

BRIEFING PAPER

Sex Workers' Experiences of Stock-outs of HIV/STI Commodities and Treatments

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Background

Sex workers are disproportionately affected by HIV. “Globally, HIV prevalence among female, male, and transgender sex workers is estimated to be 14, 18, and 34 times higher than HIV prevalence of the general population”.¹ As such, access to commodities for HIV prevention, detection and treatment is critical to the health and well-being of sex workers around the world.

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World Health Organization (WHO) guidelines provide a comprehensive package of evidence-based HIV-related recommendations for all key populations, including sex workers. These essential health sector interventions include: comprehensive condom and lubricant programming; HIV testing

and counselling; HIV treatment and care; and sexual and reproductive health interventions.² Sex worker-specific guidance produced by WHO, United Nations Population Fund (UNFPA), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Network of Sex Work Projects (NSWP) in 2012 makes additional recommendations around decriminalisation, community empowerment, stigma, non-discrimination and violence prevention. This guidance outlines the importance of condom and lubricant programming, access to a package of comprehensive prevention and STI care, and free and voluntary, confidential HIV testing and counselling.³ These recommendations now serve as the basis for the international normative guidance: ‘Implementing Comprehensive HIV/STI Programmes with Sex Workers’, known as the Sex Worker Implementation Tool (SWIT). Produced by UN agencies and NSWP, it confirms that ‘the principles that underlie this tool, and the operational approaches it represents are no less relevant to high-income countries, and should be seen as a minimum global standard’.⁴

However, progress continues to be dangerously slow. UNAIDS’ Global AIDS Update for 2018 identifies huge discrepancies between the need for commodities and treatments and the actual supply, and reports that 47% of new HIV infections globally are among key populations.⁵ Executive Director Michel Sidibé summarised: “Health is a human rights imperative and we are deeply concerned about the lack of political commitment and the failure to invest in proven HIV programmes, particularly for young people and key populations”.⁶

Despite these tools and guidelines, sex workers continue to face significant barriers in accessing commodities and treatment, including experiencing frequent and systemic stock-outs. These experiences are currently unexplored in existing literature and policy.

This briefing paper describes the experiences of sex workers relating to stock-outs of essential medicines, antiretroviral drugs (ARVs), condoms and lubricants, diagnostics for STIs and HIV, and HIV viral load testing in 20 countries. It provides direct evidence from sex workers; highlighting how these stock-outs result in increased vulnerability to infections, treatment interruptions, HIV-/STI-related drug resistance, late diagnoses, treatment failure, and death. It then provides key recommendations for addressing these issues.

1 The Lancet, 2014, “Facts about sex workers and the myths that help spread HIV”.

2 WHO, 2014, “Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations”.

3 WHO, 2012, “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”.

4 WHO, UNFPA, UNAIDS, NSWP, The World Bank, and UNDP, 2013, “Implementing Comprehensive HIV/STI Programmes with Sex Workers”.

5 UNAIDS, 2018, “Miles to go: closing gaps, breaking barriers, righting injustices”.

6 UNAIDS, 24/7/18, “At AIDS 2018, UNAIDS calls for bold leadership to tackle the prevention crisis”.

About this publication

This briefing paper is the result of a collaborative process between NSWP and the International Treatment Preparedness Coalition (ITPC) that aims to highlight the impact of stock-outs of commodities and treatments important to sex workers worldwide.

ITPC is a global network of people living with HIV and community advocates working to achieve universal access to optimal HIV treatment of those in need. Formed in 2003 by a group of 125 HIV activists from 65 countries at a meeting in Cape Town, South Africa, ITPC actively advocates for treatment access across the globe, with a particular focus on treatment education and demand creation, intellectual property and access to medicines, and community monitoring and accountability.

NSWP is a global network of sex worker-led organisations, with 258 members in 80 countries, that exists to uphold the voice of sex workers globally and connect regional networks advocating for the rights of female, male and transgender sex workers. It advocates for rights-based health and social services, freedom from abuse and discrimination, and self-determination for sex workers.

Methodology

This briefing paper summarises the key findings from in-depth research among sex workers. The research was conducted using a standardised questionnaire in two processes:

- In-country focus group discussions and interviews in 10 countries: Bangladesh, Cameroon, Côte d'Ivoire, El Salvador, Ghana, Indonesia, Jamaica, Kyrgyzstan, Malawi, and Nicaragua; and
- A global e-consultation with NSWP member organisations.

