Sex Work and the New Era of HIV Prevention and Care

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for

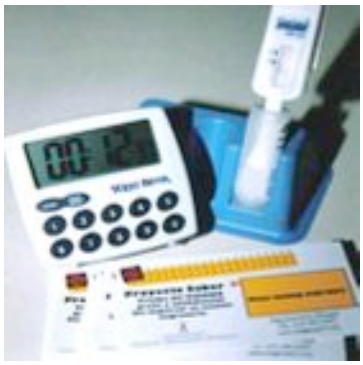
the Asia Pacific Network of Sex Workers

This book is dedicated to Carol Jenkins who died in Bangkok in January 2008. Carol's work in HIV research and programming in Asia and the Pacific embodied her support for sex workers rights and her commitment to social justice, respect for human sexuality and to amplifying the voices of female, transgender and male sex workers.

Carol placed great value on scientific rigour and sometimes despaired about the lack of sound evidence and strong data informing HIV progamming and policy, particularly on sex work. We learned a lot from her about gathering and analysing information.. The APNSW floral tribute at her funeral was the demand she used to make of policy makers and activists alike, "show me the data". In the spirit of Carol Jenkins this book aims to help sex workers to ask for the data, to analyse it and to participate in the decisions made with it...

Sex Work and the New Era of HIV Prevention and Care

HIV prevention and care has advanced significantly since the outset of the global pandemic in the 1980s. Understanding of HIV has grown and science has made important breakthroughs that have led to new and better prevention methods and more effective treatment. Recently there has been rapid progress and many new medications, products and procedures are being tested and becaoming available.
At the same time important changes in laws and policies are taking place and healthcare and other services are provided by a changing mix of donors, clinics, governments, NGOs and civil society groups.



The Asia Pacific Network of Sex Workers (APSNW) recognises the important potential of these developments to affect male female and transgender sex workers. In 2006 we partnered with the Global Campaign for Microbicides to conduct a meeting entitled "*Sex Work and the Changing Landscape of HIV Prevention.*"

At that meeting a recommendation was passed that the APNSW help its members to learn more about the emerging prevention methods, biomedical research and new policy directions and advocate for approaches that will benefit sex workers.

Many HIV agencies and civil society groups are already considering the impact of new prevention and care methods and planning to incorporate them into their programs and policies. Large organisations have staff to work on this but smaller ones who are struggling with their daily work can find it difficult to monitor emerging issues. This publication is for the many sex work projects in that situation.

Biomedical Developments

Scientists are working to identify drugs and technologies that can safely treat and prevent HIV and develop them quickly . They must then be made available with the right information and support. Some of the new drugs, products and procedures being developed and tested for reducing HIV transmission include *circumcision of men*; *Pre Exposure Prophylaxis (PrEP),* which is a pill taken before sex; *microbicides,* which are gels or creams that can be inserted into the vagina or anus to prevent HIV transmission, *anti-retroviral therapy* (ARV) for people living with HIV (PLWH) and improved condoms. (note : vaccines are not covered here because they are not likely to be available for a long time).

There is optimism that one or more of these biomedical developments will emerge as a powerful new tool for prevention and be appropriate for use by a different people with different needs, such as married women, sex workers, young people, drug users and men who have sex with men. We explore the issues that emerge around new technologies that are less effective than condoms and the potential for this to make sex workers more vulnerable to HIV. If condoms are abandoned in favour of pills, gels or circumcision, or if any of those products are misused, sex workers in particular will be at increased risk. Their risk level depends on how many partners they have and what proportion of them are likely to be HIV positive. This is of particular concern where sex workers are not able to resist demands by clients and sex business owners to use microbicides or PrEP instead of condoms.

Sex workers are often vulnerable to misinformation, unethical medical practices, counterfeit goods and lack of access to commodities and services. The same barriers and issues which limit the success of current prevention methods will affect the success of new products and drugs. Thus our emphasis is on the continued need to ensure access to health services, condoms and other "prevention commodities" and on reducing the stigma and persecution that renders many sex workers powerlessness to protect their sexual health, We also acknowledge that not all of the new technologies will prove successful and look at how that might affect sex workers. (cervical diaphragms, intensified herpes treatment and some vaccines have not shown to effectively reduce HIV as hoped)

"What drives continued expansion of the pandemic is not the absence of effective preventative technologies but discrimination, exploitation and repression of certain social groups". Peter Piot, UNAIDS.

Shifts in Policy

Law and policy on sex work has never been settled or consistent and in recent years there have been significant changes. Some new trends, such as emphasis on prevention sex work as a response to human trafficking, are driven by geo-political factors such as migration, security, globalisation and the environment, rather than as responses to the HIV pandemic.

Other policies and laws that affect sex workers have emerged as a result of scientific developments in HIV prevention and care. One of the clearest examples of this is policies and laws that encourage HIV testing and make it compulsory for some. This is linked to improvements in HIV treatment and to the potential of anti retroviral treatment (ARV) to reduce HIV transmission by lowering the amount of virus that HIV positive people have in their blood, (called the "viral load").
As science provides new tools for HIV prevention, the development of social and HIV policy continues to overlap. Some governments have introduced or strengthened criminal laws against trafficking in women and against buying sex, while others have decriminalised sex work. Some countries have introduced penalties for deliberately or recklessly transmitting HIV to uninformed sexual partners, while others have strengthened anti-discrimination law. In some places there are policies that aim to reduce HIV and the abuse of women by limiting entry into the female sex industry and encouraging women to stop selling sex, while in others the focus is on sex workers empowerment.

Policies and laws are made at local, national and international level. Here we focus on international policy. We hope that the audience understands the ways that the UN and other large international organisations influence governments and societies and have an important affect on sex workers locally.

Circumcision, microbicides and microfinance. These are some of the most promising options being examined as potential ways to prevent Aids. Some public health experts are saying that the current focus on universal access to lifesaving antiretroviral drugs has had an unintended effect of sidelining prevention.

Associated Press Nov 30 2006

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APNSW Making Sex Work Safe Work Shop 2005, At WAC, Phnom Penh.

"..communities, like individuals, cannot respond to the challenges of HIV unless they can express the basic right to be involved in decisions that affect them."

Jonathan Mann. WHO Global Program on Aids

Acknowledgements

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The ideas and views expressed are a mix of the authors and those expressed by member groups of the Asia Pacific Network of Sex Workers. The aim of the publication is to introduce issues and stimulate discussion rather than to provide a thorough and scientifically accurate account of the developments in HIV prevention and care.
Each section ends with a list of sources and internet sites that were accessed between September and November of 2007. Those requiring authoritative information should consult those, and other, websites for reliable, updated information on these rapidly unfolding, and often controversial, issues.

Please note that people from many different walks of life are quoted and pictured in this resource. Their inclusion here does not indicate their HIV status, sexual preference or their occupation, nor does it or imply that they agree with the content of the publication or the mission of the APNSW.

The APNSW hopes our work on this is helpful and easy to understand and we welcome feedback and further inputs.

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Sources and Resources

Asia Pacific Network of Sex Workers. www.apnsw.org

International Network of Sex Work Projects. (NSWP) www.nswp,org

The Global Campaign for Microbicides. www.global-campaign.org

Alliance for Microbicide Development www.microbicide.org

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Section ONE : Microbicides

Microbicides are products for vaginal and anal use to prevent sexual HIV transmission. Although no microbicide had been approved for sale by the beginning of 2008, up to thirty compounds are being tested for vaginal use as well as some potential microbicides for anal sex. During testing these are called microbicide "candidates". The first microbicides may be used as coating on condoms or as light gels and creams to be applied directly to the vagina before sex. Subsequent "generations" of microbicides are expected to be suitable for anal use and may be rings or implants which that last longer, are easier to use and even less intrusive. There are many excellent websites listed below that explain and discuss microbicides in more detail.

Will a gel that protects sex workers from HIV become a reality? What are the risks ?

Potential microbicides work in different ways. Some disable the virus while others act as a barrier against HIV or buffer the body from it. Some prevent the virus from attaching and establishing infection by building the body's natural defenses, or by changing the conditions in the body. Others contain anti-retroviral drugs that are already used to treat HIV. Some appear to also prevent transmission of other sexually transmitted infections (STIs) and some may also prevent pregnancy. Information is not available yet on whether any of them will protect a man who has vaginal sex with an HIV+ woman. There are some rectal microbicide candidates but they are less promising, primarily because the rectum is delicate and joins directly into the intestines enabling the microbicide to dissipate upwards into the body and leaving some parts of the anus or rectum unprotected.

When scientists identify a compound that they think might work as a microbicide against HIV, a long testing process takes place before the candidate is approved for manufacturing and sale. The first tests are conducted in laboratories and on animals to make sure the product is safe (called safety trials). Later tests assess whether the product can reduce HIV transmission. Additional trials explore the impact with target populations and identify specific issues such as acceptability and impact on behavior. (The process is explained further in Three : Prevention Trials)

Opportunities and Challenges

The potential benefits of a vaginal microbicide to individual women and for public health are enormous. Many women throughout the world cannot insist their male sexual partners use condoms even where they know they are at risk. For such women microbicides could bring a significant opportunity to redress the power imbalances that make women vulnerable to HIV, especially if the microbicide is in a form that ale partners won't notice. Even where men know the microbicide is being used, a gel applied to the vagina is handled by the woman and requires less cop-operation from the man. This is called "female initiated" prevention.

No one is exactly sure how effective microbicides will be. Most estimates are that the first generation will be about 60% effective in reducing women's chances of acquiring HIV in an act of vaginal sex with an HIV positive person. Even a microbicide that is not 100% effective could very quickly reduce the risk of acquiring HIV for millions of women and help reduce overall spread of the virus. Later generations are expected to be more effective, although they are unlikely to be as effective as condoms for many years to come. Partially effective microbicides will not be suitable for use by everyone and they could drive increased risk taking among some people.

Acceptability
The appeal of a cream that replaces a condom is obvious because the preference for "flesh to flesh" contact in sex appears to be virtually universal. The appeal of a cream that adds extra safety to condom use is less obvious although studies of potential users of microbicides, primarily in Africa, suggest they will be popular with men and women alike. Potential barriers and issues have been identified - fears about loss of fertility, side effects, reluctance of women to touch the vagina, men's distrust of women, access and cost.

Approval and licensing for distribution
It has not been decided yet how microbicides will be registered for distribution. It is important that they are not stigmatized and they are easy to find and to afford. They may be approved only for limited distribution through health workers and pharmacists. Microbicides that contain drugs with potentially harmful effects, such as ARVs, may even be available only by prescription. The concern that this will limit their availability has to be balanced against the potential for misuse if they are freely available. A balance needs to be found so that regulations allow for information and advice to be given to the user. The information should include instructions for correct use, contraceptive information and, where necessary, even warning some users that the product is not suitable for her/his circumstances.

Opportunities and Challenges for Sex Workers

Sex workers need as many ways as possible to practice safer sex so the APNSW certainly views microbicides as an exciting opportunity. Although there is no official data yet, many sex worker trial participants have responded positively to the idea of microbicides. These are some of their reasons:

- Female sex workers who use a microbicide and a condom for vaginal sex, will be less likely to contract HIV if a condom breaks or slips off.

- Sex workers, including males and transgenders, may be at reduced risk if the use of vaginal microbicides by men and women reduces HIV among men in the community, therefore, among their clients.

- If female sex workers use a microbicide only with a small number of clients who refuse to use condoms, their risk is likely to be lower than if they had provided unprotected sex to those customers. The combination of reducing the number of clients (who refuse to use condoms) and the efficacy of the microbicide, can reduce the risk of contracting HIV.

- If sex workers whose clients never use condoms begin to use a microbicides their risk would be reduced, depending on the how effective the microbicide is. This should not be encouraged as a long term strategy because using only

- a microbicide is not an acceptable alternative to condom use and other safe sex practices.

- Male and transgender sex workers may be at reduced risk if a rectal microbicide becomes available and they use it with condoms.

These are some of the opportunities and challenges that sex work projects, researchers and policy makers must address for sex workers to gain maximum benefit from microbicides…

- **Replacing condoms.** There is a risk that clients and sex business owners in some places will insist on the use of microbicides, and other biomedical technologies, instead of condoms to maximize their profit.

