, programs become a race to identify those who are HIV-positive and start them on treatment. The number of FSWs that access HTC, enroll into ART and maintain adherence are all undeniably important outcomes for a program. Yet this approach is predicated on the assumption that if a person is tested, she ends up in a care and treatment cascade where she is ultimately virally suppressed. However, this progression is contingent on a host of structural, social, and individual factors<sup>274</sup> and FSWs face particular barriers that remain poorly addressed. For example, programs must grapple with treatment interruption that predictably occurs in criminalized environments where FSWs are routinely detained and arrested.

Some U.S. programs demonstrate concerning outcomes for FSWs along the care continuum. CHAMP, a five-year (2014-2019) USAID-funded project in Cameroon, is but one example. Out of 1,031 FSWs testing positive for HIV, only 281 had registered on ART at 18 months of implementation. While program staff are working diligently to address gaps in the cascade, including with efforts to train providers around stigma and discrimination, such a steep drop off (over 2/3 of those testing positive) between testing and ART enrollment speaks to an urgent need to assess what other barriers may be preventing FSWs from obtaining the treatment that they need. CHAMP is an anecdotal example but it helps illustrate the continuing relevance of a 2011 recommendation by PEPFAR's Scientific Advisory Board: "Implementation science questions surround every aspect of the HIV care continuum for key populations . . . The critical implementation science questions for key populations are centered on how best to roll-out effective HIV programs while protecting rights and reducing the many barriers of stigma and discrimination shared by these groups."<sup>275</sup>

The importance of protecting human rights in the rollout of test and treat and PrEP cannot be overemphasized. There is concern among sex workers about the possibility for coercion and lack of informed consent in testing policies, along with enhanced stigma.<sup>276</sup> Where police routinely use condoms as evidence of illegal activity, sex workers have expressed the expectation that PrEP could be used in the same way.<sup>277</sup> In NSWP's global consultation on PrEP and early treatment as prevention, many participants feared these strategies would be treated as a silver bullet, thereby undermining other programs and achievements and "disregard[ing] other aspects of sex workers' sexual and reproductive health."<sup>278</sup>

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\*\*\*\* A UNAIDS target set in 2014: By 2020, 90% of all people living with HIV will know their status, 90% of all people diagnosed with HIV will receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have attained viral suppression.

## National Programs and Investment

Data submitted to UNAIDS suggests that only 14% of all funding for HIV services for sex workers and their clients comes from public, domestic sources in low- and middle-income countries. Only about one third of countries report having risk reduction programs for sex workers specifically. The remaining two thirds of countries expect sex workers to obtain services through general healthcare settings,<sup>279</sup> despite the attendant issues around stigma, discrimination, and compromised access due to criminalization.

At the same time, many countries are simply not using U.S. funds to make up the difference. Between 2013 and 2015, seventeen countries reduced planned funding for FSWs in their PEPFAR Country Operational Plans (COPs) budgets. Of those, six discontinued funding altogether for FSWs.<sup>§§§§</sup> These are countries where FSWs face a high burden of HIV: Swaziland, which budgeted \$0 for FSWs in their 2015 COP, has among the highest reported prevalence of HIV for FSWs in the world at 70% in 2011.<sup>280</sup> In 2015, planned funds for FSWs across COPs in all countries averaged about 3% of the total COP budgets, but even this low number is slightly misleading. If the two countries with exceptionally high allocations for FSWs are removed from the pool—Papua New Guinea (23.3%) and Indonesia (13.46%)—the average becomes about 2%.

### *PEPFAR Country Operational Plan (COP) Funding Directed at FSWs in 2015<sup>281</sup>*

Country	HIV Prevalence among FSWs	Planned FSWs Funds for 2015 COP	Planned FSWs Funds as % of 2015 COP total	% change from 2014
Zimbabwe	46.2%	\$781,778	0.82%	-20.23%
Angola	7.16%	\$770,500	4.75%	+5.74%
Ethiopia	24.3%	\$631,306	0.36%	-0.09%
Lesotho	71.9%	\$110,000	0.28%	-8.41%
Guyana	5.5%	\$510,000	10.27%	+145.94%

<sup>\*\*</sup>This table demonstrates how COPs funding may not necessarily be responsive to the needs of FSWs or epidemic context. All prevalence data can be found at [aidsinfo.unaids.org](http://aidsinfo.unaids.org).

The 2015 *Readiness Assessment* tool to help countries evaluate their preparedness to support key populations is a sign of progress.<sup>282</sup> This is a guide developed by the PEPFAR- and USAID-funded Health Policy Project to assess the ability of country stakeholders (including government, development partners, and civil society) to lead and sustain HIV epidemic control among key populations following U.S. funding declines.<sup>283</sup> Case studies conducted by the Health Policy Project suggest that in some countries, there is little emphasis on the hand-off to national governments to keep programs for key populations running long-term, even when successful,<sup>284</sup> leaving countries feeling as though “the rug was pulled out from under their feet.”<sup>285</sup> As PEPFAR continues to encourage country ownership and sustainability, it is necessary to apply greater pressure on countries to prioritize FSWs in their COPs and simultaneously intensify their national programs and resources for FSWs. While it is true that overall COPs spending for FSWs is on the rise, this generalization disguises tremendous country-level variation and in many places, the funds have dried up or have always been limited.