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In-country research was carried out by national consultants between January and April 2018. In some countries, national consultants also included information gleaned from interviews with other local stakeholders including community-based organisations, government and health service representatives. Additionally, in-depth interviews were held with key informants in relevant international HIV organisations, including WHO, UNAIDS, UNFPA and The Global Fund.

In total, the research included sex workers in 20 countries via in-country research (10 countries) and via the global e-consultation (10 countries). Within the in-country research, 177 female, male and transgender sex workers took part in the focus groups and interviews, including both documented and undocumented migrant sex workers, sex workers living with HIV, sex workers who use drugs, sex workers from both rural and urban settings and LGBT sex workers. The majority of participants fell within the age range of 18–50 years. Their places of work included street or public places; indoors from their own homes, hotels, or clients' residences; and managed establishments such as brothels/parlours/bars/indoor saunas. Within the global e-consultation, 14 NSWP sex worker-led member organisations participated, representing Burundi, Cameroon, Côte d'Ivoire, the Democratic Republic of Congo, Ecuador, El Salvador, France, Kyrgyzstan, Mali, Mexico, Peru, Spain, Uganda and Ukraine.

Analysis

A key finding from the consultation carried out for this paper was the observation among sex worker communities that availability of commodities and treatments is routinely lower than required by sex

Sex workers report that they experience stock-outs of commodities [...] even when other communities and populations in the same locations do not.

workers. In some countries, periods of stock-out and shortage are more common than periods of consistent supply. Sex workers report that they experience stock-outs of commodities (e.g. lubricant) even when other communities and populations in the same locations do not. Sex workers experience forced treatment interruptions and changes of medication due to stock-outs, and are forced to travel long distances to access commodities and treatments due to stock-outs in their local area. This ultimately leads to a lack of trust in health services and systems.

Causes of Stock-outs

Sex workers consulted for this briefing paper described several causes for stock-outs.

Funding

In some circumstances, there was an ongoing problem regarding the late arrival of funds to HIV and STI programmes, slowing the ability for governments, NGOs and international agencies to purchase much-needed commodities and treatments. Logistics and transport issues also hampered timely delivery. There were problems with stock ordering systems, poor programming, bad inventory practices, and an overall lack of funding for public health clinics, NGOs and sex worker-led organisations. The recent transition of some 'middle-income' countries away from the Global Fund in favour of national funding has also created gaps. The research also showed that sex workers are often now forced to pay for condoms and lubricants that were previously available to them for free.

Procurement

The production and purchase of commodities and treatments are influenced by the policies and practices of large international agencies, governments and large NGOs. These organisations make decisions about what to buy, and when. Their drug quantification and forecasting relies on having accurate information about the needs of communities. If this information is incorrect, their ability to make procurement decisions is impaired. It is common for these organisations to pool their money and organise purchases collectively. The Global Fund, UNFPA, UNDP and USAID each co-ordinate large pooled purchases of commodities and treatments for international agencies and NGOs, ordered many years in advance. UNDP sometimes purchases ARVs, condoms and lubricant when governments are unable to do so.

Overview of the global purchasing and supply architecture

Key institutions

- **Joint United Nations Programme on HIV/AIDS (UNAIDS)** – coordinates policy and oversees HIV prevention and treatment programming by UN agencies.
- **United Nations Population Fund (UNFPA)** – involved in condom procurement. UNFPA has a 'Country Taskforce' in relevant countries, responsible for distribution.
- **United Nations Development Programme (UNDP)** – primarily involved in policy, however serves as Principal Recipient for national Global Fund grants when there is no other agency or NGO able to do so.
- **The Global Fund** – an international financing organisation that aims to accelerate the end of HIV, tuberculosis and malaria as epidemics.
- **World Health Organization** – produces international normative guidelines for health, including guidelines for HIV prevention and treatment programmes. Oversees global standards on condom and lubricant production.
- **USAID** – the USA's government agency responsible for international development grants to other countries. USAID spent US\$3.5 billion on HIV/AIDS in 2017.
- **Governments** – national governments make procurement decisions and are often responsible for distribution.
- **National health departments** – act as distribution points and are accountable to governments.
- **HIV-related NGOs and health NGOs** – order commodities and treatments through international agencies or governments, and act as distribution points.
- **Local sex worker-led organisations** – when funded, purchase commodities from international agencies or governments. If unfunded, rely on health departments to purchase stock, passing it onto sex worker groups for distribution.

