A Low-Cost, Integrated Model for Sex Work Programming

Report & Recommendations

sweat

Sex Workers Education & Advocacy Taskforce

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Executive Summary

"This is an example of a simple intervention that doesn't require much but achieves a lot" — Mr Lundi Ncana (HTA Programme Manager, Eastern Cape Department of Health)

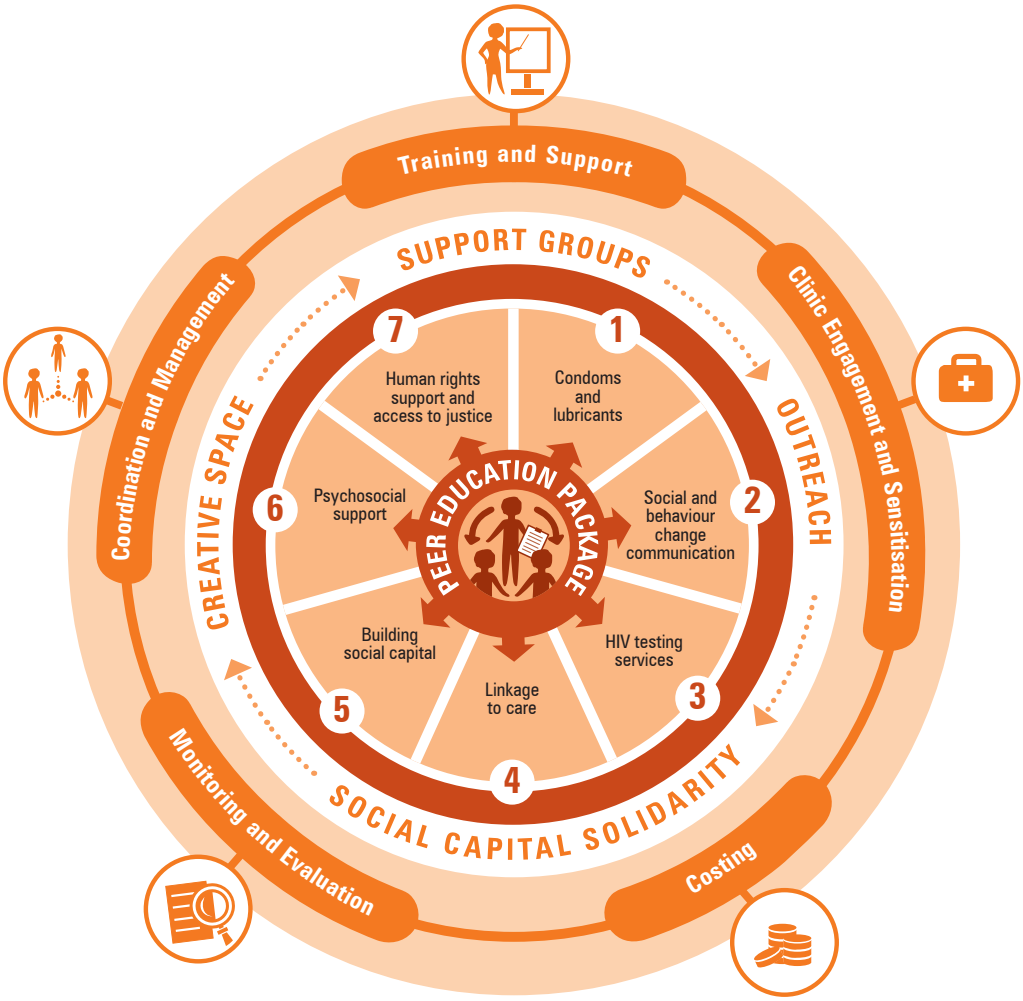
Sex workers in South Africa continue to experience stigma and discrimination in society, which has many negative outcomes, including impacting negatively on health, and health-seeking behaviour. The launch of the SA National Sex Worker HIV Plan in 2016[1] (hereafter referred to as the National Sex Worker Plan) signalled a commitment to address sex workers health through an integrated, human rights-based approach which places a firm emphasis on community-led services. The Plan set a target of 70 000 sex workers to be reached between 2016 and 2019, over half of the estimated 153 000 sex workers in South Africa[2].

Against this background, the Sex Workers Education and Advocacy Task Force (SWEAT), with the support of UNFPA, piloted a low-cost, integrated, community-based sex worker model in the Lukanji sub-district, situated in the Chris Hani District, Eastern Cape, between July and December 2017.

The model, if scaled-up, especially in similar moderate-density settings, has the potential to considerably increase the number of sex workers reached with services, in a low-cost and sustainable fashion. It is estimated that if the project was replicated in 20 towns, that an additional 10 000 sex workers could be reached with services per year.

The model is illustrated in the diagram below. A peer education package, aligned with the SA National Sex Worker HIV Plan, is at the centre of the response. Components which are necessary to support the implementation of the peer education package are: clinic engagement and sensitisation; coordination and management; training and support; monitoring and evaluation; and costing.

Figure 1: Low-cost, integrated sex worker programme model



Peer education package: The peer education package involves a small team of sex worker peer educators, led by a sex worker peer leader or site coordinator. The team provides outreach to sex workers, refers them to clinics (and accompanies them if necessary), and facilitates Creative Space workshops.

Coordination: The project was supported and coordinated by the Chris Hani District Health Department, who introduced the project to the district. The project was also endorsed after being introduced to the Eastern Cape Department of Health. Project staff submitted statistics to the District Health Department on a monthly basis, and attended multi-sectoral coordination meetings on a quarterly basis.

Training: The peer educators received training from SWEAT, based on the training provided for peer educators in the Global Fund sex worker programme (under Principal Recipient NACOSA), with slight modifications. In addition, the team received supervision at least monthly by SWEAT's Eastern Cape Area Manager. It is highly recommended that similar projects invest in the learning and development of sex worker peer educators.

Clinic engagement and sensitisation: The project collaborated closely with local health facilities. Ways of enhancing collaboration included: the peer education team giving health talks to patients; clinic staff attending Creative Space workshops to give talks and conduct health screening; and formal sensitisation workshops for facility staff and other local stakeholders. Where there was a decrease in stigmatising attitudes from health facility staff, there was also an improvement in sex workers' readiness to access health facilities, and consequently, an improvement in their health status.

Monitoring and evaluation: Monitoring focused on providing individualised health support and advice to sex workers. Monitoring and evaluation tools enabled the peer education team to keep track of each beneficiary's health status over time.

Costing: While the model is not resource-intensive, it is important that the essential costing elements, described in this report, are included when budgeting.

The low-cost integrated model has great potential for scale-up to other locations in South Africa, especially, but not limited to, towns outside of the large metropolitan areas. The model can thus address the current gap in services for sex workers in moderate density settings, suitable for "Tier 3" interventions as described in the National Sex Work Plan, ie. where parallel or specialised clinical services are not justified or feasible. In addition, the model has potential for replication not just for sex workers, but also for other key and vulnerable populations who face barriers to accessing health care.

SECTION 1: BACKGROUND

Introduction

SWEAT, with the support of UNFPA, piloted a low-cost, district-based, integrated model for sex work programming in the Lukanji sub-district in the Chris Hani District, Eastern Cape from July to December 2017. The project was implemented in a district which previously was the location of a sex work service delivery site funded by the Global Fund, but which was defunded in early 2016 because of changes in the funding model.

The primary aim of the project was to address barriers, and improve access of sex workers to health care, including care for HIV, sexually transmitted infections (STIs) and sexual and reproductive health (SRH). The South African National Sex Worker HIV Plan 2016-2019[3] recommends a flexible, context-specific approach to providing health services to sex workers. Several 'sex worker-friendly clinics', also referred to as vertical or parallel services, have been developed in urban areas in South Africa. While these clinics are proving to be successful in providing stigma-free and appropriate health services to sex workers, as evidenced by good uptake of the services they offer, this model is not affordable or appropriate in all settings. A low-cost, integrated model is potentially a more sustainable approach within resource-poor areas where sex workers might operate in high numbers but are fairly diffuse. An integrated model had not yet been formally developed or researched in South Africa, and therefore this pilot project aimed to fill that gap.

It is hoped that the results of this project will be an important tool in the continuing advocacy for health services for sex workers which meet the primary health care criteria of acceptability, availability, affordability, appropriateness and accessibility.

This report is divided into 3 sections: the first sketches the background to the project and outlines the policy framework; the second describes the assessment, planning and implementation activities that took place during the pilot, while the third section outlines the Intervention Model, describing the key components.

Definitions and socio-demographics

UNAIDS defines sex workers as including "female, male and transgender adults and young people (over 18 years of age) who receive money or goods in exchange for sexual services, either regularly or occasionally"[4]. According to SWEAT, a sex worker is a person who uses the exchange of sex as a source of livelihood, with terms negotiated by the sex workers, and with the choice to accept or reject the transaction[5]. Sex work takes many forms, and varies between and within countries and communities. Sex workers may or may not identify with the label 'sex worker'. In addition, people who engage in sex work sometimes mix sex work with other economic activities and move in and out of it over time[6].

