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Head, NASCOP

Ministry of Public Health and Sanitation
Foreword

For years, there has been silence at the global level about the disproportionate impact that HIV and AIDS have on MARPs. This silence has led to unabated epidemics and weak HIV control programming targeting these populations. Perpetuating this silence is a dearth of ethically implemented and sound surveillance, epidemiologic and social science research that could inform HIV control responses around the world. HIV prevalence among MARPs is higher than that of the general population in nearly every country that reliably collects and accurately reports HIV and AIDS surveillance data. This has significant implications to the national HIV response strategy.

In Kenya there are an estimated 100,000 new infections every year in Kenya and at least one third of these infections can be attributed to the MARPs. Complicating this situation is the fact that HIV related services targeting MARPs tend to be poorly resourced and operate under outdated policies and sometimes criminal law that is a barrier to effect programming. This is particularly true for HIV prevention programs targeting sex workers and their clients. Currently prevention services reach only a few of the MARPs and therefore there is limited impact from strategies to avert new HIV infections. Globally, recommendations have been made on combination approaches to HIV control in recent years, acknowledging the importance of effectively delivering HIV control interventions tailored to the specific needs of Sex Workers and other MARPs, while addressing more broadly their human rights and legal barriers that undermine access to HIV control services.

The Kenya National HIV Strategic Plan (KNASP III) 2009 – 2013 has identified the drivers of HIV epidemic in the country including MARPs as populations at a high risk of acquiring and transmitting HIV/STI to individuals in the community. The KNASP III has recognized the fact that MARPs also experience barriers that limit their access to health and social services because some of their behaviours and/or practices are both criminalized and stigmatized in society. One of the key MARPs groups are sex workers who form an important epidemiological link for HIV transmission to the general population.

To address this service gap for MARPs, The National AIDS and STIs Control Programme (NASCOP) and partners have developed the National Guidelines for HIV/STI Services for Sex Workers. These guidelines are expected to provide a framework to all service providers in the health sector to create an enabling environment, empower sex workers to reduce their own risk of HIV/STI acquisition and/or transmission, and to seek and get appropriate early diagnosis and treatment of HIV/STIs. Further, these guidelines will create a benchmark against which the services provided to sex workers within the health care system are monitored and evaluated regularly to inform continuous improvement in our quest to improve access, uptake and effective utilization of HIV prevention activities.

We all therefore, need to embrace these national guidelines in earnest, and implement them effectively to ensure that MARPs get optimal health and social services in line with the objectives set out in KNASP III.

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Director of Public Health & Sanitation

Dr F.M Kimani
Director of Medical Services

1. Based on Spectrum modeling estimate, 2009
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Ante-Natal Clinic</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
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<td>AUDIT</td>
<td>Alcohol Use Disorder Identification Test</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change Communication</td>
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<tr>
<td>BSS</td>
<td>Behavioural Surveillance Survey</td>
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<tr>
<td>DAST</td>
<td>Drug Abuse Screening Test</td>
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<tr>
<td>DOTS</td>
<td>Direct Observed Therapy</td>
</tr>
<tr>
<td>EC</td>
<td>Emergency Contraception</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Worker</td>
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<tr>
<td>HAART</td>
<td>Highly Active Antiretroviral Therapy</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>HSV-II</td>
<td>Herpes Simplex Virus Type II</td>
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<tr>
<td>HTC</td>
<td>HIV testing and counseling</td>
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<tr>
<td>GUD</td>
<td>Genital Ulcer Disease</td>
</tr>
<tr>
<td>IDU</td>
<td>Injecting Drug User</td>
</tr>
<tr>
<td>IGA</td>
<td>Income Generating Activities</td>
</tr>
<tr>
<td>KAIS</td>
<td>Kenya AIDS Indicator Survey</td>
</tr>
<tr>
<td>KAP</td>
<td>Knowledge, Attitude, Practice</td>
</tr>
<tr>
<td>KDHS</td>
<td>Kenya Demographic Health Survey</td>
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<td>KNASP</td>
<td>Kenya National AIDS Strategic Plan</td>
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<tr>
<td>MC</td>
<td>Male Circumcision</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
</tr>
<tr>
<td>MARP</td>
<td>Most at Risk Population</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>MSW</td>
<td>Male Sex Worker</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>NACC</td>
<td>National AIDS Control Council</td>
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<tr>
<td>NASCOP</td>
<td>National AIDS and STI Control Programme</td>
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<tr>
<td>NIDU</td>
<td>Non-Injecting Drug Use/User</td>
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<tr>
<td>OIs</td>
<td>Opportunistic Infections</td>
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<tr>
<td>OR</td>
<td>Odds Ratio</td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<tr>
<td>PAC</td>
<td>Post Abortion Care</td>
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<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PITC</td>
<td>Provider Initiated Testing and Counseling</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child transmission</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
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<tr>
<td>SA</td>
<td>Situational Analysis</td>
</tr>
<tr>
<td>SW</td>
<td>Sex Worker</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>United Nations Joint Program on AIDS</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Introduction

In Kenya, 1.3 million people between the ages of 15 – 64 are living with HIV, with a national HIV prevalence of 7.1%. As the HIV prevalence indicates, Kenya is experiencing a generalized HIV epidemic driven by discordance between sex partners, unprotected sex, multiple and/or concurrent partnerships, low male circumcision (MC) among some cultural groups and low knowledge of HIV status. Although there is a generalized epidemic in the country, different dynamics and drivers exist among certain populations increasing their HIV risk. Populations at higher risk for HIV in Kenya include sex workers (SWs) and their clients, men who have sex with men (MSM), prisoners, and Injecting Drugs Users (IDU). These populations account for one third of new HIV infections in Kenya (Figure 1).

FIGURE 1: Distribution of New HIV Infections in Kenya

Sexual dynamics between the general population and populations at increased risk are complex. Populations at increased risk mix sexually with each other and the general population while the general population mix sexually with each other. STI transmission dynamics are affected by the fact that the minority of individuals have a disproportionate number of sex partners and HIV risk. These complex sexual dynamics increase HIV/STI transmission and acquisition as shown in Figure 2.
In the past the Government of Kenya (GoK) has focused less on populations at higher risk for HIV and more on a general population response to the epidemic, but as the evidence above shows, Kenya experiences a heterogenous epidemic with certain populations at higher risk for HIV than the general population. Therefore, more focus needs to be given to populations at higher risk for HIV and especially most-at-risk populations (MARPs), which includes sex workers, their clients, MSM and IDU. Most-at-risk populations have the highest risk of transmitting and acquiring HIV/STI due to increased frequency of high risk sex and drug-related HIV risk behaviors (e.g. unprotected anal and vaginal sex, multiple partners, frequency of partners, unsafe injection practices). MARPs also experience barriers to accessing services because their behaviours are criminalized and stigmatized making them marginalized and hard to reach members of society. Therefore, HIV/STI prevention, care and treatment programs need to be developed and/or tailored to effectively reach and address the particular needs of MARPs. The GoK identified gaps in programming for MARPs and has plans to address these through the 2009-2013 Kenya National HIV/AIDS Strategic Plan (KNASP III). KNASP III focuses on implementing targeted interventions for MARPs to effectively reduce the incidence and burden of HIV in MARPs and the general population by:

1. Developing mechanisms for identifying MARPs and their networks to make it easier to offer them access to prevention interventions;
2. Increasing coverage of a package of HIV/STI and reproductive health services to MARPs; and
3. Strengthening provincial and district capacity to support effective design and implementation of decentralized response plans;

Improving capabilities of programme planners at the provincial and district levels to interpret and use research and surveillance data.

To assist the GoK in increasing coverage of quality programs for MARPs, the National AIDS and STI Control Programme (NASCOP), the National AIDS Control Commission (NACC), and other GoK departments have developed these guidelines for the implementation of a HIV/STI and reproductive health package of services for male (MSW) and female sex workers (FSW) and their sex partners. The commitment to reaching sex workers is in line with international guidance summarized in to following 3 pillars proposed by UNAIDS:

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2. Sex partners include paying and non-paying sex partners (e.g. clients boyfriends/girlfriends, husbands/wives)
3. Sex workers refer to female, male and transgender sex workers. Male sex workers include both male and transgender sex workers.
• Pillar 1: Assure universal access to comprehensive HIV prevention, treatment, care and support
• Pillar 2: Build supportive environments, strengthen partnerships and expand choices
• Pillar 3: Reduce vulnerability and address structural issues

The guidelines presented in this document address both the international pillars and objectives of KNASP III in reducing HIV/STIs among sex workers and their sex partners. Future guidelines will be developed to address programs for MSM and IDU. Although great strides have been made in reducing HIV/STI prevalence among small cohorts of sex workers in Kenya, much work is still needed to reach the intensity and coverage to reduce the burden of disease on sex workers, their clients and the general population.

**Rationale for the Guidelines**
- Promote the public health benefit of HIV/STI and reproductive health services to the individual sex worker, their sex partners and general population
- Standardize development and implementation of programmes for sex workers and their sex partners based on the best available evidence for what is effective

**Goals of the Guidelines**
- Increase access to HIV/STI and reproductive health services for sex workers and their sex partners
- Reduce HIV/STI prevalence and incidence among sex workers and their sex partners

**Objectives of the Guidelines**
- Provide guidance on developing, implementing, monitoring and evaluating HIV/STI programmes for sex workers and their sex partners
- Describe the rationale and components of the HIV/STI package of services for sex workers and their sex partners, which include the following (Figure 3):

**Target Users of the Guidelines:**
This document will be used by service providers, which includes any individual providing services to SWs such as health care workers, peer educators, program staff and implementers as well as policy makers, as the standard for the provision of HIV/STI services for sex workers and their sex partners.

**Methods in Developing the Guidelines:**
This document was developed through a collaborative process with leadership from the Government of Kenya specifically NASCOP and NACC as well as active involvement from law enforcement, other GoK offices, and development and implementing partners. Stakeholder meetings including male and female sex workers were convened to discuss and finalize the HIV/STI package and guidelines.

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4. More detail on the specifics of implementation is provided in the associated package, “Package for Implementation of the National HIV/STI Package of Services for Sex Workers”, which will include training curriculums, M&E tools, QA/QI tools, etc.
5. From this point on service providers refers to the group of individuals who will deliver the components of the HIV/STI package of services to sex workers. This includes peer educators, health care workers, nurses, clinicians, Biomedical officers and program staff.
FIGURE 3: The HIV/STI Package of Services for Sex Workers and Their Sex Partners

Behavioural Components of the HIV/STI Package of Services
- Peer Education and Outreach
- Risk Assessment, Risk Reduction Counselling and Skills Building
- Promotion, Demonstration and Distribution of Male and Female Condoms and Water-Based Lubricants
- Screening and Treatment for Drug and Alcohol Abuse

Biomedical Components of the HIV/STI Package of Services
- HIV Testing and Counselling
- STI Screening and Treatment
- TB Screening and Referral to Treatment
- HIV Care and Treatment
- Reproductive Health Services
  - Family Planning
  - Post-Abortion Care Services
  - Cervical Cancer Screening
- Emergency Contraception
- Post-Exposure Prophylaxis

Structural Interventions
- 100% Condom Use Programme
- Services to Mitigate Sexual Violence
- Support to Expand Choices Beyond Sex Work

Additonal Components of the HIV/STI Package of Services
- Psycho-Social Support
- Family and Social Services

Interventions for Sex Partners of Sex Workers
- Peer Education and Outreach
- Promotion, Demonstration and Distribution of Male and Female Condoms and Water-Based Lubricants
- Male Circumcision
- Access to HIV/STI services
CHAPTER 1: Sex Work and HIV in Kenya

1.1 What is Sex Work?

Sex work is broadly defined as the exchange of money for sexual services. Persons who engage in sex work exchange sex acts for something of value including cash, material items, etc that would otherwise not be extended to them by their sex partners. Sex partners that exchange something of value for sex are referred to as clients of sex workers.

Sex Work versus Transactional Sex

Sex work and transactional sex are often interchanged in discussions of sex work but in these guidelines the terms describe different, albeit overlapping behaviours. During sex work the clear and primary purpose of the sexual interaction is to exchange sex for money and includes the following characteristics:

- Terms of the sexual and financial transaction are usually explicit
- Provision of sexual services is the primary role of the interaction
- Sex work is usually the primary source of income for the sex worker
- Existence of a work routine (pattern of transactions – i.e. weekends only, nightly)
- Organization/pattern of transactions is widely recognized/acknowledged as “sex work” or prostitution
- Usually highly stigmatized

Transactional sex is the exchange of sex for other items of value (e.g cash, food, cell phones, rent) as a non-primary source of income. Transactional sex is primarily motivated by material gain but the primary purpose of each sexual interaction is not material gain, as it is in sex work. In transactional sex partnerships one party provides (transfers) something of perceived value (e.g. income, goods) to another individual (recipient) and the recipient reciprocates by providing sex either immediately or sometime in the future. Transactional sex is more complex and practiced differently depending on societal and cultural belief systems but include the following characteristics:

- Usually provides additional, non-primary source of income or goods
- Sexual services may be understood or presented as secondary to social/role (e.g. bar girl, massage girl)
- Terms of the sexual and financial transaction may be implicit
- Sexual transactions may be sporadic, situational, opportunistic, or reciprocal
- Pattern of interaction may not be openly or widely acknowledged/considered as “prostitution” or “sex work”
- Not necessarily stigmatized (e.g. perceived as “modern”, status-defining, natural part of reciprocal relations)
The literature focusing on women’s participation in transactional sex has identified three primary motivating factors: 1) short-term economic survival, i.e. resources for basic needs, especially during times of economic crisis, 2) longer-term aspirations for a higher standard of living and security; and 3) increasing status among one’s peers or sustaining or enhancing social relationships.11

Persons engaging in transactional sex may also have primary sexual relationships (e.g. marriage, regular main partners) and/or engage in sex work. Sexual relations may also evolve from one type (transactional, commercial, primary) to another. Sexual interactions range on a continuum from normative to non-normative. Primary sexual partnerships are usually considered acceptable and expected relationships (normative) within society while sex work is often stigmatized and considered taboo (non-normative) within society. Transactional sex falls somewhere in the middle on the continuum between normative and non-normative depending on cultural and religious practices and societal norms. Figure 4 displays the overlap and fluidity between sex work, transactional sex and primary sexual partnerships.

Even though individuals may engage in multiple types of sexual interactions these guidelines address women and men engaged in sex work because SWs are stigmatized, hard to reach and have limited access to health services. Also, SWs engage in more frequent HIV risk behaviours including unprotected anal and vaginal sex with multiple partners. In addition, strong evidence exists for effective interventions to prevent HIV in sex workers as opposed to women and men engaging in transactional sex.

Female Sex Workers (FSW)
Female sex workers are women who exchange anal, vaginal and/or oral sex for money or other items of value primarily with men. FSW is the most prominent type of sex work in Kenya. Female sex workers operate throughout the country and range in age, and socio-economic status.

Male and Transgender Sex Workers (MSW)
Men who have sex with men (MSM) is a broad category which includes but is not limited to transgender and male sex workers. According to UNAIDS, “men who have sex with men is used to describe those males who have sex with other males, regardless of whether or not they have sex with women or have a personal or social identity associated with that behaviour such as being ‘gay’, ‘bisexual’ or ‘transgender’.” 13 Male sex workers (MSW) are men who exchange sex for money or items of value with other men but may also exchange sex for money with women. Transgender sex workers are men who exchange sex for money or other material items with other men but who self-identify as female and/or exhibit a range of female characteristics but are biologically male.12 Since these guidelines focus on sex work only male and transgender sex workers will be discussed as opposed to men who have sex with men as a whole. For the remainder of the document the term male sex worker refers to both male and transgender SWs.

Sex Partners of Sex Workers
Sex workers have many different types sex partners. Men and women who exchange money for sex workers are called clients of sex workers. These individuals have a range of professions, education levels, and are from various socio-economic strata. Sex workers may also have clients who become regular sex partners that may or may not exchange money for sex with the sex workers. Sex workers also may have primary partnerships such as boyfriends, girlfriends or spouses who do not provide money for sexual services.
Sex Work versus Sex Trafficking

According to the United Nations, trafficking involves “the recruitment, transportation, transfer, harbouring or receipt of persons by means of threat or use of force or other forms of coercion, abduction or fraud, or deception, of abuse of power…or the giving or receiving of payment or benefits to achieve the consent of a person having control over another person, for the purposes of exploitation”. The majority of women and men engaged in sex work are NOT trafficked but engage in sex work for other economic or social reasons. These guidelines address sex work and not sex trafficking. Since the majority of sex workers are not trafficked, caution should be paid in protecting the rights of sex workers. Sex work is mostly voluntary and is done in the city or town where one is from. This is important as trafficking raids can lead sex work to become more hidden and therefore more dangerous to the health and safety of the individual sex worker. It is important that individuals involved in combating human trafficking understand that the majority of sex workers are not coerced or forced into sex work and therefore are not trafficked into sex work. Individuals who are found to be trafficked should be assisted and removed from the situation.

1.2 Why Do People Enter into Sex Work?

Entry into sex work is driven by:
- Poverty and limited economic/employment opportunities
- Economic support for the family (parents, children, spouse, etc)
- Gender inequality
- Low levels of education
- Substance use, abuse and addiction
1.3 What is the Structure of Sex Work?