EXAMPLE: The Global Fund's Voluntary Pooled Procurement

The Global Fund gives more than US\$4 billion a year to around 140 countries to fight AIDS, TB and malaria worldwide. The Global Fund approves a list of purchases (itemised within a 'Concept Note'), including ARVs, condoms and diagnostic equipment for each country. More than half of the countries pool their purchases together in order to buy the products at a cheaper price. This is called 'Voluntary Pooled Procurement'. In such circumstances The Global Fund then buys the products directly on behalf of the countries, and the approved purchases are shipped directly to each country.

Distribution and Supply Chain Management

Government and health departments are responsible for the distribution of most commodities and treatments of interest to sex workers. A lot of this distribution happens at public health facilities that are open to the general public. International and local non-government agencies and community organisations, including some sex worker-led organisations, are funded to undertake targeted distribution of these commodities and treatments among key populations.

Stock-out Reporting Mechanisms

There are a number of mechanisms that exist for reporting stock-outs. These include via:

- The UNFPA 'Country Taskforce'.
- The Global Fund 'Officer of the Inspector General'.⁷
- UNDP Country offices or Regional hubs (Istanbul, Bangkok, Panama).
- WHO country offices.
- UNAIDS country offices.
- The Country Coordinating Mechanism (CCM) for The Global Fund.
- Government, Ministry of Health or local public clinic.
- Civil society mechanisms, such as ITPC's Regional Community Treatment Observatory in West Africa (RCTO-WA).

Note: The existence of these mechanisms, how to access them, and the precise role of each agency are not always well-known among sex worker-led organisations or individual sex workers.

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EXAMPLE: UNFPA's Country Taskforce

After condoms are purchased in bulk for a number of countries and NGOs, UNFPA coordinates the orders to be delivered. There is a UNFPA 'Country Taskforce' in every relevant country. The 'Taskforce' is responsible for distribution and managing stock-outs. They are eager to receive reports of stock-outs directly from sex workers. They also monitor social media and mainstream media for reports of stock-outs.

Types of Commodities and Treatment Stock-Outs

I. Condoms

Condoms are recognised as an essential item for prevention of HIV and STIs for sex workers. WHO advises:

*"The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs)."*⁸

Yet sex workers from each of the 20 countries that responded to the consultation for this paper had experienced condom stock-outs in 2017 and 2018.

⁷ Office of the Inspector General, The Global Fund, "Report Fraud and Abuse".

...supplies ran out before the end of the funded prevention programmes' annual contract, or because the national government did not provide adequate funding.

For example, in Cameroon, Ukraine and El Salvador, regular stock-outs of condoms were reported, with demand regularly out-stripping supply. Sex workers were consequently forced to buy condoms – often from street vendors, due to the high prices of pharmacies. These costs further limited sex workers' income. Some sex workers in El Salvador reported

cleaning condoms out for reuse because they did not have money to buy new condoms. Sex workers in Cameroon, for example, reported being limited to fewer condoms than they needed for the number of clients they had.

Condom stock-outs occurred at government health clinics as well as at NGOs. Some interruptions in supply occurred between deliveries, because supplies ran out before the end of the funded prevention programmes' annual

contract, or because the national government did not provide adequate funding. In Ukraine, stock-outs due to poor planning are exacerbated by limits on how many free condoms sex workers are allowed to receive:

“Deliveries [of condoms] to cities are carried out every three months and during these periods there are interruptions in supplies. Similarly, when the year ends, the supply ends and the new supply does not yet exist, so condoms are issued either in limited quantities or not at all. They also issue personal protective equipment that does not coincide with real requests, for example, for one sex worker for 365 days [it] is allowed to issue about 200 condoms.”

UCO “LEGALIFE-UKRAINE”

In France, sex worker-led organisations intervened after receiving complaints about NGOs distributing out-of-date and poor quality condoms.

“Sex workers have complained that the condoms had broken so we made the necessary alerts to the authorities so that they get new condoms from other providers”

STRASS, FRANCE

Condoms are ostensibly free for female sex workers living with HIV in northern Ghana, however they reported that the number of condoms they can obtain was limited by pharmacies/regional hospitals or that peer educators ran out, and so sex workers needed to purchase additional condoms.

A similar picture emerged in Côte d'Ivoire, where sex workers reported that NGOs limited the number of free condoms available to around a dozen per month.

“When there is a stock-out [at the NGO] we all chip in together for a colleague to buy larger quantities at the pharmacy.”

