ANNEX 1: PICO QUESTIONS AND OTHER RECOMMENDATIONS

I - Based on PICO questions

PQ1: SHOULD COMMUNITY EMPOWERMENT BE AN INTEGRAL STRATEGY FOR INTERVENTIONS WITH SEX WORKERS?

Population: sex workers
Intervention: sex-worker empowerment
Comparison: no sex-work empowerment
Outcomes: as per outcome framework for prevention interventions

The answer will be based in the systematic review.

PQ2: SHOULD CONSISTENT AND CORRECT CONDOM USE BE PROMOTED AMONG SEX WORKERS AND THEIR CLIENTS TO REDUCE TRANSMISSION OF HIV AND OTHER STIs?

Population: sex workers and their clients
Intervention: consistent and correct condom use
Comparison: inconsistent and incorrect or no condom use
Outcomes: as per outcome framework for prevention interventions

The answer will be based on the existing Cochrane review focusing on the general population supplemented by additional reviews.

PQ3: SHOULD SEX WORKERS HAVE ACCESS TO PERIODIC SCREENING FOR ASYMPTOMATIC STIs (SYphilis, GonorrHOEA AND CHlamyDIA)?

Population: sex workers
Intervention: STI screening
Comparison: no screening

The answer will be based in the systematic review.

PQ4: IN SETTINGS WITH HIGH PREVALENCE AND LIMITED CLINICAL SERVICES SHOULD SEX WORKERS HAVE ACCESS TO PERIODIC PRESUMPTIVE TREATMENT (PPT) FOR ASYMPTOMATIC STIs?

Population: sex workers
Intervention: PPT
Comparison: standard management of symptomatic STIs, with or without screening
Outcomes: as per outcome framework for treatment interventions
The answer will be based in the systematic review.

PQ5: SHOULD SEX WORKERS AND CLIENTS HAVE ACCESS TO VOLUNTARY COUNSELLING AND TESTING (VCT)?

Population: sex workers and clients
Intervention: VCT
Comparison: no VCT
Outcomes: as per outcome framework for screening interventions

The answer will be based on existing guidelines for the general population.

PQ6: SHOULD ART USE IN HIV+ SEX WORKERS BE THE SAME AS THAT IN OTHER ADULT AND ADOLESCENT HIV+ POPULATIONS?

Population: sex workers
Intervention: ART
Comparison: no ART
Outcomes: as per outcome framework for treatment interventions

The answer will be based on existing guidelines for the general population.

II - Other Recommendations


The answer will be based on existing guidelines for the general population.

Draft Recommendation 8b: The management of sex workers with hazardous and harmful alcohol use should be in line with WHO (2010) Mental Health Gap Action Programme (mhGAP) guidelines on interventions for mental, neurological and substance use disorders, including screening and brief interventions for hazardous and harmful alcohol use in health settings not specialized in mental health2.

The answer will be based on existing guidelines for the general population.

Draft Recommendation 8c: The management of sex workers using psychostimulants should be in line with WHO (2010) mhGAP guidelines on interventions for mental, neurological and substance use disorders, including brief interventions in non-specialist settings providing feedback and advise for substance use reduction or termination and, in the event they do not respond to such interventions, potential referral for specialist assessment.3

2 See Alcohol PICOT Qn 1 and the 4 recommendations.
3 Substance Use PICOT Qn 1 and the 2 recommendations

_The answer will be based on existing guidelines for the general population._

Draft Recommendation 9: Recommendations regarding hepatitis B (HBV) vaccination should be in line with the WHO (2009) *Position paper on hepatitis B vaccines*,[^6] which implies that groups, including unvaccinated people with multiple sex partners (i.e. sex workers), are at higher risk of acquiring HBV infection. They should be included as targets of catch-up HBV immunization strategies in settings in which infant immunization has not reached full coverage.

_The answer will be based on existing guidelines for the general population._

ANNEX 2: OUTCOME FRAMEWORKS

Prevention interventions, outcomes of interest:
- HIV-associated morbidity
- HIV-associated mortality
- STI-associated morbidity
- STI-associated mortality

Treatment interventions, outcomes of interest:
- HIV-associated morbidity
- HIV-associated mortality
- Adverse effects of treatment

Screening interventions, outcomes of interest:
• HIV-associated morbidity
• HIV-associated mortality
• Discrimination
• Anxiety, unnecessary testing, interventions
### 3.1a. Community empowerment: evidence profile

**Author(s):** Deanna Kerrigan, Caitlin Kennedy, Virginia Tedrow, Susanne Stromdahl  
**Date:** 2011-08-15  
**Question:** Should interventions to enhance community empowerment be used in sex workers?

#### Quality assessment

<table>
<thead>
<tr>
<th>No. of studies</th>
<th>Design</th>
<th>Limitations</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 observational studies</td>
<td>serious²</td>
<td>serious⁴</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>interventions to enhance community empowerment control Relative (95% CI) Absolute Quality Importance</td>
</tr>
<tr>
<td>15 observational studies</td>
<td>serious³</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>HIV infection (follow-up mean 2.5 years)</td>
</tr>
<tr>
<td>15 observational studies</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>STI infection - longitudinal studies (follow up mean 12 months; Combined gonorrhoea and chlamydia prevalence)</td>
</tr>
<tr>
<td>116 randomized trials</td>
<td>very serious¹</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>Condom use - RCTs (follow up mean 15 months; Ratio of condoms by sex acts for last day worked¹⁻¹)</td>
</tr>
<tr>
<td>15 observational studies</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>Condom use - longitudinal studies (follow up mean 12 months; Consistent condom use in the past 30 days - new clients)</td>
</tr>
<tr>
<td>15 observational studies</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>Condom use - longitudinal studies (follow up mean 12 months; Consistent condom use in the past 30 days - regular clients)</td>
</tr>
<tr>
<td>15 observational studies</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>Condom use - longitudinal studies (follow up mean 12 months; Consistent condom use in the past 30 days - non-paying partners)</td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Social-level and individual-level community empowerment-related outcomes: not assessed</td>
</tr>
</tbody>
</table>

#### Summary of findings

<table>
<thead>
<tr>
<th>No. of patients</th>
<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>497/2825 (17.6%)</td>
<td>OR 0.837 (0.709 to 0.988)</td>
<td>28 fewer per 1000 (from 2 fewer to 51 fewer)</td>
<td>⊕ΟΟΟ VERY CRITICAL</td>
</tr>
<tr>
<td>565/2741 (20.6%)</td>
<td>76 fewer per 1000 (from 1 fewer to 120 fewer)</td>
<td>⊕ΟΟΟ VERY IMPORTANT</td>
<td></td>
</tr>
<tr>
<td>59/92 (64.1%)</td>
<td>OR 0.51 (0.26 to 0.99)</td>
<td>76 fewer per 1000 (from 1 fewer to 120 fewer)</td>
<td>⊕ΟΟΟ VERY IMPORTANT</td>
</tr>
<tr>
<td>89/112 (79.5%)</td>
<td>Beta: 0.3447, p=0.002¹⁵</td>
<td>88 more per 1000 (from 22 fewer to 165 more)</td>
<td>⊕ΟΟΟ VERY IMPORTANT</td>
</tr>
<tr>
<td>177/251 (70.5%)</td>
<td>OR 1.6 (0.9 to 2.8)²</td>
<td>88 more per 1000 (from 22 fewer to 165 more)</td>
<td>⊕ΟΟΟ VERY IMPORTANT</td>
</tr>
<tr>
<td>133/252 (52.8%)</td>
<td>OR 1.9 (1.1 to 3.3)²</td>
<td>152 more per 1000 (from 24 more to 259 more)</td>
<td>⊕ΟΟΟ VERY IMPORTANT</td>
</tr>
<tr>
<td>44/185 (23.8%)</td>
<td>OR 1.5 (0.9 to 2.5)²</td>
<td>81 more per 1000 (from 19 fewer to 200 more)</td>
<td>⊕ΟΟΟ VERY IMPORTANT</td>
</tr>
</tbody>
</table>

