National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers

Leveraging a Public Health & Human Rights Approach for HIV and Sex Work programming in South Africa

SOUTH AFRICAN NATIONAL AIDS COUNCIL
OUR ACTIONS COUNT

National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers.
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FOREWORD

Various factors, including having many sex partners, working in unsafe conditions and encountering barriers to negotiating condom use, place sex workers in South Africa at a great risk of contracting HIV and other sexually transmitted infections (STIs). Sex workers often have little control over these factors because of social marginalisation and the criminalisation of sex work. In some settings, alcohol, drug use and violence, may further exacerbate their vulnerability. Sex worker clients, the majority of whom happen to be men who have both commercial and non-commercial sex partners, are instrumental in bringing HIV infection into this community and the general population.

After more than a decade of research and intervention in sex work settings, there is much that has been learnt about what works to prevent HIV transmission amongst sex workers, about how to provide care and support services and how to empower sex workers (SWs) to improve their health and well-being.

Sex workers are an important community of South Africa and they are crucial in our plans to combat the spread of HIV. The South African National Strategic Plan (NSP) for HIV, STIs and TB 2012 – 2016, identifies sex workers as one of the communities that are at most risk of acquiring and transmitting HIV and other STIs. The NSP also recognises that SWs experience barriers that limit their access to health and social services. This is due to the fact that society frowns upon and stigmatises sex workers and that sex work is a criminalised practice.

The acquisition of HIV and other STIs are very real occupational hazards of sex work. Therefore, preventing infection among sex workers has the potential to improve both the health of individual SWs as well as to slow down HIV and STI transmission among wider populations. This is why the South African National AIDS Council (SANAC) and partners have developed the South African National Sex Worker HIV Prevention and Treatment Programme (NSWP) strategy.

This strategic document is expected to provide a framework to all service providers to create an environment that will enable and empower sex workers to reduce their own risk of HIV/STIs acquisition and/or transmission, to seek and get appropriate early diagnosis and treatment of HIV/STIs and to address structural issues related to HIV and sex work. Further, this strategy will create a benchmark against which the services provided to sex workers will be monitored and evaluated to inform continuous improvement in our quest to improve access, uptake and effective utilisation of HIV prevention activities.

Effectively addressing the HIV/AIDS epidemic among SWs also needs an emphasis on working with sex worker clients and it calls for a multi-faceted approach that coordinates a range of diverse responses. There is no single, universal model for providing prevention activities to SWs, their clients and partners. The content of the intervention package itself, and the strategies to deliver that package, have to be adapted to different situations.

The development of the NSWP is a result of unified energies and efforts from the National Sex Work Technical Working Group, which consists of sex workers, human rights activists, public health specialists and donor agencies who dedicated their time to ensure that the strategy was completed.

This strategy marks a new chapter in South Africa's efforts to respond to the HIV/AIDS challenge.

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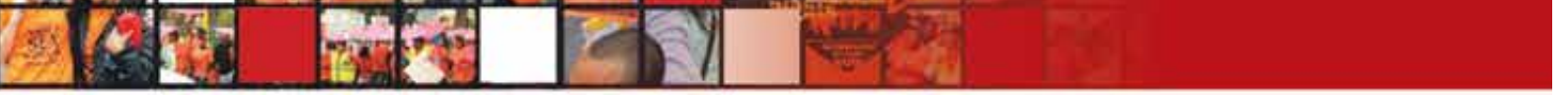

Executive summary

The South African National Sex Work Strategy was written to guide the development of the National Sex Worker Programme (NSWP). The National Strategic Plan on HIV, STIs and TB 2012-2016 (NSP), implemented through the South African National AIDS Council (SANAC), has identified the need to provide services focused on those at higher risk of HIV exposure, known as Key Populations. These Key Populations are defined as those groups most likely to be infected with HIV, or to transmit it, and include sex workers (SWs). There is a high burden of HIV among SWs. The HIV prevalence among sex workers in 1998 raged from 45% to 69% while recent modeling estimate that sex workers, their sexual partners and clients account for 20% of all new HIV infections in South Africa. In response to the high HIV-risk of sex workers, SANAC and the Sex Worker Technical Working Group (SWTWG) have developed this National Strategic Framework.

Structural factors (environmental conditions outside the control of individuals which influence their perceptions, their behaviour and their health, including features of the social, cultural, economic, political and physical environment) which place sex workers at higher risk of HIV include the criminalisation of sex work and health systems issues, such as the limited coverage of sex worker-focused services and limited access to female condoms and lubrication. High unemployment rates and low education levels contribute to the prevalence of sex work in South Africa. Social marginalisation of sex workers, prejudice and discrimination experienced when accessing health and other services add to their vulnerability to HIV infection, as well as poor health outcomes. Many sex workers use substances and are exposed to high levels of violence - both important risk factors for HIV infection. Unequal power relations between sex workers and their clients and non-commercial partners contribute to suboptimal condom use during sex.

The NSWP strategy document builds on the South African Sex Work Sector Plan, an outcome of the National Sex Work Symposium, hosted by the SANAC Sex Work Sector in August 2012. The strategy is evidence-informed and reflects current best practice and sex worker priorities. The proposed programme builds on existing capacity, coverage and expertise.

The key priorities to improve South Africa's response to the HIV and STI epidemics among sex workers are:

- Scaling-up of a comprehensive prevention package to achieve significantly increased coverage, particularly of 'hidden' sex workers.
- Improving the quality of HIV, STIs and TB prevention services.
- Building the technical skills and organisational capacity of Community-Based Organisations (CBOs) and the National Sex Worker Network.
- Strengthening the involvement of sex workers in the HIV and AIDS response through community development and mobilisation.
- Strengthening the partnership between Government, CBOs, sex workers and technical assistance providers.
- Reducing stigma and discrimination against sex workers.
- Mobilising sufficient resources for an effective response.

Aims

- To increase coverage and access to comprehensive HIV, STI and TB prevention, treatment, care, support and related services for Sex Worker, their sexual partners and families and their clients
- Reduce violence and human rights abuses experienced by sex workers through sex worker empowerment, community engagement, service provider training and progressive law reform
- Foster enabling health and related systems to enable sex workers to realise good health and their Constitutional Rights

Objectives

- To reduce social and structural barriers to HIV, STI and TB prevention, care and impact among sex workers
- To reduce the sexual transmission of HIV among sex workers, their clients and sexual partners by at least 50% using combination prevention approaches
- To sustain health and wellness in the sex work setting
- To strengthen the health system for NSWP implementation

The NSWP strategy is based on a logic model. The model outlines the requisite inputs and activities and expected results. Identified inputs include: resources; infrastructure; expert input and strategic information. Sex worker mobilisation and engagement, health and support services, advocacy and activities to strengthen the health system for NSWP implementation are planned to implement the strategy. Ultimately a decrease in HIV infections in the broader population, the realisation of human rights and improved sex worker health and well-being is expected.

Activities will occur at national, provincial and local/district levels. National level activities will include overall programme coordination, guidance, support and advocacy. Provincial level activities will link local level implementers with provincial HIV and related structures. Health and related services, sex worker community mobilisation and engagement, service provider training, advocacy and information collection for monitoring and evaluation purposes will occur at the local level. The theoretical framework developed by Simmons and Shiffman will guide NSWP scale-up.

An initial monitoring and evaluation (M&E) framework is included in the NSWP strategy document. Alignment of the M&E framework with national strategic information collection systems is underway. The rapid sex worker population size estimation has been completed and the mapping of sex worker services and needs is planned. The information collected from these activities will inform NSWP costing and the NSWP Operational Plan.

1. Background

1.1 Sex work

Sex work[1] is broadly defined as the exchange of money for sexual services. Sex work pertains to adult, consensual sex (UNAIDS, 2011)[2]. It is different to human trafficking and the commercial sexual exploitation of children, which are human rights abuses. Sex workers include those who sell sex regularly and occasionally, as well as those who may or may not self-identify as sex workers. Sex workers include female, male and transgender adults. Sex workers range in age, and socio-economic status, and are of diverse sexual orientations and gender identities. Sex partners that exchange money for sex are referred to as clients of sex workers. The stakeholders involved in sex work are varied. In addition to sex workers and their clients and regular partners, business owners and third-party intermediaries, such as taxi drivers and pimps may be linked to the sex work setting.

1.2 Sex work in South Africa

1.2.1 Sex work and the law

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

Popular legal frameworks on sex work

a) *Total criminalisation* – involves penalties for all or most parties involved in sex work, including the sex worker, the client and anyone facilitating the commercial transaction. Examples include South Africa and Kenya;

b) *Partial criminalisation* – the transaction between sex worker and client is not criminalised, but typically any third party is, and sometimes the client. The sex worker does not attract criminal sanction, and is typically regarded as a victim. Sweden and Germany are examples of this model;

c) *Legalisation* – sex work is not criminalised, but regulated and licensed. For example, sex workers may have to register with the police, undergo mandatory health checks (such as HIV-tests) and/or work in specifically designated zones (such as so-called 'red lights districts). Senegal, Mali and the Netherlands are examples; and

d) *Decriminalisation* – all forms of the criminal law are removed from sex work, sex work is regarded as a legitimate form of labour and regulated by occupational health and safety laws, and labour laws. New Zealand is an example of decriminalised model of sex work.

Box 2: Legal frameworks associated with the regulation of sex work (adapted from South African Law Reform Commission, 2009, Prostitution Law Reform Committee, 2008)

Globally, several studies have documented the harms of applying criminal law to the sex work industry. It has been shown to drive sex workers underground and away from services, increasing stigma and creating obstacles to accessing programmes[3] and, reduce sex workers' power, rendering them vulnerable to violence, human rights violations[4] and corruption. These harms and the need for an evidence-based approach to sex work have prompted various international bodies – such as UNAIDS[5], the World Health Organisation (WHO)[6], the United Nations Special Rapporteur on Health and the Global Commission on HIV and the Law prominent publications like the *Lancet and the Canadian Medical Association Journal*,[7] and various researchers[8] to call for the decriminalisation of sex work, and to approach sex work from within a human rights framework.

1.2.2 Sex work venues

A number of studies draw distinctions based on the places where sex workers solicit sex, such as indoors or outdoors, inside brothels or on the street[9] or via cell phone, online or in newspapers.[10] Some studies draw a distinction between direct and indirect sex work[11]. In such analyses, a "direct" sex worker typically self-identifies as a sex worker, while an "indirect" sex worker generally does not work in known sex work venues, may not self-identify as a sex worker and may regard the income from sex work as a supplement to other work they do.

Some studies also classify sex workers according to part-time or full-time status. Female sex workers often combined jobs,[12] even if sex work is one of a number of income strategies, it is often the most lucrative or important income-generating activity for sex workers. Part-time sex workers may not identify with the term, concept or identity associated with sex work,[13] and may not be exposed to sex work-specific health promotion campaigns or know about the risks associated with sex work. Different types of sex work may have higher risk profiles than others and may require different public health programmatic approaches.

Sex work occurs in various settings in South Africa. Formal sex work venues include brothels, hotels, escort agencies and massage parlors. Informal sex work venues include road sides, truck stops,

[1]This strategy defines sex work as, and is focused on sex work as, sexual interactions with the primary intention of exchange of money for sex, as opposed to transactional sex which may include the exchange of sex for other items of value (e.g. cash, food, cell phones, rent). A contractual relationship between client and service provider, and the upfront negotiation of price generally characterise sex work transactions. [2]UNAIDS. (2011). UNAIDS Terminology Guidelines. Geneva: UNAIDS. [3]WHO, UNICEF and UNAIDS. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. WHO, UNICEF and UNAIDS; 2009. UNAIDS Advisory Group on HIV and Sex Work, 2011 [4]Scorgie, F., Nakato, D., Akoth, D. O., Netshivhambe, M., Chakuvinga, P., Nkomo, P., Abdalla, P., et al. (2011). " I expect to be abused and I have fear ": Sex workers ' experiences of human rights violations and barriers to accessing healthcare in four African countries. Final Report. Johannesburg: African Sex Worker Alliance. [5]Joint United Nations Programme on HIV/AIDS. Sex work and HIV/AIDS. Joint United Nations Programme on HIV/AIDS; 2002. [6]WHO, UNICEF and UNAIDS. Towards universal access: scaling up priority HIV/AIDS interventions in the health sector. WHO, UNICEF and UNAIDS; 2009 [7]Goodyear, M., Lowman, J., Fischer, B. & Green, M. 2005. Prostitutes are people too. Lancet, 366, 1264-5. [8]Abel, G., Fitzgerald, L. & Brunton, C. 2009. The Impact of Decriminalisation on the Number of Sex Workers in New Zealand. Journal of Social Policy, 38, 515-531; Scorgie, F., Nakato, D., Akoth, D. O., Netshivhambe, M., Chakuvinga, P., Nkomo, P., Abdalla, P., et al. (2011). " I expect to be abused and I have fear ": Sex workers ' experiences of human rights violations and barriers to accessing healthcare in four African countries. Final Report. Johannesburg: African Sex Worker Alliance. [9]Abel, G., Fitzgerald, L. & Brunton, C. 2009. The Impact of Decriminalisation on the Number of Sex Workers in New Zealand. Journal of Social Policy, 38, 515-531; Shaver, F. M. 2005. Sex Work Research - Methodological and Ethical Challenges. Journal of Interpersonal Violence, 20, 296-319. [10]Mahapatra, B., Saggurti, N., Halli, S. S. & Jain, A. K. 2012. HIV Risk Behaviors among Female Sex Workers Using Cell Phone for Client Solicitation in India. AIDS & Clinical Research, 51. [11]Harcourt, C. & Donovan, B. 2005. The many faces of sex work. Sex Transm Infect, 81, 201-206; Busza, J. 2006b. Having the rug pulled from under your feet: one project's experience of the US policy reversal on sex work. Health Policy Plan, 21, 329-32; Vuylsteke, B., Das, A., Dallabetta, G. & Laga, M. 2009. Preventing HIV among sex workers. In: Mayer, K. & Pizer, H. (eds.) HIV Prevention: A Comprehensive Approach. London: Academic Press. [12]Ward, H. & Day, S. 2006. What happens to women who sell sex? Report of a unique occupational cohort. Sex Transm Infect, 82, 413-7. [13]Scorgie, F., Nakato, D., Akoth, D. O., Netshivhambe, M., Chakuvinga, P., Nkomo, P., Abdalla, P., et al. (2011). " I expect to be abused and I have fear ": Sex workers ' experiences of human rights violations and barriers to accessing healthcare in four African countries. Final Report. Johannesburg: African Sex Worker Alliance. Harcourt, C. & Donovan, B. 2005. The many faces of sex work. Sex Transm Infect, 81, 201-206; Agustin, L. 2005. Helping Women Who Sell Sex: The Construction of Benevolent Identities. Rhizomes, 10.

petrol stations, homes, bars, shebeens (taverns) and market stalls. Sex work also occurs in relation to occupational settings, including mines, work-sites, universities, army bases and farms. Migration and mobility of sex workers and their clients is an important feature of sex work settings in South Africa. Sex work along transport routes and border areas are not static, and are influenced by accommodation, legal documentation and client preferences.