The structure of sex work in any given location varies but is characterised by the following:

- Frequency and pattern of sex work – the amount of, the degree of openness and level of formality of the sex work
- Sector/setting of sex work (brothel-based, street-based, venue-based)
- Price/clientele (high, medium, or low price; sex act preference such as anal sex, etc)
- Management Structure (i.e. gatekeepers, controllers) the amount of autonomy SWs have over their working conditions

The list below describes the structure of sex work in Kenya:

- **Street-Based Sex Work**
  Street-based sex work is one of the most common and explicit types of sex work in the country. This type of sex worker solicits clients on the streets, car parks and/or other public places. Sexual services are provided on the side street, in the car, brothels, homes or hotels. Taxi drivers or bar owners may facilitate access to SW but most SW operate independently.

- **Home-Based Sex Work**
  Home-based sex work is the exchange of sex for money in one’s home. This is a popular form of sex work as it allows the individual sex worker and client to retain their privacy. Clients contact sex workers directly and set up appointments to meet with them or frequent the home of known sex workers.

- **Road (Truck Stop) - Based Sex Work**
  Truck-stops and towns along the highways are “hotspots” for sex work. Sex is exchanged with the truck drivers for cash, transport or accommodation. Sexual services are provided in lodgings along the road or in the trucks. Sex workers usually operate independently from the truck stop without gatekeepers or “controllers”.

- **Sex Den – Based Sex Work**
  Sex den-based sex workers operate from an establishment with a number of rooms that clients and SWs can use for sexual activities (similar to a brothel but is not regulated). Clients visit the sex den to drink and make contact with the sex workers. The client may use a room at the sex den or take the sex worker to another location. Taxi drivers, bar owners and bouncers usually facilitate the sex worker – client interaction and may or may not require a portion of the money the sex worker receives from the client.

- **Venue – Based Sex Work**
  Venue-based sex workers exchange sex for money in a designated structure or location. Venue-based sex workers operate from locations such as bars, hotels, areas around flower farms and other locations.
where a large number of people, especially men congregate. Taxi drivers and hotel staff are known to facilitate this type of sex work. Hence the venue will be at a different place most of the time

- **Escort Service**
  Escort service is the most discreet type of sex work. The client usually contacts an escort (i.e. sex worker) by calling a listed phone number, through a contact, hotel staff or online. Services are provided at the client’s home or a hotel room. Escort services are usually run by a management team that requires a certain percentage of the money sex workers receives from clients.

- **Massage Parlour**
  Massage parlours are premises licensed and opened to the public for the provision of massage services. Many times these locations are discreetly used for a range of other services, including sex work. Massage parlour owners usually facilitate this interaction and require a portion of the money given to the sex worker by the client.

- **Beach boys and Male Escorts**
  Bumsters are men and boys engaged by women for social purposes especially to fulfill their need for company during outings, shopping etc, with sex as a secondary service. Beach boys, may provide sexual services to clients of either gender in exchange for something of value.

### 1.4 Sex Work and HIV/STI Risk

Sex workers are at increased risk for HIV/STI. Risk is defined as “the probability of an individual becoming infected by HIV/STI either through his/her own actions knowingly or not, or via another person’s actions.”

Factors that increase sex workers’ HIV/STI risk include:

- Participation in high-risk sex (e.g. unprotected vaginal and/or anal sex)
- Dry sex, douching/drying practices
- Sex with multiple partners
- Frequency of partner change
- Drug and alcohol related-HIV risk behaviours (e.g. unprotected sex, sharing drug injection equipment, etc)
- Higher levels of symptomatic or untreated STIs
- Limited access to health services
- Stigma and marginalisation
- Lack of HIV prevention

Data from Kenya shows that both female and male sex workers are at increased risk for HIV/STIs because of the factors mentioned above. FSW have a high incidence of HIV and other STIs associated with unprotected sex, frequency of partner change, number of sex partners, anal intercourse, dry sex and substance use. Among nationally sampled female sex workers, 16% reported receiving and HIV positive test result. Among female sex workers condom use is moderate with clients but is very low with their regular sex partners (paying or non-paying) due to perceived trust between FSW and their regular sexual partner and/or the partner’s refusal to use a condom. Seventy-seven percent of FSW reported being involved in non-paying sexual relationships most commonly with boyfriends (52%). Female sex workers report an average of 6 different sex partners in a week (both paying and non-paying).
one percent of participants reported ever practicing anal intercourse and 36.1% reported ever practicing dry sex in a study of FSW in Meru. The majority of women surveyed believed anal intercourse and dry sex to be higher risk practices for HIV infection, but only one third and 20% of FSW used condoms during anal intercourse or dry sex, respectively. Alcohol and drug use is commonplace among sex workers with 82% of FSW reporting ever having used alcohol or harmful drugs (miraa, bhangi, heroin, cocaine, mandrax and other illicit substances) of which 80% reported having sex under the influence of alcohol or drugs. Chersich et al (2007) found that binge drinking (5 or more alcoholic drinks on one occasion in the preceding month) among female sex workers was associated with a higher number of sex partners, increased risk of condom breaks, sexual violence and STIs. In the same study FSW who ever reported drinking alcohol were 1.99 times more likely to be HIV-infected than women who reported never drinking alcohol.

Male sex workers are also at increased risk for HIV/STI due to low condom use, unprotected anal sex, high number of sex partners and frequent partner change. Studies in Kenya have shown that male sex workers report low levels of consistent condom use. Unprotected sex among male sex workers in Mombasa was significantly associated with drinking alcohol 3 or more days a week, not knowing HIV can be transmitted via anal sex, self reported burning upon urination within the past 12 months and never receiving a HIV test.

1.5 Sex Work and Vulnerability to HIV/STIs

Sex work has not only increased HIV/STIs sex workers are also more vulnerable to HIV. Vulnerability to HIV “reflects an individual’s or community’s inability to control their risk of HIV infection”. Factors that increase sex workers' vulnerability to HIV/STI include:

- Stigma and marginalization by health and program staff that create barriers for SWs to access health and social services
- Structural and policy barriers that limit access to services for sex workers
- Poverty and lack of economic opportunities, especially for young women
- Gender, economic and power inequalities that limit the ability of sex workers to negotiate safer sex practices (i.e. condom use) and encourage SWs to engage in unsafe sex behaviours (i.e. unprotected vaginal sex) for more money or because of decreased power
- Cultural norms that stigmatize certain behaviours (i.e. male-male sex)
- Violence and rape by clients, regular sex partners, law enforcement, etc
- High geographic mobility interrupting access to health services

Data from a national situational analysis conducted with female sex workers and their clients confirms the presence of these vulnerabilities. Thirty-nine percent of female sex workers report migrating
from regions where they currently stay to practice sex work, with the majority sex workers travelling to Nairobi and Coast Province. Forty six percent of FSW have had primary education while only twenty-two percent of FSW have had secondary education. Eight out of ten FSW have children whom they financially support. These factors increase SW’s vulnerability to HIV/STI.

Various types of sex work pose different levels of HIV/STI risk (i.e. high, medium or low). Table 1 adapted from Harcourt & Donovan (2005)6 outlines the HIV influencing factors that are associated with high, medium or low risk sex work. The individual risk level will be based on the specific behaviours and vulnerabilities experienced by the individual sex worker.

<table>
<thead>
<tr>
<th>TABLE 1: HIV Risk Categories based on Type of Sex Work6</th>
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<td><strong>Level of Risk</strong></td>
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It is important to note that sex work is fluid and dynamic, changing constantly. The structure of sex work will change over time therefore will need to be periodically assessed. The HIV risk behaviours of SWs will remain relatively constant but vulnerabilities will changed therefore users of the guidelines are advised to continually evaluate sex work and HIV in the country to identify and respond to the changing nature of sex work.

Sex work is a mode of HIV/STI transmission between the individual SW, other high-risk groups and the general population. Targeted interventions towards sex workers can reduce their HIV risk and vulnerability as well as reduce the number of new HIV infections among SWs and the general population. The remainder of the guidelines will focus on developing, implementing, monitoring, evaluating and ensuring quality of the HIVSTI package of services for sex workers and their sex partners.
CHAPTER 2: 

Developing HIV/STI Programs for Sex Workers

Prior to an in-depth discussion of developing programs for sex workers and describing the components of the HIV/STI package of services, it is important to emphasize the need to DO NO HARM when working with sex workers. This includes protecting the health and human rights of each sex worker, addressing issues of backlash and stigma that may occur from providing services to this population, and employing a harm reduction approach in delivering services to SWs. Each sex worker has the basic human and health rights afforded to all Kenyans and therefore efforts should be made to safeguard these rights and improve the health status of SWs. Providing services to stigmatized populations may produce backlash, therefore it is advised that programs and policy makers develop plans to minimize opportunities for backlash and address backlash if/when it occurs.

Harm reduction is a pragmatic and humanistic approach to reducing the harms (especially the risk of HIV/STIs and other blood-borne pathogens) to the individual and society from high-risk behaviors such as injection drug use and sex work. The aim of harm reduction for sex work is to reduce the adverse health and social effects of sex work through activities and approaches that safeguard their dignity, humanity and human rights. Harm reduction recognizes that sex work is a part of society, therefore programs should address the needs of sex workers by understanding where the individual is on the continuum of behavior change and help him/her reduce the acquisition and transmission of HIV/STIs. The goal is not necessary for a person to exit sex work but to reduce the burden of HIV/STI on the individual sex worker. The emphasis is on shorter term behavior change goals to reduce the risk of transmission and acquisition of HIV/STIs. The components of the HIV/STI package of services described below are based on reducing public health harm to the individual and larger society. Working with sex workers requires service providers and policy makers protect the health and human rights of the individual and above all DO NO HARM.

Developing HIV/STI Programs for Sex Workers

Effective HIV/STI programs for sex workers are based on a clear understanding of who the sex workers are, where, when and how they do their work, who their clients are, and the factors that affect their use of HIV/STI and other services. This information will help programs reach out and encourage sex workers and their clients to reduce their risk and engage with services. Qualitative and quantitative data may need to be collected periodically throughout the program to identify new populations of sex workers, monitor emerging trends, and assess HIV/STI prevalence. Existing HIV/STI services in a given area may need to be tailored so that they are acceptable, accessible, affordable and appropriate for sex workers and their sex partners.

Key steps in developing HIV/STI programs for sex workers include the following:

1.1 Review of existing data
1.2 Describe and understand the sex worker population
1.3 Determine availability and appropriateness of HIV/STI services
1.4 Tailor services as needed
1.5 Create an enabling environment

When designing programs, sex workers and those involved in the sex work industry, as well as other key stakeholders (gatekeepers, “controllers”, law enforcement, government, community-based organizations, etc), must be involved. A participatory process builds consensus and ownership of the program, empowers SW to seek services, advocate for their health and human rights and helps sustain the program as more individuals and groups have a vested interest in ensuring services and interventions continue.

2.1 Review Existing Data

Reviewing existing data on sex workers in a given area is a necessary first step for planning. Begin by searching the published and unpublished (“grey”) public health and social science literature for relevant studies. Search the Internet and ask stakeholders for unpublished reports that may provide important detail and background on sex workers in the area or region. Stakeholders often have internal reports of assessments or formative work that have not been published. Review existing national-level data on the use of sex workers, as well as any existing data from behavioral surveillance surveys that have been conducted among sex workers or their clients. When possible, the following sources of data should be reviewed: surveys (DHS, KAIS, BSS etc), qualitative studies (ethnographic research, rapid assessment, needs assessment, formative assessment, etc.), program/operational research, policy briefs and best practices literature. This information will help program planners get a broad picture of HIVSTI and sex work in the area and an understanding of what is already known.

2.2 Describe the Sex Worker Populations

In some places, there are no existing data or the data are out of date, of poor quality, or do not address information needed for interventions. Epidemiological studies provide information on disease prevalence but rarely provide information on where to find sex workers or how to engage them in services. Most programs will need to collect additional data to better understand the prevalent forms of sex work in an area and the appropriate response. Qualitative data may be needed to understand where sex work takes place and how sex workers do their work. Quantitative data may be needed to estimate how many sex workers there are in a given area. Different program designs and approaches will depend upon who is selling sex, how many people are involved, where it takes place, and what the overall environment is for obtaining services. For example a catchment area that has only home-based sex workers will need targeting approaches that are different than areas with varying structures of sex work (venue-based, street-based, etc). At a minimum, program planners need to understand the following:

- Description of sex worker populations
- Demographic characteristics of sex workers (gender, age, ethnicity, marital status)
- HIV risk behaviours (unprotected vaginal/anal/oral sex)
- Alcohol and drug use
- Use of services for HIV/STI and reproductive health
• Influencing factors/vulnerabilities (sexual violence, poverty)
• Cultural/traditional practices that may facilitate HIV/STI transmission (dry sex, vaginal douching/cleaning)
• Structure and organization of sex work
• Types and locations (brothel-based, street-based, home-based, etc)
• Typical clients in each sector
• Involvement of “controllers” or “gatekeepers”
• Peak activity hours and days
• Availability and use of condoms
• Policy and environmental factors (e.g. potential for criminalization, relationship with law enforcement)

Formative Research and Rapid Ethnographic Assessment

When designing programs, there is a need for timely, descriptive data about the nature of sex work and how services should be tailored. Data gathered through observations and mapping (see below), in-depth interviews, focus groups, and short surveys can be essential for quickly ascertaining where and when sex work takes place, who the clients are, when sex workers are likely to be available to outreach workers, and what sex workers like and dislike about the services they currently receive. Sometimes this phase is referred to as “formative” because the data are used to inform the design of the program. Formative research draws on some of the same methods as rapid ethnographic assessments and can be limited to asking a few simple questions, or can be more complex.

Rapid ethnographic assessment is a team-based, multi-method data collection and analysis approach that typically includes members of the target population (i.e current and former sex workers) as part of the planning and data collection team. A strength of rapid ethnographic assessments is that they elicit the perspective “from the inside” that is, they seek to understand sex work from the perspective of sex workers and others involved in the industry. Interviews and focus groups with key informants can be conducted with small samples of sex workers, bar owners, taxi drivers, outreach workers, and service providers, as needed. Structured observations at different times of the day or night will help planners identify key locations and know where and when to send outreach workers. Mapping will provide information about where services should be located.

Rapid assessments can vary in size and scope depending upon the needs of the program. In cases where there are no existing data on sex workers, an assessment with a broader scope may be needed. Ongoing programs may find it useful to conduct smaller periodic assessments to monitor emerging trends such as how sex work locations are changing, or where new sex workers are coming from. Either way, it is important to keep in mind that rapid assessments will require training and expertise in qualitative data collection and analysis and should be conducted in conjunction with program staff and sex workers.
Observations and Mapping

Observation and mapping are an integral part of planning for interventions because they help identify patterns of activity and locations that are important for interventions. Structured, focused periodic observations in locations where high risk behaviors take place will help the program understand how sex workers interact with clients, the times of day when sex workers are likely to be busy, and whether there are other individuals who help facilitate sex transactions (e.g. taxi drivers, street children). Mapping involves drawing maps, pictures, or making notes from visual and auditory observations to document physical settings. Mapping should identify locations where high risk activity takes place as well as the locations of existing services and institutions such as police stations. It will be important to document the following through mapping:

- Neighborhoods and locations where sex workers meet or interact with clients, including street corners, bars, massage parlors, entertainment venues, truck stops, and hotels.
- Location and types of STI/HIV and reproductive health services offered in the defined area, whether or not SWs access these services both used and not used by SWs.
- The main zones of activity of community-based organizations targeting SWs.
- Locations of potential barriers to the implementation of interventions; for example, the location of police stations.

Observation and mapping should be carried out prior to designing the program to ensure that services are appropriately located and available at hours when sex workers will use them. Programs should periodically conduct mapping and observation to monitor for changes in patterns of activity and allow the program to make adjustments that ensure it remains “sex worker-friendly.” When determining which locations are most important you would want to consider:

- Identifying sex workers
- Identifying where other sex work is done
- Identifying a variety of key informants

Population Size Estimation

To plan for interventions, program planners and policy makers need to determine the nature and magnitude of sex work. Population size estimation is used to understand the scope of the behaviour and the scale of the response needed. Size estimation can be used at the programmatic level to advocate for SWs and resources, plan, implement and evaluate HIV prevention, care and treatment programs (i.e. coverage, etc). At the national level population size estimates can be used to estimate and project HIV prevalence and/or estimate the distribution of HIV incidence within the country. The process for developing population size estimation is presented in Figure 5.

Various methods exist to document the size of a population and can be categorized into:

Category 1: Methods based on data collected from SWs (census/enumeration, capture/recapture & nomination)
Category 2: Methods based on existing data (multiplier)
Category 3: Methods based on data collected from the general population (population survey, network scale-up)

Challenges to conducting size estimation with SWs include: 1) difficulty in accurately measuring the population, because SWs are highly mobile and move in and out of sex work and 2) unintentionally harming the population if knowing the size and location of sex work adversely affects them (i.e. police raids). Therefore, programs must ensure the human rights of SWs during these activities

Size estimation can be conducted by individual programs or nationally depending on the intended use of the estimates. It is important to remember that size estimation requires ethical approval and should be conducted with input from size estimation experts, sex workers and other stakeholders.

2.3 Determine Availability and Appropriateness of Existing Services

When designing a program, planners need to first know what services are already available, where the gaps are, and whether existing services are being offered in a way that encourages sex workers to use them. Planners need to assess the local capacity and infrastructure for delivering services to sex workers and engage with local organizations and institutions to avoid duplication, improve coordination and strengthen referrals. Who is currently offering STI screening and treatment and where are the services located? Are there community organizations currently conducting outreach with sex workers? How do sex workers get family planning services? Some of this information can be collected by using an assessment tool (See Appendix 1).