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NOTE: The table above includes findings from various studies assessing the impact of interventions to enhance community empowerment on HIV infection, STI infection, and condom use among sex workers. The findings are summarized with measures of effect, such as odds ratios, along with confidence intervals and statistical significance levels. The quality assessment of each study is also indicated, with considerations for limitations, inconsistency, indirectness, imprecision, and other factors affecting the reliability of the results. The importance of the findings is rated using a scale from ⊕ΟΟΟ VERY CRITICAL to ⊕ΟΟΟ VERY IMPORTANT, depending on the strength of evidence and the relevance of the intervention for public health decision-making.
### 3.1b. Community empowerment: decision table

<table>
<thead>
<tr>
<th>Factor</th>
<th>Explanation / Evidence</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of evidence (confidence in effect estimate)</td>
<td>Very low confidence in effect estimate across all key outcomes given the evidence comes mostly from observational studies and given most studies suffer from the risk of bias.</td>
<td>Very low</td>
</tr>
</tbody>
</table>
| Balance of benefits vs harms                | HIV infection: Two observational studies measured HIV infection. The combined effect size was significantly protective (OR: 0.84, 95% CI: 0.709, 0.988). If 1000 people received community empowerment, we would expect 178 instead of 206 HIV infections. 

STI infection: One longitudinal study showed improvement on combined gonorrhoea/chlamydia (OR: 0.51, 95% CI: 0.26, 0.99). Observational studies showed reduced gonorrhoea (OR: 0.65, 95% CI: 0.47, 0.90), but non-significant effects on chlamydia (OR: 0.77, 95% CI: 0.54, 1.11) and high-titre syphilis (OR: 0.36, 95% CI: 0.17, 1.75). 

Community empowerment was associated with a significant increase in condom use with clients (OR 1.96–5.87), but not with regular partners. 

No evidence for social-level or individual-level community empowerment related outcomes identified 

No evidence for unintended consequences identified                                                                 | Benefits likely outweigh harms |
<p>| Values and preferences                       | NSWP Values and Preferences Global Consultation report: Collective empowerment was seen as an absolutely necessary component to improving working conditions for sex workers; redressing abuse and developing sex worker-led strategies for health and rights interventions. In response to questions about how to support sex workers in protecting their health, respondents frequently alluded to the connections between individual and collective rights and power over working and living conditions. One respondent referred to this interplay as “improving sex workers’ bargaining position” to enforce condom use and other safety precautions. | Very high value on community empowerment |</p>
<table>
<thead>
<tr>
<th>Resource use</th>
<th>Community empowerment requires use of human resources, but otherwise is not resource-intensive.</th>
<th>Not a major issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feasibility</td>
<td>Community empowerment interventions with sex workers have proven feasible in diverse settings.</td>
<td>Strong feasibility</td>
</tr>
</tbody>
</table>

### 3.2a. STI screening: evidence profile

**Profile authors:** F Scorgie, S Luchters, M Chersich, R Steen  
**Source of evidence:** 1 RCT, 10 observational studies  
**Informal question:** In female sex worker populations in low- and middle-income countries [population], does screening for asymptomatic STIs (syphilis, gonorrhoea and chlamydia) [intervention] compared with no screening, [comparator] reduce prevalence and/or incidence of these STIs [outcome] initially and then maintain these lower levels in the long-run (>6 months)?

<table>
<thead>
<tr>
<th>Type below the outcomes</th>
<th>Study design (# studies)</th>
<th>Limitations in design</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Publication Bias</th>
<th>Criteria for rating up?</th>
<th>Narrative summary of the evidence base</th>
<th>FINAL GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 1: HIV acquisition (individual level)</td>
<td>RCT (1)</td>
<td>-2</td>
<td>No serious (-1) very serious (-2)</td>
<td>No serious (-1) very serious (-2)</td>
<td>No serious (-1) very serious (-2)</td>
<td>No serious (-1) very serious (-2)</td>
<td>Unlikely likely (-1) very unlikely (-2)</td>
<td>No large (+1) very large (+2)</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Incomplete follow up: only 42% have an outcome at 6 months and 21% at 2 years; no description of allocation concealment; no blinding (lab-based measures somewhat mitigate this limitation). Analysis was by intention to treat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>STI screening intervention different from observational studies (monthly, irrespective of symptoms; bimanual &amp; external examination; direct visualization of the vagina and cervix; direct microscopy for white blood cells, trichomonas and yeasts)</td>
<td>Few events (16 in total)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcome 2: Syphilis</td>
<td>RCT (0)</td>
<td>-1</td>
<td>No</td>
<td>-1</td>
<td>-1</td>
<td>-1</td>
<td>No</td>
<td></td>
<td>Very low</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
All studies had incomplete follow-up (53%-82% retained). No study had an external control population, and only univariate analysis was done (failure to adequately control for potential confounding).

Four studies noted decline in syphilis in the study cohort. One study did not detect a change. Differences in screening frequency might account for inconsistency (6 monthly screening in study with no detectable change versus 3 monthly in most other studies).

Differences in tests used to measure outcomes might introduce bias given challenges with syphilis measurement. Important differences between interventions in the studies (syphilis screening accompanied by a variety of related interventions which might also impact on outcome).

Less than 400 events (syphilis incident/prevalent cases) in the cohorts.

Many similar studies have been reported (cohorts or cross-sectional studies of FSW populations, e.g. clinic samples), but do not present syphilis changes with screening. Observation al studies have large risk of reporting bias, esp. as syphilis outcomes were not primary outcome of the studies.

Indirect evidence of effectiveness of syphilis screening in pregnancy shows this is a useful strategy.

Open cohort in Bolivia, showed step-wise decline in syphilis prevalence each year (15% in 1992, then annual decrease to 8.7% by 1995). In 2 studies only 1 case of syphilis was detected at follow-up. Trend decline noted in Peru cohort, but use of different outcome measures in that study makes direct comparison difficult.

Guatemala open cohort found no change.

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**Outcome 3: Chlamydia acquisition (individual level)**

<table>
<thead>
<tr>
<th></th>
<th>RCT (1)</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incomplete follow up: only 42% have an outcome at 6 months and 21% at 2 years; no description of allocation concealment; no blinding (lab-based measures somewhat mitigate this limitation).</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Screening test differs from observational studies (monthly, irrespective of symptoms; bimanual &amp; external examination; direct visualization of the vagina and cervix; and direct microscopy for white cells).</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Few events (7 in total)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>One RCT, with non-significant decrease at 6 months and increase at 2 years, only 7 events. Women who attended at least &gt;=4 of 5 scheduled visits before their first outcome assessment at 6/12 had lower prevalence than women attending</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
### Analysis was by intention to treat

<table>
<thead>
<tr>
<th>Outcome 4: Gonorrhoea acquisition (individual level)</th>
<th>RCT (1)</th>
<th>-2</th>
<th>-1</th>
<th>No</th>
<th>-1</th>
<th>No</th>
<th>No</th>
<th>No</th>
<th>+1</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to have control population (all 8 studies lack external controls, comparison is with population before intervention); Incomplete follow-up (retention ranged from 29%, 47%, 80%, 81%, to 64%). Retention was not reported in 3 studies. Failure to adequately control for confounding (all studies report only unadjusted measures). 1 study (Laga) provides insufficient description of the intervention to be interpreted with certainty</td>
<td>Inconsistency in frequency of screening might account for between-study differences (screening monthly, 2, 3 or 6 monthly)</td>
<td>Important differences between interventions in the studies, as screening only one component of packages of services, which differs between studies</td>
<td>No evidence of publication bias, however, observational studies have large risk of reporting bias, esp. as Chlamydia infection is not the primary outcome of the studies reported, or similar studies</td>
<td>Some studies showed large effects (RR about 0.5)</td>
<td>Large reductions, with Chlamydia reducing progressively/stepwise over time (Sabido, Nagot, Ma, Kimani)</td>
<td>2 studies showed an initial increase in Chlamydia in first 3 months after screening (12.9%-6.5%), then no further change (Sanchez). Women who attended &gt;=4 of 5 scheduled visits before their first outcome assessment at 6/12 had lower N.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Observational**