Sex work differs from transactional sex: the more socially accepted exchange of material goods within sexual relationships; however, the boundaries between the two phenomena can sometimes be indistinct.

Sex work involves consensual sex between adults. Although they are often conflated, sex work and human trafficking are distinct phenomena. Trafficking involves coercion and deceit for the purposes of exploitation, including forced labour, and is a gross violation of human rights. Sex work, on the other hand, comprises freely entered into and consensual sex between adults, and like other forms of labour, provides sex workers with a livelihood.

The term sex work can also not be applied to children under the age of 18. All forms of involvement of those under the age of 18 years in selling sex, and other forms of sexual exploitation or abuse, contravene Articles 12, 19 and 34 of the global Convention of the Rights of the Child and international human-rights law, and governments have a legal obligation to protect those under 18 from such exploitation[7]. Despite the dire lack of evidence on children under the age of 18 who are involved in the sex industry, this sub-population is highly marginalised and judged to be at very high risk for HIV[8].

The 2013 sex worker size estimation study, conducted by SWEAT on behalf of the South African National AIDS Council (SANAC) gave an intermediate estimate of the total population of sex workers in South Africa as 153 000, or 0.9% of the total adult female population[9]. Most sex workers were in large urban centres (51%) or small urban centres (37%). About 22% were in Gauteng, 16% in KwaZulu-Natal and 11% in Western Cape. About 5% of sex workers were male, and 4% were transgender people.

The Eastern Cape is home to approximately 10% of sex workers in South Africa, with the majority being located in the two metropoles, Buffalo City and Nelson Mandela Bay. Provincial estimates from the 2013 study ranged from 12 437 to 17 429[10].

Sex work varies in the degree to which it is organised and formalised. Where sex work is more formal, managers or controllers (sometimes known as ''pimps'') may act as gatekeepers or intermediaries between the sex worker and client. However, in sub-Saharan Africa, sex workers predominantly operate independently and without intermediaries[11].

Legal framework

In South Africa, the following laws maintain the criminalised nature of sex work[13]:

- The Sexual Offences Act 23 of 1957 continues to be applied under the current South African constitution, and states that "unlawful carnal intercourse or act of indecency with any other person for reward commits an offence". It makes prostitution, brothel keeping, solicitation, indecent exposure, and knowingly living from the proceeds of sex work illegal.
- The Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 (2007) criminalises clients who engage the services of sex worker.

Sex workers are most frequently arrested and harassed under municipal by-laws. Currently, sex workers are commonly fined under a by-law relating to Streets, Public Places and the Prevention of Noise Nuisance GN 6469 28/09/2007, Section2 (3) (j). In many cases of arrest, the sex workers have not actually committed the offence in question, and even when the sex worker is guilty of that offence, the correct procedure for implementing by-laws is not usually followed[14].

Sex Workers and HIV

Sex workers are considered a key population for HIV. According to the 2016 UNAIDS Prevention Gap Report[15], HIV prevalence among sex workers is 10 times greater than among the general population. Even in very high prevalence countries, such as South Africa, HIV prevalence among sex workers is much higher than among the general population.

The first South African sex worker integrated bio-behavioural surveillance (IBBS) survey[16], published in 2015, conducted in Johannesburg, Cape Town and Durban, found:

- Wide variation in HIV prevalence amongst female sex workers in different urban centres: 71.8% in Johannesburg; 39.7% in Cape Town; 53.5% in Durban; and,
- Higher HIV prevalence amongst female sex workers who were 25 years and older compared to those in the 16-24 age band (e.g. in Johannesburg: 78.8% versus 59%).

A combination of biological, social and structural factors interact to heighten sex workers' vulnerability to HIV. According to the UNAIDS Gap Report (2014)[17], the top four reasons why sex workers are being left behind are: violence, criminalisation, stigma and discrimination; and lack of programmes and funding.

Background to the current project

The low-cost, integrated sex workers health project, implemented by SWEAT, with support from UNFPA, builds on the foundation laid by the Global Fund national sex worker programme. The programme, which started in 2010 is now in its third funding phase, under Principal Recipient NACOSA. SWEAT has been a sub-recipient throughout the three phases, and was instrumental in establishing the peer-led intervention model which places community empowerment at the centre. In Phase I, from 2010-2013, the programme was implemented in 8 sites by 8 organisations and employed a total of 50 peer educators. In Phase II, the programme was scaled up considerably, with 19 organisations employing a total of 56 site coordinators and 560 peer educators implementing the programme at 74 sites[18]. Two successive evaluations following the first two phases have demonstrated the positive effects of the programme in terms of access to health, behaviour change, access to justice, improved psychosocial wellbeing, and improved social capital[19/20].

In 2015, in recognition of the way in which the basic model was being adapted to local contexts, SWEAT hosted The Red Umbrella Programme Best Practice Workshop to highlight, share and promote best practices in HIV programmes for sex workers in South Africa. The workshop enabled site coordinators to share lessons, successes, and innovations through short presentations on topics such as peer power, outreach, creative spaces, HIV and health, holistic support, human rights, community, and information. The outcomes of the workshop were captured in SWEAT's Good Practice Guide to Integrated Sex Worker Programming[21]. The guide outlined fundamental principles for implementing sex worker programmes:

- "Nothing about us without us": sex workers should be at the centre of the response
- "First a person, then a sex worker": sex workers should receive holistic support and services
- "Working together we can do more": partnerships improve the outcomes
- "Only rights can stop the wrongs": the programme should be rights-based and work towards an enabling environment

In the current phase, under the New Funding Model, the Global Fund national sex worker programme model has shifted to a district-based, saturation approach. In 2016/2017, the programme reached 59 508 sex workers through 300 peer educators in 10 districts[22].

The launch of the SA National Sex Workers HIV Plan in 2016 was a watershed moment for sex workers in South Africa, signaling government commitment to taking seriously the need to address sex workers health from a human rights-based perspective[23]. The plan set ambitious targets of reaching 70 000 sex workers with HIV interventions. While it is anticipated that the bulk of these targets will be made up from Global Fund and CDC/PEPFAR/USAID programmes, the South African Department of Health(DoH) also has a critical role to play. Firstly, both the large donor-funded programmes are focused on districts with high densities of sex workers. This leaves a gap in programming for sex workers outside of these areas. Secondly, the donor environment is changing and uncertain, and in the medium-term, there is a push for greater domestic expenditure on health in general, and HIV in particular, in line with the Abuja Declaration[24]. From a sustainability and cost-effectiveness point of view, it is important that South Africa consider more integrated approaches. While DoH currently supports sex workers as a key population through its High Transmission Area programmes, it has historically been difficult for government facilities to identify and monitor sex workers. For example, sex workers are not included in the DHIS system, and are not counted at facility level. Indeed, this form of monitoring is neither feasible not advisable, as it has the potential to be stigmatising. It is vital that DoH form partnerships with NGO's in order to access sex workers, and in order to monitor access.

The South African National Sex Worker HIV Plan 2016-2019 recommends a flexible, context-specific approach to providing health services to sex workers. Several 'sex worker-friendly clinics', or vertical services, have been developed in urban areas in South Africa. While these clinics are proving to be successful in providing stigma-free and appropriate health services to sex workers, as evidenced by good uptake of the services they offer, this model is not affordable or appropriate in all settings. A low cost, integrated model is potentially a more sustainable approach within resource-poor areas where sex workers might operate in high numbers but fairly diffuse. Such a model has the potential to improve the access of sex workers in these communities to a range of comprehensive SRHR and HIV services. An integrated model has not yet been formally developed or researched in South Africa, and therefore this pilot project aims to fill that gap. The results of this project will be an important tool in the continuing advocacy for health services for sex workers which meet the WHO primary health care criteria of acceptability, availability, affordability, appropriateness and accessibility.

Policy framework

Global and national bodies have issued normative guidance on sex workers' access to health (with a predominant focus on HIV). Globally, the most detailed guidance available in this regard is the SWIT (the popular term for the *Sex Worker Implementation Tool or "Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions")*[25], which provides recommendations for implementing HIV and STI testing, treatment and prevention strategies that are directed by and that empower sex workers. The recommendations in the SWIT are drawn from the 2012 WHO Guidelines on Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Workers in low- and middle-income countries – Recommendations for a public health approach. [26]

In South Africa, the current National Strategic Plan for HIV, STIs and TB emphasises the need to reach sex workers, as a key population, with services. The goals of NSP are supported by, and expanded upon, in the South African National Sex Worker HIV Plan 2016-2019.