## Safe Abortion and the Helms Amendment

The harmful impacts of U.S. restrictions on funding for abortion are almost never raised when it comes to FSWs. Yet FSWs are experiencing rates of sexual violence at alarming levels across the globe. Recall the sample

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<sup>§§§§</sup> Vietnam, Zambia, Namibia, South Sudan, Swaziland, and Ukraine.



of Ugandan FSWs above in which nearly a fifth reported experiencing rape three or more times in the preceding six months.<sup>286</sup> The Helms Amendment is a provision of the Foreign Assistance Act of 1961 that prohibits the use of U.S. foreign assistance funds to pay for the performance of abortion “as a method of family planning” or to “motivate or coerce” any person to practice abortion.<sup>287</sup>

In place for more than 40 years, Helms has contributed to an environment where even discussion of abortion is treated as off limits. For instance, in 2013, U.S.-funded programs and organizations were expressly forbidden from attending a maternal health meeting in Kenya because the country’s 2012 safe abortion guidelines were going to be on the agenda.<sup>288</sup> In advance of the May 2016 4th Women Deliver Conference, which was the largest global women’s health conference of the past decade, U.S.-funded programs and organizations were cautioned by U.S. officials about what kinds of meetings and sessions where “abortion may be discussed” were “acceptable for participants supported by USG funds” to attend.<sup>289</sup>

The result of these funding restrictions and ensuing censorship is that FSWs who experience unwanted pregnancy due to rape are not able to obtain abortion care through U.S.-supported programs, which may be the primary source of healthcare in many settings where PEPFAR and USAID operate programs for FSWs. Additionally, the uncertainty and apprehension around abortion created by Helms and U.S. policies like the Global Gag Rule\*\*\*\* have negatively impacted the availability of abortion referral and post-abortion care.

The Leahy Amendment was introduced in 1994 to clarify the language of Helms and makes clear that information and counseling about all pregnancy options, including abortion, is permitted. However, it has done little to alter the climate of silence surrounding abortion, and in practice many U.S. contractors are unaware of its existence. In terms of U.S. programming for FSWs, there are inconsistent interpretations of what is permitted under Helms. Provisions for abortion referral do not appear in any of the LINKAGES tools or country work plans because it is generally understood to be off limits. Referral to or provision of post-abortion care, while theoretically less sensitive, is also not a priority area for LINKAGES. By contrast, PEPFAR’s stated policy is to refer women for abortion services where legal, which purportedly appears in the compliance trainings distributed by headquarters. The interagency conflict in understandings of what is permitted under Helms with respect to abortion referral or post-abortion care has a direct and adverse effect on programming for FSWs, who are disproportionately impacted by high levels of sexual violence and unwanted pregnancy.

## **Adolescents Who Sell Sex or Engage in Transactional Sex**

Under U.S. policy, girls under 18 years of age cannot sell sex as a sex worker. This is formally consistent with the definition of sex worker recognized by UNAIDS and WHO.<sup>290</sup> At the same time, in some regions of the world, up to 20-40% of FSWs may enter commercial sex as adolescents.<sup>291</sup> For the U.S., anyone under 18 in this category is classified as trafficked and is reported to the authorities. She will generally not be eligible for condoms, lubricants, referral to drop-in-centers, or any other programming that is specifically targeted at FSWs. Under PEPFAR’s DREAMS Partnership, adolescents under age 18 who sell sex cannot access PrEP.

Although U.S. programs do not systemically screen for age or ask filtering questions, on-the-ground practitioners view the trafficking/sex work distinction as a hard line. One alternative is to pursue the “don’t ask, don’t tell” approach and simply provide services, but this contributes to the invisibility of an already marginalized and difficult to access population.<sup>292</sup> More nuanced approaches should be considered to provide access to HIV programming, as well as SRHR services and commodities for adolescents and it is critical that efforts be improved to protect children from sexual exploitation and perpetrators be brought to justice.

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\*\*\*\*\* The Global Gag Rule, also known as the Mexico City Policy, is a U.S. policy first introduced during President Reagan’s administration in 1984. It has since been rescinded and reinstated by different presidential administrations and is currently not in effect. When in effect, the policy limits foreign organizations receiving U.S. family planning funds from using their own private, non-U.S. funds to provide abortion services, abortion counseling or referral, or to engage in abortion-related advocacy.

## V. CONCLUSION AND RECOMMENDATIONS

At IAC 2012, U.S. Secretary of State Hillary Clinton urged that “if we’re going to create an AIDS-free generation, we also must address the needs of the people who are at the highest risk of contracting HIV,” including FSWs.<sup>293</sup> Her charge follows a decade in which the global community has increasingly agreed upon the need for decriminalization of adult, voluntary sex work to protect the fundamental rights of FSWs and end the HIV epidemic by 2030.

Despite signs of progress within the global community and the emergence of important tools such as the SWIT and WHO et al’s *Prevention and Treatment Recommendations*, FSWs continue to be highly stigmatized and structural drivers of poor SRH outcomes are systematically overlooked in favor of biomedicalized approaches that ignore the centrality of FSWs’ fundamental rights.

