Sex work and South Africa's health system: addressing the needs of the underserved

Sex work remains illegal and highly stigmatised in South Africa, resulting in sex workers – the majority of whom are internal or cross-border migrants – experiencing ongoing human rights violations and a high HIV burden. High levels of unemployment, limited socio-economic opportunities and associated migration dynamics mean that sex work remains a key livelihood option for many cisgender and transgender women and men in sub-Saharan Africa.

This chapter reviews the health system's response to sex work in South Africa, with a focus on HIV-related programmes. The analysis is based on the World Health Organization's health system 'building blocks' framework and is informed by a policy scan, literature review, consultation with sex work experts, and reflection. We provide an analysis of the politics of much-needed structural interventions such as sex work law reform, the removal of ideological provisions in donor grant agreements, and the need for strong political will to roll-out sex work-specific health programmes.

The authors argue that South Africa will not reach the United Nations Joint Programme on HIV and AIDS (UNAIDS) 90-90-90 targets unless adequate attention and political will are invested in sensitive, appropriate and evidence-based responses to sex worker health.

Limited but important progress has been made in expanding appropriate programmes for sex workers in South Africa. Much more is needed to reach and empower sex workers to keep themselves safe, safeguard public health, and achieve health-related sustainable development goals. Delays in addressing data gaps, implementing global recommendations on sex work law reform and evidence-based interventions continue to impact negatively on sex worker morbidity and mortality, and have wide ranging implications for public health and related expenditure.

Introduction

The healthcare system is a central determinant of health, with quality and access – comprising availability, acceptability and affordability – to health services being recognised as key to achieving equity in health and wellbeing.1 This is especially relevant for populations on the peripheries: those who are often excluded from social welfare provision, face disproportionately high levels of vulnerability to illness, and endure an increased impact of poor health.2 The context of sex work in South Africa places sex workers – referred to here as adults who consent to the sale of sex3 – on the periphery: individuals involved in the sale of sex in South Africa are criminalised; are particularly vulnerable to illness, sexually transmitted infections (STIs), violence and abuse; and are underserved by the current health system. As a result, sex workers face increased exposure to health risks and are often unable to mitigate dangers. These risks are compounded by migration status, sexual orientation, gender non-conformity, working in unsafe spaces where clients are solicited, and through harmful substance use.

This chapter provides a contextual understanding of sex work in South Africa, and an overview of the health and rights inequities experienced by sex workers. These inequities are linked to their exclusion from society, and their dependence on a public health

Terminology, identity politics and sexual behaviours
Gender refers to the social attributes and opportunities associated with being male and female, which are socially constructed, learnt and therefore changeable.3

Biological sex is a classification based on reproductive organs and functions that are present from birth.3

Cisgender refers to the alignment of gender identity and expression to norms and expectations traditionally associated with biological sex.3

Transgender refers to people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth.3

Who is a sex worker?

An important assumption of sex work-specific health care programming is that healthcare users would self-identify as the target group – thus that women, men and transgender people who sell sex would perceive themselves as being 'sex workers' and would want to utilise these services. "Conceptually – but also programmatically some of the biggest challenges for policy-makers and researchers in Africa in addressing this vulnerability [to STIs] are the diverse forms of sex work and their overlap with sexual networks in the general population. The difficulty of distinguishing 'sex work' from transactional sex in all its various manifestations demonstrates this vividly".5

While precise definitions of sex work remain elusive, the outdated sociolegal understanding of 'sex-for-reward' could conceivably include a cascade of sexual interactions including transactional sex, 'sugar-daddies', survival sex and even sex within marriage.6 Although definitions remain varied and imprecise, the importance of peer educators reaching out into sex worker communities and linking health care users to specialised services remains important.

Terminology on sex work and gender identities

Cisgender-female sex workers: Refers to sex workers who were born biologically female and identify as female.

Transgender-female sex workers: Refers to sex workers who were born biologically male but identify as female.

Male sex workers: Refers to sex workers who were born biologically male.

system that may not meet their health needs. Against this background, the chapter reviews current sex worker health interventions in South Africa, and analyses policy and legal frameworks relating to sex workers, the sex work setting and public health. The analysis focuses on the World Health Organization (WHO) health system 'building blocks' framework4 from a sex worker health perspective. The chapter concludes with recommendations for health system strengthening to address the health inequities experienced by sex workers in South Africa.

Methods

A rapid analysis of sex work, health and rights, with a focus on HIV, in the South African context was conducted. The WHO Health Systems Framework was used to analyse the South African health system from a sex work health perspective, structured on the health system building blocks7 (see Figure 1). Data were collected through a policy scan and literature review, supported by engagement with sex worker service providers and reflections on the authors' professional experience. Each author has over eight years' experience of working on issues relating to sex worker health in South Africa, with various areas of focus, including HIV prevention, sex worker human rights advocacy and law reform, and migration and health.