<table>
<thead>
<tr>
<th>(8)</th>
<th>-2</th>
<th>-1</th>
<th>No</th>
<th>-1</th>
<th>No</th>
<th>No</th>
<th>+1</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to have control population (all 8 studies lack external controls, comparison is with population before intervention); Incomplete follow-up (retention ranged from 29%, 47%, 80%, 81%, to 64%). Retention was not reported in 3 studies. Failure to adequately control for confounding (all studies report only unadjusted measures). 1 study (Laga) provides insufficient description of the intervention to be interpreted with certainty</td>
<td>Inconsistency in frequency of screening might account for between-study differences (screening monthly, 2, 3 or 6 monthly)</td>
<td>Important differences between interventions in the studies, as screening only one component of packages of services, which differs between studies</td>
<td>No evidence of publication bias, however, observational studies have large risk of reporting bias, esp. as Chlamydia infection is not the primary outcome of the studies reported, or similar studies</td>
<td>Some studies showed large effects (RR about 0.5)</td>
<td>Large reductions, with Chlamydia reducing progressively/stepwise over time (Sabido, Nagot, Ma, Kimani)</td>
<td>2 studies showed an initial increase in Chlamydia in first 3 months after screening (12.9%-6.5%), then no further change (Sanchez). Women who attended &gt;=4 of 5 scheduled visits before their first outcome assessment at 6/12 had lower N.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
this limitation). Analysis was by intention to treat and direct microscopy for white blood cells.

<table>
<thead>
<tr>
<th>Observational (8)</th>
<th>2</th>
<th>No</th>
<th>No</th>
<th>No</th>
<th>4±</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome 6: Trichomoniasis acquisition (individual level)</strong></td>
<td>-</td>
<td>No</td>
<td>-</td>
<td>No</td>
<td>No</td>
<td>Low</td>
</tr>
</tbody>
</table>

- Findings are consistent, apart from 1 small study (outcomes known for 77 FSW, smaller numbers at later visits; Connolly)
- Differences in tests used to measure outcomes unlikely to introduce bias.
- Many studies showed large effects. With increased amounts of screening gonorrhoea reduced further, suggesting a dose-response effect.
- Apart from one small study (Connolly), each reported a significant decline in gonorrhoea.
- 2 studies showed a decline at several intervals up to 22-36 months, suggesting benefits of repeated screening (Kimani, Laga). 3 others found a rapid decline after one round of screening and a much smaller/negligible decline with further screening rounds (Sanchez, Sabido, Ma).
- 1 study showed decline when STI screening was extended to whole FSW population, but not when screening only confined to a small group (Levine).
Incomplete follow-up: only 42% have an outcome at 6 months and 21% at 2 years; no description of allocation concealment; no blinding (lab-based measures somewhat mitigate this limitation). Analysis was by intention to treat.

Screening test differs from observational studies (monthly, irrespective of symptoms; bimanual & external examination; direct visualization of the vagina and cervix; and direct microscopy for trichomoniasis).

Few events (33 in total).

<table>
<thead>
<tr>
<th>Observational</th>
<th>Controlled</th>
<th>Outcome</th>
<th>Population characteristics</th>
<th>Trichomoniasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>(8)</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Very Low</td>
</tr>
<tr>
<td></td>
<td>Marked</td>
<td>No</td>
<td>No</td>
<td>Reduced with each additional evaluation in Ma, Sabido</td>
</tr>
<tr>
<td></td>
<td>inconsistency in findings.</td>
<td></td>
<td></td>
<td>Following initial large reductions in trichomoniasis, no further reductions were noted with additional screening cycles after 4 months in Sanchez, 6 months in Nagot, 36 months in Laga,</td>
</tr>
</tbody>
</table>

Trichomoniasis reduced with each additional evaluation in Ma, Sabido.

Following initial large reductions in trichomoniasis, no further reductions were noted with additional screening cycles after 4 months in Sanchez, 6 months in Nagot, 36 months in Laga, 

No reduction detected in Connolly, Levine.

Marked inconsistency in findings.

This inconsistency is difficult to explain, differences in the proportion of those screened who obtained results and treatment might account for heterogeneity, but no studies reported this important differences between interventions in the studies.

The screening was only one of several interventions delivered to the cohorts, and the intervention packages differ between studies.

Decrease in trichomoniasis at 6 months 7% (8/108) versus 14% (16/117; P=0.07), but not at 12-24 months (6%, 3/56 versus 11%, 6/58; P=0.56). Women who attended >=4 of 5 scheduled visits before their first outcome assessment at 6/12 had similar prevalence to women attending <4 visits (10.8% versus 9.8%).

Few events (33 in total).

Marked inconsistency in findings.

This inconsistency is difficult to explain, differences in the proportion of those screened who obtained results and treatment might account for heterogeneity, but no studies reported this important differences between interventions in the studies.

The screening was only one of several interventions delivered to the cohorts, and the intervention packages differ between studies.

Decrease in trichomoniasis at 6 months 7% (8/108) versus 14% (16/117; P=0.07), but not at 12-24 months (6%, 3/56 versus 11%, 6/58; P=0.56). Women who attended >=4 of 5 scheduled visits before their first outcome assessment at 6/12 had similar prevalence to women attending <4 visits (10.8% versus 9.8%).

Few events (33 in total).
### 3.2b. STI screening: decision table

<table>
<thead>
<tr>
<th>Factor</th>
<th>Explanation / Evidence</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of evidence (Confidence in the effect estimates)</td>
<td>Confidence in effect estimates very low given the evidence comes mostly from observational studies and one low-quality trial. Also most studies suffer from risk of bias due to significant confounding is likely (screening was only one of the interventions delivered in the studies)</td>
<td>Very low</td>
</tr>
</tbody>
</table>
| Balance of benefits vs harms | Benefits include:  
1. Decline in syphilis following screening (4/5 studies)  
2. Consistent reductions in prevalence noted with one round of screening for Gonorrhoea, variable size of reduction with repeated screening  
3. Evidence suggests screening results in rapid and large reductions in Chlamydia infection  
4. Screening can rapidly reduce trichomonias levels in short-term, but decrease was not sustained in long-run in several studies  
Potential unintended effects include false positives, discrimination, and anxiety. No related evidence was identified | The benefits of screening likely outweigh the potential harms                                                               |
| Values and preferences | NSWP Values and Preferences Global Consultation report: ‘unanimous support for periodic voluntary screening for STIs. A great emphasis was placed on the need for screening to be truly voluntary; for STI treatment to be affordable and accessible; for medical staff to respect confidentiality and be non-discriminatory.’ | In favour                                                                                                           |
| Resource use | Positive  
5. Efficiency increases as prevalence of STI increases.  
6. Syphilis testing has minimal laboratory requirements, cost and training required.  
7. Treatment costs lower if STIs detected in asymptomatic stage | Potentially important issue                                                                                           |
|        | Negative  
8. Loss of resources/opportunities if FSW do not return to receive results of screening tests.                                                                                                                  |
<table>
<thead>
<tr>
<th></th>
<th>Feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>Requires laboratory capacity for some tests</td>
</tr>
<tr>
<td></td>
<td>assay cost high for chlamydia testing</td>
</tr>
<tr>
<td>Feasibility</td>
<td>High for syphilis screening in most settings. Low feasibility of gonorrhea and chlamydia screening due to cost and technical requirements</td>
</tr>
</tbody>
</table>
### 3.3a. Periodic presumptive treatment: evidence profile

**Author(s):** Richard Steen, Matthew Chersich, Antonio Gerbase, Elie Akl, Sake de Vlas  
**Date:** 4 May 2011  
**Question:** Should periodic presumptive treatment (PPT) for STIs be offered to sex workers?  
**Settings:** Where prevalence of curable STIs among sex workers is high, and laboratory-based screening with sensitive diagnostics is not feasible or affordable  
**Intervention:** PPT is a form of epidemiologic treatment, which has been used with female sex workers to address the problem of prevalent, curable and largely asymptomatic STIs – primarily gonorrhoea, chlamydia, syphilis and chancroid. The intervention involves periodic treatment with antibiotics – azithromycin 1 g plus cefixime 400 mg being most common. PPT is complementary to and often used in combination with STI syndrome management (for symptomatic patients) and feasible, affordable laboratory screening (such as syphilis serology).