Planners should also collect information from sex workers to find out how they feel about services. Are they currently using them? What do they like or dislike? Are the services affordable, accessible, acceptable and appropriate? These data can be collected during the formative phase or rapid assessment, but should also be part of an ongoing process to solicit input from sex workers. This is more likely to result in a program that sex workers will use.
Planners may find that while the infrastructure is in place to deliver services, some service providers might hold judgemental attitudes or are reluctant to conduct a sexual risk assessment. Additional training and tools may be needed for providers to ensure that services become more “sex worker-friendly” (defined in the next chapter).

In general, planners need to think about the following questions:

- What services are currently offered to SWs (or are being used by sex workers)? Sexual partners of SWs?
- Who offers the services?
- Where and during what hours are the services being offered?
- How often are the services being offered (daily, weekly, or once-off)?
- What are the gaps in service delivery that need to be filled?
- How do sex workers feel about these services?

Once program planners understand what services exist and where the gaps are they can modify and tailor the program to fill these gaps. This information also can be used to create a referral network discussed in the next chapter.

### 2.4 Tailor services as needed

Collecting data on the nature and organization of sex work, the size of the sex worker population, and the existing infrastructure for services are essential to developing a localized approach tailored to meet the needs of the specific SW population. Programs will need to plan and prioritize activities and may not be able to implement every component. Although each SW should be offered the package of services, the implementation of the package may differ depending on local need. Chapter 4-8 discuss the package in detail.

### 2.5 Creating an Enabling Environment

Sex workers are stigmatized, hard to reach and have limited access to services. Therefore, programs working with this population need to also consider implementing activities to create an enabling environment. An enabling environment is one in which SW have access to appropriate, affordable, acceptable and assessable health services without being penalized (i.e. arrested for accessing services). Programs can ensure an enabling environment through policy work, advocacy, and ongoing interaction with stakeholders. It is important that program implementers are aware of the potential for political backlash and work closely with government, civil society, and the target population to create an enabling environment for ethical treatment of sex workers. Creating an enabling environment is further described in Chapter 9.
CHAPTER 3:
The HIV/STI Package of Services for Sex Workers

The HIV/STI package of services is described below. Prior to this description it is important to understand the principles in delivering services to sex workers.

3.1 Principles in Service Delivery to Male and Female Sex Workers

Service providers should take into consideration the following principles which contribute to effectiveness and sustainability of HIV/STI interventions with sex workers:

- Ensure interventions do no harm
- Respect SWs' human rights and accord them basic dignity (e.g. services are voluntary)
- Respect SWs' views, knowledge and life experiences
- Recognize that SWs are part of the solution, as they are usually highly motivated to improve their health and well-being
- Build capacity and leadership among SWs in order to facilitate participation and community ownership
- Include clients/partners/ controllers/gatekeepers
- Adapt to the diversity of SW settings and people involved

To ensure increased uptake of the HIV/STI package of services, components need to be “sex worker-friendly”. In addition to the above “Sex-worker friendly” services need to be appropriate, accessible, acceptable and affordable.

- **Appropriate Services**
  Interventions must be culturally appropriate and based on the needs of the local sex worker population. Therefore, SW should be involved in all stages of program planning and implementation to ensure interventions are timely, appropriate and respond to the current needs of the population. Also service providers should be trained on the specific health needs of SWs (e.g. rectal exams for anal STI management).

- **Accessible Services**
  Accessible health services are conveniently located (e.g. near the identified “hotspots” and transport routes) and open at hours that are acceptable to sex workers. Accessible interventions limit the number of logistical barriers, thereby increasing the number of individuals seeking health services. Whenever possible, services should be integrated and/or co-located to expand the coverage for a broader range of health services accessed in a single visit.
• **Acceptable Services**
HIV/STI/reproductive health interventions should not only be accessible but also acceptable to sex workers. Service providers must adopt a non-judgemental, non-stigmatizing attitude and be trained in dealing with the special needs of this population. Health services must be confidential and voluntary to ensure the health and human rights of each sex worker are protected. Service providers need to ensure an adequate and uninterrupted supply of male and female condoms and water-based lubricants. Any health services provided to sex workers must be in line with international standards, current best-practices and guidelines within the country.

• **Affordable services**
Services targeting sex workers need to be free or affordable. A large barrier to accessing services by sex workers is the cost of services and transportation to and from service delivery sites. Since most SWs engage in sex work due to economic needs, programs are advised to offer subsidized or free services and commodities (i.e. male and female condoms and water-based lubricants) to ensure all SW have access to the HIV/STI package of services.

NOTE: Service providers must never coerce a sex worker into accessing services. Sex workers must be provided with the relevant information regarding the available services in order to make an informed decision.

### 3.2 Components of the HIV/STI Package of Services for Sex Workers

The HIV/STI package of services is a combination prevention approach that consists of behavioural, Biomedical and structural components. Combination prevention is considered the way forward for HIV prevention and consists of a bottom-up approach, encouraging ownership of the response by local communities. In conjunction with the behavioural, Biomedical and structural components other interventions (non-Biomedical components and HIV/STI interventions for sex partners of sex workers) are included in the HIV/STI package of services for sex workers. Non-Biomedical components are interventions that improve the overall health status of sex workers. Sex partners of sex workers are an important high risk population who serve as a bridge between the general population and sex workers, therefore targeted interventions are needed to reduce their HIV/STI risk behaviours. Figure 6 provides a visual representation of the various components of the HIV/STI package of services for sex workers.

#### Behavioural Components (Chapter 4)

Behavioural interventions are basic components of the HIV/STI package of services. Behavioural interventions can be implemented with individuals, couples, families, peer groups or networks, institutions, and entire communities. Behavioural components can be offered directly within the community, through a drop-in centre, and/or health facility. The goal of behavioural interventions is to reduce HIV/STI risk behaviours. To reach this goal, interventions attempt to decrease the number of sexual partners, increase the number of sexual acts that are protected, encourage adherence to Biomedical strategies preventing HIV transmission, decrease sharing of needles and syringes, and decrease substance use. To reach these goals with sex workers the following evidence-based behavioural components are included in the HIV/STI package of services:

- Peer Education and Outreach
• Risk Assessment, Risk Reduction Counseling and Skills Building
• Promotion, Demonstration and Distribution of Male and Female Condoms and Water-Based Lubricants
• Screening and Treatment for Drug and Alcohol Abuse

Biomedical Components (Chapter 5)
Biomedical components are HIV/STI and reproductive health services in which sex workers are screened, tested and/or treated for HIV/STI and reproductive health conditions. Some components of the HIV/STI package of services will be facility-based (e.g. HIV care and treatment) while others, such as HIV testing and counseling, can be delivered within the community or through a facility. Biomedical components include:

- HIV Testing and Counseling
- STI Screening and Treatment
- TB Screening and Referral to Treatment
- HIV Care and Treatment
- Reproductive Health Services
  - Family Planning
  - Post-Abortion Care Services
  - Cervical Cancer Screening
- Emergency Contraception
- Post-Exposure Prophylaxis

Structural Components (Chapter 6)
Sex workers are have increased risk and vulnerability to HIV (as described in Chapter 1.) To alter the social, economic, political and/or environmental factors that determine HIV risk and vulnerability, structural interventions need to be implemented. The structural components of the HIV/STI package of services include:

- 100% Condom Use Programme
- Services to Mitigate Sexual Violence
- Support to Expand Choices Beyond Sex Work

Additional Components (Chapter 7)
The other non-Biomedical components of the HIV/STI package consist of services to increase the overall health status and protect the human and health rights of sex workers. These components address the psychological and social harms of sex work. The components are offered in the community drop-in centres or can be facility-based. The non-Biomedical components include:

- Psycho-Social Support
- Family and Social Services

Interventions for Sex Partners of Sex Workers (Chapter 8)
As presented in Chapter 1, sex workers and their partners account for 14% of new infections. Sex partners of sex workers also serve as bridge into the general population, which may increase the spread of HIV/STIs. Interventions for sex workers are incomplete without implementation of basic activities for their sex partners, which include:

- Peer Education and Outreach
- Promotion, Demonstration and Distribution of Condoms and Lubricants

9. Skills building refers to the provision of skills to reduce risk such as condom negotiation skills, etc.
3.3 Service Delivery Models

The HIV/STI package of services include HIV, STI and reproductive health services for sex workers. These services are often delivered independently from one another, increasing the logistical challenges to accessing the entire package. Therefore, efforts should be made to develop service delivery models that increase the number of services provided at a single visit to limit logistical barriers. Several models (described below) may be considered when delivering services to sex workers.34
Program collaboration is a mutually beneficial and well-defined relationship between two or more programs to provide the components of the HIV/STI package of services. A strong referral network (described in section 3.4) is needed to ensure programs effectively collaborate to deliver the package of HIV/STI services. At a minimum service providers in a designated geographic area must collaborate (i.e. establish a strong referral network) to ensure each SW has access to the HIV/STI package of services.

Co-location of services provides components of the HIV/STI package of services in the same physical location (i.e. district hospital). If service integration is not possible, programs are encouraged to locate HIV/STI and reproductive health services in the same location.

Service integration is a distinct method of service delivery that provides SWs with access to services from multiple programs in one location. In this model, various components of the HIV/STI package are offered in the same location (i.e. clinic). If possible, services should be integrated or at least co-located as it gives sex workers access to a range of services in one location with logistical barriers.

### 3.4 Establishing a Referral Network

Since programs may not be designed to include all components of the HIV/STI package, service providers need to establish an effective referral network to ensure each SW has access to the each component of the HIV/STI package of services. This will require government, NGOs, CBOs, and international agencies working together to provide the package of HIV/STI services.

A referral network includes making and tracking referrals, establishing a referral directory, and monitoring the referral process. Referral networks are usually developed for a defined, smaller geographic area and not for the entire country or province. The referrals process ensures the HIV/STI related needs of the SW are assessed and s/he is helped to access the identified services (illustrated in Figure 7). Referrals are strengthened when a structured understanding describing the relationship between organizations/service providers is developed (program collaboration). A structured understanding ensures organizations/providers work together and avoid duplication of services improving the efficiency of program delivery.

#### Developing a Referral Network

To create a referral network service providers will:

- Map the catchment area making note of entry points to services (“SW-friendly” staff, time of day, etc); possible barriers to services (cost, location, etc) and stakeholders/gatekeepers that need to be contacted (gatekeepers, law enforcement, etc)
- Define the target population (type of sex work population, structure, etc) and geographic coverage area
- Identify a coordinating body (most likely governmental body) that will manage and monitor the referral network (who was referred, when and to what services) in the geographic coverage area.
- Identify the needs to be met by the referrals (i.e components of the HIV/STI package not provided by the individual referring program)
- Identify and sensitize a cadre of organizations to provide “sex-worker friendly” services
Develop a structured understanding between organizations within the referral network

Produce a referral listing the location, hours of operation, services provided, cost and point person of each organization within the referral network

Produce a standard referral form and register to be used by all organizations within the referral network to track referrals (NACC or NASCOP - approved forms)

Create a feedback loop for client and program follow-up on the referral service and process

Monitor the referral system, documenting the number of successful referrals (number of SWs who are successfully linked to the service they were referred to and received the service)

**Key Issues in Establishing Referral Networks**

To ensure successful implementation of a referral network it is important that service providers:

- Mobilize the target population to use the services within the referral system (demand creation)
- Ensure that organizations in the referral network are capable of providing “sex worker-friendly” services including addressing issues of capacity, accessibility, and acceptability
- Ensure confidentiality between organizations
- Ensure documentation of the referral process (who was referred, from where, to where, and was the referral successful)
- Enlist feedback on services from the target population and organizations in the referral network
CHAPTER 4:

Behavioural Components of the HIV/STI Package of Services

4.1 Peer Education and Outreach

**Definition:** Peer education and outreach programmes involve the selection and training of peer educators. Individuals who share demographic characteristics or risk behaviours (i.e. sex work) with the target population. Peer educators are trained to modify the knowledge, attitudes, beliefs, or behaviours of their peers through small group or one-on-one interpersonal interactions. This includes referral to Biomedical and non-Biomedical components of the HIV/STI package of services. Outreach is a delivery technique in which peer educators offer peer education within the community where people congregate and/or live. The goal of peer education and outreach is to 1) reduce HIV/STI risk behaviours (i.e. unprotected sex, unsafe injecting practices), 2) promote risk reduction behaviours (e.g. decrease number of partners, increase correct and consistent condom use) and 3) increase the number of peers who access HIV/STI and other services. An unanticipated benefit of many peer education and outreach programs is the empowerment of both the peer educator and peers to advocate for their own health needs by creating a sense of solidarity and collective action within the community.

**Evidence:** A systematic review and meta-analysis found peer education interventions to be significantly associated with increased levels of knowledge about HIV (OR 1.82), reduced STIs prevalence (OR 0.70), increased condom use (OR 1.61) with both casual (OR 1.65) and regular (OR 1.58) sex partners.

**Elements of Peer education and Outreach:** Peer education and outreach programs provide correct health information, demonstrate, promote and distribute condoms and water-based lubricants, encourage HIV/STI risk reduction behaviours and refer peers to Additional Components of the HIV/STI package of services such as STI screening and treatment and HIV testing and counseling. Well-trained peer educators may also be able to conduct risk assessments and help their peers develop a personal risk reduction plan.

Peer education and outreach programs rely heavily on peer educators, who are current or former sex workers who are, accepted and trusted by the sex worker community and motivated and committed to assisting their peers in reducing HIV/STI risk behaviours. They serve as role models and communicate information on HIV/STI prevention, care and treatment and reproductive and sexual health. Peer educators should be provided with initial and refresher training on HIV, signs and symptoms of STIs, family planning, condom demonstration and negotiation skills, counseling and interpersonal skills. For peer educators to be effective on-going supervision by program staff is required. Quality assurance standards for peer education and outreach are included in the package.

Peer education is most effective when an on-going relationship is established and maintained with peers over a period of time. This includes having multiple peer education and outreach sessions with the same
individual or group to provide information, build trust, encourage and reinforce behaviour change. This allows the peer educator to monitor the risk reduction progress of each peer and assist, encourage and motivate him/her to continue recognizing and reducing his/her risk and to access services.

### Elements of Peer Education and Outreach for Sex Workers

- Initial and on-going contact with peers
- Provision of correct HIV/STI and reproductive health information
- Promotion, demonstration and distribution of male/female condoms and water-based lubricants
- Risk assessment, risk reduction counseling and skills building to reduce HIV/STI risk behaviours
- Encourage and motivate peers to know their HIV status
- Assess the needs of SWs and if necessary, refer them to Additional Components of the HIV/STI package

### Expected Outcomes for Sex Workers

### Peer education and Outreach Outcomes for Sex Workers

- Increased correct knowledge of HIV/STI transmission and acquisition
- Increased correct and consistent use of condoms with sex partners
- Increased ability to recognize male and female STI symptoms
- Increased number of SWs who know their correct HIV status
- Increased uptake of components of the SWs package
- Decreased HIV/STI related risk behaviours

### 4.2 Risk Assessment, Risk Reduction Counseling and Skills Building

**Definition:** Individual risk assessment, risk reduction counseling and skills building are strategies intended to enable sex workers to identify and reduce their personal HIV/STI risk behaviours by providing them with information and developing a risk reduction plan and skills. This section provides information conducting a behavioural risk assessment. A more detailed risk assessment focused on Biomedical issues is required for STI screening and management and is discussed in the next chapter.

**Evidence:** A systematic review on the effectiveness of HIV/STI prevention interventions for female sex workers found risk reduction counseling coupled with condom promotion increased condom use and decreased STI or HIV (depending on the study outcome).

**Elements of Risk assessment, Risk reduction Counseling and Skills Building:** The goal of an individualized risk assessment (see Appendix 2) is to provide sex workers with insight into their HIV/STI risk behaviours. When conducting a risk assessment, questions should focus on frequency of oral, anal, and vaginal sex, number of clients and regular partners, condom use with clients and regular sex partners, lubricant use, douching, dry sex and substance use. In asking questions about HIV/STI behaviours, it is important that service providers are able to:
• Normalize the behaviours to reduce embarrassment and stigmatization of the behaviour
• Convey a caring and accepting attitude
• Use non-confrontational language to request more information
• Reassure the sex worker that all information will be treated confidentially and not be used to further stigmatize the individual
• Review responses to confirm understanding and to allow correction of information provided

Information from the risk assessment will assist service providers in providing risk reduction counseling. Risk reduction counseling is a tailored, client-centered behavioural intervention designed to change a person’s knowledge, attitudes, behaviours, or practices in order to reduce HIV/STI risk behaviours. It is most effective if based on the individual’s HIV status. Service providers should encourage SWs to find their own solution to reducing their HIV/STI risk behaviors, thereby ensuring ownership of both the process and outcome of the desired behaviour change. It is important that service providers do not encourage dramatic behaviour change as this will not be manageable or sustainable. Risk reduction plans should have behavioural goals that are:

- Concrete goals that are specific and clear to the SWs
- Incremental goals whereby each behavioural goal builds on a previous one
- Individualized and realistic to the SW’s circumstances and readiness to change his/her behaviour
- Challenging, yet doable to help the SW move along the continuum of decreasing risk behaviour

Once a risk reduction plan is developed, the service provider will provide risk reduction supplies (condoms, lubricants, etc) and help the sex worker develop skills to implement the goals in his/her risk reduction plan (i.e. correct and consistent condom use, condom negotiation skills).

**NOTE:** Well trained peer educators are encouraged to conduct risk assessments, provide risk reduction counseling and skills building since they are more easily accepted by their peers.