Scattershot efforts and heavy reliance on the use of technical implementers limit the sustainability and replicability of U.S. programs that are effective. PEPFAR is already committed to pushing more robust country ownership; ensuring that FSWs are not left behind must be a part of that objective. The U.S. should prioritize cooperation with Ministries of Health to encourage development of national-level programming and increased resources for FSWs. The U.S. should also continue to invest in initiatives such as the Key Populations Challenge Fund and the recently announced Key Populations Investment Fund to incentivize the development of national-level policies around the SRHR needs of FSWs and facilitate community-led efforts to address stigma and discrimination.

With such huge gaps in our understanding of what works for FSWs on the HIV care cascade, additional investment in implementation science is needed. PEPFAR should also consider how FSWs’ care and treatment outcomes could be more meaningfully and closely monitored to improve programming in the future. To fulfill the promise of Test and START for FSWs, we need to understand the particular barriers and challenges that they face to accessing treatment and remaining adherent.

FSWs experience high levels of sexual violence and unplanned pregnancy, yet access to safe, legal abortion remains extremely difficult across many settings. Currently, U.S. programs for FSWs do not consistently interpret the requirements associated with the Helms and Leahy Amendments around abortion referral and PAC. Standardized guidance and training for staff, country partners, and implementers are needed, which communicate clearly and forcefully that abortion referral and PAC are legally permitted.

While the U.S. has made important strides in the foreign assistance that it directs toward FSWs, the APLO and the conflation of voluntary sex work and trafficking function to obstruct effective, rights-based programming. The U.S. must act to reform current policy which discourages sex worker-led, community empowerment approaches that are necessary to promote the health and rights of FSWs.

Based on the findings, CHANGE offers the following recommendations:

- In order to enable sex worker-led, community empowerment interventions to more effectively promote the health and rights of FSWs, the U.S. should take the following steps:
  - The President should rescind NSPD-22. Government agencies and offices, including the TIP Office, should adopt uniform usage of the term “sex work(er)” in order to promote a coherent global health response for FSWs. This definition should ensure a clear distinction between voluntary sex work and trafficking.
  - HHS and USAID should issue guidance on how organizations are to comply with the APLO that is clear, precise, and narrow. The guidance should clarify that using non-U.S. funds to advocate for the decriminalization of sex work does not violate the law.
  - When the Global AIDS Act is reauthorized, the APLO and other provisions that undermine an evidence-based public health response should be removed.
- In order to more fully recognize the whole-woman health needs of FSWs and encourage better integration between HIV and SRHR, the U.S. should:
  - Develop a needs-assessment tool to be used by all U.S. agencies to more effectively promote integration across the full range of FSWs’ SRHR needs, including HIV, family planning, safe pregnancy, GBV, and substance use.
  - PEPFAR should produce guidance specific to FSWs on FP/HIV integration and explore ways to meaningfully monitor the quality and accessibility of FP services tailored to FSWs’ needs.
- In order to ensure that rollout of PreP and Test and START promote the rights of FSWs, the U.S. should:
  - Encourage communications around PrEP that emphasize FSWs’ right to protect themselves from HIV—as opposed to PrEP as a tool that FSWs use for the benefit of the general population.
  - In ongoing consultation with FSWs and civil society, ensure that scale up of HTC is rights-respecting and accessible. Encourage Country Operational Plans that are responsive to the particular barriers faced by FSWs along the HIV care cascade.

# ANNEX I:

## OVERVIEW OF U.S. PROGRAMMING FOR FEMALE SEX WORKERS

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Most of the U.S. programming for FSWs is through PEPFAR and is directed at HIV prevention activities. Funding for FSWs both as a hard number and as a proportion of the total budget has increased in recent years, but remains fairly limited. Most of this funding is concentrated in sub-Saharan Africa—for the approximately \$36 million of planned FSW funding for 2015, just four countries (Kenya, Tanzania, Uganda, and Mozambique) account for well over a third of the total. NGOs, such as Population Services International (PSI) or Family Health International (FHI 360), receive the bulk of these allocations, followed by universities.

Most PEPFAR-funded mechanisms include some kind of HIV prevention intervention for FSWs, ranging from peer-based promotion of female condoms in Malawi with the Tsankha Lingalira Sankha campaign<sup>294</sup> to supporting the implementation of Combination Prevention interventions as defined by Kenya's National Guidelines.<sup>295</sup> Other important types of activities include training of health workers and community outreach workers, as well as the collection and use of strategic information on FSW, e.g., estimating the size of an FSW population in a particular geographical area. Often, FSWs are targeted within the context of much larger, broader programs. For example, of FHI 360's nearly \$64 million allocation for the SIDHAS (Strengthening Integrated Delivery of HIV/AIDS Services) project in Nigeria in 2014, which is focused on building local capacity for the delivery of comprehensive HIV/AIDS services, \$10,000 was classified as directed at FSWs.<sup>296</sup> This level of detailed funding breakdown is not available prior to 2013—moreover, other U.S. agencies supporting programs for FSWs, such as USAID, provide significantly less funding information. See Annex III for a more detailed explanation of PEPFAR's FSW cross-cutting budget attribution.