In the hierarchy of dangers associated with sex work, street-based sex workers are often designated the most vulnerable. Street-based sex workers are often independent operators and are not tied to obligations and commissions associated with brothel-based sex work[14]. Yet, their visibility in public spaces increases their exposure to police arrest, harassment and abuse by the general public[15], while having sex in cars or public places, may impose time and security pressures which impede the negotiation and execution of safer sex.[16] Recent mapping of female sex workers found that 88% of female sex workers from Nairobi work from venues and only 7% on the streets.[17] In Cape Town, just over a fifth of sex workers (245 of 1 209) were street-based in 2007.[18]

1.2.3 Sex worker demographics

Female sex work is the most prominent type of sex work in South Africa, however transgender and male sex workers also exist. The prevalence of female sex workers in sub-Saharan Africa is estimated to range from 0.7% to 4.3% of the total female adult population in capitals, and 0.4% to 4.3% in other urban areas.[19] Input data required for mathematical modelling for modes of transmission calculations, employed these estimates on female sex worker prevalence and assumed that there were 132 000 female sex workers in South Africa in 2009 (assuming a 1% prevalence of female sex workers).[20]

Sex work is an important source of income in the informal sector, and sex workers often provide financially for large extended families. High unemployment rates, limited education and, low socio-economic status contribute to entry into sex work.[21] Entry into sex work could be precipitated by food insecurity, poverty, and being responsible for a number of dependents. Additional motivations such as an escape from traditional gender roles or domestic expectations were also documented.[22] Other studies have described factors influencing entry into sex work as including: seeking independence[23] and the flexibility offered by sex work,[24] being in financial debt [25] or other financial reasons,[26] family or relationship problems,[27] social mobility,[28] drug and alcohol dependence,[29] survival and not being able to find another job,[30] financing studies,[31] travelling,[32] or various combinations of these factors.

1.2.4. Sex work, stigma and exclusion

Sex work is socially stigmatised and sex workers are often severely marginalised by society. Male and transgender sex workers face additional stigma related to their sexual orientation and gender identity. Limited social and other support networks contribute to sex worker vulnerability.[33] Widespread discrimination and stigma by health, justice and security service providers towards sex workers constitute barriers to achieving health and accessing justice.[34] The on-going criminalisation of sex work compounds and legitimates the stigma attached to sex work, limits sex worker resilience and increase their risk of HIV and other STIs.

1.2.5 Sex work, alcohol and drug use

Alcohol and other drugs are employed in some sex work settings to lower inhibitions and give sex workers the courage to approach clients (Wechsberg, Luseno, Lam, Parry, & Morojele, 2006).[35] Some sex workers develop drug and alcohol dependency and may use sex to support these addictions. [36]

1.2.6 Sex work and violence

Research has documented high levels of violence, sexual assault and rape of sex workers, commonly perpetrated by clients and law enforcement officers. Sex worker vulnerability to violence is increased by work settings, hours of work, stigma and the criminalisation of sex work. Sex workers may also be survivors of other forms of gender-based violence. The criminalisation of sex work inhibits legal recourse in response to violence and human rights abuses.[37]

1.2.7 Sex work and law enforcement

For most sex workers, direct contact with the criminal law is through police officers. In South Africa, while the police have a mandate to apprehend criminal offenders, the difficulties involved in establishing evidence of sex-for-reward transactions - and the procedural challenges associated with arresting people involved in such transactions - translates into few sex workers being prosecuted under the criminal law provisions associated with sex work.[38]

Police officers have wide powers over sex workers, who often use public by-laws and other regulations to harass sex workers without following required procedures. This creates a hostile and violent environment for sex workers.[39] Municipal by-laws relating to loi-

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[32]Agustín, L. 2002. Challenging 'place': leaving home for sex. Development, 45.1, 110-117; Agustín, L. 2007a. Sex at the Margins: Migration, Labour Markets and the Rescue Industry, New York & London, Zed Books. p.6 [33]Gardener, J. (2009). Criminalising the sex act: Attitudes to adult commercial sex work in South Africa. The Prize and The Price (pp. 329 – 340). [34]Pauw, I., & Brener, L. (2003). "You are just whores—you can"t be raped': barriers to safer sex practices among women street sex workers in Cape Town. Culture, Health & Sexuality, 5(6), 465–481. doi:10.1080/1369105011851 98; Sisonke Sex Worker Movement. (2011). Submission to the Global Commission on HIV and the Law from Sex Workers in South Africa. Cape Town. [35]Wechsberg, W. M., Luseno, W. K., Lam, W. K. K., Parry, C. D. H., & Morojele, N. K. (2006). Substance use, sexual risk, and violence: HIV prevention intervention with sex workers in Pretoria. 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[39]Secretariat: The Global Commission On HIV And The Law 2012. The Global Commission on HIV and the Law - risks, rights and health. In: UNDP (ed.). Geneva: UNDP, HIV/AIDS Group, Bureau for Development Policy.

tering or creating a public disturbance are often employed to arrest sex workers.[40]

Documented police abuse of sex workers include rape and gang rape,[41] unlawful arrest when walking to the shops for example,[42] demanding bribes such as money or sex,[43] finding condoms on sex workers and using that as "evidence" that sex work has taken place[44] and sometimes confiscating these[45] and not believing sex workers when they report crimes, such as having been raped for example.[46]

Arresting sex workers as an attempt to abolish sex work is counter-productive. When released, sex workers often have to work harder to make up for the time they spent in jail.[47]

1.2.8 Clients and non-commercial partners of sex workers

Mathematical modelling estimates that sex worker clients constituted 3.0% to 13.2% of the total number of adult males or females (aged 15 to 49) in Southern Africa.[48] Regrettably, few studies describe the characteristics and behaviour of clients or other sexual partners of sex workers in sub-Saharan Africa.[49] A recent household survey with 1654 adult men in two provinces in South Africa, found that 18% of men reported ever having sex with a sex worker.[50] There was little variation between the socio-demographics of men who had sex with a sex worker, but it was less widespread among unwaged men or those who earned very little.[51] A number of studies have documented client violence against sex workers in the South African context.[52] From these studies it suggests that some sex worker clients exhibit anti-social and often dangerous behaviour.

A large number of studies have documented client resistance to using condoms during the sexual transaction[53] and either offered to pay more for unprotected sex,[54] or demanded paying less for protected sex.[55] One study found that female sex workers servicing male truck drivers in Kwazulu-Natal, who insisted on protected sex, received only a quarter of the average price for a transaction without a condom.[56] Yet, a recent prospective cohort study in Kenya and South Africa found that paying for sex was inversely associated with being HIV-positive.[57] The authors noted that this "unexpected finding" may have been associated with greater protective behaviour during commercial sex.[58]

While little data exists on sex worker clients, even less is available on the non-commercial partners of sex workers in sub-Saharan Africa. A review found that sex worker condom-use with non-commercial partners was generally lower than with non-regular clients.[59] A number of studies have documented how unprotected sex with non-commercial partners or "sex at home"[60] were not perceived as being risky by sex workers.[61] Unprotected sex signified trust among partners[62] and was an important mechanism to distinguish between commercial and non-commercial (or romantic) sex and relationships.[63] Condom-use was therefore low in such settings.[64]

1.3 Sex work & HIV in South Africa

1.3.1 Burden of disease

A recent Global AIDS response report noted that "continuing evidence indicates that unprotected paid sex and sex between men are significant factors in the HIV epidemics in several sub-Saharan African countries".[65] This is reflected in the fact that HIV prevalence among sex workers and sex worker clients is about 10 to 20 times higher than among the general population in sub-Saharan Africa.[66]

In 1998, HIV prevalence among different female sex worker groups in South Africa ranged between 46% and 69%.[67] In a 2004 to 2005 Durban study, 775 women at high risk for HIV infection – 78.8% of whom self-identified as sex workers – were screened and 59.6% were found to be HIV-positive.[68] More recent estimates for South Africa are not available.

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Sex workers in South Africa are heavily affected by HIV and other sexually transmitted infections (STIs). HIV and STI prevalence among sex workers is higher than among other population groups. It is estimated that 60% of female sex workers in South Africa are infected with HIV.[69] An estimated 20% of the 350, 000 people annually infected with HIV are connected with sex work. Approximately 6% of all new infections are estimated to occur among sex workers and 14% among sex worker clients or the sexual partners of the clients of sex workers.[70] In some settings, half to two thirds of sex workers have a curable STI at any time.[71]

In view of the immense burden of HIV that sex workers carry, it is paradoxical that less than 1.0% of global HIV prevention funding focuses on sex work,[72] while the median coverage of HIV prevention programmes is less than 50% of sex workers.[73]

1.3.2 Behavioural and individual risk factors

From a biomedical perspective, the risk for HIV infection is determined by the total number of unprotected sex acts with an HIV-infected partner and the efficiency of HIV transmission (see Figure 1 below).

Figure 1: Framework of biomedical and behavioural risk factors for HIV acquisition

Not surprisingly, proxy markers of this equation have been shown in most studies to be associated with HIV infection. These include a higher client number, duration of sex work, inconsistent condom use,[75] a high prevalence of STIs, which increases transmission efficiency and places sex workers at high risk of acquiring HIV and of transmitting STI and HIV to their clients and other partners. The risk of acquiring HIV is also influenced by the type of sexual activity as the efficiency of HIV transmission varies with anal and vaginal sex.

Data are presented here from behavioural surveys and studies in sex work settings which assessed sexual behaviours that influence the risk of HIV transmission.

a) Unsafe sex with partners of unknown or HIV-positive status

There is a body of evidence from South Africa which shows that the risk for HIV infection is lower among sex workers who use condoms consistently[76] Availability of male condoms in sex work settings has increased over the past years. Condoms are also provided free at primary health centres, though these condoms tended to be unpopular. Despite such improvements in condom access and distribution, there have been occasional reports by sex workers of the limited availability of condoms and the sale of government supplied condoms to sex workers in provincial capitals where sex worker programmes do not exist. Some sex workers have also noted a need for condoms of various sizes, a particular problem in port areas, where clients may come from several nationalities and have varying condom size requirements. Female condom availability is severely limited in most public health facilities in South Africa.

Refusal by clients remains the most important reason for non-use of condoms, and sex workers report that clients offer more money for sex without a condom. Unequal power relations between sex workers and their clients and non-commercial partners and the limited knowledge of HIV and the use of alcohol and drugs during times of sex work, contribute to high levels of unprotected sex. In addition to low levels of condom use that sex workers report with their boyfriends or spouses, these men often engage in high-risk behaviour. Almost half of the sex workers interviewed in a study in Pretoria, South Africa reported that their boyfriends had concurrent partners.

b) Number of partners

The number of partners that sex workers have varies markedly across settings, and clients of sex workers are present in all economic sectors and occupations. The sex worker population size estimation in some cities and their high number of sexual partners suggests that the expansion of the HIV epidemic in those cities is likely to be strongly influenced by the extent of the epidemic among sex worker and their clients.

To date, most interventions among client groups have focused on promoting safer sexual practices rather than reducing the demand for commercial sex, regardless of the fact that variations in the configuration of sex worker-client network patterns are likely to result in different HIV transmission dynamics.

c) Anal and oral sex

Substituting oral sex for sexual acts that have a higher HIV risk such as anal and vaginal sex is a potential strategy for reducing the risk to sex workers. In Hillbrow, South Africa, sex workers who ever performed oral sex were at reduced risk for HIV. Oral sex was more commonly reported by older sex workers in that study.[77]

d) Vaginal practices

A causal relation between vaginal practices and HIV acquisition is biologically plausible. Vaginal cleansing or other vaginal practices, previously referred to as "dry sex", could disrupt the genital mucosa or cause inflammation, increasing the risk for acquiring HIV-1. Also, it is thought that bacterial vaginosis, previously associated with vaginal cleansing, could be an intermediary factor between vaginal practices and HIV infection. Sex workers commonly use a variety of substances in their vagina in preparation for sex work and in between clients, especially after unprotected sex with clients. Some report using these practices to remove semen as they believed this action would reduce the risk of HIV infection. In addition to potential biological mechanisms, perceptions of desired vaginal states and vaginal practices themselves can undermine condom use. For example, in some parts of southern and eastern Africa, the preference for dry sex and mixing of body fluids is at odds with the use of condoms.[78] Many participants in a study of vaginal practices in KwaZulu Natal, South Africa expressed a deep reluctance to use condoms while engaging in vaginal practices.[79] Some sex workers in Pretoria, South Africa, reported that boyfriends insist on having dry vaginal sex with them, and therefore condoms are not used.[80]

[69]Baral, S., Beyrer, C., Muessig, K., Poteat, T., Wirtz, A. L., Decker, M. R., Sherman, S. G., et al. (2012). Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. The Lancet infectious diseases, 3099(12), 1–12. doi:10.1016/S1473-3099(12)70066-X [70]SACEMA. (2009). The Modes of Transmission of HIV in South Africa. Report. [71]Dunkle, K. L., Beksinska, M. E., Rees, H. V, Ballard, R., Htun, Y., & Wilson, M. (2005). Risk factors for HIV infection among sex workers in Johannesburg, South Africa. International Journal of STD and AIDS, 16, 256 – 261. [72]UNAIDS 2009. Guidance Note on HIV and Sex Work. In: UNAIDS (ed.). Geneva: UNAIDS. [73]UNAIDS 2011c. World AIDS Report 2011. How to get to zero: Faster. Smarter. Better. In: UNAIDS (ed.). Geneva. [74]WHO 2011. Preventing HIV in sex work settings in sub-Saharan Africa. Geneva: WHO. [75]Dunkle KL, Beksinska ME, Rees VH, Ballard RC, Htun Y, Wilson ML. 2005. Risk factors for HIV infection among sex workers in Johannesburg, South Africa. International Journal of STD and AIDS, 2005, 16:256–261. [76]Sex Worker Education and Advocacy Taskforce, 2013. Beginning to build the picture: South African National Survey of sex worker knowledge, experiences and behaviour. [77]Dunkle KL et al. Risk factors for HIV infection among sex workers in Johannesburg, South Africa. International Journal of STD and AIDS, 2005, 16:256–261. [78]Scorgie F et al. In search of sexual pleasure and fidelity: vaginal practices in KwaZulu-Natal, South Africa. Culture, Health and Sexuality, 2009, 11:267–283. [79]Smit J et al. Vaginal practices in KwaZulu-Natal, South Africa: implications for HIV prevention technologies. Abstract number TC-456. Microbicides Conference, New Delhi, India, 2008 [80]Wechsberg WM et al. Substance use, sexual risk, and violence: HIV prevention intervention with sex workers in Pretoria. AIDS and Behavior, 2006, 10:131–137

e) Alcohol use, unsafe sex and sexual violence

Use of alcohol among clients and sex workers at the time of purchasing sex is common. Not surprisingly, a frequent explanation for having had unprotected sex is that both the sex worker and the client were intoxicated during intercourse. In addition to affecting sexual decision-making and judgement, alcohol use also hampers condom negotiation skills. Research in Cape Town, Durban and Pretoria, found that alcohol and other drugs are commonly used prior to work to lower inhibitions and give women the courage to approach clients.[81] Many of these women also explained that they always used condoms, except when intoxicated. Different studies have shown that women with heavy episodic drinking patterns (defined as more than five drinks on one occasion) are more likely to use condoms inconsistently and incorrectly; experience sexual violence; and acquire an STI, including HIV.