The literature review on sex work and health in South Africa presented in this chapter builds on recently published work and work in press undertaken by the authors, with searches conducted via Science Direct, Pubmed and Google Scholar. Apart from data and literature used to provide a historical perspective of sex work law reform and policy

processes, data sources published between 2005 and 2015 and focusing on sex work, health and rights in the South African and sub-Saharan setting were incorporated. The review of grey literature, policy and technical documents was informed through the authors' ongoing work in this area, involvement in policy spheres, and through engagement with key actors and experts who were invited to share recent unpublished grey literature. A range of sex work experts were contacted via email or telephone and programme documentation was reviewed. Expert key informants included sex workers, programme managers, researchers and representatives from technical agencies, who were requested to provide additional information related to the WHO health system building blocks. Recommendations were developed using a social determinants of health lens.[1]

Key findings

Context

Background to sex work in South Africa

In 2013 it was estimated that between 132 000 and 182 000 people sold sex in South Africa.8 Sex work is an important livelihood strategy and approximately two-thirds of female sex workers in the sub-Saharan region report being responsible for dependants.5 The majority of female sex workers operate on their own and seldom rely on intermediaries (such as 'pimps' or 'controllers'). In South Africa, sex work typically offers higher earnings than other work available for the same education level.9–11 Many part-time sex workers do not identify with the term, concept or identity associated with sex work5,12 and as a result may not be exposed to sex work-specific health promotion campaigns or know about the risks associated with sex work. Sex work and places of solicitation are heterogeneous, such as indoor (e.g. brothels or massage parlours), outdoor (on the street) or through media platforms (e.g. cell-phone, on-line or in newspapers).13

There is a strong association between sex work and migration, usually linked to people's search for improved livelihood options. A study conducted in Johannesburg, Cape Town and Rustenburg found that the majority of female sex workers were either cross-border (46.3%) or internal (39%) migrants.

The impact of criminal law

In South Africa, all aspects of sex work are criminalised, which reinforces and compounds the stigma attached to sex work. Sex workers – and migrants – commonly experience a range of human rights violations that affect their health, including stigma and discrimination from law enforcement officers, criminal justice officials and healthcare providers. High levels of violence perpetuated by clients and police have been widely reported.5,15 Conviction with a criminal record because of the criminalisation of sex work poses additional obstacles if a sex worker chooses to exit sex work and seek other forms of employment.16 South Africa's increasingly restrictive Immigration Act – which makes it difficult for lower-skilled and job-seeking migrants to regularise their stay in the country – presents additional legal challenges for non-national sex workers who may struggle to obtain and maintain the documents required to be in South Africa legally.17,18 This compounds the discrimination experienced from healthcare providers and the police.19

Research has shown that the removal of criminal penalties for sex work – specifically the decriminalisation of sex work where no criminal law is applied and sex work is regulated within a human rights framework and existing labour laws – has a far-reaching impact on sex worker and public health.20 More specifically, a recent

modelling study based on data from Canada, Kenya and India estimated that between 33% and 46% of HIV infections could be averted among female sex workers and clients within a decade – in both generalised and concentrated HIV epidemic contexts – if sex work were decriminalised.21 The Global Commission on HIV and the Law recommends the decriminalisation of sex work; these recommendations were based on over 18 months of research, consultation, and a review of testimonies of people directly affected by HIV-related legal environments from across the world, including submissions from South Africa.20

Sex work and the law

All forms of sex work, including the purchasing of sexual services and living off the proceeds of sex work, are illegal in South Africa.

According to the Sexual Offences Act (23 of 1957) it is a crime to have 'unlawful carnal intercourse' or commit an act of 'indecency' with any person for reward. 'Unlawful carnal intercourse' is defined as sex with anyone other than ones husband or wife. The reward is not clearly explained but it is generally considered to be money. It is also an offence to keep a brothel and conduct related activities. Often, municipal by-laws rather than the Sexual Offences Act are used to arrest sex workers because of the difficulties inherent in proving the elements of the offence, particularly in relation to the client.

The South African Law Reform Commission was charged to research and provide recommendations on law reform for sex work (South African Law Reform Commission Project 107 'Adult Prostitution'). This process has been ongoing for more than 15 years, and the Commission has not yet released recommendations on amendments to this outdated law.22

Sex work, health and H IV

Whilst this chapter will focus on HIV to highlight the ways in which a range of social determinants influence the health and wellbeing of sex workers, individuals who sell sex experience a wide range of health inequities including those related to reproductive health and rights, chronic illness, mental health and substance use.23Unprotected paid sex is a significant factor in the HIV epidemics of sub-Saharan Africa;24 HIV prevalence among sex workers and sex worker clients is about 10–20 times higher than among the general population in the region.25 In 2013, the first multisite integrated