## **LINKAGES Rights in Action: Closing the GAP in the HIV Response for Sex Workers (2015)**

### **Actions to better meet the needs of sex workers:<sup>297</sup>**

- 1) Engage and empower sex-worker led groups and organizations
- 2) Develop programs to eliminate violence against sex workers perpetrated by law enforcement
- 3) Establish a coordinated referral system and network of service providers
- 4) Change laws and policies to respect the human rights of all sex workers
- 5) Build the global evidence base of strategic information
- 6) Ensure the provision of respectful services that acknowledge the unique clinical and outreach needs of sex workers
- 7) Broaden the current HIV response with sex workers to address structural drivers of HIV
- 8) Be responsive to the changing nature of sex work, e.g., the use of virtual solicitation
- 9) Target selected populations to maximize the impact of interventions
- 10) Recognize the heterogeneity of sex workers

In addition to PEPFAR's intensifying activities for FSWs, there has been an increase in USAID-supported country-level projects that are directed primarily at key populations. Examples include the Saath-Saath Project in Nepal (2011-2016), HUSKIA in Tanzania (2012-2015), and CHAMP in Cameroon (2014-2019). However, the most significant development was the announcement of Linkages across the Continuum of HIV Services for Key Populations Affected by HIV (LINKAGES) at IAC 2014, which is the first global project dedicated to key populations, funded by PEPFAR through USAID and led by FHI 360. A \$73 million dollar initiative, it will be implemented over five years and is currently in partnership with 20 countries.<sup>††††</sup> The goal of LINKAGES is to "strengthen the ability of partner governments, civil society organizations working with key populations and private-sector providers to effectively deliver comprehensive, high-quality HIV prevention, treatment and care services for key populations and their partners."<sup>298</sup> LINKAGES acknowledges the centrality of violence, as well as the need to address the unique needs of younger sex workers and women who have recently entered sex work, who are at higher risk for negative SRH outcomes.<sup>299</sup> LINKAGES is also guided by a strong human rights ethos and stresses the importance of community empowerment, meaning that "HIV programs should support sex workers in all aspects of the program—as peers, counselors, clinicians and managers."<sup>300</sup> To ensure stakeholder participation, LINKAGES receives guidance from a standing advisory board which includes representatives from key populations; currently, the Global Coordinator from NSWP serves on the board, along with officials from the U.S. government and key multilateral organizations.<sup>301</sup>

<sup>††††</sup> The countries are Angola, Botswana, Burundi, Cambodia, Cameroon, Côte d'Ivoire, Democratic Republic of the Congo, Dominican Republic, Ghana, Haiti, Honduras, India, Indonesia, Jamaica, Kenya, Laos, Malawi, Mozambique, South Sudan, and Thailand.

The DREAMS Partnership is a \$500 million public-private partnership spearheaded by PEPFAR that focuses on reducing the disproportionate level of new HIV infections among adolescent girls and young women in 10 high-burden sub-Saharan African countries.<sup>302</sup> While DREAMS features a multi-sectoral strategy with many moving parts, it also represents the first instance in which PEPFAR is directly funding pre-exposure prophylaxis (PrEP) through its HIV-prevention programming. In several of the DREAMS country plans, young sex workers are being targeted for access to PrEP, including South Africa, Swaziland and Malawi.

The U.S. supports other smaller-scale efforts impacting FSWs, all of which were announced by former Secretary of State Clinton at the 2012 International AIDS Conference. The Key Populations Challenge Fund (KPCF) is a \$33 million dollar investment that supports country-led plans in six countries and several regions to expand high-impact, comprehensive packages of HIV prevention, treatment, and care services for key populations.<sup>303</sup> Additionally, PEPFAR has directed \$15 million to an implementation science fund for key populations, which provides grants supporting research to improve knowledge about effective service provision.<sup>304</sup> Finally, the Robert Carr Civil Society Networks Fund (RCNF) receives a \$2 million dollar annual contribution<sup>305</sup> and Ambassador Deborah Birx announced in September 2015 that the U.S. will be contributing an additional \$10 million over the next three years to the Fund.<sup>306</sup> The RCNF is a cooperative fund which aims to strengthen international networks with a particular emphasis on inadequately served populations, including sex workers.



# ANNEX II: U.S. GUIDANCE AND ASSESSING PROGRAM IMPACT FOR FEMALE SEX WORKERS

Just two years after its initial authorization with the Global AIDS Act in 2003, PEPFAR issued *ABC Guidance* # 1 to U.S. government in-country staff and implementing partners, which covered the Abstinence, Be Faithful, and correct and consistent Condom use (ABC) approach to HIV prevention, a prominent component in the early years of PEPFAR's programming. It identifies "most affected populations," including sex workers, and the need for "specific outreach, services, comprehensive prevention messages, and condom information and provision."<sup>307</sup> While information on how to program for sex workers has been available since 2005 in PEPFAR's *Technical Considerations*,<sup>308</sup> PEPFAR has not generated a technical guidance document specific to sex workers as it has with other key population, including for PWID and MSM,<sup>309</sup> rather, it relies on WHO et al's 2012 *Prevention and Treatment Recommendations* and the SWIT. It is telling that the U.S. is not an official contributor to either of these tools, whereas it is to WHO et al's 2015 *Implementing comprehensive HIV and STI programmes with men who have sex with men*,<sup>310</sup> UNDP et al's 2016 *Implementing comprehensive HIV and STI programmes with transgender people*,<sup>311</sup> as well as the forthcoming collaborative tool on PWID.