1.3.3 Social factors contributing to sex worker vulnerability

Most of the time, sex work takes place within an unhealthy and unsafe working environment, with little or no promotion of safer sex, limited control over a client's behaviour and an encouragement of a high client turnover.

Because there are limited opportunities for jobs, sex work is often the only option for women, especially those with dependents. Women who sold beer and sex to truck drivers and local men at a truck stop between Durban and Johannesburg described financial support for their dependent children or relatives as a key motivator for sex work.[82]

Vulnerability is evident at a number of different levels, and is prevalent throughout sex work settings in South Africa. For example, sex work often occurs on major roads, which pass through rural areas. These rural areas, compared with urban ones, have fewer health services and little access to health information, prevention messages and condoms. Reduced sex worker resilience to HIV and its effects are further contributed by the limited existence of sex worker-led organisations and sex worker community mobilisation initiatives.

Like all human beings, sex workers are entitled to the full protection of their human rights, as specified in international human rights instruments. Within the health sector, for example, when health professionals are not adequately trained, they may reflect the stigma in the surrounding culture through judgmental or abusive treatment. Health services may subject sex workers to disapproval, refusal to treat their health problems, mandatory HIV testing, exposure of their HIV status and threats to report them to the authorities.

Sex workers on major highways in South Africa appear to be especially mobile. This is perhaps because sex work settings on transport routes do not remain static – accommodation and relaxation preferences of truckers change over time, forcing sex workers to spend time away from their usual area of work, often travelling with truckers along the highway. These shifts in population and settings complicate service provision and qualitatively demonstrate the potential for spread of HIV epidemics along the highway and to adjacent communities.

Mining communities and people living in surrounding areas often have a high HIV prevalence, fuelled by sex work. Women working in food or recreational facilities in mining areas (bars, guesthouses, hotels, disco and video halls) in communities neighbouring a mines often have a high STI/HIV burden.

1.3.4 Sex work and migration

There are strong links between migration and sex work.[83] Sex workers are a highly mobile population.[84] There are numerous reasons why sex work is a viable livelihood strategy in many settings. It pays better than other service work, has flexible working hours, often means an individual is self-employed, and requires no formal qualifications, documentation or sizable initial capital outlay.[85]

Particularly in the context of migration, an individual's social networks may assist in introducing her or him to the industry and facilitating entry to popular sex work venues.[86] Alternatively, individuals currently engaged in sex work in their place of origin may migrate to another country or province seeking improved economic opportunities or better working conditions in the sex industry.[87]

The reasons for sex workers' mobility in sub-Saharan Africa are access to different client bases, improved work conditions, following seasonal trade opportunities, providing services to mobile populations like truckers or trailing the pay-days of miners and to avoid violence or stigma.[88]

A study of 5498 mobile female sex workers in India found that participants with higher mobility experienced more physical violence, were more likely to consume alcohol before sex and reported more inconsistent condom use than those who were less mobile.[89] While mobility is a complex phenomenon and not a straightforward driver of HIV,[90] sex workers who migrate - or who are highly mobile - may experience problems accessing health care, may actively be excluded from services and may have limited support structures.[91]

Migrant sex workers are often less identifiable than other sex workers[92] and have traditionally been overlooked in sexual and reproductive health services.[93] Being a sex workers who self-identifies as a 'sex worker' is an important factor to the success and reach of public health campaigns focusing on sex work. Many migrants and non-migrants who sell sex do not consider themselves workers but rather people temporarily engaging in an advantageous but stigmatised occupation that is nothing to build an identity on".[94]

[81]Ibid. [82]Karim QA et al. Reducing the risk of HIV infection among South African sex workers: socioeconomic and gender barriers. American Journal of Public Health, 1995, 85:1521–1525. [83] Bujra, J. M. 1975. Women "Entrepreneurs" of Early Nairobi. Canadian Journal of African Studies 9, 213-234.; Busza, J. 2006b. Having the rug pulled from under your feet: one project's experience of the US policy reversal on sex work. Health Policy Plan, 21, 329-32.; Vanwiesenbeeck, I. 2001. Another decade of social scientific work on sex work: a review of research 1990-2000. Annual Review of Sex Research, 12, 242–89. p.247. [84]Day, S. & Ward, H. 1997. Sex workers and the control of sexually transmitted disease. Genitourin Med, 73, 161-8.Day et al., 1993; Van Haastrecht, H. J., Fennema, J. S., Coutinho, R. A., Van Der Helm, T. C., Kint, J. A. & Van Den Hoek, J. A. 1993. HIV prevalence and risk behaviour among prostitutes and clients in Amsterdam: migrants at increased risk for HIV infection. Genitourin Med, 69, 251-6; Ramjee, G., Abdool Karim, S. S., & Strum, A. (1998). Sexually Transmitted Infections Among Sex Workers in KwaZulu-Natal, South Africa. Sexually Transmitted Diseases, 25(7), 346–349 [85]Oliviera, E. 2011. Migrant women in sex work: does urban space impact on self-(re)presentation in Hillbrow, Johannesburg? MA degree, University of the Witwatersrand; Gould, C. 2011. Trafficking? Exploring the relevance of the notion of human trafficking to describe the lived experience of sex workers in Cape Town, South Africa. Crime, Law & Social Change, 56, 529–546; Gould, C. 2011. Trafficking? Exploring the relevance of the notion of human trafficking to describe the lived experience of sex workers in Cape Town, South Africa. Crime, Law & Social Change, 56, 529–546; Campbell, C. 2000. Selling sex in the time of AIDS: the psycho-social context of condom use by sex workers on a Southern African mine. Social Science & Medicine, 50, 479-94; Gould, C and Fick, N . 2008. Selling Sex in Cape Town, Sex Work and Human Trafficking in a South African City. SWEAT. Cape Town; Posel, D. 1993. The sex market in the inner city of Durban - the economic and social effects of criminalising sex work, and the search for alternatives. Durban: Economic Research Unit, University of Natal. [86]Nyangairy, B. 2010. Migrant women in sex work: trajectories and perceptions of Zimbabwean sex workers in Hillbrow, South Africa. MA degree, University of the Witwatersrand. [87]Busza, J. 2004. Sex work and migration: The Dangers of Oversimplification - A Case Study of Vietnamese Women in Cambodia. Health & Human Rights, 7, 231-249; Robinson, L. & Rusinow, T. 2002. 'Like plastic that blows in the wind' Mobile sex workers in southern Africa. Research for Sex Work, 5, 24-27 [88]Scorgie, F., Nakato, D., Akoth, D. O., Netshivhambe, M., Chakuvinga, P., Nkomo, P., Abdalla, P., et al. (2011). " I expect to be abused and I have fear ": Sex workers ' experiences of human rights violations and barriers to accessing healthcare in four African countries. Final Report. Johannesburg: African Sex Worker Alliance. [89]Saggurti, N., Verma, R. K., Halli, S. S., Swain, S. N., Singh, R., Modugu, H. R., Ramarao, S., Mahapatra, B. & Jain, A. K. 2011. Motivations for entry into sex work and HIV risk among mobile female sex workers in India. J Biosoc Sci, 43, 535-54. [90]Deane, K. D., Parkhurst, J. O. & Johnston, D. 2010. Linking migration, mobility and HIV. Trop Med Int Health, 15, 1458-63. [91]UNAIDS 2009. Guidance Note on HIV and Sex Work. In: UNAIDS (ed.). Geneva: UNAIDS. [92]Ghys, P. D., Diallo, M. O., Ettiegne-Traore, V., Satten, G. A., Anoma, C. K., Maurice, C., Kadjo, J. C., Coulibaly, I. M., Wiktor, S. Z., Greenberg, A. E. & Laga, M. 2001. [93]Overs, C. & Hawkins, K. 2011. Can rights stop the wrongs? Exploring the connections between framings of sex workers' rights and sexual and reproductive health. BMC Int Health Hum Rights, 11, S6. [94]Agustín, L. M. 2007b. Questioning Solidarity: Outreach with Migrants Who Sell Sex. Sexualities, 10, 519-534.

In contexts where sex work carries a potent stigma and is illegal, people engaged in sex work may be less inclined to identify themselves with the sex work industry. Cross-border migrants whose stay in a host country may be precarious – due to a restrictive immigration policy which may result in an irregular documentation status, or the presence of hostile anti-foreigner sentiments, for example - may be even more likely to distance themselves from a sex worker identity. This may make cross-border migrant sex workers the least accessible group for sex-work specific health care and health promotion. This could, ultimately, impact on their ability to protect themselves against STIs.[95]

1.3.5. Structural factors contributing to sex worker vulnerability

Despite Constitutional protection against discrimination and the right to access health and justice services, sex workers' human rights are violated often. The illegal nature of sex work makes them vulnerable to police abuse and secondary victimisation if they access services in response to gender-based violence or rape - often perpetrated by clients and the police. No occupational health and safety framework exists to protect sex workers in their workplace.[96]

1.4 Sex work and HIV response

Various international health agencies and best practice guidelines have recommended the need to pay particular attention to sex work when developing responses to address HIV,[97] including:

- outreach to sex worker communities
- clinic-based services including sex work-specific services
- peer education with active involvement of sex workers in all programmes and planning
- non-discrimination
- programmes to address structural issues
- the creation of a safe working environment to safeguard health within the sex work setting and beyond

Health care services targeting sex workers that have flexible hours, employ non-judgemental staff who offer a confidential service, and include outreach have been shown to be successful in reducing the incidence of HIV and STIs amongst sex workers.[98]

A systematic review of HIV and STI interventions in resource-poor settings showed that the combination of sexual risk reduction, condom promotion and improved access to STI treatment reduced HIV and STI acquisition in sex workers receiving these programmes. Structural interventions, policy change or the empowerment of sex workers were shown to reduce the prevalence of HIV and other STIs.[99] A recent systematic review on HIV prevention in sex work settings in sub-Saharan Africa concluded that there is adequate evidence to show the effectiveness of targeted interventions for female sex workers and recommended a focus on increasing access to HIV testing and anti-retroviral therapy for sex workers.[100]

An ethical health sector response to sex work would aim to create a safe, effective and non-judgemental space that would attract sex workers to its services. Unfortunately, the clinical setting is often the site of human rights abuses and the unethical treatment of sex workers by healthcare providers. Research with male, female and transgender sex workers in Uganda, South Africa, Kenya and Zimbabwe has documented a range of problems with health care provision in these countries including poor treatment and discrimination by health care workers, having to pay bribes to obtain services or treatment, being humiliated by health care workers and the breaching of confidentiality.[101]

Other studies in South Africa and elsewhere confirm that sex workers' negative experiences with health care services act as a barrier to effective STI provision and care.[102] Positive interactions with health care providers and health services would empower sex workers, and assist in cultivating healthy behaviour.[103]

1.4.1 Policy and governance

The South African National Strategic Plans for HIV, STIs and TB (NSP) have included sex worker-related objectives. Within the South African National AIDS Council, sex worker issues have been represented within the Women's Sector, but more recently a Sex Work Sector was established (2010). A gap analysis of key populations, including sex workers, in South Africa and a review of HIV prevention among sex workers in Southern Africa took place in the lead up of the development of the NSP. Draft Department of Health Operational Guidelines for HIV programming for Key Populations in South Africa has been developed and is in the process of final authorisation.

1.4.2 Capacity building

Sex worker community leader capacity development initiatives have commenced, along with peer educator training, however with limited coverage. Sensitisation training of health and justice service providers has been implemented to a limited number of providers. Civil society has developed sex worker sensitivity training guidelines and tools for health workers and is being evaluated.

1.4.3 Strategic information

A national HIV monitoring and evaluation (M&E) framework is currently under development. 2010 UNGASS indicators[104] relating to sex work were informed by data collected from a national household survey.[105]

Research has been conducted around HIV epidemiology (prevalence, incidence and risk factors for infection), sex work dynamics, sex worker experiences of human rights abuses and violence, as well as evaluations of small-scale sex work programmes. Population estimates and a national mapping of current sex work services (to inform the National Sex Work Strategy) along with establishment of a sex work HIV surveillance system are being planned. Evaluation of an intervention aimed to enhance the provision of enhanced sex worker services within government clinics in Durban is also planned.

1.4.4 Sex work programming & service provision

No national, government-led sex worker programme exists. Civil society and sex worker-led organisations have led sex work-focused service delivery to date. None of the objectives relating to sex work in the 2007 - 2011 NSP were met and little progress was

[95]Vearey, J., Richter, M., Núñez, L. & Moyo, K. 2011. South African HIV/AIDS programming overlooks migration, urban livelihoods, and informal workplaces. African Journal of AIDS Research, 10 (Supplement), 381–391. [96]Desmond Tutu HIV Foundation. (2011). Key Populations, Key Responses. A Gap Analysis for Key Populations and HIV in South Africa. Report. Pretoria: South African National AIDS Council. [97](WHO, 2005, UNAIDS, 2002, UNAIDS Advisory Group on HIV and Sex Work, 2011, WHO, 2011, Grover, 2010, WHO, 2012) [98]Day, S. & Ward, H. 1997. Sex workers and the control of sexually transmitted disease. Genitourin Med, 73, 161-8.Day et al., 1993). [99]Shahmanesh, M., Patel, V., Mabey, D. & Cowan, F. 2008. Effectiveness of interventions for the prevention of HIV and other sexually transmitted infections in female sex workers in resource poor setting: a systematic review. Tropical Medicine and International Health, 13, 659-79. [100]Chersich, M., Luchters, S., Ntaganira, I., Gerbase, A., Lo, Y., Scorgie, F. & Steen, R. 2013. Priority interventions to reduce HIV transmission in sex work settings in sub-Saharan Africa and delivery of these services. Journal of the International AIDS Society, 16. [101]Boyce, P. & Isaacs, G. 2011. An Exploratory Study of the Social Contexts, Practices and Risks of Men Who Sell Sex in Southern and Eastern Africa. African Sex Worker Alliance. [102]Pauw, I., & Brener, L. (2003). "You are just whores—you can"t be raped': barriers to safer sex practices among women street sex workers in Cape Town. Culture, Health & Sexuality, 5(6), 465–481. doi:10.1080/1369105011851 98 [103]Nairne, D. 1999. 'Please help me cleanse my womb' A hotel-based STD programme in a violent neighbourhood in Johannesburg. Research for sex work, 2, 18-20. [104]UNGASS 2010 South Africa Country Report. Available at http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/southafrica_2010_country_progress_report_en.pdf [105]South African Government. (2010). Country Progress Report on the Declaration of Commitment on HIV/AIDS. Final report. Pretoria: South African Government.

made towards law reform on sex work. The 2007-2011 NSP explicitly recommended the decriminalisation of sex work to achieve public health goals, but is not included in the current NSP (2012 -2016). Law reform is urgently needed and supported by evidence.