WHO Guidelines on Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Workers

The *WHO Guidelines on Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Workers in low- and middle-income countries – Recommendations for a public health approach* recommend decriminalisation of sex work and elimination of unjust application of non-criminal laws and regulations against sex workers as well as establishment of anti-discrimination and rights-respecting laws. The guidelines state that "health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health"[27] and that violence against sex workers must be prevented. Based on evidence, the following health packages and services are recommended in the guidelines:

1. package of interventions to enhance community empowerment among sex workers
2. correct and consistent condom use among sex workers and their clients
3. periodic screening for asymptomatic STIs to female sex workers
4. offering female sex workers, in settings with high prevalence and limited clinical services, periodic presumptive treatment for asymptomatic STIs
5. voluntary HIV testing and counselling to sex workers

6. using the current WHO guidance on the use of antiretroviral therapy for HIV infection for adults and adolescents for sex workers with HIV
7. using the current WHO recommendations on harm reduction for sex workers who use drugs
8. using sex workers as targets of catch-up Hepatitis B vaccine (HBV) immunisation strategies in settings where infant immunisation has not reached full coverage

The Sex Worker Implementation Tool (SWIT)

The Sex Worker Implementation Tool or *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions*)[28] covers six broad topics that provide recommendations for implementing one or more of the WHO 2012 Recommendations, with community empowerment at the core of all the recommendations. The topics and their interplay are shown in Figure 2 below:

Figure 2: The Sex Worker Implementation Tool model

National Strategic Plan for HIV, TB and STIs 2017-2022

South Africa's current National Strategic Plan (NSP) recognises that sex workers are a key population. Strategies to reach sex workers with HIV, TB and STI services are covered under *Goal 3: Reach all key and vulnerable populations with customised and targeted interventions.*

Acknowledging that key populations groups are much more heavily affected than the general population and need special attention, the NSP proposes that, in addition to services related to HIV, TB and STIs to be provided to everyone, specific strategies to reach key and vulnerable populations with packages tailored to their needs will be implemented. These strategies are:

Tailor health and social services and the mode of delivery

Services and information should be customised to address the unique needs of key and vulnerable populations. Respect for and protection of the human rights of key and vulnerable populations is a fundamental principle of the NSP. Scale-up will aim to ensure that, by 2022, at least 90% of all key and vulnerable people have access to comprehensive, integrated services. There should be increased access to health services through differentiated service delivery approaches that are tailored for the populations served. Particular efforts should be made to expand access to peer-involved and/or peer-led psychosocial support, information-sharing, adherence support and risk-reduction counselling. Physical and virtual 'safe spaces' should be created to serve as entry points to social and health services for key and vulnerable populations.

Sensitise providers to address the needs of key and vulnerable populations

Capacity-building programmes designed to improve the skills of health providers to address the needs of key and vulnerable populations will be developed. These will strengthen the providers' ability to deliver services in a compassionate, non-discriminatory manner.

Ensure multi-sectoral engagement

Broad-based collaboration and the engagement of multiple sectors, including government departments and other stakeholders, will ensure an optimally coherent and holistic response for and by key and vulnerable populations.

Engage communities in the development and implementation of social and health support activities

Peer-involved and peer-led interventions should be substantially expanded; key and vulnerable population representatives should be included in all national, provincial, district and local AIDS Councils and other cross-cutting working and advocacy groups. Civil society and community networks should be encouraged to support and mobilise key and vulnerable populations.

Build robust community capacity, engagement and inclusion

Community-level capacity among key and vulnerable populations is still weak. Inadequate community capacity and meaningful involvement of key and vulnerable populations at all levels of decision-making regarding HIV, TB and STIs diminishes the ability of these communities to play their optimal role. The NSP outlines an array of strategies and activities to build strong capacity for key and vulnerable populations, including the development of social capital by encouraging community networks that include advocacy agendas for equal health, social services and human rights.

Eliminate stigma, discrimination and punitive laws that burden key and vulnerable populations

Key and vulnerable populations are often highly marginalised, which diminishes their access to health information and deters them from seeking services. Under the NSP, actions will be taken to implement validated anti-stigma initiatives, including broad and localised anti-stigma communication campaigns. Notably, this Plan urges that the process to resolve the legal reform matters related to the Sexual Offences Act be addressed as soon as possible.

Strengthen strategic information for action on key and vulnerable populations

Concerted efforts will be made to advance reliable size estimations, additional mapping and qualitative information of key and vulnerable populations. Through implementation of the 'focus for impact' approach, these data will be used for programme development and more effective programmatic targeting.

The following specific programme elements are recommended for sex workers:

- Peer-led outreach
- Pre-exposure Prophylaxis (PrEP)
- Female and male condoms and lubricant
- Intensified psycho-social support
- Periodic presumptive treatment for STIs
- Social mobilisation, use of formal/informal peer networks to create demand
- Prevention of Mother-to-Child Transmission (PMTCT)
- Hepatitis B screening and immunisation
- Annual Pap smears
- Choice of Termination of pregnancy (CToP)
- Screening for and protection from the sexual exploitation of children
- Community empowerment

The South African National Sex Worker HIV Plan 2016-2019

The landmark South African National Sex Worker HIV Plan was the outcome of a thorough process of consultation between SANAC, government, civil society and the sex work sector. The Plan acknowledged that provision of prevention and treatment interventions for sex workers is a key goal for the country as a whole in order to address the HIV epidemic and related mortality and morbidity. The plan aims to reach 70 000 sex workers over a three-year period.

The Plan is based upon six core packages of interventions, in turn based on WHO's 2014 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations adapted for the South African context. The six are:

1. Peer education package
2. Health care package
3. Psychosocial service package
4. Human rights package
5. Social capital building package
6. Economic empowerment package

The Peer Education Package is particularly relevant to the current project. The Plan recommends that the peer education package entail: condom and lubricant distribution; social and behaviour change communication; HIV testing services; linkage to care; social mobilisation; psychosocial support; and human rights support and access to justice. The peer education package is discussed in more detail in Section 3 below.

The Plan further notes that, to stabilise and reverse HIV and STI epidemics on a national scale, effective interventions need to reach saturation levels of coverage – ideally 90% in areas where sex work takes place. As prevalence of sex work differs by province, locality (urban vs rural) and by type of hotspot e.g. trucking route or mining area, different models of service delivery are therefore needed to deliver the package of services.

There are therefore three tiers of service delivery outlined in the Plan, according the density of sex workers. Tier 3 is relevant for the current project. According to the Plan, Tier 3 is for areas with moderate density (500 – 3000 sex workers per district) and should involve combination of mobile services; fixed clinic services and outreach teams.

The National Sex Worker Programme HIV Plan set the following targets:

1.Reach 70 000 sex workers with a core package of services
2. Recruit 1000 peer educators
3. Ensure that 95% of sex workers use condoms with their clients
4. Provide PrEP for 3000 sex workers
5. Ensure that 90% of sex workers reached are tested for HIV and know their status
6. Ensure that 90% of sex workers who test positive are on ART
7. Ensure that 90% of sex workers on ART are virally suppressed
8. Reduce instances of violence against sex workers by 50%

The current project has great potential for replication in similar Tier 3, moderate-density settings, and thus can make a significant contribution towards the achievement of the goals of the National Sex Worker HIV Plan.

SWEAT SWEEEP Plan

SWEAT's service delivery programme is called the Sex Worker Empowerment and Enabling Environment Programme or SWEEEP. The programme strategy is aligned with the policy guidances outlined above, with the needs, priorities and recommendations articulated by the community which SWEAT serves, and is a part of. Thus, SWEEEP identifies two key goals, as follows:

Goal 1: To empower people who sell sex to make choices and take responsibility for their own development and wellbeing

Goal 2: To create an enabling environment in which sex workers can exercise the choices they have made

SECTION 2: DESCRIPTION OF THE PILOT PROJECT

Selection of site

The Lukanji sub-district, in the Chris Hani district of the Eastern Cape, was selected for the pilot project. Chris Hani is one of the 8 districts of Eastern Cape Province of South Africa. The seat of Chris Hani is Komani/Queenstown. According to the 2011 Census, the district has 795 461 inhabitants, most of whom speak Xhosa.

The 2016 Eastern Cape AIDS Council annual report 2014/2015, reports that HIV prevalence among antenatal women in the district was 34.5% in 2013 (and worryingly had risen from 29.5% in 2011). This made Chris Hani the district with the second highest prevalence in the province (after Amathole).[29]

The town of Komani, formerly known as Queenstown, is located in the middle of the Eastern Cape Province, and is the administrative and commercial centre of the district. It is located on the N6 route between East London and Bloemfontein. Komani had an estimated population of 68 872 in 2011.

There were several reasons for selecting this site for the project. Firstly, the site had to be in either Eastern Cape or KZN, as these are the two provinces where UNFPA provides support for SRHR, integration of HIV and SRH, and key populations programmes. Secondly, SWEAT had previously implemented a sex worker programme in the district, funded by the Global Fund, during Phase II of the Red Umbrella Sex Worker HIV Programme from 2013-2016. During that period, a similar model was implemented, peer educators from the community were trained to provide outreach, facilitate Creative Space workshops, and refer for HIV testing services (HTS). Thus, there was some remaining social capital within the sex worker community, as well as relationships with health care facilities that could be revived. Thirdly, it was intended that the pilot project would be implemented in a district with moderate densities of sex workers (500-3000), consistent with Tier 3 of the SA National Sex Worker HIV Plan 2016-2019. The 2013 Size Estimation Study indicated a conservative estimate of 1322 sex workers in the Chris Hani District. Finally, SWEAT has an office in the Eastern Cape, in Buffalo City, which is a site under the current round of the Global Fund Sex Worker Programme, and thus there was existing infrastructure to support the project, and an Eastern Cape Area Manager who could provide supervision of the project.