HIV biological behavioural surveillance (IBBS) study was conducted among female sex workers in South Africa. The IBBS (n=2 180) estimated that HIV prevalence among female sex workers was 71.8% in Johannesburg (Gauteng Province); 39.7% in Cape Town (Western Cape Province), and 53.5% in Durban (KwaZulu-Natal Province).26 In 2014, an IBBS found a sample HIV prevalence among 173 female sex workers in Harrismith (Free State Province) and Pietermaritzburg (KwaZulu-Natal Province) to be 88.4%.27 Another study in 2014/15 found HIV prevalence among female sex workers in Port Elizabeth (Eastern Cape Province) (n=410) to be 63.7%.28 These figures indicate that HIV prevalence among female sex workers is 1.9 to 5.3 times higher than among females aged 15 years and older in the general population.29 Equally worrying is the significant proportion of female sex workers who know that they are living with HIV but are not currently on antiretroviral therapy (ART): 12% in Cape Town; 25% in Durban and 38% in Johannesburg.28 A range of barriers – including mobility and their status as migrants – impede sex worker access to health care, HIV

testing, retention in treatment, care and support, and access to HIV prevention technologies. Some of these are described in this section.
Critically, a lack of national data on (1) the number of sex workers who are HIV-positive and have tested for HIV; (2) the number of sex workers living with HIV who are eligible for ART; (3) the number of sex workers on ART, and (4) the number of sex workers on ART who are virologically suppressed, hinders the quantification of progress towards reaching the Joint United Nations Programme on HIV and AIDS (UNAIDS) 90-90-90 targets that are needed to bend the trajectory of the HIV epidemic.30

Factors influencing H IV risk among sex workers

A number of characteristics of the sex work context increase the risk of HIV acquisition and ill-health among sex workers and their partners, most notably that of frequent sexual intercourse with multiple partners where protected sex cannot always be negotiated. Cisgender and transgender women and men who sell sex face different configurations of HIV risk, related to social, biological and behavioural factors.15,31 The majority of sex workers are migrants from elsewhere in South Africa (internal migrants) or from neighbouring countries (cross-border migrants) and their status as migrants presents additional HIV risk factors. Whilst a full discussion of the association between migration and HIV is beyond the scope of this chapter, please see Richter and Vearey (in press).17 In areas where sex workers are poorly organised, negotiating condom use with clients may be particularly fraught and sex workers may not be able to insist on protected sex.32,33 Various studies have documented harmful use of alcohol and drugs in sex work settings, which impacts on sex workers' ability to refuse dangerous clients or to negotiate safer sex.34,35 Violence against sex workers remains high and has been well documented as a risk factor for HIV.36,37 Regrettably, few studies on sex work in South Africa focus on exploring the risk mitigation strategies used by sex workers.5
In the hierarchy of dangers associated with sex work, street based sex workers are often designated as the most vulnerable; they tend to be independent operators not tied to obligations and commissions associated with brothel-based sex work, with flexibility of work and autonomy being prized,38 yet their visibility in public spaces increases their exposure to police arrest, harassment and abuse by the general public.39,40 Attempts at keeping their profession a secret while having sex in cars or public places may impose time and security pressures which impede safer sex.41,42
Whilst the stigmatising attitudes of healthcare workers have been well documented, an increasing evidence base highlights the police practice of using 'condoms as evidence'.43 This involves the police searching sex workers and, when finding condoms in their possession, either confiscating or destroying them, or using them as proof that the person is guilty of prostitution.44 This is in direct conflict with public health policy, and this contradiction is highlighted in the South African National Sex Worker HIV Plan.45

Sex work and the politics of HIV policy and implementation

Despite clear evidence being available since the onset of the HIV and AIDS pandemic showing that sex workers are particularly vulnerable to HIV, and that the sex work context impacts on public health, South Africa's health and policy responses to sex work have a chequered history. South Africa's first AIDS Plan in 1994 recommended that the criminal law around sex work should be removed; several years later, the only mention of sex work in the National HIV/AIDS/STD Strategic Plan for South Africa

2000–2005 was to task several government actors to investigate the decriminalisation of sex work.

The National Strategic Plan (NSP) 2007–2011 included a more rigorous engagement with sex work; it rejected discrimination against sex workers, acknowledged the increased vulnerability of sex workers to HIV, recommended the rolling out of customised prevention packages for sex workers, and proposed that sex work inSouth Africa be decriminalised.46 Regrettably, little changed during that period, with a mid-term review of the 2007 NSP noting scant progress in the implementation of sex worker programmes.47

Significantly, sex workers were recognised as a key population in the National Strategic Plan on HIV, STIs and TB 2012–2016 (the '2012 NSP').48 The drafting of the 2012 NSP in 2011 saw the insertion of several strong human rights provisions including the decriminalisation of sex work. However, these important and progressive additions were removed by Cabinet before the 2012 NSP was launched on World AIDS Day 2011, despite civil society consensus on the inclusion of these provisions.[49] The subsequent South African National AIDS Council (SANAC) compromise with the SANAC Sex Work Sector was the drafting of a separate NSP for sex workers. Regrettably, this comprehensive National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers (the 'SW NSP')50 was never officially launched.