The evolution of PEPFAR's indicators suggests an increasing recognition of the importance of FSWs as a key population in HIV programming, including in generalized epidemic settings. However, up to this point, all indicators associated with FSWs have assessed Prevention activities, as opposed to any of the Care and Support or Treatment outcomes. While disaggregation of key populations is recommended for some of these indicators, e.g. TX\_NEW, which measures scale up and uptake of ART programs, this is not required,<sup>312</sup> limiting our understanding of FSWs' experiences on the HIV care cascade within U.S.-supported programming.

Several other core strategic documents issued by PEPFAR address FSWs, including PEPFAR's gender strategy, updated in 2013. Acknowledging that the PEPFAR Gender Framework reflects a commitment to women, girls, and gender equality, it also specifies that certain populations require consideration because their sexual behavior does not conform with gender norms, including sex workers.<sup>313</sup> It outlines key approaches and activities to integrate gender issues into HIV prevention, care, treatment, and support and provides concrete examples of how sex workers can be included in that process—for example, providers may be trained to reduce stigma and discrimination toward sex workers to help overcome gender-related barriers to accessing healthcare services.<sup>314</sup>

## Measuring Program Impact for FSWs

Since its inception, PEPFAR has engaged in Monitoring and Evaluation (M&E) activities, and the way in which it has measured programmatic success around sex workers has evolved significantly over time.

- PEPFAR's original indicators, drafted by OGAC in 2004, include the following prevention outcome indicator: percent of men reporting sex with a sex worker in the last 12 months who used a condom during last paid intercourse.<sup>315</sup>
- In 2007, this was retained as a core indicator, but PEPFAR added an additional outcome indicator intended specifically for concentrated/low prevalence epidemics: percentage of female and male sex workers reporting the use of a condom with their most recent client.<sup>316</sup>

*Continued on page 37*



- In 2009, both indicators were classified as “essential” national indicators for concentrated epidemics but not required reporting to PEPFAR headquarters. However, 2009 is also the year in which PEPFAR added an indicator measuring the number of MARPs reached with individual and/or small group-level HIV preventive interventions that are evidence-based or meet minimum standards.<sup>317</sup>
- This remained unchanged until 2015 when PEPFAR transformed the MARPs indicator into the KP\_PREV indicator, which measures the percentage of key populations reached with individual and/or small group-level HIV preventive interventions that are based on evidence and/or meet minimum standards. Importantly, the indicator now requires disaggregation by sex, which the prior versions did not. PEPFAR country operating units are also required to report on the comprehensiveness of prevention interventions being offered to each key population when submitting data on the KP\_PREV indicator. The following checklist is used for FSWs to assess the overall comprehensiveness of services provided in a given country:
  - 1) Outreach/empowerment
  - 2) Targeted information, education and communication (IEC)
  - 3) Provide or refer to HTC
  - 4) Condoms/lubricant
  - 5) Refer to STI screening, prevention and treatment
  - 6) Link or refer to ART
  - 7) Refer to Reproductive Health (Family Planning; PMTCT)
  - 8) Prevention, and refer to diagnosis, treatment of TB
  - 9) Refer to screening and vaccination for viral hepatitis<sup>318</sup>

Most of what we know about U.S. programming for FSWs and its relative success is captured through PEPFAR, and the focus is primarily on prevention activities. In this respect, our understanding of how U.S. foreign assistance is meeting the full breadth of FSWs’ SRH needs is genuinely limited.

# ANNEX III:

## PEPFAR'S FSW CROSS-CUTTING BUDGET ATTRIBUTION

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In its *Country Operational Plan (COP) Guidance* for FY 2013, PEPFAR introduced a cross-cutting budget attribution<sup>319</sup> specifically dedicated to FSWs. This important change makes it possible to track activities focused on FSWs with much greater granularity and across different program areas—for instance, it is possible to see that between 2013 and 2015, the planned allocation to FSWs as a cross-cutting attribution increased from about 4.6% to 7% of PEPFAR's overall budget.<sup>320</sup>

- 2013: \$32,044,895 (4.55% of budget): 96 mechanisms
  - The majority of these mechanisms fell in one of the Prevention budget codes: HVOP (Sexual Prevention: Other Sexual Prevention) and HVCT (HIV Testing and Counseling)
- 2014: \$33,870,398 (5.74% of budget): 146 mechanisms
  - HIV prevention interventions, training of health workers and community outreach workers, and collection and use of strategic information were the most commonly reported focus areas.
- 2015: \$36,182,099 (7.17% of budget): 154 mechanisms
  - HIV prevention interventions, training of health workers and community outreach workers, and collection and use of strategic information were the most commonly reported focus areas.