<table>
<thead>
<tr>
<th>Elements of Risk Assessment, Risk Reduction Counseling and Skills Building for SWs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Conduct an initial and on-going individual HIV/STI risk assessment</td>
</tr>
<tr>
<td>• Development of a personalized risk reduction plan in collaboration with the sex worker</td>
</tr>
<tr>
<td>• Monitor progress of risk reduction routinely and modify/adjust the plan as necessary</td>
</tr>
<tr>
<td>• Provision of risk reduction supplies (i.e. male/female condoms and lubrication)</td>
</tr>
<tr>
<td>• Skills building to implement the personalized risk reduction plan</td>
</tr>
<tr>
<td>• Routine reinforcement of risk reduction skills</td>
</tr>
<tr>
<td>• Encourage and motivate peers to know their HIV status</td>
</tr>
<tr>
<td>• Assess the needs of SWs regarding Additional Components of the HIV/STI package</td>
</tr>
</tbody>
</table>
Expected Outcomes for Sex Workers

<table>
<thead>
<tr>
<th>Risk Assessment, Risk Reduction Counseling and Skills Building Outcomes for SWs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased HIV/STI risk perception by male and female sex workers</td>
</tr>
<tr>
<td>• Increased correct and consistent use of condoms with sex partners</td>
</tr>
<tr>
<td>• Increased ability to recognize male and female STI symptoms</td>
</tr>
<tr>
<td>• Increased number of SW who know their correct HIV status</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
</tr>
<tr>
<td>• Decreased HIV/STI related risk behaviours</td>
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</tbody>
</table>

4.3: Promotion, Demonstration and Distribution of Condoms and Water-Based Lubricants

**Definition:** A male and female condom is a device (sheath) that is designed to be used during sexual intercourse (vaginal, anal or oral) to reduce HIV/STI transmission, acquisition and unintended pregnancies (from vaginal sex). Water-based lubricants are one of the safest methods to reduce friction between the condom and the skin during sex. The goal of this intervention is to provide male and female sex workers with the information, skills and supplies needed to correctly and consistently use male and female condoms and water-based lubricants.

**Evidence:** Correct and consistent\(^{10}\) condom use reduces HIV incidence by 80% and is the most effective available technology to reduce the sexual transmission of HIV/STIs.\(^{41}\) A review of 62 (19 with sex workers) studies from sub-Saharan Africa and Asia found that interventions promoting condom use significantly increased self-reported condom use. Condom promotion interventions involve peer/health education, condom provision, and/or STI diagnosis and treatment. Fifteen of the 62 studies reported significant increase in condom use with 7 studies reporting condom use more than doubling (>70% post-intervention levels of condom use) with sustained increases over time.\(^{42}\)

**Elements of Condom and Lubricant Promotion, Demonstration and Distribution:** Condoms and lubricants must be readily available for sex workers and their sex partners, either free or at low cost, and conform to global quality standards. Service providers should demonstrate correct male and female condom use on a penile and vaginal model and then request each sex worker demonstrate correct condom use. It is also advised that service providers demonstrate correct use of water-based lubricants. This will help internalize the mechanics of correct condom and lubricant use. Service providers should provide skills to SWs in negotiating condom use with sex partners. Programmes can use peer educators and targeted social marketing to actively promote and create demand for condoms and lubricants. This should be accompanied by education for SWs, clients, gatekeepers and "controllers" on the benefits of correct condom and lubrication use. This will help in creating an enabling environment in which sex workers are able to advocate for condom use with their sex partners.

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10. Consistent condom use is defined as using a condom for all acts of penetrative sexual intercourse (oral, anal, vaginal)
NOTE: Condoms and water-based lubricants must be available within all components of the HIV/STI package.

**Elements of Condom and Lubricant Promotion, Demonstration and Distribution for SWs**

- Provision of information on, and promotion of, male/female condoms and water-based lubricants to SWs, clients, gatekeepers and “controllers”
- Demonstration of male/female condoms using a penile or vaginal model, respectively
- Skills building in negotiating condom use with sex partners, correct condom and water-based lubricant use
- Provision of, or easy access to, an uninterrupted supply of free or subsidized male/female condoms and water-based lubricants
- Targeted social marketing of male/female condoms and water-based lubrication to SWs
- Routine reinforcement of correct condom and water-based lubricant use and condom negotiation skills

For condom and water-based lubricant promotion, demonstration and distribution to be effective, an enabling environment needs to be created. To create this enabling environment programmes need to advocate and promote 100% condom use. Further information on implementing the 100% condom use programme is provided in Chapter 6.

**Expected Outcomes for Sex Workers**

**Condom and Lubricant Promotion, Demonstration and Distribution Outcomes**

- Increased demand of male and female condoms and water-based lubricants
- Increased correct and consistent use of condoms with sex partners
- Increased use of appropriate (water-based) lubricants
- Decreased HIV/STI incidence
- Decreased number of unintended pregnancies (vaginal sex)

**4.4 Screening and Treatment for Drug and Alcohol Abuse**

**Definition:** Screening and treatment for drug and alcohol use includes the identification of misuse, abuse and dependence and referral to appropriate treatment. The use of alcohol, non-injection and injection drugs can increase HIV-related risk behaviours. Multiple studies have found that persons who use alcohol in sexual situations are more likely to have unprotected sex, casual sex, and multiple concurrent partnerships, than persons who do not use alcohol in sexual situations. Alcohol consumption is linked with increased risk of STI and HIV infection, gender-based violence, and non-adherence to anti-retroviral medication.

People who use drugs, including Injecting Drug Users (IDU) are at higher risk of transmitting and acquiring HIV because of increased sexual and drug-related HIV/STI risk behaviours. HIV spreads rapidly among IDU because of direct exposure to the virus through the sharing of contaminated drug injection equipment (e.g., needles, syringes, and cookers). Drug use, including non-injection drug use
(NIDU), has been associated with high-risk sexual behaviours, including unprotected anal sex, having multiple and casual sex partners and exchanging sex for money or drugs.\textsuperscript{45}

**Evidence:** Among sex workers in Kenya, 80% report having sex under the influence of alcohol and drugs, increasing the likelihood of impaired judgement, which may result in unsafe sexual practices (improper use of condoms, limited ability to negotiate condom use, etc).\textsuperscript{14} Therefore service providers need to identify drug and alcohol misuse and dependence and provide referrals to treatment. Early evidence indicates that behavioural interventions may be effective in reducing alcohol-related HIV/STI risk behaviour. A brief risk reduction intervention lasting 60 minutes was significantly associated with a 25% increase in condom use and associated with a decrease in alcohol use during sexual interactions.\textsuperscript{59}

There are two treatment modalities that are effective in reducing HIV related risk behaviours among drug users are, pharmacotherapy programs and psycho-social/behavioural interventions. Opioid substitution therapy, a type of agonist pharmacotherapy program is effective in reducing the frequency of injecting drugs, sharing of injection equipment, number of sex partners, and exchanges of sex for drugs and money. It is also effective in improving retention in drug treatment programs.\textsuperscript{46} Less evidence exists for psychosocial/behavioural interventions in reducing HIV risk behaviours among drug users but results of a meta-analysis suggest that adding a psychosocial intervention to existing programs reduce overall HIV risk behaviour and increase HIV risk reduction skills.\textsuperscript{47}

**Screening and Treatment of Drug and Alcohol Abuse Elements:** Appropriately trained Services providers are advised to screen for drug and alcohol use during interactions with SWs and during other Biomedical and non-Biomedical components of the package of HIV/STI services after appropriate training. Screening for drug and alcohol abuse can be conducted using standard tools. In Kenya, the Alcohol Use Disorders Identification Test (AUDIT) developed by WHO is being used by service providers to identify alcohol misuse, abuse and dependence (Appendix 3).\textsuperscript{48} In Kenya, the Drug Abuse Screening Test (DAST) developed by Gavin, Ross and Skinner (1989) is being used by service providers to identify drug use (Appendix 4).\textsuperscript{49} Service providers are advised to also conduct an HIV/STI risk assessment (Appendix 2) to better understand the individual’s HIV/STI risk behaviors in the context of their possible drug and alcohol use.

Based on drug and alcohol screening results, SWs should be referred to a drug and/or alcohol treatment. In most circumstances SW programmes will need to refer SWs to drug/alcohol treatment program. However, service providers may be able to offer brief motivational interventions, which are 5-10 minute discussions used to provide prevention messages and skills (i.e. condom demonstration, safe disinfection of injecting equipment) to reduce alcohol and drug-related HIV/STI risk behaviours. Treatment modalities for drug and alcohol abuse include pharmacotherapy programs and psychosocial/behavioural interventions described in detail below.

Pharmacotherapy programs provide medically supervised prescription drugs to opioid drug users, which can either be agonist (mimic the effects of the drug being used) or antagonist (block the effects of the drug being used).\textsuperscript{50} Pharmacotherapy programs are shown to have high rates of retention as drug users are able to deal with other major health, social, and legal issues without the burden of withdrawal symptoms. These programs also offer an opportunity for early detection of HIV/STI and other health issues.\textsuperscript{65}
The second treatment modality, behavioural interventions, includes a variety of approaches such as counseling, behavioural therapy, brief behavioural interventions motivational interviewing, self-help programs (i.e. alcoholics anonymous/narcotics anonymous), residential/therapeutic community programs, and abstinence-based programs. Psychosocial interventions can be used to reduce drug and alcohol use and related HIV/STI risk behaviours. These interventions include activities to support lifestyle adjustments, such as reducing drug and alcohol use and HIV/STI risk behaviours and enhancing skills to reduce relapse.

<table>
<thead>
<tr>
<th>Screening and Treatment of Drug and Alcohol Abuse Elements for Sex Workers</th>
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</thead>
<tbody>
<tr>
<td>• Provision of information on alcohol and drug misuse, abuse and dependency and related HIV/STI risk</td>
</tr>
<tr>
<td>• Screen for drug and alcohol misuse, abuse and dependence</td>
</tr>
<tr>
<td>• Conduct HIV/STI risk assessment</td>
</tr>
<tr>
<td>• Brief behavioural interventions and skills building to reduce alcohol/drug use and HIV/STI risk behaviours including alcohol/drug related HIV/STI risk behaviours</td>
</tr>
<tr>
<td>• Referral to appropriate treatment for alcohol and/or drug abuse</td>
</tr>
<tr>
<td>• Promotion, demonstration and distribution of male/female condoms and water-based lubricants</td>
</tr>
<tr>
<td>• Provider-initiated HIV testing and counseling or immediate referral to HTC services</td>
</tr>
<tr>
<td>• Assess the needs of and refer SWs to Additional Components of the HIV/STI package</td>
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</tbody>
</table>

**Special Considerations for Screening and Treatment for Drug and Alcohol Use**

It is important that treatment for drug and alcohol abuse utilise a harm reduction approach. As mentioned in Chapter 3, harm reduction is an approach that recognizes behaviour change is difficult for individuals and therefore programs need to encourage small, incremental changes. This approach also recognises that since completely stopping alcohol or drug use is difficult, service providers should encourage using a step-wise approach to drug and alcohol use reduction, which includes a series of manageable behaviour change goals.

**Expected Outcomes for Sex Workers**

<table>
<thead>
<tr>
<th>Screening and Treatment for Drug and Alcohol Use for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased number of SWs who are screened for drug and/or alcohol abuse and provided with brief interventions to reduce drug and alcohol use and associated HIV risk behaviour</td>
</tr>
<tr>
<td>• Increased number of eligible SWs enrolled in drug and/or alcohol treatment</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
</tr>
<tr>
<td>• Decreased number of SWs who misuse, abuse or are dependent on alcohol and drugs</td>
</tr>
</tbody>
</table>
Chapter 5:  
Biomedical Components of the HIV/STI Package of Services

5.1 HIV Testing and Counseling (VCT)

**Definition:** HIV testing and counseling enables individuals to know their HIV status and receive counseling and support in coping with a positive or negative result. The goal of HTC with SWs is to increase the number of SWs who know their status. The goal for SWs found to be HIV positive is to increase their uptake of HIV care and treatment services and for those found to be HIV-negative to develop risk reduction skills to remain HIV-negative. Service providers must never coerce sex workers into taking a HIV test and HTC must be provided in line with the national guidelines.

**Evidence:** Evidence shows that HTC is an important intervention in and of itself because HIV positive persons who know their status are significantly more likely to reduce their HIV risk behaviours in order to protect HIV-negative partners. Weinhardt, et al (1999) found that HIV positive persons and discordant couples decreased unprotected sex and increased condom use after receiving positive HIV results. Mixed evidence exists for the effectiveness of HTC on HIV negative individuals. A cohort of 401 voluntary HIV counseling and testing (VCT) clients in Kenya showed significant reduction in the number of partners, decrease in acute STIs, and an increase in condom use after receiving a HIV negative result. However, meta-analysis of 27 published studies found that HIV negative respondents did not modify behaviour more than untested ones. There is evidence that hidden populations face substantial barriers in obtaining high quality HTC. For SWs barriers include:

- Fear of positive test result
- Distrust of free HIV testing
- Fear that results will not be confidential
- Fear of stigma and discrimination
- Lack of convenient and “sex worker-friendly” HTC services

**Elements of HIV Testing and Counseling:** During the provision of HTC, the three C’s must be maintained – consent, counseling and confidentiality. HTC service providers provide pre-test information to enable individuals to make an informed decision. Post-test counseling is provided to cope with a positive or negative result and provide appropriate referrals (i.e. HIV care and treatment for HIV positive sex workers, interventions to remain negative for HIV negative SWs). HTC also involves the demonstration and distribution of condoms. Service providers should overcome barriers to access by offering different types of HTC in various settings described below.
Types of HTC

- **Client-initiated HIV testing and counseling** refers to a situation whereby an individual, couple, or group actively seeks out HIV testing and counseling at a site where these services are provided. Client-initiated HTC puts emphasis on tailored risk assessment and counseling.55

- **Provider initiated HIV testing and counseling** (PITC) in health facilities is a model of HIV testing and counseling in which the healthcare provider offers and recommends HIV testing to patients as a standard component of medical care. Since post-test counseling is limited during PITC, service providers may need to refer SWs to further counseling services depending on the individual’s need.56

Settings for HTC

- **Stand-alone HTC centres** are facilities within the community that are not attached to other specific health services and usually target the general population but can be tailored to reach SWs.

- **Outreach HTC** refers to services offered outside a fixed site (i.e. mobile vans, tents, etc) and can be offered in the evening (referred to as moonlight HTC). This flexibility in location is important when targeting SWs, since these populations are highly mobile and may not access fixed sites for HTC.

- **Home-based HTC** is offered in the home of an individual. Home-based HTC provides high coverage and increases acceptance of HTC in the general community. This approach will be useful in reaching sex workers who work from home or do not self-identify as SWs.

- **Health facility HTC** can be initiated from any service delivery point in all sections of a hospital/health facility for any person. SWs should never be forced to receive an HIV test but should be routinely offered PITC during facility visits.

Special Considerations for HTC for Sex Workers

- **Quarterly HIV re-testing for HIV negative SWs**: Recent re-testing guidelines from WHO recommend yearly HIV testing for SWs with more frequent testing based on risk behaviours.57 SWs in Kenya have a high number of sex partners (mean: 3/day) and engage in frequent high-risk behaviours (i.e. unprotected sex)14; it recommended that HIV- negative SWs re-test for HIV at least quarterly.

- **Risk reduction counseling and skills building**: Since SWs do not seek services as frequently as the general population it is important that HTC service providers take the opportunity to conduct risk reduction counseling and skills building based on the HIV test result each time a SW is tested for HIV. Although during PITC in depth risk reduction counseling is rarely offered service providers should consider individualised counseling given the high risk nature of sex work, or at a minimum, referral to counseling services.

- **HIV testing for partners and children of SWs**: SWs are encouraged to promote HTC with their sex partners and children. Couples counseling is an important intervention and may be
appropriate for SWs and their regular partners but should be based on the SWs comfort to disclose his/her status to his/her partner. Many SWs have children who are considered vulnerable to HIV/STIs and therefore HTC should be provided to all children of SWs.

### Elements of HIV Testing and Counseling for Sex Workers

- Targeted marketing of HTC to increase demand for services by SWs
- Individual or group pre-test information session and individual provision of rapid HIV test
- Risk reduction counseling and skills building tailored to individual’s HIV status
- Promotion, demonstration and distribution of male/female condoms and water-based lubricants
- Referral of HIV-positive SWs to HIV care and treatment
- Referral of HIV-positive pregnant SWs to PMTCT services
- Referral of HIV-negative SWs to on-going support/interventions to remain negative
- Quarterly HIV testing and counseling for HIV-negative sex workers
- Provision of HTC for partners and children of sex workers
- Assess the needs of and refer SWs to Additional Components of the HIV/STI package

### Expected Outcomes for Sex Workers

### HIV Testing and Counseling Outcomes for Sex Workers

- Increased uptake of HTC by SW and their partners
- Increased number of SW who correctly know their HIV status
- Increased number of HIV positive SWs who enrol in HIV care and treatment
- Increased uptake of those components of the package needed by SWs
- Increased correct and consistent use of condoms with sex partners
- Decreased HIV/STI related risk behaviours

### 5.2 STI Screening and Treatment

**Definition:** Sexually transmitted infections are viruses, bacteria or fungi transmitted through oral, vaginal and anal sex. Sex workers are at higher risk for STIs due to sex with multiple partners, increased frequency of partner change and unprotected sex. The goal of STI screening and treatment for SWs is to identify, treat and prevent future STI acquisition and transmission.

