

OPERATIONAL GUIDANCE

Responding to the health and protection needs of people selling or exchanging sex in humanitarian settings



The United Nations High
Commissioner for Refugees
and the United Nations
Population Fund

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Abbreviations

AGD	Age, gender and diversity (policy)
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
DIC	Drop-in centre
EC	Emergency contraception
GBV	Gender-based violence
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HIVST	HIV self-testing
HPV	Human papilloma virus
HTS	HIV testing services
IAFM	Inter-Agency Field Manual (on Reproductive Health in Humanitarian Settings)
IASC	Inter-Agency Standing Committee (on Reproductive Health in Humanitarian Settings)
IDP	Internally displaced person
KESWA	Kenya Sex Worker Association
LARC	Long-acting, reversible contraceptive
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer
MoH	Ministry of Health
mhGAP	Mental health gap action plan
MHPSS	Mental health and psychosocial support
MISP	Minimum initial service package (for reproductive health in crisis situations)
NSWP	Global Network of Sex Work Projects
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother to child transmission (of HIV, syphilis and HBV)
PrEP	Pre-exposure prophylaxis
PLHIV	People living with HIV
PSS	Psychosocial support
SOGIE	Sexual orientation, gender identity and expression
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SWIT	Sex Worker HIV/STI Implementation Tool (for comprehensive HIV/STI programmes with sex workers)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
5Cs (of HTS)	Consent, confidentiality, counselling, correct (results), connection to services

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Glossary: Definition of terms

Child: a human being below the age of eighteen years, unless, under the law applicable to the child, the age of majority is attained earlier.¹

Adolescent: a person aged 10–19 years.²

Age, gender and diversity policy: requires that an age, gender and diversity sensitive approach is applied to all work aspects.

Young person/people: A person/people aged 10–24 years.

Minor: a person under the age of majority – which legally demarks childhood from adulthood and is generally 18 years, but can vary according to context and local laws.

Gender-based violence: an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private. The term is most commonly used to underscore how systemic inequality between males and females, which exists in every society in the world, acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. It also includes sexual violence committed with the explicit purpose of "reinforcing gender-inequitable norms of masculinity and femininity". It is increasingly used to highlight the gendered dimensions of certain forms of violence against men and boys – particularly forms of sexual violence committed with the explicit purpose of reinforcing gender inequitable norms of masculinity and femininity.³

Harm reduction: a comprehensive package of policies, programmes and approaches that seek to reduce the harmful health, social and economic consequences associated with injection drug use. The use of the term has expanded over time to other areas, namely sex work⁴ and abortion.⁵

Intersectionality: describes the interconnected nature of social categorizations such as race, class and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

1 UN, 1989. United Nations Convention on the Rights of the Child (Article 1). U.N. Doc. A/Res/44/25, 1989.

2 UNICEF, The State of the World's Children Report <https://www.unicef.org/reports/state-worlds-children-2011>

3 Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings, GBV Guidelines (New York, Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings, 2015).

4 Joint United Nations Programme on HIV/AIDS (UNAIDS), *Terminology Guidelines* (Geneva, UNAIDS, 2015). The term "harm reduction" originated in efforts to address negative impacts on people who inject drugs. It is now also used more broadly related to reducing harms within other behaviours, including sex work. For more explanation, see Open Society Institute, 2006. "Harm Reduction, Health and Human Rights, and Sex Work"; Rekart, Michael L., 2005. "Sex-work harm reduction," *Lancet*, vol. 366. pp. 2123–2134.

5 Julia Tasset and Lisa H. Harris, "Harm reduction for abortion in the United States", *Obstetrics & Gynecology*, vol. 131, No. 4 (April 2018).

Key populations: populations who, as a result of specific behaviours, are at increased risk of HIV, irrespective of the local epidemic type or context. Legal and social factors can increase this risk.⁶ The World Health Organization recognizes five key populations:

- Gay, bisexual and other men who have sex with men;
- People who inject drugs;
- People in prisons and other closed settings;
- Sex workers;
- Transgender people.⁷

People who sell sex: synonymous with the Joint United Nations Programme on HIV/AIDS (UNAIDS) definition of “sex worker”.⁸ The term sex worker is intended to be non-judgemental and focuses on the working conditions under which sexual services are sold. Sex workers include consenting females, males and transgender adults – as well as young people over the age of 18 years – who regularly or occasionally receive money or goods in exchange for sexual services. Sex work can take many forms and can vary in the degree to which it is “formal” or organized, and between and within countries and communities.⁹ It includes persons who may or may not identify as sex workers and persons who may not consciously define these activities as income-generating.^{10,11} Sex work is defined as the consensual sale of sex between adults; therefore, children (people under 18 years) cannot be involved in sex work. Instead, children involved in the sale of sex are considered victims of sexual exploitation. This document uses the term “people who sell sex”, and differentiates this from trafficking of persons and exploitation (see **Sexual exploitation, Sexual abuse** and **Trafficking in persons**).

Protection: a comprehensive process including “all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law (i.e. International Human Rights Law, International Humanitarian Law and International Refugee law)”.¹² Ensuring the safety of all persons affected by conflict or crisis is a central tenet of humanitarian action. All rights of affected persons and obligations of duty bearers must be understood, respected, protected and fulfilled without discrimination.¹³

6 WHO, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (Geneva, WHO, 2016).

7 Ibid.

8 UNAIDS, *Terminology Guidelines* (Geneva, UNAIDS, 2015).

9 WHO, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (Geneva, WHO, 2014).

10 UNAIDS, *Sex Workers and HIV/AIDS – Technical Update* (Geneva, UNAIDS, 2002).

11 WHO, *Sex Workers – Part of the Solution. An Analysis of HIV Prevention Programming to Prevent HIV Transmission during Commercial Sex in Developing Countries* (Geneva, WHO, 2002).

12 Inter-Agency Standing Committee, *Protection of Internally Displaced Persons*, Inter-Agency Standing Committee Policy Paper (New York, Inter-Agency Standing Committee, 1999), p. 4. See also Sylvie Giossi Caverzasio, *Strengthening Protection in War: A Search for Professional Standards* (Geneva, ICRC, 2001), p. 19.

13 Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings, *Policy on Protection in Humanitarian Action* (New York, Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings, 2016).

Sexual exploitation and abuse (SEA): ... “sexual exploitation” means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Similarly, the term “sexual abuse” means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.¹⁴

Trafficking in persons: the recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat, use of force, or other forms of coercion, abduction, fraud, deception, abuse of power, or of the giving or receiving of payments or benefits to achieve the consent of a person or having control over another person, for the purpose of exploitation. Exploitation includes, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.¹⁵

Transactional sex: a non-marital, non-commercial sexual relationship, motivated by an implicit assumption that sex will be exchanged for material support or other benefits.¹⁶ In current notion most people involved in transactional sex relationships consider themselves as partners or lovers rather than sellers or buyers. Conflating transactional sex and sex work in intervention design and funding may be counterproductive, as interventions designed for sex workers will not reach people engaged in transactional sex.

Transgender: an umbrella term describing people whose gender identity and expression do not conform to the norms and expectations traditionally associated with their sex determined 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. Transgender individuals may self-identify as transgender, female, male, trans woman or trans man, transsexual, hijra, kathoey, waria or one of many other transgender identities, and they may express their genders in a variety of masculine, feminine and/or androgynous ways.¹⁷

14 Secretary-General's Bulletin Special measures for protection from sexual exploitation and sexual abuse (October 2003). Available at <https://www.unhcr.org/protection/operations/405ac6614/secretary-generals-bulletin-special-measures-protection-sexual-exploitation.html>

15 Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (The Palermo Protocol). Adopted and opened for signature, ratification and accession by General Assembly resolution 55/25 of 15 November 2000. Available at <https://www.ohchr.org/en/professionalinterest/pages/protocoltraffickinginpersons.aspx>

16 UNAIDS, *Transactional Sex and HIV Risk: From Analysis to Action* (Geneva, UNAIDS, 2018).

17 UNAIDS, *Terminology Guidelines* (Geneva, UNAIDS, 2015).

Notes on terminology

The terminology around sexual orientation, sex work and issues in the area of sexual and reproductive health and rights is evolving constantly. There is contradiction in the use of certain terms between different documents depending on the publisher and date of publication. The present document relies mainly on UNAIDS definition of sex work but recognizes the use of alternative terms and their underlying rationale.