  It is difficult to predict how commercial sex practices around the world might change in response to a microbicide, partly because there is very little reliable information about sexual behavior in commercial sex now. Much hinges on the possibility of a condoms being replaced by microbicides, which is called

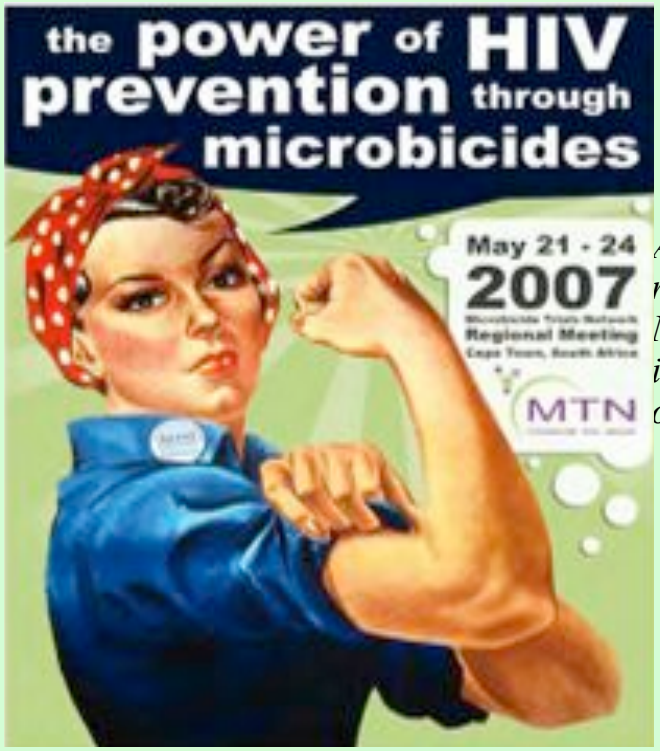
"condom migration" or "condom abandonment". If female sex workers replace condoms with a microbicide that is less effective than condoms, their risk of contracting HIV will remain the same or increase. The degree of any change in the level of risk depends on several things including the microbicide efficacy and the number of HIV positive sexual partners the sex worker has, For example if a female sex worker who currently has 70% of her vaginal sex acts protected by a condom changes to a 70% effective microbicide, her risk of getting HIV by vaginal sex would rise. It would rise even higher if she stops using condoms for anal sex at the same time. Various complex calculations have been made about the impact of condom migration in favour of microbicides with different levels of efficacy. (For more information see Vickerman and Fossa 2003 and other articles listed below). The matter is controversial and there are no clear detailed answers but it is clear that condom migration is more of a threat to sex workers than to women with small numbers of partners and much more of a threat where there are high level of HIV. We can therefore confidently say thatcondoms will still be necessary for all commercial sex acts for the foreseeable future.

- **More choices, more costs.** Although sex workers at the 2006 APNSW meeting on new prevention methods fully recognized the importance of additional prevention strategies, they expressed concern that increased choice of prevention products stretches sex workers budgets and can be confusing. For example if a sex worker wants to use a vaginal microbicide to protect her against vaginally transmitted HIV she must have other prevention and contraceptive methods to protect her against a) unwanted pregnancy; b) anal transmission of HIV and c) oral, anal and vaginal transmission of STIs. Extra options may increase the burden on sex workers to negotiate with clients, particularly if there is a prevention method that the client sees as a substitute for condoms. This is a lot to think about and it can involve buying several products. Some sex workers are concerned that clients will not believe information they give about a microbicide and stress the need for clients to be targeted with information when microbicides become available.

- **Female controlled?** Whether microbicide products will be detected by clients is particularly important for sex workers. Sex workers are very vulnerable to men's reactions if they are discovered to be using a vaginal product without his permission, especially in places where sex workers' unauthorized use of condoms or other products is seen by clients as trickery and even a form of robbery.

- **The value of a physical barrier.** Condoms can be an important psychological barrier and a matter of general hygiene. Some sex workers express reticence about the enthusiasm for a prevention method that enables, and possibly even promotes, clients ejaculating directly into the vagina

If microbicides replace condoms in commercial sex it will be difficult for sex workers who want clients to use condoms for reasons other than avoiding disease to do so.



A poster promoting a regional meeting of the Global Campaign For Microbicides. The GCM provides information and is a leading advocate on microbicides.

- **Access and affordability.** The price and availability of condoms, medicines, lubricants, contraceptives, STI services remain enormous barriers to the effectiveness of current HIV prevention and sexual health services in many places. In some places the gap is being filled by grants from donors from the Global Fund for Malaria, TB and HIV and large NGO donors. In some, social marketing companies have increased access enormously to condoms, contraceptives and other much needed health commodities them along with information and social support services.

- **Misuse.** It is less obvious how to use creams and gels than condoms. If people do not fully understand all aspects of how the product works they may misuse it and believe they are being protected when in fact, they are not. For example, the length of time the first microbicides work for will be limited. In order for sex workers to stay protected they will have to know when to re-apply it.

- **Fakes.** Gels will be more easily counterfeited than condoms and false claims of microbicide value have already been made for sprays and creams in local markets and on the internet. Sex workers in many countries are particularly vulnerable to buying substandard or fake products.

- **Dose**. The products are likely to be ineffective if the right amount is not used. Peer educators are concerned about sex workers using less (called "skimping") to save money by making the product last longer.

- **Frequent use**. In the past, a vaginal product (Nonoxynol 9) was declared safe for use as an HIV prevention method despite warnings from sex workers organizations that vaginal damage was occurring among sex workers who used it frequently. More than a decade later it was finally accepted that frequent use of N9 increases risk of HIV infection and support for it was withdrawn. Sex workers who participated in the N9 clinical trials and those who used it once it was approved were adversely affected and sex workers trust in the process was eroded.

- **Pregnancy**. The impact of microbicides on pregnancy is not understood because they are not tested on pregnant women.

- **Drug resistance or reduced efficacy of anti retroviral medication**. If sex workers who use a microbicide that contains an anti retroviral medication (ARV) become HIV positive, their future treatment options may be limited (discussed again in Two : Pre Exposure Prophylaxis)

- **"Real life" use**. Any creams gels, pessaries, rings etc that deliver microbicides must be thoroughly, and ethically tested, including for frequent/multiple use, compatibility with condoms, drug and conditions common among sex workers. The effect of the presence of a vaginal microbicide during the full range of sex acts should be explored. For example oral ingestion during oral-vaginal contact.

These concerns point to the need for careful planning to make sure that sex workers exposure to HIV and STIs is reduced and not increased by the advent of the vaginal microbicide. Access to services and products, high quality targeted information, social support, peer education and other community activities will be key to developing and delivering new messages. They also underline the important role the structure and status of the sex industry, law and market forces play in determining sex workers ability to be safe. One sex worker provided a vivid example of the futility of introducing a new product into the current situation. She imagined a future scenario in which police confiscate microbicide creams as evidence of

prostitution as they confiscate condoms now. Or that sex workers could be paraded in the street carrying tubes of microbicides instead of condoms. (there were some disturbing examples of police parading sex workers in public to humiliate them recently, notably in China and Papua New Guinea) To avoid scenarios and attitudes like those, limiting the benefits of microbicides, policies are needed that change the sex industry power dynamics in sex workers favor and recognize their right to live and work safely. More detailed recommendations about responding to the challenges around microbicides and sex work are in Eight: Summaries and Strategies

Research into Microbicides

Gus Cairns

Scientists have started doing proper research on microbicides for anal sex. The London Microbicides Conference devoted its first day to rectal microbicides. Pamina Gorbach of the University of California, Los Angeles opened by reminding the conference that unprotected anal sex was common in gay men -- with 35-48 percent of U.S. gay men reporting having it in the last year -- but common in heterosexuals too. About a quarter of U.S. women have had anal sex and up to half of women who attend STD clinics. (It was recently even discussed by the girls on "Sex and the City.")…. Women who had anal sex are three to five times more likely than other women to catch HIV.

Alex Carballo-Diéguez of Columbia University in New York said gay men were currently rather skeptical about microbicides and the concept might need to be "sold" to the community. They were used to the 95-98 percent effectiveness of condoms at stopping HIV when used consistently and correctly, and when told that microbicides might not be as effective as condoms, only 25-35 percent of gay men said they'd be interested in using them. Carballo-Diéguez said it should be emphasized that microbicides could be used with condoms as additional protection -- but also as away of making sex more pleasurable and less risky if condoms were not used.

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Section TWO : Pre Exposure Prophylaxis

Medications which can be taken regularly to prevent transmission of HIV are called pre-exposure prophylaxis which is shortened to PrEP. To date, no drugs have been approved for use as PrEP. Prophylaxis means preventative. Post exposure prophylaxis already exists and is used mainly by health workers after an injured by a needle and women who have been raped.

Similar to microbicides, PrEP trials are well underway with the first approved drugs likely to become available soon in the form of a tablet to be taken daily. Later PrEPs may be injections or implants under the skin. Like microbicides, the first generation of PrEP is expected to be between 50% and 60% effective. In addition to preventing HIV through sexual transmission, PrEP may prevent blood to blood transmission of HIV as well as sexual transmission, but this is not certain yet. If it does, it may be a significant breakthrough in prevention for injecting drug users.

Only one PreP candidate is currently being tested, Tenofovir, which is an anti-retroviral drug that is already used for HIV treatment. Currently, it's effectiveness for preventing transmission is being tested, both as a stand alone drug and in combination with another HIV medication known as Emtricitabine or Emtra. Together, their brand name is Truvanda. According to the US Centre for Disease Control (CDC), over one hundred and fifty thousand HIV patients around the world have used Tenofovir. It is reported to have milder side effects than other HIV treatments although side effects such as nausea and vomiting and concerns about its effect on the kidneys and liver have been raised. (note : accurate, current information about medicines and their side effects must be obtained from qualified advisors and certified publications)

Opportunities and Challenges

If in the future, a 100% effective PrEP with no adverse side effects was developed, individuals could eliminate the risk of HIV by simply taking a single daily dose. To stop whole epidemics of HIV most, or all, of the global population would need to know about the pills, have access to them and take them regularly. The term used to describe such a scenario is "universal access" Although both the drug, and universal access to it, will be difficult to achieve, identifying and delivering a PrEP is clearly a significant goal for researchers, HIV agencies and communities alike.

As well as being optimistic about the beneficial potential of PrEP we need to be cautious and questioning while preparing for a range of possibilities.

- More testing of the safety and the effectiveness of the drug is required to identify how a PrEP candidate will impact on various infections, conditions, and other medications. In particular sex workers advocates need to know how I will impact on HIV, ARVs and other medications, pregnancy, hepatitis, oral contraception, TB or malaria medication, recreational drugs, methadone and hormones. Information about the long term effects of constant Prep use is needed but such studies are difficult to conduct quickly.

- It is not known how PrEP might affect transmission of the various STIs. Widespread use of PrEP would obviously be likely to lead to a increase in those STIs which are not affected by PrEP.

- People who use PrEP contract HIV and continue to use it. The PrEP medication would then be acting as a treatment on the HIV. Using a single drug is known as "mono-therapy" and it is not recommended early in the infection because it can reduce the patient's treatment options as the disease progresses.

- The correct doses of Tenofovir for PrEP are not yet known. Tenofovir is currently thought to be active for 17 hours but it could stay active in the body for longer, possibly days. If this is the case, it may continue to offer protection, even if some doses are missed. If it does not, people who are taking PrEP might unknowingly take risks because they wrongly believe they are protected from HIV. When the actions of the drug are better understood scientists will be able to identify the appropriate dose. After that it is important to understand the impact of inconsistent or under-dosing (skimping) which can leave people unprotected.

- It is particularly important to know how Tenofovir and other future potential PrEPs will affect HIV transmission other than during vaginal sex-anal sex and oral sex, blood contact such as injecting and mother to child transmission. A trial among drug users is currently underway to explore its potential to limit transmission by blood.

- It is not yet known how distribution of PrEP will be regulated. Tenofovir or Truvada in the doses needed for HIV treatment are only available by prescription. As a biomedical intervention, PrEP could be delivered by physicians and in some countries available only by prescription. However doctors often don't have the time and resources to provide adequate counselling and other support services. On the other hand, community based organisations may have some of that expertise, but lack capacity to provide medication. It may prove to be a difficult balance. Some advocates urge that PrEP be approved to be sold freely to maximise access but it remains to be seen if distribution will have to be limited to minimise abuse and misuse.

- There are several ways the advent of PrEP may increase risk taking. People could be at increased risk if they substitute for condoms for a PrEP that's less effective than condoms or if they scrimp, or buy fakes. Some of this already happens – fake PrEPs are for sale and some people take Tenofovir that was prescribed for HIV treatment as prophylaxis before having unprotected sex. Detailed operations research and monitoring will be needed to inform planning programmes to deliver PrEP and to predict, observe and correct such trends should they emerge.

Sex Workers

When PrEP becomes available, it will have an immediate impact on HIV prevention for female, male and transgender sex workers. Some of the issues raised by PrEP are similar to those for microbicides, and there are some additional and different ones too.

One of the great additional benefits for sex workers of an effective PrEP would be that it covers sex with both clients and private partners. Sex workers generally have had great success in adopting condom use with clients, especially where the clients are targeted too, but less with their boyfriends, husbands and lovers. Hence private sex remains an important potential source of STIs and HIV for many sex workers.

Detailed information about pre exposure prophylaxis will be needed. It can be made available through outreach workers, print materials, the internet, telephone hotlines and in health settings

If PrEP prevents HIV transmission through blood contact sex workers whose greatest HIV risk is not unprotected sex, but sharing needles, could benefit enormously.

Sex workers who have many partners would be at particular risk if they use a partially effective PrEP is used in place of condoms and it is likely that many clients will refuse condoms if they have taken PrEP, or believe that the sex worker has. Sex workers may be less likely to require clients to use condoms for penetrative sex if they believe the PrEP will provide them adequate protection

Forced medication
Although it is accepted that patients have the right to receive medical treatment based on what is the most beneficial for him/her ("medically indicated"), sex workers are frequently forced to undergo treatments and procedures to protect the health of others. Mandatory HIV testing and STI treatment without diagnosis (called periodic presumptive treatment) are two examples. There is clear potential for PrEP to be forced on sex workers, or become mandatory, or quasi-mandatory. Clients, sex business owners, police and health authorities potentially all have the motivation, and the power, to insist that female, and possibly transgender, sex workers take PrEP (there is less precedent for forced treatment of male sex workers). In such circumstances it is to be expected that PrEP will be misused.