**Evidence:** Evidence exists for the effectiveness of STI programs to reduce STI and HIV infection in female sex workers. There is strong evidence that STI control programs reduce STIs in female sex workers and their clients. However, the impact of STI control programs in reducing HIV among sex workers remains mixed. Although evidence is mixed, STI screening and treatment is an important part of the HIV/STI package of services because identifying and treating STIs decreases future reproductive health complications such as pelvic inflammatory disease and infertility, and provides an opportunity to reach SWs with HIV/STI prevention messages.
**Elements of STIs Screening and Treatment:** STI screening begins with the service providers obtaining a sexual history from the sex worker. This includes gathering information on the present illness, reproductive and medical history, and a behavioural risk assessment similar to the one described in the previous chapter. Appendix 5 outlines the types of questions that can be asked to both FSW and MSW. STI screening consists of either etiological testings (lab tests) to identify the specific STI and/or syndromic diagnosis (presence of STI symptoms). Screening for anal, oral and genital STIs is recommended for all sex workers. After identification, STI treatment is provided based on laboratory results or syndromic diagnosis. Syndromic management is commonly used in Kenya to diagnosis and treat symptomatic STIs. The algorithms for STI syndromic management are provided in Appendix 6.11

During STI screening and treatment, service providers are expected to ensure the 4Cs – compliance (i.e. adherence), condoms, counseling, and contact tracing (i.e. partner services). Service providers should ensure compliance to STI treatment, promote, demonstrate and distribute condoms and water-based lubricants as well as provide skills to negotiate condom use, provide counseling to prevent future STIs, and if possible identify sex partners that may need treatment. Since Kenya has a generalized HIV epidemic, it is recommended by WHO that all patients receiving STI screening and treatment also receive PITC for HIV.46

**Special Consideration for STI Screening and Treatment**

- **Quarterly STI Syndromic Management:** Sex workers should be screened syndromically at least quarterly and provided treatment for STIs based on national syndromic management guidelines. Screening and treatment can be done at shorter intervals as the need arises. Quarterly screening provides an opportunity to detect and treat STIs early as well as provide risk reduction counseling and access to condoms and water-based lubricants.

- **Presumptive treatment:** Presumptive treatment is based on the local STI prevalence and provided without lab identification of the infecting STI. When the prevalence of a specific STI is high in the geographic area where a sex worker operates and within the sex worker population it may be important to treat all sex workers in that area presumptively. Presumptive treatment is only provided for bacterial STIs and may be provided once or periodically until the specific STI prevalence decreases. Presumptive treatment can also be used to treat SWs before laboratory confirmation. Syphilis, can be symptomatic in certain individuals and presumptively treated before laboratory results confirm the disease.

- **Partner STI treatment of SWs:** To reduce the spread of STIs it is important to treat the sex partners of sex workers. SWs can be provided with treatment to take to their sex partner or encouraged to bring his/her sex partner into the service delivery site for treatment. Partner treatment needs to be done with respect to the confidentiality and privacy of the sex worker. In most cases it will only be possible to provide STI services to regular sex partner(s) since. These individuals can be can easily identified and contacted by the SW.

11. The treatment for each syndrome is not provided as these are currently outdated. New guidance will be coming from NASCOP to fill this gap.
Elements of STI Screening and Treatment for Sex Workers

- Provision of correct STI information including male and female STI symptoms
- Conduct sexual history and behavioural risk assessment
- Screening of anal, oral, and genital STIs syndromically and/or through laboratory testing
- Provision of free or affordable STI treatment in line with national guidelines
- Provision of provider-initiated HIV testing and counseling and referral to appropriate services based on HIV rapid test results
- Ensure the 4 C’s
  - Compliance (i.e. adherence) to prescribed therapy
  - Promotion, demonstration, and distribution of male/female condoms and lubricants
  - Risk reduction counseling and skills building
  - Contact tracing/partner STI treatment when feasible for sex partners of SWs
- Quarterly syndromic management of anal, oral and genital STIs.
- Provision of presumptive treatment for bacterial STIs, when warranted
- Assess the needs of and refer SWs to Additional Components of the HIV/STI package

Expected Outcomes for Sex Workers

Key STI Screening and Treatment Outcomes for Sex Workers

- Increased uptake of STI screening and treatment services
- Increased ability of SWs to recognize male and female STI symptoms
- Increased number of SWs who know their correct HIV status
- Increased correct and consistent use of condoms with sex partners
- Decreased STI prevalence
- Decreased HIV/STI related risk behaviours

5.3 Tuberculosis (TB) Screening and Referral to Treatment

**Definition:** Tuberculosis is a bacterial disease caused mainly by Mycobacterium tuberculosis. TB is transmitted from person to person via droplets from the throat and lungs of people with active respiratory disease (smear-positive sputum). People that are most susceptible to TB are those with a weakened immune system including PLWHA and drug and alcohol abusers. SWs are more likely to be HIV-positive and/or abuse alcohol and drugs, increasing their susceptibility to TB, therefore service providers are advised to screen both HIV positive and negative SWs for TB. Early detection of TB in SWs will decrease the risk of further TB transmission.

**Evidence:** TB is the leading cause of death among HIV-positive individuals in Africa. Kenya is one of the 22 high TB burden countries in the world which collectively contribute 80% of the global TB disease burden. Kenya is experiencing a generalized TB epidemic affecting the young economically productive age groups (15-44 year old). People living with HIV and AIDS are the major subgroup with increased incidence of tuberculosis. Apart from the HIV epidemic, poor socio-economic status leading to
overcrowded slums coupled with poor nutrition and limited access to health services have been identified as contributing factors to the high TB burden. These factors disproportionally affect marginalized populations such as sex workers.\footnote{61}

**Elements of Tuberculosis Screening and Referral to Treatment:** Programs offering services to sex workers are not expected to provide treatment for TB, but should screen both HIV positive and negative SWs during the Biomedical components of the HIV/STI package. Sex workers presenting with signs and symptoms of TB, especially a cough for more than 2-3 weeks, sputum production, and weight loss, should be screened for TB using smear microscopy. The highest priority is to identify and cure infectious cases, those patients who are smear-positive for pulmonary TB (PTB). All smear-positive SWs must immediately be referred to the most convenient direct observed therapy (DOTS) program for TB treatment. SWs who do not know their status should be tested for HIV according to WHO.\footnote{46} Screening and treatment of TB in SWs must follow national guidelines.

<table>
<thead>
<tr>
<th>Elements of TB Screening and Referral to Treatment for Sex Workers</th>
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</thead>
<tbody>
<tr>
<td>• Provision of information on TB symptoms, transmission, links to HIV, and importance of adherence to TB treatment</td>
</tr>
<tr>
<td>• Screening for TB based on national guidelines</td>
</tr>
<tr>
<td>• Provision or referral to TB treatment immediately for suspected and/or diagnosed TB cases</td>
</tr>
<tr>
<td>• Provision of provider initiated HIV testing and counseling and referral to appropriate services based on HIV rapid test results</td>
</tr>
<tr>
<td>• Assess the needs of and refer SWs to Additional Components of the HIV/STI package</td>
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**Expected Outcomes for Sex Workers**

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<thead>
<tr>
<th>Key TB Screening and Referral to Treatment Outcomes for Sex Workers</th>
</tr>
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<tbody>
<tr>
<td>• Increased ability to recognize TB symptoms</td>
</tr>
<tr>
<td>• Increased number of sex workers with active TB who are diagnosed</td>
</tr>
<tr>
<td>• Increased number of TB diagnosed SWs who initiate and adhere to TB treatment</td>
</tr>
<tr>
<td>• Increased number of SWs who know their correct HIV status</td>
</tr>
</tbody>
</table>

### 5.4 HIV Care and Treatment

**Definition:** HIV care and treatment includes interventions to maintain the health and well-being of HIV positive individuals. The goal of HIV care and treatment is to restore immune system, reduce HIV and AIDS related morbidity and mortality, improve quality of life, decrease viral load and, reduce HIV transmission to partners of SW.\footnote{62} HIV-positive SWs must have access to HIV care and treatment in line with national guidelines.

**Evidence:** Highly active antiretroviral therapy (HAART) has been shown to be effective in slowing down the progression of AIDS and in reducing HIV-related illnesses and death.\footnote{63} Improving access to HAART for HIV positive SW is feasible and effective. A prospective study of 119 HIV positive sex
workers initiated on HAART in Burkina Faso resulted in increased probability of survival and increased CD4+ count after 36 months.64

**Elements of HIV Care and Treatment:** Sex workers should have access to a core package of HIV care and treatment services, which includes Biomedical assessments of WHO staging, provision of cotrimoxazole prophylaxis, antiretroviral treatment for those eligible (based on WHO staging and Biomedical assessment), PMTCT for pregnant women, management of opportunistic infections (OIs) (i.e. TB, STI, etc), prevention with positive interventions, psychosocial support, palliative care, and symptom management including home-based care, and safe drinking water and sanitation interventions. 65,66

**Special Considerations for HIV Care and Treatment with Sex Workers**

- **Ensure accessible services:** To increase HIV care and treatment access by SWs it may beneficial to modify comprehensive care centres hours to accommodate the SW’s, work schedule, train service providers on delivering “sex-worker friendly” services, and create demand for the services through targeted outreach and education.

- **Ensure uninterrupted supply of ART and/or OI prophylaxis:** Sex workers are highly mobile and move within and between countries. Due to this high mobility, SWs may need to be provided with ARVs to cover longer periods of time or link to other clinics offering ARVs to ensure an uninterrupted supply of drugs.

- **Tailored “prevention with positive” interventions:** Prevention with positive interventions are designed to reduce HIV transmission between sex partners and increase the well-being of the person living with HIV. For SWs, positive prevention interventions may need to be modified given the primary source of income for these women is the exchange of sex for money. Many sex workers may not be able or willing to leave sex work; therefore tailored risk reduction counseling for HIV-positive sex workers is a crucial component of positive prevention and should focus on reducing risk of HIV transmission through:
  1. Uninterrupted supply of condoms and lubricants
  2. Skills building for correct and consistent male and female condom and water-based lubricant use
  3. Promotion of 100% condom use with all sex partners
  4. Risk assessment and risk reduction counseling to reduce the number of sex partners (although this may be difficult given this is the primary source of income for sex workers) and other HIV risk behaviors (i.e. unprotected sex, injection drug use)
  5. Provision of services to expand choices beyond sex work

In addition, HIV positive SWs suffer dual stigma of being HIV positive and a sex worker. Tailored psychosocial individual or group support may be warranted to address these issues.

- **Screening and treatment for alcohol and drug abuse:** Many sex workers abuse drugs and alcohol, therefore service providers need to screen and treat SWs for alcohol and drug abuse. Alcohol and drug use interferes with adherence to ARVs and some illicit drugs are known to resulting adverse reactions when combined with ARVs.
• **Quarterly STI Screening** - HIV-positive sex workers should be syndromically screened at least quarterly and provided treatment. Quarterly screening provides an opportunity to detect and treat anal, oral, and genital STIs early, deliver risk reduction counseling and increase access to condoms and lubrication.

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### Elements of HIV Care and Treatment for Sex Workers

- Provision of HIV care and treatment information (benefits and limitations of ART, recognition and benefits of early OI treatment, importance of treatment adherence, etc)
- Baseline and on-going Biomedical and laboratory assessment
- Initiation and uninterrupted provision of cotrimoxazole prophylaxis and/or ARVs for eligible SWs
- Screening and treatment of opportunistic infections (TB, Hepatitis B and C, etc)
- Tailored prevention with positives interventions for SWs
- Adherence counseling including alcohol/drug abuse screening and treatment, if warranted
- Defaulter tracing and tracking
- Provision of PMTCT services for pregnant HIV-positive SWs
- Provision of HTC for sex partners and family of SWs
- Quarterly screening and treatment of STIs
- Assess the needs of and refer SWs to Additional Components of the HIV/STI package

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### Expected Outcomes for Sex Workers

### HIV Care and Treatment Outcomes for Sex Workers

- Increased number of HIV positive SWs who enroll in HIV care and treatment
- Increased the number of eligible SWs initiated on ART
- Increased correct and consistent condom use with sex partners
- Increased number of family members and sex partners of SWs who know their correct HIV status
- Increased uptake of those components of the package needed by SWs
- Decreased HIV/STI related risk behaviours

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### 5.5 Reproductive Health (RH) Services

Reproductive health services ensure men and women have access to prevention, care, and treatment for diseases, infections, and other health related conditions that affect the reproductive system. Programs targeting sex workers should provide access to the following reproductive health services, as needed:

- Family planning services
- Post-abortion services
- Cervical cancer screening
If programs targeting sex workers cannot provide these RH services on-site, the program should link to “sex-worker friendly” RH services through a strong referral system.

5.5.1 Family Planning (FP)

**Definition:** “Family planning helps women and men make informed choices about their sexual and reproductive lives, including the timing and spacing of births, which can improve their own health and substantially increase their child’s chances of survival and good health”. Family planning includes barrier methods such as condoms and diaphragms, contraceptive pills (combined or progestin-only therapy), injectable contraceptives, and intrauterine devices (IUD). For sex workers the goal is to provide easy, free or affordable access to family planning services.

**Need:** The unmet need for family planning services was estimated to be 25% among which 20% of births were unwanted and 25% mistimed. Among HIV-positive women, 67% desired to limit or space births, and of these 59% were not using a modern method of contraception at the time of the study. These data suggest a large unmet need for family planning among women. Since sex workers are highly stigmatized and engage in riskier sex their unmet needs are likely to be higher.

**Elements of Family Planning:** Family planning includes various methods and must be prescribed based on medical eligibility. It is important that service providers emphasize the need for dual protection (using both condoms and another FP method), since condoms are the only family planning method that can prevent HIV/STIs. Service providers must offer PITC quarterly to HIV-negative SWs or SWs with unknown status. Targeted outreach and education should be provided to sex workers to increase correct knowledge of, and demand for, family planning. Provision of family planning must be in line with national reproductive health guidelines.

<table>
<thead>
<tr>
<th>Elements of Family Planning for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provision of family planning information and the need for dual protection</td>
</tr>
<tr>
<td>• Pregnancy screening</td>
</tr>
<tr>
<td>• Referral of pregnant sex workers to ANC and/or PMTCT (if HIV positive)</td>
</tr>
<tr>
<td>• Family planning counseling to determine SWs pregnancy intentions and discussion of available family planning methods</td>
</tr>
<tr>
<td>• Determine medical eligibility for desired family planning method and prescribe FP method</td>
</tr>
<tr>
<td>• Promotion, demonstration and distribution of male/female condoms and water-based lubricants</td>
</tr>
<tr>
<td>• Provider-initiated HIV testing and counseling and referrals to appropriate services based on HIV rapid test results</td>
</tr>
<tr>
<td>• Assess the needs of and refer SWs to Additional Components of the HIV/STI package</td>
</tr>
</tbody>
</table>
Expected Outcomes for Sex Workers

<table>
<thead>
<tr>
<th>Family Planning Outcomes for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased number of SWs that desire FP method who receive FP</td>
</tr>
<tr>
<td>• Increased correct and consistent condom use with sex partners</td>
</tr>
<tr>
<td>• Increased number of SWs who know their correct HIV status</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
</tr>
</tbody>
</table>

5.5.2 Post-Abortion Care (PAC)

Definition: Several studies have shown that one of the most effective ways to curb abortion-related mortality and morbidity, regardless of prevailing abortion laws, is to provide high-quality post-abortion care (PAC). The goal of post-abortion care is to treat abortion complications and counsel these women in how to use family planning methods to prevent future unintended pregnancies and unsafe abortion.

Need: Worldwide, 20 million unsafe abortions are carried out resulting in 13% of maternal deaths. Twenty-three percent of FSWs in Kenya reported having had an abortion in their lifetime, with the majority reporting that they carry out their own abortions.

Elements of Post-Abortion Care: Post-abortion care is the care given to women who have had an unsafe abortion. It consists of the following emergency treatment of complications from an unsafe abortion, family planning counseling/services and provision of PITC. Post-abortion care should be provided to each sex worker when needed, with compassion and in line with national guidelines.

<table>
<thead>
<tr>
<th>Elements of Post-Abortion Care for Sex Workers</th>
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</thead>
<tbody>
<tr>
<td>• Assessment and treatment of health complications from an unsafe abortion</td>
</tr>
<tr>
<td>• Family planning counseling</td>
</tr>
<tr>
<td>• Promotion, demonstration and distribution of male/female condoms and water-based lubricants</td>
</tr>
<tr>
<td>• Risk assessment, risk reduction and skills building</td>
</tr>
<tr>
<td>• Provider-initiated HIV testing and counseling</td>
</tr>
<tr>
<td>• Assess the needs of and refer SWs to Additional Components of the HIV/STI package</td>
</tr>
</tbody>
</table>

Expected Outcomes for Sex Workers

<table>
<thead>
<tr>
<th>Post-Abortion Care Outcomes for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Decreased in the number of adverse health events due to unsafe abortions</td>
</tr>
<tr>
<td>• Decreased number unintended pregnancies among sex workers</td>
</tr>
<tr>
<td>• Decreased number of abortions</td>
</tr>
<tr>
<td>• Increased correct and consistent condom use with sex partners</td>
</tr>
<tr>
<td>• Increased number of SWs who know their correct HIV status</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
</tr>
</tbody>
</table>
5.5.3 Cervical Cancer Screening

**Definition:** Cervical cancer screening is the process of identifying precursor/precancerous lesions (CIN) or cancerous cells in the cervix. Human Papilloma Virus (HPV) is an STI and etiological agent of cervical cancer cases. Although there are over 100 HPV types, 20 are known to be cancer-causing, and of these HPV 16 and 18 are responsible for about 70% of all cervical cancer cases worldwide. Several techniques are used for cervical cancer screening to identify HPV or CIN. Papainoclaou smear (pap smear) is the collection of a sample from the cervix to test for HPV infection. CIN or precursor cells can be identified through visual inspection of the ectocervix washed with acetic acid or visual inspection of an iodine painted cervix. Cervical cancer screening leads to early detection and treatment of CIN decreasing the incidence of cervical cancer.

