Issue Brief

HIV/SRHR Integration for Sex Workers

How integration responds to the SRHR needs of sex workers

Sex workers have the same sexual and reproductive **rights** as anyone else – such as to choose who to have sex with and to have sexual relations free from violence. They also share many of the same **needs** for SRHR information, support, commodities and services – such as advice about family planning.

However, due to many factors, sex workers often experience **greater vulnerability** to SRH ill health than other community members. They may experience one or all of: specific or more complex SRHR needs; additional or stronger barriers to accessing SRHR services; and weaker capacity or opportunities to demand SRHR services [see Box 2]. These factors are further affected – sometimes *complicated* – by the differences between **individual sex workers**, such as in terms of their gender and sexual orientation (including whether they are female, a man who has sex with men (MSM) or transgender), age, legal status, HIV status, socio-economic status and whether they use drugs.

As a result, sex workers often have **significant unmet needs** for SRHR [see Box 1]. These can 'fall through the net' of both: HIV services (often designed to address specific risk behaviors rather than the 'whole person'); and SRHR services (often designed for the general public and focused on mainstream services, such as family planning).

Terminology: HIV/SRHR integration

HIV/SRHR integration refers to one or more components of HIV programming being integrated into (or joined with) one or more components of SRHR programming; or vice versa. This includes referrals from one service to another. The overall aim is to provide more comprehensive support.

India HIV/AIDS Alliance

Addressing the HIV/SRHR needs of sex workers matters in *all* contexts. However, the approach, scale and pace of integration depend on a range of factors, including the local HIV epidemic. Depending on whether a country has a concentrated or generalised epidemic, a **'package' of HIV/SRHR support** for sex workers might include services for all or just some of:

- **Specific HIV prevention and behaviour change communication.**
- **Regular supplies of male and female condoms and lubricant.**
- **Skills building for negotiating safer sex and risk-reduction (including for anal sex).**
- **Full range of family planning support and contraceptive options (for example, to prevent pregnancy from clients and plan a family with a partner).**
- **Prevention and counselling on sexual violence.**
- **Emergency PEP for rape or sexual assault.**
- **Testing and treatment for a full range of STIs, including attention to anal infections and re-occurring infections.**
- **Non-judgemental support for pregnancy and birth, including ANC, prevention of mother-to-child transmission (PMTCT) and maternal, newborn and child health (MNCH).**
- **Empowerment on sexual and health rights.**
- **Negotiation skills to deal with stigma and criminalised status, such as sexual harassment by police.**
- **(Where legal) safe and confidential abortion and (in all contexts) post-abortion care.**

Box 1: Unmet SRHR needs of sex workers

A study of sex workers in Andhra Pradesh, India found that:

- 70-75% usually used condoms with clients, but few used them with their regular sexual partners.
- 30% had experienced unintended pregnancies. Of those, most resorted to abortion (with 10% self-induced) and most had post-abortion complications.
- Government clinics were their least preferred services – due to judgemental attitudes and low confidentiality.

Box 2: Factors that affect sex workers in the context of SRHR

Factors	*For example, compared to other community members …*
Specific or more complex SRHR needs	• A female sex worker might experience higher levels of coerced and violent sex – increasing her need for emergency contraception and post-exposure prophylaxis (PEP). • A female sex worker might require specialized advice on how to prevent HIV and pregnancy with her clients while planning a family with her regular partner. • An MSM sex worker might require larger supplies of condoms and lubricant and more regular STI testing. • A transgender sex worker might require counseling and support on gender reassignment.
Additional or stronger barriers to accessing SRHR services	• A female sex worker might face stigma and discrimination at mainstream antenatal (ANC) services. • An MSM sex worker might work at night and not be able to access an SRHR clinic in normal opening hours. • A transgender sex worker might not access a public STI service due to threats by the police. • A female sex worker might not be allowed to register for an SRHR clinic if her status is criminalized.
Weaker capacity or opportunities to demand SRHR services	• A female sex worker might be excluded from district consultations on women's SRHR needs. • An MSM sex worker might lack a safe space to advocate on his SRHR needs to decision-makers. • A transgender sex worker might not be able to participate in SRHR decision-making because they lack legal status. • A sex worker might lack the skills to articulate their SRHR needs because they have been excluded from community capacity building projects.