There are several key limitations to the use of PEPFAR's FSW budget attribution. First, funds may be “double-counted” with other cross-cutting budget attributions (there are over a dozen). To illustrate: the same \$50,000 pot of money may be simultaneously classified in total as directed at FSWs and at MSM and transgender persons (MSM/TG), which is a separate cross-cutting budget attribution. However, it is not possible to determine the relative proportion of the \$50,000 that is actually being targeted at FSWs versus MSM/TG. It is not unusual to see identical sums of money classified as being allocated simultaneously to FSWs and MSM/TG (see Angola's 2015 *Country Operational Plan* as an example). Thus, the aggregate estimates of funding for FSWs are likely inflated. Second, it is not possible to determine with much precision what levels of funding are going to what kinds of activities. In 2013, PEPFAR relied on its standard budget codes to describe the different activities directed at FSWs. It also provided detailed narratives, making it possible to closely review the different mechanisms reportedly directed at least in part at FSWs. In 2013, virtually none of the narratives were FSW-specific. This suggests that mechanisms which are being assigned the FSW budget attribution may not be highly targeted or tailored for FSWs. Alternatively, FSW-specific activities may constitute only a very minor component of program operations.

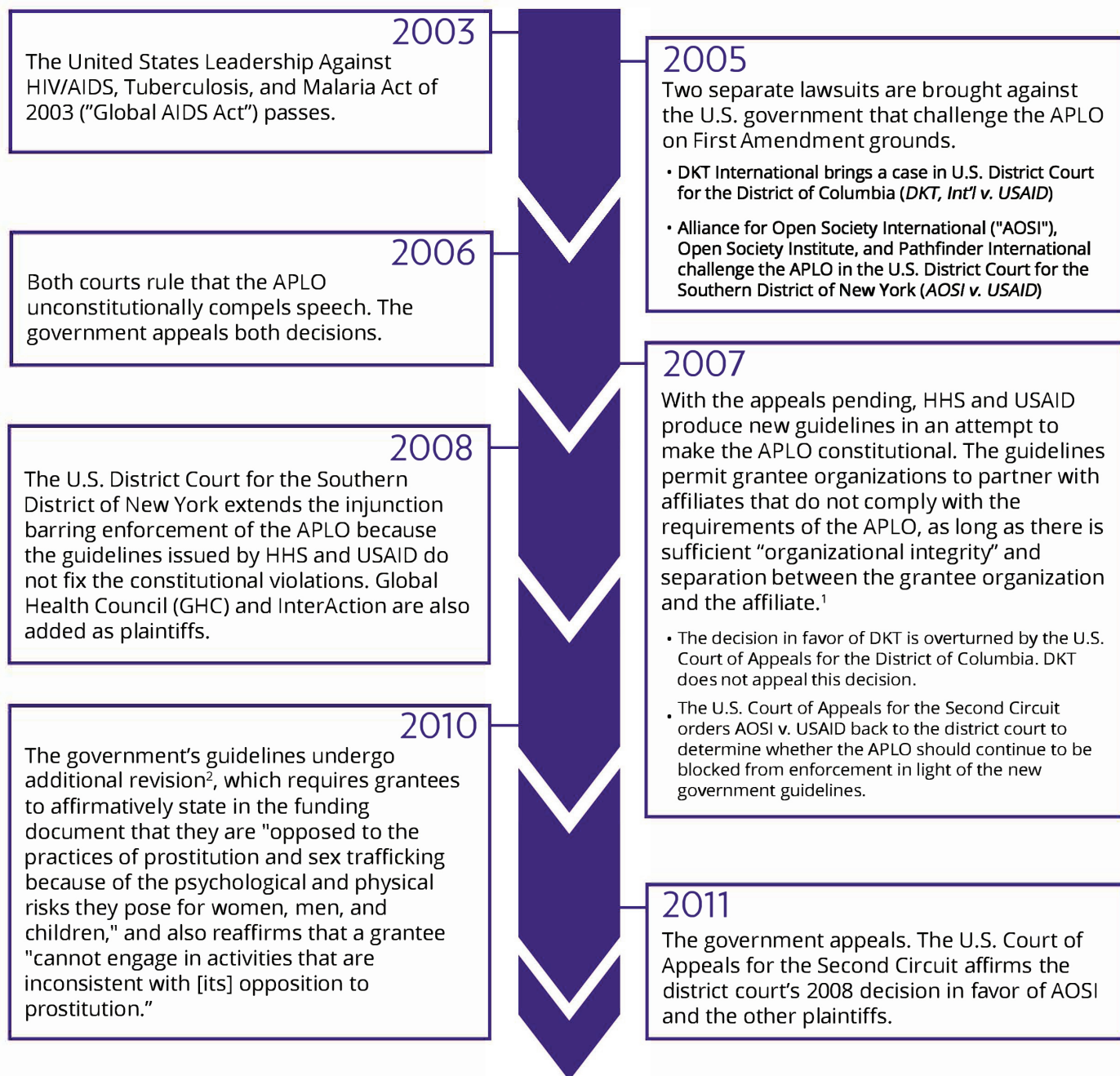
In 2014, PEPFAR shifted to the use of “focus areas” to track activities assigned the FSW cross-cutting budget attribution rather than budget codes. Although it is possible to determine how many mechanisms fall into different focus areas as a topline number, it is not possible to determine an associated funding level, e.g., how much money overall goes to monitoring and evaluation of programs versus condoms and lubricants for FSWs? Additionally, a single mechanism may be assigned multiple focus areas, but it is not possible to determine what level of funding is going to which activity within a single mechanism. Some mechanisms may be assigned five or more focus areas.