Nevertheless, the site had been selected prior to its introduction to the Eastern Cape Multi-sectoral Forum, although the Forum subsequently endorsed the project. From the point of view of coordination and accountability, it is important that coordinating structures be approached and consulted, so that they can collaborate in the selection of sites, to avoid duplication; to provide institutional support if necessary; and so that reporting can be aligned with national reporting and data management systems.

Ideally, planning meetings should be held with the provincial Department of Health, and districts and sub-districts should be identified collaboratively. Ideally also, an a memorandum of understanding (MOU) should be signed with the relevant provincial authority.

Figure 3: Map of Eastern Cape Province

Human resources

The staff complement for the pilot project consisted of one full-time site coordinator and 4 part-time peer educators. A site coordinator was appointed who had formed part of the original peer education team, and at the end of Global Fund Phase II, had continued as a peer educator in East London. The site coordinator moved back to Komani, and was based there for the duration of the project. It is recommended that site coordinators be sex workers themselves, with peer education experience, and an in-depth understanding of sex workers' health and human rights. In addition, site coordinators should have the necessary administrative skills, as well as suitable interpersonal skills to be able to engage with a wide variety of stakeholders, and to lead and manage a team of peer educators.

Next, four peer educators were recruited. Two of the peer educators, more mature sex workers, had also been part of the original peer education team. In addition, two younger sex workers were also appointed.

An important principle of sex worker peer education programmes is that peers should be sex workers themselves, and be from the community. The peer education team should reflect the socio-demographics of the local sex worker population, and furthermore, should be representative of the population in terms of work locations and social networks. Thus, this peer education team comprised sex workers who solicit clients in shebeens/taverns; on the streets and at home via word-of-mouth and social media.

In addition, adequate organisational management support, supervision and oversight is essential, in the form of a provincial, or district manager, with regular opportunities for meeting.

Training of staff

The specific training undergone by staff will be discussed in this section. General recommendations regarding training and support, will be covered in Section 3 below.

Peer education training

The team received training as peer educators at the commencement of the project. SWEAT has many years' experience in providing training which is specifically tailored to sex worker projects. For the pilot project, SWEAT was able to leverage its role as the Capacity-building Sub-recipient for the Global Fund Sex Worker Project. Thus, SWEAT's Training Coordinator provided the training, using training resources which had been developed by the organisation.

The peer education training course covers: understanding the health and human rights needs of sex workers; the role of the peer educator; and how to implement interventions with sex workers. The course is practical and interactive.

Site Coordinator training

Sweat has developed a manual for the training of Site Coordinators in the sex work sector. The manual builds on the skills acquired during the peer educator training. The training deals with the following key areas:

- Setting the Scene: deals with understanding sex workers health needs; The South African National Sex Worker Plan; The role of the Site Coordinator
- Planning: deals with the mapping of the local area, the mapping of stakeholders, the building of partnerships with peer educators and deals with supervision and leadership skills
- Outreach: deals with considerations for planning and implementing outreach
- Working with groups: deals with Creative Space and Support Groups, and includes facilitation skills
- Bringing it all together: deals with monitoring, reporting and self-care

Assessment and planning activities

Introducing the project to the district

At the start of the project, a sub-district meeting was held by the District HIV/AIDS Manager, during which the project and the project team were introduced to representatives of the 7 sub-district health care facilities. The facility representatives expressed agreement with the goals of the project. However, as will be shown later, this agreement did not necessarily translate into smooth collaboration in all of the facilities.

Mapping the district

During the peer education training, peer educators conducted a simple mapping exercise to generate strategic information in order to plan the intervention.

Peers drew maps of the town, showing the main features. They then indicated on the map where sex workers were located, including the numbers of sex workers at each location, and the gender (female, male, transgender). This exercise therefore provided an informal size estimation of the local sex worker population, disaggregated by gender. Next, they indicated on the map the location of key stakeholders and resources such as clinics, hospitals, police stations, and NGOs.

Female

Male

Transgender

Sex work in the Lukanji sub-district

Demographically, sex workers in the Lukanji sub-district are mainly cisgender female, although there are a small minority of male and transgender female sex workers. The majority are Black African and Xhosa-speaking. Workplaces where sex workers solicit clients are streets, shebeens/taverns, truckstops, the casino, and home-based via word-of-mouth or the internet. Regarding the latter, sex workers noted that they have increasingly made use of certain websites and social media over the past few years. This is seen as a positive development as it is a more discreet way of soliciting clients, and reduces the need for venue-based soliciting, with the attendant risks of violence and stigma from being publically identified as a sex worker. The increase of ICT (internet and communications technology) also requires traditional hotspot-based outreach approaches to be adapted. Thus, the main approach of the peer education team is a word-of-mouth, snowballing one.

The sex worker population was thought to be fairly stable in terms of location, with low mobility, despite Komani being located on a trucking route. Clients were reported to be diverse in terms of age, race and socio-economic status.

The peer education team report the majority of sex workers they work with work independently, without pimps. However, they noted the existence of some sex workers in the CBD, who they had heard are working for pimps, and who were using drugs. In addition, those sex workers were not linked to their known sex worker networks. The team expressed concerns that those women may be particularly vulnerable. They have only been able to access those sex workers in the final month of the project, when they started conducting outreach at night (prior to this night-time transport was not available). The team reports that they are slowly engaging and developing rapport with those sex workers. In terms of age, peer educators note that they have encountered very few minors selling sex. Otherwise, the project reaches a diverse age range, from 18 to 60's.

The peer educators also reported that most sex workers are parents, and say that they are working to support their children. Very few have been married, but some have boyfriends. The team estimates than "less than half" of sex workers use drugs (with those that do using mainly nyaope and tik), but that alcohol use is widespread.

Challenges experienced by sex workers

Challenges experienced by sex workers were assessed by the peer education team, during outreach and Creative Space workshops. The following were identified as the main challenges:

Stigma and self-stigma

The greatest fear of sex workers was being identified in their communities as sex workers. This is especially important in a small town, where exposure as a sex worker can have serious reputational consequences, including for the sex worker's children. In fact, two members of the peer education team reported examples of how their children had been told that their mothers were sex workers, and how painful and difficult this has been. This fear of identification has an impact on health-seeking behaviour, as sex workers worry that facility staff will breach confidentiality, or worse, identify them as sex workers in front of other patients in the waiting areas.

Stigma and discrimination within health care facilities have been widely reported by sex workers in Southern Africa, including in South Africa[30]. Stigma and discrimination are human rights violations which increase HIV risk in several ways: through increasing risky sexual behaviour, and through deterring people from accessing the continuum of HIV prevention, treatment and care[31]. However, in South Africa, the extent of stigma and discrimination towards sex workers; the ways in which stigma manifests and is experienced, and its impact on health-seeking behaviour have still not adequately been documented or researched. Another critical, but still under-researched area, is the role of self-stigma on sex workers.

The very real impact of stigma was noted in the course of this project. It was reported that many sex workers who were on treatment during the previous phase of the project, had defaulted from their treatment during the year that the programme had stopped. Several had become ill, and a couple of sex workers were reported to have died.

There was a lot of defaulting, and we found many passed away. ..they didn't want to go to the facilities without a peer, or maybe the health care worker wasn't as accepting when we weren't there. *— Peer Educator*

Violence

Sex workers accept violence and rape, but it has long term affects on their lives – they don't seek help when it happens… you find they have defaulted and when you go back you discover they were raped when young or while working and they have low self esteem. *— Peer educator*

Sex workers reported that violence and harassment by police used to be a concern. However, encouragingly, as a result of the advocacy conducted during the previous phase of the project, this was no longer a concern, and police attitudes had changed.

Sex workers also reported very few cases of violence from clients. Their greatest challenge with clients were: clients trying to get out of paying, or not wanting to pay the agreed-upon amount, and clients trying to persuade sex workers to have condomless sex.

On the other hand, a concern which emerged was intimate partner violence. The site coordinator reported that many sex workers experience abuse by their partners, especially if the partner knows that they are sex workers. This makes many sex workers try to hide their occupation from their partner, and makes it difficult to establish stable, trusting relationships. On the other hand, sex workers reported that, if their boyfriend knows that they are a sex worker, they usually demand money from them, whilst often at the same time insulting and degrading them.

In addition, in a country where rates of sexual violence are already very high, many of the sex workers in the project have disclosed that they have experienced sometimes multiple incidents of sexual violence, sometimes starting during childhood, and often perpetrated by people known to the victim.

Mental health

Although no formal mental health assessments were conducted, the peer education team expressed empathy and concern for the mental health of the sex workers in their community. It was described that sex workers had experienced multiple severe traumas and stressors, which had impacted negatively on their self-esteem and self-worth. Stressors included the violence and rape documented above; being orphaned or abandoned by parents; being single parents; and being economically abandoned by their children's fathers. These existing difficulties are further compounded by the stigma, discrimination, and social marginalisation, associated with being sex workers.