Adherence and misuse
Like microbicides, the information that accompanies PrEP will be key to its success or failure. Health workers' skills at history taking and communicating about sex and health will also be crucial. Unfortunately sex workers contact with doctors and clinic staff is too often confusing and stigmatising, as well as expensive.

Just as unwanted pregnancies result from missed birth control pills, individuals may miss taking their pills and expose themselves to HIV. Many sex workers live and work in conditions that make consistent use of medication difficult. This includes lack of food, accurate information, routine, money or control and choice.

Trial participants [in Sth Africa] are encouraged to use condoms to help protect themselves against possible infection; here, a clinician explains condom use to a participant.

Population Council

Access
Throughout the HIV pandemic, sex workers have not had the access to the medications/ commodities, accurate information and supportive programmes needed to prevent HIV. These factors that have limited the success of existing prevention methods are likely to continue do so unless there are significant policy changes, increased resources for sex work programmes and improvements to sex workers living and working conditions.

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Section THREE : Sex Workers and Prevention Trials

All health technologies, devices and drugs have to pass through a series of tests before being approved and made available for widespread use. Prior to entering a clinical trial, drugs are developed and tested in laboratories and some are tested on animals. Clinical trials are then conducted in steps known as “phases”. During Phase one, a new drug or treatment is tested with a very small number of people for safety, to determine dosage and to check for side effects. Phase two trials examine effectiveness and safety amongst a larger group of people. Phase three trials involve large numbers of participants and judge effectiveness, safety and compare the new drug or treatment with existing ones, should they exist. Phase four trials are done once the new product is on the market, in order to collect information about its impact across the community.

These are three human trial phases of microbicides…

Jim Maynard.
Fenway institute of Fenway Public Health

Phase 1. *Safety Trials* determine the safety of the product when used by 20 to 50 healthy, low-risk volunteers over several weeks or months. In the case of microbicides, scientists look to see whether the product causes irritation or negatively affects the vagina or rectum's normal environment.

Phase 2. *Expanded Safety Trials* test the safety of the product in a larger number of volunteers over a longer period of time. Phase 2 trials generally take place among volunteers whose risk profile resembles that of the women or men who will be enrolled in large-scale effectiveness trials.

Safety is assessed in HIV positive people because HIV+ people will want to use microbicides, including those who do not know their HIV status. Penile safety studies are done to ensure that product is safe and acceptable for the user's male partner.

Phase 3. *Effectiveness Trials* enrol thousands of people in several sites, and measure whether or not the microbicide actually works to prevent HIV and STIs. Some Phase 2 trials of microbicides can "roll into" Phase 3 trials as long as the data shows good results. (For more information see The Global Campaign for Microbicides: *Information sheet on clinical trials* and *Evaluating the safety of vaginal microbicide: The fundamentals*.)

Randomised controlled trials

Tests to determine if a drug prevents HIV transmission are called *randomised controlled trials.* A large group of participants with specific characteristics is recruited and assigned randomly into groups. One group will receive the trial drug and the other receives a fake or "dummy" version of the drug – this is called a "*placebo*". If neither the participants nor the researchers know who has the placebo and who has the real drug, this is called a "*double blind" randomised controlled trial*. The number of participants who use the real drug and contract HIV (called "seroconversions") is compared with the number who seroconvert while using the placebo. To tell if the drug or product works or not, and how well, researchers identify why the various seroconversions happened. There are several options - the failure of the product; the product not being used at all; the product not being used correctly; the product being used with condoms; or participants having little or no sex. To design such a study researchers calculate how many people must be in the trial for enough of them to contract HIV to provide this information. This number is the "sample size". The smallest sample sizes are needed for trials of prevention technologies where the women in the sample a) have many sexual partners, b) do not always use condoms and c) are likely to be having unprotected sex with HIV+ men. Therefore, poor, female sex workers in communities where there are a lot of HIV + people are ideal trial participants. Conversely, such research is much less feasible in places where sex workers economic and social conditions are better because too few people contract the virus to make the necessary observations.

"*Increasing the awareness of researchers, funders, trial participants and community stakeholders of essential good practices for community engagement through these guidelines can help reduce unnecessary conflict, confusion, or non constructive criticism and assure that research is meaningful, applicable and correctly interpreted." Good participatory practice guidelines for biomedical HIV prevention trials. UNAIDS.*

Opportunities and Challenges

The testing of drugs and vaginal products among groups of sex workers raises a range of practical and ethical issues for researchers, pharmaceutical companies and communities. In recent years, a number of trials involving sex workers have been stopped because ethical and practical issues were not resolved and others have failed because too few people contracted HIV.This has slowed vital progress on developing new HIV prevention methods. However sex worker groups have argued that trials should only go ahead when ethical issues are resolved and when sex workers have assured access to the benefits of new biomedical prevention methods.

The Asia Pacific Network of Sex Workers (APNSW) encourages sex work projects to share information among communities involved in prevention research. Its website contains several tools to guide sex worker communities through the process of negotiating participation in prevention trials (www.APNSW.org).

The UNAIDS has published guidelines on good participatory practice for biomedical HIV prevention trials. (UNAIDS 2007) It recommends mechanisms such as "community advisory boards" and developing a "monitoring and issues management plan" for each study. It advocates for resources to enable communities and potential participants to learn about research (called "research literacy").

The following are some of the issues sex workers have said affects their participation in prevention trials…

Informed consent
Informed consent is a cornerstone of accepted ethical standards. All researchers must make sure the people enrolled in studies are fully informed about all aspects of the research before they agree to participate. It is not sufficient for participants to merely sign a consent form, especially when they are not literate, or are less powerful members of society, like sex workers. Rather …

- information should be provided in relevant and accessible ways,
- resources should be available to help potential participants to learn about research, and
- there should be an ongoing process to check that all trial participants have understood all information correctly

Prevention services
Participants in randomised control trials of drugs and prevention must be provided with proven prevention services. This can include counselling, condoms, contraception and STI diagnosis and treatment. However, if these services are successful and all the trial participants use condoms, the study will not produce the data needed to measure the impact of the drug or product.

Although ethical standards specify that proven prevention services must be available to trial participants, the quality of counselling, the number of condoms and the accessibility and quality of the STI services are not standardised and disputes do occur. Sex workers using a trial product they understand to be protective, or likely to be protective, may be less likely to use condoms if they are not properly counselled.

Because there is no agreement about the acceptable types and standards of HIV prevention or care, these must be negotiated at the beginning of each trial. Counselling can mean anything from ongoing one-to-one support by a trained

counsellor who has experience with sex workers to a single short visit with an untrained person. Concerns have been repeatedly expressed that prevention services do not redress the potential effects on condom use of sex workers using the trial product they understand as being protective or likely to be protective.

Sex worker groups have argued that trials should only be conducted where the whole community has access to comprehensive HIV services and where there are effective protections for the human rights of sex workers. This includes protection of sex worker's human rights, violence reduction, peer education, community development and other interventions to empower sex workers.

Sex Workers Support HIV Prvention Trial

A section of sex workers are involved in the PRO 2000 microbicide trials being conducted by the Medical Research Council/Uganda Virus Research Institute in Masaka. Learning from their colleagues who have been using condoms and gel bought from retail shops they believe their participation in the trial will help reduce their chances of catching STIs. "Because women do not have the social or economic power to insist on condom use or abandon our daily customers who put our lives at risk, we adopted the idea of using gel before sexual intercourse," some of the sex workers said last week. During an interview conducted on Sunday in one of the lodges in Kyotera town, a 39-year-old [sex worker] said she has been using 'Night Rose' cream for the last 15 years and this has protected her from contracting HIV/Aids and unwanted pregnancies. The woman, who says she became a sex worker in 1988, did not reveal whether the cream she has been using has any side effect. "Prostitution is a risky business. I was forced to use gel as a protective measure because some men do not want to use condoms," she said.

Aliga Issa. The Monitor (Kampala)21 August 2007

Healthcare

The experience of the Tenofovir trial in Cambodia among others, raises the issue of how arrangements are made for ongoing health care and/or compensation for people who contract HIV or suffer injuries related to participation in a drug trial (see box) Sex workers and other trial participants have demanded guaranteed health care, in some cases for a long time after the trial finishes. Researchers have said this would provide an unacceptable incentive to trial participants and that it is beyond their financial and logistical capability to make such a guarantee. UNAIDS (2007) recommends researchers "lay out" the health care conditions and "present" them to community partners in clear language. It remains to be seen if this approach will prevent further breakdowns between researchers and communities in future trials.

Confidentiality
Confidentiality is an important issue all organisations working with sex workers must address, including in the context of HIV drug trials. Often sex workers' concerns around confidentiality differ from traditional formulations of confidentiality which govern HIV agencies and researchers. For example, in biomedical research, there is a focus on record keeping to protect the names of trial participants. However, sex workers have expressed concerns about other potential breaches of confidentiality and raised issues including accessing buildings and services without being seen by police and other members of the community, or the media.

Access to data
It is good practice to share information from any kind of research with the community that participated in the study but unfortunately, this doesn't always happen. Sometimes, the only information presented is in reports that are not meaningful or understandable to the community. Some research projects have overcome this by…

- Involving sex workers in the planning, design and implementation of the research.
- Translating reports to appropriate language.
- Developing innovative ways to present the data to gather feedback. (see APNSW and TREE Bangladesh, theatre for development group www.treefoundationbd.com).

The Role of Sex Work Projects

Sex work projects can work with researchers to develop ethically sound and innovative ways to recruit sex workers into trials while helping to ensure that sex workers best interests are served. Recent aborted trials are certainly perceived as a "wake up" call for researchers entering vulnerable communities. Keen to avoid further costly mistakes, researchers are now likely to be more receptive to sex work projects providing information on local issues and facilitating dialogue with sex workers before the study is planned and recruitment begins.

Cambodia Stops Important Tenofovir Prevention Trial

James S. AIDS Treatment News 23rd August 2004

On August 11, 2004 the Cambodia's government ordered researchers not to proceed with a trail to test whether once-daily use of Tenofovir reduces HIV transmission. Phnom Penh sex workers organised in the Wemen's Network Unity (WNU), who strongly objected to what they refer to as unthical aspects of the proposed trail, including insufficient guarantees of long-term medical care for trail participants who might develop side effects.

The WNU objected further since there had been no actual consultation with sex workers, only a show of consultation with several non-government organisations claiming to speak on sex workers behalf. They reported that Cambodians employed by the reseachers to recruit trial participants were telling sex workers that there were no side effects from Tenofovir and were pretending to represent an NGO that assisted the WNU.

The WNU has also pointed out that if participants believe the drug makes them more resistant to HIV infection, they may be less likely to use condoms, thereby increasing their risk of HIV infection. The government of the African country of Cameroon suspended a Tenofovir trial after complaints by Cameroon human rights activists and ACT UP-Paris concerning inadequate counselling and protection of trial participants

Warning Is Sent to AIDS Vaccine Volunteers
South Africans Among Recipients Who May Be at Higher Risk of Contracting Virus
By Craig Timberg

South African AIDS researchers have begun warning hundreds of volunteers that a highly touted experimental vaccine they received in recent months might make them more, not less, likely to contract HIV in the midst of one of the world's most rampant epidemics. The move stems from the discovery last month that an AIDS vaccine developed by Merck & Co. might have led to more infections than it averted among study subjects in the United States and other countries. Among those who received at least two doses of the vaccine, 19 contracted HIV compared with 11 of those given placebos.

Washington Post Foreign Service, Thursday, October 25, 2007; A20

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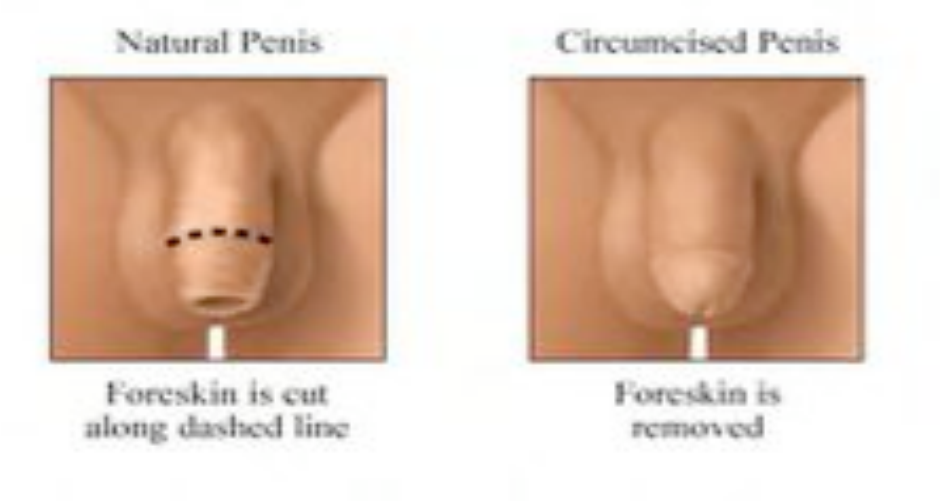
Section Four : Male Circumcision

Male circumcision is the surgical removal of the foreskin of the penis. According to WHO and UNAIDS thre is strong evidence that male circumcision could significantly reduce HIV transmission and could prevent two million new HIV cases and 300,000 AIDS-related deaths in sub-Saharan Africa over a span of 10 years.

Circumcision works to reduce vulnerability to HIV in at least two ways. It removes cells specific to the foreskin which are particularly receptive to HIV. It also provides some degree of protection against STIs, such as, syphilis, chancroid, HSV-2, human papilloma virus, urinary tract infections, and penile cancer. Men with STIs and young heterosexual HIV negative men have been identified as highest priority for circumcision.

