SOUTH AFRICA'S NATIONAL SEX WORKER HIV, TB AND STI PLAN

2019 - 2022

REPUBLIC OF SOUTH AFRICA

2030 NDP

SOUTH AFRICAN NATIONAL AIDS COUNCIL
OUR ACTIONS COUNT

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AGYW	Adolescent Girls and Young Women
AFSA	AIDS Foundation South Africa
ART	Antiretroviral Treatment
BBS	Biological and Behavioural Survey
CDC	Centers for Disease Control and Prevention
COC	Cultuur en Ontspanningscentrum (Center for Culture and Leisure. COC Nederland is a Dutch organisation for LGBT people)
DDP	Dignity, Diversity and Policing project
DHA	Department of Home Affairs
DHET	Department of Higher Education, Science and Technology
DHIS	District Health Information System
DoH	Department of Health
DOJ&CD	Department of Justice and Constitutional Development
DSD	Department of Social Development
DR-TB	Drug-Resistant Tuberculosis
DS-TB	Drug-Sensitive Tuberculosis
EPOA	Enhanced Peer Outreach Approach
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
FSW	Female Sex Workers
HBsAb	Hepatitis B Surface Antibody
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
HSRC	Human Sciences Research Council
HTA	High Transmission Area
HTS	HIV Testing Services
IDP	International Development Partner
IDU	Injecting Drug User
IEC	Information, Education and Communication
LGBTI	Lesbian, Gay, Bisexual, Transgender, or Intersex individual
M&E	Monitoring and Evaluation
MDIP	Multi-sectoral District Implementation Plans
MDR-TB	Multidrug-Resistant Tuberculosis
MMC	Medical Male Circumcision
MSM	Men Who Have Sex With Men
NAC	National AIDS Council
NACOSA	Networking HIV/AIDS Community of South Africa
NDoH	National Department of Health
NDP	South African National Development Plan
NGO	Non-Governmental Organisation
NPA	National Prosecuting Authority
NSP	South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022
NSWP	National Sex Worker HIV, TB & STI Plan 2019-2022
OST	Opioid Substitution Therapy
PCA	Provincial AIDS Council (formerly abbreviated as PAC)
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PIP	Provincial Implementation Plan
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SANAC	South African National AIDS Council
SAHMS	South Africa Health Monitoring Survey
SAPS	South African Police Services
SASSA	South African Social Security Agency
SBCC	Social and Behaviour Change Communication
SITTT	Strategic Information Technical Task Team
SNS	Social Network Strategy for HIV Testing Recruitment
SRs	Sub-recipients
STI	Sexually Transmitted Infection
SWEAT	Sex Workers Education and Advocacy Taskforce
TB	Tuberculosis
TTT	Technical Task Team
U=U	Undetectable = Untransmittable
UCT	University of Cape Town
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
XDR-TB	Extensively Drug-Resistant

GLOSSARY OF TERMS

Note: Several indicators have different definitions across programmes and International Development Partners. For consistency, the definitions below were adopted in the development of the NSWP 2019-2022. Most terms were defined using the UNAIDS Terminology Guidelines, 2015.

Accountability is the obligation of people and organisations to live up to what is expected of them and to report on the use of resources; it also is the assumption of responsibility for one's actions and the consequences of such actions [1].

Advocacy means getting public support for or recommendation of a particular cause or policy. Advocacy is further putting a problem on the agenda, providing a solution to that problem, and building support for acting on both the problem and the solution.

Best practice: A technique or methodology that through experience and research has proven reliably to lead to the desired result [1].

Collective identity refers to the shared sense of belonging to a group or social support network.

Combination HIV prevention seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence-informed behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic. Combination HIV prevention also can be used to refer to an individual's strategy for HIV prevention—combining different tools or approaches (either at the same time or in sequence), according to their current situation, risk and choices [1].

Condomless sex refers to a sex act which is not protected by male or female condoms. Previously known as unprotected sex, this is now increasingly referred to as condomless sex; this is done to avoid confusion with the protection from pregnancy that is provided by other means of contraception. As oral pre-exposure prophylaxis (PrEP) becomes more widespread (and if topical PrEP is introduced), it is important to be clear about the different methods of protection against HIV and the other consequences of sex, and how those methods might be used or combined [1].

Cost-effective integrated model refers to integrated Sex Worker services delivered by funded NGO partners in a Department of Health facility, usually an HTA site [8].

Crisis Response Teams (CRTs) create a structured platform for partner organisations, Department of Health facilities, local municipality, local health and social welfare departments, state clinics and local hospitals, and the police—to safeguard Sex Workers from violence and violation. CRTs provide multisectoral and local response to incidents of violation of human rights as they become aware of [3].

Critical enablers are activities that are necessary to support the effectiveness and efficiency of basic programme activities. Programmes that are critical enablers "should be primarily assessed in terms of their effectiveness in increasing the uptake, equitable coverage, rights-based delivery and quality of basic programme activities." Critical enablers also "overcome major barriers to service uptake, including social exclusion, marginalisation, criminalisation, stigma and inequity." [1]

Enabling environment. There are different kinds of enabling environments in the context of HIV. For instance, an enabling legal environment would not only have laws and policies against discrimination on the basis of

sex, health status (including HIV status), age, disability, social status, sexual orientation, gender identity and other relevant grounds, but they would be enforced. In such an environment, people would also have access to justice—that is, a process and remedy if they are aggrieved. An enabling social environment is one in which social protection strategies (e.g. economic empowerment) are in place, and where social norms support knowledge, awareness and healthy behaviour choices [1].

Enhanced Peer Outreach Approach (EPOA). The EPOA is led by peer outreach workers, who engage key population members to persuade peers in their own social and sexual networks to be tested for HIV. It focuses on those who are not found at traditional hot spots, which is particularly important because technology changes the ways that some key population members contact and meet sexual partners [4].

Gender-based violence (GBV) describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender. It encompasses acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty [1].

High transmission area (HTA) refers to an area in a Department of Health geographical area, which contains hot spots, and places where people are at highest risk for acquiring or transmitting HIV, TB and STIs due to social factors, which make them vulnerable [5].

HTA facility refers to a designated health facility, rendering all primary health services at a fixed/mobile/outreach service point with focus on key populations [5].

HTA site refers to an identified geographical site where HTA interventions are rendered, targeting people at high risk of acquiring/transmitting HIV, TB and STIs due to social factors, which make them vulnerable to the diseases [5].

HIV testing is the gateway to HIV treatment and care, and it is critical in the scale-up of universal access to HIV prevention, including in the context of male circumcision, elimination of new infections among children and antiretroviral medicine based prevention approaches (including pre-exposure prophylaxis or post-exposure prophylaxis) [1].

The term HIV testing services (HTS) is used to embrace the full range of services that should be provided together with HIV testing. HIV testing should be undertaken within the framework of the 5Cs: consent, confidentiality, counselling, correct test results and connection/linkage to prevention, care and treatment.[1].

HIV treatment cascade refers to the chain of events that are involved in an HIV-positive person receiving treatment until his or her viral load is suppressed to undetectable levels. The stages of the HIV treatment cascade are as follows: the number of people living with HIV; the number who start HIV treatment; and, finally, the number who suppress HIV to undetectable levels in their blood [1].

Hot spots in the context of HIV, connotes small areas within a bigger province/city/country where there is high HIV prevalence or incidence [1]. In the context of intervention prioritisation, a hot spot can be a concept used to help prioritise HIV, TB and STIs programme activities to an area where there is known high-risk practices.

Key populations are populations that are at a higher risk of HIV exposure or onward transmission as identified in the NSP 2017-2022. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. These include Sex Workers, men who have sex with men, people who use drugs, transgender people and inmates [6, 7].

Men who have sex with men (MSM) refers to males who have sex with males regardless of whether they also have sex with women or have a personal or social gay or bisexual identity. This concept is inclusive of men who self-identify as heterosexual but have sex with other men [5].

Microplanning is a methodology of outreach used to decentralise the planning and management of outreach to peer educators who work at the grass roots level. It allows each peer to decide how best s/he reaches all the Sex Workers at his/her site. Through planning down to a place level, it allows peer educators to better understand specific sites, follow a cohort of Sex Workers and provide deeper quality services. Microplanning is therefore a tool in planning, implementing, as well as monitoring and evaluating outreach interventions [9]. Also see EPOA and SNS strategies.

Positivity rate is the total number of individuals who tested positive as a proportion of total number of individuals tested. Numerator = number tested HIV-positive in the period. Denominator = Number of individuals tested during the same period. Compare with Yield, which refers to number of individuals who were newly diagnosed HIV positive during the reporting period.

Pre-exposure prophylaxis (PrEP) refers to antiretroviral medicines prescribed before possible exposure to HIV. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission [1].

Post-exposure prophylaxis (PEP) refers to the use of antiretroviral medicines to prevent HIV infection in an HIV uninfected person who has been exposed to HIV [5]. Treatment must begin within 72 hours of a possible exposure by an uninfected individual and continues for 4 weeks.

Psychosocial support (PSS) addresses the ongoing psychological and social problems of HIV infected and affected individuals, their partners, families and caregivers [6].

Sex Worker refers to consenting male, female and transgender adult and young people (18 years or older) who work in different settings with the primary intention of exchanging money, goods and/or services for sexual services, either regularly or occasionally [1]. Sex work is consensual sex between adults. As defined in the Convention on the Rights of the Child (CRC), children and adolescents under the age of 18 who exchange sex for money, goods or favours are sexually exploited and not defined as Sex Workers.

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing [10].

Sexually transmitted infection (STI) refers to infections that are spread by the transfer of bacterial and/or viral organisms from person to person during sexual contact.

Social and behaviour change communication (SBCC). Behaviour change communication promotes tailored messages, personal risk assessment, greater dialogue and an increased sense of ownership of the response by the individual and the community. It uses a mix of communication channels to encourage and sustain positive, healthy behaviours. Social change communication is the strategic use of advocacy, communication and social mobilisation to systematically facilitate and accelerate change in the underlying determinants of HIV risk, vulnerability and impact [1].

Social capital refers to the networks, norms, and social trust that facilitate cooperation for mutual benefit.

Social Network Strategy (SNS) for HIV Testing Recruitment is an evidence supported approach to engaging and motivating a person to accept a service. SNS is particularly useful to recruit persons at risk for HIV testing. The approach to SNS includes identifying clients or peers who are HIV positive or at high risk for HIV, and enlist them to become Recruiters. Recruiters are short-term, unlike peer advocates or peer educators, and require coaching, rather than training and supervision. The Recruiters identify their Network Associates. Network

Associates are people in their social networks (e.g., friends, sex or drug partners, family members, etc.) who may be at risk for HIV. Typically, Recruiters identify Network Associates whom they believe would benefit from HIV testing. The Recruiters then talk with the Network Associates they identified, and refer or accompany them to HIV testing [11].

Stigma and discrimination refers to opinions or judgements held by individuals or society that negatively reflect on a person or group. Discrimination occurs when stigma is acted on [12].

Transgender is an umbrella term to describe people whose gender identity and expression does not conform to the norms and expectations traditionally associated with their sex at birth. Transgender people include individuals who have received gender reassignment surgery, individuals who have received gender-related medical interventions other than surgery (e.g. hormone therapy) and individuals who identify as having no gender, multiple genders or alternative genders [1].

Undernutrition. A state of undernutrition is the consequence of an insufficient intake of energy, protein and/or micronutrients, poor absorption or rapid loss of nutrients due to illness and increased energy expenditure. The term undernutrition encompasses the terms low birth weight, stunting, wasting, underweight and micronutrient deficiencies [1].

Young people who sell sex. Persons under the age of 18 selling sex are considered exploited and are not legally recognised as adults under the Constitution or the Children's Act 38 of 2005. Young people who sell sex need specialised and child sensitive services [9].

FOREWORD

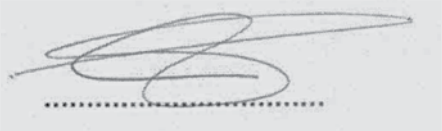
With the launch of the first National Sex Worker HIV Plan 2016-2019, South Africa demonstrated its commitment to Sex Workers and their unique needs. The plan described six integrated packages of care for comprehensive Sex Worker programming and supported the decriminalisation of sex work.

This second national plan for Sex Workers, The National Sex Worker HIV, TB and STI Plan 2019-2022, builds on the lessons learned during the three years of implementation and incorporates the latest evidence available. This is aligned with South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022 (NSP), which represents the country's national response to HIV, TB and STIs.

The structure of the National Sex Worker HIV, TB and STI Plan 2019-2022 follows the same format as the NSP, enabling provinces and districts to incorporate activities, with ease, directly into Provincial Implementation Plans and Multi-Sectoral District Implementation Plans.

The pledge for decriminalisation is also reconfirmed with clear direction on the need for law reform and the evidence supporting it. The National Sex Worker HIV, TB and STIs Plan 2019-2022 further introduces new national strategies to reduce gender-based violence and human rights violations against Sex Workers.

Responsibility for multi-sectoral leadership, accountability, and sustainability is assigned to a variety of public and private sector stakeholders. Progress against goals, objectives and activities will be closely tracked through a monitoring and evaluation framework supported by a research and surveillance agenda.



Hon. Mmamoloko Kubayi-Ngubane, MP
Acting Minister of Health

EXECUTIVE SUMMARY

South Africa's second National Sex Worker HIV, TB and STI Plan (NSWP 2019-2022) recognises that the individual capacities of Sex Workers are intimately tied to the enabling (or disabling) character of criminalisation and human rights (the policy framework), social norms (gender inequality), and practices and institutions (the health system). The NSWP 2019-2022 builds on the strengths of the first Sex Worker HIV Plan (2016-2019), addressing gaps identified over the past three years and supporting the call for decriminalisation of sex work.

The NSWP 2019-2022 is aligned with South Africa's National Strategic Plan for HIV, TB and STIs (NSP 2017-2022) and outlines the strategic framework for a multi-sectoral partnership to reduce morbidity (illness), harms (human rights violations) and mortality (death) associated with HIV, TB and STIs in female, male and transgender Sex Workers in South Africa. The plan aligns all implementers in support of the Department of Health's High Transmission Areas (HTA) programme and its stepwise improvement for the provision of customised targeted services to key populations as envisioned in the NSP, to promote sustainability of the response. The plan also highlights the importance of the contribution of the Departments of Health, Social Development, Justice and Police Services in ensuring the optimal provision of services to Sex Workers.

Non-governmental organisations (NGOs) and other groups in civil society, including people living with HIV, have played and must continue to play a critical role in shaping government action and in bringing prevention and care to people that governments cannot easily reach[13]. Central and localised planning coordinated by AIDS Councils at all levels will ensure that Sex Workers are reached with a minimum package of services. This decentralised multi-sectoral approach will enable the national strategies for HIV, TB and STIs to be tailored to the specific needs and conditions of Sex Workers across South Africa.

Development of the NSWP 2019-2022

The NSWP 2019-2022 is informed by the end of term review of the previous NSWP 2016-2019, identified best practices, the latest research evidence, and consultation with all stakeholders. A multi-sectoral Steering Committee guided its development. The Plan scales up best practices to ensure that quality, evidence and innovation underpins rights-based Sex Worker service provision in the country.

Target group

The target groups for the NSWP 2019-2022 are consenting male, female and transgender adults, and young people (18 years or older) who work in different settings with the primary intention of exchanging money, goods and/or services for sexual services, either regularly or occasionally [1].

The plan recognises that certain sub-groups of Sex Workers are more at risk, are more stigmatised and are more hidden. Reaching these groups and enrolling these Sex Workers in care requires specialised strategies to find and engage them. These groups were identified as male and transgender Sex Workers.

A Sex Worker size estimation study commissioned by SANAC in 2013 and led by the Sex Workers Education and Advocacy Taskforce (SWEAT), estimated that about 153,000 Sex Workers operate in South Africa, from 12 sites nationwide. Of this number, about five percent were estimated to be men and four percent are transgender Sex Workers. Half of the Sex Workers (51%) are operating in large urban centres, 37% in small urban centres and 12% in rural areas. HIV prevalence rate amongst female Sex Workers is estimated to be as high as 59.6%, compared to 13.3% amongst women in the general population. There is limited data on the absolute population size of Sex Workers due to social marginalisation and criminalisation of sex work.

Note: Young people, under the age of 18 who sell sex are considered exploited and are not legally recognised as adults under the Constitution or the Children's Act 38 of 2005 [14]. In South Africa, children have the right to more protection because of their age. Although a child of 16 years is able to consent to sex under Sexual Offenses Act [15], and although the majority of young people that sell sex may not be kidnapped or trafficked victims, all children selling sex are considered vulnerable to abuse and exploitation. Young people who sell sex need specialised and child sensitive services [9], which fall outside the domain of this plan. 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.

Alignment with the NSP 2017-2022

The NSWP 2019-2022 retained the six packages of care (Figure 1) identified in the Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations [7], which were included in the previous Sex Worker HIV Plan.

FIGURE 1 Packages of services NSWP 2016-2019 [7]

The six packages of care were aligned with the NSP goals (Table 1) and incorporated into the Goals, Objectives and Activities framework. This enables provinces and districts to incorporate NSWP 2019-2022 activities directly into Provincial Implementation Plans (PIPs) and Multi-Sectoral District Implementation Plans (MDIPs).

TABLE 1 Alignment between NSP and NSWP 2019-2022 goals

NSP GOALS	PACKAGE OF CARE	NSWP 2019-2022
Goal 1: Accelerate prevention to reduce new HIV and TB infections and STIs	Peer education Health care	Deliver a comprehensive package of peer-led prevention services: health information, SBCC, condoms, PrEP, SRH services, TB and STI screening
Goal 2: Reduce morbidity and mortality by providing HIV, TB and STI treatment, care and adherence support for all	Health care	Provide access to tailored treatment services for HIV (90-90-90), TB (90-90-90) and to reduce STIs and Hepatitis B
Goal 3: Reach all key and vulnerable populations with customised and targeted interventions	Peer education Social capital building	Train and empower peer educators to reach and deliver standardised services. Strengthen social capital and Sex Worker representative organisations

NSP GOALS	PACKAGE OF CARE	NSWP 2019-2022
Goal 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the NDP	Psychosocial services Economic empowerment	Establish referral networks for psychosocial services, substance use, social grants, and violence. Economically empower Sex Workers and peer educators through capacity building
Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches	Human rights	Launch a national human rights strategy to monitor and to reduce stigma and discrimination, provide access to justice, and sensitise providers, lawmakers and law enforcers. Implement a framework for decriminalisation, the protection of Sex Workers against human rights violations and the reduction of sexual and gender-based violence
Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs	Leadership and accountability	Multi-sectoral peer-led programmes coordinated by SANAC and delivered by South African Government departments and implementing partners
Goal 7: Mobilise resources to support the achievement of NSP goals and ensure a sustainable response	Financed response	Ensure sustainable funding for customised peer led services for Sex Workers
Goal 8: Strengthen strategic information to drive progress towards achievement of the NSP goals	Research, monitoring and evaluation	Conduct research, surveillance, mapping, monitoring and evaluation to track progress against targets and to improve the efficiency and effectiveness of the response

What is new in the NSWP 2019-2022

The NSWP 2019-2022 introduces several improvements to address the gaps and challenges in delivering available, accessible, acceptable and quality HIV, TB, and STI services for Sex Workers [7]. These are based on lessons learned from the review of the previous plan and available evidence (Table 2).