**Need:** Current estimates in Kenya indicate that every year 2,454 women are diagnosed with cervical cancer and 1,676 die from the disease, with 60.9% of invasive cervical cancers attributed to HPVs 16 or 18. Risk factors that increase acquisition of HPV include multiple partners and infection with other STIs including HIV. Risk factors that increase progression to precursor lesions or cancer include infection with HPV 16 or 18, family history of cervical cancer, immunosuppression (i.e. HIV positive, pregnancy), diabetes mellitus and smoking. Sex workers are at greater risk for acquiring HPV and more likely to be HIV infected, increasing their risk of progressing to cervical cancer. It is recommended that cervical cancer screening be offered to all FSWs.

**Elements of Cervical Cancer Screening:** Cervical cancer screening should be conducted in line with national guidelines. The type of screening technique will be determined by service providers and comply with national standards. Some methods may be to costly to offer routinely (i.e. pap smear) therefore other methods (i.e. visual inspection) may be warranted. It is important that a routine (e.g. yearly) cervical cancer screening schedule is created for SWs based on local epidemiology and available resources.

**NOTE:** A HPV vaccine exists to prevent the 4 types of HPV linked to 80% of cervical cancer cases. Although the vaccine is recommended for individuals who are not infected there is no harm in vaccinating sex workers even if they are infected with HPV. Once the vaccine is available service providers should consider vaccinating sex workers and their female children.

### Elements of Cervical Cancer Screening for Sex Workers

- Provision of information on causes, prevention, screening and treatment of cervical cancer
- Free or affordable cervical cancer screening
- Referral to free or affordable treatment for CIN lesions and cervical cancer
- Promotion, demonstration and distribution of male/female condoms and water-based lubricants
- Provider-initiated HIV testing and counseling
- Assess the needs of and refer SWs to Additional Components of the HIV/STI package
Expected Outcomes for Sex Workers

<table>
<thead>
<tr>
<th>Cervical Cancer Screening Outcomes for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Decreased number of cervical cancer cases</td>
</tr>
<tr>
<td>• Increased proportion of sex workers receiving cervical cancer screening</td>
</tr>
<tr>
<td>• Increased correct and consistent condom use with sex partners</td>
</tr>
<tr>
<td>• Increased number of SWs who know their correct HIV status</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
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</table>

5.6 Emergency Contraception (EC)

**Definition:** Emergency contraception (EC) is also referred to as “second option” or the “morning after pill”. EC is provided to women to prevent pregnancy from unprotected vaginal sex. EC is provided to females who are not currently using a contraceptive method and are not already pregnant. Female sex workers must have access to EC due to their increased likelihood of engaging in unprotected sex.

**Evidence:** The use of emergency contraception (EC) has been demonstrated to be effective in reducing pregnancy when used within 120 hours after the exposure incident.

**Elements of Emergency Contraception Provision:** Emergency contraception should be provided for free or at an affordable cost to female sex workers. When prescribing EC service providers should:

1. Establish eligibility (exposure within last 5 days, not currently using a contraceptive method or already pregnant)
2. Provide EC (1 or 2 day dose)
3. Provide family planning counseling and FP options
4. Promote, demonstrate and distribute condoms and lubricants
5. Conduct risk reduction counseling and skills building to reduce unprotected sex

**NOTE:** Programs targeting sex workers should have strong links with health providers who prescribe and pharmacies that dispense EC without a prescription to ensure FSW have access to EC within 120 hours of exposure. Currently no guidance exists on how frequently EC can be used. Therefore, service providers should use caution and monitor how many times EC is used by a FSW. FSWs should be encouraged to use long-term family planning methods (i.e. contraception, IUD, etc) as EC is not a long-term family planning method.
### Elements of Emergency Contraception Provision for Sex Workers

- Provision of information on the benefits and limitations of emergency contraception
- Determine eligibility for EC (time and type of exposure, not currently using a contraceptive method or already pregnant)
- Provision of EC based on national guidelines
- Information, counseling and provision of family planning methods
- Promotion, demonstration and distribution of male/female condoms and water-based lubricants
- Risk reduction counseling and skills building
- Provision or referral to PITC
- Referral of pregnant FSWs to ANC and/or PMTCT (if HIV positive)
- Assess the needs of and refer SWs to Additional Components of the HIV/STI package

### Expected Outcomes for Sex Workers

<table>
<thead>
<tr>
<th>Emergency Contraception Provision Outcomes for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased number of FSW who receive EC when warranted</td>
</tr>
<tr>
<td>• Increased demand of family planning methods</td>
</tr>
<tr>
<td>• Increased correct and consistent condom use with sex partners</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
</tr>
<tr>
<td>• Decreased number of unintended pregnancies</td>
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</table>

## 5.7 Post-Exposure Prophylaxis (PEP)

**Definition:** Post-exposure prophylaxis is the provision of antiretrovirals to reduce the risk of becoming infected with HIV after exposure to fluids from a source that is HIV positive or of unknown status. PEP is used for occupational exposure, such as a needle stick with infected blood, vaginal, oral or anal rape, and/or accidental unprotected sex (i.e. condom break).

**Evidence:** Use of PEP has been demonstrated in case control studies to be effective in reducing the risk of HIV infection by about 80% for occupational exposure when taken within 72 hours of exposure.  

**Elements of PEP:** Post-exposure prophylaxis should be provided for free to HIV-negative sex workers for suspected exposure to HIV. For SWs, PEP is recommended for accidental exposure due to a condom break, or for exposure due to vagina/anal/oral rape. When prescribing PEP service providers should:

1. Establish eligibility for PEP (HIV negative client with a suspected risk of HIV exposure in the last 72 hours from a HIV positive or person of unknown status)
2. Counsel SW on benefits, limitations, and side effects of PEP
3. Provide PEP regimen and conduct adherence counseling
4. Retest for HIV at 6 wks, 3 and 6 months
5. Promote, demonstrate and distribute condoms and lubricants
6. Conduct risk reduction counseling and skills building to prevent further possible HIV exposure

**NOTE:** Currently no guidelines exist for the amount of PEP that can be offered in a year but health care workers are encouraged to exercise caution and only offer PEP when warranted based on risk and HIV status.

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**Elements of Post-Exposure Prophylaxis for Sex Workers**

- Provision of information on PEP
- Determine eligibility for PEP based on national guidelines (HIV negative client with a defined risk of HIV exposure within the last 72 hrs from a HIV positive person or person of unknown status)
- Provision of PEP regimen for eligible HIV negative SWs based on national guidelines
- Ongoing adherence counseling and monitoring to ensure compliance with PEP regimen
- Provision of HIV retest at 6 weeks, 3 and 6 months after completing PEP regimen
- Referral of HIV positive sex workers to HIV care and treatment
- Referral or provision of EC for FSW who have been exposed to HIV through vaginal sex
- Risk assessment, risk reduction counseling and skills building
- Promotion, demonstration, and distribution of male/female condom and water-based lubricants
- Assess the needs of and refer SWs to Additional Components of the HIV/STI package

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**Expected Outcomes for Sex Workers**

**Post-Exposure Prophylaxis Outcomes for Sex Workers**

- Increased number of SWs who receive PEP when warranted
- Decreased incidence of HIV infection among SWs completing PEP
- Increased number of SWs who know their correct HIV status
- Increased correct and consistent condom use with sex partners
- Increased uptake of those components of the package needed by SWs
To address the underlying factors that determine HIV risk and vulnerability, structural approaches are needed. Structural approaches aim to mitigate the impact of HIV/STI by altering structural factors, which include physical, social, cultural, organisational, community, economic, legal or policy aspects of the environment that determine HIV risk and vulnerability. For sex workers, structural interventions aim to alter the physical and social environments in which sex work takes place. Structural interventions involve more than the service providers and beneficiaries; they include working with various government agencies and addressing the factors that impede or facilitate efforts to prevent HIV infection.

**6.1 100% Condom Use Programme**

**Definition:** 100% Condom Use Programmes (CUP) mandate condom use in commercial sex settings and place responsibility for enforcement on the establishments rather than on just the individual sex worker. The goal of 100% CUP is to prevent sexual transmission of HIV/STI by individual SWs and in the general population by creating an enabling environment that empowers SWs to refuse sex services if clients do not want to use condoms. 100% CUP includes enactment of a policy in which condoms are used 100% of the time, in 100% of commercial sex relationships, and in 100% of commercial sex settings.

**Evidence:** The Thailand 100% CUP was effective in increasing condom use during commercial sex acts from 14 to 94% and decreasing five major STD’s among men by 79%. The Thai 100% CUP included a 100% condom use policy, government led supply of condoms to SW establishments, sanctions for establishments that failed to adhere to the 100% condom use policy, large scale media campaign, increased number of STI clinics, and free weekly STI screening and treatment for SWs.

**Elements of the 100% Condom Use Programme:** The 100% condom use programme is appropriate for sex work establishments including sex dens, truck stops, hotels, bars, or any venue where men and women gather with the primary intention to sell/buy sex. The purpose is to promote the use of condoms by sex workers and their clients without exception. It also encourages SWs to refuse clients who do not want to use condoms. Several models exist for a 100% condom use programme; the following components draw from programmes implemented in Thailand and the Dominican Republic:

- Identification of lead implementing organizations (NACC/NASCOP), which will oversee the implementation of the 100% CUP. NASCOP offices (both at the provincial and district level) will lead implementation in a defined geographic area (i.e. district or region), be responsible for implementing and monitoring the 100% CUP and advocating for policy changes.

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12. Syphilis, Gonorrhoea, Non-Gonoccal Urethritis, Lymphogranuloma Venerum and Chancroid
• Solidarity and collective commitment including routine workshops and meetings with sex workers, clients (if possible), establishment owners, law enforcement, government officials and other gatekeepers and “controllers in, the catchment area to discuss the benefits of the 100% CUP and each stakeholders role in the program. This can be strengthened by population-specific educational materials to reinforce each stakeholder’s responsibilities and benefits in adherence to the 100% CUP. If possible a memorandum of agreement signed by all relevant parties is advised to solidify the commitment of stakeholders to the 100% CUP.

• Commitment by establishment owners to the 100% CUP, which includes maintaining a stock of condoms at the establishment, displaying and providing condoms throughout the establishment ,and targeted media campaigns to explain and promote the 100% CUP.

• Promotion, demonstration, and distribution of male and female condoms and water-based lubricants in sex work establishments, which includes education on condoms and lubricants, ensuring an adequate supply of affordable condoms, and ongoing demonstration of correct condom and lubricant use.

• Effective and tailored behaviour change communication through a variety of channels to make condom use the social norm especially in sex work establishments

• Ongoing monitoring of the 100% CUP, which includes ensuring condoms are visible and readily available in each establishment, and the 100% CUP is actively promoted (i.e. posters, tailored media events in the establishment, etc).

• Supportive policies, which includes altering and/or enacting regulations that support the 100% CUP. For the 100% CUP to be effective in Kenya, policies should be enacted that penalize establishments that do not adhere to the 100% CUP. Sanctions can range from fines to forced closure of the establishment. The purpose of supportive policies is to ensure the establishment complies with each component of the program. This component will be implemented at the national level with leadership from NASCOP/NACC.

### Elements of the 100% Condom Use Programme for Sex Workers

- Provision of information on male and female condoms, water-based lubricants, and the 100% CUP to SWs, clients, establishment owners, law enforcement, other gatekeepers and “controllers” (stakeholders)
- Easy access to an uninterrupted supply of free or subsidized male and female condoms and water-based lubricants within the sex work establishment
- Promotion and demonstration of male/female condoms and water-based lubricants
- Ongoing workshops and meetings with stakeholders to promote and strengthen commitment to the 100% CUP
- On-going advocacy for policies that support the 100% CUP and penalize establishments that do not adhere to the programme
- Implement tailored BCC to normalize condom use during commercial sex
- Ongoing monitoring of the 100% CUP to ensure adherence to the program by all relevant stakeholders
**Expected Outcomes for Sex Workers**

<table>
<thead>
<tr>
<th>Condom and Lubricant Promotion, Demonstration and Distribution Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased demand of male and female condoms and water-based lubricants</td>
</tr>
<tr>
<td>• Increased correct and consistent use of condoms (100% condom use) with clients</td>
</tr>
<tr>
<td>• Increased use of appropriate (water-based) lubricants</td>
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<tr>
<td>• Decreased HIV/STI incidence</td>
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<tr>
<td>• Decreased number of unintended pregnancies</td>
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**6.2 Services to Mitigate Sexual Violence**

**Justification:** Sexual violence (i.e. rape) is common among both male and female sex workers. Sexual violence is associated with unprotected sex and an increased risk of HIV transmission. SWs experience sexual violence from their clients (82%), law enforcement (27%) and strangers (23%).

Sexual violence is rarely reported by SWs. Reasons for not reporting sexual violence includes fear of prosecution over the illegal nature of their work and past harassment by law enforcement agencies. Even when serious harm results from sexual violence, the fear of prosecution for being a SW outweighs the desire to seek justice. Therefore, SWs must have access to interventions that prevent sexual violence, effective treatment of related health conditions, and provision of psycho-social support to cope with sexual violence without fear of prosecution.

**Elements to Mitigate Sexual Violence:** Service providers should assist SWs in developing skills to deal with violent clients and circumstances. Programs to mitigate sexual violence, should also engage and sensitize clients, gatekeepers, “controllers” and sex partners to stop sexual violence.

Service providers are advised to refer sex workers who experience sexual violence (i.e. rape) to a “SW-friendly” health facility to obtain PEP, EC, and a general examination. The collection of specimens during the examination will also assist in the legal prosecution of the perpetrator. After the examination, SWs will be provided with psychosocial support to begin to cope with the distress that is likely to occur because of rape. Sex workers should also be referred to other Biomedical and non-Biomedical services as required.

**Elements to Mitigate Sexual Violence for Sex Workers**

- Provision of “sex-worker friendly” services
- Provision of skills to assist SWs in dealing with violent clients/circumstances
- Sensitize clients, partners, gatekeepers and “controllers” to stop sexual violence against SWs
- Provision or referral to health facility for post-rape examination, PEP and EC services
- Provision or referral to psycho-social support
- Distribution of male/female condoms and water-based lubricants
- Assess the needs of and refer SWs to Additional Components of the HIV/STI package
Outcomes for Sex Workers

<table>
<thead>
<tr>
<th>Services to Mitigate Sexual Violence Outcomes for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased number of SWs who access services for sexual violence when they require them</td>
</tr>
<tr>
<td>• Increased number of SWs who receive PEP or EC when warranted</td>
</tr>
<tr>
<td>• Increased number of SWs who know their correct HIV status</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
</tr>
<tr>
<td>• Decreased violence against SWs</td>
</tr>
</tbody>
</table>

6.3 Support to Expand Choices Beyond Sex Work

Justification: Some sex workers may want to exit sex work or develop other skills to reduce the number of paying sex partners. Policies and programs should support sex workers to acquire the life, education, and vocational skills and training needed to make informed choices about their lives. By obtaining income from other activities SWs will be able to reduce their number of partners and negotiate safer sex practices, reducing their HIV/STI risk and vulnerability.

Elements of Expanding Choices Beyond Sex Work: Sex workers who want to expand their choices beyond sex work should have access to a meaningful and comprehensive set of services that respond to their individual circumstances. Programs must also address substance dependency, family rejection, psychosocial distress, children, and legal issues. A comprehensive package of services to facilitate expanding choices beyond sex work includes the following:

• Alternative employment and livelihood opportunities including income generating activities, financing (microcredit and microfinance, banking services, repayment of debts) and alternative livelihood skills training
• Assistance in obtaining family and social services (e.g. secure housing, children’s school fees, etc)
• Provision of education for life including literacy classes, vocational, and skills training
• Comprehensive assistance for HIV positive sex workers including access to HIV care and treatment, food supplements, etc

Elements of Expanding Choices Beyond Sex Work

• Provision of information on choices beyond sex work
• Referral to services that expand SW’s choices beyond sex work
• Assess the needs of and refer SWs to Additional Components of the HIV/STI package
**Expected Outcomes for Sex Workers**

<table>
<thead>
<tr>
<th>Expanding Choices beyond Sex Work Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased number of SW’s who seek alternative employment and livelihood opportunities who access these programs</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
</tr>
<tr>
<td>• Decreased HIV/STI related risk behaviours</td>
</tr>
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</table>
Chapter 7: Additional Components of the HIV/STI Package of Services

7.1 Psychosocial Support

**Justification:** Psychosocial stress among SWs is caused by the nature of sex work, sexual violence, lack of money, harassment by law enforcement agencies and predatory gangs, stigma and discrimination.\(^1\)

**Elements of Psychosocial Support:** Service providers should be trained on the specific psychosocial stresses experienced by SWs. Service providers are advised to educate and counsel SWs on ways to manage and cope with psychological and social stressors. Trained providers are encouraged to conduct a risk assessment, risk reduction counseling and skills building as well as provide condoms and water-based lubricants to sex workers during psychological support services.

**Elements of Psychosocial Support for Sex Workers**

- Provision of information on available psychosocial support
- Provision of skills in identifying signs and symptoms of psychosocial distress
- Counseling or other support services to manage and cope with psychosocial distress
- Risk assessment, risk reduction counseling and skills building to reduce HIV/STI risk
- Distribution of male/female condoms and water-based lubricants
- Assess the needs of and refer SWs to Additional Components of the HIV/STI package

**Expected Outcomes for Sex Workers**

**Psychosocial Support Outcomes for Sex Workers**

- Increased number of SWs with psycho-social needs who receive counseling
- Increased uptake of those components of the package needed by SWs

7.2 Family and Social Services

**Justification:** Sex workers are in need of family & social services to support the well-being of their families. These include services for their children as well as legal support. Many female sex workers care for multiple children and may need access to services for orphan and vulnerable children to ensure the children in their care receive food, health, shelter and education. Many sex workers are victims of
sexual and physical violence, and therefore need access to legal services to ensure their human and health rights are protected.