Terminology regarding children

Transactional sex, selling sex, exchanging sex and sex work are all terms that should be avoided when referring to children under 18 years of age because the use of such terms: (1) risks legitimizing certain forms of child sexual exploitation; and (2) may harm the child or risk shifting the blame onto the child.¹⁸ That said, guidance documents refer to “young people who sell sex” as people aged 10–24 years, including children aged 10–17 years who are sexually exploited and young adults aged 18–24 years who are sex workers.¹⁹

Rights-based terminology

This terminology should be used whenever discussing the sale of sex or individuals who sell or exchange sex. Rights-based terminology is non-judgemental and non-stigmatizing. It does not evaluate people’s behaviour as being good or bad. Saying that someone “sells sex” or “exchanges sex” or “does sex work” is rights based. Terms that are value laden, or are based on assumptions about why someone is selling sex, should be avoided. The term “survival sex” is one example. Similarly, language that refers to selling sex as a “negative coping strategy” is judgemental and can reinforce stigma. Terms that impute an identity onto someone because they sell sex are also inappropriate, such as referring to someone as a “prostitute”.

18 Interagency Working Group on Sexual Exploitation of Children, Terminology Guidelines for the Protection of Children from Sexual Exploitation and Sexual Abuse, 2016, p. 31–34. https://www.ohchr.org/Documents/Issues/Children/SR/TerminologyGuidelines_en.pdf

19 WHO, *Technical Brief on HIV and Young People Who Sell Sex* (Geneva, WHO, 2015).

Terminology regarding trafficking in persons

The language contained in the Palermo Trafficking in Persons Protocol²⁰ often leads to problematic conflation between sex work and sexual exploitation. Defining sex work as “sexual exploitation” exacerbates the vulnerability of sex workers and results in the abuse of their human rights, and should therefore be avoided. Conflating sex work with either “sexual exploitation” or trafficking perpetuates coercive and dangerous working conditions in sex work, and leads to harmful legislation that limits sex workers’ access to justice and services. The United Nations Office on Drugs and Crime reflected on the concept of “exploitation” in the Trafficking in Persons Protocol, acknowledging that sex work must not be conflated with human trafficking and that “sexual exploitation” does not refer to all sex work. When used in the context of the Protocol, the term “trafficking” should not be applied to prostitution generally, as Member States have made it clear that this was not their intention.^{21, 22} This current guidance on people who sell sex in humanitarian settings differentiates the sale of sex from trafficking in persons and exploitation, for which separate guidance is available.²³

Terminology regarding diverse sexual orientation, gender identity and expression (SOGIE)

Various terms are used to refer to specific gender and sexual minorities, including gay men, bisexual men and other men who have sex with men, queer people, trans men, trans women and non-binary individuals. While aiming to be precise, terminology is diverse and varies widely. Experience suggests that it is important to undertake a contextualized assessment of the terms used locally to refer to gender identity and sexual orientation, and how these identities shape protection and health needs, during the service planning stage.²⁴

20 Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (The Palermo Protocol). Adopted and opened for signature, ratification and accession by General Assembly resolution 55/25 of 15 November 2000.

Available at <https://www.ohchr.org/en/professionalinterest/pages/protocoltraffickinginpersons.aspx>

21 United Nations Office on Drugs and Crime, *Issue Paper: The Concept of Exploitation in the Trafficking in Persons Protocol*

(Vienna, United Nations Office on Drugs and Crime, 2015).

Available at https://www.unodc.org/documents/human-trafficking/2015/UNODC_IP_Exploitation_2015.pdf.

22 NSWP, *Briefing Note: Sex work is Not Sexual Exploitation* (Edinburgh, NSWP, 2019).

23 Global Protection Cluster, *An Introductory Guide to Anti-trafficking Action in Internal Displacement Contexts* (Global Protection Cluster, 2020). Available at <https://publications.iom.int/books/introductory-guide-anti-trafficking-action-internal-displacement-contexts-2020>

24 UNHCR, *Protecting Persons with Diverse Sexual Orientations and Gender Identities* (Geneva, UNHCR, 2015).

1. Introduction

People affected by conflict and crisis experience disruptions to their personal, social and economic lives, including family separation, loss of income and assets, cultural upheaval, and the collapse of traditional social structures and livelihood opportunities. Access to basic needs and livelihoods can remain interrupted for extended periods. All these factors may increase pressure on people to sell or exchange sex for money or goods to support themselves and their dependants.

Additional drivers of selling and exchanging sex in humanitarian settings relate to the breakdown of social networks. People may find themselves rejected from family or excluded from the broader community for a variety of reasons, including their sexual orientation and gender identity,²⁵ or because they have experienced sexual violence, particularly rape or unintended pregnancy.²⁶

Although there are no reliable prevalence estimates of the sale or exchange of sex in humanitarian settings, a number of documents reflect the fact that people who engage frequently or occasionally, for a brief period or for longer, in the sale or exchange of sex are a very heterogeneous group and include men, women, young people,²⁷ persons of diverse sexual orientation, gender identity and expression, married and unmarried people (living as a couple or not, with and without children) and people with a disability.

Reasons for and factors driving the sale or exchange of sex are diverse in any context, and this is true also of humanitarian settings. While personal choice may be severely limited, a human-rights-based approach attributes each person with “agency”- the right to choose their actions - however challenging these actions may appear to others, and this calls for non-discrimination and respect. Choosing to sell sex, for example because there are few other options for income generation, is different from being forced, coerced or deceived into selling sex, which constitutes exploitation or abuse.

This guidance does not make any judgement, one way or another, in this regard and does not attempt to define categories pertaining to the voluntary or otherwise sale or exchange of sex. It recognizes the critical vulnerability of all people who sell or exchange sex, and how each and every person’s situation may differ, and needs to be addressed accordingly. Despite the many differences in context and circumstance, all types of sex work share some important inherent commonalities, and all people who sell or exchange sex face the same specific health risks as well as increased risk of exposure to violence.

25 Ibid.

26 Doris Burtscher and Catrine Schulte-Hillen, *Better Dead than Being Mocked. Unwanted Pregnancy and Abortion – An Anthropological Study on Perceptions and Attitudes* (Doctors Without Borders, 2018).

27 While this guidance does not specifically address the sale or exchange of sex by minors, it is not uncommon for young people, including minors in displacement settings, to sell or exchange sex. The circumstances under which they do so are diverse, along with their needs. For specific guidance on working with children and adolescents who sell or exchange sex, humanitarian actors are encouraged to refer to WHO’s Technical Brief on HIV and Young People Who Sell Sex (2015).



1.1. Purpose

This guidance proposes actions for responding to the health and protection needs of people who sell or exchange sex in humanitarian settings – actions that can be implemented to varying degrees in different settings (e.g. in acute emergencies or during periods of transition or stabilization or protracted displacements; in or out of camp; and in rural or urban settings), and among different groups (refugees, asylum seekers, internally displaced persons, stateless persons or other persons affected by humanitarian crises). The guidance is directed specifically at health and protection staff in UNHCR and UNFPA, as well as their partners, but may also be useful to other relevant actors.

The guidance highlights how humanitarian practices should align with broader human rights frameworks for responding to the health and protection needs of people who sell or exchange sex.²⁸ It draws from normative guidance and good practice standards developed by UN agencies in collaboration with sex worker organizations, and aligns with human rights standards enshrined in international human rights treaties.²⁹

Safeguarding the rights and meeting the health and protection needs of people who sell or exchange sex are urgent priorities. The guidance focuses first and foremost on technical recommendations for actors in health and protection sectors/clusters. However, the key principles and approaches outlined here are relevant in all sectors, including in camp management; supply and logistics; water, sanitation and hygiene (WASH); and food security.

28 UNAIDS. *Guidance Note on HIV and Sex Work* (Geneva, UNAIDS, 2012); WHO, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (Geneva, WHO, 2016); WHO, *Implementing Comprehensive HIV/STI Programmes with Sex Workers* (Geneva, WHO, 2013); International Labour Organization (ILO), *Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS* (Geneva, ILO, 2017).

29 WHO, *Sexual Health, Human Rights and the Law* (Geneva, WHO, 2015).



1.2. Limitations of this guidance

This guidance focuses on actions to improve access to health services – particularly sexual and reproductive health (SRH) care – and to protection, for all people who sell or exchange sex in humanitarian settings. However, further specific regulations and guidance relate to:

- Minors (under the age of 18 years) involved in the sale or exchange of sex, considered under international law as experiencing sexual exploitation;³⁰
- Situations amounting to coercion, use of force or trafficking, considered as forms of sexual violence and therefore as crimes;³¹
- Specific situations, referred to as “sexual exploitation and abuse”, perpetrated by aid workers themselves.³²

These situations are subject to specific regulations, guidance and action, not discussed here. Health services – in particular SRH care, including clinical management for rape survivors – and protection services are important entry points for identifying people who are subject to specific forms of violence, enabling them to be referred to established pathways that can address their specific needs. All persons who are selling or exchanging sex should receive the services covered in this guidance, but vigilance is called for to ensure that additional assistance and protection measures are put in place where violence, force or coercion have occurred.

30 The United Nations Conventions on the Right of the Child (UNCRC) is an international treaty that legally obligates nations to protect children’s rights. Articles 34 and 35 of the UNCRC require states to protect children from all forms of sexual exploitation and sexual abuse.