Sex worker-focused services are being provided through specialist sex work clinics and through peer outreach by sex worker-focused and sex worker-led organisations in several provinces. A government programme (High Transmissions Area, HTA) supports clinical and non-clinical sites providing peer-based services. Sex worker client-focused services are mostly targeted at long distance truck drivers. Support services for survivors of violence, human rights abuses, sexual assault and for drug users is limited, and rarely included as an accessible package of services at specific primary health care facilities.

A National Department of Health's High Transmission Area (HTA) Programme has been established to increase HIV-related services for Key Populations. Currently there are 686 HTA sites, employing 2 494 peer educators in nine provinces. Non-medical sites are managed by peer educators and provide education and outreach, sexual health screening, risk reduction, counselling and skill building, condom and information material distribution and referral. Clinical sites have access to a professional nurse and provide HIV counselling and testing, STI screening and treatment, TB screening and sexual and reproductive health services, including family planning.

Social and physical mapping processes are conducted in each site, followed by appropriate capacity building and implementation. Indicators are collected (number of male and female condoms distributed; number of peers and number of STIs treated and referred). The degree and scope of service standardisation can be improved and the degree to which outreach workers are sex worker peers may vary.

Current service provision:

The Sex Worker Education Advocacy Taskforce (SWEAT) runs a sex worker focused center in Cape Town, providing services to over 20 000 sex worker contacts annually, and employs 16 peers. A multi-site sex worker project funded by the Global Fund to Fight AIDS, TB and Malaria (GFATM)und is also underway, operating in seven sites nationally, employing 50 peers with a cumulative two year contacts of 26 000. A recent evaluation has been completed.

The WITS Reproductive Health and HIV Research Institute (WHRI) runs a sex worker-focused programme in Hillbrow, consisting of a sex worker-focused clinic and a mobile unit that visits places of sex work.

The Sisonke Sex Worker Movement is a sex worker-led organisation working in four sites, with a coverage of approximately 2 000 sex workers.

Lifeline Durban - ITHUBALETHU (Our Chance) has been operational for ten years and focuses on youth at high risk, particularly sex workers. Prevention (Awareness & Education), a risk reduction plan, psycho-social support, skills development and p peer education is provided. In the last financial year, day and night outreach activities reached 720 and 3223 sex workers respectively, and 358 risk reduction plans were developed.

North Star Alliance provide sex worker and client services along transport routes. Two centres located in Kato Ridge in KwaZulu Natal) at a truck stop and in Ficksburg in the Free State see on average 20 clients daily (including truckers, sex workers and community members).

Trucking Wellness through the Corridor Empowerment Project, a public-private partnership, has 22 road-side and five mobile wellness centres in operation. Since inception, 13 million condoms and 500 000 awareness education materials have been distributed. Additionally 185 925 medical consultations and treatment of 64 194 cases of STIs among truck drivers and women at risk have been provided.

The Women's Legal Centre, Tswaranang Legal Advocacy Centre, Thohoyandou Victim Empowerment Programme provide human rights and legal support for sex workers in selected areas.

The Global Fund to Fight AIDS, Tuberculosis and Malaria-funded Networking HIV/AIDS Community of South Africa (NACOSA) sex worker programme is aiming to decrease HIV incidence in the sex worker population, create HIV-competent communities with regard to the sex work and its effects, improve uptake of HIV programmes and accessing of HIV Counselling and Testing (HCT) services by sex workers, HIV competent CBOs/NGOs successfully implementing sex worker support programmes in their coverage areas, and that Sex Work Sector expertise and experiences are organised and integrated so that national gaps, needs, challenges, and priorities can be identified. To date, this program has funded 17 NGOs to provide sex work HIV prevention programme in 56 sites across the nine provinces of South Africa, employing 560 peer educators.

1.4.5 Medical supplies and technology

Government is the principle supplier of male condoms which are widely available, particularly where sex worker-focused programmes have been implemented. Female condoms are very rarely available in the public sector and are urgently needed. Lubricant is not currently provided by government. Medication and technology for reproductive health services are obtainable from government, however integration between sexual and reproductive health and HIV and TB services remains limited.

1.4.6 Financing

Bilateral (PEPFAR), multilateral (GFATM) and United Nations' agencies (UNFPA) have provided the majority of support for the larger sex worker programmes. Conditional grants allocated to the Department of Health are used to support HTA programme implementation. Concerns have been raised about PEPFAR's so-called "anti-prostitution pledge" and its impact on rights-based sex worker health services (Ditmore and Allman, 2013, Ahmed, 2011).

2. Aims & objectives

2.1 Aims

- To increase coverage and access to comprehensive HIV, STI and TB prevention, treatment, care, support and related services for sex workers, their sexual partners and families in South Africa
- Reduce violence and human rights abuses experienced by sex workers through sex worker empowerment, community engagement, service provider training and progressive law reform.
- Foster enabling health and health-related systems to ensure sex workers and their clients can realise health and their Constitutional Rights.

2.2 Objectives

1. Reduce social and structural barriers to HIV, STI and TB prevention, care & impact among sex workers

1.1. Reduce stigma and discrimination towards sex workers in health, justice and security contexts
1.2. Increase sex worker community mobilisation and collective empowerment
1.3. Increase sex worker capacity for self determination
1.4. Increase access to sex worker-safe spaces
1.5. Increase access to support in response to human rights violations
1.6. Decriminalise sex work

2. Reduce the number of new HIV infections among sex workers by at least 50% using combination prevention approaches, by 2016

2.1. Increase coverage of, and access to, a minimum package of HIV and related prevention services for sex workers by 50% by 2016
2.2. Increase sex worker client access to relevant HIV/STI prevention services by 50% in areas of sex work client concentration by 2016

3. Sustain sex worker health and wellness

3.1. Provide antiretroviral therapy to 80% of eligible sex workers by 2016
3.2. Increase access to female condom
3.3. Increase sex work-specific health care services in areas of high sex work concentration and sex work-friendly health services in areas of low sex work concentration
3.4. Roll-out of drug and alcohol intervention programmes

4. Strengthen the health system for NSWP implementation

4.1. Ensure constant supply of commodities
4.2. Improve quality of HIV and related services received by sex workers
4.3. Pilot and evaluate Pre-Exposure Prophylaxis and Test and Treat strategies for sex workers
4.4. Ensure availability of female condoms in all sex work settings

3. Guiding Principles

The NSWP is informed by practice, including recommendations in the Department of Health and SANAC's Operational Guidelines for HIV, STIs and TB Programmes for Key Populations in South Africa and the World Health Organisation's Prevention and Treatment of HIV and Other Sexually Transmitted Infections for Sex Workers in Low- and Middle-Income Countries.

Guiding principles for the NSWP include:

- Sex workers and their families are viewed as equal members of society
- Sex work is viewed as a livelihood option and as work and thus necessitates urgent law reform
- Interventions should not harm, and should respect sex worker rights and choices
- Sex workers' rights, dignity, views and experiences are respected
- Sex worker capacity development and programme owner ship is essential
- Sex workers lead the NSWP process - "nothing for us without us"
- Interventions should be adapted to local settings
- Evidence and best practice recommendations are used to inform the NSWP
- Sex worker partners, clients and gate-keepers are to be included in the NSWP process
- Linkage between national, provincial and local structures is essential for NSWP success

4. Strategy

4.1. Sex Worker Programme Logic model

The sex work programme can be simplified into programme inputs, activities, outputs, outcomes and impact (see Error! Reference source not found.).

4.1.1. Inputs

Sufficient financial and technical resources and infrastructure are essential programme inputs. Participation of sex workers and organisations experienced in working with sex workers are required in the development and implementation of programme stages. The sex work programme should be aligned with South Africa's National Strategic Plan for HIV, STIs and TB. Estimations of the national sex worker population size, current services (provided and identified gaps), surveillance of HIV epidemiology and available financing are required to inform programme implementation and evaluation.

4.1.2. Activities

a) Sex worker community mobilisation and engagement will be achieved through the establishment of local (community-based) sex worker-led organisations. Peer-led engagement activities will be used to mobilise sex workers and link them with sex worker organisations, engagement platforms and relevant services. Support for the establishment and maintenance of sex work-focused organisations will be established to facilitate knowledge and skill sharing, as well as capacity building.

b) Service provision will include a minimum package of comprehensive sex worker-focused services, inclusive of HIV/TB/ STI, sexual and reproductive health, psychosocial and justice-related services. The composition of the package of services, and mode of delivery, will be contextually determined.

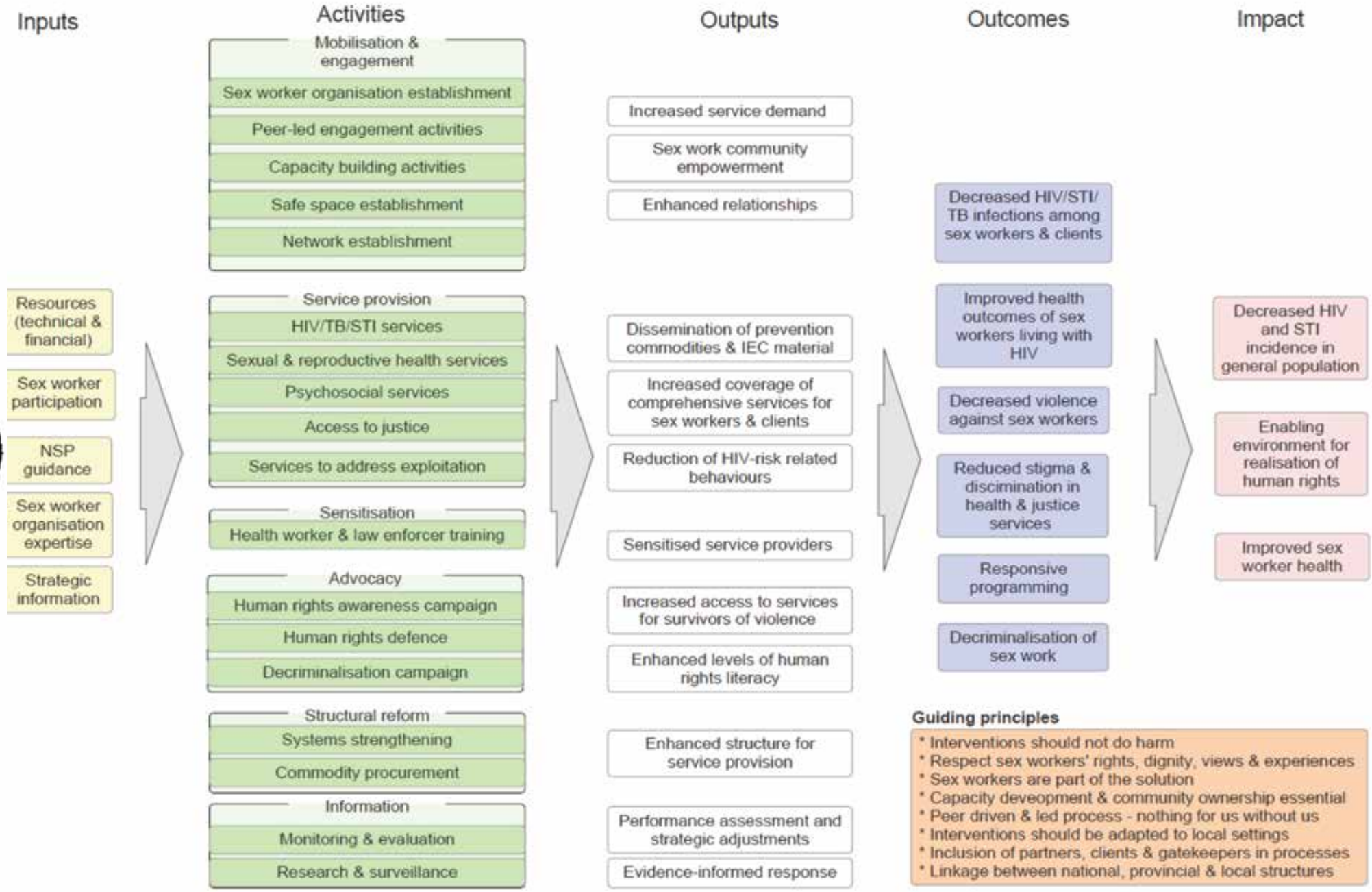
c) Sensitisation of service providers (including health workers, security and justice service providers) around sex work, sex worker vul nerability and the role service providers can play in assisting people to realise their Constitutional Rights and justice, will be provided.

d) Advocacy efforts will be focused on deepening society's awareness of sex work and the effects of marginalisation and prejudice through a combination of communication and advocacy methods, including human rights awareness campaigns, activities in support of
defending human rights violations and a decriminalisation campaign.

e) Health systems strengthening will occur through human resource capacity development, commodity procurement and quality assurance activities.

f) Strategic information to inform programme adjustment will be obtained from monitoring and evaluation, surveillance, research and quality assurance activities.

Figure 2: Sex Worker Programme Logic Model



4.1.3. Outputs

NSWP programme activities will result in the following:

- Mobilisation and engagement: increased service demand, sex work community empowerment, and enhanced relationships.
- Service provision: dissemination of prevention commodities and information education and communication (IEC) materi al, increased coverage of sex worker and client services, and reduction of HIV-risk related behaviours.
- Sensitisation: sensitised health workers and law enforcement officers and better recognition of the rights of sex workers.
- Advocacy efforts: increased understanding of sex workers' human rights and accelerated law reform. Understanding of how structural factors, particularly the current legal framework, are linked to HIV and health among sex workers will be deepened through advocacy efforts.
- Health system strengthening: an enhanced service quality.
- Performance assessments and research findings will be used to adjust programme implementation in order to meet NSWP objectives.

4.1.4. Outcomes

Collectively, activities are expected to result in:

- Decreased HIV/STI/TB infections among sex workers and clients
- Improved health outcomes of sex workers living with HIV
- Decrease in violence against sex workers
- Reduced stigma and discrimination in health and security services
- Responsive programming
- The decriminalisation of sex work

4.1.5. Impact

Ultimately, the sex work programme is expected to result in:

- Decreased HIV and STI incidence in general population
- An enabling environment for realisation of human rights
- Improved health and well-being in the sex work setting

4.2. Activities at different levels of engagement:

The sex work programme will operate nationally and require different activities at a national; provincial and local level.