TABLE 2 New approaches in the NSWP 2019-2022

PROGRAMME AREA	APPROACH
Peer-led programming	Best practices incorporated to improve efficiency, effectiveness and quality of peer-led services for Sex Workers: • Multi-sectoral crisis response teams to reduce violence against Sex Workers • Microplanning, Enhanced Peer Outreach Approach (EPOA), or Social Network Strategy (SNS) to build trust relationships with Sex Workers and to set and continuously review local targets to account for migration of Sex Workers • 'Know Your Rights' standardised legal literacy training integrated into all delivered peer educator materials

PROGRAMME AREA	APPROACH
Health care package	• Expansion of PrEP rollout and monitoring of PrEP retention to accelerate prevention of new HIV infections • Piloting of mail delivery of PrEP medication to facilities • Navigated referral and linkage to care for Sex Workers after testing and tracking across the continuum of care • Hepatitis B screening and vaccination depending on the implementation of new national guidelines for hepatitis • Intensified screening for and syndromic management of symptomatic STIs • Piloting of point-of-care testing for asymptomatic STIs • Screening, detection, and treatment of TB to find missing TB cases
Human rights	Guidance for law reform towards decriminalisation and increased access to justice for Sex Workers. Reviewing the impact of and improving laws, regulations and policies relating to HIV and TB, including laws criminalising sex work. A human rights strategy to reduce stigma and gender-based violence using a national campaign and community anti-stigma programmes: • HIV and HIV/TB-related legal literacy and services to promote and extend legal support for human rights violations • Community-based organisations and peer educators trained as human rights defenders to monitor and respond to human rights violations • Police engagement through the Dignity, Diversity and Policing project to sensitise law-makers and law-enforcement agents through in-service training • Sensitisation and medical ethics training of healthcare providers to remove Sex Worker stereotypes, and stigma related to HIV and HIV/TB • Civil society organisations and Sex Worker-led education, sensitisation and mentoring of healthcare workers on the rights of Sex Workers
Psychosocial services	Increased focus on mental health and the provision of psychosocial support of Sex Workers
Social capital building	To empower Sex Workers to lead Sex Worker programming: • Augmenting services of community health workers with additional trained Sex Worker peer educators in the HTA programme • Sex Worker representation in AIDS Councils at all levels
Economic empowerment	Training Sex Workers as auxiliary social workers supervised by the Department of Social Development to strengthen social support and provide mental health support as part of the programme to help Sex Workers deal with post-traumatic stress syndrome and depression
Sustainability	Improved integration between the HTA programme and donor funded programmes for a sustainable national response to Sex Worker needs
Strategic information	Monitoring and evaluation framework to strengthen data driven planning and programming

NSWP 2019-2022 vision, principles and targets

Vision A long and healthy life for male, female and transgender Sex Workers
This will be achieved through the delivery of six integrated packages of care through peer-led programmes.

Guiding principles

A MULTI-SECTORAL RESPONSE	ENSURING THAT NO ONE IS LEFT BEHIND
A RELIANCE ON SOUND EVIDENCE	INCLUSIVE AND PARTICIPATORY PROGRAMMING
PERSON-CENTRED SERVICE DELIVERY	RIGHTS-BASED PLAN COMMITTED TO PROTECTING AND PROMOTING HUMAN RIGHTS

Targets

PACKAGE		TARGET	GOAL
Peer-led service delivery	1	Reach 90% of Sex Workers in a catchment area (HTA) with a tailored package of combination prevention services	3
Healthcare	2	Initiate 14 200 Sex Workers on PrEP by 2022	1
	3	Provide regular access to HIV testing services for Sex Workers not knowing their status for at least 90% of Sex Workers in all gender and age sub-groups	2
	4	Provide appropriate ART initiation, compliance support and re-linking to services for Sex Workers living with HIV for at least 90% of Sex Workers in all gender and age sub-groups living with HIV who know their status	2
	5	Provide appropriate care to Sex Workers on ART for at least 90% of Sex Workers in all gender and age sub-groups living with HIV who are on ART to become and remain virally suppressed	2
	6	Screen all Sex Workers for co-infections: TB, symptomatic STIs and Hepatitis B	1
	7	Treat or link all Sex Workers diagnosed with co-infections: TB, symptomatic STIs and Hepatitis B to care	2
	8	Provide all Sex Workers with access to a comprehensive package of sexual and reproductive health services	1
Psychosocial services	9	Screen all Sex Workers in need of mental health services	4
Economic empowerment	10	Recruit 500 Sex Worker peer educators in the HTA programme and 500 Sex Worker peer educators through donor funding	4
Human rights	11	Reduce by 50% the number of cases of human rights violation perpetrated against Sex Workers and reported to law enforcement officers	5
Social capital building	12	Include Sex Worker representation in all AIDS Councils at all levels	6

NSWP 2019-2022 goals and objectives

GOAL 1

Accelerate prevention to reduce new HIV and TB infections and STIs

Objective 1.1: Reduce new HIV infections to less than 100 000 by 2022 through combination prevention interventions

Objective 1.2: Reduce TB incidence by at least 30%, from 834/100 000 population in 2015 to less than 584/100 000 by 2022

Objective 1.3: Significantly reduce T. pallidum, gonorrhoea and chlamydia infection, to achieve the virtual elimination of congenital syphilis, and maintain high coverage of HPV vaccination

GOAL 2

Reduce morbidity and mortality by providing treatment, care and adherence support for all

Objective 2.1: Implement the 90-90-90 Strategy for HIV

Objective 2.2: Implement the 90-90-90 Strategy for TB

Objective 2.3: Improve STI detection, diagnosis and treatment

GOAL 3

Reach all key and vulnerable populations with customised and targeted interventions

Objective 3.1: Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities

Objective 3.2: To provide an enabling environment to increase access to health services by key and vulnerable populations

GOAL 4

Address social and structural drivers of HIV, TB and STI infections and linking them to NDP goals

Objective 4.1: Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion

Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender-based violence in the 27 priority districts by 2022

Objective 4.3: Scale-up access to social protection for people at risk of and those living with HIV and TB in priority districts

Objective 4.4: Implement and scale-up a package of harm reduction interventions for harmful use of alcohol and drugs in all districts

Objective 4.5: Implement economic strengthening programmes with a focus on youth in priority focus districts

Objective 4.6: Address physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs

GOAL 5

Ground the response to HIV, TB and STIs in human rights principles and approaches

Objective 5.1: Reduce stigma and discrimination among people living with HIV or TB

Objective 5.2: Facilitate access to justice and redress for people living with and vulnerable to HIV and TB

Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination

Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination

GOAL 6

Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

Objective 6.1: Strengthen AIDS Councils to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP

Objective 6.2: Improve collaboration and co-operation between government, civil society, development partners and the private sector

GOAL 7

Mobilise resources and maximise efficiencies to support the achievement of NSP Goals and ensure a sustainable response

Objective 7.1: Improve efficiency and mobilise sufficient resources to achieve the goals, objective and targets of the NSP

GOAL 8

Strengthen strategic information to drive progress towards achievement of NSP Goals

Objective 8.1: Optimise routinely collected strategic health information for data utilisation in decision making

Objective 8.2: Rigorously monitor and evaluate implementation and outcomes of the NSP

Objective 8.3: Further develop the national surveillance system to generate periodic estimates of HIV, TB and STI in the general population and in key and vulnerable populations

Objective 8.4: Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact

NSWP 2019-2022 Theory of Change

Figure 2 shows that peer educators are the foundation of the NSWP 2019-2022. Peer educators are responsible for supporting and facilitating the delivery of a comprehensive packages of services. Improved programme coverage and greater access to commodities and services, such as condoms and lubricants, and substance use interventions, decrease Sex Worker exposure to HIV, TB and STIs by encouraging safer sexual behaviour.

The idea behind these interventions is to foster an enabling environment. An enabling environment is one where various role-players, such as health and social workers, law enforcement officials, legal representatives and community members, help to improve Sex Workers' wellbeing. An enabling environment results in decreased experience of human rights violation. Additionally, it allows Sex Workers to protect themselves, their clients, non-commercial sex partners and children from HIV infections and facilitates their access to care and treatment, to reduce HIV incidence and HIV-related mortality.

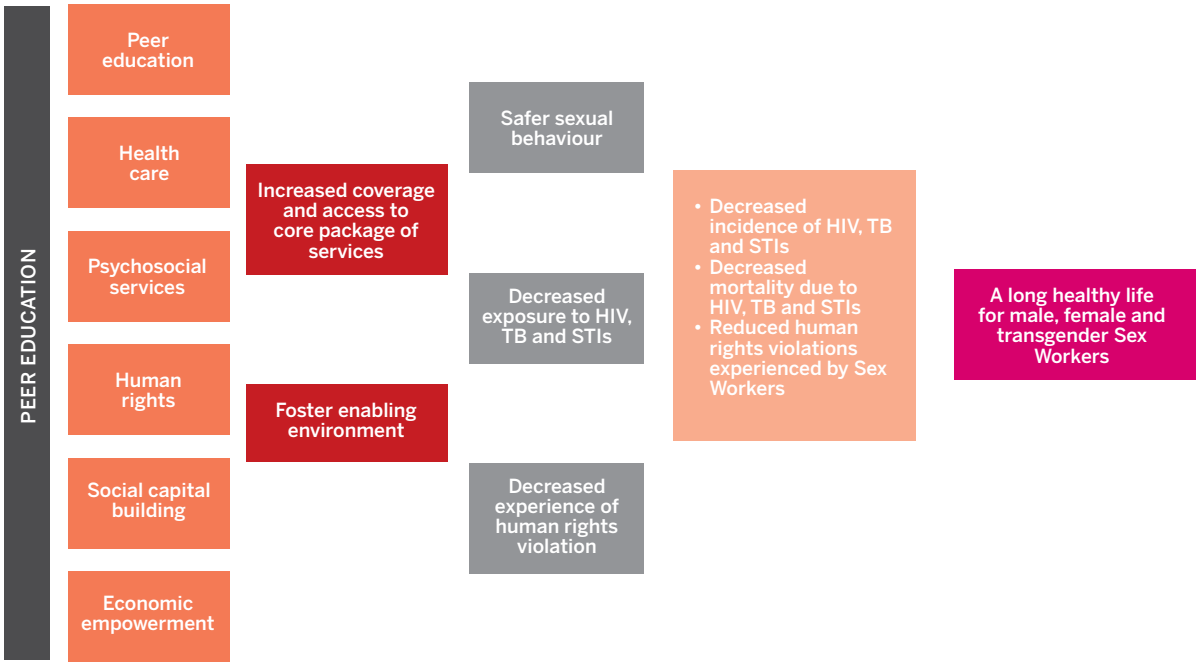


FIGURE 2 NSWP 2019-2022 Theory of Change

INTRODUCTION

While sex work is a global occupation, it is in sub-Saharan Africa where Sex Workers are at most risk of HIV and STI acquisition and violence because of criminalisation, the social and structural and legal barriers, [7, 13, 16] and high prevalence in the general population [17]. Sex Workers were identified as a key population for HIV and STIs in the NSP 2017-2022 [6].

There are several reasons for prioritising the health and rights of Sex Workers. These include, for example: 1) the physical and psychological circumstances of Sex Workers are often debilitating or life-threatening because of criminalisation, stigma, social marginalisation, alcohol and drug abuse, and violence; 2) Sex Workers in their diversity, require an extensive set of medical and non-medical services; 3) in general the health system is not fulfilling its role to provide for groups who may have complex needs, such as Sex Workers; 4) their multi-faceted needs are often not adequately met through existing financing, policy, legal, research, or service delivery arrangements; 5) Sex Workers experience compounding compromising factors because of the intersection of criminalisation, violence, stigma and discrimination, and are often members of more than one key population or vulnerable group (LGBTI, people who use drugs, migrants), 6) global concern about the ability to deliver services at the necessary scale and complexity to achieve HIV epidemic control in key populations.

Current Situation

South Africa is home to the largest number of people living with HIV in the world as well as the highest burdens of TB and STIs globally [18]. Almost two out of three people living with HIV are co-infected with TB, emphasising the need to manage the illnesses at the same time [19]. Almost 40 years after HIV was discovered, South Africa faces a generalised and maturing HIV epidemic. In 2019, South Africa had around 7.97 million people living with HIV [20]. The national HIV prevalence for people living with HIV in South Africa was estimated at 13.5% in 2019; significantly higher than the 2012 prevalence estimate of 12.2%. Generally, females had a higher HIV prevalence (17.3%) than males (10.6%) (Figure 2) [17, 20].

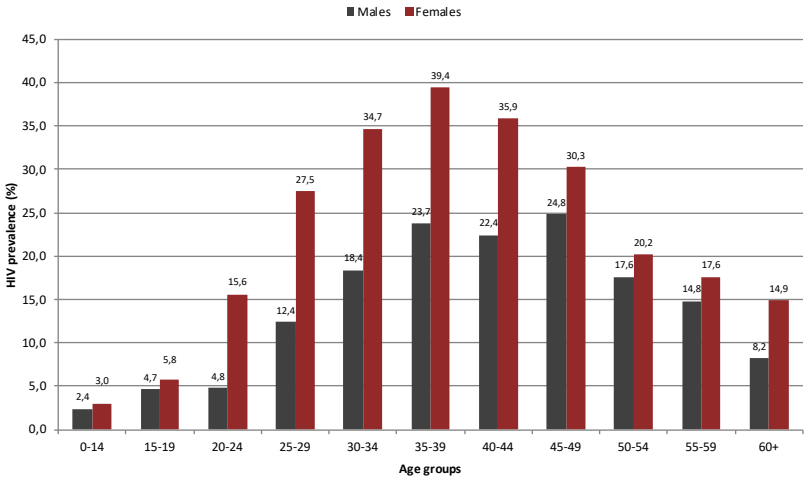


FIGURE 3 HIV prevalence broken down by male and female, South Africa, 2017 [17]

The increase in the HIV prevalence over time could be ascribed to South Africa's large HIV treatment programme. It was estimated that 4.4 million people had been initiated on antiretroviral treatment (ART) by 2017 [17]. Putting more individuals on ART resulted in a sharp increase in national life expectancy in South Africa; from 58.3 years in 2011 to 65 years (61.5 years for males and 67.7 years for females) in 2019 [20].

HIV in Sex Workers

Compared to the general population, Sex Workers are disproportionately affected by HIV, STIs, violence, stigma and discrimination [9, 10, 14, 15]. Given these barriers, intensive efforts are needed to ensure that Sex Workers have access to high-quality and rights-based HIV, STI, TB and reproductive health services, including referral for social and legal support and playing an active role in law reform [7, 13, 21–24]. South African data on male and transgender Sex Workers is scarce. Available research shows that transgender women who engage in sex work have a disproportionate risk for HIV compared with male and female Sex Workers [25,26]. Stigma, discrimination, and exclusion from social and economic opportunities are common barriers to accessing services for transgender Sex Workers and for some transgender women, sex work provides a way to find community and affirm their femininity [25, 27]. Research on male Sex Workers in Pretoria, found that men who sell sex to other men were more likely to have anal sex with other men and were far more likely to have female sex partner too, when compared to other men who have sex with men, compounding risk for HIV acquisition [28].

Because of criminalisation, Sex Workers are frequently exposed to sexual and gender-based violence perpetrated by police, clients, and intimate partners as well as stigma and discrimination in health care settings and from the public, restricting their ability to advocate for their own health and human rights and to access services. Combined, these factors decrease the agency of Sex Workers in decision making about important health, social, behavioural and economic issues [16–21] and prevent Sex Workers from accessing services, increasing their risk to poor health, social and economic outcomes [7, 22, 27, 29, 30].

A recent survey among female Sex Workers in three cities in South Africa showed that South Africa is making progress on the 90-90-90 HIV treatment cascade for Sex Workers but still has a long way to go. The level of awareness of HIV status was 81%, and 86% respectively in Johannesburg and eThekwini, and 69% in Cape Town (Figure 3) [31]. The proportion of HIV-positive Sex Workers aware of their status and on ART was higher in 2018 in all three cities compared to 2014: from 27% to 60% in Johannesburg, from 23% to 28% in Cape Town and from 35% to 51% in eThekwini. Programmatic data show a similar steep drop-off in ART initiation. Viral suppression (VS) (<1 000 copies/ml) as a proportion of people living with HIV was recorded as 52% in Johannesburg, 21% in Cape Town and 43% in eThekwini (this indicator was not reported in the first South Africa Health Monitoring Survey (SAHMS)). The SAHMS II treatment cascade analyses demonstrated that Sex Workers faced barriers in not only accessing services but also to stay adherent to treatment regimens [31].

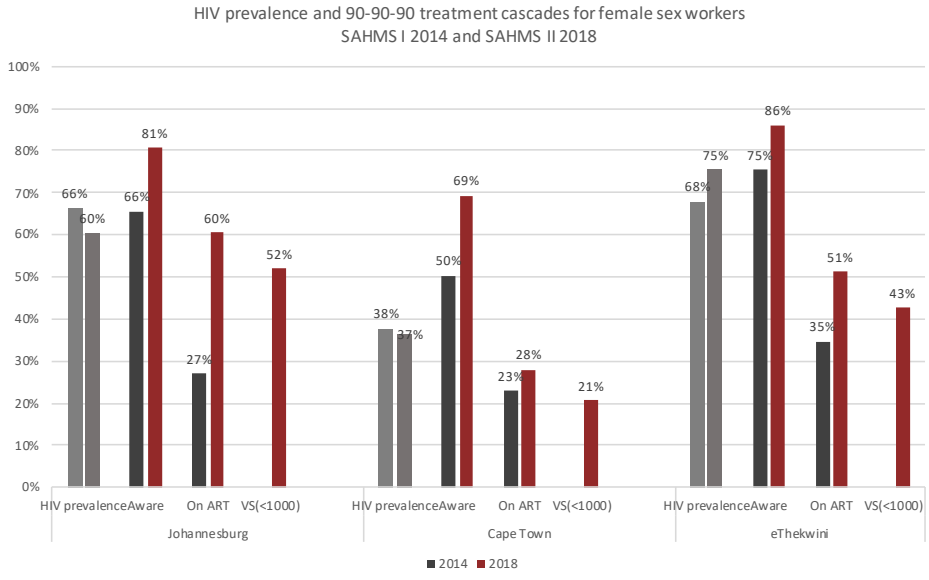


FIGURE 4 Comparison of HIV prevalence and 90-90-90 treatment cascades SAHMS I (2014) and SAHMS II (2018) [31] .

Note: The denominator for % Aware, On ART, and Viral Suppression (VS) are those who are HIV-positive.

Interventions addressing reasons for non-initiation are critical to the success of HIV test and treatment strategies. In addressing the reasons cited for not starting ART it is beneficial to urge peer educators and health providers to: 1) emphasise the large health and prevention benefits of ART and its low side effects through for example U=U messaging; 2) reduce stigma at the patient and community levels and guarantee confidentiality where stigma persists; 3) be non-judgemental and support clients in integrating ART into their lives; 4) offer peer-led outreach services to reduce the economic burdens (example transport cost) of ART; and 5) urging Sex Workers to remain in care if they move away from the current place of operation [7, 32].

A review of the comprehensive health needs of young Sex Workers and other key populations found that the younger groups were even less adept at condom negotiation than their older peers and therefore at heightened risk of having condomless sex [33].

Literature indicates that effective HIV prevention, care and treatment packages for Sex Workers, include combinations of biomedical, behavioural, social, and structural interventions tailored to local contexts [6, 7, 22, 34]. When implemented at sufficient scale, combination prevention programmes among Sex Workers and their clients can have a dramatic impact [16].

TB in Sex Workers

Although the number of new TB cases in South Africa is declining (Figure 5), TB remains the leading cause of death, specifically among people living with HIV [35]. As of March 2019, the USAID TB South Africa Project alone had found 19 570 "missing TB patients", out of the 104 776 missing TB patients [86].

In the absence of data, Sex Workers are assumed to have the same TB prevalence as the general population despite increased vulnerability to TB because of high HIV prevalence and associated risk factors. The probability of developing TB disease

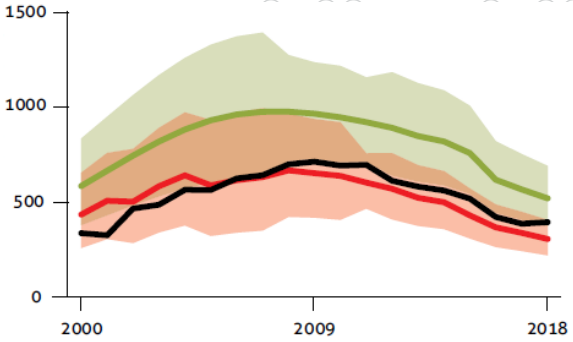


FIGURE 5 Trends in estimated TB incidence in South Africa 2000-2018.

TB incidence rate is shown in **green** and incidence rate of HIV-positive TB are shown in **red**. The **black** line shows notifications of new and relapse cases for comparison with estimates of the total incidence rate [37].

ismuch higher among people infected with HIV, and also higher among people affected by risk factors such as undernutrition, diabetes, smoking and alcohol consumption, and poor living conditions [37]. The rapid increase in ART coverage among people living with HIV led to a massive reduction in TB incidence over the past eight years in South Africa. In 2018, an estimated 42 000 TB deaths occurred among people living with HIV and 21 000 TB deaths in HIV negative people [37]. In 2018, over 200 000 (227 999) new and relapse TB cases were diagnosed, started on TB treatment, and notified to the national TB programme. This represents 76% TB treatment coverage for new and relapsed cases, potentially leaving a large gap of TB cases that were not diagnosed, notified, or received treatment [36].