31 Global Protection Cluster, *An Introductory Guide to anti-trafficking Action in Internal Displacement Contexts* (Global Protection Cluster, 2020).

32 The United Nations Country Team assigned sexual exploitation and abuse focal point is responsible for coordinating inter-agency processes to address such instances of sexual exploitation and abuse. Secretary-General’s Bulletin on Special Measures for Protection from Sexual Exploitation and Sexual Abuse (2003).



1.3. Guiding principles for working with people who sell or exchange sex

Principles for all decision-making, interventions and engagement with people who sell or exchange sex in humanitarian settings are already established in humanitarian frameworks.

1. Ensure a human-rights-based approach, including the right to:

- Self-determination, autonomy and agency;
- Safety, security and protection from violence;
- Privacy and confidentiality;
- Equality and non-discrimination;
- The highest attainable standard of health.

2. First, do no harm – a core ethical approach, including:

- Provide services without judgement or discrimination;
- Act in accordance with the wishes of people selling or exchanging sex;
- Maintain the confidentiality and privacy of people selling or exchanging sex;
- Obtain informed consent for any referral or service;
- Consider the harm your words, actions and attitudes may cause, to avoid negative consequences.

3. Use harm reduction approaches – policies, programmes and practices that reduce negative health, social and legal impacts, including:

- Community empowerment;
- Community-based and peer-led outreach and education;
- Risk mitigation – promotion of health and safety in sex work.

4. Ensure evidence-informed action – there is substantial evidence of “what works” to improve the health and safety of people who sell or exchange sex. Much of this knowledge has originated outside the humanitarian field.³³ Existing tools and resources – published by development partners, often in collaboration with sex worker organizations – are adapted for humanitarian settings in this guidance.

5. Ensure a community-based protection approach – including through participatory programming and peer-led engagement. Empowerment of the community of people who sell sex is an intervention in itself, and is also essential for effective planning, implementation and monitoring.³⁴ For example, programmes should engage people who sell or exchange sex as peer educators for others who sell or exchange sex. Community empowerment involves collective ownership that enables individuals to work together to increase awareness, build personal skills and provide mutual assistance. It acknowledges people’s agency and their own ability to undertake harm reduction, and reduce risks and vulnerability for themselves and peers.

33 WHO, *Implementing Comprehensive HIV/STI Programmes with Sex Workers – Practical Approaches from Collaborative Interventions (SWIT)* (Geneva, WHO, 2013).

34 Ibid.

- 6. Ensure an age, gender and diversity (AGD)-sensitive approach³⁵** – taking into account the diverse profiles and intersectional risk profiles of people who sell or exchange sex. An AGD-sensitive approach is nuanced and contextually relevant, and ensures people-centred services and needs-based action. Programmes should include an essential minimum package of health and protection services, tailored to address each person’s individual situation, needs, values and wishes. Flexible programmes ensure support for a diverse group of individuals, including people of different genders and cultures. There is a need to avoid making any assumptions about people who sell or exchange sex, and to ask each individual what their needs and preferences are.
- 7. Coordinate with the host government and other community actors** – explore and build linkages with host country actors; open lines of communication to establish coordinated responses; and map existing services, resources and laws governing sex work. Consult with and establish links with a range of partners, including the national Ministry of Health; the National AIDS Council; non-governmental organizations (NGOs) and community-based organizations, including those led by host community sex worker organization, networks and allies; SRH clinic providers; sex worker “drop-in” centres (DICs); and legal aid providers.

35 UNHCR, *Policy on Age, Gender and Diversity* (Geneva, UNHCR, 2018).

2. Health and protection actions and responses

Actions to support people who are selling or exchanging sex can be integrated in broader humanitarian responses, or they can be developed as separate, stand-alone activities, programmes and structures. In each setting there is a need to weigh the pros and cons of each approach – i.e. the advantages of a stand-alone programme that focuses on specific actions for a specific population (e.g. improved access, specialized care and provider knowledge and capacity) have to be weighed against the disadvantages, including the dangers of drawing increased attention to a stigmatized group, emergent security challenges and additional costs.



2.1. Overview

The overriding goal of the guidance is to improve the health, well-being and safety of people who sell or exchange sex in humanitarian settings. Specific objectives can be summarized as follows:

- Ensure non-discriminatory access to primary, secondary and tertiary health-care services, including SRH care and services in response to gender-based violence (GBV), such as mental health and psychosocial support (MHPSS);
- Reduce transmission of HIV, viral hepatitis (hepatitis A virus, hepatitis B virus and hepatitis C virus) and other sexually transmitted infections (STIs);
- Reduce the number of unintended pregnancies;
- Reduce the need for abortions, prevent unsafe abortions and ensure post-abortion care;
- Increase survival and improve the health of people living with HIV (PLHIV);
- Protect against violence, discrimination, abuse and other human rights violations;
- Ensure that medical care and protection is available for survivors of violence;
- Enhance community empowerment among people selling or exchanging sex;
- Reduce the risks and security threats related to the sale or exchange of sex;
- Combat stigma and discrimination against people who sell or exchange sex, and against their families;
- Build safety, and health knowledge and skills of people selling or exchanging sex;
- Prevent, respond to and document violence, including sexual assault;
- Ensure access to legal support.

The guidance acknowledges the challenges inherent to humanitarian assistance, including working in different phases of a crisis – from onset and acute emergency to protracted situations – and in diverse settings, which include in-camp and out-of-camp, as well as rural and urban situations. The capacity to develop specific responses to address the health and protection needs of people who sell or exchange sex in humanitarian settings depends on the availability of resources, the willingness of different actors to engage, and the capacity to mobilize and coordinate different responders' actions.

The guidance outlines, in order of priority, actions to improve access to health services and protection for people who sell or exchange sex. Most actions are relevant in a “minimum response”. However, these initial actions can be developed into more comprehensive programmes in transition and stabilized humanitarian situations. For example, availability of condoms and lubricants should be ensured in all settings at all times, independently of health programmes. Depending on the capacity, awareness and willingness of actors, this initial supply of condoms and lubricant can be further developed into active engagement with communities, to identify relevant distribution points, promote the use of female condoms, promote peer-led teaching of condom negotiation skills, and identify more diverse outlets and distribution channels for improving availability, acceptance and use.³⁶

36 Note: lubricant sachets should always be made available together with condoms for people selling or exchanging sex, to ensure full lubrication, reduce vaginal or anal abrasion and to reduce the risk of a condom tearing during sex.

This guidance is not a blueprint for interventions; rather it presents a series of actions for responding to the health and protection needs of people selling or exchanging sex. The guidance is divided into sections outlined in the following table:

Preparation	Increasing awareness of humanitarian actors - understanding risks and improving attitudes
Response	General response guidance regarding the importance of raising awareness, shifting humanitarian actor attitudes and combating stigma; health response guidance for minimum and comprehensive action with a focus on SRH; and protection guidance for minimum and comprehensive action for addressing protection needs

All of these activities need to be guided by a community engagement and empowerment approach.



2.2. Preparation

The following actions are proposed in order of sequence, from immediate, minimum initial responses to longer-term actions in more stable situations. Raising the awareness of relevant humanitarian actors, community members and service providers is the first and most important action and should occur in every situation. Awareness of the circumstances, and of the health and protection needs of people who sell and exchange sex and their dependants enables and facilitates their access to non-discriminatory services. The following preparatory actions will enable services to be developed and implemented.

1. **Include programming for people who sell or exchange sex in humanitarian action plans.** The ability to address in a timely manner the needs of people who sell sex is directly linked to the inclusion of these needs in preparedness and contingency plans. When doing so, it is important to involve all relevant stakeholders, including national or local sex worker organizations, health workers from implementing agencies involved in SRH care, protection actors and representatives from communities, women's groups and other relevant populations. In the preparedness phase, sex workers should be involved in conducting both a situation analysis and a needs assessment, adapted to the national context.
2. **Become familiar with the local legal context.** This includes having knowledge of local laws and regulations that criminalize or regulate the sale of sex, same-sex relations, sexual relations out of wedlock, contraception and abortion as well as legal provisions regarding mandatory testing for HIV and STIs. Both host community and affected population national laws may be relevant. Relevant regional or international legal provisions should also be considered:
 - Consult with host community lawyers and/or local community-based organizations that work and liaise with law enforcement officers. Engage with local actors to understand if and how laws are enforced (e.g. policing, arrest, prosecution and detention practices), as well as enforcement-related risks for displaced persons (e.g. risks of abuse in detention, or of refoulement for persons arrested for selling or exchanging sex).³⁷ Where possible, apply an AGD-sensitive approach to the analysis [e.g. lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+), indigenous or female displaced persons may face different risks to other displaced people].
 - Information gathered during the initial needs assessment may be used to develop a response plan for providing legal support to any displaced individual who is arrested for activities related to selling or exchanging sex. Health and safety information provided to people who sell or exchange sex should include recommendations on how to deal with police and/or camp security officials. This information should be developed in a way that is contextually appropriate and accessible to different groups of people who sell or exchange sex (e.g. considering language, format and media).