National level activities

SANAC will provide leadership, in collaboration with partners, in creating a supportive environment for HIV, AIDS and STI programs for sex workers. Policy, standards, guidelines, operating procedures, broad activity description and targets will be defined at a national level. SANAC will develop a national policy statement on sex workers and HIV, AIDS, and STI and advocate for, and facilitate, the involvement of other sectors in the Sex Worker National Strategic Framework. SANAC will promote the involvement of the relevant government departments at National, Provincial, District and Local Municipality levels in support of the NSWP. An overview of national level activities is provided in *Error! Not a valid bookmark self-reference.*

Increased coordination and collaboration among partners

SANAC will coordinate the implementation of the NSWP in consultation with the SWTWG). Key areas of coordination for the SANAC will be:

- Setting evidence based programme priorities
- Setting geographic priorities and ensuring that there is no duplication between the work of different organisations
- Promoting close collaboration between donors, technical assistance providers and Community Based Organisations
- Promoting a multi-sectoral response by other Ministries to the issue of HIV and sex workers
- Monitoring the NSWP regarding quality, achievements and results
- Resource mobilisation
- Facilitating a multi-stakeholder review prior to the end of the NSWP, including development of key recommendations for a future strategic plan

Coordination between the different technical assistance providers will be achieved by regular meetings of the SWTWG. Coordination between CBOs implementing sex worker projects will be achieved through collaborative day-to-day working relationships and meetings to share lessons learned and plan joint activities. At the Provincial and District levels, implementing agencies will continue to work closely with officials and local communities.

Table 1 Overview of National NSWP activities

Category	Activity	Description	Responsible agency
1. Mobilisation & engagement	1.1 Sex worker organisation development	Development of framework for development (curriculum, model of practice)	National TWG & partners; consultants
	1.2 Peer-led engagement	Best-practice guidelines (engagement/ approach methods; content/ knowledge; structure for career development etc.)	
	1.3 Capacity building	Training curriculum	
	1.4 Safe space establishment	Best-practice guidelines	
	1.5 Networking & representation	Negotiate high level representation of sex workers - SANAC, provincial AIDS councils, presentations to parliament	SANAC secretariat, resource team, National TWG & partners, consultants
2.Service provision	2.1 HIV/STI/TB prevention, treatment, care & support	Development of guidelines and quality assurance programme	National TWG & partners, consultants
	2.2 Sexual and reproductive health services		
	2.3 Psychosocial		
	2.4 Access to justice		
	2.5 Addressing exploitation 2.6 National toll free Help line		
3. Sensitisation training	3.1 Health care workers	Curriculum development; training of trainers; evaluation of programme; (consider integration with KP sensitisation training and linkage with Regional Training Centres)	National TWG & partners, consultants
	3.2 Other service providers		
4. Advocacy	4.1 Human rights campaign	Develop advocacy agenda & strategy Develop advocacy messages Implement national level advocacy efforts Best practice for responding to human rights violations/ crime and exploitation	National TWG & partners, consultants
	4.2 Human rights defense		
	4.3 Decriminalisation campaign		
5. Health systems strengthening	5.1 Quality assurance	Develop outline of quality assurance, operating procedures (SOPs) and procurement processes	National TWG & partners, consultants
	5.2 Commodity procurement		
6. Information	6.1 M&E	National M&E framework Collation of national data and reporting	National TWG & partners, consultants
	6.2 Surveillance & research	Develop research agenda, coordinate research activities and surveillance system	

Provincial level activities

Provincial level activities will link local implementers, provincial structures and national coordinating bodies. These activities will allow for sharing of information and alignment of HIV prevention, treatment, care and support efforts.

Local level activities

The way in which SW services will be provided will be based on the facility type, service demand and other contextual factors, as provided in Table 2.

Table 2 Service provision models

	Mainstream facility/ site	Sex-worker focused facility/ site
Services provided	Minimum services & activities	Additional add-on services
Sex worker population	Not clearly a "hot spot" Not feasible/ efficient for sex work focused site	High concentration of sex workers ("hot spot") High concentration of sex work clients Sex worker focused site development feasible
Existing & potential infrastructure	No existing SW-focused organisations Not a HTA site	Existing SW-focused programmes Existing SW-focused CBOs Well-functioning HTA sites

Table 3 Overview of local level services

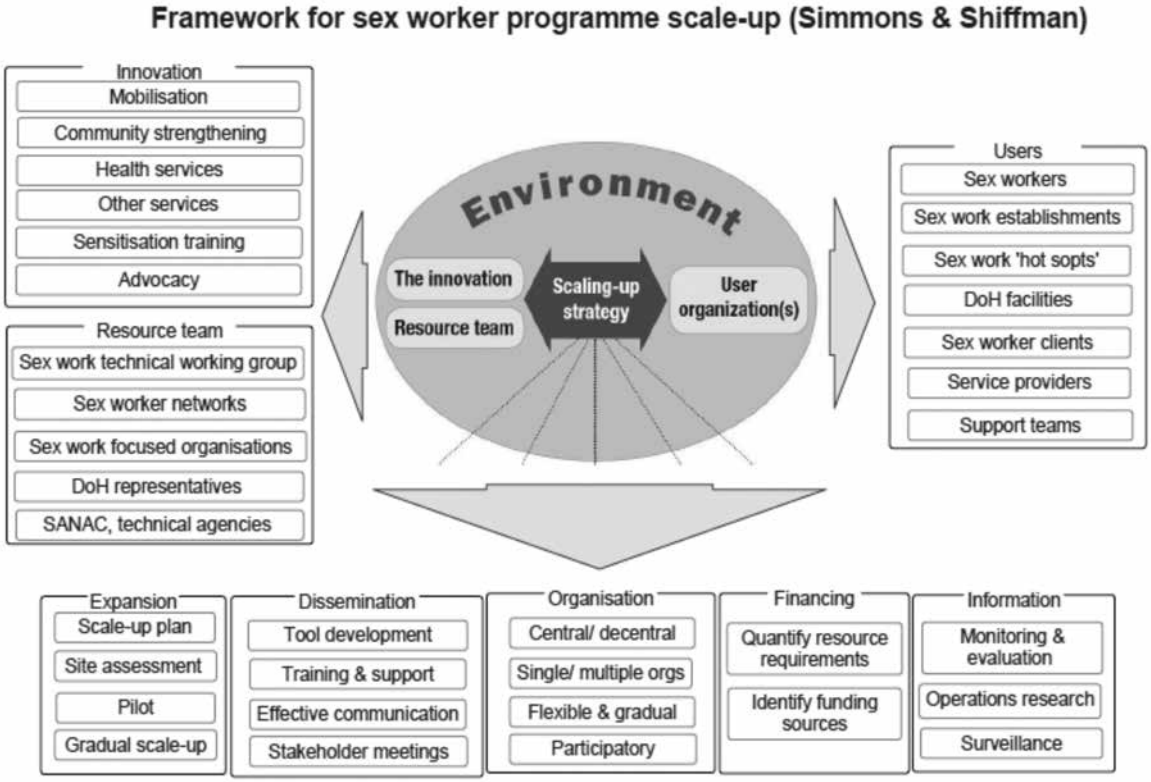
Category	Activity	Description		Implementer	Modes of delivery
		Minimum services	**Additional add-on services**		
1. Mobilisation & engagement	1.1 Sex worker organisation development	Establish local sex work organisation, linked existing organisation	Enhance structure of existing sex worker led organisation	Identified organisation	Based at a facility/ site
	1.2 Peer-led engagement	Establish programme for peer delivered services (listed 2.1 - 2.5)	Develop programme for peer career development & leadership	Developed & coordinated by identified organisation	Based at a facility/ site
	1.3 Capacity building	Training: human rights; basic HIV, STIs, TB awareness; condom negotiation skills; access to justice; peer support; referral to services; managing violence and exploitation	Training: developing local campaigns; leadership; advocacy & communication skills; alcohol & drug support, para-legal support	Conducted by provincial/ national trainers	Done at strategic provincial sites, allow for sex work peers to network
	1.4 Safe space establishment	Specified area for SW to engage with peers; access information; also serve as venue for training & meeting place for sex worker organisation		Identified organisation	Based at a facility/ site
	1.5 Networking & representation	Guided linkage of new organisation with local partners and representation on local structures (e.g. ward & facility committees)	Linkage of sex worker organisation with provincial, national & international partners & structures (e.g. representation on provincial AIDS councils, national and international sex worker organisations)	Provincial task team in liaison with provincial sex worker organisations	n/a
2. Service provision	2.1 HIV/STI/TB prevention, treatment, care & support	HIV prevention commodities & BCC material HIV Counselling & testing STI/TB screening & treatment/ referral Referral for PEP, ART	Additionally: ART & TB treatment Post-exposure prophylaxis Tailored services to address sex worker clients: prevention commodities, BCC material, HCT, STI management, PEP and referral	Medical and non-medical sites respectively - peer based referrals & support	Facility based, mobile units
	2.2 Sexual and reproductive health services	Family planning (including emergency contraception) PAP smear / referral Termination of pregnancy & support / referral	Comprehensive sexual & reproductive health services	Medical and non-medical sites respectively - peer based referrals & support	Facility based, mobile units

Category	Activity	Description		Implementer	Modes of delivery
		Minimum services	Additional add-on services		
	2.3 Psychosocial	Psychosocial counselling & referral Alcohol & drug use screening & brief intervention & referral	Screening & support for alcohol & drug use and referral Mental health services in line with primary care programme	Medical and non-medical sites respectively - peer based referrals & support	Facility based
	2.4 Access to justice	Train sex workers on their rights Support to report crime & violence Support to report discrimination by service providers	Additionally: Support to access legal support	Peer delivered, support by local SW organisation	In the field
	2.5 Addressing exploitation	Referral protocol to services related to violence and exploitation	Paralegal Peer educators assist sex workers to lay charges, seek redress at CCMA and other institutions etc.	Organisations	Facility based & in relevant provincial structures
3. Sensitisation training	3.1 Health care workers	Provision of services for health care workers (ALL staff - security, clerks, nurses, CNPs)		Conducted by provincial/ national trainers	Done at strategic medical and non-medical sites participating
	3.2 Other service providers		Sensitisation training for police officers, justice officials (prosecutors and clerks of the court), other		Done at strategic police stations
4. Advocacy	4.1 Human rights campaign	Peer led information dissemination (see 1.1 - 1.5)		Local SW organisation	Among peers; at community structures & events
	4.2 Human rights deference	Peer led support and referral to access services (see 2.4)	As per minimum (see 2.4) Peer paralegal officers support sex workers in accessing justice, addressing exploitation	Local SW organisation support from legal support center	Legal support centre
	4.3 Decriminalisation campaign	SW organisation and network discussion & advocacy through representation on local structures	Advocacy at provincial & national structures (PCAs, SANAC, parliament)	Local SW organisation	Among peers; at community structures & events
5. Structural reform	5.1 Systems strengthening	Develop standard operating procedures for: peer activities; referral pathways; local resource list; implement existing policy; human resource capacity building and record keeping		Provincial task team in partnership with local SW led/focused organisation & health sector	Sites & facilities
	5.2 Commodity procurement	Ensure adequate supply & distribution of prevention commodities (male & female condoms & lubrication)			
6. Information	6.1 M&E	Monitoring: collection data on process indicators and participation in evaluation activities		SW led and/or focused organisation	n/a
	6.2 Surveillance & research	Participation in relevant research		SW led and/or focused organisation in partnership with others	n/a

4.3. Implementation

The implementation strategy is based on the framework developed by Simmons and Shiffman used to scale-up sexual and reproductive health services in similar contexts (Simmons & Shiffman, 2007)(see 3). The "innovation" is the package of services described earlier, the resource team is described below along with linkages, and the users include sex workers, their clients (particularly in areas of high concentration e.g. truck stops, mines), peer workers, implementing organisations and the technical working group.

Figure 3 Framework for NSWP scale-up



4.3.1. Scale-up strategy

Guided expansion

Scale-up plan to be developed, inclusive of:

- Baseline situational and needs assessment per province, city or location (inclusive of size estimation, service mapping & sentinel site HIV prevalence assessment)
- Sex worker population estimations processes:
  - SANAC supported SWEAT population size estimate completed in 2013, using mixed methodology (secondary data analysis, enumeration and knowledge of the crowd)
  - Centre for Disease Control-supported University of California, San Francisco (UCSF) is implementing formal research in 14 sites including the development of a surveillance system is underway, to be completed in 2014.
- Sex work service mapping and plans to be refined for implementation. Information from the evaluation of the SWEAT Global Fund Sex Worker project completed, data being analysed.
- Refinement of operational plan and pilot implementation in select sites.
- Review of progress, refine plan, tools and structures based on pilot performance.
- Gradual expansion to other sites.

4.3.2. Dissemination

National, provincial and local level activities including personal and "impersonal" types of advocacy, marketing and information dissemination is needed to support scale-up activities - before and during implementation. Clear diffusion channels needs to be outlined in a communication plan. The types of information dissemination methods and tools are provided in Table 3

Table 3 Overview of NSWP related information dissemination

Level	**Personal**		**Impersonal**	
	Campaigns & dialogue	Capacity building & support	Tools	Information dissemination
National	Stakeholder meetings to enhance buy-in and engagement SANAC & NDOH launch Presentation to multisectoral ministerial committees Presentation at national HIV conferences etc.	Sensitisation of policy makers on sex work & HIV Site visits for Key Provincial government. partners to SW organisations SW presentations	National Sex Worker Programme document Best practice guidelines - for package of services National operational plan Communication plan M&E plan Research agenda Programme briefs & communiqués	At campaigns & dialogues Websites, databases
Provincial	As above, with targeted provincial stakeholders & provincial structures & SW participation	As above, tailored to provincial context	As above, tailored to provincial context	As above, tailored to provincial context
Local	As above, with targeted local stakeholders & structures & SW participation	As above, tailored to local context	As above, tailored to local context	As above, tailored to local context

5. Management model

5.1. National Sex Worker Programme Organisation

The organisational structure of the National Sex Work Programme (NSWP) will broadly include national and local level structures and is outlined in Figure and Table 4.

National Level Organisation
The South African National AIDS Council (SANAC) secretariat, a SANAC NSWP coordinating body, national sex work technical working group (SWTWG) and representatives of the SANAC sex work sector will make up national level structures.

The SANAC Secretariat will oversee the overall implementation of the National Strategic Plan for HIV, STIs and TB (2012 - 2016) (NSP). The NSWP will be aligned to reach the overall NSP goals and objectives.