Lessons learned about HIV/SRHR integration for sex workers

There are many general lessons about the challenges of implementing HIV/SRHR integration for key populations [see Box 3]. There are also insights into success factors. Examples include that it helps to: start by building on what's there, gathering evidence and identifying entry points; ensure a strong chain of services (including high quality referrals); and address the political, legal and funding context of HIV/SRHR. In addition, experiences around the world suggest specific lessons about integration for sex workers. These include that it is vital to:

- **Identify, understand and respond to the different SRHR/HIV needs of different types of sex workers.** For example, a study among sex workers in Andhra Pradesh, India, found that 35% were street-based, 27% home-based, 26% based in a secret location, 7% in lodges and 6% in brothels – affecting their HIV/SRHR needs and access to services.
- **Provide comprehensive HIV/SRHR integrated services that address the holistic needs of sex workers, rather than treating them as 'transmitters' of infection to clients.** For example, a PATH study in four states in India found that sex workers wanted a full range of SRHR services, including family planning, abortion, ANC and delivery. Meanwhile, a study in Cambodia found that less than 5% of sex workers used a modern contraceptive method (other than condoms) with their regular partner.
- **Pay specific attention to the SRHR needs of sex workers who are living with HIV**, including providing access to a non-discriminatory contraception, PMTCT, MNCH and abortion services [see Box 4].
- **Address the cross-cutting issue of violence.** For example, partners of the International HIV/AIDS Alliance in different countries have found that, although violence against sex work is common and affects their vulnerability, it is rarely taken into account in the development of programmes. In response to such challenges, the Avahan Programme, India, combined advocacy to the police with capacity building of sex workers to protect themselves and hold perpetrators to account.
- **Advocate on the benefits of HIV/SRHR integration to gatekeepers within sex workers' communities.** For example, Community Support Concern and HMAP in Pakistan found that it was critical to engage pimps in the development of integrated programming.
- **Avoid assumptions about the sexual 'norms' and needs of sex workers.** For example, within integrated programmes, female sex workers may need diagnosis and treatment services for anal STIs.
- **Address the wider social and cultural context and its implications for sex workers.** For example, in Nepal, the Family Planning Association partnered with the Durbar Mahila Samanwaya Committee (a sex workers' cooperative in Kolkata, India) to design integrated HIV/SRHR services for young girls and women being trafficked for sex work. Meanwhile, a study in Andhra Pradesh, India, found that some sex workers were forced to have abortions by their caretakers or family members, with the procedure sometimes taking place in their own homes.

Box 3: Top 10 challenges to HIV/SRHR integration for key populations

1. Stigma and discrimination about HIV and key populations.
2. Low demand for HIV/SRHR integrated services.
3. Lack of rights-based approaches to HIV/SRHR.
4. Low attention to gender inequality in HIV/SRHR integration.
5. Missed obvious opportunities for HIV/SRHR integration.
6. Low understanding of key populations' specific HIV/SRH needs.
7. Presumptions or lack of expertise among service providers.
8. Lack of a strong referrals systems for HIV/SRHR.
9. Inappropriate design of HIV/SRHR integration.
10. Lack of technical and financial support to over-stretched groups.

Box 4: SRHR needs of female sex workers living with HIV

"Sex workers living with HIV who become pregnant need to be given a full range of options and not coerced to have terminations. Many sex workers report that it is assumed that any pregnancy they have must be unwanted. Pressure on HIV-positive sex workers to have terminations is reported in most countries. Due to this focus, most HIV-positive pregnant women do not get the full range of options explained to them and, if they decide to continue with the pregnancy, often receive sub-optimal care."

Advancing the Sexual and Reproductive Health and Human Rights of Sex Workers Living with HIV: Policy Briefing, Global Network of People Living with HIV and Global Network of Sex Work Projects (2010)

‘Snapshots’ of HIV/SRHR integration for sex workers

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INDIA: Avahan Programme provided clinics combining HIV/STI components (such as male/female condoms, behaviour change communication and STI prevention) with wider SRHR (such as pregnancy testing, family planning, cervical cancer screening, safe abortion and MNCH) for key populations, including sex workers and clients. The services were provided by facilities and peer outreach, with referrals for specific services such as PMTCT. Integration involved training staff and expanding the range of ‘sex worker friendly’ services. The results included increased uptake of dual protection (against HIV and unwanted pregnancy).

BANGLADESH: Young Power in Social Action (YPSA) has an Integrated Health Centre combining services for SRHR (such as condom promotion and STI diagnosis) and HIV (such as HIV counselling and testing (HCT) and needle/syringe exchange) for sex workers and people who use drugs. Referrals are provided to other services. The challenges include the services’ illegal status and poor donor/ national policies on integration. Its lessons include that condoms provide an entry point to explore dual protection for sex workers.