SEX WORKER, CÔTE D'IVOIRE

Other reported causes for stock-outs included primary or sub-recipients of the Global Fund grants not purchasing enough condoms. When this happened in Nicaragua, sex workers informed the CCM. In this case the CCM did not respond to the situation. In Peru there are political issues that have prevented relevant government departments from purchasing condoms, resulting in peer educators having no supplies to distribute to sex workers. Additionally, a lack of secure funding for sex worker-led organisations led to stock-outs of condoms in some territories.

8 World Health Organization, 2012, “Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update” P. xvii.

Indirect factors also contributed to a lack of access. For example, police raids on sex work areas in Jamaica prevented sex workers from being able to reach the supplies provided by the local sex worker organisation. In Ukraine, cases were reported of outreach workers delivering free

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condoms to managers of establishments, who then sold them to sex workers. In rural El Salvador the lack of public clinics results in no condom distribution to sex workers. Condom vending machines intended for street-based sex workers in Ghana were occasionally destroyed by law enforcement officers.

CASE STUDY: Bangladesh

Sex workers first noticed a problem with free condom supplies at the beginning of 2016, and report it has worsened in the last year. Despite Bangladesh being a Global Fund grant recipient, currently sex workers report they can now only buy limited supplies from outreach/peer workers, rather than access free condoms, and coverage was reported as low.

NGOs in Bangladesh receiving money through the Global Fund for the sex worker programme sell condoms through a 'social marketing' programme. 'Social marketing' programmes and campaigns seek to increase condom and lubricant affordability by selling subsidised condoms and lubricants to individuals who can afford to pay only some of the total commodity cost. They are intended to destigmatise condom use, increase availability and improve the sustainability of condom programming over time.

The SWIT clearly states that social marketing:

*"should not be a substitute for the distribution of free condoms and lubricants to sex workers. ...Condom social marketing programmes should complement and supplement free distribution, improving the choice and desirability of condoms and lubricants and making them more widely available."*⁹

However, sex workers reported that no NGOs distributed condoms for free. One project manager did say that they provide a limited number of condoms for free, but outreach workers often sell those to get extra money. Outreach workers said that if they cannot sell the condoms, the managers cut their salary.

"We need condoms from peer workers because there is no stigma and discrimination, but we cannot buy condoms from other sources because there is stigma and discrimination, so we need condom from peer educators, and for free."

SEX WORKER, BANGLADESH

⁹ WHO, UNFPA, UNAIDS, NSWP, World Bank & UNDP, 2013, "Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions" p.92.

...stock-outs of these commodities are very common, but they are commodities frequently used by sex workers in their work...

II. Flavoured Condoms, Different-Sized Condoms, Gloves, Dental Dams, Female Condoms

UNFPA arranges the purchase of billions of condoms and maintains multi-year contracts with condom companies, meaning they can secure a very low price (less than US\$0.04) for standard-sized condoms. The Global Fund, and countries funded by them, also buy most of

their standard-sized condoms through UNFPA. Different-sized condoms, flavoured or ribbed condoms, female condoms, gloves and dental dams are more expensive by comparison, take longer to purchase and are not pre-ordered like standard condoms. As a result, stock-outs of these commodities are very common, but they are commodities frequently used by sex workers in their work:

- Sex workers in Uganda reported regular stock-outs of female condoms.
- Stock-outs of flavoured condoms are common in Kyrgyzstan.
- Sex workers in Malawi reported almost no availability of dental dams.
- Sex workers in Spain reported periodic stock-outs of flavoured or different-sized condoms.
- UNFPA distribute latex gloves, however they are intended for nursing and medical needs and not for sex workers. Many sex workers use gloves in their work when participating in anal play and fisting activities.

III. Lubricant

There are specific problems with stock-outs of lubricant supplies for sex workers.

Lack of funding affects Kyrgyzstan and Ecuador. In Mexico, sex workers report that while NGOs always have lubricant for sex workers, government clinics do not order enough, leading to stock-outs. In Ghana, supplies are at crisis levels compared to condom stocks. Sex workers there reported that peer educators frequently run out of lubricant packets, forcing them to resort to other lubrication methods including using shea butter or saliva.

“Sometimes you see [us] chewing gum, it’s not because we like it, but it is to generate enough saliva...”

SEX WORKER, GHANA

The approaches taken by some conservative governments also have an impact. In Uganda the government has been withholding lubricant, causing a national stock-out, due to homophobic policies. Similar policies have contributed to stock-outs in Peru.