The NSWP coordinating body will include representatives from relevant SANAC departments (M&E, grants, finance) and representatives from the SANAC sex worker sector. SANAC technical officers will support the NSWP programme coordinator and NSWP programme officer who will coordinate the implementation of the NSWP, engage with relevant stakeholders and enable process required for programme success. Relevant representatives from the National Department of Health (NDOH) high transmission area (HTA) programme and the HIV and STI prevention directorate will also form part of the NSWP coordinating body to maximise synergies between the NSWP and the DOH's HTA programme. The NSWP coordinating body will enable mobilisation, engagement, and advocacy at a national level.

The SANAC Sex Work sector, representing sex workers and organisations working on sex work, will engage with the NSWP coordinating body and relevant technical support groups and where appropriate principal recipients. The SANAC Sex Work sector will work with the NSWP coordinating body to enable programme success, and will be a platform for engagement around sex work issues.

A technical working group (resource group) will be established to provide ongoing technical support, including sex worker community input, into programme implementation, monitoring and adaptation to overcome challenges. The working group will be comprised of sex workers, sex worker service providers, researchers, members from SANAC and technical and development agencies.

Local Level Organisation
Through a grant making system, awards will be developed for the implementation of NSWP to 4 - 5 principal recipients (PRs). PRs will enter into formal contracts with SANAC outlining key targets and programme standards in line with the national sex work strategy and operational/work plans and relevant national guidelines. PRs will sub-contract organisations (sub-recipients, SRs) to implement the work at a local level. SRs will be responsible for implementing programme activities. PRs will enable networking between SRs and between SRs and local HIV structures (e.g. District AIDS Councils).

Figure 4 Overview of National Sex Worker Programme Organisational Structure

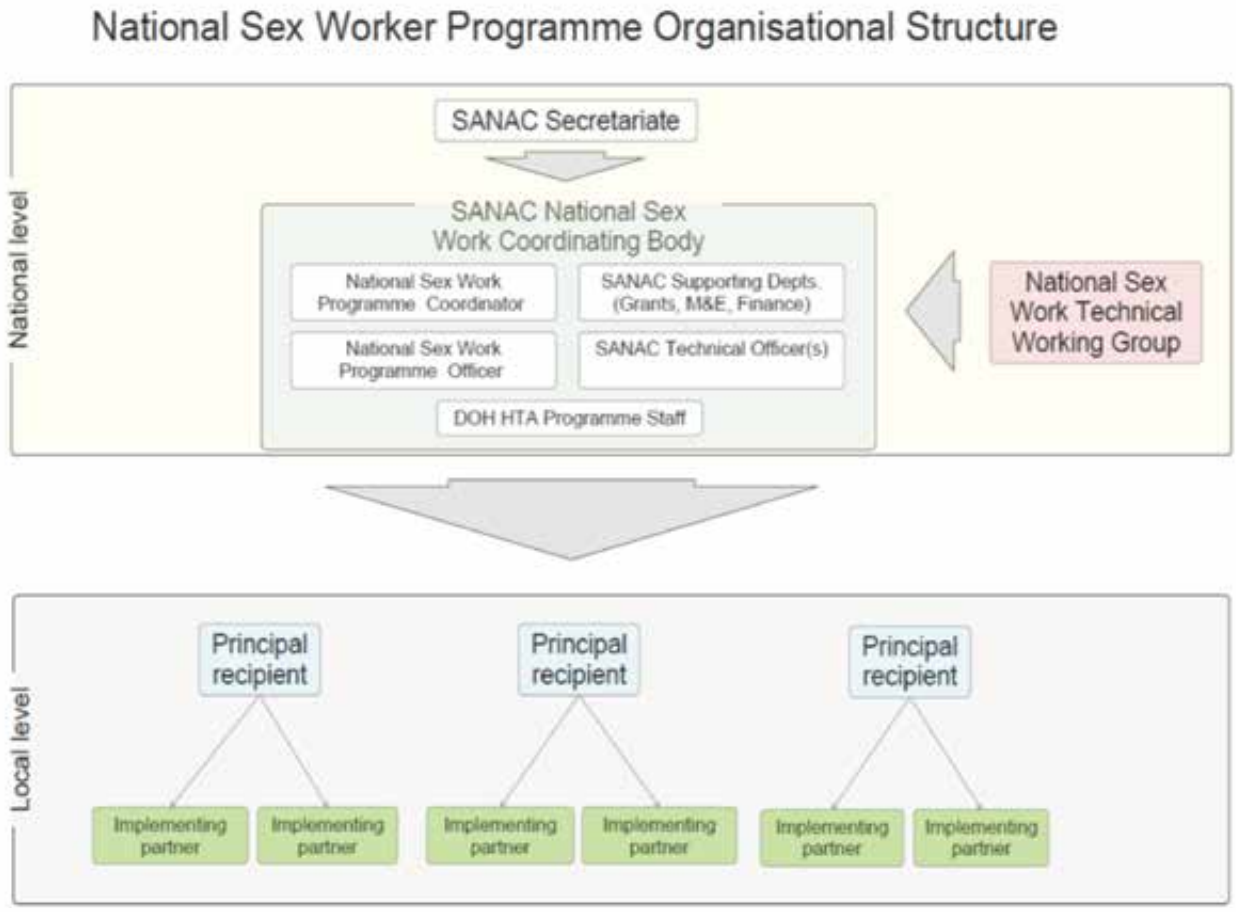


Table 3 Overview of NSWP related information dissemination

National level		
Component	Members	Role & Responsibility
SANAC Secretariat	SANAC Secretariat	Overarching stewardship for SANAC and engagement with other SANAC structures in relation to the NSWP
SANAC NSWP coordinating body	Representatives from SANAC departments (M&E, grants, finance)	Ensure NSWP financing, grant management and M&E structures and mechanisms operational and support implementation
	SANAC technical officers, NSWP programme coordinator & officer	Employed to work specifically on the NSWP to coordinate implementation in line with the strategy documents and operational/work plan(s). Be focal point for principal recipients for SW grants, members of the TWG and the SW sector - ensure linkages with relevant SANAC departments
	National Department of Health (NDOH) high transmission area (HTA) programme and HIV and STI prevention directorate representatives	Facilitate collaboration between HTA programme and the broader NSWP, and for coordination of HTA work and that of principal recipients
SANAC SW sector	Representative(s) from the SANAC sex work sector	Represent the priorities and interests of civil society organisations, working with government, in HIV-related matters. Members of the sex work sector may be represented on various SANAC structures and task teams (particularly prevention and human rights) and should allow for communication of NSWP activities
SANAC SW TWG	Representative from technical and development agencies, researchers, service providers, advocates and sex workers	Provide technical and scientific input into planning, implementation & evaluation of the NSWP, inclusive of inputs from SWs.
Local level		
Component	Members	Role & Responsibility
Principal recipient	Grant winners	Oversee and coordinate the implementation of the NSWP by local level organisations. Coordinate the financing, reporting and support needed for local implementation. Facilitate networking, mobilisation and capacity building of sub-recipients to provide appropriate, evidence based programmes, in line with NSWP guidelines and targets.
Implementing partner	Sub-recipients of grants	Implement SW programmes in line with national guidelines, adapted to local context. Ensure standards, quality and coverage of services. Engage with district and where appropriate provincial AIDS structures.

5.2. Resource teams & linkages

The individuals and agencies that will support NSWP scale-up (resource teams) will work and the linkages with relevant structures are outlined in Table 5.

Table 5 Resource team outline

Level	Resource team	Supporters	Structures & linkages
National level	SANAC National Sex Work Programme Coordinating body; National Sex Work Technical Working Group	Dept. of Social Development, Premier's offices, Dept. of Transport, private sector (mining, farming, transport) police, DOH key population TWG/F & represented organisations, researchers, other technical & development agencies	SANAC Inter-ministerial committees
Local level	Service providers (DOH facility, NGO, HTA site, specialist sex work facilities)	Referral partner organisations, police, sex worker client facilities (truck stop owners etc.)	Local AIDS councils; Health facility committees; Ward Councils ; Community Police Forums

5.3 Capacity building strategy:

Strengthened leadership and advocacy capacity by all partners
The capacity of SANAC, to provide national leadership through effective accomplishment of its core functions, will be developed. This will concentrate on developing skills in coordination, advocacy, facilitating the involvement of additional partners, resource mobilisation, and monitoring and evaluation.

A capacity assessment of members of the SWTWG will be conducted, and a capacity development strategy formulated. Advocacy training for CBOs working with sex workers will be conducted. The leadership skills of CBOs will be developed to facilitate more effective representation of the interests of sex workers and CBOs in national policy and program decision making forums.

Strengthened technical and organisational capacity of CBOs to undertake quality prevention activities and referral to care, support and treatment services

The quality of work undertaken by peer educators and outreach volunteers will be improved by developing skills to go beyond basic HIV education. This will include developing skills in delivery of strategic behaviour change communication messages, based on evidence relating to sex worker attitudes, beliefs and behaviour, improved operational research, and how to develop messages appropriate for segmented audiences. A sex worker training curriculum for peer educators and outreach volunteers will be developed.

Other priorities for CBO capacity building are strengthening organisational capacity, developing skills in reaching hidden sex workers, condom social marketing, advocacy, resource mobilisation, and monitoring and evaluation.

Strengthened involvement of Sex Workers and Sex Worker-CBOs in the HIV and AIDS response

The greater visibility of sex workers in South Africa can be achieved by strengthening the Sisonke Sex Workers' Movement. Tapping into this network will provide an opportunity for building a community development and mobilisation approach. The greater involvement of sex workers in HIV prevention programmes will enable the establishment of community norms such as consistent condom and lubricant use, which will be more sustainable than a service delivery approach to prevention, which positions CBOs as providers of services and sex workers as consumers. Strengthening the skills of CBOs in community development and mobilisation will be focused, and this will be accompanied by capacity building of the National Sex Worker Movement, Sisonke, to build a grass-roots community response to HIV and AIDS.

Strengthened capacity of STI services to provide quality and stigma-free STI services to sex workers

The National Department of Health will take the lead in developing the basic skills of all government STI clinicians to provide appropriate and stigma-free STI services to sex workers. More advanced clinical skills for STI care and treatment for sex workers will be developed in primary healthcare facilities in provinces with larger numbers of sex workers. The scope of training of STI clinicians will be broadened to include a sensitisation module on stigma and discrimination and sexuality, to ensure sex worker-friendly and stigma-free services. For HIV counseling and testing personnel, a training module will be developed on HIV prevention specific to sex workers, psycho-social and sexuality issues, and stigma and discrimination.

5.4 Resource mobilisation

Mobilisation of additional resources is essential if South Africa is going to be able to develop sex worker prevention interventions to a scale sufficient to reduce HIV prevalence. Additional resources will be needed above what South Africa has sought in its Global Fund Round 11 proposal, the PEPFAR-funded sex worker programmes, as well as the National Department of Health HIV and AIDS Conditional Grant funding.

SANAC will lead processes to identify potential donors to finance full implementation of the NSWP. This will include advocacy with donors on financial resource needs and the National Treasury. SANAC will also facilitate processes for development of multi-agency joint funding proposals.

5.5 Sustainability

To ensure sustainability of the South African Sex Worker programme, SANAC will be putting processes for sustainability planning in place, that will identify processes that will help lead to such sustainability. These include routinisation that is typically viewed as the extent to which the programme has been integrated into existing organisational systems and practices, and institutionalisation that considers the role of institutional standards, and the extent to which innovation and learning not only gets adopted and sustained, but is also reflected in NSWP norms and standards that govern multiple organisations within the broader health system.
This will be done by:

1. Supporting government capacity – activities include
   - enhancing the technical and managerial skills of government staff members through training and mentoring
   - supporting government HIV/AIDS prevention structures and the systems necessary for those structures to operate effectively
   - supporting the development and production of training materials as well as government norms and guidelines for sex worker programming

2. Supporting NGO capacity, including the provision of capacity development support to implementing partners (NGOs/CBOs) as well as foster linkages with the NDOH High Transmission Area (HTA) programmes.

3. Supporting community capacity, including support to community organisations through strengthening management and governance structures and through building networks of CBOs. Establish linkages and coordination for sex worker programming at local, district and provincial levels.

4. Alignment of interventions – alignment of the technical, managerial, and cost elements of CBO/NGO-led sex worker programmes with government norms so as to facilitate transition.

5. Sustaining and monitoring commitment – government commitment to high levels of service coverage for high-risk groups is critical to sustainability. Securing and maintaining such commitment is inherently political and thus may be difficult to plan for. While government commitments are already documented in the current NSP, SANAC will monitor these commitments, so as to help ensure that they are sustained.

6. Monitoring and Evaluation

6.1. Strategic Information Strategy

The key objective of this section will be to provide programme design, review, and quality improvement that will be informed by enhanced collection and application of strategic information.

HIV and STI surveillance and behavioural data is collected and used to inform the response

The University of California San Francisco (UCSF) South Africa Health Monitoring Study Formative Assessment for Integrated Biological and Behavioral Surveillance (IBBS) with sex workers is underway, with activities that include:

- the measuring the prevalence of HIV and associated risk behaviors
- estimating the population size and distribution of the SW population
- assessing the use of and access to health and social welfare services
- enhancing the local capacity to conduct HIV surveillance

The findings of this survey will be used to monitor the HIV and STI epidemics in sex workers, trends in behaviour and to inform programme and project design and monitoring of coverage. SANAC, together with NDoH, will facilitate a national consultation meeting of key stakeholders to reach a consensus on the estimated number of sex workers in South Africa, based on the SANAC/SWEAT Rapid Sex Worker Population Size Estimate, the UCSF IBSS Population Size Estimation results, and any other national and provincial research.

Improved social and operations research on sex worker and sex worker interventions

Research priorities for improved evidence-based programming will be identified as part of the NSP key populations research agenda. SANAC will facilitate periodic monitoring of trends in attitudes, beliefs and behaviours for use in strategic behaviour change communications and programming.

Improved monitoring of sex worker programmes and evaluation of the efficiency, effectiveness and impact of interventions

Sex worker data elements have been included in the core indicators of the NSP Monitoring and Evaluation Framework. These indicators will be used, along with other data, to monitor implementation of the HIV prevention treatment, care and support programming for sex workers.

The NSWP Monitoring and Evaluation framework, highlighting the NSWP impact and outcome indicators is provided in **Error! Reference source not found..** The collection of this data will be coordinated by SANAC using specific evaluations and audits.

In addition, MAP studies will be commissioned to measure coverage and quality assurance tools will be developed for sex worker prevention programmes. Reviews and evaluations of key components of the strategy will be commissioned. The skills of CBOs in using monitoring data to analyse the pattern of service provision and make improvements will be developed.