Overall, the cross-cutting budget attribution undoubtedly enables improved monitoring of PEPFAR's funding and programming for FSWs, but how the money is actually used remains far from transparent and aggregate totals associated with the attribution must be interpreted with extreme caution.

**Activities Captured Under the Cross-Cutting Budget Attribution (Focus Areas):**

- 1) Implementation of core HIV prevention interventions consistent with PEPFAR guidance on sexual prevention
- 2) Training of health workers and community outreach workers
- 3) Collection and use of strategic information on FSWs
- 4) Conducting epidemiological social science and operational research among FSWs, their partners and clients
- 5) Monitoring and evaluation of FSW programs
- 6) Procurement of condoms, lubricants, and other commodities essential to core HIV services for FSWs

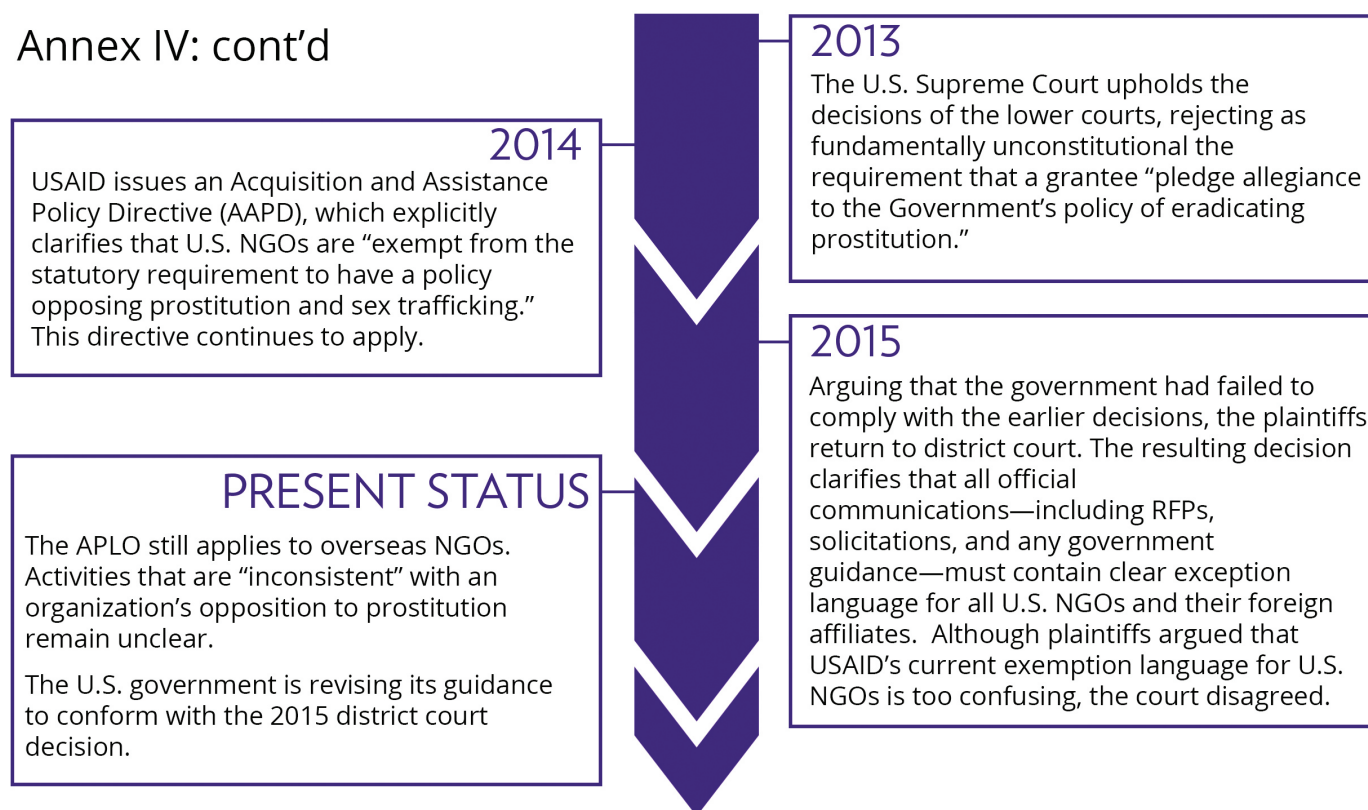
## Annex IV: Timeline of Major Events in the APLO Litigation