37 The principle of non-refoulement forms an essential protection under international human rights, refugee, humanitarian and customary law. It prohibits states from transferring or removing individuals from their jurisdiction or effective control when there are substantial grounds for believing that the person would be at risk of irreparable harm on return, including persecution, torture, ill treatment or other serious human rights violations. <https://www.ohchr.org/Documents/Issues/Migration/GlobalCompactMigration/ThePrincipleNon-RefoulementUnderInternationalHumanRightsLaw.pdf>

- A number of further national laws and directives may be relevant, for example relating to specific medical actions and situations of violence. These include abortion law, contraception (i.e. the need for the husband's consent and regulations regarding sterilization), medical care for minors (assent and parental or guardian consent), sexual violence – specifically rape and other forms of violence (medico-legal certification and/or obligatory reporting requirements). More information on legal constraints and issues can be found in the reference documents provided in **Annex 13**.

Specific legal considerations regarding minors

- WHO guidance³⁸ observes that “criminalization of sex work can particularly impact access to health services for young people under 18 engaged in sex work. ... Many legal regimes that criminalize sex work simultaneously prosecute not only the people who coerce minors into sex work but also the minors themselves. Prosecution of people under 18 as criminal offenders achieves little other than stigmatizing young people and making their lives even more difficult.” Further, the guidance clarifies that “even though international human rights law, international labour law³⁹ and international criminal law⁴⁰ consider any engagement of persons under 18 in sex work a crime, millions of young people and children are engaged in the commercial sex sector. ... Strategies that offer education and alternative ways of making a living for people under 18 engaging in sex work are most likely to be productive.” In humanitarian settings, the priority is to meet the immediate health and protection needs of young people who sell sex, including young people who chose to continue to sell sex.⁴¹ Diversionary interventions can be considered as secondary responses on a case-by-case basis, depending on the individual's age and preference and options for sources of support.
- Minors selling or exchanging sex have the right to be protected from criminal charges, law enforcement violence and arbitrary “rehabilitation” or detention.⁴² A number of recommendations are available regarding working with young people who sell sex and can be integrated into humanitarian responses. These include the need for youth-friendly, comprehensive SRH care and highlight the importance of peer-education. It is the service provider's responsibility to respect the views of each child and recognize their evolving capacity to exercise their rights on their own behalf, in accordance with the United Nations Convention on the Rights of the Child. This is particularly important when it comes to minors' access to HIV testing and treatment, contraception and other medical treatment that a minor may wish to access without relying on parental consent. These issues should be considered as part of national policy discussion and related advocacy, always prioritizing the consideration of the best interests of the child.

38 WHO, *Sexual Health, Human Rights and the Law* (Geneva, WHO, 2015), pp. 28–29.

39 ILO, *Declaration on Fundamental Principles and Rights at Work*. (Geneva, ILO, 1999), “the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances”. Available at https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---declaration/documents/publication/wcms_decl_fs_46_en.pdf.

40 UN General Assembly Resolution A/RES/54/263, <https://undocs.org/en/A/RES/54/263>

41 WHO, *HIV and Young People Who Sell Sex* (Geneva, WHO, 2015).

42 Ibid.

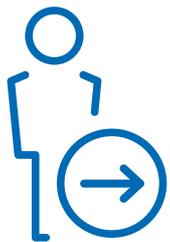
3. Map and consult local host community partners. Identify all local actors⁴³ who may be involved or have an influence in the area of health and protection for people who are selling or exchanging sex. Include national and local government agencies, NGOs, community organizations and service providers with expertise in working with key populations.

- Link up with local actors to help to improve the affected population's capacity to respond to a humanitarian crisis. This requires an understanding of the needs of both the whole population and specifically those who sell or exchange sex. Local dynamics in the host community can markedly influence potential risks and challenges. Initial consultations can occur during the mapping of existing services, resources and laws governing sex work, to identify both potential local sources of support and risks of violence.
- Identify partners to specifically provide health and protection services to people who sell or exchange sex. This may include some UNHCR and UNFPA operational and implementing partners, plus other local organizations. Potential partners may not initially have a full understanding or capacity, or be fully supportive of working with people who sell or exchange sex. These partners can be invited to join values clarification workshops so that they are sensitized prior to formal engagement. All partners should agree to the guiding principles reflected in this guide and abide by a code of conduct in line with humanitarian principles. Once in place, monitoring can identify services that may be avoided, underused or that display poor quality of care, including negative attitude of providers and breach of confidentiality. Regular focus groups can help to build a qualitative understanding of such challenges.

4. Pre-position medical supply buffer stocks, and redistribute supplies to areas of greatest need.⁴⁴ Provide support for transport and emergency procurement to ensure availability of drug and commodity supplies in humanitarian settings. In acute emergencies, when no buffer stocks are in place, ensure that the needs of persons engaged in exchanging or selling sex are considered in emergency supply orders such as condoms, lubricant, treatment for sexually transmitted infection (STI), antiretroviral drugs (ARVs) – for pre- and post-exposure prophylaxis (PrEP and PEP, respectively) and prevention of mother-to-child transmission (PMTCT) and antiretroviral therapy (ART) starter kits, HIV testing services (HTS) and combination prevention services/commodities.

43 Relevant local groups and institutions include: national ministries of health; HIV/STI prevention and treatment teams; NGO sex worker allies; local SRH clinics; drop-in centres for sex workers; health clinics or community-based organizations working with or led by host community sex worker networks, legal aid providers and human rights groups.

44 Critical supplies for people who sell sex include male and female condoms and lubricant, other forms of modern contraception, HIV test kits and ART, other STI test kits and treatments, PrEP, PEP and STI prophylaxis, and post-abortion care commodities.



2.3. General response

2.3.1. RAISE AWARENESS AND IMPROVE UNDERSTANDING OF RISKS

Open dialogue is needed between health and protection actors for the sharing of information, experiences, guidance and implementation tools. The main approaches include:

- During team meetings, raise the issue of the health and protection needs of people who sell or exchange sex and discuss this issue with other actors during sector or camp coordination meetings. These discussions can help to identify others who want to get involved. They also enable the consideration of specific, local contexts and challenges faced by people who sell or exchange sex. A short formal presentation with facts and figures may help to set the stage. This should be made available in hard copy or via a web link.
- Sensitize a range of actors regarding the rights and needs of people who sell or exchange sex and the social and economic challenges people face during a humanitarian crisis. This includes talking with:
 - Community members representing different and diverse perspectives, including women leaders, and other influential community members and local leaders (e.g. local faith leaders), military commanders, police chiefs and other community members;
 - Volunteers and community workers;
 - Security officers, including police.

These actors will be critical in enabling and creating change (i.e. breaking the silence and shifting community attitudes). Topics covered should include (1) principles of harm reduction;⁴⁵ (2) human rights – such as the right to privacy, to access health and protection services, and to live free of violence and discrimination; (3) preventing and mitigating risk for people who sell or exchange sex; (4) security practices that impact human rights; and (5) the role of security personnel in HIV prevention.⁴⁶

Bring different partners together to discuss, identify and agree on local situations where urgent health and protection needs must be addressed. While comprehensive action may not be possible at the onset of an emergency or in some resource-poor settings, all actors need to respond to urgent health and protection needs. Key actors, contacts and referral pathways need to be established in advance, taking into account the specific situations of people who sell or exchange sex. Standard operating procedures for dealing with threats and violence should be developed to guide interventions.

45 See related comments in the above point “2.2 #3. Map and consult local host community partners”.

46 United Nations Office on Drugs and Crime, *Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs – Module 3 Overview of the Role of Police in Public Health and the Importance of Working with Key Populations* (Vienna, United Nations Office on Drugs and Crime) Available at https://www.unodc.org/documents/hiv-aids/Lemannual/LE_Manual_presentations_and_annexes.pdf.

The Masisi Project, the Democratic Republic of the Congo (2014-2015) - a UNHCR case study

Background: More than 20 years of instability and conflict resulted in major population displacement in South-Kivu, DRC. In Masisi, IDPs lived in four IDP camps.

A survey carried out by UNHCR among a random sample of 582 displaced women and girls aged 15-49 in December 2013 showed that:

- 33 per cent of minors and 48 per cent of adult females had sex for money in the past three months
- 37 per cent of women/girls had been sexually abused in the past 12 months: 44 per cent by an unknown person, 27 per cent by a client during sex work and 13 per cent by an intimate partner
- 13 per cent of women/girls had four to 10 partners in the past three months, of whom 38 per cent never used condoms.