Despite promising initial studies, little is certain and the matter remains controversial. While some see male circumcision as a one time procedure that could offer benefits over a lifetime, some leading agencies and activists have questioned the conclusions of research on circumcision, and urged caution until more data is available. For example, it is not known how circumcision affects anal HIV transmission, which is an issue for both homosexual men and the many heterosexuals who have anal sex.

Regardless of these debates, circumcision is set to be an important part of HIV prevention programmes. At the 4th IAS Conference on HIV Pathogenesis, Treatment and Prevention in 2007 the executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria said, "I believe that the evidence is overwhelming for the efficacy of circumcision,"adding, " and if countries come to us... I see no reason at all why we wouldn't fund that".



Risk Compensation

It is clear, like the other biomedical developments, male circumcision does not provide complete protection against HIV. Circumcised HIV negative men can still contract the virus and HIV positive men will still be able to transmit HIV to their sexual partners after circumcision. Therefore, HIV risk could increase if circumcised men abandon condoms in the belief they are protected by circumcision. Even where they understand partial effectiveness, some men may have unprotected sex because circumcision makes it less risky than before. Researchers call this "risk compensation".

Distribution of benefits

The public health benefits of male circumcision will only emerge over time as the number of men contracting HIV declines. UNAIDS predicts if circumcision programs begin now, results will begin to emerge in 20 years. The greatest benefits will be in places where a significant number of the population have HIV (generalised epidemics) and transmission is mainly between men and women. In places where HIV is concentrated among sex workers, MSM and drug users, the benefits of mass circumcision would, at best, be very limited.

- **Women :** It is uncertain if male circumcision will reduce the sexual transmission of HIV from men to women. Women would benefit if fewer men had HIV or STIs. Male circumcision reduces infertility and cervical cancer among women.

- **Sex workers :** Male circumcision has the potential to reduce the vulnerability of sex workers to HIV and STIs, so long as condoms continue to be used. That benefit could be eroded if circumcised clients are less willing to use condoms. Sex workers have already noted the possibility of clients using circumcision as an argument against condoms use with sex workers.

  Sex worker peer educators stress the importance of correct information for clients, not just for sex workers. They say even when sex workers are well informed about such issues, they often can't correct clients beliefs.

- **Men and transgenders** who have anal sex with men have not been included in circumcision trials, so there is no data about how circumcision might affect them. However, it is important to note there have been large HIV epidemics among gay men in places where circumcision is the norm, such as the United States. This does not bide well for circumcision of homosexual men in countries, such as, Kenya, where an estimated 40 % of men who have sex with men are already HIV positive or Senegal, where 22 % are believed to be infected.

Safety

Poor medical expertise could lead to injuries as mass male circumcision begins. UNAIDS (2007) stated, "circumcision should not be scaled up without assurance of quality and safety of services and appropriate follow up of clients". However circumcision will probably start anyway in many places. This could place additional strains on already under-resourced and under-staffed clinics and hospitals and lead to infections and leave patients without adequate support and information.

Ethics

Ethical standards require policy makers and programme managers to thoroughly analyse all the cultural, economic and gender implications of promoting circumcision in any community. There is less clarity on how to do this.

While standard informed consent procedures apply to adults seeking circumcision, the framework for ethical circumcision of minors requires more attention. This includes examination of local laws and rules.

Female genital mutilation

It is important that information about male circumcision is not misused to encourage cutting female genitals. Female genital mutilation is a serious threat to women's health and has no medical benefits or protective value against HIV or STIs.

It is critical to ensure that clear and correct information on other HIV prevention measures is provided to men who are circumcised for HIV prevention to prevent them developing a false sense of security and engaging in high-risk sexual behaviours.

UNAIDS and WHO New Data on Male Circumcision and HIV Prevention Policy and Programme Implications. UNAIDS, Montreaux, March 2007

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Section Five : Condoms

According to the World Health Organisation (WHO) using latex condoms correctly and consistently reduces HIV transmission. Condoms prevent sexual transmission of HIV by blocking the path of the virus in genital secretions from one person to another. Condoms also prevent pregnancy and most STIs including sexually transmitted hepatitis.

In the face of growing emphasis on sexual abstinence, HIV testing and biomedical prevention, it is important to remember that condoms are the backbone of HIV prevention. Not a single country has successfully limited HIV without promoting condoms, making them more accessible, attractive, or affordable, and overcoming other barriers to their use. As we have already illustrated in the previous sections, this will be the situation for many years even if an effective vaccine or other medical prevention methods are developed.

Latex condoms can provide up to 98-99 percent protection against pregnancy and most STDs, including HIV infection, but only if they are used consistently and correctly. Condom Effectiveness Studies. Just Rubbers.

WHO

Public condom promotion was key to limiting HIV in Thailand. Sex workers say it made it much easier to get clients to use condoms.

Challenges

Many factors limit the use of condoms:

- **Risk perception** – people will not use condoms for HIV prevention if they do not see themselves at risk for HIV. Throughout the world, many people do not take the HIV test or protect themselves against HIV because they fail to recognise their own vulnerability, often because they associate AIDS with poverty, injecting or immoral sex.

- **Access** – To prevent HIV, high quality condoms must be universally accessible. This has yet to be achieved. UNFPA estimates the current supply of condoms in poorer countries is 40% less than the number required. This is called the "condom gap". Even where there are enough condoms, stigma and cost can stop people accessing them.

- **Knowledge and skills** - Research proves most condom failure occurs as a result of lack of skills by the users, not faulty condoms. Hence, understanding which behaviours and characteristics are most strongly associated with condom failure is critical to improving the effectiveness of condoms through public health messages and counselling.

- **Fertility** - condoms contraceptive, so, they are not suitable for couples who want to have a family.

- **Pleasure** - skin contact in penetrative sex is almost universally preferred for sexual pleasure. Almost every culture expresses dislike for condom use, describing them as akin to " taking a shower in a raincoat" or "eating a sweet with the wrapper still on."

Opportunities - Better condoms now !

Almost every culture expresses dislike for condom use, describing them as like," taking a shower in a raincoat" or "eating a sweet with the wrapper still on."

There are few "big ideas" to revolutionise condoms or to assure universal access to them. Marge Brerer of Reproductive Health Matters contrasts the level of investment and enthusiasm for the biomedical prevention methods with that for condoms. She points out that "condoms have no well funded champion anywhere, not even a full time person at UNAIDS." (Reproductive Health Matters, 2006).

There have been few changes to condoms since the outset of the HIV pandemic and even less progress in making lubrication more accessible or user friendly. Condoms are still mainly latex sheaths rolled down onto the penis (called male condoms).

Developments have primarily been limited to variations in shape, size, sensitivity, perfume, colour, marketing or packaging rather than fundamental changes. Different types of condoms are marketed to specific groups or for specific sex acts such as anal and oral sex.

Most of these are marketed as novelty or specialist condoms, are more expensive and are not widely available in developing countries.

The "female" or insertive condom was the last major innovation to the condom to have reached the market. It is a condom made of strong plastic (polyurethane) with two rigid rings which is inserted into the vagina before sex. One of the rings anchors the device at the cervix and the other sticks out from the vagina. Women who use it often feel that they have more control because they insert it, rather than relying on her partner to put a condom on his penis. The Global Coalition on Women and AIDS, describes it as, "the closest thing we have to a female initiated prevention method even though it is not fully female controlled and still usually requires some cooperation from male sexual partners."

The first generation of female condoms were bulky, intrusive and noisy. Now there are several softer and less intrusive female condoms available (the FC2, the VA Feminine Condom, and the PATH Woman's Condom). Supplies of female condoms have been limited in most countries primarily because they cost too much, on average, 27 times as much as ordinary condoms. The new generation female condoms may be cheaper, although it remains to be seen if they will be cheap enough for unsubsidised distribution in developing countries.

New materials, new designs

Condoms are now being made from plastics as well as latex. This has opened up the possibility of new condom designs that are easier to use, more comfortable and more sensitive. The Unique (for males) and the Unisex (for male and females) are two very thin plastic condoms which are available in Colombia and elsewhere in South America although overall availability of innovative condoms is very limited in developing countries). Plastic condoms are approximately the same thickness as

the latex condoms. Their advantage is being less constricting, non allergic, and can be used with with oil-based lubricants. http://www.infoforhealth.org/pr/h9/h9chap5_2.shtml Ansell, is one of several condom companies who has launched a condom that aims to be easier to use. Named Xtra Pleasure, the Ansell product has an enlarged, bulb-like area at the head of the condom. Another type, Sensicon condoms, is made of a plastic called Tactylon and has a "baggy" design.

Unisex condoms, such as the EZON (easy-on), is a polyurethane condom which can be inserted into the vagina or pulled on to the penis, rather than being rolled and stretched over it. EZON is only available in some parts of Europe and has not been approved in the US. Another condom called Pronto has an applicator that makes it faster and simpler to apply (for video demonstrations see - www.prontocondoms.co.za/demo.htm and www.youtube.com/watch?v=GiG9MaGSN64

There are yet more condoms waiting for patent approval. Some of these condoms have applicators, and one has an adhesive (glue) layer to keep it in place www.freepatentsonline.com

Condoms are now being made from plastics as well as latex. This has opened up the possibility of new condom designs that are easier to use, more comfortable and more sensitive.
This is the EZON condom.

Sex workers

As partially effective biomedical prevention methods become available, special efforts will be needed to maintain and expand condom promotion for male, female and transgender sex workers and their clients.

- **Peer distribution**

  Condom promotion with sex workers is most successful when condoms are free or inexpensive, where the supplies are plentiful and are accompanied by well targeted and helpful information. They also need to be available during the night. Ideally condoms should be available from sex worker peer educators.

- **Clients**

Condoms can be promoted to more clients. Sex workers have always said condom and safer sex education for clients is crucial to reduce the demand for unprotected sex. Client education has played a major role in those countries that have reduced rates of HIV and STIs among female sex workers.

- **Sexual and Reproductive Health Services**

It is increasingly recognised the networks of family planning clinics, which exist in many countries, should be accessible to, at least, female sex workers and possibly to male and transgenders as well. This could provide an important new opportunity to promote and distribute condoms to sex workers as "dual protection". Using condoms with clients enables female sex workers to have children with their private partners.

- **Laws and Policies**

The policy and legal environment directly impacts condom promotion and on sex workers ability to use condoms. An example of helpful government policy is the promotion of condom use with the general public which drastically increases condom usage in commercial sex. An example of misguided policy is the use of condoms as "evidence" of prostitution which discourages condom use by sex workers in many countries.

Those sex workers who have strong links with, families and community and state institutions are most successful at using condoms (Kerrigan 2007). Those who are the least successful in negotiating condom use are those subject to debt bondage, displacement, poverty, violence and social alienation.

Policies which enable sex workers to access safe places to live and work, education, housing, and protects their civil rights, economic options contribute significantly to reducing sex workers vulnerability to HIV.

Female Condoms for Sex Workers

Insertive condoms should be available to all sex workers. Although those currently available are not suitable for all sex, they are very useful to sex workers for specific situations. These are some of them:

- They are safe to re-use if properly cleaned, especially when other condoms are not available.

- They are very strong for anal sex.

- They can be used with men whose erection is not strong enough to use an ordinary condom but are still able to achieve penetration and ejaculation.

- They are less likely to break or split during anal sex or with men with large penises.

- They are useful during menstruation because they usually prevent blood escaping. This can be particularly useful in places where sex with women during menstruation is taboo.

- They can be used with oil based lubricants. For some sex workers, it is not possible to use water based lubricant and they are in an environment in which there are many oily substances such as massage oil.

- *In Kalémie, Congo, men I worked with had absolutely no doubt that if men didn't regularly inject sperm actually into women's bodies, they, the men, would go insane.*
- *In Monrovia, Liberia, men in the group…agreed that for women to have pleasure, the man's juices absolutely needed to blend with those of the woman. If women's pleasure was important why would a man use a condom?*
- *In Azerbaijan the group argued that whatever the reason, a man needs to do what a man has to do – and condoms risk puncturing his dignity, his control, his authority.*
- *In Norway medical students argued that the size of the 'male gland' required more action that the smaller organ of the woman.*
- *In America, students argued for 'authentic' flesh on flesh proving of love, commitment and all that.*

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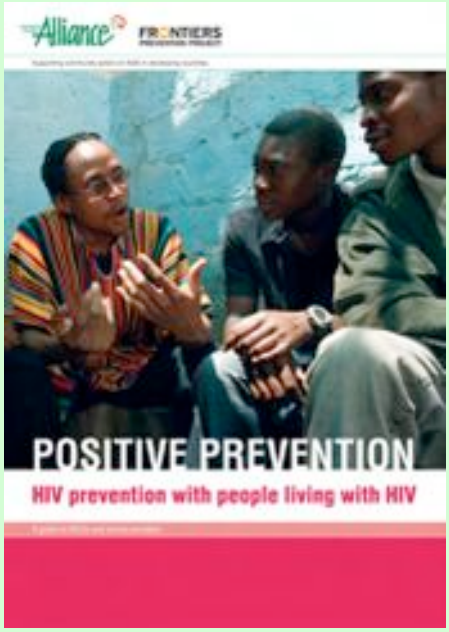
Section Six : HIV Testing and treatment

When Anti-Retroviral (ARV) medications for HIV disease first became available, it was feared that by prolonging life, they would extend the time people living with the HIV (PLWH) have to transmit the virus. People with HIV who have access to treatment and care have benefited enormously and there are strong suggestions that people who know their status, have access to condoms and good treatment and care are less likely to transmit HIV than those who remain untested. Ethical testing and high quality treatment are therefore important prevention strategies. However there is no consensus about how conclusive the evidence is that increased testing and treatment leads to fewer HIV transmissions. (see box Halperin 2007)

There is consensus that uptake of HIV tests and access to treatment are eroded by discrimination, human rights violations, poverty, stigma and lack of accessible counselling. This particularly affects sex workers of all genders, migrants, men who have sex with men, prisoners, drug users and other vulnerable communities.