Despite the removal of some key human rights sections, the final version of the 2012 NSP did include a number of key programmatic areas for sex workers. In spite of this, the 2012 NSP Progress Report noted limited successes in reaching the sex worker population, despite citing studies that showed HIV prevalence among sex workers to be 26–59.6%, thus highlighting the urgent need for programmes to reach sex workers. The report described the Sex Worker NSP (that was never officially launched), and a sex workers size estimation survey, as "important achievements".51

In 2015, the SANAC Secretariat brought together a Sex Worker Technical Working Group to draft a South African National Sex Worker HIV Plan 2016–2019 ('the Sex Worker Plan 2016–2019'). This plan was launched in March 2016 and emphasises a "comprehensive and nationally coordinated response". It delineates clear aims and targets, and recommends the decriminalisation of sex work.45

Review of South Africa's health systems building blocks from a sex work perspective

This section presents a brief analysis of current responses to sex worker health in relation to the health systems building blocks, noting successes and shortcomings.

Leadership and governance

Leadership, governance, legislation and policies – and the ways in which they are implemented and monitored – are considered to constitute the most critical and complex health system building block.7 Many of the health inequities that sex workers experience, including the high HIV burden, are compounded by the ongoing criminalisation of sex work in South Africa and the lack of political will to reform criminal law in this regard. UNAIDS, the WHO and the United Nations Development Programme (UNDP) recommend the decriminalisation of sex work.52 These recommendations are informed by recommendations of the Global Commission on HIV and the Law, which synthesised available evidence around the advantages and disadvantages of a range of legal frameworks and their influence on health and rights with a mounting evidence base.20 The delay in legal reform and lack of high-level commitment to address sex work issues in South Africa has contributed to ongoing HIV infections among sex workers, their clients and society at large. The lack of high-

level stewardship to interrogate outdated morally based frameworks that are often used to influence policy and laws also contributes to the high levels of stigma and discrimination faced by sex workers in the community, and ultimately in health facilities.53

Ideologically based (as opposed to evidence-based) considerations in addressing sex work are also evident in international funding decisions. Much of the funding for HIV prevention and programming in South Africa comes from the international community, particularly through the United States Presidents Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight HIV, Tuberculosis and Malaria (the 'Global Fund').54 However, organisations that receive financial support from PEPFAR are required to sign a so-called 'Anti-prostitution Pledge'. According to the United States' 'Leadership Against HIV/ AIDS, Tuberculosis, and Malaria Act of 2003', all non-United States (US) non-governmental organisations (NGOs) that receive United States Government Grants (i.e. PEPFAR, United States Agency for

International Development (USAID), Centers for Disease Control and Prevention (CDC)) are required to sign an agreement with PEPFAR that commits them to the following (section 22 U.S.C. § 7631(f)):

No funds made available to carry out this chapter, or any amendment made by this chapter, may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking, except that this subsection shall not apply to the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, the International AIDS Vaccine Initiative or to any united nations agency.

Even though these funding requirements have been found in various court challenges to violate freedom of speech in the United States and cannot be applied to NGOs in the US ('domestic affiliates') or to its 'foreign affiliates' in other countries,55 they still apply to 'foreign NGOs'.a,56 Commendably, PEPFAR has enabled the scale-up of much-needed services and has thereby averted millions of AIDS-related deaths and prevented HIV infections. Against the backdrop of such far-reaching success and impact, it is regrettable that organisations receiving PEPFAR funds that are aware of sex worker human rights violations enabled under a criminalised system, cannot promote law reform for sex work in case they are in contravention of the Anti-prostitution Pledge.57

Stewardship around enabling all people to realise their rights to health and freedom from discrimination is important. Mobilisation and representation of sex workers on decision-making bodies and public platforms are gaining traction and challenging negative stereotypes of sex workers. Successes include the establishment of the Sisonke Sex Worker Movement (a South African national movement of sex workers) that has grown in size and in political influence. SANAC established a Sex Work (Civil Society) Sector in 2009 comprising representatives involved in sex work, health and rights.49

Due to the high levels of migration and mobility within South Africa and the region, health policy and programmatic responses should engage with migration and enable all people who migrate, including sex workers, to have continued access to public healthcare services.58 Within the Southern African Development Community (SADC), efforts are under way to harmonise responses relating to mobility and healthcare access, including the ratification of a declaration on tuberculosis (TB) in the mines and the drafting of a financing framework for a regional response to communicable diseases and population mobility.58,59

Financing

Globally, less than 1.0% of HIV prevention funding focuses on sex work,60 while fewer than 50.0% of sex workers had access to HIV prevention services in 2009.61,62 This investment-burden of disease mismatch is reflected in South Africa's investment in the HIV response. In 2013/14, R130.7 million (R3.6 million by the Global Fund, R23.7 million by PEPFAR and R103.4 million by the South African Government) was spent on HIV prevention, HIV testing and linkage to care programmes for sex workers. This is equivalent to about 1.5% of spending on ART, half the amount spent on communication for behaviour change, and almost a tenth of the amount spent on HIV testing services for the general population.54

Investments in 2013/14 were higher than in 2011, and reflected investments from the South African Government, PEPFAR and the