“Since December of 2017, condoms and lubricants have not been delivered to the population, because the state does not assume its commitment to purchases and much less to distribution, with the Global Fund. Ultimately, due to the change of government and ministers who are of a strong and fundamentalist opposition, it does not favor HIV prevention strategies in our population.”

ASOCIACIÓN CIVIL ÁNGEL AZUL, PERU

Government and NGO decisions about priority populations for lubricant supplies have also had an impact. In the DRC, parts of Spain, and Malawi, government-clinic lubricant supplies are free for men who have sex with men or transgender people, however other sex workers are expected to pay. In Mexico City there are no free lubricant supplies for sex workers. Sex workers in DRC, Ghana, Malawi and Kyrgyzstan report that lubricant is too expensive for them to buy.

“Lubricants are provided only in the framework of the Global Fund project and only some sex workers can afford to buy them in pharmacies or on the market, as the price is expensive and not everyone knows that they are being sold.”

TAIS PLUS, KYRGYZSTAN

Packaging and distribution policies also contribute to stock-outs. In Bangladesh, lubricant is only available to purchase in single-use sachets (not tubes, which sex workers would prefer), and in Malawi, condoms and lubricants are not provided as a single package, which means sex workers have to source the two commodities separately.

“I often have the day when it’s good – even 10 customers [and] the same customer may want to do it again. You see when he gives me just five lubricating gels, I have to do it like that”.

SEX WORKER, CAMEROON

IV. HIV Treatment: Anti-Retrovirals (ARVs)

The Global Fund buys ARVs for 17.5 million people worldwide¹⁰, purchased in multi-year contracts. More than 90% of Global Fund ARV expenditure is on generic-branded drugs. Generic drugs are cheaper copies of brand-name drugs made by different manufacturers that contain the same active ingredients. The Global Fund’s ‘Rapid Supply Mechanism’ aims to ensure manufacturers have enough ARVs in stock to respond to stock-outs within two weeks by providing them with

estimates of demand. However, sex workers’ reports of stock-outs demonstrate that this mechanism does not always function adequately. For example, sex workers in Bangladesh reported that local NGO HIV programme managers are not aware of ARV stock-outs in the field, indicating a lack of communication channels for reporting and responding to stock-outs.

Sex workers experienced stock-outs of ARVs in more than half of the countries that responded to the consultation, in all types of health care settings – suggesting more systemic problems. In

DRC, Côte d’Ivoire, Peru, Bangladesh, Cameroon, Nicaragua and Jamaica the stock-outs occurred in public clinics, and in both public and private clinics in El Salvador. In Mali, Ukraine, and Burundi stock-outs were also reported in NGO clinics.

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10 The Global Fund, “The Global Fund”.

Stock-outs of ARVs result in sex workers experiencing forced interruptions to their treatment which can cause drug resistance, create long-term health complications and pose a risk to life.

Stock-outs of ARVs result in sex workers experiencing forced interruptions to their treatment which can cause drug resistance, create long-term health complications and pose a risk to life. ARVs, when taken regularly, suppress an individuals' viral load, improve their health outcomes significantly, and radically reduce the chance of transmitting HIV.

"I went to the pharmacy at the hospital and they said they did not have the medication. I was directed to another location and when I went there they were also out. I went to four other locations and it was no different. I got frustrated and went home. My doctor had told me about 6 months ago

that I was virally suppressed. I was out of medication for 2 months and when I did my next viral load and CD4 test it showed that I was no longer virally suppressed."

SEX WORKER, JAMAICA

In Cameroon, sex workers reported sharing medications so that they don't have to interrupt their treatment:

"I had [anxiety], I was traumatised and I had palpitations ...Hum! It's a friend who helped me as he had two boxes. Otherwise I think I may have been tempted to the worst."

SEX WORKER, CAMEROON

Sex workers also reported being prescribed a substitute medication because of stock-outs. Similar to forced treatment interruptions, unnecessary changes to treatment can create long-term health complications. In Jamaica, a Global Fund recipient country, during an extended stock-out of ARVs, sex workers reported being prescribed substitute medications that led to different side effects and this caused some to stop taking their medication.

"There have been cases of interruptions in the supply of ART, some of the drugs, they are seeking replacement schemes without any indication, simply because there is no 'this' or 'that' drug."

UCO "LEGALIFE-UKRAINE"

In El Salvador, ARVs are free from public hospitals, however when the hospital has stock-outs sex workers must purchase ARVs from pharmacies, where they are sometimes sold expired medication, or it is too expensive.