Voluntary testing and counselling

Throughout the history of HIV/AIDS, voluntary counselling before and after the test (VCT) has been considered best practice and it is recommended by UNAIDS. Counselling before an HIV test aims to ensure that the person taking the test fully understands and wants the test. It helps the person prepare by considering how a negative or a positive result would affect them.



Prevention efforts should not be exclusively aimed at HIV negative people. Access to services, medicines, support and information help people with the virus to live safe, healthy lives.

Counselling after the test is an important opportunity to discuss plans for future prevention with both HIV positive and negative people. Counselling after a positive test focuses on issues such as positive living, psychological support, family issues and treatment options. The counselling, after a negative result, provides prevention information to help them maintain their HIV negative status.

Provider and client initiated testing

The World Health Organization (WHO) and UNAIDS are concerned that as few as twelve percent of the population in Sub-Saharan Africa have received results of an HIV test, and probably less in other regions. They recently endorsed two new approaches to ensure more HIV testing takes place. These new approaches are called Provider Initiated Testing ad Counselling (PITC), or Opt-Out testing, and Client Initiated Testing (CIT).

- **Provider Initiated Testing** Health care providers recommend HIV tests as a standard component of medical care. Testing is recommended for babies born to HIV positive mothers; children with inadequate growth, men seeking circumcision and high-risk populations. The recommendations are different for places with different levels of HIV. Patients have the right to refuse the test which is called "opting out".

- **Client Initiated HIV Testing and Counselling.** People go for a test, usually special VCT units. This is being expanded to a wider range of settings including mobile testing vans, social clubs and public events. In some places door-to-door where VCT has been initiated and the testing takes place in people's homes.

According to WHO, provider and client initiated testing should be accompanied by anti discrimination measures, a full range of support services and access to treatment and primary health care for people with HIV. WHO and all UN agencies oppose mandatory or compulsory testing.

How does HIV testing and treatment link to prevention?

Throughout the pandemic, information and advice about HIV has been available to people testing for HIV. Both positive and negative people can access condoms and other prevention services at HIV treatment centres. Since ARV medications have improved and been more widely available, scientists have become certain the risk of sexual transmission of HIV is lower when the amount of virus in the blood (viral load), of a HIV+ partner, has been reduced by the medicines In other words, people taking ARVs seem to be less "infectious"

Sex workers need access to voluntary counselling and testing with sympathetic health workers. HIV testing must be linked to access to treatment and care for those who test positive

than if they did not take medication(s). This raises complex issues. Should ARVs be provided for prevention to those HIV+ people that are most likely to transmit the virus? Should ARVs be given to people earlier in the disease than they need for treatment to prevent them transmitting HIV? Treatment is usually only considered ethical when it is provided for the good of the person, not to prevent them infecting others. This conflict is sharpest if ARVs are taken early in an infection, rendering them less effective later, or causing drug resistance in the patient.

The viral load is affected by a variety of other factors. It is highest soon after the HIV positive person has contracted the virus. Illnesses which deplete the immune system, such as malaria or genital ulcers, raise the viral load of a person with HIV. This means that HIV treatment, primary health care and good nutrition for PLWH are prevention strategies.

The potential for ARV therapy to reduce HIV transmission is hopeful, nevertheless, it can only reduce risk *per sex act.* Any overall benefit of helping people avoid transmitting or contracting HIV possibly could be outweighed if more unprotected sex took place as a result of people on ARV therapy.

For sex workers, people who use drugs and gay men, health care clinics are notoriously forbidding places. These populations require other sources of HIV testing that are not provider initiated and which are offered in a peer based and non- judgemental manner. Rather than promoting opt-out provider initiated testing for these populations, concentrated efforts should be undertaken to develop human rights based policies, reflecting the needs of these populations; to implement and promote safe, voluntary and accessible HIV testing and counselling for them.

The UNAIDS Reference Group on HIV and Human Rights. 2007

Sex workers and HIV testing, treatment and care

The policies that shape HIV testing and access to services for HIV positive people impact in particular ways on sex workers :

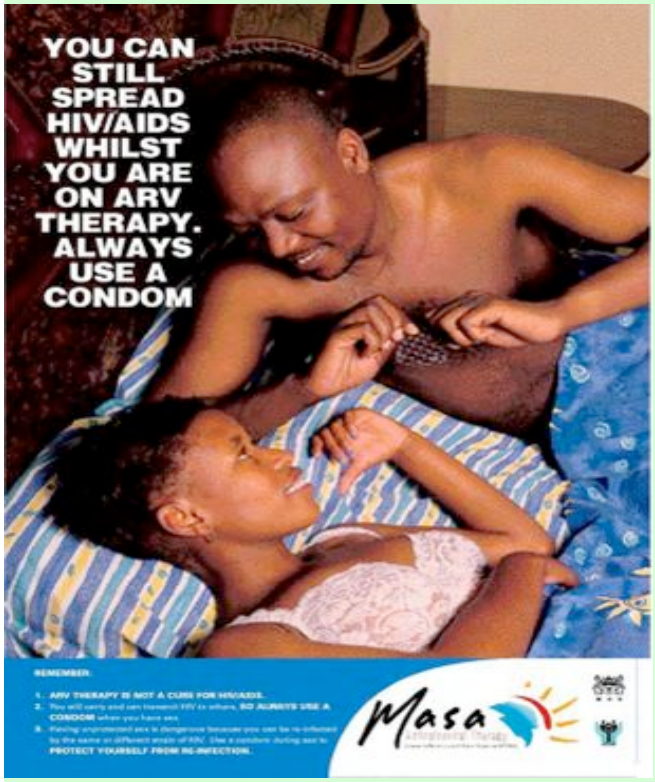
Discrimination
Access to HIV treatment is an incentive for many people to be tested. Where sex workers believe, correctly or not, that they will not have access to treatment, care and social support they will have less incentive to take the test. That incentive is even further eroded if a positive result will have negative consequences, including discrimination and human rights violations, loss of income or violence. Sex workers from all over the world often say they avoid HIV testing because of fears about staff attitudes and lack of confidentiality. A 2005 study in Andhra Pradesh, India found only 7.9% of more than 6000 sex workers had been tested for HIV and three-quarters of the rest were unwilling to undergo HIV testing in the future (Dandona 2005).

Mandatory and Coerced HIV and STI Testing
Some sex worker organisations have been hesitant to support broader HIV testing and therefore, Universal Access to treatment due to fears about discrimination and access to treatment that are based on both current experiences and history. Female sex workers have historically been subject to forced medical examinations and treatment. Forced HIV and STI testing currently occurs in dozens of countries.
It violates human rights and threatens effective public health strategies.

Peer educators in many countries report that pro-testing policies, including Provider Initiated Testing, are leading to sex workers being subject to mandatory or coerced testing for HIV and STIs. This sometimes occurs as a result of official policy or simply because sex workers are simply unable to negotiate or refuse HIV and STI testing when they are pressured by health service providers, police, sex business operators or clients.

The most rigorous study yet conducted of the impact of testing on sexual behaviour, a randomized trial from Zimbabwe published last month in the journal AIDS, found an increased rate of HIV after people underwent testing and counselling compared with those who did not, though the increase was not quite statistically significant. The London-based researchers noted that some other studies similarly have found "disinhibition," or a worsening of behaviour, among people who learned they were not infected. While it might seem intuitive that knowing one's HIV status and, ideally, receiving good counselling would lead to behaviour change and reduced risk, the real-world evidence for this conventional wisdom is still unclear, especially for the large majority who test negative.

Daniel Halperin Washington Post October 22, 2007



This poster addresses fears that people, who are taking ARVs, will have more unprotected sex because they see themselves as less likely to infect others and feel better.

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Section Seven : HIV and Sex Work Policy

"Sex workers living and working conditions need to be made safer and healthier. It is essential that these strategies be implemented concurrently i.e. using peer education and outreach approaches while ensuring the provision of basic health and social services and moving to decriminalise sex work"

UNAIDS HIV and Sex Work Technical Update 2002

Throughout the world, and much of history, sex workers have been seen as a social, moral or public health problem and policies and laws on prostitution reflected those views. Attempts to eradicate prostitution as a criminal activity are called Abolitionist. Relatively few countries take that approach. They include the US, Mongolia, Vietnam and Saudi Arabia. In most of the world prostitution is regulated by laws that criminalise just some ways of selling sex and those who profit from it. Some countries, including Senegal, Cambodia, Bolivia, Turkey and Curacao, have health regulations that require sex workers to be monitored for STIs and HIV Another approach that also emphasises public health is Harm Reduction. It involves providing information condoms and education, voluntary testing and counselling and access to clinical services. Countries as diverse as Bangladesh, Ethiopia, Thailand and Burma favour harm reduction. Yet another response is recognition of sex workers' human and labour rights which entails decriminalisation of sex work with measures to limit workplace abuses and social marginalisation. New Zealand, Brazil, Hungary, the Netherlands and Australia are among the countries whose policies reflect a human rights stance. A new form of abolitionism has been a recent and important addition to this traditional mix of approaches to sex work. Some countries are beginning to criminalise clients and forcibly rescue and rehabilitate sex workers. The purchase of sex from women (not from men or transgenders) is viewed as violence, slavery and "trafficking".

Male and transgender sex work has rarely been addressed in policy and laws that address prostitution. Rather laws against homosexuality have been used against male and transgender sex workers in most places. Policies that aim to prevent HIV among "men who have sex with men" are assumed to cover male and transgender sex workers in most national and international policies on HIV/AIDS.

On this analysis women cannot consent to sell sex, just as slaves cannot agree to their enslavement. The term "sex worker" is rejected by advocates of this view, replaced with the terms "prostituted women" or "trafficking victim". The approach originated in Sweden with support from US feminists and it has rapidly been adopted by socially conservative politicians in several countries including India and Great Britain.

Policies and laws based on some combination of these ideas change as governments and trends come and go. In much of the world little of this is important because sex work is neither illegal or recognised so that there are no policies in place to respond to sex work.

"The juxtaposition of the terms prostitution and sex trafficking demonstrates a belief that both share similar characteristics, and thus reflects moral ideology rather than objective reality. Trafficking, though variously defined covers coercion, forced labour, and slavery. Prostitution describes the sale of sex, by no means necessarily without consent or with coercion. At a time when trafficking is increasing, as are international efforts to tackle it, it is critical to clarify the differences between the issues".

Kate Butcher The Lancet 2003

Significant Developments in International Policy

These are three examples of important developments and trends in the international policy that affects female, male and transgender sex workers.

- In 2003, one of the largest donors for HIV/AIDS programmes, the United States government, called for the global "eradication of prostitution". The Pefar legislation imposes a condition on all organisations that receive HIV/AIDS funding from the US government explicitly oppose prostitution and agree not to support moves to legalise of sex work or challenge the laws that prohibit sex work and punish sex workers.

- In 2001, Sweden made it illegal to buy sex and several other countries have followed, or are considering doing so. Since 2000 various government, non-government and faith-based organisations have been locating and forcibly removing women they claim to be slaves from brothels in developing countries.

- In 2007 UNAIDS issued new guidance on sex work that focuses on reducing the numbers of women who take up sex work, reducing demand for commercial sex and helping women to stop selling sex.

1. United States Government

The U.S. Government approach toward sex work has shifted during the President Bush's administration. In May 2003, the President's Emergency Plan for AIDS Relief (PEPFAR), a five-year, $15 billion American Government initiative, was introduced to combat the HIV/AIDS pandemic. Three aspects of the PEPFAR in particular changed HIV prevention and care programmes for sex workers in developing countries.

a) ABC: Abstinence, Be Faithful, Condoms.
The Pepfar approach to HIV prevention is known as *ABC, for Abstinence, Be Faithful, Condoms*. This formula describes, a) instructing young people to delay their first sexual contact b) discouraging sex outside of marriage, and c) recommending condoms for those who do have sex outside of marriage. At the same time the unreliability of condoms is stressed.

For many USAID funded programs, ABC generated confusion. Some organisations tried to incorporate contradictory messages about abstinence and condoms. However, others spoke out against the ABC approach. For example, Christian Aid who expressed concern the ABC messages have added to the stigma surrounding HIV because too often it has been presented as a moral hierarchy: "abstain; if you can't abstain, then be faithful; and if you can't be faithful, then use a condom." It developed an alternative, SAVE stands for: **S**afer practices, **A**vailable medication, **V**oluntary **c**ounselling and testing and **E**mpowerment.

b) Anti-Prostitution Pledge
The Administration of President Bush identified female prostitution as one of the main drivers of HIV epidemics and announced its intention to work toward global eradication of prostitution. Requirements for grantees for U.S. HIV and human trafficking funds are based on this link between HIV prevention and the eradication of prostitution. The legislation specified that in order to receive AIDS funds from the U.S. all grantees must have,

(1) a policy explicitly opposing prostitution and sex trafficking and

(2) certification of compliance with the "Prohibition on the Promotion and Advocacy of the Legalization or Practice of Prostitution or Sex Trafficking, " This applies to all organization activities, including those with funding from private grants.