Global Fund to support the scale-up of sex worker prevention and testing services. Current funding mechanisms have supported civil society organisations to provide sex work-appropriate services and also enable effective public-private partnerships, largely through the South African Government's HIV/AIDS Conditional Grant,b PEPFAR through CDC and USAID, and the Global Fund's 'Red Umbrella Programme' that is co-ordinated through SANAC and the Networking HIV/AIDS Community of South Africa (NACOSA).63,64

Regrettably, HIV expenditure on ART is not disaggregated by key population group. Current government financing does not allow for the provision of oral pre-exposure prophylaxis, 'Universal Treatment' and 'Test and Treat', which are key components to safeguarding sex worker health. These are currently under consideration by the South African Government.65 Decreasing international donor funding poses a particular threat to sex work programming as it currently accounts for a quarter of direct financing for sex work programmes.54

New mechanisms for financing health care in South Africa are becoming more important as the country moves towards the implementation of National Health Insurance which will finance health services by pooling funds to increase access to quality and affordable personal health services in the country. In the context of the criminalisation of sex work, sex workers will not be able to contribute to National Health Insurance through salary-based taxation, while cross-border migrant sex workers may face particular barriers to care. Compared to existing legislation, the current National Health Insurance White Paper suggests a regression of the right to access public health care for non-nationals, with full fees being proposed for all undocumented migrants and asylum seekers.66 Given the linkages between migration, sex work and HIV, it is essential that access to health care for all – regardless of documentation status or livelihood activity – is ensured within the framework of the National Health Insurance system.

Health workforce

Healthcare providers in the community and in health facilities play an important role in enabling health. An ethical health sector response to sex work would aim to create a safe, effective and non-judgemental space that would attract sex workers – including non national sex workers – to its services, with a workforce capacitated to provide high-quality, acceptable health services.67,68

Peer-delivered prevention, testing and linkage to care services are recommended best practices for sex work programming.52 Peers provide a range of services within South African communities. Between 2012 and 2015, there were 2 240 peer educators employed as part of the National Department of Health's High Transmission Areas

programme, 560 sex work peers through the Global Fund-supported Red Umbrella programme, and 122 through PEPFAR-supported programmes.

In 2012, Quality Assurance Standards for Peer Education and Outreach Programmes for High Risk Vulnerable Populations in South Africa were developed by ICF International, with input from organisations implementing large-scale sex work programmes.69 The National Department of Health's High Transmission Area Guidelines include minimum standards for peer outreach programmes and recommendations for community mobilisation for key populations, including sex workers.70 In 2015, South African Partners used these as part of quality assurance and quality improvement processes for key population peer programmes, including sex worker programmes.71 While a recent systematic review found that community empowerment-based approaches to addressing HIV among sex workers were significantly associated with reductions in HIV, and with increases in consistent condom use with all their clients, it found pernicious challenges to scaling up these programmes, including the legal context, ideological approaches to sex work, and the stigma attached to sex work.72 The Disseminating Avahan Lessons in South Africa Project, implemented by FHI360 between 2011 and 2015, provided technical support to SANAC and the National Department of Health to enhance sex worker-related policy and programmes in South Africa. This project was informed by lessons learnt through India's Avahan project that successfully used sex worker community empowerment to reduce HIV-related morbidity and improve the wellbeing of sex workers.73,74

The clinical setting remains the site of human rights abuses and the unethical treatment of sex workers by healthcare providers. Research with sex workers in South Africa and the region documents a range of problems associated with healthcare provision in these countries: poor treatment and discrimination by healthcare workers; having to pay bribes to obtain services or treatment; being humiliated by healthcare workers; and breaches of confidentiality.5,15 Other studies in South Africa and elsewhere confirm that sex workers' negative experiences with healthcare services act as a barrier to accessing services and contribute to delays in treatment, not accessing treatment, and loss to follow-up with associated poor health outcomes. In addition, non-nationals are known to face challenges in accessing health care, further marginalising cross border migrants engaged in the sex industry.75,76

Initial systems have been developed by civil society organisations to capture human rights violations systematically within the health sector. Systems include a telephonic hotline and paralegal training for peer outreach workers.77 However, data quantifying rights violations in healthcare settings are not currently available.

To our knowledge, the University of Pretoria's medical students' service learning and community-based education programme is the only undergraduate training programme for health professionals that exposes students to community-based HIV-related programming. Through this project, medical students engage with community-based HIV prevention services for sex workers provided by civil society organisations.78 The Desmond Tutu HIV Foundation developed sex worker sensitisation training tools79 and organisations working with sex workers implement in-service health worker sensitisation training around sex work in line with WHO recommendations.52 Most recently, the South African Government partnered in a programme that integrated issues relating to sex work and other key populations. Regrettably, inclusion of this training into medical and nursing training colleges and into regional training centres, and subsequent scale-up, have not happened.80 Laudably, the Southern African HIV Clinicians' Society has recently supported the

decriminalisation of sex work,81 while bodies such as the South African Medical Association and the Nursing Council have yet to develop a position statement on the provision of services for sex workers.
A key concern relates to ensuring treatment continuity for HIV – and other chronic conditions – for migrant and mobile sex workers. The World Health Assembly passed a Resolution in 2008 that provides specifically for the need to improve health systems responses to migrant and mobile populations, which are critical for sex workers in South Africa.58 Whilst healthcare workers currently receive no training on migration, which results in misunderstanding about mobility and movement in the country and region, training modules produced by the International Organization for Migration in partnership with the African Centre for Migration and Society at the University of the Witwatersrand, and helpful guidelines produced by the United Nations High Commissioner for Refugees – in partnership with various organisations including the Southern African HIV Clinicians' Society – are available.