Similarly, in the DRC, free treatment often runs out and sex workers cannot afford the pharmacy price. Participants in Côte d'Ivoire also reported having to pay for ARVs due to regular shortages. Sex workers are then forced to self-fund their treatment, creating financial strain that may impact the way they can work:

"If you're in need of the money and a client wants to go directly (have sex without a condom) you will accept, because you need to [get] money."

SEX WORKER, CÔTE D'IVOIRE

Patients who experience treatment failure when they develop resistance to their original drugs (referred to as 'first-line' drugs), need to be prescribed alternative ('second-line') ARVs. However, sex workers in Cameroon reported that there is only one hospital with second-line ARVs in the whole western Cameroon region. Not only does this require extra time and travel costs, but the long queues at the specialist pharmacy service means patients have their health status exposed and are left stigmatised.

...participants stated they would prefer to be able to access medications and services directly from sex worker-led organisations...

Other indirect factors affecting ARV access included discrimination by staff in public health facilities in El Salvador, Côte d'Ivoire and Malawi. In Nicaragua sex workers resorted to private health care, reducing the money they had to spend on food. In Côte d'Ivoire participants stated they

would prefer to be able to access medications and services directly from sex worker-led organisations:

"We come here, we feel OK, we feel relaxed, why can't we access our medicines here?"

SEX WORKER, CÔTE D'IVOIRE.

In several countries sex workers observed that stock-outs of ARVs contributed to an increase in deaths in their community:

"[Stock-outs] leads to poor medical compliance, causes treatment failures, and increases HIV-related morbidity and mortality in the sex worker community and their clients.

AVENIR JEUNE DE L'OUEST, CAMEROON

V. STI and HIV testing

Sex workers in all 20 countries that responded to the consultation reported that demand for testing is higher than the availability of tests. Stock-outs of HIV and STI testing equipment were reported in the DRC, Uganda, Ecuador, Jamaica, Côte d'Ivoire and El Salvador.

"Sex workers want to take the tests, but in the months of October, November, December and January is almost impossible due to the shortage of materials."

ASOCIACIÓN DIVERSIDAD SEXUAL MILAGRO, ECUADOR

"Access to HIV testing is easier, STI testing is hard due to failure to get reagents and testing kits."

SERVING LIVES UNDER MARGINALIZATION, UGANDA

"During prevention interventions, NGOs refer us to the health clinic if there are symptoms of STIs. But when you go to the clinic you can wait for up to six hours, and then the meds are missing or are expired. It's discouraging. NGOs tell you it's free, but it's not true. We lose trust"

SEX WORKER, CÔTE D'IVOIRE

Sex workers in Mexico, Spain, France and Ukraine also reported a lack of availability of testing for STIs other than syphilis:

"In general it is only HIV tests available, everything else is difficult to access in general public health clinics. In NGO organisations HIV and syphilis tests are offered."

MOVIMIENTO DE TRABAJO SEXUAL DE MÉXICO

Quality Assurance of Testing Equipment

Almost 150 countries use Global Fund money to purchase HIV and STI testing equipment and laboratory supplies. Government clinics check their testing equipment regularly through a process called 'External Quality Assurance'. This usually involves 5-10 samples being sent to the clinics for testing and the results are checked for accuracy by an external laboratory.

Many sex workers however, attend NGO clinics that are not subject to this quality assurance. For example, Bangladeshi sex workers reported problems with inaccurate results, which may be a result of faulty equipment going unchecked in NGO clinics. This is despite WHO guidelines recommending "quality assurance mechanisms should be in place to ensure the provision of correct test results to the person tested."¹¹

VI. Routine viral load testing (RVLT)

Viral load testing remains a critical component in HIV treatment. RVLT helps identify recipients of care who may need counselling and adherence support – or a switch to a more effective regimen to prevent drug resistance and progression to advanced HIV disease.

Sex workers in Kyrgyzstan reported regular breakdown of RVLT equipment in the local HIV NGOs. A lack of RVLT equipment was reported in Peru, Ukraine and Ghana.

In El Salvador and Côte d'Ivoire RVLT is free and available at public health facilities. However, in El Salvador, due to stock-outs, medication is not always able to be modified. A respondent in Côte d'Ivoire reported a lack of equipment for viral load testing in their country, as well as a lack of qualified personnel. Sex workers in Ghana reported that RVLT is not routinely offered and

that when they requested the service, they were informed that the machine was not working and the only machine available was in a government hospital elsewhere in the region.