The mental health of sex workers in South Africa has barely been researched; however, a recent study conducted with Sisonke members in KZN found rates of depression, anxiety, substance abuse and trauma that were extremely high compared to rates in the general South African population.[32]

Health Care Facilities and barriers to access

In some facilities nurses are interrogating sex workers and judging them making it difficult for us when referring sex workers to the clinic. We believe sensitisation of health care workers should be done regularly to try and make them understand what sex work is and how important it is for workers to visit clinics often. *— Site coordinator, Komani*

The Lukanji sub-district has 7 primary health care facilities. During one of the first Creative Space workshops, a discussion was facilitated with sex workers around levels of satisfaction with each of the clinics. Sex workers indicated which clinics they preferred, at which clinics they felt staff were sensitised, and where they felt they were treated in a non-judgemental and non-discriminatory manner.

Some of the clinics had developed positive working relationships with the sex worker project during the previous phase. These clinics were considered to be most sensitised by sex workers. At other clinics, some sex workers complained that staff were judgemental, harsh and rude, and that they did not feel free to disclose that they were sex workers, or, that if the staff knew that they were sex workers, that they feared being treated poorly, or that confidentiality would be breached. At one clinic, nursing staff were reported to have insulted, humiliated and embarrassed sex workers. The project staff reported that sex workers refused to be referred to clinics where they were treated poorly, even if they fell into those clinics' catchment areas.

During the course of the project, the team continued to experience barriers to engaging with some of the clinics and smooth referrals of sex workers. Despite the fact that facilities had been requested to cooperate with the project, and that facility staff had been introduced to the project team, some facilities refused to engage with them, citing lack of uniforms and ID badges.

Logistical considerations

In terms of the space where the project would be based, the original intention was that the project would be located within a health care facility, and would use the facility as a base from which to conduct community-based services. A facility-based space is ideal in that it can reinforce the partnership approach which underpins this intervention. However, such a space could not be secured. This was not a deterrent, and the project was therefore run out of the site coordinator's house, with just a lap top and data. While this showed that the goals of the project could be achieved with minimal resources, it was not ideal, and it would be preferable for the team to have a basic office space with the necessary equipment (in particular access to a computer and printer/scanner, and phone and internet access).

SECTION 3: THE INTERVENTION MODEL

The Peer Education Package

The intervention package is aligned with the peer education package in the SA National Sex Worker HIV Plan, and includes the components of condoms and lubricants; social and behaviour change communication; HIV testing services; linkage to care; social mobilisation; psychosocial support; human rights support an access to justice. Guidance on the implementation of these components is shown in the table below. The service is provided to all sex workers, for the purpose of this project defined as all people who sell sex, whether they self-identify as sex workers or not.

Figure 4: The low-cost, integrated sex worker programming model

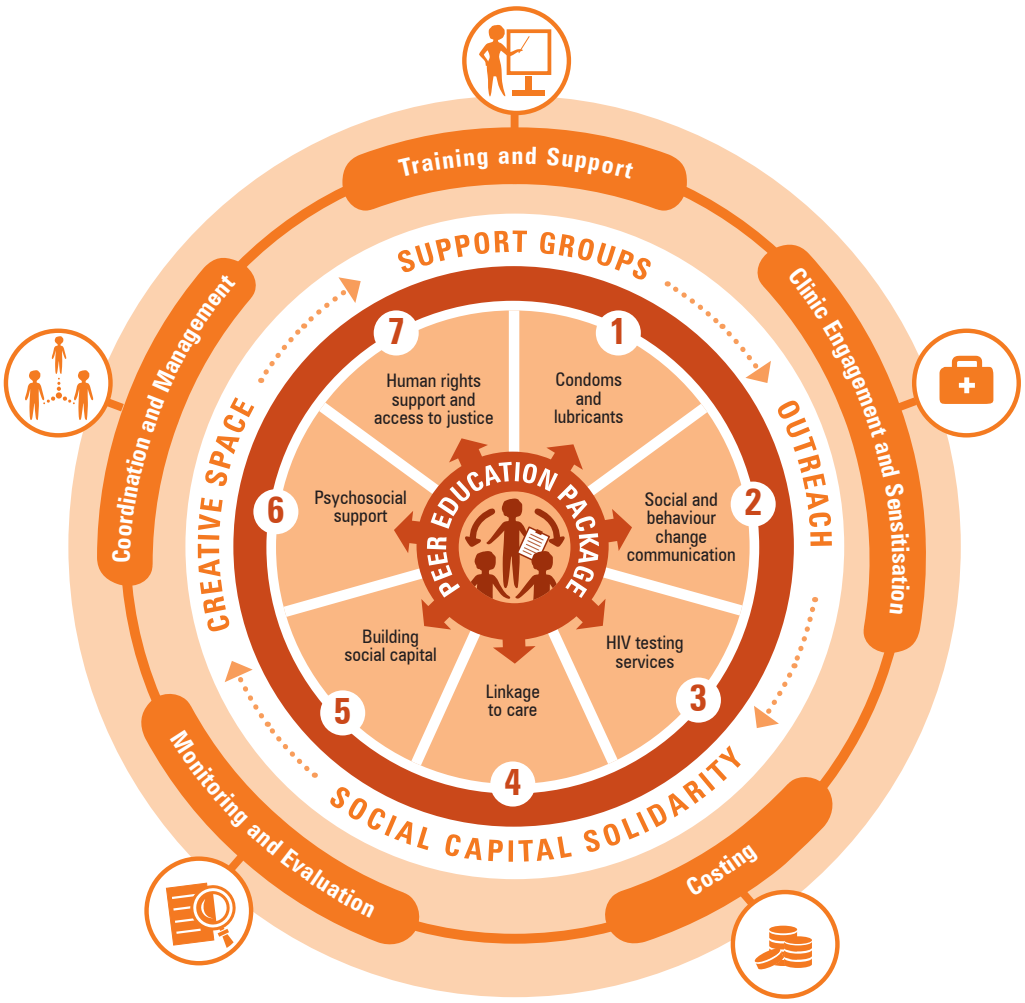


Table 1: Peer education: activities, implementation considerations and responsibilities

Component	Specific activities	Implementation Considerations
1.1 Condoms and lubricants	1.1.1 Peer educators to distribute male and female condoms and lubricants through outreach, at safe spaces, sex work locations and in risk reduction workshops	Availability of male and female condoms and lubricants
	1.1.2 Peer educators to promote, educate and demonstrate correct and consistent condom use and build skills to negotiate condom use	
1.2 Social and behaviour change communication	1.2.1 Peer educators to distribute IEC material through outreach, at sex work locations, at safe spaces and in risk reduction workshops	• Standard messaging to be provided • Availability of IEC materials • Communication channel dependent on funding • Standardised training in health communication skills and HIV is needed.
	1.2.2 Peer educators to undertake one-on-one or small group level communication on HIV, broader sexual health, human rights and psychosocial topics	
	1.2.3 Peer educators to conduct risk reduction workshops on HIV, broader sexual health, human rights and psychosocial topics	
	1.2.4 Peer educators to conduct small group interventions on HIV, broader sexual health, human rights and psychosocial topics	
1.3 HIV testing services	1.3.1 Peer educators to promote HTS, STI and TB screening and regular pap smears	Peer educators must have good knowledge of available health services
	1.3.2 Trained peer educators to conduct HTS with sex workers	• Standardised training • HTS should not overshadow other peer educator responsibilities
1.4 Linkage to care	1.4.1 Peer educators to link sex workers to health care services	Linkage to sex worker sensitised services wherever possible
		Follow up should be routinely undertaken to confirm successful client confirmed linkage
	1.4.2 Peer educators to support adherence to ART, PrEP, Prevention of mother-to-child transmission (PMTCT), STI and TB treatment	Peer educators should be trained in appropriate adherence support
	1.4.3 Peer educators to link sex workers to other services such as Thuthuzela Care Centres (TCC), safe houses, substance use, harm reduction, SASSA grants, legal aid centres, DSD and others	Peer educators need to map local services and build relationships with organisations
1.5 Social mobilisation	1.5.1 Peer educators to promote collective identity of sex workers	Sensitivity towards male, female and transgender sex worker identities
	1.5.2 Peer educators to promote membership of sex worker collective such as Sisonke	Membership should be voluntary
1.6 Psychosocial support	1.6.1 Peer educators to support implementation of the psychosocial service package	Peer educators should be trained in psychosocial support provision
1.7 Human rights support and access to justice	1.7.1 Peer educators to provide paralegal support	Specialised peer educators trained as paralegals
	1.7.2 Peer educators to provide legal literacy services for sex workers, clients, health care providers, social workers and law enforcement officials	Legal literacy services tailored to each target audience and addressing pre-existing attitudes and beliefs

Outreach

During the pilot project, outreach took place 3-4 times per week, initially only during the day, and later on in the project, also at night. Sex workers are accessed via the peer educators' networks. Due to the relatively small size of the sex worker population, the peer educators between them know the majority of sex workers in Komani personally. They are also referred to other sex workers via word of mouth in a snowballing manner. Due to the relationship of rapport and trust, the peer educators knew the phone numbers and addresses of sex workers in the community. It is generally preferable, wherever possible, to engage with sex workers on outreach when they are off-duty, so as not to disturb them when they are working. Therefore, during the pilot period, most outreach visits took place at sex workers' homes. Typically, outreach covers a particular area on a certain day. The peer education team travel to the area by taxi, and then proceed to do home visits on foot. Some sex workers are visited individually, while sometimes a group meet at someone's home. Each sex worker is visited at least monthly.