### Quality assessment

<table>
<thead>
<tr>
<th>No. of studies</th>
<th>Design</th>
<th>Limitations</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
<th>Summary of findings</th>
<th>Quality</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonorrhoea infection (among female sex workers, mean follow up 2 patient-years; infection assessed by NAAT)</strong></td>
<td>1 randomized trials</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>RR 0.46 (0.31 to 0.68)</td>
<td>61/480 (12.7%)</td>
<td>75 fewer per 1000 (26 to 135 fewer)</td>
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<tr>
<td><strong>Chlamydia infection (among female sex workers, mean follow up 2 patient-years; NAAT)</strong></td>
<td>1 randomized trials</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>RR 0.38 (0.26 to 0.57)</td>
<td>70/483 (14.5%)</td>
<td>87 fewer per 1000 (30 to 160 fewer)</td>
</tr>
<tr>
<td><strong>Syphilis infection (among female sex workers, mean follow up 2 patient-years; serology [RPR with TPHA confirmation])</strong></td>
<td>1 randomized trials</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>serious imprecision</td>
<td>none</td>
<td>RR 1.02 (0.28, 3.68)</td>
<td>19/500 (3.8%)</td>
<td>2 more per 1000 (46 fewer to 95 more)</td>
</tr>
<tr>
<td><strong>Genital ulcers (among female sex workers, mean follow up mean 1 month; clinical examination for ulcers)</strong></td>
<td>1 observational</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>+1 for effect size</td>
<td>OR 0.23 (0.08-0.66)</td>
<td>26/407 (6.4%)</td>
<td>49 fewer per 1000 (22 to 60 fewer)</td>
</tr>
<tr>
<td><strong>HIV infection (among female sex workers, mean follow up mean 2 patient-years; ELISA)</strong></td>
<td>1 randomized trials</td>
<td>no serious limitations</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>OR 0.76 (0.58 to 0.99)</td>
<td>123/1107 (11.1%)</td>
<td>24 fewer per 1000 (1 to 43 fewer)</td>
</tr>
</tbody>
</table>

* Confidence interval (CI) too wide to rule out a beneficial or a harmful effect
† OR <0.5
‡ CI too wide to rule out a beneficial or a harmful effect

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* Confidence interval (CI) too wide to rule out a beneficial or a harmful effect
† OR <0.5
‡ CI too wide to rule out a beneficial or a harmful effect
<table>
<thead>
<tr>
<th></th>
<th>observational</th>
<th>no serious limitations</th>
<th>no serious inconsistency</th>
<th>no serious indirectness</th>
<th>no serious imprecision</th>
<th>none</th>
<th>169/1550 (10.9%)</th>
<th>183/1107 (16.8%)</th>
<th>OR 0.65 (0.51 to 0.82)</th>
<th>51 fewer per 1000 (26 to 73 fewer)</th>
<th>IMPORTANT</th>
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<tbody>
<tr>
<td><strong>Chlamydia infection (among clients/high-risk males; infection assessed by NAAT)</strong></td>
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<td><strong>Genital ulcer disease§ (among clients/high-risk males; multiplex PCR, follow up: 6–9 months; clinic case reports, follow up: 2 years)</strong></td>
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<td><strong>Adverse effects (mild to moderate, assessed by survey and clinic reports)</strong></td>
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§ Only 1 site reported high GUD/chancroid prevalence at the study onset. This evidence is of particular importance in areas with poor STI control in high HIV prevalence settings in Africa, where the association between GUD/chancroid with high HIV incidence has been documented and . [Vickerman 2010]

** Large effect: OR <0.5

†† A dose–response (distance gradient in surveillance data) was reported with increasing STI reductions with closer proximity to the intervention site (-x² for trend P=0.002).

‡‡ There are no reports associating development of antibiotic resistance with PPT (or with other STI interventions such as syndromic case management that include some degree of presumptive treatment). Among STIs, *Neisseria gonorrhoeae* is the main concern as clinically relevant resistance to *Chlamydia trachomatis* and *Treponema pallidum* is rare. *Haemophilus ducreyi* can develop resistance but is easily eliminated in populations following effective interventions among sex workers, making resistance a mute point. Choice of antibiotic regimen is an important consideration.‡‡

§§ No evidence of behavioural risk compensation: increased or same level of condom use reported in 8 studies, a non-significant decrease in 1 (no trends reported in 4 studies)

*** Comparison of 2 regimens: 1) azithromycin 1gg plus metronidazole 2 g plus ciprofloxacin 500 mg, and 2) azithromycin 1 g plus metronidazole only

37.4% of women in group 1 complained of mild, moderate, or severe side-effect symptoms at day 3 compared with 30.7% in group 2 (x² test for trend = 14.1; P =0.007). The difference was related to moderate gastrointestinal side-effects (12.3% in group 1 compared with 2.2% in group 2, x² = 11.8; P = 0.008). There was no difference in the rate of mild, moderate, or severe side-effect symptoms between the 2 groups at day 7 (x² =3.7; P = 0.4). Overall, only 3 women reported severe symptoms (1 reported gastrointestinal symptoms and 2 reported headache) at day 3 and none at day 7.
### 3.3b. Periodic presumptive treatment: decision table

<table>
<thead>
<tr>
<th>Factor</th>
<th>Explanation / Evidence</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of evidence (Confidence in the effect estimates)</td>
<td>The confidence in the effect estimates is high for GC and CT. The confidence is low for HIV due to imprecision. The confidence for genital ulcers comes from observational studies but was rated up to moderate due to large effect size.</td>
<td>Moderate to high</td>
</tr>
<tr>
<td>Balance of benefits vs harms</td>
<td>If 1000 individuals receive the intervention 10. In high prevalence settings: 135 will avoid gonorrhoea infection 160 will avoid chlamydial infection 11. In intermediate prevalence settings: 75 will avoid gonorrhoea infection 87 will avoid chlamydial infection 12. In low prevalence settings: 26 will avoid gonorrhoea infection 30 will avoid chlamydial infection No effect for syphilis. No effect on HIV. Large effect on genital ulcers (GUD), largely due to effect on chancroid Mild gastrointestinal side effects of antibiotics No antimicrobial resistance has been reported  No evidence of increased risky sexual behavior: condom use was maintained or increased in all but one study</td>
<td>Benefits outweigh harms</td>
</tr>
<tr>
<td>Values and preferences</td>
<td>NSWP Values and Preferences Global Consultation report: Overwhelming but not unanimous disapproval of PPT. Has been used as part of mandatory health regimes in a number of countries, violating sex workers’ rights. Leading to stigmatizing. Effect of furthering public perception that “all sex workers are sick”. Causing false sense of security and making condom use more difficult. Perception that PPT can enforce resistance and can impair digestive tract and vaginal health as important side-effects. The very few sex workers in Africa who supported PPT interpreted it as voluntary and most interpreted it as an adjunct to (not a substitute for) voluntary screening. Unanimous against non-voluntary implementation of PPT and accepting the interventions only appropriate as a temporary emergency response.</td>
<td>Consensus arrived at the meeting was for a conditional recommendation,</td>
</tr>
<tr>
<td>Resource use</td>
<td>PPT is not resource-intensive.</td>
<td>Not a major issue</td>
</tr>
<tr>
<td>Feasibility</td>
<td>Including PPT as a component of STI services for sex workers has proven feasible in diverse settings. Operational considerations have been described and are important in adapting services to specific settings.</td>
<td>Consideration in certain settings</td>
</tr>
</tbody>
</table>
ANNEX 4: NSWP GLOBAL SEX WORKER CONSULTATION

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

October 2011
The Global Network of Sex Work Projects (NSWP) exists to uphold the voice of sex workers globally and connect regional networks advocating for the rights of female, male, and transgender sex workers. It advocates for rights based health and social services, freedom from abuse and discrimination, and self-determination for sex workers.