There is currently very little data available on TB prevalence and burden among Sex Workers in South Africa. Criminal laws that prohibit sex work exacerbate stigma and discrimination, increasing barriers to healthcare, contact tracing and disrupting TB treatment adherence, as Sex Workers relocate or change trading spots, as they avoid harassment by law enforcers and the public. The criminalisation and discrimination contribute to poor working conditions and make Sex Workers more vulnerable to TB infection.

STIs in Sex Workers

Available evidence highlights the seriousness of STIs as a public health problem and as a risk factor for HIV infection [6, 38] and poor reproductive health outcomes [6, 7, 10]. More than 1.4 million STIs were treated in South Africa in 2016 [6, 39]. South Africa's 2017 adult prevalence estimates of 6.6% and 3.4% for gonorrhoea and 14.7% and 6.0% for chlamydia in women and men respectively, were among the highest in the world [40]. Although prevalence of syphilis declined steadily between 1990 and 2017, prevalence for gonorrhoea and chlamydia remained unchanged [38].

Like with HIV prevalence, Sex Workers report a higher burden of STIs than the general population. In 2014, Sex Workers prevalence of STI symptoms in the previous year was 38.7% in Cape Town 56.6% in Johannesburg, and 76.6% in eThekwini 2014 [41].

Another complicating factors is that healthcare workers are unable to screen Sex Workers routinely for asymptomatic STIs.

Lessons Learned from Review of Previous NSWP

In 2016, when the first NSWP 2016-2019 was developed, it was a ground-breaking step towards a national response to Sex Workers in South Africa. Since then the country adopted the NSP 2017-2022, which necessitated realignment and the opportunity to evaluate progress towards the targets set in the previous NSWP 2016-2019. In 2019, a review was undertaken to measure progress against the targets set (Table 3).

TABLE 3 Summary of NSWP 2016-2019 targets and progress

DOMAIN	TARGET	ACHIEVED
Service Delivery	1. To reach 70 000 Sex Workers with a core package of services	170 346
	2. To recruit 1 000 peer educators	329
HIV Prevention	3. To ensure that 95% of Sex Workers use condoms with their clients	Jhb 81 % CT 88% eThek 89.5%
	4. To provide PrEP to 3 000 Sex Workers	6 205
HIV Treatment	5. To ensure that 90% of Sex Workers reached are tested for HIV and know their status	Jhb 81% CT 69% eThek 86%
	6. To ensure that 90% of Sex Workers who test positive are on ART	Jhb 60% CT 28% eThek 51%
	7. To ensure that 90% of Sex Workers on ART are virally suppressed	Jhb 52% CT 21% eThek 43%
Violence	8. To reduce instances of violence against Sex Workers by 50%	Unclear

Successes of NSWP 2016-2019

- Both the 'Reach' and 'PrEP' targets in the previous Sex Worker plan were met with ease. It was clear from the review that current population size estimations understated the number of Sex Workers in need of services in the country. This is partly because of the narrower definition used during surveillance and the absence of a unique identifier across the country.
- Surveillance data showed significant improvement in the 90-90-90 HIV treatment cascade for female Sex Workers [31], which indicated improved linkage and retention in care and treatment. Data for men who have sex with men (MSM) and transgender Sex Workers was not available.
- Feedback from key informant interviews and focus group discussions reflected increasing social capital, including sense of community, social cohesion, collective action, and mutual support.

Challenges of NSWP 2016-2019

- Unmet targets from the review of the previous Sex Worker HIV plan included the failure to recruit 1 000 peer educators and to reach 90% targets on each pillar of the treatment cascade.
- Two of the targets were impossible to determine progress or failure: 95% condom use with clients and decreased violence. The condom use target was adjusted to 90% after consulting with the latest evidence and more appropriate indicators were included into the NSWP 2019-2022 to evaluate condom use and violence reduction. Surveillance data did not show a significant decrease in violence since the previous survey [31].
- Inherent measurement challenges in identifying reliable indicators to assess the plan's real impact on violence and other human rights abuses of Sex Workers, including directionality of impact (increasing, decreasing, or unchanged); enablement of redress through police services and courts.

THE NSWP 2019-2022

Geographic Prioritisation

The NSWP 2019-2022 targets female, male and transgender Sex Workers, as well as young people older than 18 years. For funded NGOs the focus is mainly on the 27 high-burden HIV districts (for the general population) identified in the NSP 2017-2022 (Figure 6) [6]. In line with the NSP 2017-2022, there is an imperative to move from a focus only on the 27 high HIV burden districts, as the whole of these districts is not at greatest risk, to more focused localised areas for greatest impact.

These more focused localised areas throughout the country will be identified using the Focus for Impact methodology, a key principle of the NSP, to identify high transmission areas for implementation, informed by localised information from communities. This will allow a more focused response that is built on community identified needs, without leaving anyone behind. The HTA programme targets Sex Workers in high transmission areas in all 52 districts.

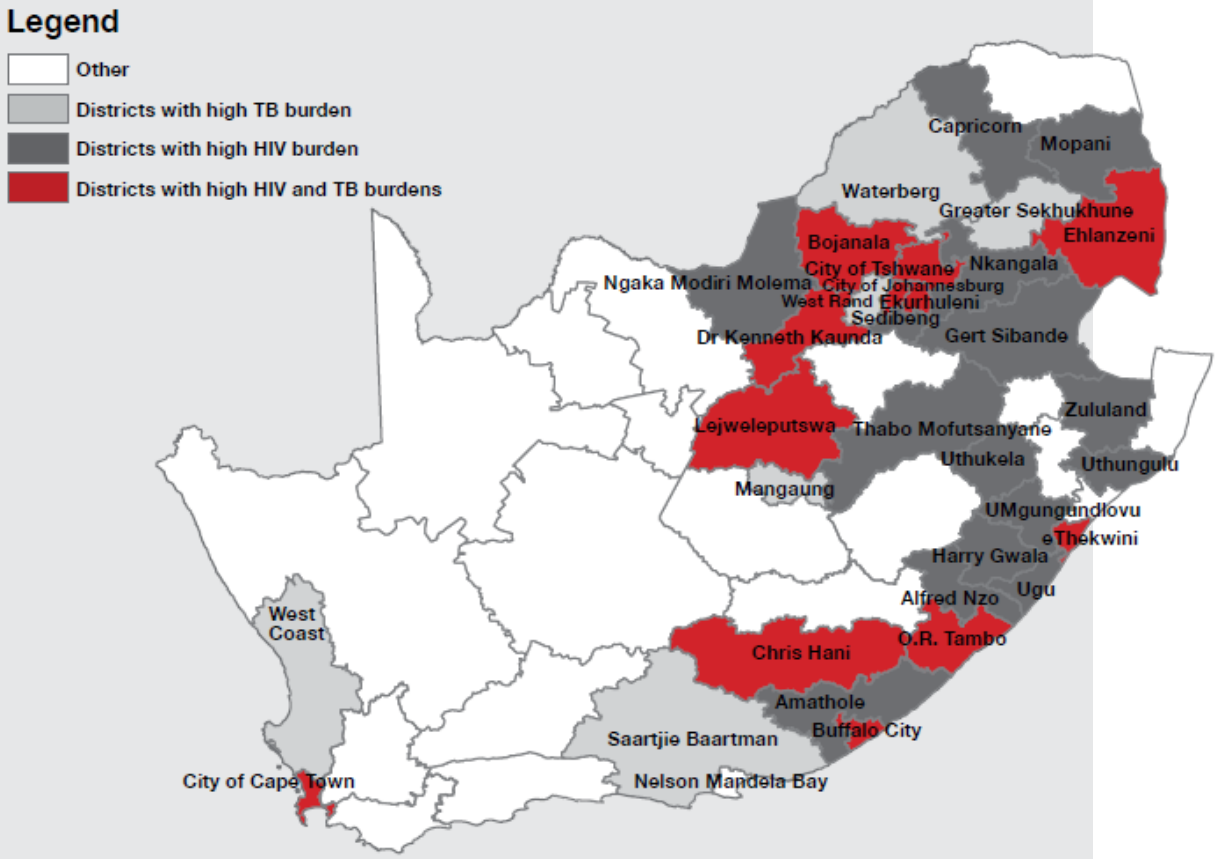


FIGURE 6 Districts with high HIV and TB burdens identified in NSP 2017-2022

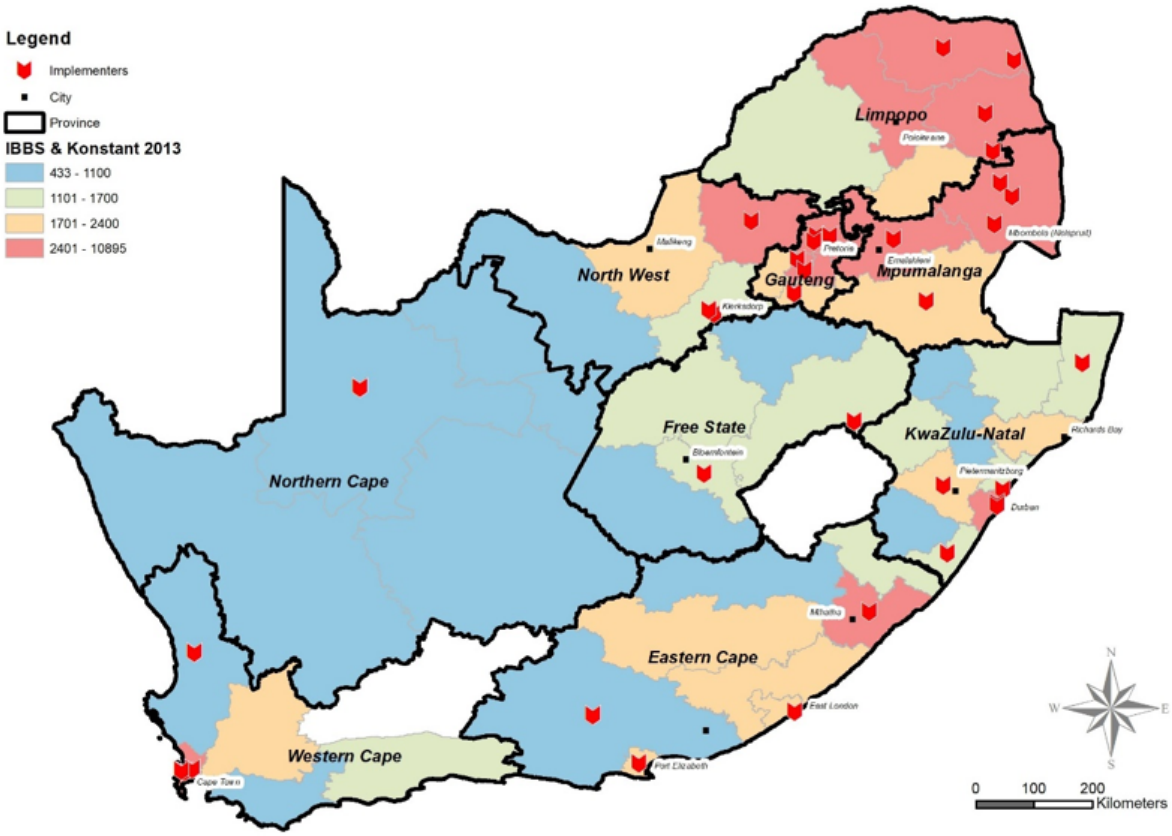


FIGURE 7 Population size estimations of female Sex Workers in South Africa [31]

Figure 7 depicts the population size estimations of female Sex Workers in the country (SAHMS II) and the distribution of NGO Sex Worker service sites (PEPFAR and Global Fund). Although Sex Workers in HIV high-burden areas seemed to have access service sites, those in rural areas, reportedly did not have access to specialised services.

GOALS

GOAL 1

Accelerate prevention to reduce new HIV and TB infections and STIs

Strategic context

Every available indicator of the burden of HIV epidemic among Sex Workers clearly demonstrate the need for intensified efforts at primary prevention of HIV infection. Biologically, their work carries the accumulated risks of long term and repeated exposure to HIV from multiple sexual partnerships. Critical to successful delivery of a prevention programme is the deployment of trained peer educators to reach Sex Workers where they work and to build trust to engage with programmes [5, 7, 42]. Literature shows interventions that prevent the transmission of HIV among Sex Workers with the highest rate of partner change will achieve the greatest reduction in new HIV infections [6, 7, 13, 43, 44].

Peers who establish trust relationships with Sex Workers during outreach and those who are early adopters of HIV prevention behaviours and technologies provide the most effective means of disseminating information and influencing social norms that will ultimately sustain community members' behavioural choices. In key populations such as Sex Workers, who are marginalised and often alienated from mainstream institutions and communication platforms that typically promote behaviour change, this peer influence is often the only social cue available to promote and reinforce healthy behaviour change. In this way the success of primary HIV prevention approaches with Sex Workers is contingent upon meeting the NSWP's ambitious targets of peer recruitment and management of peer educators to promoting effective, evidence-based primary prevention service packages among those they reach. Effective upstream interventions include peer-based outreach to attain high coverage, condom programming and STI services that address both symptomatic and asymptomatic infections. Basic interventions that address condom use and curable STIs in sex work appear to be core elements of an effective prevention response even in contexts where ART is being rolled out [45].

Very high condom use rates during paid and unpaid sex - approximately 80% to 90% are needed to bring about major and sustained reductions in new HIV infections. However, in high-prevalence settings in Sub-Saharan Africa, reported high use of condom among Sex Workers appears insufficient to contain the epidemic [13, 45–48]. This is consistent with the data from SAHMS II, showing >80% condom use at the last sexual act (an indicator generally understood as a marker for consistent condom use). Reasons for this apparent discrepancy between consistent condom use and the general epidemic burden among Sex Workers may include high background prevalence among clients, high incidence among specifically young Sex Workers who are unable to negotiate safe sex, and high rates of violence and rape. They may also include a social desirability bias inherent in self-reporting sexual behaviour in surveillance surveys, and programme impact in monitoring and evaluation data.

However, intensifying existing primary programmes to reach young Sex Workers with behaviour change communication also provides an opportunity to inform Sex Workers about PrEP and early ART [16]. In a demonstration project, PrEP and ART received good uptake for both PrEP and early ART in high-prevalence urban settings; however retention rates for PrEP were low [49].

Most Sex Workers consider risk reduction and in particular condom use as beyond their control or even unnecessary [13, 50]. Therefore, one critical area of intervention is the need to assist Sex Workers to develop accurate means of assessing their personal vulnerability through risk screening during outreach, one-on-one interventions with peers, and risk reduction workshops. Changing behaviours of Sex Workers (and their clients) is therefore critical to reducing HIV and STI transmission.

Evidence also shows the increasing risk of HIV drug resistance. Pro-active ART management must therefore be strictly adhered to, to ensure that those affected by resistance are moved to new regimens as appropriate [51].

As a common opportunistic infection among HIV-positive South Africans, TB-HIV coinfection is presumed to be as prevalent among HIV-positive Sex Workers as the general population. Their work often takes place in poorly ventilated spaces and requires intimate contact that facilitates transmission. As with HIV, South Africa cannot hope to reduce and eliminate its TB burden without intensifying screening, case finding efforts and TB treatment among Sex Workers [52].

Sex Workers, identified as a key population for STIs, need intensive support in identifying and treating STIs other than HIV. Ways to reduce STIs include 1) behaviour change, for example, by correct and consistent condom use, 2) routine screening of Sex Workers symptomatic STIs, 3) treating all STIs (asymptomatic and symptomatic), and 4) health education and risk-reduction counselling [39].

Strategic approach

Combination prevention packages must be rights-based, evidence-informed, community-owned and with high impact. Comprehensive HIV prevention packages, which are inclusive of information and services necessary to reduce TB incidence and STI morbidity could also benefit from peer-led programming. This includes dissemination of information about Sex Workers' TB risks and infection control in health facilities, hotspots and households where Sex Workers work and live; as well as linking Sex Workers to STI diagnosis, treatment, prevention, and social and structural support services [6, 7, 16, 29, 43].

Activities to prevent new HIV, TB and STI infections include:

- Tailored Information, Education and Communication (IEC) programmes to promote behaviour change towards safer sex behaviour, and information on available biomedical prevention options such as condoms, PrEP, Post Exposure Prophylaxis (PEP), and Prevention of Mother to Child Transmission (PMTCT);
- Distribution of condoms and lubricants to all Sex Workers, sex work establishments and hotspots in adequate quantities, including through using existing distributors of other goods and services (examples liquor distributors);
- Provision of and/or referral for PrEP, PMTCT, and PEP to prevent new HIV and STI infections;
- Provision of and/or referral for modern contraceptives, safe abortion services, cervical cancer screening, and other sexual and reproductive health services (SRH) to improve outcomes;
- Increased coverage of TB screening and Preventive Therapy Uptake (PTU) to prevent new TB cases; and
- Screening for symptomatic STIs and screening for and vaccination against Hepatitis B to reduce STIs.

GOAL 2

Reduce morbidity and mortality by providing treatment, care and adherence support for all

Strategic context

South Africa's progress in treating HIV, STIs, and TB in the 2012-2016 period is evident among Sex Workers. Results from the SAHMS II showed high knowledge of HIV status and significant progress towards desired engagement in treatment among Sex Workers in Johannesburg and eThekwini [31]. Yet the unevenness of this progress is evident among Sex Workers in Cape Town, who lagged well behind their Johannesburg and eThekwini counterparts in the 90-90-90 cascade. It is likely that those outside of large metros still lag further behind. The numerous benefits of ART are reliant on successful engagement in HIV care and treatment, including linkage to care shortly after HIV diagnosis, timely initiation onto ART, and optimal ART adherence to achieve viral suppression [53]. Sex Workers living with HIV must be linked to care, initiated and sustained on treatment to receive the clinical benefits of ART. Treatment and adherence support, such as those provided in peer navigation service models, have shown promise in increasing ART uptake and adherence among HIV-positive people in all populations, including Sex Workers [5, 54]. Also, given the evidence supporting ART for treatment as prevention, Sex Workers who are virally suppressed decrease the likelihood for ongoing transmission to their sexual partners [53, 55, 56].

Strategic approach

All efforts under this goal focus on reaching the 90-90-90 targets for HIV and TB, including finding and treating STIs and Hepatitis B in Sex Workers. This approach is consistent with and complementary to the peer-led approach to primary prevention outlined above. In districts where targeted Sex Worker programmes are being implemented, peer educators can link Sex Workers after HIV, STI, and TB screening with appropriate treatment services; whether these are offered through the Department of Health's HTA programme or primary health care facilities, the low-cost integrated model [8] or NGO-provided 'specialty' services.

Clinical services for Sex Workers in the NSWP 2019-2022 include:

- Targeted HIV Testing Services (HTS), same day initiation on ART or peer navigation to Department of Health facilities for ART, follow-up and adherence support on ART (including delivery of ARVs to non-health facilities for stable patients, to avoid the queues at health facilities) to achieve ongoing viral suppression (example U=U);
- Finding TB cases, initiation on TB treatment and adherence support to complete treatment; and
- Detection and treatment of STIs and Hepatitis B.

GOAL 3

Reach all key and vulnerable populations with customised and targeted interventions

Strategic context

Selling sex is stigmatised, and sex work is criminalised. In this context it is reasonable to assume that only the most exceptionally empowered Sex Workers have been able to rise above these social and structural obstacles to seek and receive the prevention, care and treatment they need. Recognition of these unique, population specific, and multi-sectoral challenges prompted the drafting and adoption of the first NSWP, and the rationale for peer-led interventions to reach all Sex Workers, including the more vulnerable sub-groups, such as young people who sell sex, male and transgender Sex Workers.

There needs to be recognition that peer education is a specialised job accompanied by special training to provide the necessary services and link Sex Workers to the appropriate services e.g. health facilities, social workers etc. These peer educators need support to travel to where the Sex Workers are and to connect them to services. Peer educators also need special IEC materials. Peers have much to contribute not only to the dissemination of information and engagement of Sex Workers but to every stage of design, implementation, and assessment of impact of intervention. Peers should be Sex Workers themselves, and be from the community [7, 8, 57]. Creating safer working conditions for Sex Workers and engaging them closely in the planning and delivery of programmes make a big difference in reaching Sex Workers [16, 58, 59]. Sex Workers recruited and trained to deliver specialised services should be deployed in the HTA programme as well as in in funded Sex Worker sites to make services more accessible and acceptable to Sex Workers [5, 57].