"The Prostitution Pledge," as this is often called, has evoked strong and mixed reactions. Some NGOs interpreted the regulations as preventing them from addressing sex worker empowerment or providing sex worker friendly services at all. Many decided that working with sex workers was untenable and abandoned

their programmes. Those that provided rights based HIV prevention and care services with sex worker involvement became ineligible for U.S. money. Some of those tried to continue their work with sex workers, avoiding advocating for the legalisation of prostitution and noting the absurdity of simultaneously sending out the messages that sex work can be safe and is immoral or abusive. Hence, sex workers access to information and services have been severely curtailed in many developing countries

(to watch a video about sex workers views on the impact of U.S. policy on sex work see the Network of Sex Work Projects video, "Taking the Pledge". www.sexworkerspresent.blip.tv)

***Sangram** : Hundreds of women protest against violent a "rescue and raid" in India. This is a scene that has been repeated in many countries throughout Asia and the Pacific.*

A further consequence of the U.S. anti-prostitution policy is tense relations between the U.S. government, civil society groups and other governments. In Brazil, sex worker participation and reducing the stigma surrounding sex work are established parts of the national response to HIV/AIDS. The government refused $40 million in aid from the U.S. government in 2005 rather than agree to U.S. conditions. The legality of the "pledge" has been challenged in courts by several non-profit organisations who say that the U.S. government is violating their right to free speech government by attaching a requirement to agree with an ideology to its criteria for allocating humanitarian aid.

"Sex workers are part of implementing our AIDS policy and deciding how to promote it…they are our partners. How could we ask prostitutes to take a position against themselves?"
Pedro Chequer, Director, National STD and AIDS Program of Brazil in The Nation in May 2005 after Brazil rejected US policy therefore US founding

c) Anti Trafficking Policy

The U.S. government's approach to combating human trafficking for prostitution stresses prevention, protection and assistance for victims and prosecution against traffickers. It claims to prevent trafficking and to protect victims by reducing the vulnerability of women, children and men to traffickers, by promoting political will, legal and institutional capacity and by establishing "partnerships with NGOs faith-based institutions and governments that are actively fighting trafficking to prosecute traffickers and brothel owners". The trafficking policy specifically precludes partnerships in anti-trafficking efforts with "organizations advocating prostitution as an employment choice or which advocate or support the legalization of prostitution". (see the Report for Congress on Trafficking in Persons. 2007).

Merging of the terms "prostitution" and "sex trafficking" is central to the U.S. government policy. According to the U.S. State Department "Prostitution and related activities—including pimping and patronizing or maintaining brothels—fuel the growth of modern-day slavery by providing a façade behind which traffickers for sexual exploitation operate" (www.state.gov/r/pa/ei/rls/38790.htm). However, the combining of trafficking with sex work has been rejected by sex workers and it is not accepted by the scientific literature on HIV/AIDS or by international agencies with HIV prevention programs. Many organisations have described U.S. anti-trafficking policy and programmes as "resembl[ling] a global campaign against

prostitution" (Cohen 2005) and there are widespread predictions that this approach will diminish with the influence of "the religious right" in the US in coming years.

International law is very clear that sex work and trafficking are distinct. If no violence or coercion was used in the process of recruitment or travel, no trafficking occurred. Despite this U.S. sex work policy is based on the assertion that most, if not all, female sex workers are trafficking victims.
Jo Doezema. Network of Sex Work Projects

Sex worker organisations consistently report that NGOs and government anti-trafficking initiatives are responsible for violent raids by police and claims of human rights abuses linked to anti-trafficking raids are widespread. Advocates say the raids often result in women and their families being arrested, incarcerated and

often deported or released for money rather than genuinely "rescued". They say that raids are violent, entrapment is used and "rescuers" do not distinguish between "sex slaves" and sex workers or between adults and minors. Sex workers say the approach violates their human rights, fails to protect women and children from trafficking and other kinds of crime and reduces their ability to mobilise for better health and living conditions. These issues have been well documented by sex workers and human rights groups. (for more information see www.VAMP.org International Justice Mission www.ijm.org, Human Rights Watch http://www.hrw.org Network of Sex Work Projects www.nswp.com and apnsw.org. Videos about "raids and rescues can be seen at http://sexworkerspresent.blip.tv)

A substantial body of peer-reviewed published studies suggests the empowerment, organization, and unionization of sex workers can be an effective HIV prevention strategy and can reduce the other harms associated with sex work, including violence, police harassment, unwanted pregnancy, and the number of underage sex workers. While sex work may be exploitative, and is illegal in many jurisdictions, sex worker advocates and HIV prevention program leaders generally agree sex workers themselves need services, protection, peer outreach, and support from health professionals to reduce their risk of HIV infection (Masenior 2007).

2. Criminalisation

Sex workers in India say the proposed change to the Indian prostitution law (ITPA Sections 2 and 5) will, if passed, both undermine HIV prevention among sex workers and obstruct sex workers attempts to organize and empower themselves to resist HIV, discrimination and violence

Gouri Ray. Durbar Mahila Samanwaya Committtee. Kolkata, India.

In most countries, sex work is governed by criminal laws and police actions, primarily directed at sex workers and those who manage sex businesses. Until recently there has been no tradition of buying sex being a crime other than when nuisance is caused. (there are some exceptions, including China). The effects of laws vary from country to country, yet, sex workers everywhere agree anti-prostitution laws limit the success of HIV prevention and care programmes by limiting access to safe places to work and to support services.

As well as prostitution specific laws, there are legal and policy trends around HIV that impact upon sex workers…

- Police arresting or harassing HIV educators (Human Rights Watch).
- Laws criminalising HIV transmission and imposing responsibility on PLWH to tell their sexual partners they are HIV positive
- Increasing reports of police taking away condoms which they claim to be evidence of prostitution.

Some countries, such as Hungary and New Zealand, have recently reformed their sex work laws and reduced the role of police and criminal law in the sex industry. Other countries have extended the role of law enforcement.

For example in several Asian countries police and other authorities are authorised to inspect sex business premises to ensure that information about condoms are available and sex workers have attended a medical facility (APNSW 2006).

Law enforcement has also been extending by the criminalisation of buying sex. In 1999, Sweden was the first country to make buying sex a criminal offence. The government stated, "in Sweden, prostitution is regarded as an aspect of male violence against women and children. It is officially acknowledged as a form of exploitation of women and children and constitutes a significant social problem...

gender equality will remain unattainable so long as, men buy, sell, and exploit women and children by prostituting them." Several other countries have enacted or are considering similar laws (Korea, Canada, India, Britain, Italy, Bulgaria, Finland).

Sex workers from Sweden and beyond have spoken out against the "Swedish model". There have been protests by sex workers in other countries about "demand reduction laws" or the criminalisation of clients. The International Network for Sex Work Projects, the International Union of Sex Workers and their supporters at the EUROPAP/TEMPEP Conference in the UK, in 2002, called on Sweden to abandon this approach and other countries to reject it. They said the model…

- is counterproductive and inhumane,
- increases the vulnerability of sex workers
- increases levels of violence,
- violates human rights of sex workers and clients.

Buying sex is increasingly being criminalised. This makes sex workers more vulnerable to HIV and to violence because they must work in more hidden places.

"The solution to trafficking must be multifaceted. We must address the official corruption, indifference and fraud that allow traffickers to move people across borders and sell their services without repercussions. We mustalso address the root causes of human trafficking: the low social status, poverty and lack of education or other options that traffickers exploit when they trick people into forced labor situations. We must also recognize that many persons become involved in sex work because they live in conditions of poverty and discrimination, and it is the only way they can support their families. Tactics and strategies that further undermine their rights increase their marginalization, rather than allowing them to seek their own solutions."

Meena Seshu

3. The United Nations

UNFPA became the lead UN agency for sex work in 2005. After conducting consultation it produced a *Guidance Note* on Sex Work in 2007, which set out a revised approach to HIV/AIDS and sex work for UN agencies. The new policy defines sex workers as "adults, 18 years and over". Although it acknowledges the existence of male and transgender sex work, it focuses mainly on women. The guidance is presented as a framework of "three pillars":

Sex Workers reject approaches that label them victims and programs that aim to save them. They say that the solutions to traffiking, poverty abuse & child sexual exploiration are human rights for sex workers.

Pillar 1 : Reducing vulnerabilities and addressing structural issues.
Reduce women and girls vulnerability to entering sex work, calls for broad-ranging efforts to tackle poverty, reduce gender inequalities, improve access to education and work, protect the rights of vulnerable people such as migrants and reduce demand for commercial sex.

Pillar 2 : Reducing risk to HIV infection.
Recommends risk reduction such as condom distribution to both sex workers and clients; improved access to sexual and reproductive health and HIV services for sex workers; protection from abuse and violence and reduction in the demand for commercial sex.

Pillar 3 : Building supportive environments and expanding choices.
This focuses on encouraging women to stop sex work through alternative, employment, skills training, micro credit and efforts to combat stigma. It recommends sex worker involvement in HIV prevention.

Sex workers organisations and civil society groups have responded to the guidance notes by producing a document that sets out their alternative vision of HIV prevention and care. This can be seen as text and video at www.sexworkpolicy.wordpress.com. These are some of their views…

- Despite stated commitments to evidence based programming, little or no evidence can be located to support the overarching priority of reducing the numbers of women who sell sex. Well implemented income generating, vocational training and micro credit programmes are worthwhile as an economic empowerment enables sex workers to improve their lives in many ways) However there is no evidence that rehabilitation and alternative livelihood programmes can successfully reduce the number of sex workers.

- Rather than focussing on helping women to avoid sex work, the UN should encourage member states to improve sex workers conditions and increasing their control over their lives, and thus, their motivation and opportunities to maintain good health.

- There is no evidence that reducing demand for sex work reduces HIV or makes sex work safer or less exploitative.

- HIV/AIDS programmes sometimes drive human rights abuses and further stigmatise sex workers. The UN should provide meaningful guidance for avoiding that.

- The UN recommendation that sex workers health be a matter for "partnerships with law enforcement" is inappropriate. Sex workers' advocates specifically oppose police involvement in sex workers health.
  They claim that police in most countries do/will abuse those powers.

- The policy calls for advances on some of the world's biggest social problems: poverty, lack of access to education, and gender inequality, all with a view to reducing numbers of people in sex work. In this view, every source of social vulnerability and economic weakness is seen as a determinant of entry into sex work. Sex workers are concerned that this could divert resources intended for HIV prevention and care away from evidence based programmes toward longer term and general development goals. This is of particular concern given the recognition in the first paragraph of the UN Guidance Note telling us, "less than one in three sex workers [are] receiving adequate HIV prevention services, and even fewer [are] receiving appropriate treatment, care and support" (Greenhall 07).

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Section Eight : Summaries and Strategies

We have described some of the new policies and interventions for HIV prevention and care that are already in place or on their way and discussed some of the opportunities and threats that they might bring to men, women and transgenders who sell sex, in different ways, in various parts of the world. Much remains to evolve in HIV prevention and care in the coming months and years and there is much to learn. In the meantime, sex workers van play an important role by continuing to advocate for evidence-based programs and policies that reduce vulnerability to HIV and secure access to HIV prevention and care for sex workers and their children.

Although it is obviously impossible to predict the future of HIV prevention we can already see that new "biomedical" technologies could be valuable tools for sex workers but that they could also lead to increased HIV risk and undermine existing HIV prevention and care efforts. However, like other medicines and medical procedures, human rights violations and other damage can occur if they are tested or marketed unethically or incompetently.

We illustrated some of the ways that stigma and sex workers lack of power over their living and working conditions increases vulnerability to HIV and looked at how policies and legal approaches affect vulnerability and facilitate, or obstruct, HIV programs. We argued that future successes in HIV prevention depends on interventions and policies that improve sex workers living and working conditions and ensures their access to services. A case was made for expansion of community led interventions in view no vaccine being forthcoming, and with condoms remaining necessary with the upcoming pills, creams and circumcision. This case is made stronger by the need for community involvement in testing, delivering explaining and monitoring the various new prevention methods and policies.

Many HIV activists have expressed concerns that peer education and empowerment initiatives will be undermined as HIV is "re-medicalised" in the new era of prevention. Certainly we need to be alert to unrealistic and hopes, expectations and claims about the potential of new approaches that promise easier, cheaper, and less controversial HIV prevention. An example of such a claim is that anti-trafficking and rehabilitation/anti-poverty initiatives can reduce prostitution in developing countries to the degree needed to reduce or stop HIV for which there is no evidence or credible statistical and methodological model. Similarly we need to challenge unhelpful and confusing predictions that biomedical prevention will soon eliminate the need for condoms and social interventions or that they can redress power imbalances between men and women that make women vulnerable to HIV
(* see examples in sources and resources)

If there is any single conclusion of this book it is that for the new approaches to be effective we need more strategies and solutions for the old problems.

"The challenge for the microbicides field is to find the correct balance between building enthusiasm and support for microbicides while avoiding raising expectations. Unfulfilled expectations can backfire and create doubt that could erode continued financial and community support."