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Scotland UK
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FEMALE, MALE AND TRANSGENDER SEX WORKERS' PERSPECTIVES ON HIV & STI PREVENTION AND TREATMENT SERVICES: a global civil society consultation
October 2011

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Sylvia Mollet (Africa)
Alison Murray (Asia-Pacific)
Peninah Mwangi (Africa)
Anna-Louise Crago (Latin America, Europe - including Central & East Europe & Central Asia)

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

EMPOWER THAILAND
Closing Ceremony XVth International AIDS Conference
Bangkok, Thailand, 11-16 July 2004
ABOUT THIS REPORT

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

ACKNOWLEDGEMENTS

We would like to thank the individual sex workers, sex worker groups and sex work projects that generously shared their time, experiences and expertise with us in the hopes of contributing to improving HIV-prevention and treatment for sex workers around the world.
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BACKGROUND

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

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

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

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

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

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

---

UNFPA Media Fact Sheet on Sex Work and HIV, July 2010.
See the most recent results of sex work HIV-interventions based on community mobilization as a key component in UNAIDS 2010 Report on the Global AIDS Epidemic.
METHODOLOGY

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

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

BALANCING REPRESENTATION

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

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

In the table below, a star indicates that there were at least that number of participants of a given gender per region, but the exact number is unknown because of a collective response.
RESPONDENTS BY REGION AND GENDER (TABLE)

<table>
<thead>
<tr>
<th></th>
<th>Africa</th>
<th>Asia</th>
<th>Caribbean</th>
<th>CEE/CA</th>
<th>Latin America</th>
<th>Western Europe</th>
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<td>11*</td>
<td>4</td>
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Interviews were done in the following countries:
**Africa:** Botswana, Cameroon, Congo (DRC), Kenya, Mali, South Africa, Uganda, Zimbabwe.
**Asia:** Cambodia, Fiji, India, Indonesia, Malaysia, Papua New Guinea, Timor Leste, Thailand.
**Caribbean:** Antigua and Barbuda, Dominican Republic, Grenada, Jamaica, Saint Lucia, and Trinidad.
**CEE/CA:** Bulgaria, Macedonia, Serbia, and Ukraine.
**Latin America:** Argentina, Bolivia, Guatemala, Mexico, Peru.
**Western Europe:** France, Sweden

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

**Africa:** Street, bars.
**Asia:** Brothels, bars, street, massage parlours, home, hostels, and mobile (“any where where sex work is possible...which means anywhere.”).
**Caribbean:** Street, massage parlour, “tour guide”.
**Europe:** Street, apartment, strip club, mobile (“out-call”), massage parlour.
**Latin America:** Street, brothels, apartments, mobile (“out-call”), massage parlour, *whiskerías.*
SUMMARY OF FINDINGS

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

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

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

Sex worker strongly supported: condom promotion for clients.

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

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

In some countries, laws against sex work were specifically gendered and applied only to “common prostitutes” (understood to be women) or “immoral women”. In other cases, they were gender-neutral, though in practice, often applied in a gendered way. A number of countries had laws against same-sex behaviour that were used to criminalize male sex workers having sex with men as well as many transgender sex workers. Laws against cross-dressing, vagrancy offenses, immigration offenses, drug laws and trafficking laws were also often used to repress sex workers.

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

2. HUMAN RIGHTS CONTEXTS

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

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

Sex workers also cited discrimination in many facets of their lives from difficulty opening a bank account; evictions from homes or neighborhoods; children being unable to go to school; rejection by health staff at hospitals; and impunity for violence against them. Some sex workers also spoke of the lack of application of protective laws such as worker health and safety laws, non-discrimination laws and social security laws to sex workers.

3. ACCESS TO HEALTH SERVICES

Sex workers were often highly dependent on a few NGOs to obtain HIV-prevention materials, although a few received them through state-run clinics. Respondents frequently reported that prevention materials and information were difficult to access and inadequate. Sex workers

This term generally refers to brothel-owners; managers; support, cleaning and security staff. However, in a number of contexts laws against third-parties who profit from or facilitate prostitution are used against sex workers working together and can be used against sex workers’ family members.
reported a lack of information on prevention-strategies relevant to their work contexts; insufficient materials and insufficient quantities of available materials. Sex workers generally had to attend state-run clinics, or if they could afford to, private clinics for testing and treatment. In a few contexts, sex workers could attend clinics specifically for sex workers, though this did not always guarantee that health personnel were non-discriminatory. Ill-treatment was particularly a problem when sex workers had to attend such clinics under mandatory testing regimes.

Some sex workers spoke favourably of clinics for sex workers in brothel areas (India) and for sex workers as well as people in a given neighborhood (Argentina) that had been successful due to sex worker-leadership in their implementation. Some sex workers hoped instead for respectful, quality and confidential treatment so they could attend clinics like anyone else. In parts of Asia and Africa, many sex workers self-medicated with antibiotics or other medication they could purchase on the street in order to evade ill-treatment and discrimination from health care workers and/or because health care was unaffordable.

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

1. BARRIERS TO PREVENTION AND TREATMENT

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

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

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

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

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

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

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

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

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

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

INAPPROPRIATE AND INADEQUATE SERVICES
Available STI and HIV services were often closed during hours when sex workers could frequent them, located in inconvenient areas, and unable to provide specific and pertinent information about safer sex work, safer gender transitioning, safer drug use or safer sex between men.
When services narrowly addressed HIV and STIs, sex workers were unable to get the support to address many of their social determinants of HIV-risk such as working conditions, homelessness, police repression and human rights abuses. Prevention-materials and HIV and STI treatment were often insufficiently available or unaffordable. In some cases, they were inappropriate, such as written materials handed out to sex workers with low literacy levels.

Funds diverted to programs with no evidence-base

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

DECRIMINALIZATION/DEPENALIZATION/NON-REPRESSIVE POLICY
Sex workers spoke at length of the need to change what one respondent called “both unwritten and written laws on sex work”; to repeal punitive laws and policies that contradicted public health objectives and human rights standards. A number of sex workers stated that efforts to address HIV would consistently fall short if they neglected to address the criminalization of sex work, of same-sex activity and of gender expression.

HIV INTERVENTIONS IN LINE WITH HUMAN RIGHTS STANDARDS
Sex workers affirmed the need for governments to repeal HIV-related law and policy measures that contributed to greater rights abuses through mandatory or forced testing, public disclosure of results or arrest of HIV-positive sex workers. Sex workers underlined the importance of ensuring that as voluntary testing was increased, it remained truly voluntary. Furthermore, respondents underscored the importance of ensuring that sex workers had access to the highest attainable standard of health care and safeguarding against this right being curtailed due to a desire not to spend more money on sex workers’ health.

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

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

COMPREHENSIVE PROGRAMS
Sex workers affirmed the importance of supporting programs that did not deal exclusively and narrowly with HIV and STIs but holistically addressed sex workers’ needs. In some cases this referred to the need to address “human rights, health rights, legal rights,” in order to address sex workers’ vulnerabilities to HIV.
In other places this meant addressing issues of working conditions, homelessness, conjugal violence, gender transition and migration as part of addressing access to prevention and treatment.

SEX WORKER-LED STRATEGIES
Sex worker repeatedly affirmed the necessity of meaningful partnerships between governments and sex workers within the planning, implementing and evaluating of HIV and STI prevention and treatment initiatives. The results of this consultation highlight how in different locales, sex workers’ needs, issues and priorities are vastly different. Sex workers are the best placed, in their varying contexts, to help design successful health strategies for their milieu and communities.
THEMES SPECIFIC TO HIV and STI PREVENTION and TREATMENT SERVICES

1. CONDOM PROMOTION

Respondents unanimously supported condom promotion and distribution to sex workers.