6.2 Indicator Matrix

Strategic objective 1

Sub Objective	No.	Indicator	Type	Frequency	Data source	Responsible Person	Comments
1.1 Reduce stigma and discrimination towards sex workers in health, justice and security contexts	1.1.1	Number of national legislations, provincial legislation and municipal by-laws that present obstacles to effective HIV prevention, treatment, care and support for sex workers.	Outcome	Annual	Desktop review	NSWP manager	Disaggregate by types and content
	1.1.2	Percentage of sex workers who report experiencing stigma in the last 12 months.	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	1.1.3	Percentage of sex workers reporting sexual violence within the last 12 months.	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	1.1.5	Percentage of sex workers reporting harassment within last 12 months	Outcome	Bi-annual	Integrated Biological Behavioural	NSWP Manager/	Disaggregate by perpetrator
					Survey	SANAC	
	1.1.6	Number of sex workers referred for medical care in a district in a reporting period	Output	Quarterly	SANAC M&E System	M&E Manager	

Strategic objective 1

Sub Objective	No.	Indicator	Type	Frequency	Data source	Responsible Person	Comments
	1.1.7	Number of legal assistance(new) provided for sex workers in a district during reporting period	Output	Quarterly	SANAC M&E System	M&E Manager	Disaggregate by type of service
	1.1.8	Number of sex workers consultations seeking information and referral for care and support provided in a district	Output	Quarterly	SANAC M&E System	M&E Manager	Disaggregate by mode of consultation- virtual or contact
	1.1.9	Number of people trained on Human rights, Stigma and discrimination of sex workers	Output	Quarterly	SANAC M&E System	M&E Manager	Disaggregate by occupational group and content of training
	1.1.10	Number of people sensitised on Human rights, Stigma and discrimination of sex workers	Output	Quarterly	SANAC M&E System	M&E Manager	Disaggregate by purpose
	1.1.11	Number of sensitisation sessions conducted during reporting period	Output	Quarterly	SANAC M&E System	M&E Manager	Disaggregate by purpose
	1.1.12	Number of people reached with advocacy campaign during reporting period	Output	Quarterly	SANAC M&E System	M&E Manager	
	1.1.13	Number of decriminalisation campaigns conducted	Output	Quarterly	SANAC M&E System	M&E Manager	

Strategic objective 1							
Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
1.2 Increase sex worker community mobilisation and collective empowerment	1.2.1	Number of sex workers completed an adult education programme	Output	Quarterly	SANAC M&E System	M&E Manager	Disaggregate by type of educational programme
	1.2.2	Number of sex workers participating in an economic empowerment initiative	Output	Quarterly	SANAC M&E System	M&E Manager ILO	Disaggregate by type of service empowerment initiative
	1.2.3	Number of organisations providing sex worker friendly services in a district	Output	Quarterly	SANAC M&E System	M&E Manager	
	1.2.4	Number of people reached by a sex worker led programme	Output	Quarterly	SANAC M&E System	M&E Manager	

Strategic objective 1							
Sub Objective	**No**	**Indicator**	**Type**	**Frequency**	**Data source**	**Responsible Person**	**Comments**
1.3Increase sex worker capacity for self determination	1.3.1	Percentage of sex workers reporting unprotected receptive anal sex at last time that had sex with a male partner	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	

Strategic objective 1							
Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
	1.3.2	Percentage of sex workers reporting use of injecting drugs in last 12 months	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	1.3.3	Percentage of sex workers who inject drugs reporting use of clean needle the last time injected	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	1.3.4	Percentage of protected sex acts in the last week	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	1.3.5	Number of peer educators active in peer group activity (service) delivery.	Output	Quarterly	SANAC M&E System	M&E Manager	

Strategic objective 1							
Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
1.4 **Increase sex worker access to safe spaces**	1.4.1	No of High Transmission Areas with safe spaces	Outcome	Annual	Facility survey	NSWP Manager/ SANAC	Disaggregate by province

Strategic objective 1							
Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
1.5Increase access to support in response to rights violation							See 1.1.7

Strategic objective 2							
Sub	No	Indicator	Type	Frequency	Data	Responsible	Comments
Objective					source	Person	
2.1 Increase coverage of, and access to, a minimum package of HIV and related prevention services by sex workers by 50% by 2016	2.1.1	HIV prevalence among sex workers	Impact	Bi-annual	Sero-prevalence survey	NSWP Manager /SANAC	UNGASS #23
	2.1.2	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	UNGASS # 18
	2.1.3	Percentage of sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	UNGASS # 14

Strategic objective 2							
Sub Objective	**No**	**Indicator**	**Type**	**Frequency**	**Data source**	**Responsible Person**	**Comments**
	2.1.4	Percentage of sex workers that have received an HIV test in the last 12 months and who know their results	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	UNGASS # 8
	2.1.5	Percentage of sex workers reached with HIV prevention programmes	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	UNGASS # 9
	2.1.6	Percentage of sex workers reporting symptoms an STI in the past 12 months	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	2.1.7	Percentage of sex workers reached by condom promotion and distribution programme in the past 12 months	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	2.1.9	Number of sex workers provided with condoms by HIV prevention programmes for sex workers for a reporting period	Output	Quarterly	SANAC M&E System	M&E Manager	

Strategic objective 2

Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
	2.1.10	Number of male condoms distributed by HIV prevention programmes for sex workers for a reporting period	Output	Quarterly	SANAC M&E System	M&E Manager	
	2.1.11	Number of female condoms distributed by HIV prevention programmes for sex workers for a reporting period	Output	Quarterly	SANAC M&E System	M&E Manager	

Strategic objective 2

Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
2.2 Increase sex worker client access to relevant HIV/STI prevention services by 50% in areas of sex work client concentration by 2016	2.2.1	Number of coordinated mass media campaigns - that address stigma towards sex works during the reporting period	Output	Quarterly	SANAC M&E System	M&E Manager	Disaggregated by audience
	2.2.2	Number of sex workers reached by peer educators to utilise health services	Output	Quarterly	SANAC M&E System	M&E Manager	

Strategic objective 3

Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
3.1 Provide anti-retroviral therapy to 80% of eligible sex workers by 2016	3.1.1	Percentage of eligible adults (sex workers) currently receiving antiretroviral therapy	Output	Quarterly	SANAC M&E System	M&E Manager	
	3.1.2	Percentage of adults (sex workers) with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Output	Quarterly	SANAC M&E System	M&E Manager	
	3.1.3	Percentage of sex workers diagnosed with TB in the last quarter starting TB treatment	Output	Quarterly	SANAC M&E System	M&E Manager	

Strategic objective 4

Sub- Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
4.1 Ensure constant supply of commodities	4.1.1	Percentage of provinces with M&E plan for HIV, TB and STI that includes all of the components for M&E of HIV prevention programme for sex workers	Outcome	5 yearly	SANAC desk review	SANAC M&E	
	4.1.2	Total funds expended on programmes for sex workers	Outcome	Annual	National AIDS Spending Assessment (NASA)	UNAIDS/ SANAC	

Strategic objective 4							
Sub- Objective	**No**	**Indicator**	**Type**	**Frequency**	**Data source**	**Responsible Person**	**Comments**
	4.1.3	Percentage of sex works reporting that they could get condoms on their own if they wanted	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	4.1.4	Percentage of sex works reporting that they could get lubricants on their own if they wanted	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	

Strategic objective 4							
Sub Objective	**No**	**Indicator**	**Type**	**Frequency**	**Data source**	**Responsible Person**	**Comments**
4.3 Pilot and evaluate Pre exposure prophylaxis and test and Treat strategies for sex worker	4.3.1	Percentage of sex workers receiving the minimum package of services in the past 12 months	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	Disaggregate by province

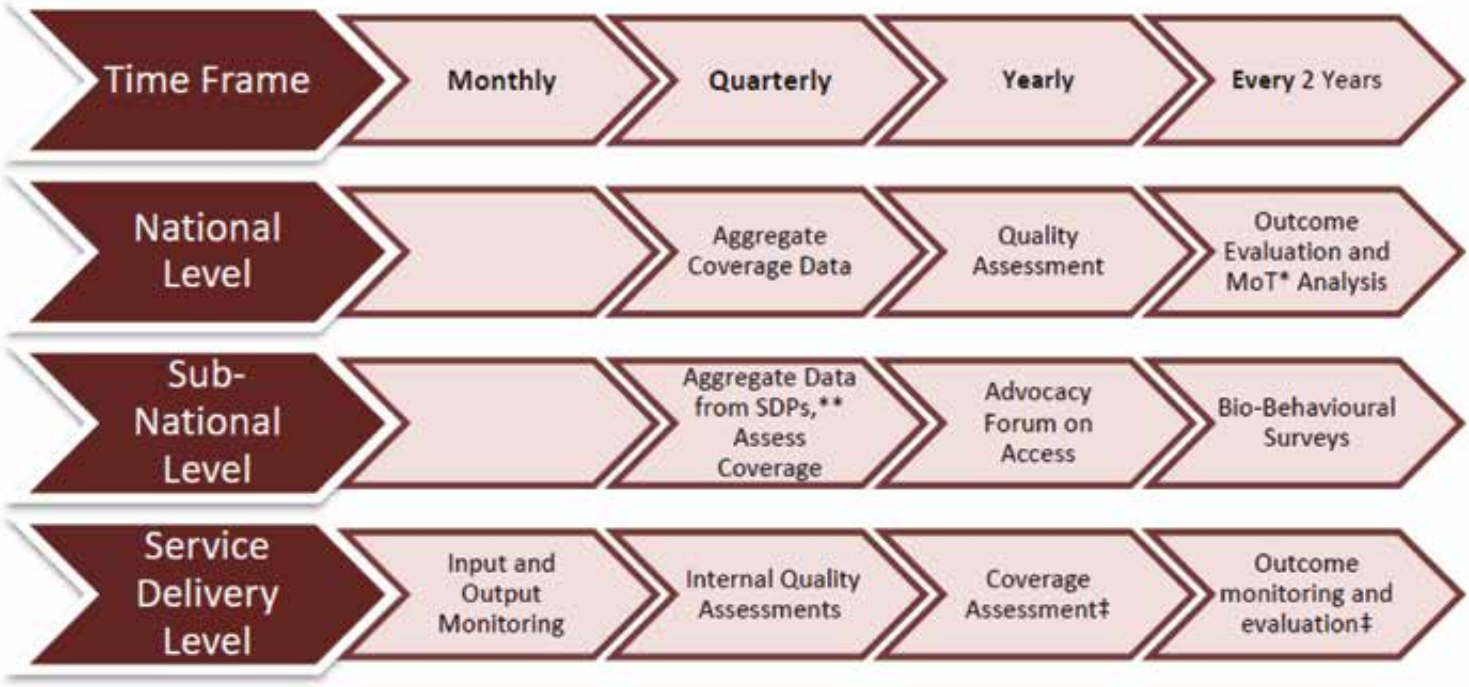
Strategic objective 4

Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
4.2 **Improve quality of HIV and related services received by sex workers**	4.2.1	Percentage of sex workers reached with HIV prevention programmes	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	4.2.2	Percentage of sex workers who have received IEC	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	
	4.2.3	Percentage of sex workers reached with HIV counseling & testing programmes	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	UNGASS 8
	4.2.4	Percentage of sex workers screened for STI in the past 12 months	Outcome	Bi-annual	Integrated Biological Behavioural Survey	NSWP Manager/ SANAC	

Strategic objective 4

Sub Objective	No	Indicator	Type	Frequency	Data source	Responsible Person	Comments
	4.2.5	Number of dedicated sex worker service sites including HTA programme sites in province	Input	Annual	Facility survey	NSWP Manager/ NDoH	Disaggregate by district Rural/urban
	4.2.6	Percentage of facilities meeting the minimum quality standards for the delivery of services for sex workers	Outcome	Annual	Facility survey	NSWP Manager/ NDoH	

Estimated / Proposed timeframes for conducting M&E activities at each level:



* Modes of transmission
**Service delivery provider
‡ If capacity exists

Data Sources and Flow

Fifty indicators have been selected for monitoring the NSWP. This will require the establishment of a system for the routine collection of data for 21 indicators. The other indicators would be obtained from non-routine sources to generate the required information.

Routine
The implementation of the activities according to the strategic plan results in interaction of implementers with individuals or groups of individuals.

Accurate recording of these activities in registers or files by the different implementers serves as the primary source of data for the monitoring system.

These data sources must have as minimum all the data elements required on the monthly data summary form. These data sources must be well secured and available for verification by data auditors at any point in time.

Examples of such registers include workshop attendance registers, training registers, referral registers, and commodity distribution records.

Non–routine sources of data

Integrated Biological Behavioural Survey (IBBS)
Biological behavioural surveys are conducted as a component of a second generation surveillance systems. They are designed to be an on-going continuous collection of data on sex workers pertinent to the control and management of the response among sex workers.

IBBS will provide data on 23 of the indicators, proving important information at the outcome level for the programme.

Health facility survey
A health facility survey will be required to generate information on 3 of the selected indicators. The information will be required bi-ennially. It is desirable to undertake this exercise at all health care facilities regardless of the level in both private and public sector.

Other sources
Information for two important indicators will obtained from the reports generated from two desk reviews. The indicators are 1.1.1 and 4.1.1. and the reviews will be commissioned by the SANAC secretariat.

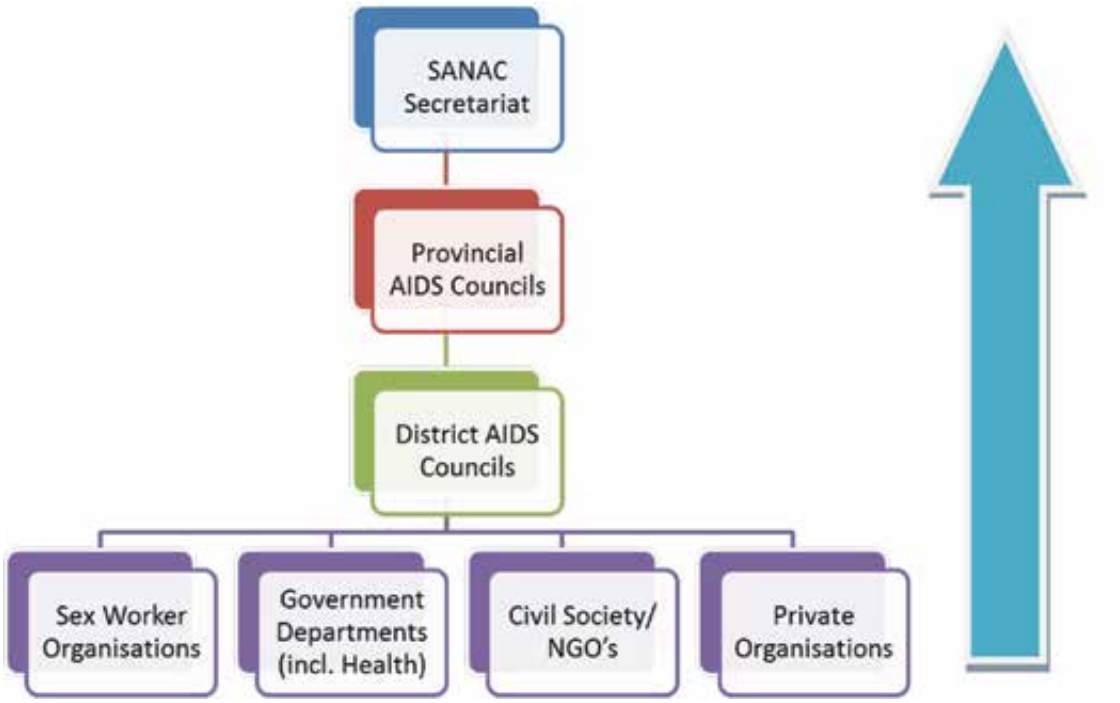
The National AIDS Spending Assessment is a study conducted annually by the SANAC in collaboration with UNAIDS. The review will take into account indicator 4.1.2 to generate information on employment of resources for NSWP.