Approach: The project intended to address the medical and protection needs and rights of women exchanging sex for money. It aimed to contribute to the reduction of HIV and STI transmission, to reduce the number of unwanted pregnancies, to promote respect for the human rights of sex workers and to reduce sexual violence. The project used a systematic step-by-step approach as follows:

1. Initial assessment;
2. Creation of a multisectoral team;
3. Pre-project training and communication to build awareness and ownership among stakeholders;
4. Identification and mapping of hotspots and snowball effect;
5. Profiling and individual risk reduction plans;
6. Engagement of sex workers for leadership, design and peer support (inclusion in the multisectoral team);
7. Service strengthening (SRH, HIV, GBV, PSS, protection, referral);
8. Referral to protection actors for children found to be in exploitative situations;
9. Monitoring and evaluation.

Results: A routine data collection system was set up at the start of the project. The analysis of the data collected between December 2013 and December 2014 showed the following results (n = 880 women who sell sex):

- 68 (7 per cent) received post-exposure prophylaxis after rape during the first year of the project;
- 83 (9.4 per cent) received emergency contraception;
- No HIV seroconversion was observed among the participants of the programme;
- 100 per cent were attending their quarterly reproductive health check-ups in a timely manner.

Conclusions:

- Service providers' and other stakeholders' language and attitudes may be judgemental or inappropriate. Taking time to explain the approach and obtain provider buy-in before starting the project is essential for a coordinated and respectful approach.

- Sex workers take risks by participating in the programme because they are more visible, and this can lead to discrimination and violence against them or their children. All efforts should be made to protect their anonymity and their safety, with the support of health-care providers, the police and teachers (e.g. safe record-keeping, small groups sessions, use of different meeting spaces).
- Clients are frequently violent and often refuse to use condoms. Restoring dignity and enhancing support mechanisms among women who sell sex is the first step to reducing GBV against sex workers and to ensuring the use of condoms. The sex worker-led programming approach, coupled with psychological support and education or the provision of information about women's rights, is an essential strategy.
- Sexually abused children, children in exploitative situations and children of sex workers are in great danger and require rapid interventions. Health and protection programming should include referral pathways and interventions targeting these children.
- Empowering and engaging women who sell sex and supporting them to steer the project resulted in appropriate and innovative solutions (e.g. work with teachers and child protection actors to stop bullying of children of sex workers and avoid school dropout in girls who are in exploitative situations).

2.3.2. IMPROVE ATTITUDES AND REDUCE STIGMA

Stigma is one of the largest drivers of violence and discrimination against people who sell or exchange sex.⁴⁷

Not only women who sell sex, but also gay, bisexual and other men who have sex with men (MSM), and transgender persons engaged in sex work, may face double stigma, as well as criminalization, and they stand out as particularly vulnerable to different forms of violence, discrimination and abuse. To improve attitudes, ensure respect, dignity and to do no harm, a number of basic actions can be considered:

- Organize short training sessions to share information on the circumstances and needs of all people selling or exchanging sex, and suggest strategies for addressing their diverse needs;
- Set minimum training standards for raising awareness, clarifying values and developing supportive, non-stigmatizing attitudes among health and protection staff;
- Provide tools, guidance and exercises in a structured way – to help actors to recognize how their values and attitudes influence their decision-making, actions (and inactions) towards people who sell or exchange sex;
- Values clarification and attitude transformation (VCAT) tools have been developed for other issues that create stigma and discrimination.⁴⁸ For example, specific guidance is available for comprehensive care for minority groups such as trans people.⁴⁹ Such tools and approaches can be adapted to reflect on and clarify values and attitudes of actors regarding people who sell or exchange sex;
- Help participants to recognize that conscious and unconscious biases influence their attitudes and values. Training can cover conducting objective needs assessments, non-judgemental and positive approaches, ensuring a professional disposition for assisting others, attitudes displayed during interactions and conversations, and the need to take reports of violence seriously;
- Open up dialogues at all levels to identify specific challenges and strategies to address them: between humanitarian actors, with health care providers and protection staff, with community leaders and within communities, and with sex workers themselves.

47 *Implementation of Comprehensive HIV/STI Programmes with Sex Workers (SWIT)*

48 Recommended resource: IPAS, <https://www.ipas.org/resources/abortion-attitude-transformation-a-values-clarification-toolkit-for-humanitarian-audiences>

49 USAID, United Nations Development Programme (UNDP), WHO, Asia Pacific Transgender Network and Health Policy Network, *Blueprint for the Provision of comprehensive care for trans people and trans communities in Asia and the Pacific* (New York, UNDP, 2010).



2.4. Health response

2.4.1. MINIMUM INITIAL HEALTH SERVICES

This section summarizes the priority health responses for people selling or exchanging sex in humanitarian settings. Technical guidance is developed below and should be accompanied by specific consideration of the following:

- **The need for non-discriminatory access to all health services.** Sensitization of all health actors is necessary to ensure the delivery of non-stigmatizing/non-discriminatory health services to all people who sell or exchange sex, as well as those perceived as such and their dependants.
- **Ensure access to necessary medical supplies and an operational supply chain.** Identify additional medical supply needs and agree on procurement and supply chain mechanisms. Refer to UNFPA guidance for reproductive health supplies in humanitarian settings.⁵⁰
- **Ensure adequate clinical capacity of health service providers.** Identify and address training and support needs.
- **Identify specific referral pathways.** Engage people who sell and exchange sex as peer educators and navigators in the development of referral pathways, and gather feedback to continuously monitor the acceptance and utility of these pathways while ensuring responses to any inputs received.

Condoms and water-based lubricants

Correct and consistent condom use is the most effective way to prevent sexual transmission of HIV and other STIs among people who sell or exchange sex, their clients and their other sexual partners. Condoms also contribute to averting unintended pregnancy.

Male and female condoms and lubricant should be openly displayed and available free of charge in public places, health facilities, sanitary installations and other convenient locations. Condoms and lubricant need to be compliant with UNFPA/WHO specifications (i.e. be water based) and are best co-packaged and distributed together. Health-care providers and peer educators need information on the correct use of both male and female condoms if they are to be able to increase awareness and teach people how to use condoms. Female condoms should also be included in condom procurement and programming in stable settings, and where female condoms were used prior to the development of the prevailing humanitarian situation.⁵¹ The distinct characteristics and advantages of female condoms can be promoted:

50 UNFPA guidance at <https://www.unfpaprocedurement.org/humanitarian-supplies>.

51 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, chapter "Minimal Initial Service Package (MISP)", p. 40.

- Unlike the male condom, the female condom is inserted inside the woman and can be inserted before sex;
- It can be used when clients cannot maintain an erection;
- Use of the female condom requires less cooperation from the sexual partner;⁵²
- It increases choice and grants women greater control.

While ensuring easy access to condoms, it is also important to protect people's privacy and confidentiality, and any potential barriers to access should be anticipated (e.g. easily observed location, restricted access hours and any identification requirements).

All male and female condoms are single-use commodities and should never be reused. Male and female condoms should not be used at the same time, owing to the potential for friction breakage.

Tailored communication messages need to be developed and disseminated to people who sell or exchange sex to reduce barriers to condom use. People who sell sex should be:

- Enabled to take as many condoms and lubricants as they may need;
- Informed about correct and consistent use of both male and female condoms with lubricant;
- Informed about where to find condoms and lubricants;
- Knowledgeable on how to use and safely dispose of condoms as well as the use of the correct type of lubricant, and on the avoidance of oil-based lubricants and substances that weaken latex condoms.

Pre-exposure prophylaxis for HIV

PrEP is the use of ARVs to prevent acquisition of HIV by people who are not infected but who are at "substantial risk", including people who sell or exchange sex.⁵³ It is recommended that PrEP containing tenofovir disoproxil fumarate (TDF) should be offered for all people at substantial risk of HIV infection as part of combination HIV prevention approaches, including for people who sell or exchange sex.⁵⁴ As PrEP for at-risk people is increasingly part of national programmes, people affected by humanitarian emergencies may already be on PrEP, and continuation of PrEP should be ensured.

Post-exposure prophylaxis for HIV⁵⁵

ART for PEP should be offered and initiated as early as possible in all individuals with an exposure that has the potential for HIV transmission (e.g. unprotected sexual intercourse with a sexual partner of unknown HIV status, skin penetration with use of unsterilized injecting equipment or occupational exposure). PEP treatment should be commenced as early as possible and not more than 72 hours after exposure.

PEP is not necessary for people who are already diagnosed with HIV infection and who are receiving ART.

52 SWIT, chapter 4: "Condom and lubricant programming" p. 86.

53 "Substantial risk" is defined as HIV incidence ≥ 3 per 100 person-years.

54 WHO, *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection – Recommendations for a Public Health approach – Second Edition* (Geneva, WHO, 2016).

55 WHO, *Consolidated Guidelines on the Use of ARV Drugs for Treating and Preventing HIV Infection* (Geneva, WHO, 2016).

Repeated use of PEP is not contraindicated; however, there are better protection strategies, particularly condom use, harm reduction programmes for people who inject drugs, and potentially PrEP (see “Pre-exposure prophylaxis for HIV”). Although HIV testing is not required, it may be provided, if desired by the exposed person.