MYANMAR: TOP Project is led by sex workers and combines HIV services (such as HCT and ART) with SRHR services (such as contraceptives, pregnancy testing and cervical cancer screening). TOP has programmes in 19 cities and provides peer outreach, drop-in activities, clinical services and HIV care and support (for sex workers living with HIV). Its lessons include that integration needs to combine clinical services (such as STI treatment) with psycho-social support (such as recreation and support groups).

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ASIA & THE PACIFIC: UNFPA works with partners to better address the HIV/SRHR needs of sex workers. Its initiatives include: a Consultation on HIV and Sex Work (highlighting the need for non-discriminatory SRHR services for female, MSM and transgender sex workers); and a stock-take of recommendations from the Commission on AIDS in Asia and the Pacific (finding that countries largely offered sex workers narrow programmes focused on condoms and STIs). UNFPA now supports a Thematic Working Group on HIV and Sex Work which will develop operational guidance on a comprehensive and integrated response.

INDIA: Aastha Project provides clinics and outreach integrating family planning into HIV and STI support for female, MSM and transgender sex workers in brothels, on the street, in bars and at home. The services include condoms for dual protection, information on sexuality and counselling on negotiation. Integration started with a needs assessment (involving sex workers, brothel owners and bar managers), review of organisational systems and resources and establishing a referral network.

PAKISTAN: Community Support Concern (CSS) and HMAP provide integrated HIV/SRHR support to marginalised adolescents, including sex workers, through a Drop-In Centre and community outreach. The sex workers are highly vulnerable – some as young as 12 years and many suffering exploitation and sexual abuse. The NGOs’ approach builds incrementally – starting by addressing general health (such as personal hygiene and contraception), then moving to more specific issues (such as HIV and abortion).

5 key messages about HIV/SRHR integration for sex workers

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1 **HIV/SRHR integration is a vital strategy** for moving from treating sex workers as 'transmitters of infection' to recognising their rights (including to sexuality and reproduction) and providing holistic, 'whole person' support.

2 **HIV/SRHR integration for sex workers requires particular attention to the cross-cutting issues of violence and stigma and discrimination.** Both issues can present significant barriers to effective programming, but can also serve as an entry point to explore a range of overlapping issues and provide comprehensive services.

3 **Groups by and for sex workers are vital to HIV/SRHR integration.** However, the strategy can bring additional work and pressure to already over-stretched groups, particularly where sex work is criminalised; Start small. Comprehensive HIV/SRHR integration may be a good long-term goal for some organizations, but, in the short-term, full integration is not required. Instead, efforts should start with joining selected HIV and SRHR services that are priorities for sex workers and have an obvious overlap.

4 **HIV/SRHR integration must address the diversity of sex workers.** A 'one size fits all' approach will not work for sex workers that, for example, are of a different gender and age and have very different types and levels of SRHR needs.

5 **Integration can be an important opportunity to balance the 'work-related' HIV/SRHR needs** of sex workers (such as for STI screening) and personal needs (such as to plan a family and care for children).

About this brief

This issue brief is part of a series of materials resulting from a review of good practice in the integration of HIV and sexual and reproductive health and rights (SRHR) for key populations. The review was commissioned by the India HIV/AIDS Alliance and explored experiences and lessons from Asia and the Pacific and globally.

Background information – such as what HIV/SRHR integration is, what particular benefits it brings to key populations and what lessons have been learned among such communities – are summarized in *Policy Brief: Key Linkages and Key Populations: Is HIV/SRHR Integration Serving the Needs of Vulnerable Communities*? Further detail, including the references for the information in this document, can be found in the full report of the review[1].

This brief specifically focuses on the importance, but also challenges, of HIV/SRHR integration for sex workers. It is based on the experiences of a growing number of groups working with such communities to put integration into practice in a range of setting. These have given important insights into 'what works'. But they also highlight that *everyone is still learning* and questions remain about what constitutes good practice.

This issue brief promotes integration as a desirable goal in the long-term. However, it also emphasizes that organizations must work in a way and at pace that is appropriate and feasible for them – to ensure that the joining of HIV and SRHR services and systems *enhances*, rather than *compromises*, support for sex workers.

1. India HIV/AIDS Alliance (2012). HIV/SRHR integration for key populations: A review of experiences and lessons learned in India and globally. New Delhi. India HIV/AIDS Alliance.

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India HIV/AIDS Alliance

India HIV/AIDS Alliance (Alliance India) is a diverse partnership that brings together committed organisations and communities to support sustained responses to HIV in India. Complementing the Indian national programme, we work through capacity building, knowledge sharing, technical support and advocacy. Through our network of partners, we support the delivery of effective, innovative, community-based HIV programmes to key populations affected by the epidemic.

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Unless otherwise stated, the appearance of individuals in this publication gives no indication of their HIV or key population status.

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