VII. STI treatment

The Global Fund, the largest international agency involved in HIV commodities, does not include procurement of STI treatments within their scope, despite WHO recommendations that STI testing and treatment form part of a comprehensive approach to HIV prevention.¹²

In 2017 the government of the USA reintroduced and expanded its 'Mexico City Policy'¹³ that bans global health funds from the USA (e.g. via USAID) being given to NGOs that provide information about abortion. This will have an enormous impact on organisations offering comprehensive HIV and sexual and reproductive health services, including those who primarily offer STI testing and treatment. It will significantly reduce the funding and capacity of sex workers' primary health service providers, disrupting existing service relationships and sex workers' access to essential services.

A respondent in Côte d'Ivoire reported a lack of equipment for viral load testing in their country, as well as a lack of qualified personnel.

¹¹ WHO, 2012, "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" p.31.

¹² WHO, 2014, "Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations" p.74.

¹³ NSWP, 2017, "US Global Gag Rule Expansion".

...a 2017 study showed that 64.7% of female sex workers have had an STI during the past 12 months, but only 67.3% of those had consulted a health professional in the same period.

Sex workers experienced stock-outs of STI treatments in a quarter of the countries that responded. In Bangladesh, sex workers reported experiencing many stock-outs of STI treatments, resulting in the need to work with STIs or painful ulcers and lesions, or to refuse clients and experience hardship. Some reported resorting to potentially dangerous self-treatment.

In Côte d'Ivoire, a 2017 study showed that 64.7% of female sex workers have had an STI during the past 12 months, but only 67.3% of those had consulted a health professional in the same period.¹⁴ Sex workers here reported stock-outs of STI kits, reporting that they had to buy them at the pharmacy, or on the black market.

In many middle-income countries, STI treatment was previously free and funded by the Global

Fund, however the transition to national funding (for example in Kyrgyzstan and Thailand) means treatment is no longer free.

Some of the reported causes of these stock-outs include:

- Late delivery of medicines, availability of only expired or near-expired medicines
- Government departments are slow to order medicines, creating stock-outs in public health facilities. Private clinics may still have availability, but at a higher cost
- In Bangladesh, service managers cited lack of funding, funding gaps, the complex process for funding clearance, phasing out of projects, and corruption as the main reasons for stock-outs
- Lack of clinics in rural areas means complete stock-outs for sex workers living outside of cities, including in Peru, Kyrgyzstan and El Salvador.

VIII. The other 'stock-out': affordable STI testing and treatment

In half of the countries who responded, HIV testing is substantially more accessible to sex workers than STI testing. For example, in El Salvador and Kyrgyzstan HIV testing is available routinely, while STI testing is often only offered if the sex worker has symptoms. Even where STI testing is free, pharmacies charge a 'service' fee to fill scripts. The costs of STI testing and treatment create an ongoing economic burden for sex workers. In Cameroon and Bangladesh, HIV testing is subsidised, while STI testing remains expensive. Sex workers have to make difficult financial decisions about necessities in order to pay for testing and treatment.

"A week ago, I went to the clinic, I was prescribed 12,000 CFA (22 USD) in medicines, but they were not available in the hospital, I had to buy them at the pharmacy".

"If you don't have money to buy them right away, you leave it like that, you live with the disease".

SEX WORKERS, CÔTE D'IVOIRE

¹⁴ Becquet V, Nouaman M, Masumbuko J, Anoma C, Soh K, Alain T, Plazy M, Danel C, Eholié S & Larmarange J, 2017, "The challenges of implementing PrEP: the case of female sex workers in Côte d'Ivoire," Poster n°WEPDC159 presented at 19th ICASA International Conference on AIDS and STIs in Africa, Abidjan.

Conclusion

Sex workers frequently and systemically experience stock-outs of the commodities and treatments they want and need for their health and well-being. This results in forced treatment interruptions, involuntary regimen changes, and other factors (i.e. extensive travel and additional cost) that directly impact and jeopardise sex workers' health and safety.

The accessibility of commodities and treatments is dependent on relationships between international aid agencies, national governments, and the large, global non-government organisations (NGOs) contracted to make commodities and treatments available. Poor programming, lack of funding, intellectual property barriers, and broken procurement systems – exacerbated by a lack of political will to protect, respect and fulfil the right to health for all – leaves sex workers unacceptably vulnerable.

Many of the issues relating to HIV and STI prevention and treatment for sex workers could be addressed by improving funding mechanisms. Late arrival of funds to HIV and STI programmes, slows the ability for governments, NGOs and international agencies to purchase much-needed commodities and treatments. The transitioning of some 'middle-income' countries away from the Global Fund in favour of national funding has also had an impact, creating gaps.