**Elements of Family & Social Services**
Service providers should assess the needs of the sex worker and refer him/her to the appropriate family or social services. Service providers of family and social services are advised to distribute condoms and lubricants to SWs as this increases condom/lubricant coverage. Family and social services should also include referral of SW’s children to HTC.

<table>
<thead>
<tr>
<th>Elements of Family &amp; Social Services for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provision of information on available family and social services</td>
</tr>
<tr>
<td>• Education and skills development on identifying family and social service needs</td>
</tr>
<tr>
<td>• Distribution of male/female condoms and water-based lubricants</td>
</tr>
<tr>
<td>• Referral to HTC services for SWs and their children</td>
</tr>
<tr>
<td>• Assess the needs of and refer SWs to Additional Components of the HIV/STI package</td>
</tr>
</tbody>
</table>

**Expected Outcomes for Sex Workers**

<table>
<thead>
<tr>
<th>Family and Social Services for Sex Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased number of SW’s who need family and social services who access family and social services</td>
</tr>
<tr>
<td>• Increased number of SWs and children who know their correct HIV status</td>
</tr>
<tr>
<td>• Increased uptake of those components of the package needed by SWs</td>
</tr>
</tbody>
</table>
Sex workers and their partners account for at least 14% of new infections in Kenya. Sex workers have many different types of sex partners. Men and women who exchange money with sex workers are called clients of sex workers. These individuals have a range of professions, education levels, and come from various socio-economic strata. Sex workers may also have clients who become regular sex partners that may or may not exchange material items for sex with the sex workers. Sex workers also may have primary partnerships such as boyfriends, girlfriends, co-habitating partners and/or spouses. Sex partners of sex workers also serve as a bridge into the general population, which may increase the spread of HIV/STIs. Interventions for sex workers are incomplete without implementation of the following interventions for sex partners of SWs.

8.1 Peer Education and Outreach
8.2 Promotion, Demonstration and Distribution of Condoms and Water-Based Lubricants
8.2 Male Circumcision
8.3 Access to other HIV/STI Services

8.1 Peer Education and Outreach

Clients of sex workers report the following occupations: trade/self-employed (27%), transport worker/trucker (20%), informal employment (20%), private services (13%), public services (12%) and hotel/restaurant/lodge workers (7%). Many of these occupations require large groups of men to congregate. Since these men congregate and are identified clients of sex workers it may be feasible to provide peer education and outreach at targeted locations including bars, truck stops, and other places where these men work. Peer education and outreach for clients should be similar to peer education and outreach provided to SWs and includes the following.

- Initial and on-going contact with peers
- Provision of HIV/STI, sexual reproductive health and substance abuse information
- Promotion, demonstration and distribution of male and female condoms and water-based lubricants
- Risk assessment, risk reduction counseling and skills building
- Referrals to HIV/STI services

Peer education and outreach is best when programs utilize peers, such as truck drivers or trade workers who can deliver accurate information effectively and serve as a positive role model to their peers. Peer education and outreach with clients is most feasible as regular sex partners of SWs may not belong to...
a specific group of individuals therefore be harder to reach with prevention messages. If possible, SWs should encourage their regular sex partners to practice safe sex and seek HIV/STI services.

8.2 Promotion, Demonstration and Distribution of Condoms and Water-Based Lubricants

In Chapter 4, the benefit of male and female condoms and water-based lubricants was described in detail. It is important for both SWs and their sex partners to receive condom demonstrations and be provided with free or affordable condoms. Only about 60% of clients reported using condoms with their last non-regular partners,\textsuperscript{14} showing the need for further targeted condom programming. Also for the 100% condom use programme to be effective, clients of sex workers need to understand the importance of using condoms correctly 100% of the time in commercial sex acts. Similar to SWs, promotion, demonstration and distribution of condoms and water-based lubricants includes:

- Provision of information on male and female condoms and water-based lubricants
- Demonstration of male and female condoms using a penile or vaginal model, respectively.
- Targeted social marketing and distribution of male and female condoms and lubrication to sex partners
- Skills building in correct condom use
- Provision of, or, easy access to an uninterrupted supply of free or subsidized condoms and water-based lubricants

8.3 Male Circumcision (MC)

Male circumcision is the surgical removal of the foreskin of the penis. Male circumcision is an effective intervention in reducing female to male transmission of HIV. Three randomized controlled trials in African men have demonstrated that male circumcision reduces the risk of HIV acquisition by approximately 60%.\textsuperscript{79,80,81} In addition, male circumcision has been shown to reduce the incidence of genital ulcer disease, and infection with human papilloma virus, the agent that causes penile cancer in men and cervical cancer in female partners of uncircumcised men.\textsuperscript{82}

Male circumcision is currently recommended for HIV negative males to prevent HIV acquisition from female sex partners. MC is not a HIV prevention intervention for women.\textsuperscript{83} HIV negative male sex partners of FSW and HIV negative male sex partners of MSW who also have sex with females should be referred to MC services in line with the National Guidance on Voluntary Male circumcision.\textsuperscript{84} The effect of male circumcision on reducing male-male sex is unknown therefore HIV negative men who only have sex with other men are not actively targeted for MC services. The minimum package for MC services includes:\textsuperscript{85}

- HIV testing and counseling
- Active exclusion of symptomatic STIs and syndromic treatment, where required
- Provision, promotion and demonstration of male and female condoms
- Counseling on risk reduction and safer sex
- Male circumcision surgical procedures performed as described in the WHO/UNAIDS/Jhpiego Manual for male circumcision under local anaesthesia

This is the minimum package of services that should be offered in terms of MC, but for male sex partners
of sex workers it may be important to include additional interventions such as: counseling on reducing violence towards sex workers, motivational counseling to use condoms with SWs and screening and brief interventions for drug or alcohol abuse. Service providers can use the presence of male sex partners of SWs in MC services to deliver other much needed interventions that will contribute to changing male norms around sex work and the treatment of sex workers.

**NOTE:** MC services must be provided with full adherence to medical ethics and human rights principles. Informed consent, confidentiality and absence of coercion (i.e. voluntary services) should be ensured.

### 8.4 Access to HIV/STI Services

Sex partners of sex workers are at risk for acquiring and transmitting STIs/HIV. Therefore, it is important sex partners of SWs have access to HIV/STI services, which includes HIV testing and counseling and STI screening and treatment. If feasible services targeting sex workers should also target sex partners of sex workers. Given the fleeting relationship sex workers may have with their clients, contact tracing and partner treatment for STIs may not be feasible (although it may be feasible for regular sex partners). Services should be appropriate, accessible, acceptable and affordable to the sex partners of sex workers and delivered through a variety of service delivery models. The goal is to ensure sex partners of sex workers have access to HIV/STI services to increase the number of people who know their correct HIV status and to reduce the risk of transmission and/or acquisition of HIV/STIs.
Sex workers are often hard to reach and stigmatized, creating barriers to accessing the HIV/STI package of services. Programs need to work with other stakeholders to create an enabling environment that reduces HIV/STI risk and vulnerability and increases access to services, and ensures no harm is done to SWs.

9.1 Community Mobilization

Engaging SWs will ensure “ownership” of the program and can lead to program sustainability. Service providers are advised to engage SWs during the program planning cycle and encourage these individuals to organize themselves and advocate for their health and human rights. Programs are encouraged to promote community mobilization initiatives as these empower SWs to advocate for local structural changes to reduce stigma and increase access to HIV/STI services. Community mobilization initiatives bring together people with similar backgrounds and encourage and motivate them to advocate for their own rights. This process allows SWs to advocate for protection of their human and health rights as well as take an active role in program planning, implementation, monitoring, and evaluation.

9.2 Service Providers Sensitization and Training

Many service providers may be unfamiliar with providing services to sex workers; therefore it will be important to train these individuals on offering “sex worker friendly” health services. Service providers will be provided with appropriate training (through NASCOP) and mentorship to strengthen their skills in interacting, counseling, and treating sex workers with compassion and care. Service providers will need to be trained on addressing the HIV/STI behaviours of SWs including anal sex, douching practices, oral sex, etc. Service providers will also be trained on other issues related to sex work including sexual violence, legal issues, stigma, and discrimination.

All service providers will be sensitized to ensure their attitudes (i.e. personal views, beliefs, judgments, etc) do not override the health needs of the sex workers. Privacy and confidentiality of SWs must be maintained, unless they give consent for the information to be shared. In training service providers the goal is to provide acceptable services that address the needs of the population while respecting their health and human rights.

9.3 Stigma and Discrimination Reduction

SWs suffer stigma and discrimination from health care providers, society, and law enforcement agencies that lead to barriers in accessing services and increase vulnerability to HIV/STI. To reduce the stigma associated with SW, training will be provided to sensitize health workers, program staff members, law enforcement agencies, and other relevant parties on providing “sex-worker friendly” services that protect the health and human rights of SWs. BCC activities may also be used to educate the public to reduce stigma and discrimination towards sex workers.
Chapter 10:

Quality Assurance, Improvement, Monitoring and Evaluation of Sex Worker Programs

Quality programs are based on evidence and/or best practice and must be monitored and evaluated. The goal of quality assurance/improvement, monitoring, and evaluation is to ensure programs reach desired outcomes. Monitoring and evaluation is an on-going process that assists in program improvement and documentation of processes and outcomes. The goal is to deliver the most effective services, address issues, and document successes.

10.1 Quality Assurance (QA) and Quality Improvement (QI)

Quality can be defined as the presence of services and management that meet an agreed criteria or standard. Quality refers to the care that the beneficiary receives in accordance with current evidence and best practices and the way the delivery system should be organized for effective service delivery. The goal of QA and QI is to ensure SWs are provided with the best care that is based on current evidence and best practices.

Quality begins with a clear definition of the agreed/minimum standard. Quality assurance is the process of ensuring the agreed upon standards are met at both the service and management level. QA activities address various dimensions of quality which include but are not limited to the following: technical competence, access to services, effectiveness, interpersonal relations, efficiency, continuity, safety, and amenities. Definitions of these dimensions are provided in the Table 2.

<table>
<thead>
<tr>
<th>Table 2: Dimensions of Quality§1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical Competence</td>
</tr>
<tr>
<td>Access to Services</td>
</tr>
<tr>
<td>Effectiveness</td>
</tr>
<tr>
<td>Interpersonal relations</td>
</tr>
<tr>
<td>Efficiency</td>
</tr>
<tr>
<td>Continuity</td>
</tr>
<tr>
<td>Safety</td>
</tr>
</tbody>
</table>
Amenities

Other features of health services that do not directly relate to service effectiveness but may enhance the client’s satisfaction

Quality improvement is a set of concepts and tools to help improve the quality of services and management by identifying and implementing needed changes to the services and management structures. QA and QI are part of the quality assurance process (QAP). The QAP includes the following steps:

- Planning for quality assurance
- Developing guidelines and setting standards
- Communicating standards and specifications
- Monitoring quality
- Identifying QI opportunities
- Defining the problem(s)
- Choosing a team to address issues in quality
- Analyzing the problem(s) to identify the root causes
- Developing solutions and actions for improvement
- Implementing and evaluating QI efforts

QA/QI tools and standards for the components of the HIV/STI package of services for SWs are provided in the package. Where standards are not available the government will facilitate the creation and implementation of national standards for those components. All components will be standardized at the national level through a set of program and service standards to assure quality of each component of the HIV/STI package of services for sex workers. Regular monitoring and evaluation of HIV/STI services provided to sex workers will be undertaken including periodic external quality assurance exercises and exit interviews with SWs to ensure quality and inform quality improvement activities.

10.2 Monitoring and Evaluation (M&E)

Monitoring and evaluation is a critical part of program development as it allows program staff to assess progress, refine activities, and evaluate for outcomes and impact. Effective M & E of a program/project starts with the setting of specific goals, objectives, strategies, and measurable targets with clear timelines for their achievement during program planning. Clear targets form a benchmark against which to measure performance, and are used to inform program planning and modifications. As mentioned in Chapter 2, M&E should answer the following questions:

1. Are we doing the right thing?
2. Are we doing it right?
3. Are we doing it on a large enough scale?

To ensure streamline with the national M&E framework the following model for M&E is recommended.
A M&E framework specific to MARPs will be available through NASCOP, which will include specific indicators for SWs and associated data collection tools.

To understand the effect of programs on the national population of sex workers a behavioural surveillance survey (BSS) is useful. BSS are designed to routinely monitor, evaluate and track changes regarding knowledge, attitudes and behaviour related to HIV and AIDS in subpopulations considered at high risk of HIV infection such as sex workers. The BSS methodology uses standardized questionnaires, sampling frame, survey implementation, and data analysis procedures to ensure the systematic replication of cross-sectional surveys over time. Behavioural surveillance surveys can be conducted as bio-behavioural surveillance surveys in which survey participants are provided free HIV and selected STI testing. BSS are conducted by experts in this methodology at the national level. Although most programs will not be involved in collecting and analyzing the data, program implementers should advocate for involvement in designing the questionnaire to ensure the data collected reflect programmatic needs and gaps in knowledge.
Appendix 1: Assessment of HIV/STI activities with SWs and Their Sex Partners

Appendix 2: HIV/STI Risk Assessment for Sex Workers

Appendix 3: The Alcohol Use Disorder Test (AUDIT)

Appendix 4: Screening Tool for Drug Use

Appendix 5: Syndromic Management of STIs in Female, Male and Transgender SWs

Appendix 6: Syndromic Management of STIs in Female Sex workers
Appendix 1:

Assessment of HIV Activities with Sex Workers and Their Sex Partners

1. Name of organization: _____________________________________________________

2. Does your organization carry out any interventions that target sex workers?
   - [ ] No
   - [ ] Yes

3. What type of interventions do you carry out targeting sex workers? (Check all that apply)
   - [ ] Peer education and outreach
   - [ ] Risk assessment, risk reduction and skills building
   - [ ] Promotion and distribution of water-based lubricants
   - [ ] Promotion of 100% condom use programme
   - [ ] HIV testing and counseling
   - [ ] STI screening and treatment
   - [ ] TB screening and referral to treatment
   - [ ] HIV care and treatment on-site
   - [ ] HIV care and treatment through referral
   - [ ] Referral to ANC and/or PMTCT
   - [ ] Screening and treatment for drug and alcohol use
   - [ ] Family planning
   - [ ] Emergency Contraception
   - [ ] Post-exposure prophylaxis
   - [ ] Post-abortion care services
   - [ ] Advocacy
Psycho-social support
Services to mitigate sexual violence
Family and social services
Support to expand choices beyond sex work
Other (Specify)

4. Does your organization carry out any interventions that target sex partners of SWs?
   □ No □ Yes □ What type of sex partners? □ Clients □ Regular Partners

5. What type of interventions do you carry out with sex partners of sex workers?
   □ Peer education and outreach
   □ Risk assessment, risk reduction counseling and skills building
   □ Promotion, demonstration and distribution condoms and lubricants
   □ HIV testing and counseling
   □ STI screening and treatment
   □ TB screening and treatment
   □ HIV care and treatment on-site
   □ HIV care and treatment through referral
   □ Screening and treatment of drug and alcohol use
   □ Post-exposure prophylaxis
   □ Other (Specify)

6. What is your catchment area?

7. Do you have an estimate of the size of the sex work population in your catchment area?
   □ No □ Yes, what is it?
For questions 8 though 17, please fill out one form for each activity or program you have.

8. Activity/Program Name: _____________________________ (leave as blank if no name)

   Type of Intervention (Please list from Question 3 or 5): _____________________________

9. When was the project initiated?
   _______ / _______
   Month       Year

10. What is your target number of sex workers to reach for the year?
   a. In the last 12 months, what is the number of sex workers you have reached?

11. What is your target number of sex partners to reach for this year?
   a. In the last 12 months, what is the number of sex partners you have reached?