Outreach is the primary tool of peer education and means going to the 'place' of sex work to meet with the Sex Workers and provide them with services and information. Microplanning decentralises the planning and management of outreach to peer educators who work at the local (hotspot) level.

Through outreach, trained peer educators build trust with Sex Workers, enhancing reach and communication [9, 42]. Peer educators providing outreach services are required to [9]:

- Meet Sex Workers at least monthly at sites designated to the peer (Place-based methodology or Hotspot mapping);
- Assess the HIV prevention care and support needs of each Sex Worker and devise a plan together with the site coordinator to address these needs;
- Assess the psychosocial, human rights and risk elements of the site, and develop a plan together with the site coordinator to address these needs;
- Assess condom requirements for each Sex Worker and provide adequate condoms for the site to cover the time until the next contact;
- Encourage and recruit Sex Workers to access health services either at clinics, through mobile clinics that go to hotspots, dedicated Sex Worker-friendly drop-in centres or site visits by healthcare workers, HTS counsellors or a professional nurse;
- Link Sex Workers who test HIV-positive to care and treatment;
- Provide a combination of prevention services, including PrEP for Sex Workers who test HIV-negative;
- Counsel and support Sex Workers to adhere to ART and encourage Sex Workers to ensure their viral load is checked as per the guidelines (some clinics do on-the-spot viral load measurement and return results immediately);
- Provide information and linkage to appropriate services for Sex Workers who experienced violence and human rights violations; and
- Conduct group or one-on-one messaging sessions for behavioural adjustments, including practicing safe sex.

To increase social capital of Sex Workers, implementers of Sex Worker programmes and representatives from the sex work sector will be included in AIDS Councils at all levels and Sex Worker

representative organisations will be strengthened to protect the rights and interests of Sex Workers.

Vulnerable Sex Worker sub-groups

The NSP identified Sex Workers as a key population for HIV and STIs. In addition, Sex Workers often belong to other key groups, such as people who use drugs (PWUD), MSM, transgender people and people living with HIV (Key population for TB), or identified vulnerable populations for example adolescent girls and young women, children including orphans and vulnerable children, mobile populations, and people living in informal settlements [6].

Vulnerable sub-groups identified in the NSWP 2019-2022:
- MSM Sex Workers
- Transgender women who are Sex Workers

The NSWP 2019-2022 recognises that certain sub-groups of Sex Workers experience additional barriers to accessing services and claiming their human rights because of the overlapping risks of the different key and vulnerable populations. Vulnerable sub-groups in the NSWP 2019-2022, include male and transgender Sex Workers.

Male Sex Workers and transgender women who are Sex Workers often experience additional stigma and discrimination because of nonconforming sexual orientation, gender identity and expression, resulting in homophobic and transphobic rape, assault and robberies [27]. Surveillance and research involving transgender women consistently demonstrate higher HIV prevalence among transwomen Sex Workers than other female and male Sex Workers [25, 26, 60, 61].

Strategic approach

All providers of Sex Worker services are to deploy peer educators—including young-, male- and trans Sex Workers—appropriately trained using an evidence-based peer education module [57]. Training topics must include health promotion, risk assessment, mental health issues, basic trauma containment, referral practices, condom use and negotiation, human rights, legal literacy, and HIV, TB and STI screening, tracing or testing. Peer educators should be encouraged to use standardised materials to deliver IEC, such as cue cards and checklists. Peer educators must further be familiarised with microplanning/SNS/EPOA, data collection and other best practices to expand their roles and expertise [3, 4, 9, 11, 42].

Directories of referral services for psychosocial services, substance use, and social grants, must be available at all Sex Worker sites and Sex Workers should be encouraged to use the SWEAT 24-hour helpline: 0800 60 60 60 for assistance. Sex Workers will be further supported by encouraging community networks that include advocacy agendas for equal health and human rights, including membership of Sisonke, and support for strengthening of Sisonke's governance and administrative capabilities and coverage.

NSWP 2019-2022 support for vulnerable sub-groups:

- Peer educators can perform a screening for young people who sell sex if they suspect that the young person is underage. The young person should be counselled and reported to the site coordinator for further management. All children under 18 who sell sex must be referred to organisations or government departments that specialise in working with children; Implementing partners must ensure that the child is supported throughout the referral process. Young people between the ages of 16 and 18 will be assisted to access health and other support services [9]; and
- Male and transgender Sex Workers will be supported by peer educators recruited from MSM and transgender groups. All health workers will be sensitised to the unique needs of MSM and transgender Sex Workers.

GOAL 4

Address social and structural drivers of HIV, TB and STI infections and linking them to NDP goals

Strategic context

Sex Workers' relationships with both clients and partners are characterised by social norms and gender inequalities in the wider population. These belief systems are supported and reinforced through the criminalisation of sex work and are enacted through widespread physical, sexual and gender-based violence [7, 29, 30, 62, 63]. For Sex Workers, entrenched patriarchy combined with criminalisation normalise the violence they experience. The common belief that "it is impossible to rape a Sex Worker" is symbolic of the social and structural barriers Sex Workers experience. The violence, stigma and discrimination against Sex Workers increase their risk of STI and HIV infection, and also prevent Sex Workers from accessing health, social and legal services and information. Forms of violence range from societal stigma, discrimination, and humiliation to beatings, rape and theft [7, 29, 63]. Nearly half (45%) of the 101 Sex Workers who died in South Africa in 2018 and 2019, were murdered, and 9% of deaths could potentially be related to HIV or TB [85].

The main perpetrators of this violence are clients and police officers. Community-based and community-led initiatives that empower Sex Workers, improve their working conditions and widen access to comprehensive HIV and reproductive health services are highly effective and will be taken to scale [7, 16, 44]. Seventy-one percent of Sex Workers reported experiencing violence in 2015. Sex Workers reported emotional violence to be the most damaging and painful form of violence [63].

Economically, sex work is a viable option to gain employment. However, criminalisation and shorter term economic imperatives may override long-term safe behavioural choices. According to a review of the HIV treatment experiences of female Sex Workers in Sub-Saharan Africa, stigma and discrimination are among the main barriers to HIV testing, treatment and care services [53]. Sex Workers who are able to access health services are often stigmatised by healthcare providers, through refusal of service, abusive treatment, or the provision of inadequate or inappropriate care [64–66]. Many Sex Workers may not feel comfortable discussing their health concerns and reproductive desires with healthcare providers out of fear that providers will not support their choices or help them make informed decisions about life choices [65]. For Sex Workers, another barrier to receiving appropriate care may be concern that providers may not maintain the confidentiality of their health status or occupation [67]. In addition, Sex Workers who desire pregnancy may face stigma from health providers, who may perceive them to be unfit parents [24] or they may be coerced into medical procedures without their informed consent [65]. Trans and male Sex Workers face additional and intersecting stigma related to their gender identity and sexual orientation [25, 27, 61]. Female, male and transgender Sex Workers are often denied treatment for injuries suffered during physical assault or rape and when they report condom breaks; hostility from public sector healthcare providers is a commonly reported experience [23, 64, 68–70].

Many Sex Workers have internalised this stigma. Such self-stigmatisation is known to inhibit behavioural intentions to preserve and enhance one's own health.

It is only recently that literature started describing sex work as a rational, financially motivated choice by adults. The literature increasingly describes the

exchange of sex for money as a complex social phenomenon firmly grounded in social, economic, political, legal, and sexual relations in which many actors play a role [7, 43, 50].

Strategic approach

Sexual and gender-based violence against Sex Workers will be prevented through a national human rights strategy – See Goal 5 – that includes activities to sensitise law enforcement officers and health workers. The NSWP 2019-2022 expands access to and availability of services for all survivors of sexual and gender-based violence through the introduction of local crises response teams [3, 63], an increased number of crises centres, and improved post violence support, including PEP at facilities .

Social support for survivors of violence includes strengthened ties with and enhanced referral to the police (for forensic evidence and reporting of sexual assault and other violence), Thuthuzela Care Centres and their equivalents (which are linked to health facilities) for sexual assault, and to Department of Social Development for access to social grants, psychosocial support, and counselling.

Economic empowerment for Sex Workers is supported through skills workshops and access to adult based education and training (ABET) and tertiary training through the Department of Higher Education, Science and Technology. Training for peer educators as auxiliary social workers will be explored with Department of Social Development to provide additional career pathing opportunities.

GOAL 5

Ground the response to HIV, TB and STIs in human rights principles and approaches

Strategic context

Criminalisation of sex work is in direct conflict with global and national efforts to increase Sex Workers' access to HIV, TB and STI prevention, testing and treatment services and to protect the rights of Sex Workers to stop new infections [7, 29, 43, 61, 71–74]. Because sex work is criminalised, Sex Workers face additional violence, stigma and discrimination based on gender, race, HIV status, drug use and other factors. Most occurrences are a manifestation of gender inequality and discrimination directed at women or at men and transgender individuals who do not conform to gender and heterosexual norms [29].

Sex work is criminalised in South Africa in terms of the Sexual Offences Act 23, 1957 which provides that any individual who has "unlawful carnal intercourse or an act of indecency with any other person for reward commits an offence". The various provisions of the Act make selling sex, brothel keeping, solicitation, indecent exposure, and knowingly living from the proceeds of sex work illegal.

Furthermore, the provisions of the Sexual Offences and Related Matters Amendment Act, 2007 also criminalise clients who engage the services of Sex Workers [15].

Laws and policies that criminalise sex work condone discrimination, harassment and violence, isolating Sex Workers and stopping them from accessing vital health and other support services [16, 23]. Criminalising sex work contributes to the dismiss of violence against Sex Workers as consequential to sex work and therefore self-inflicted. Law reform must be based on sound evidence and aimed at removing the disconnect between a public health response and a criminal justice system that criminalises adult consensual sex for money [7, 15, 23, 29, 75–79].

Criminalisation and arrest cause Sex Workers to move their place of business and to change the way they solicit clients, to avoid prosecution. These efforts reorganise the problems associated with sex work, relocates Sex Workers into isolated and dangerous work locations and increase their risk further, but fail to eliminate sex work [13, 80]. Sex Workers are also likely to become more difficult to reach with public health interventions.

Violence prevention should therefore be rooted in decriminalisation of sex work, reducing stigma and discrimination (by service providers and law enforcers), community empowerment, collective solidarity of Sex Workers, building Sex Workers' knowledge on their rights and increasing Sex Workers' confidence to claim these rights [7, 15, 23, 29, 44, 72, 76]. In addition, decriminalisation makes it easier to regulate and reach Sex Workers with health information, condoms, care and treatment [7, 15, 23, 29, 75–79].

Strategic approach

To reduce HIV, STIs, violence, stigma and forced condomless sex and to ensure health and human rights for all Sex Workers, require decriminalisation of sex work accompanied by political and funding investments to support community and structural interventions [44, 80].

The NSWP 2019-2022 introduces a framework to law reform and a national strategy to decrease stigma, strengthen access to justice and reduce violence against Sex Workers. Implementation will be driven by Sex Worker networks and organisations, informed by evidence, and supported by SANAC structures.

Law reform

SANAC will continue to advocate for decriminalisation of sex work. See framework for decriminalisation under Goal 5: Table 8.

National human rights strategy

SANAC will roll out a national human rights campaign to reduce stigma and discrimination and gender-related barriers for people living with HIV, people living with TB, and vulnerable and key populations. The strategy has three objectives:

1. To reduce stigma and discrimination amongst people living with HIV and TB;
2. To facilitate access to justice and redress for people living with, and vulnerable to, HIV and TB; and
3. To promote an environment that enables and protects human and legal rights.

The human rights strategy identified the following actions to achieve the objectives:

1. Implement social and behaviour change communication (SBBC) community education campaigns to reduce stigma and discrimination and community-based support groups to deal with internalised stigma;
2. Use legal literacy ('Know Your Rights') campaigns to reduce stigma and discrimination and improve legal literacy on human rights and laws relevant to HIV and TB;
3. Strengthen access to legal support services, including community-based services, human rights institutions and other complaint mechanisms, to enable people to respond to human rights abuses and to access justice and redress;
4. Sensitise lawmakers and law enforcers to protect and promote human and legal rights;
5. Sensitise and train health workers on human rights and medical ethics;
6. Monitor HIV and TB-related human rights abuses and programmatic responses, as well as law and policy review and reform, to identify areas for improvement; and
7. Reduce gender inequality, harmful gender norms and gender-based violence.

A national stigma and discrimination reduction campaign will include a focus on reducing stigma and discrimination against Sex Workers, through a communication campaign as well as community level anti-stigma activities.

The Department of Health and PEPFAR developed training materials to strengthen coordinated, integrated and standardised training of healthcare workers with an improved focus on the rights of Sex Workers and other key populations. Department of Health is implementing the healthcare worker sensitisation Tool Kit for all healthcare workers through regional training centres to eliminate stigma, discrimination and violence at health facilities. Training will be included in the basic training of doctors, pharmacists, nurses and allied health workers as well as standalone modules for in-service skills training. Sex Worker-led civil society organisations will be funded to scale up sensitisation training, mentorship and collaboration with health facilities.

A web-based platform for monitoring, addressing and responding to human rights violations in the country will also be introduced. All Sex Worker sites are expected to keep accurate records of human rights violations and to refer all cases to SWEAT or Sisonke (Sex Worker representative organisation) for follow-up and referral. Trained peer educators will act as monitors and human rights defenders in all sub-districts. SANAC will provide capacity development to Sisonke and SWEAT.

Legal and paralegal support services will be strengthened to improve access to justice for Sex Workers whose rights are violated.

The police service's treatment of Sex Workers reporting violence will be improved through engagement with South African Police Service (SAPS) and national sensitisation of law enforcement officers through in-service training and communication [81].

GOAL 6

Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

Strategic context

Goal 6 of the NSP calls for leadership and shared accountability for a sustainable response to HIV, TB and STIs. It is necessary for leadership at all levels to advance all the goals of the NSP, including advocacy for:

1. customised targeted programmes for Sex Workers;
2. prevention of stigma and discrimination and other human rights abuses;
3. comprehensive decisive action to deal with the social and structural drivers of HIV and TB;
4. promotion of the necessary actions to mobilise resources and build sustainability;
5. monitoring, evaluation and research; and
6. the legal reform that is needed to optimise the treatment and prevention cascades for the achievement of the UNAIDS 90-90-90 strategies and the accelerated HIV prevention targets.

A multi-faceted approach is needed with an emphasis on strengthening leadership at the community level, where multi- and inter-sectoral programmes are implemented. Therefore, Premiers, Members of Executive Councils and Mayors will strengthen their HIV, TB and STI leadership and programmes. Tailoring the response to specific locations and populations is critical to improve efficiencies and this needs to be done by all stakeholders. Districts must define their own responses for implementing the NSP, with provincial and national leadership supporting this decentralised approach.

SANAC has led the country's response to HIV, TB, and STIs since its creation in 2000 and has played a visible role at the national level in articulating multi-sectoral, human-centred policies and action plans, particularly as these relate to key populations including Sex Workers. The purpose of SANAC is to bring together government, civil society and the private sector to create a collective response to HIV, TB and STIs in South Africa. As such, SANAC's objectives relate directly to the successful coordination and implementation of the NSWP 2019-2022 [82]. The review of the NSWP 2016-2019 identified areas for improvement including the engagement of multi-sectoral government departments (for example Department of Health, Department of Social Development, Department of Higher Education, Science and Technology, SAPS) at national, provincial and local levels.

The HTA Programme leads, standardises, and represents the key population response by the Department of Health in South Africa [5]. The programme aims at rendering services where key populations, including Sex Workers, congregate across South Africa. Given the fact that Sex Workers are hesitant to visit Department of Health clinics, peer educators do onsite visits at hotspots (within HTA areas), and promote and distribute condoms and offer risk assessment. Sex Workers in need of services are referred to key population-friendly mobile clinics or accompanied to Department of Health or NGO facilities. The HTA programme provides outreach from Department of Health fixed clinics, from NGO implementing partner sites, from mobile units or from their homes in remote communities. All HTAs are encouraged to link with a local Department of Health facility and each HTA consists of hotspots within a demarcated area.

The HTA programme experiences multiple challenges and has been relying heavily on funded NGO partners to deliver the majority of health services to Sex Workers. The following challenges were identified in the review of the previous NSWP [82]:

1. The HTA programme was not multisectoral and relied mostly on the Department of Health for resources;

2. Accurate reporting posed many difficulties:
    - In the absence of accurate population size estimates of Sex Workers, target setting was not accurate;
    - Monitoring was paper-based, which caused problems with lost data and incorrect data capturing;
    - There was no way to disaggregate data in the DHIS, neither on the HTA programme, nor per key population group nor on any other indicator;
    - In the absence of a national unique identifier, it was impossible to track Sex Workers across the continuum of care;
    - NGOs reported to Department of Health as well as to funders resulting in double counting of the same project beneficiaries;
    - The HTA programme was measured against multiple indicators not all relevant to key populations;
    - Very few of the 'peer educators' employed by the HTA programme were Sex Workers;
    - The HTA programme was not standardised across provinces;
    - Apart from the healthcare package, the HTA programme offered limited services on the other five packages of care, described in the NSWP 2016-2019; and
    - Delays in the finalisation of partnership agreements between the Department of Health and funded implementing partners resulted in limited services to Sex Workers in some areas.

These challenges must be addressed to ensure sustainability of Sex Worker services.

Strategic approach

AIDS Councils will be held accountable for supporting HTA sites, Sex Worker programme implementers and other Sex Worker stakeholders and for including Sex Worker representatives in meaningful roles in the councils. Funding should be made available to transport Sex Worker representatives to and from meetings. The representatives must be mentored to enable them to fully participate in meetings. Resources such as data and airtime should be provided to Sex Worker representatives to enable them to carry their functions efficiently. The SANAC sex work sector and the NGO implementers are co-accountable for the implementation of the NSWP 2019-2022.

The SANAC Secretariat and provincial, district and local AIDS Councils are responsible for coordinating the involvement of other South African government departments (at the appropriate level), such as:

- engaging SAPS to issue an instruction prohibiting members from arresting, searching or harassing individuals on the basis of possession of condoms. Address police practices that affect Sex Workers and take disciplinary steps in addressing attempts by some members of the service to elicit bribes or otherwise threaten Sex Workers with arrest in return for money and sexual services;
- strengthening collaboration between Sex Worker sites, the HTA sites, Department of Health primary healthcare clinics and Department of Social Development, to enable referrals for psychosocial services, social grants, post-violence support, child support services, and care and treatment for alcohol and substance misuse;
- engaging Department of Home Affairs to support undocumented local and foreign Sex Workers to obtain official documentation;
- ensuring that teams leading HTA and local crises response teams are multisectoral consisting of representatives from the Sex Worker population as well as representatives from government departments;
- supporting Sex Workers-led, law enforcers-led and civil society-led anti-trafficking initiatives to prevent human trafficking; and
- AIDS Councils are further responsible for the sustainability of Sex Worker services as described in Goal 7.

GOAL 7

Mobilise resources and maximise efficiencies to support the achievement of NSP Goals and ensure a sustainable response

Strategic context

Sex Worker services and services for other key populations are delivered through the HTA programme, in partnership with funded NGO implementers. The HTA programme is funded through the conditional grant to provinces. The cooperation between the HTA programme and funded Sex Worker specific services is an example of a working public-private-partnership and must be expanded to support sustainability of Sex Worker-friendly services in South Africa. In exchange for either parallel or integrated services aligned with Department of Health plans and treatment algorithms, and monthly reporting to Department of Health, the department supplies commodities, ART, and laboratory services to NGOs, depending on the signed agreement between the partners. The main non-governmental International Development Partners of Sex Worker services in South Africa are PEPFAR through CDC and USAID implementing partners, and The Global Fund to Fight AIDS, Tuberculosis and Malaria through NACOSA sub-recipients.

The 2018 sustainability review of The Global Fund funding to South Africa, highlighted the following challenges affecting the sustainability of customised targeted services for Sex Workers:

- The HTA programme needs to ensure that peer educators are actually Sex Workers who are appropriately trained to deliver the services as described in the NSP. Data from the HTA programme needs to be disaggregate according to key population, to enable tracking of services and appropriate budgeting;
- At a community level, practical capacity building support should be provided to NGOs who currently provide the peer educators, to boost sustainability. Activities to consider include innovative ways of working, sustainability planning, resource mobilisation and leadership development;
- There is a need to experiment with different models of service delivery e.g. specialised service within a general health facility that can then be integrated once staff competency is adequate;
- Inadequate provision of commodities at the right time to meet the needs of Sex Workers;
- There is limited planning for sustainability of programmes to move from being funded by external donors to being absorbed in the HTA programme under the conditional grant for HIV;
- There is a need to co-ordinate and map the provision of services and linkages to care and to adopt uniform methods of monitoring, evaluation and analytics to respond to the changing environment; and
- Lack of progress with law reform continues to inhibit efforts to improve access to care and support services.