Without effective action to address these issues sex workers will continue to be disproportionately affected by HIV globally...

Without effective action to address these issues sex workers will continue to be disproportionately affected by HIV globally, and UNAIDS' ambitious 90-90-90 treatment and prevention target to help end the AIDS epidemic will not be met by 2020.

Sex workers are truly being left behind.

Recommendations

The following recommendations are made for national governments, donor organisations, policy-makers and programmers, based on the evidence presented in this briefing paper:

Financing and capacity building

- Global financing of HIV/STI prevention and treatment for sex workers must be prioritised and maintained in order to meet UNAIDS global targets. Funding shortfalls, delays and interruptions must be addressed urgently to ensure that stock-outs of essential treatments and commodities do not occur. This must include ensuring that national governments take responsibility for mainstreaming provision for sex workers when they transition from global funding mechanisms.
- The Global Fund and other donors need to invest in community monitoring, capacity-building, awareness-raising and advocacy to allow sex worker-led organisations to systematically track and report stock-outs to CCMs and other key stakeholders.

- Existing mechanisms for reporting stock-outs (e.g. the Global Fund's Office of Inspector General) need to be reviewed and strengthened. The relevant organisations are either not hearing about stock-outs of commodities and treatments experienced by sex workers, or those organisations are not sufficiently empowered or resourced to adequately address stock-outs when they are reported.
- Sex worker-led community organisations should be funded and meaningfully involved in supply and distribution chains at a local level, to advise and support on access barriers, transport challenges and other problems.
- Donor organisations should **prioritise** funding, including mentoring and capacity-building, to enable sex worker-led organisations to provide comprehensive sexual and reproductive health services to their communities, as part of a differentiated service delivery (DSD) model. This will also address the stigma and discrimination experienced at public health and other NGO facilities.

Accountability and monitoring

- International agencies involved in the global purchasing and supply architecture need to improve their monitoring of contracts with providers who supply and distribute commodities and treatments to sex workers. Providers should be held accountable for failures and stock-outs.
- Governments, donor organisations and programmers must ensure that 'social marketing' programmes complement and supplement, **rather than replace**, free distribution programmes.
- Services **must not** place unnecessary and dangerous restrictions on essential supplies available to sex workers e.g. limiting numbers of condoms and lubricant. Provision of commodities must include non-standard sized condoms, female condoms, dental dams, gloves and lubricants (including tubes) to adequately meet the needs of sex workers.
- Testing equipment at NGO clinics should be made to comply with Quality Assurance Testing to avoid incorrect test results.

Legislative and political change

- Governments, policy-makers and advocates must actively pursue the full decriminalisation of sex work. Criminalisation is a primary driver of the stigma and discrimination experienced by sex workers when accessing health services and a major reason for why they continue to be disproportionately affected by HIV.
- Governments and international organisations must demonstrate political will to ensure access to essential medicines (including a wider range of treatments that are available internationally) for key populations, including sex workers. Trade-related barriers must be removed and high pricing for patented medicines must be challenged.

The Global Network of Sex Work Projects uses a methodology that ensures the grassroots voices of sex workers and sex worker-led organisations are heard. The Briefing Papers document issues faced by sex workers at local, national, and regional levels while identifying global trends.

The NSWP Secretariat manages the production of briefing papers and conducts consultations among its members to document evidence. To do this, NSWP contracts:

- Global Consultants to undertake desk research and a global e-consultation with NSWP member organisations, coordinate and collate inputs from National Consultants, analyse regional differences and draft the global briefing papers.
- National Consultants to gather information and document country case studies.

The term 'sex workers' reflects the immense diversity within the sex worker community including but not limited to: female, male and transgender sex workers; lesbian, gay and bi-sexual sex workers; male sex workers who identify as heterosexual; sex workers living with HIV and other diseases; sex workers who use drugs; young adult sex workers (between the ages of 18 and 29 years old); documented and undocumented migrant sex workers, as well as and displaced persons and refugees; sex workers living in both urban and rural areas; disabled sex workers; and sex workers who have been detained or incarcerated.



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NSWP is an alliance partner of Bridging the Gaps – health and rights for key populations. This unique programme addresses the common challenges faced by sex workers, people who use drugs and lesbian, gay, bisexual and transgender people in terms of human rights violations and accessing much-needed HIV and health services. Go to: www.hivgaps.org for more information.