12. Where is the intervention being implemented? (Check all that apply)
   □ Bar
   □ Brothel
   □ Clinic
   □ Community Center
   □ Household
   □ Mobile Unit
   □ Street-Based
   □ Other (Specify)
13. Location of the intervention (Please list all and be specific):

<table>
<thead>
<tr>
<th>Province</th>
<th>District</th>
<th>City</th>
<th>Townships or other specific localities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. What are the education and other distribution materials you have developed? (Check all that apply)

- [ ] Pamphlets
- [ ] Communication Materials
- [ ] Audiovisua
- [ ] Media
- [ ] Dramatization
- [ ] Training materials for O ansmitted Infections
- [ ] Skills Building Materials for Condom Negotiation
- [ ] Other (Specify)
- [ ] None

15. What materials do you distribute to clients? (Check all that apply)

- [ ] Condoms
- [ ] Lubricants
- [ ] Pamphlets
- [ ] Referrals to clinics
- [ ] Other (Specify)___
- [ ] None
### Appendix 2:

**Example Questions for Risk Assessment Form**

#### SEXUAL PRACTICES AND RISK ASSESSMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>When did you last have sex?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you use a condom?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>12345</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What genders are your sex partners?</td>
<td>Male</td>
<td>Female</td>
<td>Both</td>
</tr>
<tr>
<td>Any known/suspected HIV+ sex partners in the last 6 months?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>If yes, how many</td>
<td>Always (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you use a condom?</td>
<td>Sometimes (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never (3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you now [past 3 months] active in sex work?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Average number of casual clients per day? per week?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you practice the following sexual behaviors with casual clients?</td>
<td>Never</td>
<td>Sometimes (&lt;50%)</td>
<td>Most (&gt;50%)</td>
</tr>
<tr>
<td>Vaginal Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex during Menses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you use a condom with casual clients when engaging in the following?</td>
<td>N/A</td>
<td>Never</td>
<td>Sometimes (50%)</td>
</tr>
<tr>
<td>Vaginal Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex during Menses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who supplies the condoms?</td>
<td>Yourself (0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clients (1)</td>
<td>Both (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a regular partner (s) (boyfriend, husband or lover)</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>How many regular partners?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many items did you have sex with a regular partner last week?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you practice the following sexual behaviors with regular partner(s)?</td>
<td>Never</td>
<td>Sometimes (&lt;50%)</td>
<td>Most (&gt;50%)</td>
</tr>
<tr>
<td>Vaginal Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex during Menses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How often do you use a condom with regular partner(s) when engaging in the following?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td>Never</td>
<td>Sometimes (50%)</td>
<td>Most (&gt;50%)</td>
</tr>
<tr>
<td>Vaginal Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anal Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex during Menses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who supplies the condoms?</td>
<td>☐ Yourself (0)</td>
<td>☐ Clients (1)</td>
<td>☐ Both (2)</td>
</tr>
</tbody>
</table>

| Do you use lubricants? | ☐ Yes | ☐ No |
| If yes, what do you use? | ☐ Salvia |
| | ☐ KY Jelly |
| | ☐ Other, specify |
| If yes, when do you use lubrication? | ☐ During anal sex |
| | ☐ During vaginal sex |

**SUBSTANCE ABUSE**

Have you used alcohol in the past month? | ☐ Yes | ☐ No |
| If yes, how many day? | Per day | Per week |

Have you used drugs in the past month? | ☐ Yes | ☐ No |
If yes, what types | | |
How often? | Per day | Per week |

**DOUCHING**

Do you practice vaginal douching (Inserting cleaning fluid in the vagina)? | ☐ Yes | ☐ No |
If no, got to the next section |
When do you douche? | ☐ After sex (1) |
| | ☐ When showering or bathing (2) |
| | ☐ Condom burst (3) |
| | ☐ When no condom used (4) |
| | ☐ Other [(5) explain] |

How many times do you douche | Per day | Per week |

What do you use to douche? | ☐ Water only (1) |
| | ☐ Water and cloth (2) |
| | ☐ Waster & bath soap (3) |
| | ☐ Water and bleach (4) |
| | ☐ Water and lemon (5) |
| | ☐ Water & Herbs (6) |
| | ☐ Other (7) [specify] |

Did you douche today? | ☐ Yes | ☐ No |
Appendix 3:

The Alcohol Use Disorders Identification Test (AUDIT)

Read questions as written. Record answers carefully. Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. Code answers in terms of “standard drinks”. Code answers based on “standard drinks”. Place the correct answer number in the box at the right.

One unit of alcohol is ½ pint average strength beer/larger or one glass of wine or single measure of spirits. Note: A can of high strength beer or larger may contain 3-4 units.

<table>
<thead>
<tr>
<th>#</th>
<th>Questions</th>
<th>Answer</th>
<th>Number (0-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How often do you have a drink containing alcohol?</td>
<td>0) Never [Skip to Qs 9-10]</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Monthly or less</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) 2 to 4 times a month</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) 2 to 3 times a week</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) 4 or more times a week</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>How many drinks containing alcohol do you have on a typical day when you are drinking?</td>
<td>(0) 1 or 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) 3 or 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) 5 or 6</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) 7, 8, or 9</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) 10 or more</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>How often do you have six or more drinks on one occasion? Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</td>
<td>(0) Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Less than monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) Weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>(0) Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Less than monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) Weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>How often during the last year have you failed to do what was normally expected from you because of drinking?</td>
<td>(0) Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Less than monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) Weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</td>
<td>(0) Never</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1) Less than monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) Weekly</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) Daily or almost daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Options</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| 7 | How often during the last year have you had a feeling of guilt or remorse after drinking? | (0) Never  
(1) Less than monthly  
(2) Monthly  
(3) Weekly  
(4) Daily or almost daily |
| 8 | How often during the last year have you been unable to remember what happened the night before because you had been drinking? | (0) Never  
(1) Less than monthly  
(2) Monthly  
(3) Weekly  
(4) Daily or almost daily |
| 9 | Have you or someone else been injured as a result of your drinking?     | (0) No  
(2) Yes, but not in the last year  
(4) Yes, during the last year |
| 10| Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? | (0) No  
(2) Yes, but not in the last year  
(4) Yes, during the last year |
| 11| Record total of specific items here  
If total over 8, alcohol use disorder likely. Please refer to alcohol disorder treatment programs |  |
## Appendix 4:

**Drug Abuse Screening Test (DAST)**

<table>
<thead>
<tr>
<th>No</th>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have you used drugs other than those required for medical reasons?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>2</td>
<td>Have you abused prescription drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>3</td>
<td>Do you abuse more than one drug at a time?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>4</td>
<td>Can you get through the week without using drugs (other than those required for medical reasons)?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>5</td>
<td>Are you always able to stop using drugs when you want to?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>6</td>
<td>Do you abuse drugs on a continuous basis?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>7</td>
<td>Do you try to limit your drug use to certain situations?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>8</td>
<td>Have you had “blackouts” or “flashbacks” as a result of drug use?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>9</td>
<td>Do you ever feel bad about your drug abuse?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>10</td>
<td>Does your spouse (or parents) ever complain about your involvement with drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>11</td>
<td>Do you friends or relatives know or suspect you abuse drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>12</td>
<td>Has drug abuse ever created problems between you and your spouse?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>13</td>
<td>Has any family member ever sought help for problems related to your drug use?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>14</td>
<td>Have you ever lost friends because of your use of drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>15</td>
<td>Have you ever neglected your family or missed worked because of your use of drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>16</td>
<td>Have you ever been in trouble at work because of drug abuse?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>17</td>
<td>Have you ever lost a job because of drug abuse?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>18</td>
<td>Have you gotten into fights when under the influence of drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>19</td>
<td>Have you ever been arrested because of unusual behavior while under the influence of drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>20</td>
<td>Have you ever been arrested for driving while under the influence of drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>21</td>
<td>Have you engaged in illegal activities to obtain drugs</td>
<td>Yes: No</td>
</tr>
<tr>
<td>22</td>
<td>Have you ever been arrested for possession of illegal drugs?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>23</td>
<td>Have you ever experienced withdrawal symptoms as a result of heavy drug intake?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>24</td>
<td>Have you had medical problems as a result of your drug use (e.g. memory, oss, hepatitis, convulsions or bleeding)</td>
<td>Yes: No</td>
</tr>
<tr>
<td>25</td>
<td>Have you ever gone to anyone for help for a drug problem?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>26</td>
<td>Have you ever been in hospital for medical problems related to your drug use?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>27</td>
<td>Have you ever been involved in a treatment program specifically related to drug use?</td>
<td>Yes: No</td>
</tr>
<tr>
<td>28</td>
<td>Have you been treated as an outpatient for problems related to drug abuse?</td>
<td>Yes: No</td>
</tr>
</tbody>
</table>

Scoring: Each item in bold = 1 point (6 or more – substance use problem and individuals need referral to treatment)

**Score:**
Appendix 5:

History-Taking and Risk Assessment Guide for FSW and MSW

### History-Taking Guide for Female Sex Workers

<table>
<thead>
<tr>
<th>Present illness (Presenting complaints and duration)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>If a vaginal discharge:</td>
<td>Itching? Odor? Color and consistency of discharge?</td>
</tr>
<tr>
<td>If lower abdominal pain</td>
<td>Vaginal bleeding or discharge? Painful or difficult pregnancy of childbirth? Painful or difficult or irregular menstruation? Missed or overdue period? History of recent delivery or abortion? Painful vaginal intercourse? Fever?</td>
</tr>
<tr>
<td>If rectal pain or discomfort?</td>
<td>Rectal bleeding or discharge? Diarrhea? Abdominal pain or cramping? Fever?</td>
</tr>
<tr>
<td>If a genital or peri-anal ulcer</td>
<td>Site? Painful? Recurrent? Appearance? Spontaneous onset?</td>
</tr>
<tr>
<td>If urinary symptoms</td>
<td>Pain when passing urine? Frequency?</td>
</tr>
<tr>
<td>If oral or pharyngeal symptoms?</td>
<td>Sore throat or ulcers?</td>
</tr>
<tr>
<td>Any other symptoms</td>
<td>Discomfort? Warts? Lumps? Skin rashes?</td>
</tr>
</tbody>
</table>

### Medical History (Focus on reproductive and STI history)

| Regular STI check-ups                              | Date of last STI check up? Medications provided? |
| Past STI                                           | Type? Dates? Any treatment and response? Results of any prior tests? |
| Obstetric history                                  | Pregnancies and outcomes? Date of last menstrual period? Contraceptive use? |
| Other illness                                      | Type? Dates? Any treatment and response? Results of tests? |
| Medications                                        | Current medication? |
| Drug allergies?                                    | Name of drugs? Type of reactions (rash, hives, etc) |

### Risk Assessment

| Duration of sex work? Number of partners in last working day/week? Sites of sexual exposure (oral, vaginal, anal)? Regular partner? Symptomatic partner? Condom use with paying clients? Condom use with regular partners? Partner violence? |

### History-Taking Guide for Male and Transgender Sex Workers

| Present illness (Presenting complaints and duration) |  |
If a urethral discharge:  | Color and consistency of discharge? Difficulty or pain with urination? Frequency of urination?
---|---
If rectal pain or discomfort? | Rectal bleeding or discharge? Diarrhea? Abdominal pain or cramping? Fever?
If a genital or peri-anal ulcer | Site? Painful? Recurrent? Appearance? Spontaneous onset? Pain and swelling in the inguinal region?
If oral or pharyngeal symptoms? | Sore throat or ulcers?
Other Symptoms | Warts? Lumps or swelling? Skin rashes?

Medical History (Focus on reproductive and STI history)

| Regular STI check-ups | Date of last STI check up? Medications provided? |
| Past STI | Type? Dates? Any treatment and response? Results of any prior tests? |
| Other illness | Type? Dates? Any treatment and response? Results of tests? |
| Medications | Current medication? Feminization practices (where relevant)? |
| Drug allergies? | Name of drugs? Type of reactions (rash, hives, etc) |

Risk Assessment

| Duration of sex work? Number of partners in last working day/week? Types of sexual behavior practiced (oral, anal, receptive or penetrative role)? Gender of sexual partner? Contraceptives use by female partners? Regular partner? Symptomatic partner? Condom use with paying clients? Condom use with regular partners? Partner violence? |

Appendix 6: Syndromic Management of STIs in Female, Male and Transgender SWs
6a: Syndromic Management of STIs in Female Sex Workers

**Take history**
(sexual, medical, and reproductive)

- Unprotected sex with partner with STI
  - YES: Give treatment according to partner’s symptoms

**Examine patient**
(external anogenital, speculum, bimanual examination, and if necessary proctoscope / anoscope exam)

- Lower abdominal or cervical motion tenderness
  - YES: Treat according to lower abdominal pain flowchart (Appendix 6c)

- Presence of genital or ano-rectal ulcer
  - YES: Treat according to genital ulcer disease flowchart (Appendix 6d)

- Presence of vaginal discharge
  - YES: Treat according to vaginal discharge or puritis flowchart (Appendix 6e)

- Presence of anal discharge/tenesmus/reporting unprotected receptive anal sex
  - YES: Treat according to anal discharge, tenesmus, or asymptomatic patients reporting unprotected receptive anal sex (Appendix 6f)
Treatment for syndromic management is not included since types of medication vary due to resistance, availability, etc. Also, the revised syndromic algorithms will be available soon through NASCOP.
Appendix 6c: Syndromic Management of Lower Abdominal Pain

Patient complains of low abdominal pain

Do abdominal and bimanual examinations

- Abdominal mass or abdominal tenderness due to surgical or gynecological causes
  - Refer for surgical or gynecological assessment*

- Abdominal tenderness or tenderness on moving the cervix
  - PID Rx and 4C’s

- No tenderness on abdominal examination
  - Symptomatic Rx or vaginitis Rx if there is vaginal discharge

If no improvement after 7 days?

- Refer for investigations
- Start flow chart again after repeating abdominal examination

*Surgical or gynecological causes are determined by rebound tenderness and/or guarding; last menstrual period overdue; recent abortion or delivery; menorrhagia or metrorrhagia
Appendix 6d: Syndromic Management of Genital or Ano-Rectal Ulcers

Patient complains of genital sore or ulcer

Take history and examine for ulcer

Is an ulcer present?

Yes

Treat for HSV2; syphilis and chancroid and 4C’s. Review in 7 days

Ulcer healing?

Yes

Offer or refer for HIV counseling and testing and 4C’s

No

Continue HSV2 treatment for a further 7 days with alternate GUD RX. Review in seven days

Is the ulcer healing?

Yes

Treat for GUD and 4C’s. Review in 7 days

No

Offer or refer for HIV counseling and testing and 4C’s

**GUD heals slowly, improvement is defined as sign of healing and reduction of pain. People with HIV infection will be slower in responding to GUD treatment**
Appendix 6e: Syndromic Management of Vaginal Discharge or Pruritus

History of vaginal discharge – Enquire about lower abdominal pain and examine

No lower abdominal pain or tenderness

Vaginitis Rx and 4 C’s

If no improvement after 7 days

Cervicitis RX and 4 C’s

If discharge persists after 7 days – Refer for further investigations

Lower abdominal pain and tenderness

Follow the flow chart for lower abdominal pain
Appendix 6f: Syndromic Management of Anal Discharge, Tenesmus or Asymptomatic Patients Reporting Unprotected Receptive Anal Sex

Take history and examine

Anal discharge & tenesmus? Diarrhea, blood abdominal cramping? (lower GI infection) or nausea and bloating? (upper GI infection)

- Yes
  - Perform anoscope examination
  - Note the presence of rectal puss or ano-rectal ulcers – If ulcer present refer also to “genital ulcer” algorithm
  - Treat for Gonorrhea and Chlamydia
  - Treat for giardiasis or amebic dysentery (Metronidazole 400mg orally BD 5 days)
  - Provide anti-diarrheal medication
  - Provide HTC and 4C’s

- No
  - Reported unprotected receptive anal sex
  - Yes
    - Treat for Gonorrhea & Chlamydia
    - Provide HTC and 4C’s

No
Appendix 6g: Syndromic Management of Urethral Discharge

- History of urethral discharge or symptoms
  - Take history and examine milk urethra if necessary
    - Discharge present
      - Urethritis Rx and 4 C’s
        - If discharge persists after 7 days
          - Alternative Urethritis Rx and 4 C’s
            - If discharge persists after 7 days – Refer for further investigations
    - Discharge absent
      - Symptomatic Rx and 4 C’s
Appendix 6h: Syndromic Management of Scrotal Swelling

Patient complains of scrotal swelling/pain

Take history and examine for ulcer

Swelling/pain confirmed?

Yes

Testis rotated or elevated, or history of trauma?

Yes

Refer for surgical opinion

No

Treat for Gonorrhea and Chlamydia; 4C’s; HTC

Review in 7 days

If no improvement after 7 days

Refer for further investigation

No

Appendix 6h: Syndromic Management of Scrotal Swelling

- Reassure patient and educate
- Provide analgesics, if necessary
- Promote condom use and provide condoms
- Offer HIV counseling and testing if both facilities are available
Appendix 6i: Syndromic Management of Inguinal Bubo

Patient complains of inguinal swelling

Take history and examine

Inguinal/femoral bubo(s) present?

Yes

If ulcer present

Yes

Use genital ulcer flowchart

• Treat for LV and Chancroid
  • If fluctuant, aspirate through healthy skin
  • Provide HTC and 4C’s

If no improvement after 7 days

Continue treatment if improving or refer if worse

No

No

Any other genital diseases

Yes

Use appropriate flowchart

Provide HTC and 4C’s

No
Chapter 11:

References


the trans-Africa highway: the continuing role for prevention in high risk groups. Sexually Transmitted Infections, 82, 368-371.


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Medical Series. The Academic Edge, Bloomington, IN.


48. World Health Organization, Department Mental Health and Substance Dependence (2001). AUDIT: The Alcohol Use Disorders


Switzerland


88. Family Health International/AVAHAN (2007): STI Clinic Handbook, Comprehensive STI services for Sex Workers in Avahan-Supported Clinics in India. New Delhi, India

Collect Sample

Perform test using DETERMINE rapid screening test, as approved by MOH

Test result NON-REACTIVE
- Report test result as NEGATIVE

Test result REACTIVE
- Test specimen using second different rapid test, (BIOLINE) as approved by MOH

Test result NON-REACTIVE
- Test specimen using UNIGOLD as approved by MOH

Test result REACTIVE
- Report test result as POSITIVE

Test result NON-REACTIVE
- Test result REACTIVE
- Report test result as NEGATIVE
- Report test result as POSITIVE
How to use a male condom

1. Always check the expiry date printed on the sachet.
2. Do not use an expired or damaged package.
3. The package should have an air bubble.
4. Do not use sharp objects to open the package.
5. Pull back foreskin if uncircumcised.
6. Place condom at the tip of the penis.
7. Pinch condom at the tip.
8. If uncircumcised, pull back foreskin.
9. Roll completely.
10. Move away from your partner.
11. Remove and discard condom.