ENABLING CONDITIONS

Respondents emphasized the importance of condom promotion strategies being peer-led (not just peer-implemented) in order for them to be relevant and thus effective. Some respondents stressed the importance of advice about condoms linked to advice about working conditions and the negotiation of commercial transactions rather than generic information. Some respondents expressed concern that if condom-promotion was not part of a broader project supported by governments to increase sex workers’ power over their working conditions and living conditions, it would fail to be effective. In particular, laws against the sale of sex, the purchase of sex, or brothel-keeping meant that in many countries, sex workers and brothel owners feared keeping condoms on them, lest they be a tip off to police and lead to arrest, extortion or abuse.

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

MALE CONDOMS, FEMALE CONDOMS, LUBRICANT

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

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

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

Female condoms were generally unavailable or too expensive to be affordable. A number of female sex workers in Africa and Asia spoke of wishing they could access them because they felt safer with them. One male sex worker spoke of male and transgender sex workers preferring female condoms as more pleasurable. Other respondents found female condoms of little interest.

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

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

2. PERIODIC VOLUNTARY SCREENING FOR STIs

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

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

3. PERIODIC PRESUMPTIVE TREATMENT OF STIs (PPT)

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

Many cited resistance, strain on the immune system, digestive tract and vaginal health as important side effects. One respondent expressed alarm that such measures “could lead to sex workers and clients becoming reservoirs of resistant strains” creating a long-term obstacle to fighting HIV among a most-at-risk group. One respondent had experienced PPT in the 1980s when it was widely practiced in Peru (and mandatory) and had had negative health consequences, including experiencing a resistant strain of an STI.

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

4. MANDATORY TESTING

Respondents expressed overwhelming disapproval of mandatory testing. Respondents’ interpretation of mandatory testing varied. One respondent was uncertain but did express concern that it would result in discrimination against people living with HIV given laws criminalizing HIV-positive people who practice safe sex but do not disclose their status.

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

5. PROVIDER-INITIATED TESTING

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

6. VOLUNTARY COUNSELING AND TESTING FOR HIV (VCT)

Respondents unanimously supported VCT. As with other clinical practices, they said that voluntary STI-testing must encompass confidentiality, accessibility and respectful service. A number of respondents in Asia and Africa expressed concern that, as one respondent put it “Voluntary Counseling and Testing” had actually become “Virtually Compulsory Testing”. One respondent in Asia expressed great concern that “indicators of intervention programs based around number of sex workers tested are leading to more mandatory testing.” An African respondent echoed this concern and cited an NGO subjecting sex workers to coercive testing. Yet another respondent replied that:

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

Many respondents expressed concern that “counseling” often consisted of rote messages that were rarely relevant to the barriers sex workers faced in their personal and work lives to preventing HIV transmission or taking care of their health. A respondent commented that “Counselling is simply a routine set of questions that lead to a HIV test, rather than a discussion to help sex workers decide whether to have a test or not.” A number of respondents expressed concern at how new laws criminalizing non-disclosure of HIV status (even during protected interactions) were an obstacle to testing.

7. ANTI-RETRO VIRAL TREATMENT (ARVs)

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

Many respondents stressed that for ARVs to be more available to sex workers, more sex workers must know their status. In order for this to occur, there must be less discrimination from health care personnel are more sex worker-led and empowerment-based projects that provide testing. A number of African respondents cited the need for nutritional counseling and the need for harm-reduction based alcohol counseling as necessary to improve ARV access. Sex workers faced a number of barriers in taking their ARVs regularly such as fearing discrimination if people learned of their status, needing to hide their pills from clients when
traveling with them (in their trucks, for example), the distance to clinics and frequent ARV stockouts. In some countries in Asia a further problem is that a person’s CD-4 count has to be as low as 250-300 to get ARVs yet the person still has to be healthy enough to tolerate them in order to access them.

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

CONCLUSION

A few major themes emerge in sex workers’ responses. The first is the need to stop harmful laws, policies and practices that either contribute to HIV-transmission or impede successful prevention and treatment. The second is the need to scale-up successful interventions and to make them more relevant and accessible by involving sex worker-leadership. The third is the need to see HIV and STI outside of a medical vacuum: to consider the important weight of obstacles such as human rights abuses, state repression, poor working conditions and discrimination and yet, to also see the remarkable possibilities presented by decriminalization, collective empowerment, rights-based programs and comprehensive strategies.
Interview Guide - NSWP Global E-Consultation for WHO Guidelines on Sex Work and HIV

Country: 
Gender: 
Sector of the Sex Industry: 
Member of a Group that is Part of the NSWP: Yes/No

General

- How do sex workers access health services?
  - How do sex workers access HIV-prevention materials, testing, treatment and care?
  - Has it been easy for sex workers access health care services including HIV prevention materials, testing, treatment and care? Please explain.

- What are the major barriers sex workers face in accessing health services (including prevention materials, testing, treatment and care) in your country? Please explain.

- Do sex workers face routine human rights abuses in your country?
  - If so, please explain briefly what these are.

HIV-Specific

I will now ask you about what you think about a series of interventions for addressing HIV:

- We know that if a person uses a (male or female) condom correctly every time they have sex it is an important way to avoid getting HIV. Is promoting condoms to sex workers a good intervention?
  - What are some benefits or disadvantages for sex workers?
  - What are key issues to consider about implementing this intervention?
  - Do you feel the same way about male and female condoms?
  - What do you think about distributing lubricant?
  - Are male condoms, female condoms and lubricant available and accessible in your context?
  - What needs to be done to help sex workers use condoms regularly at work?
  - What needs to be done to help sex workers use condoms in their personal lives?

- Is promoting condoms to customers a good intervention?
  - What are key issues to consider about implementing this intervention?
  - What are some benefits or disadvantages for sex workers?
  - What should be done to get clients to use condoms?

5. STIs is a short way of saying sexually transmitted infections. We know that untreated
STIs are not only harmful to a person’s health, but can also increase their chance of contracting HIV during sex. Should sex workers be given periodic voluntary testing for STIs (in particular, syphilis, gonorrhea and chlamydia) even when they have no symptoms showing (asymptomatic)?

- If no, are there any circumstances where this would be a good strategy?
- If yes, are there any circumstances where this would be a bad strategy?
- What are key issues to consider about implementing this strategy?
- What are some benefits or disadvantages for sex workers?
- What strategies do you think are needed to make this sort of service sex worker-friendly?

*Periodic means that something happens regularly, every so often.
*Voluntary means that it is the sex worker’s free choice to do so with no pressure and no negative consequences if he or she refuses.

6. In the general population, as a general rule, doctors only prescribe antibiotics to treat a bacterial STI (like gonorrhea or chlamydia) if the patient has either tested positive for an infection or has a group of signs and symptoms that indicate that they have an infection. Periodic presumptive treatment (PPT) is where a person or a population is given antibiotic pills without having been tested first to see if they actually have an infection or not. Should sex workers be regularly given antibiotics without having been tested to see if they have an infection or not (PPT)?

- If no, are there any circumstances where this would be a good intervention?
- If yes, are there any circumstances where this would be a bad intervention?
- What are key issues to consider about this intervention?
- What are some of the ways this intervention would impact sex workers in your context?
- We know that overuse of antibiotics due to unnecessary prescriptions contributes to certain bacteria that cause infections becoming resistant to treatment (the usual medicine is no longer effective to treat these infections. This is the case with some strands of gonorrhea for example), is this of concern for sex workers? Why?
- Does PPT for sex workers exist in your country?

7. Patient-initiated HIV testing and counselling is also known as voluntary counselling and testing (VCT). Patient-initiated or Voluntary testing means that a person chooses without pressure to find out if they have HIV through a test. The Counselling means that the basics of HIV are explained to the person before and after the test. A person who tests positive for the virus, which means they have HIV, is offered support and information on living with HIV. Is VCT for sex workers a good strategy?