This approach enables the peer educators to develop supportive and trusting relationships with sex workers. During visits, the peer educators check in with the sex worker, and discuss any current issues she* may be experiencing. The peer educators are usually familiar with the sex worker's HIV status, as the trusting relationship established is conducive to sharing this information. If she is known to be negative, HIV testing every six weeks is recommended. While it is recommended that peer educators are trained to be able to conduct HIV testing themselves, currently they are not qualified to do so. If a sex worker is HIV positive, the peers enquire about adherence, and address any queries she may have. If the sex worker is non-adherent, this is discussed in a supportive manner to identify challenges, and to jointly problem-solve how to address these. Peer educators are also trained to screen sex workers for symptoms of STIs and TB, as well as to enquire after and provide support and referrals regarding psychosocial and human rights issues.

The peer educators also distribute condoms and lubricant during outreach. Commodities are obtained from the clinics. Unfortunately, however, lubricant was not always available, or not sufficient to meet demand. As lubricant for key populations is stipulated in the NSP, adequate supplies of lubricant should always be available at facilities, and thus it is recommended that Procurement and Supply Chain Management obstacles be addressed in this regard.

The peer education team also sometimes implements specific campaigns. For example, during one month, the project ran a Pap smear campaign. They thus provided education to sex workers on cervical cancer, and the need for sex workers to have annual Pap smears, and referred more than 50 sex workers for Pap smears that month.

Linkage to Care

Based on the sex worker's needs, the peer educators either refer or accompany sex workers to the local health care facility. For each referral, a form is completed with referral details, including the presenting problem (see Annex 2). While some sex workers are comfortable to attend alone, many prefer to be accompanied by a peer educator. Although relationships with the clinics vary, in about half of the clinics, the project is known and acknowledged by facility staff. Peer educators are able to navigate the clinics to ensure that the sex worker is treated kindly, respectfully and appropriately.

Creative Space

Creative Space workshops address the vital component of community systems strengthening, in addition to having many other benefits. Creative Space workshops are meetings which are held on a fortnightly basis. The workshops provide a safe space where sex workers can come together to share their experiences, provide mutual support, learn and socialise. They provide a very important function amongst a community which is stigmatised, discriminated against and marginalised.

In Komani, Creative Space workshops take place in a local church hall. The workshops are very popular: sex workers arrive early to secure a place.

The meetings are organised and facilitated by the peer education team. The facilitator starts by welcoming participants, asking them how they are and usually asks a particular open-ended question to trigger discussion, for example, "What are the challenges for people who are on ARV's?" Nurses and community health care workers from the clinics are invited to attend the workshops. They usually give a talk on a health topic, and are also available throughout the workshop to do HIV testing. However, Creative Space remains a community-owned space; the tone is set by sex workers themselves, it is a stigma-free space, and visitors are advised to respect that according to the site coordinator, "We ask clinic staff not to ask too many questions like 'Why are we doing this?' 'Where is your husband?'"

**The majority of sex workers accessed by the project are female, thus the female pronoun will be used*

Clinic engagement and sensitisation

It started when this project was introduced to us, at the meeting we were told we were chosen for this project. I sat down with my team – and told them – from the cleaner and everyone that we will be doing this. When we introduced something new, it was hard. Some are pastor's wives – I said, "You have you part, even a pastor's wife. If you are an aunty, you have your part to play to these children". We sat down with their managers, we made a plan: how are we going to work with them? They started with their Creative Space, we delegated two staff and myself as an older person. I tried by all means to attend the Creative Space, to support and render services and not judge. We continued the process and we changed as staff...When we hear their problems, and their needs, I saw they are not only in our catchment area, so I went to two other facilities where they were defaulting. I invited them to come [to Creative Space workshops] to just listen. [Now] we are well established with them, even if they have a topic, I stand with them, next to [Charity, the site coordinator] to support.
— Sr. Nosipho Goso, Lizo Ngcana Clinic

A critical component of this model, which is key to improving sex workers' access to health care in a sustainable manner, is to work collaboratively with health facilities to address the barriers which sex workers face. The above quote from Sr. Nosipho Goso, from Lizo Ngcana clinic describes how the project was introduced to one clinic by District management, how resistance amongst staff was overcome and how collaboration between the facility staff and SWEAT led to improved relationships and a decrease in stigma. Importantly, Sr Goso stressed that staffs' moral belief systems should not stand in the way of the duty to treat every patient with respect, dignity and care. Once sex workers in the Lizo Ngcana catchment area witnessed the attitudinal change amongst the facility staff, they began to feel safer to attend the clinic, which in turn led to improved health outcomes.

The project was very fortunate in having a champion in the form of Sr Goso, who was then able to share the experiences at her facility with staff from other facilities, encouraging them to follow suit.

Three specific project activities were key to improving collaboration with health facilities. These were: facility staff participating in Creative Space workshops (as discussed above); SWEAT staff conducting health talks at facilities; and sensitisation training.

To improve collaboration between the project and some of the clinics, the project team undertook to give health talks to patients in the waiting areas. The most recent talk had been on lubricants, which apparently patients found very interesting, and the talk generated a lot of questions and discussion. This is a very smart intervention, as it achieves several outcomes beyond providing patients with education: it supports facility staff in terms of providing health education, one of their functions which can sometimes be neglected due to heavy workloads; it ensures that the project team are known by clinic staff, and are integrated into the facility, thus improving their collaboration; and it decreases stigma and marginalisation from the community by reframing sex workers as having safe sex and health expertise.

During the pilot programme, a one-day sensitisation workshop was conducted by SWEAT's Training Manager. The workshops facilitated an understanding of sex workers: who they are, what their challenges are, how they are impacted by stigma and discrimination, and how health care facilities can be made more welcoming and sex worker-friendly, in order to improve uptake of, and retention in, services. Pre- and post-workshop assessments of staff attitudes showed that attitudes shifted in a positive direction as a result of the workshop. This finding is supported by research done by Poteat et al[33], which found that "*sustainable* decreases in negative attitudes toward gender and sexual minorities are achievable with a one-day training".

Although a one-day training is cost-effective and effective, in some cases it may be useful, if feasible, to implement more sustained engagement. For example, ANOVA Health has developed a training programme to improve health facility sensitivity and competence in dealing with key populations[34]. The programme involves developing an ongoing engagement with the clinic, including the training of all staff, including non-clinical staff such as security guards and clerks, who, as the gatekeepers to the facility, have the potential to contribute negatively or positively to the patient's experience of the facility. The programme further involves a process of assessment of the facility, with the ultimate goal of accrediting the facility as being key population-competent.

Coordination and overall management

The Site Coordinator provides day-to-day management of the activities of the intervention, including managing and supporting the peer education team, scheduling activities, overseeing monitoring and administration, submitting monthly reports, basic finance administration, and liaison with the District Department of Health, local health facilities and other district stakeholders.

A Provincial or Area Manager should oversee the project, provide support to the Site Coordinator and to the team; ensure compliance with standards of care, administrative and financial management, as well as liaise with the Provincial Department of Health and other provincial stakeholders.

A strong relationship with both District and Provincial Departments of Health is critical for the success of this project, in terms of alignment with strategies and policies, sharing of information, reporting of data, as well as participation in multi-sectoral coordination platforms.

Training and support

Unless you build capacity within sex worker communities, your intervention is not sustainable — Sally Shackleton, SWEAT Director

It is important that peer educators have opportunities for continuous learning and development. This includes formal peer education training and supportive orientation on commencing work, as well as ongoing formal and informal learning opportunities thereafter. It is especially important not to neglect learning and development when teams are in remote locations, as was the case with this project.

Beyond basic peer education training, peer educators should have access to further training, in order to expand their skills, to specialise in particular intervention areas, to keep abreast of developments and to build sex worker leadership and career pathing. It is recommended that peer educators attend at least one course annually, and that this be included in costing. However, the project should also make use of learning and development opportunities which arise locally. It is also important that peer educators get opportunities to attend trainings with peers from other locations, as this enables the sharing of lessons and connects peers to the broader sex worker collective.

Further training builds the capacity of the peer education team to respond holistically to the needs of sex workers. Thus, training could include:

Human rights and paralegal support: Such training should equip peer educators to provide education and advice to sex workers on their human rights, their rights in dealing with the police, and how to access justice. For example, SWEAT provides training on human rights defence for sex workers.

Counselling and psychosocial support training: Such training is a vital requirement so that peer educators can respond empathically to the psychosocial challenges and traumas which sex workers commonly experience. Basic counselling and referral skills would be very beneficial. Examples of courses include Lifeline South Africa's Personal Growth and Basic Counselling courses.