Strategic approach

A successful sustainability plan for Sex Worker programmes requires appropriate decision-making structures, capacitated to assume the responsibility. A national sustainability working group will be established, led by SANAC Secretariat, and at the provincial level, by the Head of Secretariat of the Provincial AIDS Councils (PCAs).

Multi-sectoral policies and guidelines must be put in place to guide programme implementation and to optimise funding mechanisms across different sources of funding. Activities to improve programme efficiency and effectiveness would include influencing the research agenda, improving knowledge sharing, and a costed implementation plan of the best value for money package of services. Activities to improve funding mechanisms should include a framework for social contracting, regularly updated funding gap analyses, and an analysis of existing

funding mechanisms. This national collaboration for sustainable change will take place through the existing SANAC structures i.e. Civil Society Forum, Programme Review Committee, Plenary and Inter-Ministerial Committee. It is critical to include all government departments (e.g. Department of Health, Department of Social Development, Department of Basic Education and Department of Higher Education, Science and Technology) because the sustainability of programmes require commitment and multisectoral collaboration.

The sustainability of programmes implemented by all external donors needs to be considered and the role of the SANAC structures such as the Resource Mobilisation Committee and the Donor Co-ordination Committee will play an important role in doing this. The SANAC Secretariat will develop the necessary technical documents for presentation to these structures for refinement, finalisation, approval and implementation. These technical documents will also be informed by the plans from the provincial sustainability working groups.

Provincial multi-sectoral working groups have to engage with the current donor funded Sex Worker programmes to understand what is implemented where, how and by whom and then prioritise within that province where to start with planning sustainability. These multisectoral working groups need to understand the service delivery gaps of their provinces and the contribution made by external donors in addressing the gaps, and then incorporate the findings into their sustainability planning and budgeting cycles and tools. Each province needs to identify concrete actions, timelines and support and incorporate these into their multi-disciplinary implementation plans and Annual Performance Plans for inclusion in the annual medium-term expenditure framework. This is necessary given the fact that long-term government funding needs to be secured through existing budget mechanisms at provincial and district levels.

The optimisation of the services for Sex Workers relates to the commitment by Treasury to take over and scale up programmes that are aligned with the NSP and that have proven outcomes and impact with well-defined costs. To improve sustainability, Sex Worker programmes supported by external donors need to demonstrate value for money, to make the business case for streamlining and inclusion within existing structures. Generating evidence of cost effectiveness and impact to meet government decision making information requirements is therefore critical. Evaluations should include the cost of national scale-up. Findings from ongoing monitoring and evaluation must be shared with the relevant government departments including the sector officers at Treasury and provincial planning and budget units in the Department of Health, to enable efficient costing for Sex Worker programmes scale-up.

As part of this optimisation, it is important that NGOs continue to do essential parts of the work for key and vulnerable populations, as per the NSP, and that the contracting system for these NGOs be improved. This includes the formulation of systems that ensure that funds flow to the NGOs timeously, the necessary training and support is offered whilst ensuring that high quality work is being done and reported on, to clearly show the full picture of the multi-sectoral implementation plans.

For improved sustainability, NGO facilitated programmes will be integrated into the multi-sectoral HTA programme. Where possible, NGO services will be linked to HTA sites in one of three models:

- Cost-effective integrated model where NGO services are fully integrated with HTA services [8]. This model applies to low density areas and where funding for services is limited;
- NGO services operating in cooperation with and as a satellite of an HTA site where specialised Sex Worker services are not currently offered for Sex Workers in local Department of Health facilities; and
- Independent NGO programmes in areas where HTA programme services are not available yet.

Under the NSWP 2019-2022, SANAC will coordinate with responsible departments to develop an action plan to strengthen HTA services nationally and to expand clinical services delivered through the programme to include TB and STI services. The plan will include the allocation of conditional grant funding to HTA sites and the deployment of Sex Worker (and other key population) peer educators in provinces.

GOAL 8

Strengthen strategic information to drive progress towards achievement of NSP Goals

Strategic context

The NSP has noted a gap in the country's coordination of strategic information despite relatively sophisticated and robust data systems. This coordination gap was particularly evident in key populations. In reviewing the previous NSWP, evaluators noted multiple sources of data, misaligned indicator definitions, and lack of baseline measures against which targets could be set to evaluate progress objectively, as issues that complicated an assessment of progress and impact [82].

Target setting is fundamental to effective monitoring and evaluation. Targets concretely define what a successful national programme and/or projects should achieve within a specific timeframe. They should be set for both cross-cutting and intervention-specific indicators. Targets should be set at national level and for subnational areas. Modelling can help to identify how different target levels will affect the epidemic. Targets should reflect programme strategies that are tailored to the local epidemic and be based on what can realistically be achieved given available resources and any additional capacity and funding that may need to be mobilised [83].

The NSWP 2019-2022 recommends key strategic approaches to further coordination that will benefit both the sex work sector and other sectors, as they aim to achieve measurable progress towards the NSP goals. Based on the review of the previous NSWP, key improvements in coordinating Sex Worker strategic information include the following initiatives:

Monitoring and evaluation. The NSWP 2019-2022 uses an explicitly multi-sectoral approach to measure the social, structural, psychological, and economic dimensions of health and well-being. Under the NSP's aim for a 'whole of government', 'whole of society' approach, the activity plan for the NSWP 2019-2022 allocates responsibility to, for example, the Department of Social Development, Department of Higher Education and Training, SAPS, and the Department of Justice and Constitutional Development (DOJ&CD).

Surveillance and surveys. Among key populations sectors, the sex work sector is most advanced in terms of having routinised bio-behavioural surveillance (BBS) surveys and population size estimation methods. Evaluation of progress towards NSWP's goals would benefit from implementing sentinel surveillance at all implementation sites. This would lead to improved data quality for some key clinical proxy measures recommended in the NSWP 2016-2019 Review, for example, STI incidence at the site as a proxy for condom use, or counts of Sex Workers presenting for treatment of physical harms caused by gender-based violence as a proxy for violence against Sex Workers.

Research. Experience has shown that Sex Worker issues must be clearly articulated and prioritised if they are to attract attention and funding from government, private sector and general population. For example, there is currently very little data on male and transgender Sex Workers. Without research efforts specifically focused on these subgroups it is impossible to implement inclusive, peer-led programming that is truly data-informed. Additionally, both monitoring and evaluation data, as well as surveillance data, generate questions that may require research to answer.

Capacity building and coordination for improving sex work sector strategic information. Technical capacity for strategic information has involved

years-long partnerships with technical advisors from PEPFAR, academic and other global health stakeholder institutions. The short-term capacity support and technical assistance from international partners has resulted in rapid improvements in the volume and quality of Sex Worker strategic information. South Africa's strategic information should and can be generated by South Africa's institutions, and made immediately available to the South African public when it is needed.

Additionally, SANAC has made significant progress towards improved coordination of strategic information in a transparent, participatory process that explicitly seeks and disseminates 'bottom-up/ top-down' knowledge, learnings, and perspectives [84]. This process has aligned stakeholder review of Sex Worker strategic information with Department of Health, PEPFAR, and Global Fund, and the alignment of the NSWP with the NSP. This consensus-based decision making has the potential to inform streamlined monitoring and evaluation, surveillance activities; and an implementation research agenda for the sex work sector as well as other key population groups.

Strategic approach

To promote data integration with the HTA programme and other government departments, the following activities will be initiated to improve monitoring and evaluation:

- Microplanning or other evidence-based population size estimation methodology will be used at all HTA and NGO sites for accurate local population size estimations [4, 11, 42]. Peer educators must further be familiarised with microplanning and other best practices to expand their roles and expertise;
- Accurate population size estimates will also improve the targeting and retention of Sex Workers within a cohort, as well as further tailor interventions to specific needs. Accurate local population size estimations will support more exact target setting for 'Reach' and 90-90-90 indicators;
- Alignment of Sex Worker indicators with NSP indicators to monitor and evaluate Sex Worker services and reporting;
- Disaggregation of HTA indicators according to key population served at the sites and then in the DHIS;
- Reporting of validated deduplicated NGO programme data in the District Health Information System (DHIS) to avoid duplication of reporting and placing an additional reporting burden on implementing partners; and
- Additional human rights documentation, including data from the South African Police Services and Department of Justice on arrests, prosecutions of human rights violations and violent crimes committed against Sex Workers.

Surveillance data will be improved through annual SANAC stakeholder meetings to review population size estimations for programmatic target setting. Annually updated 90-90-90 cascades and progress data against NSWP 2019-2022 will assist with flagging underperforming areas and capacity gaps. Identified activities under monitoring and evaluation and surveillance will assist in the identification of research topics to inform the most effective and efficient way forward.

ANNEXES

1. Activities, implementation considerations and responsibilities

2. M&E framework – Core indicators

GOALS, OBJECTIVES AND ACTIVITIES

TABLE 4 Goal 1: Accelerate prevention to reduce new HIV and TB infections and STIs

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 1: Accelerate prevention to reduce new HIV and TB infections and STIs		
Objective 1.1: Reduce new HIV infections to less than 100 000 by 2022 through combination prevention interventions		
Sub-objective 1.1.1 Revitalise Information Education Communication (IEC) programmes in school, health, workplace and community settings	Develop and implement a communications campaign to sensitise the general population (and communities) to Sex Workers and create awareness of the effects of violence and human rights abuses	SANAC Secretariat DoH
	Develop tailored and evidence-informed healthcare and behaviour change information on HIV, STIs and TB, to reach all Sex Workers	DoH HTA programme Implementing partners DSD
	Engage Sex Workers in evidence-informed risk perception and reduction workshops and other small group interventions to promote individual health responsibility	DoH HTA programme Implementing partners
	Develop a condom distribution plan based on microplanning, risk assessments, site mapping and social marketing campaign	DoH HTA programme Implementing partners DoH
Sub-objective 1.1.2 Implement targeted biomedical prevention services tailored to setting and population	Peer educators to provide condoms, lubricants and demonstrations to all Sex Workers, and to clients in hotspots, in adequate quantities	DoH HTA programme Implementing partners
	Through outreach, peers to offer group risk reduction workshops and one-on-one health promotion events and campaigns	DoH HTA programme Implementing partners DOH
Sub-objective 1.1.3 Provide sensitive and age appropriate SRH and comprehensive sexuality education (CSE)	Distribute IEC on sexual and reproductive health, behaviour change and condom and lubricant use	DoH HTA programme Implementing partners DOH
	Ensure peer-led Sex Worker-friendly services delivered through: • Low cost model – integrated HTA and NGO sites • NGO services supporting HTA through a service level agreement or memorandum of understanding • Parallel HTA only or NGO only sites	DoH HTA programme Implementing partners SANAC Secretariat, Civil Society Forum and Plenary DoH

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 1: Accelerate prevention to reduce new HIV and TB infections and STIs		
Sub-objective 1.1.4 Provide pre-exposure prophylaxis (PrEP) to identified risk populations	PrEP roll out in all provinces for Sex Workers with the possibility of mail delivery of PrEP medication to sites. In addition to drugs, the package (de-identified) will include self-screening kits (for negatives), condoms, lube, IEC material, and possibly point-of-care STI screening kits	DoH Implementing partners
	Offer education and support for the promotion of PrEP and retention on PrEP including information on possible side effects	DoH HTA programme Implementing partners DoH
Sub-objective 1.1.5 Provide targeted services to prevent MTCT of HIV and syphilis in the prenatal and postnatal period	Provide referrals for pregnant Sex Workers to PMTCT services	Implementing partners DoH HTA programme DoH referral facilities
Objective 1.2: Reduce TB incidence by at least 30%, from 834/100 000 population in 2015 to less than 584/100 000 by 2022		
Sub-objective 1.2.1 Increase coverage of Preventive Therapy Uptake (PTU). This refers to promptly finding people who have been exposed to TB or who are at higher risk of TB (like people living with HIV), accurately excluding TB disease, assessing whether the exposed individual has been infected with TB, and providing optimal treatment of latent TB	Screen all Sex Workers for TB	DoH HTA programme Implementing partners
	Initiate HIV-positive Sex Workers on Isoniazid Preventative Therapy (IPT)	
	Follow-up on Sex Workers on IPT and ensure they take treatment for 12 months	DoH HTA programme Implementing partners
	Collect or refer for collection of sputum	
Sub-objective 1.2.2 Promote TB Infection control	Observe standard precautions in all Sex Worker sites	DoH HTA programme Implementing partners
	Enforce compliance to standard precautions in all Sex Worker sites	
	Reinforce messaging and IEC around TB	
Objective 1.3: Significantly reduce T. pallidum, gonorrhoea and chlamydia infection, to achieve the virtual elimination of congenital syphilis, and maintain high coverage of HPV vaccination		
Sub-objective 1.3.1 Scale up STI prevention by providing high-quality health information and timely health services for persons at risk	Screen all Sex Workers for symptomatic STIs. Screen Sex Workers for Hepatitis B and initiate vaccination for HBsAb	DoH HTA programme Implementing partners DoH

TABLE 5 Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all		
Objective 2.1: Implement the 90-90-90 Strategy for HIV		
Sub-objective 2.1.1 90% of all people living with HIV know their HIV status	Provide targeted HTS through outreach at Sex Worker sites and HTA facilities and introduce the Department of Health risk screening tool to ensure that Sex Workers are not over-tested	DoH HTA programme Implementing partners DoH
	Test 90% of reached HIV-negative Sex Workers for HIV	
	Link Sex Workers to care and treatment	
Sub-objective 2.1.2 90% of all people with diagnosed HIV infection receive sustained antiretroviral therapy	Initiate 90% of Sex Workers on ART on the same day or refer for ART on the same day (within 14 days)	DoH HTA programme Implementing partners DoH DSD
	Provide focused adherence counselling and follow up	
	Peer educators to track and trace Sex Workers lost to follow up	
Sub-objective 2.1.3 90% of all people receiving antiretroviral therapy are virally suppressed	Support Sex Workers to remain in care	DoH HTA programme Implementing partners DoH
	Strengthen client tracking across service providers, linking to care when Sex Workers default or move	
	Identify reasons why Sex Workers drop out of care and at which facilities	
	Work with peers to address reasons for discontinuation of treatment	
	Sensitisation training for facilities with high rates of discontinuation	
Objective 2.2: Implement the 90-90-90 Strategy for TB		
Sub-objective 2.2.1 Find 90% of all TB cases and place them on appropriate treatment	Screen all Sex Workers for TB.	DoH HTA programme Implementing partners DoH
	Collect sputum from clients potentially exposed to TB for testing or refer for testing	
	Ensure that all Sex Workers referred for suspected TB get assessed and put on treatment as needed	
Sub-objective 2.2.2 Find at least 90% of the TB cases in key populations (the most vulnerable including people living with HIV with low CD4 counts, under-served, at-risk populations) and place them on appropriate treatment	Trace the missing TB patients and place them on or refer them for appropriate treatment	DoH HTA programme Implementing partners DoH
	Ensure all Sex Workers with positive sputum tests are initiated on TB treatment: either at the programme site or at DoH facility	

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 2: Reduce morbidity and mortality by providing treatment, care and adherence support for all		
Sub-objective 2.2.3 Treat successfully at least 90% of those diagnosed with DS-TB (and 75% for those with DR-TB)	Use adherence clubs, psychosocial support groups and creative space workshops to promote adherence	DoH HTA programme Implementing partners DoH DSD
	Monitor and support Sex Workers diagnosed with TB, Multidrug-Resistant Tuberculosis (MDR-TB) and Extensively Drug-Resistant Tuberculosis (XDR-TB) to complete treatment	
Objective 2.3: Improve STI detection, diagnosis and treatment		
Sub-objective 2.3.1 Increase detection and treatment of asymptomatic STIs by 50%	Train peers on various types of STIs, symptoms and treatment and on DoH STI screening questionnaire	DoH HTA programme Implementing partners DoH
	Screen all Sex Workers for symptomatic STIs and treat/refer for treatment	
	Screen all Sex Workers for active Hepatitis B (ELISA test) once point of care tests are available from DoH. Offer Hepatitis B vaccination if it becomes available. If positive refer to primary healthcare site	Implementing partners DoH
Sub-objective 2.3.2 Increase the detection and treatment of STIs	Provide or refer for timely syndromic STI treatment for all Sex Workers with STI symptoms	DoH HTA programme Implementing partners DoH National Health Laboratory Service (NHLS)

TABLE 6 Goal 3: Reach all key and vulnerable populations with customised and targeted interventions

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 3: Reach all key and vulnerable populations with customised and targeted interventions		
Objective 3.1: Increase engagement, collaboration and advocacy of key and vulnerable populations in the development and implementation of social and health support activities		
Sub-objective 3.1.1 All national and provincial AIDS Councils will include at least one representative from a key and vulnerable population group	Nominate organisations to be included in provincial, district and local AIDS Councils: either a Sex Worker organisation, implementing organisation or a network group	Provincial, district and local AIDS Councils SANAC Secretariat Civil Society Forum NDoH External donors Resource Mobilisation Committee
	Allocate budget to support the sex work sector and provide mentorship	
Sub-objective 3.1.2 Support key and vulnerable population social capital by encouraging community networks that include advocacy agendas for equal health and human rights	Build financial, governance and administrative capabilities of sex work network groups	SANAC Secretariat Civil Society Forum External donors DSD DoH
	Provide fundraising and organisational capacity building support to sex work network groups	SANAC Secretariat Civil Society Forum External donors DSD DoH
	Advocate for Sex Workers to join sex work network groups	SANAC Sex Work Sector
	Share the NSWP with Sex Workers to build in-group affiliation of Sex Workers	DoH HTA programme Implementing partners
	Offer accredited courses for Sex Worker leaders in leadership and corporate management through implementing partners	DoH Implementing partners DHET External donors DSD
	Include sex work network groups in consultation on Sex Worker-related policies and research	Global Fund Country Coordinating Mechanism External donors Donor Coordination Committee SANAC Secretariat NDoH NDSD
	Sex work sector to lead advocacy strategy for Sex Worker rights and law reform with appropriate support through the helpline, legal defence centre	DOJ Sisonke SWEAT Asijiki Coalition SANAC Secretariat

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 3: Reach all key and vulnerable populations with customised and targeted interventions		
Sub-objective 3.1.3 All key and vulnerable population programmes should adopt a peer educator-led approach to implementation	Standardise Sex Worker programming to improve quality of psychosocial services using best practices identified: • All Sex Worker programmes to use the evidence-based peer education training modules • Use microplanning / EPOA / SNS methodology to improve trust relationships between Sex Workers and peers • Conduct training on group trauma release exercises to improve access to debriefing and counselling of Sex Workers and peer educators in the programme teams	DoH HTA programme Implementing partners Sex Worker sector
	Recruit and train peer educators (Sex Workers) on: • the role of peer educators • communication skills • health promotion • condom use • human rights • legal literacy • HIV, TB and STI screening/testing • basic lay counselling and trauma containment to enable improved response to immediate psychological distress/post rape etc	DoH HTA programme Implementing partners DoH
	Recruit and train peer educator coordinators in an appropriate ratio to manage peer educators	DoH HTA programme Implementing partners
	Prioritise employment and training of Sex Workers to fill vacant HTA positions	DoH HTA programme
	Provide screening tools for peers and innovative interactive education material (Cue Cards)	DoH HTA programme Implementing partners
Objective 3.2: To provide an enabling environment to increase access to health services by key and vulnerable populations		
Sub-objective 3.2.1 Enable increased access to health services through differentiated service delivery approaches that are tailored for the populations served	Provide peer-led access to Sex Worker-friendly services to all Sex Workers through HTA programme and Sex Worker specific NGO clinics	DoH HTA programme Implementing partners
	Develop and make a directory of Sex Worker-friendly referral services available at each site	DoH HTA programme Implementing partners
	Provide sensitisation training to all healthcare providers	DoH HTA programme Implementing partners DoH
	Increase funding and access to the 24-hour helpline for Sex Workers	SWEAT DoH External donors