Medical products, vaccines and technologies
Currently, a minimum package of HIV prevention services is provided through peer-delivered mechanisms and a somewhat more comprehensive service from mobile clinics, specialised sex worker health services and the public health sector. Although condoms are widely available, the use of condoms as evidence of sex work remains a barrier to their uptake and use by sex workers.44 Lubricant is not widely distributed and access is limited; a government tender for lubricant was only issued in 2014.
Condoms remain the major
HIV prevention technology, but the limited range of sizes, colours and scents has limited their appeal. Access to female condoms is more limited than male condoms.34 Provincial Departments of Health have started to place orders and receive stock of the National Department of Health's tender for one billion coloured and scented male condoms and 20 million litres of lubricant as part of the Department's efforts to increase condom usage. c Dental dams, a barrier prevention method to prevent STIs through oro-genital and/or oro-anal contact, are not included as a standard part of sex work HIV prevention commodities. While these prevention technologies and their accessibility are of benefit to HIV prevention efforts in general, problems with supply and availability would have a disproportionate effect on sex workers and their clients due to their necessity and increased demand in the sex work setting.
The National Department of Health is developing Oral Pre-Exposure Prophylaxis (PrEP) and Test and Treat guidelines.65 The targets of the Sex Worker Plan 2016–2019 include the provision of PrEP to 3 000 sex workers and that 90% of sex workers who test positive are on ART. HIV self-testing is currently being researched among key populations.83 The National Department of Health's National Contraception and Fertility Planning Policy and Service Delivery Guidelines and National Contraception Clinical Guidelines (2012) explicitly include consideration of sex workers and of migration.84

Information
The provision and use of high-quality information is another building block of an effective health system. Information includes research, surveillance and programmatic data.
A range of quantitative and qualitative sex worker research is ongoing, spanning HIV biomedical prevention research (including oral and topical PrEP and Test and Treat), health systems strengthening (inclusion of sex worker services in existing health

systems), and epidemiology and other social determinants of health (including violence and rights abuses).85–87 The process and ethics of research on sex work is improving and sex workers are more involved in all stages of research. Research–sex worker organisation partnerships are being established, improving the quality and ethical nature of research and enabling advocacy. Despite advances in research and surveillance data, evidence-informed responses are lacking and research gaps remain on male and transgender female sex workers and the non-HIV health burden affecting sex workers.

There is a paucity of sex work programmatic and facility-based data. The Division of Revenue Reporting Act indicators for the High Transmission Areas programme were updated in 2014 to include the number of sex workers seen at High Transmission Area programme sites, which will increase understanding of the programme's sex worker reach.88

The criminalisation of sex work and associated stigma translate into sex worker fears about discussing their occupation with healthcare workers. Furthermore, none of the standard Department of Health tools routinely enquires about sex work, and no indicators in the District Health Information System or Tier.Net collect data from patients who engage in sex work.89 Therefore, there are no data on sex workers who access public health services, or who are on ART, which limits the ability to monitor progress towards reaching the 90-90-90 targets for sex workers.

Some progress is being made to improve referrals and tracking for ART service provision across borders, as well as between provinces within South Africa. This takes the form of a patient-held record and the provision of standardised referral letters. The TB/HIV Care Association has been piloting the use of unique identification numbers to enable tracking of sex workers who access services, potentially from multiple locations, while protecting confidentiality. This mechanism could provide a platform for the use of biometric systems or other systems that link with the government health information systems to improve client management and monitor the impact of interventions.90 Issues of confidentiality remain crucial.

Routine data collection within the health information system does not include any measure of migration or mobility.58 As a result, health system responses are not migration-aware nor responsive to migration. Failure to collect information that can be disaggregated by migration status or sex work prevents monitoring of health system performance in real time, relies on expensive surveillance activities (i.e. IBBS), and will result in problems in managing migration, movement and ART adherence.

Data gaps – including a lack of data on migration and mobility – impact resource allocation and the monitoring of impact. Challenges in linking data between community and facility-based elements should be addressed, as these are important components for tracking linkage to care and adherence, and for continuity of treatment for other conditions.