In most contexts, national PEP protocols will be available and should be used as reference. If national guidance is not available, refer to international guidance. Recommendations for ART, including for PEP, are often updated – at present, the following general guidance⁵⁶ is validated by WHO. Up-to-date WHO guidance should be checked when developing protocols.

The PEP regimen entails:

- A 28-day treatment with at least two and preferably three ARVs as recommended following risk assessment;
- Enhanced adherence counselling for all individuals initiating HIV PEP (see **Annex 1**).

Contraception

In addition to using male or female condoms to prevent HIV, other STIs and pregnancy, further protection against unintended pregnancy may be required with another modern contraceptive method. Double protection (using condoms plus another modern method) is recommended because: (1) condoms are less consistently used with intimate partners or spouses than with other partners or clients; and (2) condoms require consistent use at the time of sex and full collaboration with the sexual partner. In addition, condoms have a relatively high failure rate when used as the sole contraceptive method.⁵⁷ Long-acting, reversible contraception (LARC) has the lowest failure rates, with injectable hormonal contraceptives (intramuscular or subcutaneous) considered the most discreet.

Ensure availability of a range of long-acting reversible and short-acting contraceptive methods [including male and female condoms and emergency contraception (EC)] at primary health-care facilities to meet demand.⁵⁸ An overview of methods and their effectiveness is provided in **Annex 2**.

EC should be available everywhere and offered to any woman or girl of reproductive age who presents with concerns following unprotected sexual relations. EC should not be reserved solely for rape victims. EC has no side effects and can be used several times if necessary; however, in the case of continuous risk of pregnancy, more effective methods are recommended. Oral EC does not harm an established pregnancy and can be used without a prior pregnancy test. Oral EC is taken best within 72 hours of unprotected sex but can be used up to 120 hours after unprotected sex with reduced effectiveness.

As an alternative to oral EC, the copper-bearing intrauterine device (IUD) can also be used up to 120 hours after unprotected sex. If chosen, the copper-bearing IUD can then be retained by a woman as LARC. The copper IUD can be left in place for up to 10 years; it can also be removed any time the patient wishes, with an immediate return of fertility.

56 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, chapter “MISP”, pp. 32–33

57 Typical failure rate is 13 per cent for male condoms and 21 per cent for female condoms. CDC, <https://www.cdc.gov/reproductivehealth/contraception/index.htm>. Contraceptive efficacy chart <http://www.contraceptivetechnology.org/the-book/take-a-peek/contraceptive-efficacy/>

58 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, chapter “MISP”, pp. 50–51.

It is necessary to exclude an ongoing pregnancy and treat any reproductive tract infection or STI prior to placing a copper IUD. IUDs with hormonal action (non-copper-bearing) are not indicated as EC. While current guidance calls for caution in the use of IUDs among women who are at elevated risk of STIs, it also recognizes that not all women who sell or exchange sex share the same life situations and STI risks. For this reason, the IUD remains a viable option for certain women, even if they do not self-identify as sex workers. In such cases, use of an IUD should be considered in close consultation with a qualified health-care provider, taking into consideration the individual woman's STI risks and other relevant factors.⁵⁹ For all methods of contraception, seek elimination of barriers to their use, including cost and any third-party authorization requirement.⁶⁰

Management of abortion complications

Abortion complications are one of the four main causes of direct maternal mortality worldwide.⁶¹ Abortion complications are considered obstetric emergencies and need to be treated accordingly. As a priority, health staff need to be trained regarding the clinical management of abortion-related complications. Values clarification and attitudinal change should accompany this training to ensure non-discrimination of patients and awareness of potential provider bias that may influence clinical judgement and action. Staff need to be aware of their professional responsibilities regarding women and girls presenting with abortion-related complications, including their responsibility to safeguard medical confidentiality. In most contexts national protocols will be available and should be used as reference. If national guidance is not available, refer to international guidance.

Clinical management of rape

People who sell or exchange sex are particularly vulnerable to violence, including sexual violence, as a result of stigma and discrimination and their frequent isolation. They need the same clinical care as any other rape survivors, including compassion, active listening, professional attitude, clinical care and protection action. Clinical management of rape utilizes a survivor-centred approach and follows the guiding principles of safety, respect, confidentiality and non-discrimination.⁶² The legal requirement for obligatory reporting should be carefully assessed because it has the potential to cause survivors further harm, rather than being a protective measure.

Clinical care for survivors of rape or intimate partner violence aims to address the physical and psychological needs a victim may experience after an aggression, and to provide the treatment necessary to prevent long-term health consequences, including treatment of injuries, prevention of tetanus, prevention of HIV and HBV, presumptive treatment of STIs and prevention of unintended pregnancy. Psychosocial support (PSS) is an integral part of the clinical management of rape – all health-care providers should be familiar with psychological first aid.

59 Lisa Dulli, Samuel Field, Rose Masaba and John Ndiritu, "Addressing broader reproductive health needs of female sex workers through integrated family planning/HIV prevention services – a non-randomized trial of a health-services intervention designed to improve uptake of family planning services in Kenya", *PLOS ONE*, vol. 14, No. 7 (July 2019).

60 WHO, *Ensuring Human Rights in the Provision of Contraceptive Information and Services* (Geneva, WHO, 2014).

61 WHO, "Maternal mortality". Available at <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>.

62 *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, chapter "MISP", pp. 24–25.

Under most national laws, rape is considered a crime and the survivor is entitled to a medico-legal certificate. Directives on who is qualified to fill out and sign this certificate vary from context to context, but, in case of doubt, a standard certificate should be filled out, signed and made available to the survivor to support potential future claims. A copy of the certificate should be kept in a safe and confidential place, usually in the health facility.

Apart from immediate and longer-term health needs, including MHPSS, rape survivors may have other needs, including for a safe place, protection, legal support, and actions to improve resilience through safety training and skills building.⁶³

Health care providers need to ensure the immediate safety of rape survivors (as for any other survivor of violence). This can be done by using established referral pathways to other reliable actors or by offering hospitalization until more suitable care can be found. Any action, be it for immediate health care or referrals, requires the patient to be fully informed of the options and alternatives and to consent.⁶⁴ In the case of children and in the absence of a legal representative or when the goodwill of the legal representative is in doubt, health workers commit to acting in the best interest of the child.⁶⁵

In most contexts, national protocols will be available and should be used as reference. If national guidance is not available, refer to international guidance. Recommendations are often updated – the latest guidance from the WHO, UNFPA and UNHCR is *Clinical Management of Rape Survivors and Intimate Partner Violence*.⁶⁶ Up-to-date guidance should be checked when developing local protocols.

Note: People who sell or exchange sex can be subject to other forms of GBV. Gay men, other men who have sex with men and transgender people who sell sex can be particularly vulnerable to discrimination and abuse based on their sexual orientation or gender identity or expression. Further elaboration on different forms of GBV and related actions is provided in **Section 2.5**.

Maternal health care (antenatal and postnatal care, and emergency obstetric and neonatal care)

Pathways to all maternal, and emergency obstetric and newborn care should be identified and related services should be supported to ensure improved access for people who sell or exchange sex. Please see the *Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings*⁶⁷ for further information.

63 *Interagency Gender-Based Violence Case Management Guidelines*, IASC 2017.

<https://reliefweb.int/report/world/interagency-gender-based-violence-case-management-guidelines>

64 Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings, *GBV Guidelines, Guiding Principles and Approaches* (New York, Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings), 2015, pp. 45–47.

65 OHCHR, Convention of the Rights of the Child (Article 3), “in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration”. Assessing the best interests of a child means to evaluate and balance all the elements necessary to make a decision in a specific situation for a specific individual child or group of children” (Geneva, OHCHR, 1989).

66 WHO, UNFPA and UNHCR, *Clinical Management of Rape and Intimate Partner Violence* (Geneva, WHO, 2020).

67 Inter-Agency Working Group on Reproductive Health in Crises, *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (Inter-Agency Working Group on Reproductive Health in Crises, 2018).

Management of sexually transmitted infections

It is important that people who sell sex know how to recognize STI symptoms and seek STI-related health care. Syndromic management of STIs is a component of the Minimal Initial Service Package (MISP) for reproductive health in crisis, implemented in many countries where laboratory services are not available or where this approach is considered most cost-efficient. Syndromic management uses an algorithm based on each patient's self-reported symptoms and clinical signs – for example lower abdominal pain, genital ulcers, urethral or vaginal discharge, or anorectal ulcer or discharge – to identify the most likely treatment or treatments needed. The approach allows a one-stop consultation with no laboratory work required. Antibiotics recommended by WHO for syndromic treatment of STIs⁶⁸ are available in the Inter-Agency Reproductive Health kits. As the syndromic approach is widely used, national protocols are also likely to be available. Where STI pathology services are available, aetiological diagnosis of STIs can be offered – for example where individual refugees or refugee settlements are located in or close to urban centres.