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 3: Reach all key and vulnerable populations with customised and targeted interventions		
Sub-objective 3.2.2 Expand the provision of rehabilitation, comprehensive psychosocial support and mental health services for people living with and affected by HIV and TB	Engage with social workers, employed by Department of Social Development for referral and social services, identification documents, social grants, and child protection services as needed	DoH HTA programme Implementing partners DSD Dept of Home Affairs
	Train peer educators to provide psychosocial services, counselling and mental health screening	SANAC Secretariat DoH HTA programme Implementing partners
	Offer debriefing sessions for peer educators	DoH HTA programme Implementing partners
	Screen all Sex Workers for mental health issues with DoH PHC questionnaire	DoH HTA programme Implementing partners
	Screen all Sex Workers for harmful alcohol and drug misuse including injection of non-prescription drugs	DoH HTA programme Implementing partners
	Refer Sex Workers in need of alcohol and drug care and treatment to appropriate harm reduction facilities provided by the Departments of Social Development and Health	DoH HTA programme Implementing partners DSD NDoH
	Refer Sex Workers with a history of non-prescription injection drug use to counselling, support, Hepatitis B and C screening and treatment, and/or opioid substitution therapy programmes for persons who inject drugs	DoH HTA programme Implementing partners
	Support for foreign Sex Workers to access healthcare, official documentation, passports etc.	PWID programme Implementing partners DSD Dept of Home Affairs
Sub-objective 3.2.3 Further train and sensitise healthcare professionals in the identification and delivery of appropriate services for key and vulnerable populations	Sensitise all health workers in the provision of Sex Worker-friendly services through regional training centres	NDoH DHET HPCSA South African Nursing Council
	Incorporate sensitisation module in basic training of all health providers	
	Incorporate sensitisation module in continued professional development of all health providers	
Sub-objective 3.2.4 Integrate rights-based components in all health and social programmes to holistically serve key populations and vulnerable population clients and patients	Integrate 'Know Your Rights' standardised legal literacy training into all delivered peer educator materials	SANAC Secretariat DoH HTA programme Implementing partners
	Train peer educators as human rights defenders to monitor, respond to, and refer human rights violations for legal services in each sub-district	

TABLE 7 Goal 4: Address the social and structural drivers of HIV, TB and STIs and linking them to NDP goals

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 4: Address social and structural drivers of HIV, TB and STI infections and linking them to NDP goals		
Objective 4.1: Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion		
Sub-objective 4.1.1 Reduce risky behaviour through the implementation of programmes that build resilience of individuals, parents and families	Create safe spaces and support groups to assist Sex Workers	Implementing partners DSD DoH HTA Programme
	Offer trauma release exercises to support debriefing and individual counselling	
Sub-objective 4.1.3 Strengthen the capacity of families and communities	Offer parenting skills workshops to Sex Workers	Implementing partners DSD
	Screen for and refer families at risk	
	Consider support groups for mothers	
	Offer community empowerment activities that can mobilise Sex Workers to take agency and engage in issues impacting on them	
Objective 4.2: Increase access to and provision of services for all survivors of sexual and gender-based violence in the 27 priority districts by 2022		
Sub-objective 4.2.1 Increase access to provision of services for all survivors of sexual and gender-based violence	Establish local Crisis Response Teams to support Sex Workers after violent incidents. The multi-sectoral teams should include a combination of representatives from local Department of Health facilities, implementing partners, the police, Department of Social Development, local ward councillors, and religious groups [3, 63]	Implementing partners DSD DoH SAPS Religious groups Ward councillors
	Work through senior channels to ensure Law Enforcement Agencies at all levels do not violate the rights of Sex Workers	SANAC Secretariat SAPS Human Rights and Justice TTT NDoH
	Offer PEP after all accidental exposures to HIV at all sites (HTA sites, health facilities, NGO sites)	DOH HTA programme Implementing partners DoH
	Increase the number of crisis centres in HTA to at least 1 per district	
	Ensure access to emergency contraception, adoption and safe abortion services as options during unintended pregnancy	DoH HTA programme Implementing partners DoH DSD
Sub-objective 4.2.2 Provide support for survivors of sexual assault interventions	Provide psychosocial support and counselling for survivors of sexual assault and referral to Thuthuzela centres and Rape Crises Centres	DoH HTA programme Implementing partners DSD, SAPS and DoH Prosecuting Authority

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 4: Address social and structural drivers of HIV, TB and STI infections and linking them to NDP goals		
Objective 4.3: Scale-up access to social protection for people at risk of and those living with HIV and TB in priority districts		
Sub-objective 4.3.1 Ensure that all HIV and TB-infected persons who are eligible have access to social grants	Create referral network with DSD to support and refer Sex Workers eligible for social grants	DoH HTA programme Implementing partners DSD DoH
	Ensure all Sex Workers have access to counselling on HIV, TB, and other chronic illness treatment adherence, coping skills, trauma etc.	
Objective 4.4: Implement and scale-up a package of harm reduction interventions for harmful use of alcohol and drugs in all districts		
Sub-objective 4.4.1 Scale-up access and provision of in and outpatient rehabilitation services for all who use alcohol and drugs	Train peer educators on and provide screening tools for problematic alcohol and drug use	DoH HTA programme Implementing partners DoH DSD
	Refer Sex Workers with a history of injecting drugs to counselling, support, Hepatitis C screening and treatment, and/or opioid substitution treatment programmes	DoH HTA programme Implementing partners PWID programme Implementers DSD DoH
	Scale-up access and provision of in and outpatient rehabilitation services and support groups for all who use alcohol and drugs	DSD DoH Implementing partners
Objective 4.5: Implement economic strengthening programmes with a focus on youth in priority focus districts		
Sub-objective 4.5.1 Economically empower targeted groups of young people by increasing the availability of economic opportunities	Provide access to career counselling, internships and soft skills training	Implementing partners
	Create face-to-face and online training opportunities through linkage with DHET	SANAC Secretariat DHET
	Engage with DSD to train Sex Workers as auxiliary social workers	SANAC Secretariat DSD
	Build capacity of NGOs and Sex Worker movements working with Sex Workers on fundraising and development of income generating strategies for Sex Workers, with evidence-based exit models (SWEAT)	SANAC Secretariat Sex worker sector Civil Society Forum DSD
Objective 4.6: Address physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs		
Sub-objective 4.6.1 Improve ventilation and indoor air quality in congregate settings	Observe Standard Precautions for infection control in all facilities	DoH HTA programme Implementing partners

TABLE 8 Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches		
Objective 5.1: Reduce stigma and discrimination among people living with HIV or TB		
Sub-objective 5.1.1 Revitalise community based support groups to deal with internalised stigma	Reduce stigma and discrimination through a national campaign and community anti-stigma programmes in all districts	SANAC Secretariat UNAIDS NDoH Provincial AIDS Councils DSD
	Refer victims of violations for counselling or consultation with a social worker	DoH/Thuthuzela Care Centres HTA programme DSD Implementing partners
	Refer victims of violations to safe spaces or debriefing	Implementing partners
Sub-objective 5.1.2 Reduce stigma through community education	Introduce community anti-stigma interventions through the national human rights strategy	SANAC Secretariat DSD
Objective 5.2: Facilitate access to justice and redress for people living with and vulnerable to HIV and TB		
Sub-objective 5.2.1 Improve legal literacy about human rights and laws relevant to HIV and TB	Keep updated human rights violations register in all sites	Implementing partners Government departments
	Train peer educators as human rights defenders	AFSA (GF) Implementing partners DSD
	Appoint at least 1 human rights defender per sub-district	NACOSA (GF) DoH Provincial AIDS Councils
	Educate Sex Workers on municipal bylaws and their responsibilities	Sisonke
	Coordinate the implementation of HIV and HIV/TB-related legal services to promote and extend legal support services in South Africa	AIDS Councils with AFSA
	Inform Sex Workers about their rights to reduce self-stigmatisation through outreach, safe spaces, support groups, SWEAT booklet on rights	DoH HTA programme Implementing partners
Sub-objective 5.2.2 Make HIV and TB-related legal services available and accessible	Facilitate access to justice and redress after incidents of violence	Sisonke and SWEAT DOJ SANAC Secretariat
	Create strategic partnerships for redress, representation and litigation	SANAC Secretariat Sex Worker sector
	Refer cases of violence to Sisonke / SWEAT	Implementing partners DoH DSD

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches		
Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination		
Sub-objective 5.3.1 Implement a Human Rights Accountability Scorecard	Include Sex Worker rights in Human Rights Accountability Scorecard	SANAC Secretariat
	Include Sex Worker organisations in expanded community-based monitoring system?	SANAC Secretariat
	Create a web-based platform for monitoring human rights violations in the country	SANAC Secretariat with AFSA
Sub-objective 5.3.2 Monitor implementation of laws, regulations and policies relating to HIV and TB and identify areas for reform	Develop a national advocacy strategy to address law reform and violence against Sex Workers (plan should be localised and sit at the provincial level)	SANAC Secretariat
Sub-objective 5.3.3 Sensitise law-makers and law enforcement agents	Implement the Dignity, Diversity and Policing project to sensitise law-makers and law-enforcement agents through in-service training using a piloted training manual	SAPS with COC
	Work with the SAPS to improve communication with all their staff and volunteers in order to sensitise them	SANAC Secretariat with SAPS
Objective 5.3: Promote an environment that enables and protects human and legal rights and prevents stigma and discrimination		
Sub-objective 5.3.4 Train healthcare providers on human rights and medical ethics related to HIV	Implement the sensitisation Tool Kit for healthcare workers through Department of Health regional training centres	NDoH DHET HPCSA South African Nursing Council
	Include sensitisation training as part of basic training	
	Include modular sensitisation training as part of continued professional development	
FRAMEWORK FOR DECRIMINALISATION, STIGMA REDUCTION AND DECREASED VIOLENCE AGAINST SEX WORKERS [7, 16, 23, 29, 75–79]		
Political pressure for decriminalisation	Increase pressure in parliament for the decriminalisation of sex work with specific focus on: • Department of Justice and Constitutional Development supporting decriminalisation • Police developing a national policing of sex work framework and issuing a national instruction on unlawful arrest, harassment of Sex Workers, and rights-based policing • National Prosecuting Authority releasing case statistics • Department of Home Affairs issuing official documentation to migrants for the protection against sexual violence	SANAC Secretariat SANAC sex work sector DOJ SAPS NPA Dept of Home Affairs

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 5: Ground the response to HIV, TB and STIs in human rights principles and approaches		
Awareness creation through human rights campaigns	Launch a national human rights campaign to reduce stigma and gender-based violence against Sex Workers in the general population and in communities using public health and human rights evidence that: • raise awareness about human rights violations of Sex Workers; • raise awareness on harmful gender norms; • provide information on access to legal support for survivors of violence; • create access to post violence support; and • establish multisectoral crises response teams in each sub-district.	SANAC Secretariat
Sensitisation	• Sensitise law makers, law enforcement officers, healthcare workers and other govt service providers, including Dignity, Diversity and Policing training for all law enforcement officials	SAPS DoH
Educating and holding perpetrators of violence accountable	• Support Sex Workers to report all human rights violations • Provide access to legal support for survivors of violence • Protect the identity and safety of complainants • Uphold the rights of victims of crime and violence	SANAC Secretariat Implementing partners HTA programme AIDS Councils
Social capital building to empower Sex Workers	Support Sex Workers to advocate for decriminalisation and provide meaningful platforms for participation: • train sex work sector leaders to advocate for decriminalisation; • educate Sex Workers on how to reduce risk of violence, and assert their human rights; • build the capacity of Sex Worker representation organisation (governance, fundraising, administration, etc); • secure Sex Worker representation in AIDS Councils at national, provincial, district and local levels; and • work with sympathetic human rights organisations to support Sex Worker-led advocacy.	SANAC Secretariat Implementing partners HTA programme AIDS Councils Advocacy organisations: SWEAT, Sisonke, Asijiki coalition
Documenting violation of human rights of Sex Workers for policy change	Combine multisectoral data on human rights violations against Sex Workers: • Programmatic data from implementing organisations • National web based platform for reporting of cases • Data from national 24-hour helpline • Case statistics from National Prosecuting Authority • Data on arrests of Sex Workers and types of offences • Data from Thuthuzela centres • Reports from Crises Response Teams	SANAC Secretariat and AIDS Councils International Development Partners SWEAT NPA SAPS DSD DoH

TABLE 9 Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 6: Promote leadership and shared accountability for a sustainable response to HIV, TB and STIs		
Objective 6.1: Strengthen AIDS Councils to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP		
Sub-objective 6.1.1 Formally establish the structures of AIDS Councils at national, provincial, district and local levels	Formally task the structures of AIDS Councils at national, provincial, district and local levels to support HTA sites and Sex Worker programme implementers and advocate for their sustainability	SANAC Secretariat Provincial AIDS Councils
Sub-objective 6.1.2 Ensure representation of all stakeholders in decision-making structures at all levels	Hold AIDS Councils responsible for inclusion of sex work sector in decision-making structures at all levels of AIDS Councils	SANAC Secretariat
	Ensure representation of all relevant Sex Worker stakeholders in AIDS Councils at all levels, such as DSD, SAPS, DHET, Sisonke	SANAC Secretariat Provincial AIDS Councils
Sub-objective 6.1.3 Ensure a central role for Civil Society and community groups	Engage the SAPS to develop a standard operating practice to stop unnecessary arrests, harassment of Sex Workers for possession of condoms	SANAC Secretariat Law enforcement agencies
	Engage with the Positive Policing Partnership to improve policing practices that reduce harm	
Sub-objective 6.1.4 Monitor annually the implementation of the accountability framework through an Accountability Scorecard	Fund and hold regular meetings with the SANAC sex work sector	SANAC Secretariat DoH DSD International Development Partners
Objective 6.2: Improve collaboration and co-operation between government, civil society, development partners and the private sector		
Sub-objective 6.2.1 Ensure that plans of government and the non-government sector are aligned with the NSP	Align the Sex Worker programmes of all stakeholders with the NSWP 2019-2022	SANAC International Development Partners DoH DSD Law enforcement agencies
	Strengthen collaboration between Sex Worker sites, HTA and DSD	SANAC Secretariat Provincial AIDS Councils
	Strengthen links with DSD at all levels to support peer educators in the fulfilment of their roles, access to social grants, child protection	SANAC Secretariat Provincial AIDS Councils
	Support undocumented Sex Workers to obtain official documentation	Implementing partners Home Affairs SANAC
Sub-objective 6.2.2 Strengthen collaboration between and co-ordination of government departments	Ensure that teams leading HTA are multisectoral consisting of representatives from the key population groups as well as other South African Government Departments	SANAC, DSD, DHET, SAPS

TABLE 10 Goal 7: Mobilise resources and maximise efficiencies to support the achievement of NSP Goals and ensure a sustainable response

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 7: Mobilise resources and maximise efficiencies to support the achievement of NSP Goals and ensure a sustainable response		
Objective 7.1: Improve efficiency and mobilise sufficient resources to achieve the goals, objective and targets of the NSP		
Sub-Objective 7.1.1 Maximise the funds available for implementation of the NSP and the impact of these funds	Develop a plan for integration of NGO services for Sex Workers into the HTA programme	SANAC structures DoH International Development Partners
	Ensure that Conditional Grant allocations for Sex Worker programmes are allocated according to the NSWP activities in provincial implementation plans (PIPs)	SANAC Secretariat Provincial AIDS Councils
FRAMEWORK FOR SUSTAINABILITY OF SEX WORK SERVICES		
Establish a national working group on sustainability, accountable to SANAC Programme Review Committee (PRC)	Establish national sustainability working group in year 1 to: • Develop a framework for social contracting that defines roles and responsibilities of all players in current and future implementation of Sex Worker programmes; • Facilitate a more structured engagement with civil society on sustainability; and • Create a compendium of best practices and a list of experts who can support NGOs and government on how to formulate effective social contracts.	SANAC Secretariat
Establish provincial working groups on sustainability in all provinces where Sex Worker programmes are being implemented by external donors	Establish provincial sustainability working groups in year 1 to: • Identify the exact contribution of the external donor funded Sex Worker programme to Multi-Sectoral District Implementation Plans (MDIPs) and Provincial Implementation Plans (PIPs). • Prioritise various steps towards sustainability for each programme	PCAs
Clarify the roles and responsibilities of NGOs and government as it relates to Sex Worker programme implementation	Establish a sub group of the national sustainability group to focus on social contracting: • Convene a national meeting in the context of HIV and TB responses and the new Community Health Worker policy indicating when government should implement and when government should continue to contract with NGOs and their peer educators, to achieve maximum impact and cost-effectiveness • Agree on a structure/forum where engagement of all key population stakeholders can take place	National Sustainability Working Group
Develop implementation plans for the NSWP	• Develop guidelines on linkages between Sex Worker community programmes and health facilities • Each Provincial Sustainability Working Group to track implementation of these guidelines • Develop an implementation plan for the NSWP 2019-2022 • Cost implementation plan and identify funding gap for full implementation • Develop M&E plans for the implementation plans and track and report quarterly	National and Provincial Sustainability Working Groups SANAC Secretariat

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 7: Mobilise resources and maximise efficiencies to support the achievement of NSP Goals and ensure a sustainable response		
Link external donor funded Sex Worker programmes to existing health facilities	• Ensure all Sex Worker sites/programmes are formally linked to large health facilities and ensure that reporting takes place through the facility • Receive Sex Worker programme commodities from linked health facilities • Identify one or two staff from health facility and engage them on an ongoing basis including mentorship on Sex Worker issues	SANAC Secretariat Provincial AIDS Councils NDoH HTA programme Implementing partners
Increase scope of the package of services for Sex Workers reached through the Department of Health's HTA program	• Focus on how best to move from HTA strategy to include peer led customised targeted service for all key populations • Conduct evaluation of HTA programmes and identify opportunities for improvement • Reach consensus on inclusion of a core package of services for Sex Workers in the HTA programme with plans to roll out • Amend reporting on HTA programme to allow disaggregation by key population serviced	Subgroup of the National Sustainability Working Group
Identify political leadership to support progressive Sex Worker policy implementation	• Identify political champions for Sex Workers (Mayors, Members of Executive Committees, Premiers and Ministers etc.) and have this endorsed through SANAC structures • Deputy President to drive champions for Sex Workers to report at Inter-Ministerial Committee on their contribution	National and each Provincial Sustainability Working Groups
Capacitate PCA leaders to advocate for Sex Worker issues in AIDS Council meetings and decision making structures	• Develop a capacity building plan for the Sustainability Working Group members at national and provincial level on Sex Worker issues and programmes • Train chairs, co-chairs and heads of secretariats from PCAs on Sex Worker issues to enable a safe space for meaningful participation of all Sex Worker groups in a safe environment	SANAC Secretariat
Mobilise additional resources for key population programmes	• Develop a resource strategy (including implementation efficiencies and innovative funding mechanisms) to fund the full implementation of key population programmes using government funding • Conduct a rapid assessment of resource mobilisation strategies for key populations in other regions • Map out existing and potential funding sources for Sex Worker programmes through government – including for HTA programme and DSD HIV grant • Develop a resource mobilisation strategy for key population programmes in South Africa (including private sector, corporate social investment (CSI) initiatives and international philanthropists) • Pilot innovative financing initiative for key population programmes – social impact bond (SIB) or co-financing model	National and Provincial Sustainability Working Groups
Support reallocation of funds within existing government budgets	• Advocate for national, provincial, and municipal Department of Health to include line items for key population health service (PrEP, viral hepatitis screening and vaccination and treatment, needle and syringe programmes, opioid substitution therapy) • Advocate for Department of Social Development to allocate a component of the HIV grant to key population programmes as per the targets in the implementation plans	National and Provincial Sustainability Working Groups

TABLE 11 Goal 8 Strengthen strategic information to drive progress towards achievement of NSP Goals