HIV testing training: Such training enables sex workers to provide HIV testing services, along with pre-and post- test counselling, to sex workers in the community.

However, additional training and responsibilities must be balanced with realistic expectations of what peer educators, as part-time workers, are able to accomplish.

Monitoring and evaluation

Indicators and outcomes

The monitoring system measured the outputs of the intervention according to a set of indicators. These indicators relate to outreach activities, referrals and creative space workshops. Importantly, the monitoring tools are able to identify the number of unique individual sex workers reached in a quarter. A unique identifier system has been developed based on the sex worker's name and surname. Thus, the system is also able to track how many times an individual sex worker is reached per quarter. This is useful for providing individualised care, for example, reminding a service user that they are due for an HIV test.

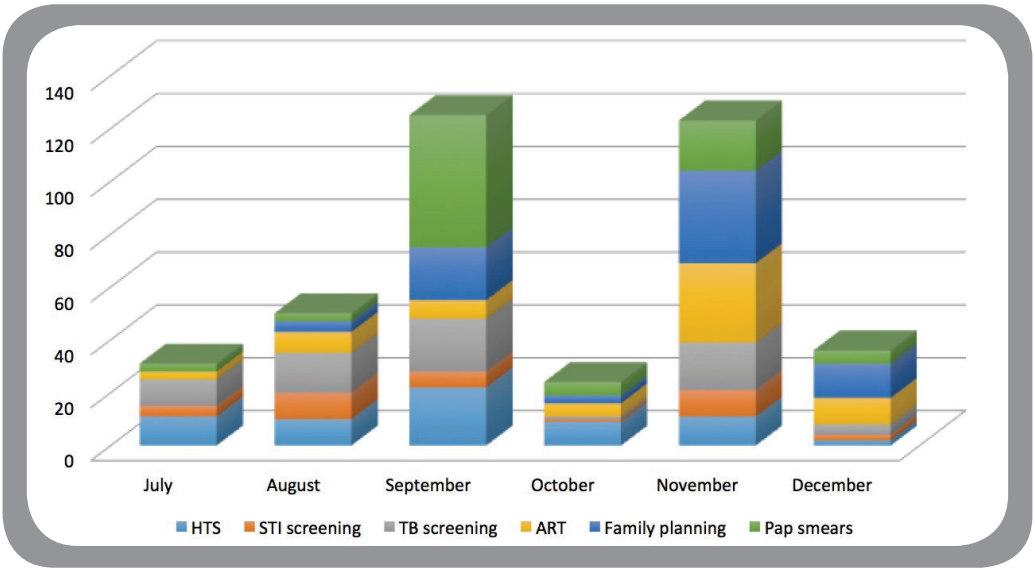
There has been extensive debate around unique identifiers within sex worker programmes in South Africa. In some settings, basing a unique identifier on a sex worker's name may not be feasible as sex workers may provide different names at different times. However, this system is workable in a smaller community like Komani.

The graphic below shows that 428 unique individuals were reached in the first quarter of the project (July-September 2017) and 550 in the second (October-December 2017).

Table 2: Statistics for all activities conducted during pilot project

	FIRST QUARTER						SECOND QUARTER					
	JULY		AUGUST		SEPTEMBER		OCTOBER		NOVEMBER		DECEMBER	
INDICATORS	Unique	Non Unique	Unique	Non Unique	Unique	Non Unique	Unique	Non Unique	Unique	Non Unique	Unique	Non Unique
Number of sex workers reached during outreach	208	179	311	141	256	108	371	215	488	252	221	83
Number of sex workers referred for HTS	11		10		22		9		11		2	
Number of sex workers referred for STI screening	8		7		6		1		10		2	
Number of sex workers referred for TB screening	10		15		20		1		18		4	
Number of sex workers referred for ART	3		8		7		5		30		10	
Number of sex workers referred for Family planning	0		4		20		3		35		13	
Number of sex workers referred for Pap Smears	3		3		50		5		19		5	
Number of sex workers attending risk reduction workshops	49		147		145		116		131		63	
Number of Risk Reduction Workshops held	2		4		4		4		4		2	
Number of Health Talks held at health facilities	0		4		5		6		5		3	
Male condoms distributed	4835		7200		4280		7380		8400		4460	
Female condoms distributed	416		622		561		738		4200		226	
Lubricants distributed	1850		3110		2580		3690		1102		2230	
IEC materials distributed	208		349		366		708		1102		226	

Figure 4 below shows the range of issues for which sex workers were referred to health facilities. These referral indicators are aligned with sex workers' most important health needs, not limited to HIV, and are also aligned with the National Sex Work Plan. Only *successful* referrals are counted.



Data collection

Data was collected from 3 sources: outreach forms, referral forms and workshop registers.

Outreach forms

Peer educators used paper-based outreach forms to record sex workers reached and interventions provided. Sex workers provided personal details which enabled the project to count unique individuals reached. Although in this setting, due to the rapport and trust which was established with the peer education team, sex workers were comfortable to provide personal details, request for personal details should always be treated sensitively, and if beneficiaries do not wish to disclose personal details, or, for example, want to provide an alias, this choice should be respected, and sex workers should not be pressurised.

Peer educators then submitted their forms to the site coordinator, who captured the data on an electronic database. The electronic database automatically creates a unique identifier for each beneficiary, based on letters from their name, surname and decade of birth. The unique identifier enables the team to track the health status of the sex worker, as well as services received, for example to monitor when last the sex worker was tested for HIV. Thus, sex workers can be provided with personalised health advice and support, for example, reminders of when screenings are due, or when clinic appointments are scheduled.

In addition, as the indicator refers to **number of sex workers reached per quarter**, the electronic database shows if a sex worker has already been reached on outreach during that quarter. Although services will still be provided, and recorded, that sex worker is counted once per quarter. This monitoring system thus allows for counting of unique individuals reached per quarter.

An example of the outreach form is shown in Annex 1.

Referral form

Sex workers who are referred to clinics, or any other organisation or agency, are given a referral form detailing the reason for referral. A duplicate of the referral form is kept in a referral book. The staff member who treats the sex worker is requested to sign and stamp the referral form. The peer education team then regularly collect the signed, stamped forms and cross-reference with the referral book, to count a successful referral.

This system generally works well in Komani due to the support of facility staff for the project. However, during a field visit to one of the clinics, the consultant and site coordinator were told of a staff member who refused to sign the form. We paid a visit to the sister, who was new to the facility, and was not aware of the project, to explain to her what the project was about, and why the referral form was needed. Thus, ongoing engagement and education is necessary to ensure the smooth monitoring of referrals. The referral form is shown in Annex 2.

Workshop register

A register is also used to record participants in Creative Space workshops. The register is shown in Annex 3.

Costing

While the model is not resource-intensive, it is important that the essential costing elements, are included when budgeting. This includes adequate budgeting for operational costs, including communications and transport; costing towards management support for the project; as well as for and learning and development activities.

The budget shown below is a recommended budget for the effective implementation of a low-cost, integrated sex worker project (reflecting 2017 costs).

BUDGET: LOW-COST, INTEGRATED SEX WORKER PROGRAMME		
ITEM	**ANNUAL COST**	**UNIT COST**
Staffing		
Peer educators (4 part time)	134 400.00	2 800.00
Peer Leader/Site Coordinator full time	102 200.00	8 100.00
M&E and coordination	98 800.00	
Operational		
Monthly office space & once off basic furniture	70 000.00	
Communication (including airtime for peers/leader)	6 960.00	
Uniform & kit	1 500.00	
Activities		
Outreach (might vary to context)	49 500.00	
Risk Reduction Workshops	69 600.00	
Mapping (quart)	13 500.00	
Meetings, networking/follow up to referrals/Facility Meetings	7 200.00	
SUBTOTAL	**553 660.00**	
Training		
Peer training	33 500.00	
Sensitisation training (35 participants)	15 750.00	
TOTAL ANNUAL COST	**602 910.00**	

Other considerations

How do you recruit peer educators?

Firstly, is imperative that the peer education team are sex workers, and ideally from the community where the project is being implemented. Since sex work is illegal, stigmatised and clandestine, recruitment therefore has to be modified. For example, advertising in the traditional ways will not be effective. Informal, and - if available – formal sex worker networks, should therefore be used, for example, asking Sisonke to spread the word, or using outreach and workshop activities, or social media.

Secondly, the recruitment criteria also have to take consideration of the fact that many sex workers have not completed their secondary education, and therefore "hard skills' such as level of education and qualifications are less relevant. More important, 'soft skills' to consider include: familiarity and rapport with local sex worker networks; interpersonal communication skills; commitment to the improvement of living and working conditions for sex workers; and reliability.

How do you retain peer educators?

There should be no expectation that peer educators stop sex work, firstly because they would no longer be peers, and secondly because it is necessary for the project to have current, up-to-date knowledge of the local sex worker community.

Once recruited, it is important to recognise that many sex workers lack formal employment histories, and for some, it may be their first experience of being employed. Peer educators may therefore need support, guidance, and some degree of patience, to develop work skills, such as working in a team, professional communication and punctuality.