Service delivery

UNAIDS recommends that the health system's response to sex work should be based on commitments to achieve universal access, a supportive environment, and the reduction of sex worker vulnerability.60 Sex work programming should be guided by the principles of meaningful involvement of sex workers, promotion of rights-affirming public health approaches, and implementation of appropriate interventions.60 The 2014 WHO Key Population HIV Guidelines include a package of essential health sector interventions, which are outlined in Box 2.52

Sex worker healthcare services that have flexible hours, employ non-judgemental staff who offer a confidential service, and include outreach, have been shown to be successful in reducing the incidence of HIV and STIs among sex workers.91 Important progress has been made to increase access to a basic package of HIV prevention services, HIV testing services and linkage to care for sex workers in South Africa, as outlined in the following section.

Box 2: WHO Comprehensive Package for Key Populations

Essential health sector interventions

❖❖ Condom and lubricant programming

❖❖ Harm reduction interventions for substance use

❖❖ Behavioural interventions

❖❖ HIV testing and counselling

❖❖ HIV treatment and care

❖❖ Prevention and management of co-infections (viz. viral hepatitis, TBand mental health conditions)

❖❖ Sexual and reproductive health interventions

Essential strategies for an enabling environment

❖❖ Supportive legislation, policy and financial commitment, including decriminalisation of certain behaviours of key populations

❖❖ Addressing stigma and discrimination

❖❖ Making health services available, accessible and acceptable

❖❖ Community empowerment

❖❖ Addressing violence against people from key populations

Sex worker programming

The increased focus on HIV prevention programming for sex workers has enabled 152 993 interactions with sex workers to be documented between 2012 and 2015 (see Table 1). The majority of programmes employ peer-based mobilisation approaches that include basic behaviour change interventions, prevention commodities, and linkage to testing and other community-based services. This approach is employed through the High Transmissions Area Programme which has the greatest reach, although the need for peers working in areas targeting sex workers to be sex workers themselves was emphasised only in 2014.70

In 2015, the Red Umbrella Programme, implemented by the Sex Workers Education Advocacy Taskforce and 18 other sub-recipient organisations through NACOSA, made contact with approximately 40 000 sex workers per quarter across 70 sites across the country and provided them with basic health services.92 However, a reduction in Global Fund investments for sex work programmes in South Africa has commenced, with the number of Global Fund supported sex worker programmes diminishing to nine districts between 2016 and 2019

Sex worker programmes supported by PEPFAR through USAID and the CDC include the University of the Witwatersrand's Reproductive Health and HIV Institute's sites in the City of Johannesburg, Ekurhuleni and Pretoria, and in collaboration with North Star Alliance, eight sites along transport routes in Gauteng, Northern Cape, KwaZulu-Natal, Mpumalanga, North West, Limpopo and Free State provinces.93 The CDC funds the TB/HIV Care Association to provide mobile peer-based HIV prevention, testing and linkageto- care programmes in five major metropolitan areas;90 Re-Action!

Consulting, which provides HIV-related services to sex workers along transport routes and in mining areas of Mpumalanga and North West provinces; and Health Development and Africa, which provides peer-led prevention programmes targeting sex workers who operate in shebeens and bars in Mpumalanga Province.94

Sex worker-led movements such as Sisonke, and spaces formed for sex workers to come together ('Safe Spaces' in the Red Umbrella Programme, 'Community Advisory Groups' established by the TB/ HIV Care Association, and 'Creative Space' set up by Sisonke) provide mechanisms for community engagement and mobilisation. Novel modalities of research, alongside the development of new information, education and communication materials, have been developed to improve research and to provide sex workers with appropriate and attractive materials (see Box 3). Service delivery has been informed by local evidence, and will be bolstered by the implementation of the Sex Worker Plan 2016–2019.

However, in line with processes of primary health care re-engineering and service integration, approaches should incorporate TB, chronic illnesses, maternal and child health, and other primary health care services into sex worker services.96 The provision of support services and programmes to deal with substance use disorders is also of importance.

Box 3: Innovative communication

The Amaqhawe magazine provides sex workers with information to reduce risk and improve safety, packaged in a glossy magazine format. Nine editions have been developed and 10 236 copies were distributed between July 2012 and September 2015. The magazine has been reported to be a useful resource for sex workers.97

Izwi Lethu newsletter:f Our Voice, a monthly newsletter, written by sex workers, was launched in 2015 as a collaboration between the African

Centre for Migration and Society and the Sisonke Sex Worker Movement. The newsletter has focused on Johannesburg, with special issues featuring Musina and Pretoria. Sex workers participate in a writing workshop to produce stories. An advice column, "Dear MaStoep," is used to respond to sex worker questions. Many sex workers write stories of their trajectories into the sex industry, often tied to their journey to Johannesburg, as well as issues related to violence, homelessness, drug use, HIV, and access to services. One writer composed "The Ten Commandments of Sex Work", including number 9: "Make sure you have enough condoms and go for regular clinic visits" (Issue 7). A guest column provides other health and related information. Izwi Lethu offers sex workers the opportunity to share their stories with sex workers, policy-makers and service providers whose decisions affect them.98