Global Campaign on Microbicides

Old Problems

At the conclusion of the Changing Landscape of Prevention meeting, where sex workers first began to discuss changes in prevention, Hazera Begum of Durjoy, Bangladesh summarised the feeling of the group. She said, "it is clear to me that for any of these new [biomedical prevention methods] to work for sex workers some of the old problems will have to be solved."

Police confiscate condoms from sex workers in many countries. The photo above is confiscated condoms being presented by police in the US to the media and the court as evidence of prostitution.

Louisville Takes Aim at Parlor Prostitution
The Courier- Journal Louisville Kentucky.
11 July 2004

The following is a list of factors that limit the success of existing HIV prevention methods for sex workers. None of these obstacles to HIV prevention can be overcome easily by simply introducing a drug, a product or a procedure. Nor can any of them be swept away by any single policy or law. Yet, these are the barriers to prevention that must be addressed if microbicides, PrEPs, expanded HIV testing, circumcision, high quality HIV treatment or improvements in condoms are to help limit HIV epidemics.

- Lack of accurate information.
- Lack of motivation to avoid transmitting or contracting HIV.
- The strong preference of men and sometimes women for flesh-to-flesh sexual contact.
- Lack of human and financial resources for HIV prevention, particularly behavioural and social components.
- Poor quality interventions, misinformation.
- Lack of sustained supplies of condoms, lubricants and medications.
- Lack of resources and political support for community development, empowerment and human rights.
- Lack of control for sex workers over conditions in commercial sex workplaces.
- Fear of HIV and sex work stigma.
- Fear of persecution (for example carrying condoms as evidence of homosexuality or prostitution)
- Desire to have a family.
- Lack of political and social will to remove laws and policies that obstruct HIV prevention.
- Physical limitations to condoms use (such as erectile dysfunction).
- Rape and other sexual abuse of men, women and transgender sex workers.
- Lack of risk perception,
- Power imbalances that enable men to demand unprotected sex from wives and sex workers like.
- Drug and alcohol misuse.
- Inaccessible and unfriendly STI services.

Issues and strategies

This is our summary of the issues that have been covered and some recommendations for strategies that sex workers, HIV agencies and human rights organizations might use to address them.

I. Issue: Partially effective biomedical prevention methods are no "magic bullet"

"There is no "magic bullet" for HIV - none of these new HIV prevention methods is likely to be 100 % effective. All would require the continued use of current prevention methods which have already been proven to be effective. It is also essential to ensure risk behaviour does not increase with the introduction of new prevention methods."

The Global Working Group on Prevention

Whichever of the different calculations are most accurate about how many infections microbicides, circumcisions and PrEP might prevent, it is clear the benefits of biomedical prevention will be greatest for women who have one, or very few, partners and do not currently use condoms at all. The protective value will be much lower for people who replace any amount of condom use with a partially effective technology. A key challenge is for sex workers to achieve or maintain adequate levels of condom use. If syringe use is a factor, this would include safe injecting practices. It is particularly important sex workers understand the limitations of PreP, circumcision and microbicides. Thus developing and communicating strong, clear messages to explain partially effective prevention and its implications will be crucial to their success

Unfortunately there are mixed understandings of what "continued use of current prevention methods" means. In fact, to reduce HIV epidemics it must apply at *both* the individual and programme levels. This means that individuals will have to use a condom with any new prevention method to prevent transmission and, for example, quality STI services will need to be provided alongside promotion of any the new drug or product.

The *fact that each of these ''prevention technologies'' ultimately relies on human behaviour – putting on the condoms, inserting the microbicides, taking the pills, deciding to fund a programme – seems not to be noticed."*

Gary Dowsett

Strategies to increase benefits and limit damage of partially effective biomedical interventions for sex workers.

1. More knowledge. At the moment, there are still many important gaps in our knowledge about new prevention technologies. How any of them might work in commercial sex settings and their effect on the attitudes of men who buy sex or run sex businesses have not yet been researched. Research must explore the impact of

each new product in "real world" commercial sex scenarios. This includes, for example, examining the effect of frequent use, of oral ingestion of vaginal products, anal use of vaginal products and of combinations with legal and illegal drugs, hormones and ARVs. Effective and ethical research methods for doing this have not yet been fully developed.

Innovative ways must be developed to ensure that products and medications deliver benefits while avoiding bad consequences. For example, perhaps partially effective microbicides could be approved for sale as a condom lubricant only, rather than, a gel or cream that can be used without a condom.

2. Global leadership. Unambiguous, authoritative statements and information about all aspects of HIV and sex work are needed to guide civil society, academic institutions, governments, researchers and pharmaceutical companies on sex work and HIV prevention and care. The Global Campaign for Microbicides, International Council of AIDS Service Organizations (ICASO), International Microbicide Rectal Working Group, and the AIDS Vaccine Advocacy Coalition (AVAC) are some of several organizations that provide leadership and reliable and accessible information on their websites.

3. Developing complex messages. Because biomedical products and procedures will work differently for different people, and some people should not use them at all, targeted messages will be needed for specific populations. Complex messages about how to use new prevention technologies, along with their limitations, will have to be delivered to male, female and transgender sex workers, their clients and others involved in the sex industry. For example, if microbicides that are suitable for vaginal, but not anal, use become available it will be crucial to for sex workers to know that they need another form of protection if they have anal sex.

Individuals learn and retain information in different ways. Complex health issues are best explained and reinforced when different approaches to send messages are used repeatedly. Various messages should be developed and tested well in advance to prepare for effective dissemination of accurate information.

4. Increased resources for services and information dissemination. Increased resources are urgently needed to take HIV prevention "to scale" – that is, to reach high numbers of sex workers and clients with quality prevention services. New products will generate even more work for HIV prevention organizations. This will impact the mass media, outreach workers, pharmacists, clinic staff and NGOs. Information will need to be made available in print, electronically, as product labels, as targeted educational materials and as "word of mouth".

Expanded specialized services and stronger health systems are both urgently needed to support new prevention methods and increased emphasis on HIV testing and treatment.

5. Sex worker involvement. Sex workers and sex work **projects** must be involved in all stages of the development and introduction of new prevention interventions. Sex workers can offer valuable resources and knowledge in the areas of designing research projects, understanding the needs and working linking communities with government and NGOs. Also, there are sex workers throughout the world with substantial experience in research and project planning and implementation and well developed networks that can quickly share information among sex worker organizations.

The success of any HIV prevention project for sex workers depends on sex worker involvement.

Sex workers need support to "build capacity" to understand and participate in programs for promoting biomedical HIV prevention and policy issues. This is a challenge for sex workers from countries where literacy is low and sex workers have not usually had access to education and most speak a local language only. The APNSW has developed an innovative method for building sex workers knowledge and skills for HIV programming. Called *Making Sex Work Safe in Asia and the Pacific and A Guide to Participatory Production of IEC,* (www.APNSW.org) it uses community art and cultural methods to overcome these barriers.

It is difficult to calculate how many minutes per year of contact we have with each [female] sex worker [in Dhaka]. But it is not enough to meet the needs. It is not enough to even explain condoms which are quite straightforward compared to all these new complex technologies we have heard about over the last few days. My head is spinning as I try to imagine explaining all of this in those few minutes. We need increased resources. We hear they are out there somewhere, but our budgets get smaller each year.

Hazera Begum. Durjoy
Sex Work and the Changing Landscape of Prevention meeting, December 2006.

II. Issue: Access

According to UNAIDS, “fewer than one in five people who are at higher risk for HIV currently have access to effective prevention and less than one in three female sex workers … even less have access to appropriate treatment, care and support”. This raises the question of to what extent the current shortcomings in the success of HIV prevention are due to inadequacies of the methods themselves and what can be attributed to them not being used because people do not have access to them. Without far reaching reform, the problems that create the “condom gap” described in section five will limit access to any new prevention method.

To reach those who need them, approved biomedical prevention products must be correctly priced and easy to find. If they are too cheap and freely available, they maybe misunderstood and misused. Consequently, vital opportunities to deliver complementary messages and services may be lost.
These are some of the important lessons we have been learned about access in the first two decades of HIV.

Strategies to ensure sex workers access to HIV prevention and care.

1. Strengthen and extend procurement and distribution systems. Systems for delivering reliable and sustained supplies of high quality condoms, must be extended to continue to privide condoms and to add new HIV prevention tools to their services.

2. Innovative ways to deliver the tools with information and support.
All condoms, lubricant, PrEP, microbicides and HIV treatment should be distributed with information that encourages and supports correct use and social support.
This information, sometimes called “behaviour change communication”, is much broader than instructions for use of the products or warnings about the dangers of HIV. Strategies for the promotion and distribution of new as well as old prevention products should include increased funding for strategies that aim to deliver accurate information and support services to sex workers.

A businessman who claimed to have invented a spray that acts as an "invisible condom" faces fines for misleading his investors. (www.news.com.au/dailytelegraph) But China’s health and drugs administration have formally approved a “spray-on condom” for which the manufacturer makes similar unsupported claims. Fake products are a serious threat.

Manufacturers, suppliers, public health systems, and governments should work together with sex workers to develop the communication, marketing, logistics, and pricing plans needed to successfully promote condoms and biomedical prevention tools. We need innovative ways to expand access to services too. For example, using the extensive network of sexual and reproductive health services to increase sex workers access to prevention services where there are no specialist projects for sex workers or MSM. Social marketing is another example. It has proved very successful in providing access to condoms, contraceptives and other health commodities to millions of people in developing countries and has been very successful in reaching sex workers and MSM in several countries.

3. Stigma reduction and large scale training programmes for health workers must be increased to successfully increase access to all aspects of HIV prevention and care for sex workers.

4. Licensing and Regulation. Decisions about how products must be licensed for distribution should be based on sound and independent research that has looked closely at the likely impact on male, female and transgender sex workers. Distribution of products containing potentially dangerous substances, such as, HIV drugs, should only be available by prescription or in clinical settings, including community based clinics.

New drugs and products must be carefully labeled so sex workers can easily understand the information. Adequate information and guidance about their correct use, limitations and safety issues suitable for low literacy consumers should be a condition of regulatory approval in many countries and possibly universally.

5. Sex worker involvement. Community mobilisation, peer support and participation in programme design by sex workers have proved to be among the most powerful tools for expanding access to HIV prevention. Local policy makers, clinics and HIV prevention programs should work with sex workers and local NGOs to develop plans for ensuring that the products and the right balance of information are accessible to sex workers.

III. Issue: Sex workers ability to use their chosen prevention method.

Many female sex workers cannot choose their method of contraception or HIV prevention, rich and poor countries alike. They are sometimes compelled to see clients that demand unprotected sex. For sex workers to achieve consistent and correct use of any prevention method, or combination of methods, he or she must have information, access to the method, co-operative clients, supportive of management, co-workers and others around the sex industry, as well as personal motivation. Access to a safe workplace where condoms can be stored and used is crucial too. When all of those things are in place, we can say that sex workers are “empowered”.

The role of clients who are willing to use condoms cannot be overstated. HIV programs have too often focussed on sex workers, and not enough on persuading their clients to stop demanding unprotected commercial sex. Less intrusive prevention products, including better condoms, certainly make it easier for sex workers to provide only safe sexual services.

Strategies for empowerment and sexual health

1. Community Action for Empowerment. Men, women and transgender sex workers can sell sex more safely when: they experience less stigma, violence and discrimination; when they have safe food, housing and medical care; are included in families and communities; and have safe places to work. Sex worker communities in many different places have organized to address marginalization, poverty, violence and lack of access to services and to change conditions in the sex industry. Community responses have also successfully reduced police abuse, child prostitution, human trafficking and other factors that drive sex workers vulnerability to HIV and human rights abuses.

2. More sexual health education for men. "*Tell my clients*" is one of the sex workers movements' slogans on HIV prevention. Condom use in commercial sex is highest where sexual health educational campaigns and condom promotion that normalizes condoms have reached hetero and homosexual men of all ages, and the broader society.

HIV/AIDS projects targeting heterosexual men have been increased. This should expand to cover sexual health, encouraging respect for women and preparing men for responsible fathering.

3. Law and policy reform. Regulations and laws can reduce or increase sex workers control their worklives. International and national policies and laws should be reviewed with the objective of enabling sex workers more control over their working conditions, rather than the aim of preventing people from selling and buying sex. This includes local policy decisions to reduce violence against sex workers by prosecuting offenses, among other things.

4. Rectal microbicides. Men, women and transgenders need both condoms and microbicides that safely and effectively reduce HIV transmission during anal sex.

5. Better condoms now! Some of the tensions about condom use between sex workers and clients could be diffused by condoms that offer more sensation, that are less intrusive and easier to use. In this respect, it would be greatly beneficial to invest energy and resources in condom development as well as biomedical prevention methods.

6. More information and services for sex workers. Although creative and participatory methods for disseminating HIV and other information have proved to be very successful, they rarely reach the "critical mass" of sex workers that need information in most countries. Information should be made available to all sex workers ("scaled up") and it should be broadened to include other aspects of about health and wellbeing issues as well as information about human rights and ways to work and live more safely.

Over the years, critical thinking around targeted intervention program has expanded from the issues of individual risk to those of social vulnerabilities. The changing discourse around social dynamics of HIV/AIDS has led to a revision in the dominant construct of prevention strategy and reinforced the importance of 'collective empowerment' and 'community mobilization' as effective prevention strategies. **Bharati Dey DMSC, Sonagachi Project. India**

IV. Issue: Community involvement in prevention trials

New HIV prevention technologies are thoroughly tested for safety and efficacy. To successfully integrate new products and procedures we will also need to understand how they actually affect behavior and risk taking in commercial sex. For this to happen, ethical methodologies and respectful relationships between communities and researchers are necessary. But this is not always straightforward because biomedical research for HIV prevention raises profound challenges by addressing a complex mix of behavioural, social, cultural, ethical and medical issues from relatively narrow scientific and commercial perspectives.