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 8: Strengthen strategic information to drive progress towards achievement of NSP Goals		
Objective 8.1: Optimise routinely collected strategic health information for data utilisation in decision making		
Sub-Objective 8.1.1 Link clinical, laboratory and pharmacy data	Support all NGO sites to sign service level agreements / memoranda of understanding with Department of Health for laboratory services and commodities	SANAC DoH Principal recipients (coordinating SRs) DSD
	Accredit NGO sites as full sites instead of satellite under Department of Health facilities to disaggregate Sex Worker data	
Sub-Objective 8.1.2 Increase data utilisation	Use programme data for decision making	SANAC Secretariat Provincial AIDS Councils
Objective 8.2: Rigorously monitor and evaluate implementation and outcomes of the NSP		
Sub-Objective 8.2.1 Strengthen and promote multi-sectoral ownership and accountability of the NSP and PIP M&E systems	SANAC to coordinate the collection and presentation of Sex Worker data to both International Development Partners and various government stakeholders	SANAC
Sub-Objective 8.2.2 Strengthen M&E capacity to effectively use available data to monitor NSP and PIP performance and HIV, TB and STI at all levels	Use the peer education strategy, including microplanning to map all hotspots within HTAs and NGO operating areas	DoH HTA programme Implementing partners
	Establish accurate population size estimations for HTAs and NGO operating areas	DoH HTA programme Implementing partners
	Set disaggregated targets for individual hotspots against local population size estimations	DoH HTA programme Implementing partners
Sub-Objective 8.2.3 Ensure harmonised, timely and comprehensive routine systems to provide quality health data at national, provincial and district levels and across sectors	Report validated deduplicated data (integrate IP data into DHIS) and institutionalise routine M&E supervision and data quality audits	DoH HTA programme Implementing partners
Sub-Objective 8.2.4 Disseminate timely, relevant HIV, TB and STI information to the public	Develop a strong dissemination plan for the NSWP 2019-2022	SANAC Secretariat Sex Worker sector NAC
Objective 8.3: Further develop the national surveillance system to generate periodic estimates of HIV, TB and STI in the general population and in key and vulnerable populations		
Sub-Objective 8.3.1 Institutionalise HIV, TB and STI surveillance within the Department of Health	Convene government and civil society stakeholders at least annually for technical review and updating of population size estimates for national, provincial and district target setting	SANAC Secretariat NDoH Researchers Implementing partners Sex Worker sector
	Monitor national progress on 90-90-90 cascade, behavioural, social and structural factors that increase risk of HIV and STI acquisition and transmission	SANAC Secretariat

RELEVANT NSP OBJECTIVE	NSWP ACTIVITIES	ACCOUNTABLE PARTIES
Goal 8: Strengthen strategic information to drive progress towards achievement of NSP Goals		
Sub-Objective 8.3.2 Conduct routine HIV, TB and STI surveillance activities	Repeat Sex Worker Biological and Behavioural Survey (BBS) every 3 years	SANAC Secretariat NDoH International Development Partners Researchers Sex Worker sector
Sub-Objective 8.3.3 Conduct routine HIV, TB and STI surveillance activities among key and vulnerable populations	Identify technical and other human resource capacity gaps in government, non-governmental civil society and advocacy organisations and secure appropriate technical assistance and capacity building support to indigenise strategic information collection and use by 2022	SANAC Secretariat International Development Partners
Objective 8.4: Strengthen strategic research activities to create validated evidence for innovation, improved efficiency and enhanced impact		
Sub-Objective 8.4.1 Develop a coordinated research agenda for the NSP	Develop a coordinated research agenda for the NSWP 2019-2022	HIV Think Tank TB Think Tank SANAC SITTT
	Develop research partnerships with institutions of higher learning	
More research to inform decisions for sustainability and scale up	• Ensure size estimations and programme mapping is done and reviewed regularly to inform programming focus, and conduct evaluation of existing programmes	Sub group of National and Provincial Sustainability Working Groups
	• Conduct external programme evaluations of all donor-funded Sex Worker programmes to build the case for sustainable financing of Sex Worker programmes	
	• Perform continual district-based size estimations to inform programme targeting and implementation	Implementing partners

M&E FRAMEWORK

Note: The NSWP 2019-2022 acknowledges the importance of the HTA programme in terms of the sustainability of the implementation of all Sex Worker programmes responding to the epidemic. However, the HTA programme is not cited as a data source in the M&E framework considering that key populations data is included in general populations data, in the DHIS. There is ongoing advocacy for the disaggregation of data according to key populations, under the HTA programme. The sources for the disaggregated key populations data are donor-funded programmes.

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIs								
Objective 1.1 Reduce new HIV infections to less than 100,000 by 2022 through combination prevention interventions								
Number of new HIV infections	Impact	Modelled *for Sex Workers use incidence	Geographic area Type of Sex Worker Age (15 – 24, 25 – 49 years)	Thembisa model			Annual Every 3 years	UCT SANAC
Number of people tested for HIV	Output	Numerator: Number of Sex Workers tested for HIV Denominator: N/A	Geographic area, Sex, Age (15+)	Programme data HTA programme	37 855		Annual	DoH IDPs
Number of male condoms distributed	Output	Numerator: Number of male condoms distributed to Sex Workers Denominator: N/A	Geographic area, Sex, Age (15+)	HTA programme Programme data			Annual	DoH IDPs
Number of female condoms distributed	Output	Numerator: Number female condoms distributed to Sex Workers Denominator: N/A	Geographic area, Sex, Age (15+)	HTA programme Programme data			Annual	DoH IDPs
Number of AGYW, FSW, MSM, IDU receiving oral PrEP for the first time during the reporting period	Output	Numerator: Number of Sex Workers newly enrolled on PrEP during the period Denominator: N/A	Total, Sex, Age, AGYW, FSW, MSM, IDU	NDoH PrEP M&E report	6 205		Annual	DoH
Number of individuals who received an HIV service or referral at HTA sites	Output	Numerator: Number of Sex Workers who received an HIV service or referral at HTA sites	Geographic area Type of Sex Worker Sex, Age (15+)	HTA programme			Annual	DoH

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 1: ACCELERATE PREVENTION TO REDUCE NEW HIV AND TB INFECTIONS AND STIs								
Individuals from key populations reached with individual/ small group HIV prevention and behaviour change interventions	Output				12 090		Annual	
Percentage of Sex Workers who are still on PrEP after 1, 3 and 6 months	Output	Numerator: Number of Sex Workers on PrEP after 1, 3 and 6 months Denominator: Number of Sex Workers enrolled on PrEP 1, 3 and 6 months before	Geographic area Type of Sex Worker Age	NDOH PrEP M&E report Programme data			Annual	DoH IDPs
Percentage of Sex Workers reached with a defined, comprehensive package of HIV prevention services	Output	Numerator: Number of Sex Workers reached Denominator: Total number targeted	Geographic area Type of Sex Worker Age	HTA programme Programme data	170 346		Annual	DoH IDPs
Percentage of Sex Workers who have access to a defined (annual PAP smear, pregnancy test, PAP smear, abortion, modern contraception) package of SRH services	Output	Numerator: Number of Sex Workers who have access to a defined package of SRH services Denominator: Total number of Sex Workers	Geographic area Type of Sex Worker Age	Programme data			Annual	DPs
Objective 1.2: Reduce TB incidence by at least 30%, from 834/100,000 population in 2015 to less than 584/100,000 by 2022								
Percentage Sex Workers screened for TB symptoms	Output	Numerator: Number of Sex Workers screened for TB symptoms Denominator: Total number seen	Geographic area Age Drug resistance	HTA programme Programme data	60 496		Annual	DoH IDPs
Objective 1.3: Significantly reduce T Pallidum, gonorrhoea, and chlamydia infection, to achieve the virtual elimination of congenital syphilis, and maintain high coverage of Human Papillomavirus (HPV) vaccination								
Percentage of Sex Workers screened for symptomatic STIs	Output	Numerator: Number of Sex Workers screened for symptomatic STIs Denominator: Total number screened	Geographic area Type of Sex Worker	Programme data	59 590		Annual	DoH IDPs
Percentage of Sex Workers tested for asymptomatic STIs		Numerator: Number of Sex Workers tested for asymptomatic STIs Denominator: Total number tested	Geographic area Type of Sex Worker	Programme data			Annual	DoH IDPs

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL								
Objective 2.1: Implement the 90-90-90 Strategy for HIV								
Percentage of people living with HIV who know their HIV status	Outcome	Percentage of Sex Workers living with HIV who know their HIV status Modelled	Geographic area Age Type of Sex Worker	Thembisa model BBS Programme data	Jhb: 81% CT: 69% eThek: 86%	90%	Annual Every 3 years	UCT SANAC IDPs
Number of adults and children living with HIV on ART (TROA)	Outcome	Numerator: Total number of Sex Workers remaining on ART Denominator: Total number HIV+ Sex Workers	Geographic area Age Type of Sex Worker Institution	BBS Programme data	Jhb:60% CT:28% eThek: 51%	90%	Annual Every 3 years	DoH UCT SANAC IDPs
Percentage of adults and children living with HIV known to be on ART 12 months after starting (Retention)	Outcome	Numerator: Number of Sex Workers who are still alive and receiving ARVs 12 months after initiating treatment Denominator: Total number of Sex Workers initiating ART	Geographic area Age Type of Sex Worker	Programme data			Annual	DOH UCT SANAC IDPs
People living with HIV viral load suppressed rate (VLS) at 12 months	Outcome	Numerator: Sex Workers living with HIV viral load under 1000 copies/mL Denominator: Total number of Sex Workers living with HIV	Geographic area Age Type of Sex Worker	BBS Programme data	Jhb: 52% CT: 21% eThek: 43%	90%	Annual Every 3 years	DoH UCT SANAC IDPs
Objective 2.2: Implement the 90-90-90 Strategy for TB								
Percentage of all people/clients started on TB treatment	Outcome	Numerator: Number of Sex Workers treated for STIs	Geographic area Type of Sex Worker	HTA programme Programme data			Annual	DoH IDPs

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 2: REDUCE MORBIDITY AND MORTALITY BY PROVIDING TREATMENT, CARE AND ADHERENCE SUPPORT FOR ALL								
TB treatment success rate	Outcome	Numerator: Number Sex Workers cured from TB and completed treatment Denominator: Total number of Sex Workers with TB initiated on treatment	Geographic area Type of Sex Worker Drug sensitive drug resistant TB	HTA programme Programme data			Annual	DoH IDPs
TB clients lost to follow-up rate	Outcome	Numerator: TB patients who are Sex Workers lost to follow-up Denominator: TB patients who are Sex Workers started on treatment	Geographic area Drug resistant TB				Annual	DoH IDPs
Proportion of TB/ HIV co-infected patients on ART	Outcome	Numerator: Number of registered co-infected Sex Workers on ART Denominator: Number of registered HIV / TB co-infected Sex Workers	Geographic area Type of Sex Worker				Annual	DoH IDPs
Objective 2.3: Improve STI detection, diagnosis and treatment								
Increase the detection and treatment of STIs	Outcome	Numerator: Number of Sex Workers treated for STIs	Geographic area Type of Sex Worker	Programme data			Annual	DoH IDPs

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS								
Number of key population surveillance activities conducted	Output	Numerator: Number of Sex Worker surveillance activities conducted Denominator: N/A	Type of Sex Worker	BBS	1	1	Every 3 years	SANAC
HIV prevalence among specific key and vulnerable populations	Impact	Numerator: Number of Sex Workers who test positive for HIV Denominator: Total number of Sex Workers tested for HIV	Geographic area Type of Sex Worker Age	Thembisa model BBS	Jhb: 60% CT: 37% eThek: 75%		Annual Every 3 years	UCT SANAC
Percentage of specific key populations who correctly identify risks of HIV, STI and TB transmission and how to prevent them and reject major misconceptions about HIV	Outcome	Numerator: Number of Sex Workers who gave the correct answer to all five questions Denominator: Total number of all respondents	Geographic area Type of Sex Worker Age	BBS			Every 3 years	SANAC
Percentage of specific key and vulnerable populations reporting using a condom	Outcome	Numerator: Number Sex Workers who reported using a condom with a client at last sex Denominator: Total number of respondents	Geographic area	BBS	Jhb: 81% CT: 88% eThek: 89.5%	90%	Every 3 years	SANAC
Percentage of Sex Workers who reported using a condom with a non-paying partner at last sex	Outcome	Numerator: Number of Sex Workers who reported using a condom with a non-paying partner at last sex Denominator: Total number of respondents	Geographic area	BBS			Every 3 years	SANAC IDPs

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS								
Percentage of specific key and vulnerable populations with access to core package of HIV, TB and STI services	Output	Numerator: Number of Sex Workers reached with a core package of HIV, TB and STI services Denominator: Total number of respondents	Geographic area	BBS		100%	Every 3 years	DoH SANAC
Percentage of people who inject drugs receiving opioid substitution therapy (OST)	Output	Numerator: Number of Sex Workers who inject drugs and are on OST at a specified date Denominator: Total number of opioid-dependent people who inject drugs	PWID High burden Areas	BBS Programme data			Every 3 years	SANAC IDPs
Percentage of specific key populations who ever experienced human rights violations	Outcome	Numerator: Number of Sex Workers who experienced human rights violations Denominator: Total number of respondents	MSM, SW, Transgender, PWID	BBS Programme data			Every 3 years	SANAC IDPs
Percentage of Sex Workers who experienced verbal abuse from a client / non-commercial partners / public in the past 12 months	Outcome	Numerator: Number of Sex Workers who experienced verbal abuse from a client/ non-commercial partners/ public in the current year Denominator: Total number of respondents	Geographic area Type of perpetrator	BBS	Jhb: 62.8% CT: 67.6% eThek: 86.3%	50% reduction	Every 3 years	SANAC IDPs

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 3: REACH ALL KEY AND VULNERABLE POPULATIONS WITH CUSTOMISED AND TARGETED INTERVENTIONS								
Percentage of Sex Workers who experienced physical violence from a client/ non-commercial partners/ public in the past 12 months	Outcome	Numerator: Number of Sex Workers who experienced physical violence from a client/ non-commercial partners, public in the current year Denominator: Total number of respondents	Geographic area Type of perpetrator	BBS	Jhb: 25% CT: 29% eThek: 40%	50% reduction	Every 3 years	SANAC IDPs
Percentage of Sex Workers who experienced sexual violence from a client/ non-commercial partners/ public in the past 12 months	Outcome	Numerator: Number of Sex Workers who experienced sexual violence from a client/ non-commercial partners/ public in the current year Denominator: Total number of respondents	Geographic area Type of perpetrator	BBS	Jhb: 16% CT: 15% eThek: 35%	50% reduction	Every 3 years	SANAC IDPs
Number of Sex Workers who had condoms confiscated as evidence by police officers		Numerator: Number of Sex Workers who reported they had condoms confiscated as evidence by police officers Denominator: N/A	Geographic area	BBS	Jhb: 9.9% CT: 30.1% eThek: 43.5%	50% reduction	Every 3 years	
Number of trained Sex Worker peer educators employed	Output	Numerator: Number of Sex Worker peer educators employed Denominator: N/A	Geographic area Type Sex Worker	HTA programme Programme data	329	500 500	Annual	DoH IDPs

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 4: ADDRESS SOCIAL AND STRUCTURAL DRIVERS OF HIV, TB AND STIs, AND LINK THESE EFFORTS TO THE NDP								
Objective 4.1: Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion								
Proportion of Sex Workers who received post-violence care	Outcome	Numerator: Number of Sex Workers reporting rape incidents who received post-violence care Denominator: Total number rape cases reported by Sex Workers	Geographic area Type of Sex Worker Type of violence	Programme data BBS		100%	Annual	SANAC IDPs
Objective 4.3: Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts								
Number of beneficiaries receiving social grants	Output	Numerator: Number of Sex Workers receiving social grants Denominator: N/A	Geographic area Type of Sex Worker Type of Grant	Programme data			Annual	DSD IDPs
Objective 4.4: Implement and scale-up a package of harm reduction interventions for alcohol and substance use in all districts								
Number of people reached through substance abuse prevention programmes	Output	Numerator: Number of Sex Workers reached through substance abuse prevention programmes Denominator: N/A	Age: Sex Workers below 18 years Above 18 years	Programme data			Annual	DSD IDPs
Number of Sex Workers screened, diagnosed and referred for mental health services	Output	Numerator: Number of Sex Workers screened, diagnosed and referred for mental health services Denominator: N/A	Geographic area Type of Sex Worker	Programme data			Annual	
Number of Sex Workers reached with mental health services	Output	Numerator: Number of Sex Workers screened Denominator: N/A	Geographic area Type of Sex Worker	Programme data			Annual	
Number of Sex Workers referred to care and treatment programmes for alcohol and substance misuse	Output	Numerator: Number of Sex Workers referred to care and treatment programmes for alcohol and substance misuse	Geographic area Type of Sex Worker	Programme data			Annual	DSD IDPs

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 5: GROUND THE RESPONSE TO HIV,TB, AND STIs IN HUMAN RIGHTS PRINCIPLES AND APPROACHES								
Objective 5.1: Reduce stigma and discrimination among people living with HIV or TB by half by 2022								
Percentage of people living with HIV who report stigma and discrimination	Outcome	Numerator: Number of people living with HIV who report external or internalised stigma Denominator: Total number of respondents	Geographic area Type of Sex Worker Type of stigma	Stigma index			Every 2 years	SANAC
Number of Sex Workers reporting human rights violation cases	Output	Numerator: Number of Sex Workers reporting human rights violation cases Denominator: N/A	Geographic area Type of Sex Worker Type of violation	Stigma index Programme data BBS			Every 2 years	SANAC IDPs
Number of human rights violations reported to Sisonke	Output	Numerator: Number of human rights violations referred to Sisonke Denominator: N/A	Geographic area Type of Sex Worker	Programme data			Annual	Sisonke
Number of police officers trained on Dignity and Diversity in Policing programme	Output	Numerator: Number of police officers trained Denominator: N/A	Geographic area	SAPS data			Annual	SAPS

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 6: PROMOTE LEADERSHIP AND SHARED ACCOUNTABILITY FOR A SUSTAINABLE RESPONSE TO HIV, TB AND STIs								
Objective 6.1: Strengthen AIDS Councils to provide effective co-ordination and leadership of all stakeholders for shared accountability in the implementation of the NSP								
Number of PCA Secretariats that are allocated sufficient funds to coordinate the PIP	Output	Numerator: Number of PCA Secretariats that are allocated sufficient funds to support the HTA programme Denominator: Total number of PCA Secretariats	Provincial AIDS Councils	SANAC Report		9	Annual	PCA
Percentage of AIDS Councils with Sex Worker representative	Output	Numerator: Number of AIDS Councils (PCAs/ DACs) with Sex Worker representative Denominator: Number of PCAs/ DACs	Province District Municipality	SANAC report Programme data		100%	Annual	SANAC IDPs
Objective 6.2: Improve collaboration and co-operation between government, civil society, development partners and private sector sectors								

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 7: MOBILISE RESOURCES AND MAXIMISE EFFECENCIES TO SUPPORT THE ACHIEVEMENT OF NSP GOALS AND ENSURE A SUSTAINABLE RESPONSE								
Total expenditure on HIV, TB and STIs	Outcome	Numerator: Total expenditure on HIV, TB and STIs for key populations (HTA conditional grant + International Development Partners spent) Denominator: Total expenditure on HIV, TB and STIs (national)	Funding source: Disease Programmatic area	Expenditure Review			Annual	DoH SANAC IDPs
Percentage of budget from sources other than government	Outcome	Numerator: Total budget from all sources other than government Denominator: Total budget on HIV, TB and STIs	Funding/ Budget Sources	DoH International Development Partners			Annual	DoH SANAC IDPs

INDICATOR	TYPE	CALCULATION	DISAGGREGATION	DATA SOURCE	BASELINE VALUE	TARGET 2021/22	REPORTING FREQUENCY	RESPONSIBILITY
GOAL 8: STRENGTHEN STRATEGIC INFORMATION TO DRIVE PROGRESS TOWARDS ACHIEVEMENT OF NSP GOALS								
Objective 8.2: Rigorously monitor and evaluate implementation and outcomes								
Number of NSP mid-term and summative evaluations conducted	Output	Numerator: Number of NSWP mid-term and summative evaluations Denominator: N/A	National Province	NSP Reports		1	Mid and End term	SANAC Secretariat
Number of provinces and districts with Annual HIV, TB and STI profiles/ implementation plans/quarterly reports/annual	Output	Numerator: Number of HTAs mapped through microplanning Denominator: N/A	Province District	Profiles		9 52	Annual	SANAC Secretariat

BIBLIOGRAPHY

1. UNAIDS (2015). **Terminology Guidelines**. Available from: http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdfdition.pdf.
2. World Health Organization (2017). **A Guide to Identifying and Documenting Best Practices in Family Planning Programmes**. Geneva: WHO. Available from: http://apps.who.int/iris/bitstream/10665/254748/1/9789290233534-eng.pdf?ua=1.
3. Slabbert M (2018). **Crises Response Teams: Field-Tested Best Practice for Violence Against Sex Workers**.
4. FHI 360 (2017). **Linkages Enhanced Peer Outreach Approach (EPOA)**. North Carolina. Available from: https://www.fhi360.org/sites/default/files/media/documents/resource-linkages-enhanced-peer-outreach-implementation.pdf.
5. Department of Health (2014). **High Transmission Area Guidelines**. Pretoria.
6. SANAC (2017). **South Africa's National Strategic Plan for HIV, TB and STIs 2017-2022**. Pretoria. Available from: http://sanac.org.za/2018/09/26/download-the-full-version-of-the-national-strategic-plan-for-hiv-tb-and-stis-2017-2022/.
7. World Health Organization (2016). **Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations**. Geneva. Available from: https://apps.who.int/iris/bitstream/handle/10665/246200/9789241511124-annexes-eng.pdf?sequence=5.
8. SWEAT (2018). **A Low-Cost, Integrated Model for Sex Work Programming Report & Recommendations**. Cape Town.
9. NACOSA (2018). **Micro Planning Manual: Sex Work Programme**. Cape Town.
10. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al (2018). **Accelerate Progress—Sexual and Reproductive Health and Rights for All**: The Lancet, (391), pp. 2642–2692.
11. CDC (date unknown). **Social Network Strategy for HIV Testing Recruitment**. Available from: https://effectiveinterventions.cdc.gov/en/care-medication-adherence/group-4/social-network-strategy-for-hiv-testing-recruitment.
12. UNESCO (2018). **International Technical Guidance on Sexuality Education: An Evidence-Informed Approach**. Paris. Available from: https://www.unaids.org/sites/default/files/media_asset/ITGSE_en.pdf
13. World Bank (1999). **Confronting AIDS: Public Priorities in a Global Epidemic**. Geneva. Available from: http://documents.worldbank.org/curated/en/211211468779168446/pdf/multi0page.pdf.
14. Republic of South Africa (2006). **Children's Act [No. 38 of 2005]**. Available from: https://www.gov.za/sites/default/files/gcis_document/201409/a38-053.pdf.
15. Republic of South Africa (2007). **Sexual Offences and Related Matters Amendment Act** [No. 32 of 2007]. Available from: http://www.chr.up.ac.za/chr_old/indigenous/documents/South Africa/Legislation/Criminal Law Sexual-Offences Amendment-Act-2007.pdf.
16. UNAIDS (2018). **Miles To Go: Closing Gaps, Breaking Barriers, Righting Injustices**. Geneva.
17. Simbayi L, Zuma K, Zungu N, Moyo S, Marinda E, Jooste S, et al (2017). **South African National HIV Prevalence, Incidence, Behaviour and Communication Survey**.