Periodic presumptive treatment of sexually transmitted infections

In places with high STI prevalence (e.g. > 15 per cent gonorrhoea or chlamydia) and limited health services, periodic presumptive treatment (PPT) for common STIs may be offered to people who are selling or exchanging sex. This should always be on a voluntary basis and offered only as a short-term, emergency measure.⁶⁹ Presumptive treatment can start on the same day as EC and PEP for HIV. Furthermore:

- PPT should always be free, voluntary, with informed consent, and confidential, and should be accompanied with counselling, including on the potential side effects of PPT;
- PPT should be part of more comprehensive SRH care (including community empowerment, peer outreach, and enhanced condom promotion and negotiation skills). PPT can be only a temporary measure while STI services are further developed;
- There should be ongoing monitoring of the possible benefits and harm that people who are selling or exchanging sex could experience from being offered PPT;
- PPT should be phased out as soon as possible, and after six months maximum, even if prevalence has not declined, as other measures should by then be in place to prevent and maintain control of STIs.⁷⁰

In most contexts, national protocols will be available and should be used as reference. If national guidance is not available, refer to international guidance. Current recommended treatments for common STIs are given in **Annex 4**. If other STIs are also prevalent in the area (such as chancroid), presumptive treatment for these infections should also be given. The included WHO guidance is the latest version, and recommendations are often updated. The latest WHO guidance should be checked when developing protocols.

68 Inter-Agency Working Group on Reproductive Health in Crises, *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, chapter "MISP", p. 30, table 3.2.

69 See SWIT chapter 5: "Clinical support services".

70 Previously sex workers have reported that the potential risks of PPT outweigh the benefits. There should be ongoing monitoring of possible harm that people who sell or exchange sex may experience. PPT should be offered only together with all relevant information, and should be voluntary and not imposed as part of a mandatory public health effort.

2.4.2. COMPREHENSIVE HEALTH RESPONSE

As an emergency situation stabilizes, or in longer-term and more protracted situations, more comprehensive programming and further community empowerment, outreach and health promotion need to be built on the initial health-care and protection measures. Immediate, minimum responses should be replaced with more considered and comprehensive actions that aim to encourage and enhance further health-seeking behaviours. This involves a shift from an approach that is one of primary health care and mainly takes place on fixed sites to one involving more outreach, home visits and active case-finding of specific individuals, and engaging with vulnerable and hard-to-reach groups – including people who sell or exchange sex. Health messaging can be refined and the profile of interlocutors (humanitarian responders and actors) can be adjusted to increase trust and acceptance by people who sell or exchange sex. Sex worker peer educators can be used to identify and recruit persons into health services, and peer sex worker navigators can accompany people who sell or exchange sex to guide and reassure them when approaching health and protection services.

Health and protection services warrant a rights-based and people-centred approach throughout, ensuring voluntary and informed consent and avoiding any form of coercion or judgemental attitudes. High-quality care, adequate information and patient empowerment are all necessary to enable people to make their own choices about accepting treatment and care.

Efforts should be made to promote access to national health and social services among populations in humanitarian settings, including people who sell or exchange sex. This includes access to national HIV and tuberculosis programmes, ART, human papillomavirus (HPV) vaccination and screening, and cervical cancer screening and treatment.

Intake file with context-specific screening questions

For each new person enrolled in a health service, community health and clinic workers can complete an intake form, enabling patient follow-up and monitoring of services that they receive. Individuals are assigned a unique and confidential identification code, and information is collected on: (1) the individual's risks and vulnerabilities; and (2) the services they received at each visit. This enables better follow-up and helps to build rapport with each individual – illustrating the professional and competent nature of the care received,⁷¹ (see examples of enrolment forms **Annexes 3.1, 3.2 and 3.3**). Intake files are not obligatory, and a person declining an intake file must be able to access all available services without restriction.

71 See also SWIT, chapter 5.1: “Operational principles for clinical and support services”.

Further programming on condoms and lubricants, and contraceptive services

As part of comprehensive action, consistent condom use can be further promoted, through:

- Training of users to improve life skills and condom negotiation skills;
- Peer education and outreach – furthering distribution, promotion and teaching of correct use of condoms;
- Specific health-care provider and peer educator training on condom use.
- Further elements of condom programming with people who sell or exchange sex include: condom supply planning, diversifying outlets, peer-led condom promotion, further co-packaging of condoms and lubricants, suggestions for non-penetrative sexual services that do not require condoms, and condom programming with male and transgender individuals who sell or exchange sex.

Comprehensive contraceptive services build on the initial availability of condoms, EC and other contraceptive methods (typically oral contraceptive pills and injections), increasing the availability and promotion of the whole range of modern contraceptive methods. Health staff can receive further training for the provision of all long-acting methods, including implants and IUDs.

Specific training on contraceptive methods as well as values clarification should be considered at an early stage to ensure that service providers have the necessary clinical knowledge, appropriate supportive attitudes and skills for administering implants, IUDs and other LARC. Providers should be aware of potential provider bias when discussing contraceptive options. Specific discussion on contraceptives for adolescents should occur and related legal restrictions may need to be considered, as well as ways of removing any barriers these may present. The best interest and the immediate health and protection needs of the young person who is selling or exchanging sex should always be considered paramount.

Contraceptive services⁷² should provide information on:

- Medical eligibility criteria for contraceptives,⁷³ including guidance on whether or not people with certain medical conditions can safely and effectively use specific contraceptive methods;
- Selected practice recommendations for contraceptive use, which should address questions about how to use various contraceptive methods.

Contraceptive needs, preferences and potential constraints may be different for each person, and the final choice of method is made solely by the person seeking contraceptive protection.

72 WHO, *Family Planning – A Global Handbook for Providers* (Geneva, WHO, 2018).

73 WHO, *Medical Eligibility Criteria for Contraceptive Use in Humanitarian Settings* (Geneva, WHO, 2020).

Pre-exposure prophylaxis for HIV

PrEP should be offered to anyone who has tested negative for HIV, and who is at increased risk of HIV exposure, including people who have contracted another STI and people who sell or exchange sex. PrEP requires administration of a daily oral dose, taken as a fixed-dose combination pill.⁷⁴ Patient monitoring should occur at least every three months. To date, no adverse effects of PrEP on mothers or infants have been observed during pregnancy and breastfeeding. Counselling is important to advise that PrEP does not protect against other STIs or against unintended pregnancy. People who sell or exchange sex should continue to use barrier protection – condoms for vaginal and anal sex and dental dams for oral sex, with PrEP providing an extra level of protection against HIV.

Appropriate messaging and counselling are essential for increasing uptake and optimal use of PrEP, which should be offered in accordance with prevailing national guidelines. If national guidelines are not available, refer to latest international guidance. Ensure to check for updates as treatment approaches and protocols change regularly:

- *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations;*⁷⁵
- *Prevention and control of sexually transmitted infections (STIs) in the era of oral pre-exposure prophylaxis (PrEP) for HIV.*⁷⁶

In addition to PrEP, targeted action for the prevention of HIV infection should further include HIV testing services (HTS), condom use, and STI screening and treatment.

HIV testing services and treatment

Voluntary HIV testing, and subsequent treatment of persons diagnosed with HIV with ART and treatments for opportunistic infections, are important measures that contribute to reduced transmission, and increased survival and health of people living with HIV (PLHIV).

- People who sell or exchange sex require access to voluntary HIV counselling, testing and treatment;
- HTS are guided by the 5Cs: consent, confidentiality, counselling, correct test results, and connection to HIV prevention, treatment and care.⁷⁷ Any person tested and confirmed to be HIV positive should be offered lifelong ART, independent of their CD4 count and viral load at time of diagnosis.⁷⁸ Establishment of access to voluntary testing and pathways to treatment are therefore a priority;
- Depending on the context and resources available, voluntary testing can be made available through a variety of settings, including safe spaces, such as DICs, homes and households, bars, clubs and brothels, and through mobile outreach;

74 CDC, "Pre-exposure prophylaxis". Available at <https://www.cdc.gov/hiv/risk/prep/index.html>.

75 WHO, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (Geneva, WHO, 2016).

76 WHO, *Prevention and Control of Sexually Transmitted Infections (STIs) in the Era of Oral Pre-exposure Prophylaxis (PrEP) for HIV* (Geneva, WHO, 2019).

77 WHO, *Consolidated Guidelines on HIV Testing Services – 5Cs: Consent, Confidentiality, Counselling, Correct Results and Connection* (Geneva, WHO, 2015).

78 WHO, *Guideline on When to Start Antiretroviral Therapy and on Pre-exposure Prophylaxis for HIV*. (Geneva, WHO, 2015).