<sup>1</sup>Guidance Regarding Section 301(f) of the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003, 72 Federal Res. 41076 (July 26, 2007); USAID, AAPD-05-04 AMENDMENT 1: IMPLEMENTATION OF THE UNITED STATES LEADERSHIP AGAINST HIV/AIDS, TUBERCULOSIS AND MALARIA ACT OF 2003 – ELIGIBILITY LIMITATION ON THE USE OF FUNDS AND OPPOSITION TO PROSTITUTION AND SEX TRAFFICKING (2007), available at [https://www.usaid.gov/sites/default/files/documents/1868/aapd05\\_04\\_amendment1.pdf](https://www.usaid.gov/sites/default/files/documents/1868/aapd05_04_amendment1.pdf)

<sup>2</sup>Organizational Integrity of Entities That Are Implementing Programs and Activities Under the Leadership Act, 75 Fed. Reg. 18760 (April 13, 2010) (to be codified at 45 CFR pt. 89)

## Annex IV: cont'd



*Current exemption language used by the U.S. government:*

### **USAID**

PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING (SEPTEMBER 2014)

(a) The U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons. None of the funds made available under this agreement may be used to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides.

(b)(1) Except as provided in (b)(2), by accepting this award or any subaward, a nongovernmental organization or public international organization awardee/subawardee agrees that it is opposed to the practices of prostitution and sex trafficking.

(b)(2) The following organizations are exempt from (b)(1):

(i) the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Health Organization; the International AIDS Vaccine Initiative; and any United Nations agency.

(ii) U.S. non-governmental organization recipients/subrecipients and contractors/subcontractors.

(iii) Non-U.S. contractors and subcontractors if the contract or subcontract is for commercial items and services as defined in FAR 2.101, such as pharmaceuticals, medical supplies, logistics support, data management, and freight forwarding.

See USAID AAPD 14-04: IMPLEMENTATION OF THE UNITED STATES LEADERSHIP AGAINST HIV/AIDS, TB, MALARIA ACT OF 2003, AS AMENDED – CONSCIENCE CLAUSE IMPLEMENTATION , MEDICALLY ACCURATE CONDOM INFORMATION AND OPPOSITION TO PROSTITUTION AND SEX TRAFFICKING 9 (2014), *available at* <https://www.usaid.gov/work-usaid/aapds-cibs/aapd-14-04-w>

### **U.S. Department of Health and Human Services**

“A standard term and condition of award will be included in the final notice of award; all applicants will be subject to a term and condition that none of the funds made available under this award may be used to promote or advocate the legalization or practice of prostitution or sex trafficking. In addition, non-U.S. nongovernmental organizations will also be subject to an additional term and condition requiring the organization’s opposition to the practices of prostitution and sex trafficking.”

See, e.g., CDC, *Local Non-governmental Partnerships for Sustained Country Leadership in Uganda under the President’s Emergency Plan for AIDS Relief, Funding Opportunity No. CDC-RFA-GH14-1412* (September 15, 2014), <http://www.cdc.gov/globalaids/global-hiv-aids-at-cdc/FY2014/CDC-RFA-GH14-1412.pdf>



# ANNEX V:

## ADDITIONAL DOCUMENTS AND RESOURCES

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- Global Network of Sex Work Projects (NWSWP), *Only Rights Can Stop the Wrongs: The Smart Person's Guide to HIV and Sex Work* (2010)
- Open Society Foundations, *Public Health Fact Sheet: Common Human Rights Violations Experienced by Sex Workers* (2011)
- UNAIDS, *UNAIDS Guidance Note on HIV and Sex Work* (2012)
- WHO, UNFPA, UNAIDS, & NSWP, *Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries: recommendations for a public health approach* (2012)
- NSWP, *Documenting Good Practice by Sex Worker-Led Organizations #01: Addressing Violence Against Sex Workers* (2012)
- India HIV/AIDS Alliance, *HIV/SRHR Integration for Key Populations: A review of experiences and lessons learned in India and globally* (2012)
- WHO, UNFPA, UNAIDS, NSWP, World Bank, & UNDP, *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions* (the Sex Worker Implementation Tool or “SWIT”) (2013)
- UNAIDS, *Guidance Note: Services for Sex Workers* (2014)
- UNAIDS, *Briefing Note: The Legal Status of Sex Work: Key Human Rights and Public Health Considerations* (2014)
- NSWP, *Good Practice in Sex Worker-Led HIV Programming* (2014)
- WHO, *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations* (2014)
  - Supplement: WHO, *Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations* (2015)
- WHO, *Technical Brief: HIV and Young People Who Sell Sex* (2015)
- Global Fund, *Information Note: Addressing Sex Work, MSM, and Transgender People in the Context of the HIV Epidemic* (2015)
- ICASA Key Populations Communiqué (2015)
- Health Policy Project, *Ensuring Responsible Donor Transitions for Key Populations* (2016)
- Amnesty International, *Policy on State Obligations to Respect, Protect and Fulfill the Human Rights of Sex Workers*

# ENDNOTES

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- 2 GLOBAL NETWORK OF SEX WORK PROJECTS (NSWP), ON SEX WORK, HUMAN RIGHTS AND THE LAW (2013), available at <http://www.nswp.org/sites/nswp.org/files/ConStat%20PDF%20EngFull.pdf>.
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