Conclusions

Sex work like much other human behaviour is a complicated experience, and reductionist approaches, in which researchers and public health intervention implementers assume that sexual intercourse is always heterosexual, penile-vaginal, that all clients seek services of sex workers without the knowledge of their spouses, and that sex work is motivated by poverty, may not be as meaningful as when the actual practices are understood.99

Approximately R153000 individuals in South Africa make a living in the sex industry.100 In a context of high unemployment and limited income-generating options, sex work enables many cisgender and transgender women and men to earn a livelihood and to provide for their families. However, the prevailing sex work context involves a number of health risks that are compounded by the criminalisation of sex

work and the challenges associated with a restrictive Immigration Act. Until recently, the rights and health issues of sex workers have been largely ignored and similarly have been reflected in the dearth of information and research available on sex work in South Africa. This omission in turn has shaped blunt responses to the sex work context by the health system and healthcare providers, and has continued to render sex workers invisible.

The pace at which the health system's building blocks are preparing to improve the health outcomes for sex workers has been slow. Current legal frameworks on sex work and migration have far reaching negative health and economic consequences, not only for sex workers, their clients and their families, but also for the population as a whole. The devastating consequences of HIV on the sex worker population is a clarion call for health practitioners, community activists and researchers to demand the rapid implementation of the SANAC Sex Worker Programme 2016–2019.

Recommendations

Leadership and governance

➢➢ The Department of Justice should propel the law reform process and ensure that sex work is decriminalised. Government should provide stewardship and support social norms and values that recognise sex work as work, and ensure that sex workers receive the same protection as other people who work.

Financing

➢➢ The South African Government should increase investments in evidence-based, rights-affirming health programmes to address existing inequities in access to health care for sex workers.

➢➢ Novel methods of private sector financing for sex worker focused programmes should be explored.

➢➢ Financing should support the health and rights-related activities of civil society organisations and sex worker-led movements.

Health workforce

➢➢ The Departments of Education and Health should ensure that pre-service health professional training includes greater emphasis on understanding the social determinants of health and the dimensions of stigma and discrimination. Sensitive and appropriate care for all marginalised groups – including sex workers and migrants – must be emphasised and values clarification training should be conducted.

➢➢ In-service training, particularly in large urban areas, along transport routes and other locations where the demand for sex work is high, should pay increased attention to building health worker capacity to provide sex worker- and migration appropriate and competent services.

➢➢ SANAC and the National Department of Health should implement mechanisms to monitor and quantify human rights violations within the health system and the findings should be used to inform appropriate remedies.

➢➢ The National Department of Health should strengthen mechanisms to enable sex workers to report poor-quality health services. Platforms to register complaints, like MomConnect101 which provides a channel for patients accessing perinatal services to register complaints, could be adapted for use for other sexual and reproductive health service quality improvement.

Medical products, vaccines and technologies

➢➢ Universal access to a minimum package of health services (peer-delivered HIV prevention commodity distribution, peer education and behaviour change, HIV testing services and linkage to other services, including biomedical interventions) should be prioritised.

➢➢ The South African Government should fast-track the inclusion of new HIV prevention methodologies, particularly PrEP, Test and Treat, and access to HIV self-test kits, into an expanded package of services that should be made available in areas with a high HIV burden and areas with large sex worker populations.

➢➢ Human papillomavirus vaccines and cervical screening services and other sexual reproductive and health technologies should be made available to sex workers.

Information

➢➢ Researchers should address current gaps in knowledge around HIV (i.e. gaps among transgender and male sex workers; in areas beyond major metropolitan areas; effectiveness of interventions to retain sex workers in HIV treatment) and the broader health and social factors that are essential for health and rights.

➢➢ The National Department of Health and other health service providers should enhance surveillance systems in order for data to be collected and used at the local level, and such systems should facilitate size estimations, HIV prevalence (and where possible incidence) and risk assessments, as well as measures of entry and retention along the HIV treatment cascade.

➢➢ Information and new research findings should be released and made freely available as soon as possible. This is in line with research ethics that stipulate respect for sex workers who participate in research and the organisations involved. A responsive health system is reliant on high-quality, timeous information.

➢➢ Health information systems should capture information about sex work and migration more efficiently, while ensuring privacy and confidentiality. The use of biometric systems, which can be used for community-based interventions and could link data with government systems while maintaining confidentiality in the interim, should be explored in collaboration with the sex worker community.

➢➢ The intelligent use of information and the decriminalisation of sex work and removal of legal risks posed by breaches in confidentiality are needed to achieve the Sustainable Development Goals.

Service delivery

➢➢The current models of service delivery should be scaled up to ensure continued, universal access.

➢➢ Services should be provided by sensitive and competent staff, with flexible and appropriate hours in locations that are accessible to sex workers.

➢➢ Regional responses around mobility and migration are required to enable harmonisation of protocols for ART, to support retention in care across geographical boundaries, to maximise health outcomes and to reduce the risk of increased costs due to treatment failure and new HIV infections.

Taken from South African health review May 2016

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