- What are key issues to consider about implementing this intervention?
- What are some benefits or disadvantages for sex workers?
- What strategies do you think are needed to make VCT easy for sex workers to access?
- What strategies do you think are needed to make VCT sex worker-friendly?
7. Is VCT for customers a good intervention?
   -What are key issues to consider about implementing this intervention?
   -What are some benefits or disadvantages for sex workers?
   -What strategies do you think are needed to make VCT easy for sex workers to access?

8. Provider-initiated HIV testing means that a doctor automatically tests someone for HIV during the course of a regular doctor’s visit, unless the person specifically says that they refuse to be tested. Is provider-initiated testing for HIV a good intervention for sex workers?
   -What are key issues to consider about implementing this intervention?
   -What are some benefits or disadvantages for sex workers?

9. Mandatory testing is where sex workers must undergo regular HIV testing every few months, whether they wish to or not. What do you think of this strategy for sex workers?
   -Are there any circumstances where this would be a good intervention?
   -Are there any circumstances where this would be a bad intervention?
   -According to most laws or policies that call for the mandatory testing of sex worker, if sex workers refuse to test or lack government-issued proof that they tested negative and they get caught, they can face fines. In some places, they can also face arrest or imprisonment. What do you think of this strategy?

10. Should treatment for HIV with anti-retroviral therapy (ART) be the same with HIV+ sex workers as in other adult and adolescent populations?
    -What are key issues to consider about implementing this intervention?
    -What are some benefits or disadvantages for sex workers?
    -What are the main elements needed to make treatment accessible for sex workers?
    -We know that for treatment to be successful, it is important first, to have access to the medication (to get it free or be able to afford it), to take the medication regularly (this is called “adherence”) and to access to basic nutrition. Are there any issues that might be of specific or greater importance for sex workers linked to taking ART successfully that might be of specific importance to sex workers?
    -Providing ART to HIV+ people greatly reduces their chances of transmitting HIV to others. When HIV+ people are given ART, partly, in the hopes of reducing HIV transmission, this is called “Treatment as Prevention”. What are your thoughts on this with regards to sex workers?

11. Should interventions to support the sex worker community to mobilize for their health and rights be an integral part of a strategy addressing HIV and sex work?
    -What could such interventions look like?
    -What are some benefits or disadvantages for sex workers?
    -What are the main elements needed to make community empowerment and mobilization happen for sex workers?
-What happens when this is not included in a strategy to address HIV and sex work?

12. What are the laws and policies that govern sex work in your country?
   -How are they actually applied?
   -What is the authorities’ approach to sex work?

13. Should governments remove or introduce any laws or policies in order to make sex workers less vulnerable to HIV-infection, discrimination or violence?
   -If yes, then what laws are you thinking about?
   -What are the main elements needed to make this happen?
   -What are key issues to consider about implementing this strategy?
   -What are some benefits or disadvantages for sex workers?

14. How can health services be made more inclusive of sex workers?
   -What are the main elements needed to make this happen?
   -What are key issues to consider about implementing this strategy?
   -What are some benefits or disadvantages for sex workers?

15. Other than what has been mentioned, how can governments address HIV and sex work?
   -What are key issues to consider about implementing this strategy?
   -What are some benefits or disadvantages for sex workers?

16. Are there groups of sex workers (for instance: sex workers who use drugs/alcohol, male sex workers, transgender sex workers, migrant sex workers, HIV+ sex workers) that need specific kinds of government intervention to address HIV and sex work?
   -If so, please specify.

17. Of all the interventions mentioned in addressing the overlap between HIV and sex work in your country (including ones you may have just mentioned), which interventions do you see as being priorities?

18. Please give some examples of things you consider “best practices” in addressing HIV and sex work in your country and why.

19. Please give some example of “worst practices” in addressing HIV and sex work in your country and why.
Annex 5: Search strategies

5.1. Community empowerment

Search strategy
1. Electronic database searching: PubMed, PsycINFO, Sociological Abstracts, CINAHL (Cumulative Index to Nursing and Allied Health Literature), and EMBASE
2. Reviewing reference lists of included articles, WHO database of articles, and contacting experts

Data abstraction
3. Two coders abstracted data using standardized forms with differences resolved through consensus

Meta-analysis
4. Random effects models using Comprehensive Meta-Analysis program

Inclusion criteria
5. Published in a peer-reviewed journal between January 1, 1990 – October 15, 2010
6. Evaluates a sex worker community empowerment intervention
7. Uses a pre/post or multi-arm design comparing individuals who received the intervention to those who did not on post-intervention outcomes of interest
8. Measures one of the following key outcomes: HIV infection, STI infection, or condom use
9. Conducted in a low, lower-middle, or upper-middle income country, according to the World Bank

Flow Diagram of Included Studies

Records identified through database searching (N=6634) → Additional records identified through other sources (N=30) → Records after duplicates removed (N=4318) → Records screened (N=4318) → Records excluded (N=4246) → Full-text articles assessed for eligibility (N=72) → Studies included in qualitative synthesis (N=10) → Studies included in quantitative synthesis (meta-analysis) (N=10) → Full-text articles excluded (N=62) because:
- Not an empowerment strategy (N=37)
- Does not meet study design criteria (N=7)
- High-income country (N=1)
- Background articles (N=17)

Studies included in qualitative synthesis (N=10)
5.2. STI screening

Methods
10. Search for eligible articles, following search strategy in protocol
11. Screen articles on title, abstract and/or full text – in duplicate
12. Single reviewer extract data into a Microsoft Word extraction form (exposures, outcomes and study quality)
13. Extracted data entered into Microsoft Excel spreadsheet, separated by infection
14. Data summarised in GRADE and risk–benefit tables

Inclusion
15. Systematic reviews (for screening reference lists); RCTs and non-randomized comparisons reporting on the association between STI screening and prevalence or incidence of STIs in FSWs
16. Before-and-after studies and time-trend analyses
17. Studies conducted in low- and middle-income countries
18. English language publications
19. Studies published between 01/01/1990 and 23/08/2010

Exclusion
20. Studies that include only symptomatic FSWs
21. Non-interventional, modelling or cost-effectiveness studies
22. Repeat cross-sectional studies

Search strategy
23. MEDLINE: ((prostitut* OR sex work*) AND ((STI OR STD OR (sexuall* AND (transmit* OR transmis*)) OR syphilis OR treponem* OR chlamydia* OR trachomatis OR gonoc* OR gonorr*)).

5.3. Periodic presumptive treatment
Search strategy
24. MEDLINE: ((prostitut* OR sex work*) AND ((STI OR STD OR (sexual* AND (transmit* OR transmis*))) OR syphilis OR treponem* OR chlamydia* OR trachomatis OR gonoc* OR gonorr*))).

**Data abstraction**
25. Two reviewers abstracted data using standardized forms with differences resolved through consensus

**Meta-analysis**
26. Using RevMan5 with random effects models, stratified by study type

**Inclusion criteria**
27. Published in a peer-reviewed journal or report between 1990 and October 2011
28. Evaluates a PPT intervention among FSWs
29. Uses a controlled or observational design comparing individuals who received the intervention to those who did not
30. Includes data on STI outcomes
31. Conducted in a low- or middle-income country
## ANNEX 6: EVIDENCE SUMMARIES