Meaningful community participation and conditions for trial participants have been key stumbling blocks to prevention research. Clashes between sex worker communities and researchers regarding how that risk is managed have resulted in some trials being halted. This appears set to worsen in the light of the recent collapse of trials of vaccine and prevention methods in which it appears that participation in the trial has actually increased participants risk of contracting HIV. (see box)

"Imagine the uproar if dozens of drug-trial patients in America were to perish from deadly side effects known to the FDA. Consider the commotion if AIDS babies in Europe were to die while being administered placebos rather than potentially life-saving drugs."

The Body Hunters: Testing New Drugs on the World's Poorest Patients by Sonia Shah

Strategies for ethical participation of sex workers in prevention trials.

Sustained action is needed to resolve around sex worker community participation in prevention and vaccine trials. The first recommendation is develop a mechanism enabling sex workers to engage with UNAIDS, research institutions and pharmaceutical companies around participation in prevention trials.

These are some significant factors sex workers say should be in place for trials to be successful and ethical:

1. Agreed protocols and standards to govern drug and vaccine trials (specifically) and prevention research (generally).

2. Resources for capacity building and protocols to support dialogue between researchers, communities and potential trial participants.

3. Improved guidance and governance for researchers developed in consultation with sex workers organisations.

4. Trial participants who contract HIV while in the trial will have guaranteed access to the best possible standard of care available in their country and to ARV treatment regardless of its availability. Those who suffer other direct adverse affects of their participation in a trial should receive adequate compensation. Some suggest that this should be dealt with by the provision of long term health insurance for all participants.

5. Support for community mobilisation and an acceptable environment for sex workers. This might include negotiating with the host government for improved responses to violence against sex workers, fairer law enforcement, funding for a drop in centre or a playground for sex workers children.

6. More ways are needed for engaging sex worker trial participants and communities in designing studies, interpreting data and disseminating results. To do this, methods and language which are meaningful and accessible for community members must be used. The time and inputs sex workers require to "build capacity" and develop "research literacy" should be determined by sex worker groups and delivered by technical support providers that are not connected to the drug company or other institution conducting he study.

When a biological intervention is being tested trial sponsors should have a clear strategy in place for ensuring rapid, affordable and sustainable access to the intervention for trial participants at a minimum, should it prove effective.

UNAIDS

V. Issue: HIV Testing and Treatment.

Growing access to anti-HIV drugs and improved treatment of opportunistic infections has certainly resulted in less HIV related deaths and helped millions of people with HIV to stay well. However, they have some limitations. For instance, they are expensive to supply and administer, not available everywhere, complicated to follow and have long-term side effects. Plus, they cannot eradicate the virus from the human body and resistance to them is growing.

In both rich and poor countries access to ARVs, and the ability to take them, is hampered by many factors. Some of those barriers link to sex work - such as discrimination, homophobia, unfriendliness at clinics and interventions by police. Some are more general barriers such as lack of money, being unable to travel to a clinic and inconsistent supply of medicines. Sex workers have no reason to seek a test if they believe (correctly or not) that they will not have access to treatment if they test positive.

Policies that encourage HIV testing can be problematic for sex workers because discrimination and abuse are highly likely to follow a positive result. Poor HIV testing procedures, lack of confidentiality and quality counselling for male, female and transgender sex workers reduce many sex workers incentive to be tested. This is further complicated in countries where testing is forced on sex workers; where information to identify HIV positive sex workers is deliberately distributed or where extra punishments are given to PLWHA who are caught selling sex .

In addition to the consequences of large number of sex workers not knowing their HIV status, poor testing regimes, discrimination and lack of support for HIV

positive sex workers mean that opportunities are missed to provide positive sex workers with the support they need to protect their health, and that of others. *(Authors note: Mandatory or coerced testing occurs where a sex worker agrees to an HIV or STI test to avoid arrest or to gain a contingent advantage that has been offered.)*

Strategies for Universal Access to HIV treatment and care and ethical HIV testing.

1. Global Leadership. Clearer, stronger leadership is needed to discourage coercion and other abuses of sex workers associated with HIV testing. In particular, UN member states must be reminded that national laws against any aspect of prostitution have no effect on the universal human rights, including those that prohibit coercive testing.

2. Develop acceptable testing regimes for sex workers. Voluntary testing and counselling should not be replaced with other testing protocols, such as provider initiated testing. National governments responsible for testing policy must guarantee sex workers are comfortable with HIV testing procedures, testing is voluntarily and sex workers are collecting their results. Fortunately, UN agencies and donors are in the position to support governments to properly monitor and review testing strategies. To prevent large numbers of sex workers from remaining untested, or being testing coercively, funding for National AIDS Programmes testing programmes should be conditional to voluntary testing of people who buy or sell sex and linked to equitable access to HIV treatment.

3. Improve the quality and availability of counselling. For counsellors to be able to offer appropriate pre and post-test counselling to sex workers, who test negative or positive, dramatic increases are needed in resources for both training and facilities where they are tested.

4. Guarantee access to treatment and care. Clinics and facilities, which offer low barrier access for treatment and care, are critical to the overall well being of a sex worker. Equally critical are the services offered must be in a safe, supportive and non-judgemental environment.

5. Sex Worker Involvement. HIV testing policy should be developed in close consultation with sex workers and there must be meaningful involvement of sex workers in monitoring HIV testing and treatment procedures.

VI. Issue: How will we know what's going on?

We have raised questions to inform the regulations and marketing of them as they become available. How do we explain new products in order to avoid

misunderstandings about their use? Are they being counterfeited? How are clients responding? How do they taste? How are they affecting condom use? Are they affecting reproductive health? Some of these questions may be irrelevant or easily solved. Others will take time to understand. And many more issues that haven't been considered yet are sure to emerge. The current methods of monitoring HIV prevention and care via interested drug companies, university departments and HIV implementing agencies can not provide the independent, complex and "joined–up"

information needed to develop HIV prevention, care interventions and products that reduce vulnerability in general and sex workers vulnerability specifically. Monitoring systems need to be refined to understand the effect new era of prevention and HIV testing has on sex workers in different parts of the world.

Unfortunately, the history of sex workers and HIV prevention does not bide well here. As early as the Montreal AIDS Conference in 1989, sex workers rejected Nonoxynl-9 because it is a vaginal irritant. However it is still sold with claims that it has value as a microbicide despite conclusive evidence that it can increase HIV vulnerability in frequent users. Similarly, sex workers objections toward coercive STI and HIV testing has been ignored and there is considerable policy support for HIV interventions based on "partnerships with law enforcement agencies"

Coerced HIV or STI testing is not acceptable. Sex workers organisations have protested against law enforcement agency involvement in HIV prevention initiatives

Strategies for monitoring policy and interventions

1. Independent mechanisms for reporting and monitoring. Co-ordinated and agreed strategies are essential for monitoring all HIV prevention interventions, including new ones that incorporate biomedical products, new approaches to HIV testing, STI reduction and circumcision. To successfully gather and analyse the information needed to understand and refine interventions a wide range of stakeholders must use the same tools and language - and use them in good faith. To achieve the balance of competing commercial political and ideological interests of the stakeholders needed to manage the new era of HIV prevention significant improvements in global leadership will have to take place.

2. Monitoring and action against counterfeits and false claims has begun with organisations such as the Global Campaign for Microbicides providing responsible leadership.

3. Capacity building. Peer educators, project officers and managers of implementing organisations should be adequately trained and resourced to understand and effectively monitor biomedical HIV prevention and care. Organisations should also provide an environment where they can contribute to the development of tools and systems together with being able to analyze information.

4. Sex worker involvement. Although sex workers have just begun to consider the implications of biomedical developments in prevention and care, there is great potential for them to function in a "watchdog" role in partnership with other civil society and PLHA groups. It would be appropriate for them to form a group, similar to the existing Global Working Group on Sex Work and HIV Policy, which consists of HIV specialists, policy analysts and sex workers from frontline organisations.

"[at the International Aids Conference] in Toronto I realised how difficult it is to raise any concerns about new prevention technologies. When there is so much positive press for them you feel like the party pooper by drawing attention to possible negatives" **Anonymous**

VII. Issue: Global Policy on Sex Work and HIV

According to the Network of Sex Work Projects and the Global Working Group on Sex Work and HIV Policy (sexworkpolicy.wordpress.com), many of the rights claimed by sex workers globally, in the last two decades, are now being eroded because they are seen to conflict with public health, women's rights or national/international security. Trafficking in women is increasingly fused with sex work. This has resulted in attacks on sex workers, police increasingly enforcing HIV prevention measures and clients being criminalised in more and more countries.

Men and transgenders who sell sex are increasingly seen only as "men who have sex with men" which shifts focus away from their needs as sex workers

At the same time, resources are increasingly directed away from sex worker empowerment programmes and toward economic activities aimed at helping women to avoid prostitution. Male and transgender sex workers are now largely excluded in discussions and programming around HIV prevention and care, having been re-categorised as "men who have sex with men" despite protests from sex worker advocates of all genders.

Global policy on HIV should strengthen rather than undermine those efforts and refocus on reducing sex workers vulnerability to HIV. It can do this by addressing human rights violations, including criminal laws against prostitution, violence and lack of citizenship rights.

National, regional and global level policies that will reduce HIV should,

- be formed in partnership with sex workers,
- fully recognise the human rights contained in international human rights covenants and declarations,
- with understanding of how vulnerability is created and sustained or reduced
- be founded in evidence, both traditional and from those affected.

Sex worker mobilisation and collectivisation has been a part of all successful strategies for reducing abuse of sex workers, including their exclusion from HIV and sexual and reproductive health services, trafficking and child sexual abuse. More resources and increased political support for sex worker mobilisation and friendly services are a necessary condition of scaling up and improving HIV prevention and care.

An Aussie sex gel to be coated on condoms

Getty Images

Australian-made sex gel which helps block HIV and herpes infections will be added to condoms in a new bid to beat the emerging epidemic of sexually-transmitted infections (STIs). The experimental lubricant developed by Australian researchers will now be coated on condoms under an agreement signed between Melbourne-based Starpharma and the owner of condom company Durex. The vaginal microbicide, called VivaGel, has been found to prevent HIV and genital herpes in animal and human studies presented at the International AIDS Society conference in Sydney in July. It is designed to work by preventing viruses from entering cells, avoiding infection.

Sydney Morning Herald, October 18, 2007

"Building the capacity of sex workers to take the lead in programmes that respect human and citizen rights has proven to be one of the most successful strategies in preventing the spread of HIV. It promotes solidarity, enables them to reach more of their peers and share their knowledge on health matters. They no longer need to rely on outsiders, thus giving them increased control over their own health."

Mahooba Mahmood, Naripokkho, Bangladesh

Sources and resources

* One of the strategies that will truly contribute to protection of women against infection with HIV is the development and accessibility of products, which women control themselves, whose use they do not have to negotiate, can initiate at their sole discretion and without disclosure to their partners, such as microbicides. Elizabeth N. Mataka, the Executive Director of the Zambia National AIDS Network, Vice Chair of the Global Fund Board and UN Secretary General's Special Envoy on AIDS in Africa.

* If it works, Tenofovir will be a form of prevention women could control. They would not need to get men to put on condoms, nor tell men they are using protection against HIV. And for both men and women, this kind of prevention would not require people to change their sexual behaviour -- avoiding a major obstacle to the effectiveness of HIV prevention today. Cambodia Stops Important Tenofovir Prevention Trial. John S. James. AIDS Treatment News. August 23, 2004. www.thebody.com

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Sex workers take an important role in disseminating information to other sex workers and to men. This role will be crucial to the success of new prevention methods.

Appendix. What Works? Comprehensive, rights based, HIV prevention and care for sex workers at a glance

HIV and STI transmission associated with commercial sex can be reduced by services and policies that empower male, female and transgender sex workers to sell only protected sexual services and access health care, condoms and social justice.

Providing all of these things to most sex workers in a city or country is called "best practice." Many programs begin by providing only some services to a small number of sex workers. Although that can be a good start, to successfully limit epidemics of HIV, STIs, unwanted pregnancies and abuse this must be expanded over time to involve large numbers of sex workers and reach most with the following activities and condictions. All of these components combined are called a comprehensive prevention programme.

- Information for sex workers about HIV, human rights, sexual health, condoms, safe sex and accessing health services. This can be delivered via peer educators, publicity and health professionals.

- Information about HIV, STIs and condoms for men who buy sex and others involved in the sex industry such as sex establishment operators and staff, taxi drivers, police and local authorities.

- Access to condoms, lubrication, medications, contraceptives, clean water and secure food supplies.

- Access to sexual and reproductive health services and medications.

- Freedom from abuse, discrimination, and persecution.

- Safe places to work, live and care for children.

- Psychological and social support and access to resources that enable sex workers to increase their control over their civil, personal and work lives.

- Opportunities that can help sex workers to reduce dependency on commercial sex and to realize their personal goals.

- Confidential HIV testing accompanied by "sex worker friendly" counselling and access to social support, care and treatment for sex workers who test positive for HIV.

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