Data flow for routine data collection

- All data should flow from the implementing organisation through the normal channels of data flow within that organisation/institution.
- Data should flow from the organisation to the district level for further transmission to the provincial office.
- Where no district level offices exist, the data flows straight to the provincial office of the organisation.
- Data from the provincial office of the organisation should be forwarded to the M&E secretariat of the Provincial AIDS Council after cleaning and collation.
- Data from private and civil society organisations implementing non-health interventions should forward the data to the M&E secretariat.
- Data from providers of health care interventions in the

private sector should forward their interventions through the district health office of the department of health.
- Data should be reported at fixed dates in every month as agreed upon from the institutions to the next level of reporting.
- Systems should be established within reporting organisation for the collection and data verification to take place as priority and expedited process.
- Monthly reports from each provincial office should reach the M&E secretariat of the Provincial AIDS Council by the 30th (or nearest working day) of the following month.

Data Flow Chart for Routine Reporting on NSWP



6.3 Information products and data dissemination

6.3.1 Introduction

Information generated must reach all those who need the information to facilitate decision making that would strengthen the response and improve the performance of the organizations and institutions. Dissemination is an active and systematic process to ensure that all implementers in all sectors, provinces and stakeholders receive timeously the information that they would need, in a desirable format as an information product at the time they would need it for decision making.

6.3.2 Information Products

The following information products would be generated on a regular basis for a variety of stakeholders.

6.3.2.1 Quarterly Report on NSWP

Purpose This report is a review of the implementation of the response strategies over the last quarter.
The quarterly report will provide information on all the input/process/output indicators as counts, ratios or proportions and charts. Cumulative data for the year to date will also be reported on. Trends will be shown. Comparisons will be made with baseline, with previous quarter and explanations and significance of changes observed will be discussed.
Source SANAC M&E secretariat
Format Published booklet/newsletter.
PDF or HTML for the website.
Periodicity Quarterly within 30 days of commencement of next quarter.

6.3.2.2 Annual Report on NSWP

Purpose This report is a comprehensive review of the implementation of the responses over one full calendar year from January to December.
The annual report will provide information on ALL the indicators.
Trends will be shown. Comparisons will be made with baseline and within the provinces and explanations and significance of changes observed will be discussed. It may also report on best practice. It may also provide guidance and recommendations for future implementation.
Sources SANAC M&E secretariat
Format Published booklet
PDF or HTML for the website
Publication By the end of March each year

6.3.2.3 IBBS reports

Purpose To disseminate as widely as possible the findings on surveys and surveillance undertaken on sex workers and other key population.
Sources UCCF/SANAC
Format Abstract
Full research report
PDF or HTML for the website
Publication Within one month of feedback to the province.

6.3.2.4 Others

In addition to the above mentioned periodic products, the NSWP Manager would respond to specific and ad hoc information requests made by stakeholders.

6.4 Dissemination Plan

The NSWP will ensure proper dissemination of the information products to all stakeholders and to the general public. The following methods will be employed to achieve maximum dissemination of the information products.

6.4.1 Emailing
Reports will be sent as PDF or MS word documents to all stakeholders identified and willing to receive reports via email.

6.4.2 Posting
A mailing list of all implementing organization will be maintained and the reports posted by mail to them on request.

6.4.3 Stakeholders Partnership forum
SANAC will facilitate the functioning of the NSWP coordinating body, The SANAC sex worker sector and TWG to serve as partnership fora for all stakeholders. The purpose is to create a platform for engagement, review and joint evidence informed planning. Information products would also be distributed at the forum.

6.4.4. Mass media
Excerpts from the various reports will be made available for publication in existing newsletters in various implementing organisations.
In addition, there will be bi-annual press release on progress on the response to coincide with special occasions such Workers' day in May, Women's day in August and World AIDS day in December.
There would be ad hoc press release on findings on research undertaken.

6.4.5. SANAC Website
The following reports will be available on the official website of the MPAC secretariat
- Quarterly Report on NSWP
- Annual Report on NSWP
- IBBS report

6.5 Approval for dissemination
All information for dissemination must be approved for release by MPAC secretariat. All efforts should be made to introduce a system with timelines such that the time schedules are met for the release of the product and not hampered by the approval process.

All information products will be shared with SANAC, other national departments as well as development partners and international organisations with interest in HIV and AIDS.

6.6 Conclusion
The need for wide dissemination of information for all those who would benefit from the information for advocacy, planning and decision making is well recognized.
The information generated through the implementation of the M&E plan will be used in generating information products that would be disseminated through print, oral, mass and web-based media. Face-to-face fora and press conferences would also be established. Information will be widely shared to development partners, government departments and to SANAC.

6.7 Implementation plan
The chapter is organised around the 12 components of a functional M&E system. This is an organizing framework developed under the auspices of UNAIDS that provides (1) a description of the main components of a functional national HIV M&E system, and (2) some benchmarks against which to assess progress in establishing such a system. This chapter therefore describes activities under each components of the NSWP M&E system that need to be undertaken to an acceptable standard for it to function effectively.

6.7.1 Component 1: Organisational Structures with M&E Functions
Performance Goal: Establish and maintain a network of organizations responsible for NSWP M&E at national, provincial and service delivery levels

The NSWP coordinating body will provide overall oversight, for the NSWP and its M&E system. Reporting to the SANAC secretariat, this body is responsible for mobilisation, engagement and advocacy for the programme to ensure its effectiveness, efficiency and sustainability.

The M&E Unit of SANAC secretariat will take responsibility for the management, coordination and implementation of the M&E plan for NSWP.

The secretariat of the Provincial AIDS council should have an officer delegated for the management and coordination of M&E activities of the NSWP at the provincial level.

All implementing partner organisations of the NSWP shall have an M&E unit or focal person to coordinate M&E activities within the organisation. Adequate number of skilled persons should be assigned to the unit depending on the size of the organisation.

The responsibilities for persons assigned for M&E roles should be clearly defined in their job descriptions and their performance contracts should specify important M&E outputs as a key performance area.

6.7.2 Component 2: Human Capacity for M&E
Performance Goal: Ensure adequate skilled human resources at all levels of the M&E system in order to complete all tasks defined in the costed, national NSWP M&E work plan

Adequate number of skilled individuals are needed to implement the M&E system at different levels There is a need to undertake M&E capacity assessment, formulate capacity building plan and provide training to address the skills gap.

Mentorship and supportive supervision shall be carried out by supervisors form SANAC to support and strengthen the technical skills of officers in implementing organisations

6.7.3 Component 3: Partnerships to plan, coordinate and manage the M&E system
Performance Goal: Establish and maintain partnerships among in-country and international stakeholders who are involved in planning and managing the National NSWP M&E system

The M&E Technical working Group of the NSWP has representa-

tion from major stakeholders. This task team will have clear terms of reference and service as a vehicle for coordinating and standardisation key issues in the implementation of the M&E work plan

Decentralised M&E coordination structures
There is a need to create at national, provincial and district levels a structure that fosters partnership among implementing partners, development partners, public service and civil society organisations implementing NSWP. The SANAC sex worker sector represents this structure will serve as a platform for engagement, advocacy and capacity building for M&E. SANAC and Provincial AIDS Councils will facilitate their creation and nurture them to be champions for coordinated implementation of M&E for the programme.

The Extended sex work technical working group which is a partnership forum that will promote data sharing, interpretation and information use among stakeholders, will comprise programme/project managers in public and private sectors, NGOs, researchers and leaders of organisations of sex workers and for sex workers, SANAC and technical and development agencies.

6.7. 4 Component 4: National, Multi-sectoral M&E plan for NSWP
Performance Goal: Develop and maintain a national M&E plan including identified data needs, national standardized indicators, data collection tools and procedures, and roles and responsibilities in order to implement a functional NSWP M&E system

This document fulfills this component for the creation of a functional system for M&E. However, its implementation needs to be monitored.

6.7.5 Component 5: Annual, Costed, NSWP M&E work plan
Performance Goal: Develop an annual, costed, national M&E work plan including specified and costed NSWP M&E activities of all relevant stakeholders and identified sources of funding

The implementation plan for the NSWP M&E plan will be developed annually and costed. The process will be aligned with the National guidelines on the budget cycle. This activity will be synchronised with other programmes coordinated by SANAC

6.7.6 Component 6: Advocacy, Communication and Culture for NSWP M&E
Performance Goal: Ensure knowledge of and commitment to NSWP M&E and the M&E system among policy-makers, programme managers, programme staff, and other stakeholders

The NSWP manager and the secretariat will assume a leadership role through effective communication among partners for creating M&E culture and the coordination of activities to strengthen the M&E system.
Principal and sub recipients of funding from the Global Fund, Programme directors of the High Transmission Area programmes will serve as ambassadors in advocating and promoting the practice of M&E in all programme areas under their control.

6.7.7 Component 7: Routine HIV Program Monitoring
Performance Goal: Produce timely and high quality routine NSWP monitoring data.

A system shall be established, that is integrated with the existing reporting system for reporting on the National M&E plan for HIV, STI's and TB. A reporting tool will be created for the collection of data on the routine indicators on the NSWP.

Programme implementers will record their activities and service provisions in appropriate registers that will serve as data sources. This will be an ongoing record keeping, documentation and storage of the registers. The records pertaining to the required element will be tallied, collated and captured onto the monthly/quarterly summary form.

The monthly summary form will then follow the data flow guidelines as described in chapter 5. Efforts should be made to adhere to the strict timelines prescribed for dataflow.

6.7.8 Component 8: Surveys and Surveillance and Assessments
Performance Goal: Produce timely and high quality data from surveys and surveillance

The NSWP will obtain information from 2 existing surveillance systems for sex workers

1. South Africa National Health Monitoring Survey for Sex Workers
2. Sex Worker & Long Distance Truck Drivers (LDTD) Surveillance on transportation routes in KwaZulu-Natal

CDC-South Africa has awarded UCSF a multi-year grant to provide technical and methods expertise to strengthen capacity in South Africa for routine HIV surveillance of key populations

There is in place effective collaboration between UCSF and local/provincial/National DOHs, NGOs, and stakeholders to implement HIV surveillance among sex workers. Implementing partners include ANOVA health institute and Wits RHI.
The surveillance systems will provide high quality data timeously to inform policies and programming for sex workers. The IBBS implementation will also strengthen local capacity to collect and use IBBS data effectively in mobilizing resources to areas of greatest need

Health facilities survey is required to meet the needs for three indicators. The most efficient method would be adopted to add the data elements to the health facility surveys to be conducted by the NDOH

National AIDS Spending Assessment will be guided to uniquely identify the flow of resources and expenditure for sex work programmes.

6.7.9 Component 9: National and Provincial Databases for NSWP
Performance Goal: Develop and maintain national and pro vincial databases for NSWP that enable stakeholders to access relevant data for policy formulation, programme management and improvement

The data elements for the indicators that need routine reporting will be incorporated into the SANAC and Provincial AIDS Council electronic databases. This will facilitate storage, retrieval, transfer and sharing of the data. The databases will be managed with maximum data security measures.

6..7.10 Component 10: Supportive Supervision and Data Auditing
Performance Goal: Monitor data quality periodically and

address obstacles to producing high quality data (i.e., valid, reliable, comprehensive, timely)

All programme implementing organisations are expected to create and maintain high data quality standards. Managing data quality should be seen as an on-going process and quality assurance mechanisms should be planned and integrated within the workflow processes. Support will be provided to them to build their technical competence. The M&E Unit of SANAC secretariat will provide supportive supervision to strengthen the M&E system at the provincial and district levels.
Implementing organisations will be trained in the use of the RDQA tool. External data quality audits will be conducted by the SANAC secretariat and feedback given to the organisation.

Supportive supervision and data quality audits will be guided by the standard guidelines of the NDOH

6..7.11 Component 11: Evaluation and Research Agenda for sex workers
Performance Goal: Identify key evaluation and research questions and coordinate studies to meet the identified needs.

The M&E Technical working group of the NSWP will deliberate, formulate and prioritise the research agenda for the NSWP. It is envisaged that participatory approaches would be adopted. Hence, peer led sex worker organisations will be important stakeholders when this activity is being undertaken.

Important questions for consideration should adopt a public health and human rights approach. Such questions will include; What are we doing? Are we doing it right? Are we reaching the beneficiary population? Is the programme creating a change in the occurrence of HIV/TB in Sex workers, and is the NSWP bringing about change in the quality of life of sex workers.

All studies to be undertaken will adhere to a high ethical and research standards and clearance should be obtained from a recognised institutional research review board or committee.

A mid- term and –end of term review of the programme will be conducted to provide comprehensive overview and insight into the relevance, effectiveness and sustainability of the programme that would inform the next strategic planning process.

6.7.12 Component 12: Data Dissemination and Use
Performance Goal: Disseminate and use data from the NSWP M&E system to guide policy formulation and pro gramme planning and improvement

The information products described in chapter 5 will be produced and disseminated timeously to all stakeholders. An audience analysis of all stakeholders would be conducted and a communication plan instituted to keep all stakeholders well informed.

All stakeholders would be encouraged to use the information to inform programme planning and decision making. The NSWP coordinating body and the Technical working Group will play a lead role in the use of the information by having it as a permanent item on their agenda.

The M&E plan was developed through a facilitated consultative process by major stakeholders, organisations and individuals committed to the health and welfare of sex workers. It leads to the creation of an M&E system that is dedicated to the generation of information to be used for the improvement of the NSWP.

The plan was modelled around the UNAIDS's 12 components of a functional M&E system. A plan of action was developed around each component. Timelines for the implementation of the activities were agreed upon for generating data from both routine and non-routine sources.

Sustained expression of interest in the data, the information and its use leads to the development of an M&E culture whereby value is attached to the data and all efforts are made by personnel to maintain the quality of the data. Data quality should be a regular and standing item at all meetings and fora to discuss M&E activities and products.

There is need to see continuing improvement in the M&E system that is responsive to the strategic plans. A functional M&E system therefore needs to have the M&E plan that is monitored, reviewed and updated under the initiative and guidance of the SANAC M&E secretariat supported by the M&E Technical Working Group for NSWP.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