Finally, it is important to be mindful of the psychological impact of the stigma, trauma and other stressors which many sex workers have experienced, which have been discussed, thus a supportive working environment is important.

How should working hours be scheduled?

For the pilot project, the peer coordinator was employed full-time, while the peer educators work part-time 16 hours per week. These hours are in line with the Global Fund national sex worker programme. Scheduling should be flexible, and will depend on the type of setting, including whether outreach will be conducted at day or night, during the week or over weekends. In general, each week should be scheduled to make time for a regular team meeting, 3-4 outreaches per week, accompanying sex workers who are referred to clinics or other services, Creative Space workshops, administration activities, as well as occasional stakeholder meetings.

How can the pitfalls of working in a remote location be overcome?

Some of the pitfalls of working in a remote location include isolation from the organisation, potential drop in the quality and consistency of services, inadequate financial and administrative control, and a drop in motivation of staff. This can be overcome through regular contact and communication between the project and provincial and national management. Adequate support for electronic communication is necessary so that staff can email, skype, WhatsApp or phone to keep in contact. Regular site visits (at least monthly) by the provincial manager are necessary. In addition, developing strong networks and linking to local stakeholders can build potential resources and support systems.

How can the project team be assisted to feel part of the larger organisation?

Project staff should be provided with opportunities to get to know and interact with their colleagues from other sites. The Komani project staff were included in monthly teambuilding sessions which took place together with the East London team were paid transport costs to get them to East London to join the team. Staff should also be included in training workshops and national meetings as much as possible. In addition, staff should be included in organisational internal communications, and encouraged to link to the organisation's social media, e.g Facebook and Twitter.

How can the project interact with the sex workers movement?

Sex worker social movements are important to build the social capital of sex workers to advocate for their human rights, for a legally and socially enabling environment, to amplify the voices of sex workers, and to ensure that they are represented in decision-making processes that concern them. The project interacted with Sisonke sex workers movement, as the peer educators are members and could promote Sisonke in the course of their work. It is recommended that Sisonke provide support to its membership, for example by conducting visits to the community, and attending Creative Space to inform members of Sisonke's role, link sex workers to national processes, attract membership and follow up on issues arising regarding human rights.

How can the project ensure that it remains responsive and accountable to sex workers' needs?

It is recommended that both formal and informal feedback mechanisms be established. Informal feedback mechanisms provide a quick and simple feedback loop, and include soliciting verbal feedback, or simple anonymous rating systems (such as indicating levels of satisfaction and providing comments on a form, and dropping it into a box at Creative Space workshops). In addition, both sex workers and staff should be made aware of more formal ways that they can report grievances and lodge complaints. Of course, it is also important to develop mechanisms for sex workers to lodge their praises.

Conclusion and Recommendations

Sex workers in South Africa are at high risk for HIV, STIs and other occupational health issues. Human rights barriers to accessing health care, such as stigma and discrimination, mean that sex workers have been reluctant to access health services for all their health needs. Their marginalisation from health services leads to negative health outcomes: indeed, a very real illustration of that is that, during the period between projects when targeted interventions were not operating in Komani, it was reported that sex workers stopped attending clinic, some got sick, and a few even died.

The South African government has committed to extending stigma-free services to sex workers. The model described in this report is not costly, is comprehensive, is sustainable, and supports government health facilities and other stakeholders to work in partnership to improve services for sex workers. In the words of Mr Lundi Ncana, the Eastern Cape Department of Health HTA Manager, the model *"is an example of a simple intervention that doesn't require much but achieves a lot".*

Replication of the model

While the model has been developed to fill the need for sex worker programmes in moderate density areas, it also has potential to be used in higher density areas. Many of the metropolitan areas of South Africa now have targeted health interventions for sex workers, in the form of sex worker friendly clinics, implemented by NGO's, or through NGO/government partnerships. While appreciated and well-utilised by sex workers, such facilities are also costly. The current model provides a more affordable alternative.

As indicated above, if an average of 500 sex workers were reached per quarter per site, at 20 sites, an additional 10 000 sex workers could be reached per quarter, contributing greatly towards the target of 70 000 in the National Sex Worker Plan

Ongoing training for peers to expand services

While the project's outcomes were positive in terms of improving the willingness of sex workers to attend facilities, and improving their health outcomes, especially with regards to HIV, it is recommended that peer educators receive training to be able to provide health promotion and education on a range of health issues, in line with sex workers' main health needs, as outlined in the NSP and the National Sex Worker Plan. This should include including STIs, family planning, cervical and breast cancer screening, PMTCT and support regarding substance abuse. Further, while PrEP is not yet available in Chris Hani District, peer educators can play a role in educating sex workers about PrEP, assessing their interest in PrEP, and generating demand and advocacy in that regard.

With regards to HIV, it is highly recommended that the peer education team are trained to be able to provide HTS.

Monitoring, and responding to, human rights abuses

Human rights violations against sex workers are not as yet monitored routinely on a national basis. It is necessary to monitor and respond to human rights violations, primarily so that sex workers can enjoy the human rights to which every citizen is entitled, but also because human rights violations have a detrimental effect on sex workers health. SWEAT is working towards the development of a national human rights monitoring framework; such a system should be supported, and training should be given to the peer education team to be able to document, report and respond to rights abuses.

Responsiveness of facilities

Partnership-building and collaboration with clinics and other stakeholders should be ongoing. Sensitisation training should be provided, especially with clinic staff, but also potentially with local stakeholders such as social workers, police, magistrates and NGO staff. While working in a spirit of partnership, if necessary, there should be an accountability system for addressing poor or discriminatory service, in line with the Batho Pele Principles[35]. District health management has a leadership and coordination role to play in laying the ground work for the introduction of the project, and also being available to resolve obstacles that may arise.

Condoms and lubricant

Condoms and lubricant should be always and freely available from health facilities. While the project did not struggle to obtain adequate quantities of condoms, lubricants were only available erratically from facilities. As lubricants are a recommended commodity for sex workers in the NSP, the project, the clinic and the District should collaborate in estimating needed quantities and ensuring adequate supply.

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SWEAT OUTREACH MONITORING FORM

DISTRICT:	SUBURB:	PLACE/SITE:
NAME OF P.E/P.L:	DAY:	DAY/NIGHT:

TYPE OF SITE (O,U,S,B,I,T,C,Ts,Hm,H[1])	FIRST NAME	SURNAME	YEAR OF BIRTH	[2]GENDER (FSW, TG, MSM,)	OTHER KEY POP[4] (P, CL, M/A, TD, TXD, GP,	SISONKE MEMBERSHIP (Y/N)	LEVEL OF EDUCATION (NS, P, S, T)	HEALTH *(S,Rp,R)*	BEHAVIOURAL (S,Rp,R)	SERVICES AND REFERRALS[5]			MATERIALS DISTRIBUTED (Y/N)
										PSYCHO SOCAIL (S,Rp,R)	HUMAN RIGHTS VIOLATIONS (S,Rp,R)	OTHER (S,Rp,R) (Please specify in notes)	

[1]Street, T=Tarven,C= Club,I= Internet, B=Brothel,H= Hotel, Hm=Home, Ts=Truck Stop, University or college, O=Office
[2]FSW=Female Sex Worker; M = Men Who have Sex With Men; TG = transgender
[3]P=Pimp, CL=Client, Manager/Admin, TD=Truck Driver, TXD=Taxi driver, GP=General Public
[4]NS=No School,T= Tertiary, P=Primary, S=Secondary
[5]Write S if you talked about any of the items, write R if it was a referral, write SR if you discussed and referred, write Rp for issues reported

Always attach referral form if referral is made

ANNEX 2: Referral Form

REFERRAL FORM
NO:

Date: _____

Referral to (organisation name): _____

Referred by (name): _____

Name of person referred: _____

Date of birth: _____

Contact tel. no: _____

Address or place of contact: _____

Referral for:

- ☐ HIV counselling & testing (HTS)(including STI screening)
- ☐ STI treatment
- ☐ ART
- ☐ Legal services
- ☐ PREP
- ☐ Psycho-social support
- ☐ Other

_____

To be completed by person at organisation where person has been referred to:

FACILITATOR NAME:	SIGN:	PARALEGAL NAME:	SIGN:
FUNDER:			

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NACOSA
COLLECTIVELY TURNING THE TIDE ON HIV, AIDS AND TB

CREATIVE SPACE WORKSHOP REGISTER

TYPE OF WORKSHOP:		DISTRICT/PROVINCE:	
DATE:		TOPIC:	
VENUE:		SITE/OFFICE:	

FIRST NAME	SURNAME	YOB[1]	[2]GENDER (FSW, TG, MSM,)	#OF DEPENDENTS[3]		SISONKE MEMBERSHIP (Y/N)	MATERIALS DISTRIBUTED (Y/N)	RESOURCE REFERRED	CELL PHONE NUMBER	SIGNATURE
				CHILD	ADULT					

[1] YOB = Year of Birth
[2] FSW=Female Sex Worker; M = Men Who have Sex With Men; TG = transgender
[3] # = Number
[4] Y/N = Yes or No

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