18. UNAIDS (2017). **Addressing a Blind Spot in the Response to HIV — Reaching Out to Men and Boys**. Available from: http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf.

19. World Health Organization (2017). **Framework For Implementing The "End TB Strategy" in the African Region 2016-2020**. Geneva. Available from: http://www.afro.who.int/publications/framework-implementing-end-tb-strategy-african-region-2016-2020.

20. Statistics SA (2019). **Mid-Year Population Estimates**. Available from: https://www.statssa.gov.za/publications/P0302/P03022019.pdf.

21. Scorgie F, Nakato D, Akoth DO, Netshivhambe M, Chakuvinga P, Nkomo P, et al (2011). **"I Expect To Be Abused And I Have Fear": Sex Workers' Experiences of Human Rights Violations and Barriers to Accessing Healthcare in Four African Countries**. African Sex Worker Alliance, 76 p.

22. Slabbert M, Venter F, Gay C, Roelofsen C, Lalla-Edward S and Rees H (2017). **Sexual and Reproductive Health Outcomes Among Female Sex Workers in Johannesburg and Pretoria, South Africa: Recommendations for Public Health Programmes**. BMC Public Health, 17(Suppl 3), pp. 442.

23. SWEAT and Sisonke (2017). **#SayHerName Report 2014 - 2017**. Cape Town. Available from: http://www.sweat.org.za/wp-content/uploads/2019/08/Sweat-Say-Her-Name-Report_HI-RES.pdf

24. Ippoliti NB, Nanda G and Wilcher R (2017). **Meeting the Reproductive Health Needs of Female Key Populations Affected by HIV in Low- and Middle-Income Countries: A Review of the Evidence**. Stud Fam Plann, 48(2), pp. 121–151.

25. Poteat T, Wirtz AL, Radix A, Borquez A, Silva-Santisteban A, Deutsch MB, et al (2015). **HIV Risk and Preventive Interventions in Transgender Women Sex Workers**. Lancet, 385(9964), pp. 274–286.

26. Operario D, Soma T and Underhill K (2008). **Sex Work and HIV Status Among Transgender Women: Systematic Review and Meta-Analysis**. J Acquir Immune Defic Syndr, 48(1), pp. 97–103.

27. Samudzi Z and Mannell J (2016). **Cisgender Male and Transgender Female Sex Workers in South Africa: Gender Variant Identities and Narratives of Exclusion**. Culture, Health & Sexuality, 18(1), pp. 1–14.

28. Boyce P and Isaacs G (2011). **An Exploratory Study of the Social Contexts, Practices and Risks of Men Who Sell Sex in Southern and Eastern Africa**. African Sex Work Alliance. Available from: http://sro.sussex.ac.uk/10331/.

29. WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP (2013). **Addressing Violence Against Sex Workers. Implement Compr HIV/STI Program With Sex Work Pract Approaches From Collaborative Interventions**. Available from: http://www.who.int/hiv/pub/sti/sex_worker_implementation/swit_chpt2.pdf.

30. WHO (2005). **Violence Against Women And HIV/AIDS: Critical Intersections**. Available from: http://www.who.int/gender-equity-rights/knowledge/sexworkers.pdf?ua=1.

31. Aurum Institute, UCSF (2018). **SAHMS 2: Preliminary Findings**. Pretoria

32. Ahmed S, Autrey J, Katz IT, Fox MP, Rosen S, Onoya D, et al (2018). **Why Do People Living With HIV Not Initiate Treatment? A Systematic Review of Qualitative Evidence from Low- and Middle-Income Countries**. Soc Sci Med, (213), pp. 72–84. d

33. Delany-Moretlwe S, Cowan FM, Busza J, Bolton-Moore C, Kelley K and Fairlie L (2015). **Providing Comprehensive Health Services for Young Key Populations: Needs, Barriers and Gaps**. J Int AIDS, 18(2Suppl 1), pp. 29–40.

34. Bekker L, Johnson L, Cowan FM, Overs C, et al (2015). **Combination HIV Prevention for Female Sex Workers: What is the Evidence?** Lancet, 385(9962), pp. 72–87.

35. Statistics SA (2018). **Mortality and Causes of Death in South Africa, 2016: Findings from Death Notification**. Pretoria. Available from: https://www.statssa.gov.za/publications/P03093/P030932016.pdf

36. National HIV Think Tank (2018). **A Strategy for Finding Missing TB Cases**.

37. World Heath Organization (2019). **Global Tuberculosis Report**. Geneva: WHO. Available from: https://apps.who.int/iris/bitstream/handle/10665/329368/9789241565714-eng.pdf?ua=1

38. Kularatne RS, Niit R, Rowley J, Kufa-Chakezha T, Peters RPH, Taylor MM, Johnson LF and Korenromp EL (2018). **Adult Gonorrhea, Chlamydia and Syphilis Prevalence, Incidence, Treatment and Syndromic Case Reporting in South Africa: Estimates Using the Spectrum-STI Model, 1990-2017.** PLoS One, (13), pp. 1–22. Available from: https://doi.org/10.1371/journal.pone.0205863

39. Department of Health (2018). **Comprehensive STI Clinical Management Guidelines**.Pretoria, South Africa

40. Newman L, Rowley J, Hoorn SV, Wijesooriya NS, Unemo M, Low N, et al (2015). **Global Estimates of the Prevalence and Incidence of Four Curable Sexually Transmitted Infections in 2012 Based on Systematic Review and Global Reporting**. PLoS One, (10), pp. 1–17. Available from: https://doi.org/10.1371/journal.pone.0143304

41. UCSF, ANOVA Health Institute and Wits RHI (2014). **South African Health Monitoring Survey (SAHMS): An Integrated Biological and Behavioural Survey Among Female Sex Workers, South Africa 2013 – 2014**. Johannesburg, South Africa. Available from: https://www.knowledgehub.org.za/search/elibrary#kh_modal-node-34720.

42. Bill & Melinda Gates Foundation (2013). **Micro-planning in Peer Led Outreach Programs: A Handbook Based on the Experience of the Avahan India AIDS Initiative**. New Delhi, India. Availabel from: https://docs.gatesfoundation.org/documents/Microplanning Handbook (Web).pdf.

43. WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP (2013). **Implementing Comprehensive HIV/STI Programmes With Sex Workers: Practical Approaches from Collaborative Interventions**. Geneva, World Health Organization. Available from: https://apps.who.int/iris/bitstream/handle/10665/90000/9789241506182_eng.pdf?sequence=1.

44. Shannon K, Crago AL, Baral SD, Bekker LG, Kerrigan D, Decker MR, et al (2018). **The Global Response and Unmet Actions for HIV and Sex Workers**. Lancet, 392(101480, pp. 698–710.

45. Steen R, Hontelez JAC, Veraart A, White RG and De Vlas SJ (2014). **Looking Upstream to Prevent HIV Transmission: Can Interventions With Sex Workers Alter the Course of HIV Epidemics in Africa as they did in Asia?** AIDS, 28(6), pp. 891–899.

46. Ghys P, Diallo M, Ettiegne-Traore V, Kale K, Tawil O, Carael M, et al (2002). **Increase in Condom Use and Decline in HIV and Sexually Transmitted Diseases Among Female Sex Workers in Abidjan, Cote d'Ivoire, 1991-1998**. AIDS, 16(2), pp. 251–258.

47. Lowndes CM, Geraldo N, Alary M, Bernier F, Gnintoungbè CAB, Joly JR, et al (2002). **Decline in the Prevalence of HIV and Sexually Transmitted Diseases Among Female Sex Workers in Cotonou, Benin, 1993–1999**. AIDS, 16(3), pp. 463–470

48. Ngugi E, Chakkalackal M, Sharma A, Bukusi E, Njoroge B, Kimani J, et al (2007). **Sustained Changes in Sexual Behavior by Female Sex Workers After Completion of a Randomized HIV Prevention Trial**. J Acquir Immune Defic Syndr, 45(5), pp. :588–594.

49. Eakle R, Gomez GB, Naicker N, Bothma R, Mbogua J, Cabrera Escobar MA, et al (2017). **HIV Pre-Exposure Prophylaxis and Early Antiretroviral Treatment Among Female Sex Workers in South Africa: Results from a Prospective Observational Demonstration Project**. PLoS Med, 10(14), pp. 1–17.

50. Huschke S and Coetzee J (2019). **Sex Work and Condom Use in Soweto, South Africa: A Call for Community-Based Interventions with Clients**. Cult Health Sex, (22)1, pp. 1–15.

51. Coetzee J, Hunt G, Jaffer M, Otwombe K, Scott L, Bongwe A, Ledwaba J, Molema S, Jewkes R and Gray GE (2017). **HIV-1 Viraemia and Drug Resistance Amongst Female Sex Workers in Soweto, South Africa: A Cross Sectional Study**. PLoS One, 12(12), pp. 1–13.

52. Ankomah A, Omoregie G, Akinyemi Z, Anyanti J, Ladipo O and Adebayo S (2011). **HIV Risk-Related Perception Among Female Sex Workers In Nigeria.** HIV/AIDS - Research and Palliative Care, 93–100. Available from: www.ncbi.nlm.nih.gov/pmc/articles/PMC3218705/pdf/hiv-3-093.pdf.

53. Lancaster KE, Cernigliaro D, Zulliger R and Fleming PF (2016). **HIV Care And Treatment Experiences Among Female Sex Workers Living With HIV in Sub-Saharan Africa: A Systematic Review**. African J AIDS Res, 15(4), pp. 377–386.

54. Steward WT, Agnew E, DeKadt J, Gilmore H, Ratlhagana MJ, Grignon J, Shade SB, Tumbo J, Barnhart S and Lippman S (2017). **Peer Nagivation Enhances HIV Care Retention: An RCT in South African Primary Clinics**. Proceedings of the 2017 Conference of Retriviruses and Opportunistic Infections held at Seattle, Washington

55. Genberg BL, Shangani S, Sabatino K, Rachlis B, Wachira J, Braitstein P, and Operario D (2016). **Improving Engagement in the HIV Care Cascade: A Systematic Review of Interventions Involving People Living with HIV/AIDS as Peers**. AIDS Behav, 20(10), pp. 2452-2463.

56. UNAIDS (2014). 90-90-90 **An Ambitious Treatment Target to Help End the AIDS Epidemic**. Geneva;. http://www.unaids.org/Sites/Default/Files/Media_Asset/90-90-90_En_0.Pdf.

57. NACOSA (2018). **Programme Guidelines Sex Work Programme**. Cape Town.

58. Vassall A, Chandrashekar S, Pickles M, Beattie TS, Shetty G, Bhattacharjee P, et al (2014). **Community Mobilisation and Empowerment Interventions as Part of HIV Prevention for Female Sex Workers in Southern India: A Cost-Effectiveness Analysis**. PLoS One.;9:e110562. doi:10.1371/journal.pone.0110562.

59. Genberg BL, Kerrigan D, Kennedy CE, Morgan-Thomas R, Reza-Paul S, Mwangi P, et al (2015). **A Community Empowerment Approach to the HIV Response Among Sex Workers: Effectiveness, Challenges, and Considerations for Implementation and Scale-Up**. Lancet, 385(9963), pp. 172-85.

60. Panopoulou G, Gonzalez-Pier E (2019). **Challenges in HIV Infection Control in Transgender Women Sex Workers**. The Lancet Public Health, 4(3), pp. 117–118.

61. Beyrer C, Crago AL, Bekker LG, Butler J, Shannon K, Kerrigan D, et al (2015). **An Action Agenda for HIV and Sex Workers**. Lancet, 385(9964), pp. 287-301.

62. World Health Organization and UNAIDS (2000). **Violence Against Sex Workers and HIV Prevention**. Available from: https://www.who.int/gender/documents/sexworkers.pdf.

63. AidsFonds (2016). **Sex Work and Violence in South Africa: Needs Assessment Report**.

64. Wanyenze RK, Musinguzi G, Kiguli J, Nuwaha F, Mujisha G, Musinguzi J, Arinaitwe J and Matovu JKB (2017). **"When They Know That You Are A Sex Worker, You Will Be The Last Person To Be Treated": Perceptions and Experiences of Female Sex Workers in Accessing HIV Services in Uganda**. BMC Int Health Hum Rights, (17)1, 11.

65. Chingore-Munazvo N, Furman K, Raw A and Slabbert M (2017). **Chronicles of Communication and Power_ Theoretical Medicine and Bioethics_Final_29-01-16**. Available from: https://link.springer.com/article/10.1007%2Fs11017-017-9405-0.

66. Mtetwa S, Busza J, Chidiya S, Mungofa S and Cowan F (2013). **You Are Wasting Our Drugs: Health Service Barriers to HIV Treatment for Sex Workers in Zimbabwe**. BMC Public Health, 13(698)

67. Delany-Moretlwe S, Kelley K, Bolton-Moore C, Fairlie L, Cowan FM and Busza J (2015). **Providing Comprehensive Health Services for Young Key Populations: Needs, Barriers and Gaps**. Journal of the International AIDS Society (JIAS), 18(2 Suppl 1).

68. Scorgie F, Vasey K, Harper E, Richter M, Nare P, Maseko S and Cherish MF (2013). **Human Rights Abuses and Collective Resilience Among Sex Workers in Four African Countries: A Qualitative Study**. Global Health, 9(1), 33

69. Chingore-Munazvo N, Furman K, Raw A and Slabbert M (2017). **Chronicles of Communication and Power: Informed Consent to Sterilisation in the Namibian Supreme Court's LM Judgment of 2015**. Theor Med Bioeth, 38(2), pp. 145–62.

70. SWEAT and Sisonke (2017). **The Policing of Sex Work in South Africa: A Research Report on the Human Rights Challenges Across Two South African Provinces**. Available from: www.genderjustice.org.zawww.sweat.org.za.

71. Shannon K, Strathdee SA, Goldenberg SM, Duff P, Mwangi P, Rusakova M, et al (2015). **Global Epidemiology of HIV Among Female Sex Workers: Influence of Structural Determinants**. HIV and Sex Workers, 385(9962), pp. 55-71.

72. Landsberg A, Shannon K, Krüsi A, DeBeck K, Milloy MJ, Nosova E, Kerr T and Hayashi K (2017). **Criminalizing Sex Work Clients and Rushed Negotiations Among Sex Workers Who Use Drugs in a Canadian Setting**. J Urban Health, 94(4), pp. 563–71.

73. Kismödi E, Cottingham J, Gruskin S, Miller AM (2015). **Advancing Sexual Health through Human Rights: The Role of the Law**. Glob Public Health, 10(2), pp. 252–267.

74. Amnesty International (2016). **Amnesty International Policy on State Obligations to Respect, Protect and Fulfil the Human Rights of Sex Workers**. Available from: https://www.amnesty.org/en/documents/pol30/4062/2016/en/.

75. Benoit C, Jansson SM, Smith M and Flagg J (2017). **Prostitution Stigma and Its Effect on the Working Conditions, Personal Lives, and Health of Sex Workers**. The Journal of Sex Research, 55(4-5):1-15

76. Scheibe A, Howell S, Müller A, Katumba M, Langen B, Artz L and Marks M (2016). **Finding Solid Ground: Law Enforcement, Key Populations and their Health and Rights in South Africa**. Journal of the International AIDS Society (JIAS), 19(4Suppl 3)

77. Sonke Gender Justice and SWEAT (2017). **Sonke Gender Justice & SWEAT Submission to the Civilian Secretariat for Policing Sex Work Sector Civil Society Consultation on the White Paper for Safety & Security Sex Work Sector Contribution**. Available from: https://www.saferspaces.org.za/uploads/files/Final_-_WPSS_2017_Sex_Work_Sector_Indicators_Submission_11_Dec_2017.pdf.

78. UNAIDS (2014). **The Gap Report: Sex Workers**. Available from: http://158.232.15.93/sites/default/files/media_asset/06_Sexworkers.pdf.

79. Global Network of Sex Work Projects (2018). **Advocacy Tools and Resources Used By Sex Worker-Led Organisations to Combat Violence: The Smart Sex Worker's Guide**. Available from: https://www.nswp.org/resource/smart-guide-advocacy-tools-and-resources-used-sex-worker-led-organisations-combat-violence.

80. Platt L, Grenfell P, Meiksin R, Elmes J, Sherman SG, Sanders T, Mwangi P and Crago AL (2018). **Associations Between Sex Work Laws and Sex Workers' Health: A Systematic Review and Meta-Analysis of Quantitative and Qualitative Studies**. Available from: PLoS Med. 2018;15:1–54. doi:10.1371/journal.pmed.1002680.

81. Katumba MI (2017). **The South African Police Service's Dignity, Diversity and Policing Project: The Promotion and Protection of Human Rights, Dignity and Safety for All Policing**. Available from: https://international.coc.nl/wp-content/uploads/2018/12/LL-48-October-2018_Original.pdf.

82. Slabbert M and Lane T (2019). **Review of the South African National Sex Worker HIV Plan 2016-2019**.

83. World Health Organization (2015). T**ool to Set and Monitor Targets for HIV Prevention, Diagnosis, Treatment and Care for Key Populations**. Geneva: WHO

84. Lane T, Grasso M, Scheibe A, Liu G, Marr A, Aynalem G, et al (2018). **Building Key Populations HIV Cascades` In Data-Scarce Environments: Towards a Participatory Stakeholder Methodology for Cascades Construction, Adoption, and Utilization**. Available from: doi:http://dx.doi.org/10.1101/452417.

85. [Author unknown] 2020. **Nearly Half of the 101 Sex Workers Who Died in SA in 2018 and 2019 Were Murdered**. The Citizen, Johannesburg, 4th March 2020. Available from: https://citizen.co.za/news/south-africa/investigation/2249903/nearly-half-of-the-101-sex-workers-who-died-in-sa-in-2018-and-2019-were-murdered/.

86. USAID (2019). **Finding Missing TB Patients Repor**t. Available from: https://tbsouthafrica.org.za/sites/default/files/6.%20Finding%20Missing%20TB%20Patients%20Report%20Aug%202019.pdf.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