### 6.1. Community empowerment

<table>
<thead>
<tr>
<th>Study citation and location</th>
<th>Description of the empowerment intervention</th>
<th>Other intervention components</th>
</tr>
</thead>
</table>
| Basu et al., 2004 Cooch Behar and Dinhata Districts of West Bengal, India | Peer educators were first “apprenticed” under Sonagachi trainers and to build local peer educators skills and confidence in providing education and to foster empowerment and advocacy among sex workers. The team engaged in community organizing and advocacy activities with local stakeholders and power brokers who exerted control over the sex workers’ lives, with the goal of building increased dignity, autonomy, and self-determination among the sex workers. Empowerment activities included sustained engagement with local sex workers; prioritizing their overall health and well-being and that of their children; nurturing group solidarity; and raising consciousness about sex worker rights. “High-status advocates” (medical doctor, evaluation team, Sonagachi representatives) conducted advocacy towards local police, elected officials, and shop owners to effect changes in structural barriers related to sex workers’ HIV risk. | • Peer education regarding HIV/STI transmission and prevention  
• Condom social marketing  
• Health clinics were established and free services focused on sexual and reproductive health were provided to sex workers including STI screening. |
| Blankenship et al., 2008 East Godavari District of Andhra Pradesh, India | The community mobilization intervention was implemented through a local NGO that identified social change agents (SCA) among female sex workers to serve as peer educators and community organizers. The SCAs also advocated on behalf of sex workers and promoted the idea that sex work is work and the importance of collective power among sex workers. The SCAs also encouraged the formation of community-based organizations composed of and led by sex workers. Drop in centers were also established where sex workers could come for services. | • Social change agents engaged in HIV/STI peer education intervention activities and condom distribution.  
• Encouragement and facilitation of sex workers attendance of NGO sponsored STI clinics for screening and treatment. |
| Gangopadhyay et al., 2005 Kolkata, India | The Sonagachi project initiated a process of empowerment of sex workers to increase their collective power to improve their social, political, and economic conditions. The sex workers formed a forum of their own, the Durbar Mahila Samanwaya Committee, which promoted sex worker dignity and betterment of working conditions. Whenever there was a complaint regarding a given sex worker, the members of the committee stood advocated for her. As a result, they acquired the power to influence powerbrokers e.g. brothel owners, pimps, regular customers, and police. | • Peer educators disseminated information regarding the prevention of STI/HIV and distributed condoms.  
• The project arranged for the provision of health services for sex workers, including for STIs from a central clinic. |
| Halli et al., 2006 Karnataka, India | A state-wide network of collectives (sanghas) and self-help groups for sex workers was established that provide literacy training, health care, financial support and legal support. Collectivization activities were primarily undertaken and managed by peers, usually older sex workers identified as knowledgeable about their communities and willing to assume a leadership role with other sex workers. Their activities included fostering a sense of community, solidarity, and empowerment among sex workers in order to take collective control over their | • HIV/STI peer education  
• Condom distribution  
• Encouragement of STI care seeking |
<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jana et al., 1998*</td>
<td>Kolkata, India</td>
<td>The project began with a philosophy based on the 3Rs of Reliance, Respect and Recognition, e.g., giving due respect to sex workers, relying on their knowledge and recognizing their profession as work. Empowerment intervention activities involved the formation of a sex worker organization and mobilization of sex workers to discuss and prioritize their needs including a savings cooperative, legal services, and childcare. Training was provided to enable sex workers to take charge of solving their own problems.</td>
</tr>
<tr>
<td>Kerrigan et al., 2006</td>
<td>Santo Domingo and Puerto Plata, Dominican Republic</td>
<td>Group workshops and follow-up meetings were held with sex workers as well as establishment owners/managers, and other employees to strengthen a sense of solidarity and the collective commitment toward STI/HIV prevention within and across sex establishments. Specific roles and responsibilities were agreed upon for each actor to support sex workers safer sex negotiating power. Educational materials discussing collective commitment and environmental-structural support systems were developed and distributed to sex workers, owner/managers and employees. Posters and DJ messages reinforced the idea of collective commitment in participating sex establishments. Workshops and materials also focused on the role of trust and intimacy and lower condom use with regular partners. Sensitivity trainings were conducted with government health clinics providing STI services to sex workers and peer educators were brought on as clinic counselors.</td>
</tr>
<tr>
<td>Kerrigan et al., 2008</td>
<td>Rio de Janeiro, Brazil</td>
<td>A local sex worker organization was formed, Fio da Alma (The Soul’s String), with a headquarters that functioned as a drop-in center that aimed to create a safe space for sex workers to come together and discuss their priorities and mobilize for collective action. The intervention created a new role for existing project peer educators by emphasizing the idea of being an agent of social change. Regular group meetings took place among sex workers to discuss common concerns. Sex workers prioritized actions and then received financial and technical support from a local NGO to implement suggested activities including advocacy with local police regarding the treatment of sex workers, violence prevention, kits and materials, literacy classes, money management activities and psychosocial support.</td>
</tr>
<tr>
<td>Lippman et al., 2010**</td>
<td>Corumba, Brazil</td>
<td>The project was designed to engage the sex workers on a community level through outreach and social activities. Community-based activities were designed to extend and strengthen collegial relationships by providing sex workers opportunities to engage in dialogue around sex work, human rights, discrimination, and violence prevention. Examples of community activities included sex worker participation in local government prevention forum, International Women’s Day activities, cultural activities, film screening, parties, and income generating activities. A sex worker organization was formed and members of the group were integrated into ongoing government HIV prevention activities including community outreach. Sensitization training to create sex worker friendly environment and psychosocial counseling offered by trained psychologists within government STI services.</td>
</tr>
<tr>
<td>Study Design/Main Findings</td>
<td></td>
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</tbody>
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### 6.2. STI screening

#### Study design / Main findings

Overall, we found positive trends regarding the impact of STI screening among sex workers on STI outcomes.

Five observational studies presented outcomes of syphilis screening, mostly done three-monthly.

32. Four of these reported a reduction in syphilis prevalence, but few had adequate levels of participant retention (53%–82%).

For chlamydial infection, 9 studies were located, 8 of which lacked external control groups.

33. Five detected an initial lowering of chlamydial infection

34. A further 3 demonstrated long-run reductions.

The 9 studies reporting gonorrhoea outcomes used a wide range of gonorrhoea screening and diagnostic tests and similarly lacked external controls.

35. Screening was associated with a gonorrhoea reduction in all, aside from one small study.

36. Findings were mixed, however, on the benefits of repeated screening.

37. Marked inconsistency was noted regarding the benefits of screening for trichomoniasis.
### 6.3. Periodic presumptive treatment

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Location</th>
<th>Study design / Main findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaul, 2004</td>
<td>Nairobi, Kenya</td>
<td>RCT. NG and CT lower. Syphilis and HIV no change.</td>
</tr>
<tr>
<td>Labbe, 2012</td>
<td>Benin and Ghana</td>
<td>RCT. NG lower, CT no change (already very low).</td>
</tr>
<tr>
<td>Reza-Paul 2008</td>
<td>Mysore, India</td>
<td>Adjusted cross-sectional. NG and CT lower. CU higher.</td>
</tr>
<tr>
<td>Ramesh, 2010</td>
<td>Karnataka, India</td>
<td>Adjusted cross-sectional. NG and CT lower. CU higher.</td>
</tr>
<tr>
<td>Majid, 2010</td>
<td>Indonesia</td>
<td>Adjusted cross-sectional. Syphilis lower.</td>
</tr>
<tr>
<td>Magnani, 2010</td>
<td>Indonesia</td>
<td>Adjusted cross-sectional. NG/CT lower.</td>
</tr>
<tr>
<td>Holmes, 1996</td>
<td>Philippines</td>
<td>Time series. NG lower.</td>
</tr>
<tr>
<td>Steen, 2000</td>
<td>South Africa</td>
<td>Time series. NG, CT and GUD lower. CU higher.</td>
</tr>
<tr>
<td>Behets, 2003</td>
<td>Madagascar</td>
<td>Time series. NG and CT lower.</td>
</tr>
<tr>
<td>O'Farrell, 2006</td>
<td>Lao PDR</td>
<td>Time series. NG and CT lower. CU higher.</td>
</tr>
<tr>
<td>Wi, 2006</td>
<td>Philippines</td>
<td>Time series. NG and CT lower. CU higher.</td>
</tr>
<tr>
<td>McKormick, 2007</td>
<td>Bangladesh</td>
<td>Time series. NG and CT lower. CU lower but PSA lower.</td>
</tr>
<tr>
<td>Bollen, 2010</td>
<td>Indonesia</td>
<td>Time series. NG and CT lower. CU higher.</td>
</tr>
<tr>
<td>Bruce, 2011</td>
<td>Papua New Guinea</td>
<td>Time series. NG and CT lower. CU higher.</td>
</tr>
</tbody>
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