- Where feasible, HIV self-testing (HIVST) should be offered as an additional approach to HTS.⁷⁹ HIVST is a process whereby a person who wants to know their HIV status collects a specimen, performs a test and interprets the test result in private. Community outreach workers, peer educators and lay counsellors can be trained to play an important role in encouraging HIVST, as well as in counselling and ensuring treatment adherence. HIVST is a screening test – it does not provide a definitive diagnosis – and so confirmatory testing is required if the initial result is positive. HIVST may increase the number of people who test, know their status and, if testing positive, are linked to treatment. WHO updated its self-testing guidelines in 2019,⁸⁰ and encourages countries to conduct demonstration and pilot projects to identify effective approaches for implementation in key populations. For self-testing to be effective, confirmatory testing and treatment services must also be available;
- As a minimum, HTS should be available in all health services.⁸¹ It should be systematically offered to key populations, including people who sell or exchange sex in all health services and to anyone presenting with an STI;
- HIV testing should not be mandatory for people who sell sex, nor should they be coerced into testing.

For persons who are confirmed to be living with HIV, ART protocols are generally available at national level and should be followed as long as these do not contradict latest WHO recommendations for first- and second-line ART⁸² and specific ART treatment guidance for key populations.⁸³ Treatment for opportunistic infection(s) needs to be considered systematically.

For HIV testing and treatment, use national guidance whenever available. Where this is not available, refer to:

- *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*,⁸⁴
- Additional guidance in **Annex 13** that is specific to sex workers.

Unintended pregnancy

Unintended pregnancy can be a reason for isolation, including family or community rejection. Furthermore, isolation is recognized as a contributing factor to the decision to sell or exchange sex.

Women and girls who become unintentionally pregnant may seek a termination. If safe care is not available, they may choose unsafe methods despite the risk to their health, life and future fertility.

79 WHO, *Consolidated Guidelines on Self Care interventions for Health: Sexual and Reproductive Health and Rights* (Geneva, WHO, 2019).

80 WHO, *Policy Brief: WHO recommends HIV self-testing – evidence update and considerations for success*. (Geneva, WHO, 2019). Available at <https://www.who.int/publications/i/item/WHO-CDS-HIV-19.36>

81 WHO, *Consolidated guidelines on HIV testing services for a changing epidemic*. (Geneva, WHO, 2019). Available at <https://www.who.int/publications/i/item/WHO-CDS-HIV-19.31>

82 WHO, *Update of Recommendations on First and Second Line Antiretroviral Regimes* (Geneva, WHO, 2019).

83 WHO, *Key Considerations for Differentiated Antiretroviral Therapy Delivery for Specific Populations: Children, Adolescents, Pregnant and Breastfeeding Women and Key Populations* (Geneva, WHO, 2017).

84 WHO, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations* (Geneva, WHO, 2016). <https://apps.who.int/iris/bitstream/handle/10665/246200/978924151124-eng.pdf?sequence=8>, pp. 53–54.

Unsafe abortion is one of the main causes of maternal death worldwide,⁸⁵ in some contexts representing up to 30 per cent of all maternal deaths. Preventing unsafe abortion is considered a public health priority.⁸⁶ Management of unsafe abortion is deemed to be emergency obstetric care and is not subject to legal restriction in any country.

Cervical cancer screening and treatment

Cervical cancer screening is recommended as priority for every woman aged 30–49, with screening even once in her lifetime also beneficial.⁸⁷ Screening may be carried out through visual inspection with acetic acid (i.e. vinegar) or conventional Pap smear. If available, testing for infection with human papilloma virus (HPV) – the primary cause of cervical cancer – can also be conducted. Pre-cancerous and cancerous lesions should be treated immediately. HPV infections are more likely to occur, persist and progress to cancer in people living with HIV,⁸⁸ who should undergo regular screening and immediate treatment of pre-cancerous lesions.⁸⁹ Treatment referral pathways need to be established. Screening for other cancers such as breast, anorectal and prostate cancer, should be part of routine care, and links to treatment services should be provided.⁹⁰

Note: HPV vaccination of female adolescents is recommended in all stable settings, particularly in countries where the prevalence of cervical cancer is high. The primary target group is young adolescent girls, aged 9–14. However, increasingly, older adolescents and young women, as well as adolescent boys, are included in vaccination programmes. Two or three doses are necessary for full protection against the main HPV serotypes.⁹¹

Where national vaccination programmes are available, ensure that refugees are included.

Care for people living with HIV

In addition to HTS, ART and cervical cancer prevention, screening and treatment services for people living with HIV, further testing and treatment of tuberculosis and hepatitis B virus is recommended. HBV vaccination can be provided for people living with HIV who are seronegative for HBV.

Mental health

Crisis-affected populations may experience a substantial and diverse range of mental and neurological problems. Sex workers may be particularly vulnerable to mental health problems, with poverty, criminalization, marginalization, discrimination and violence compounding the existing stresses of a humanitarian crisis.

85 WHO, UNFPA, World Bank Group and UNPD, *Trends in Maternal mortality 2000–2017* (Washington DC, World Bank Group, 2019).

86 WHO, *Unsafe Abortion – Evidence Brief* (Geneva, WHO, 2019).

87 WHO, *Guidelines for Screening and Treatment of Precancerous Lesions for Cervical Cancer Prevention*. (Geneva, WHO, 2013).

88 WHO, *Guide to Introducing HPV Vaccination into National Immunization Programmes* (Geneva, WHO, 2016).

89 WHO, *Guidelines for Screening and Treatment of Precancerous Lesions for Cervical Cancer Prevention*. (Geneva, WHO, 2013).

90 SWIT, chapter 5, Clinical and Support Services, p. 127.

91 WHO, “Human Papillomavirus (HPV)”. Available at <https://www.who.int/immunization/diseases/hpv/en/>.

Poor mental health may be a barrier to seeking testing or treatment for HIV and for continuing care for those who are living with HIV. Programmes should monitor and address any obstacles to accessing mental health services, for example barriers created by service providers who are either unskilled in recognizing mental health problems or actively stigmatize sex workers with such problems.⁹²

The WHO Mental Health Gap Action Programme (mhGAP) *Humanitarian Intervention Guide*⁹³ contains first-line management recommendations for mental, neurological and substance use conditions for non-specialist health-care providers in humanitarian settings, where access to specialists and treatment options is limited. It is a practical tool that aims to support general health facilities in assessing and managing acute stress, grief, depression, post-traumatic stress disorder, psychosis, epilepsy, intellectual disability, harmful substance use and risk of suicide. Health-care providers in many refugee situations have been trained in the mhGAP. Programme managers should identify referral pathways and raise awareness of service providers of the rights and mental health needs of people who sell or exchange sex.

Whether or not specialized mental health services are available, health workers play an important role in the psychosocial well-being of people who sell or exchange sex. According to the Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, psychosocial considerations that respect the dignity, safety and autonomy of people accessing basic services contribute to the prevention of mental disorders and to the psychological resilience of service users.⁹⁴

In addition, support from community members can have both a protective and therapeutic effect for persons experiencing or vulnerable to psychosocial distress. This underscores the importance of safe spaces, community-led outreach and other actions detailed in **Section 2.5.2: Substance use.**

There is a documented overlap between sex work and substance use, often compounding mental health issues.⁹⁵ People selling or exchanging sex in humanitarian settings, and those who use or inject drugs, should be offered non-judgemental referral to available harm reduction services such as needle and syringe programmes, opioid substitution therapy, HTS, mental health services and other interventions where these are available. If not yet available, efforts should be made to advocate that national programmes be extended to or established in locations hosting humanitarian crisis-affected populations.

92 SWIT, chapter 5, Clinical and Support Services, p. 128.

93 WHO and UNHCR. *mhGAP Humanitarian Intervention Guide – Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies* (Geneva, WHO, 2015).

94 Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings. *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (New York, Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings, 2005).

95 United Nations Office on Drugs and Crime, *HIV-related Vulnerabilities and the Intersection of Sex work and Drug Use* (Vienna, UNODC, 2013).



2.5. Protection

People who sell or exchange sex may face increased risk of violence as a result. It is essential for humanitarian – and particularly protection – actors to understand, recognize and respond to the factors contributing to violence against people who sell or exchange sex. These include stigma, marginalization, harassment and extortion, and criminalization of sex work. While selling or exchanging sex increases people’s vulnerability to violence, the sale or exchange of sex is not inherently a form of violence. It is important to recognize that in humanitarian settings there is potential, partial overlap of sale or exchange of sex with GBV. While there are common health needs for all people engaged in the sale or exchange of sex, protection considerations need to differentiate between:

- People who consider that they are engaging in the sale or exchange of sex without being forced or coerced by another person;
- People who consider that they are being forced or coerced by another person to sell or exchange sex;
- Minors engaged in selling or exchanging sex.

The first group needs to be provided with a safe environment and given skills enabling them to sell or exchange sex safely. The last two are forms of GBV and need to be addressed accordingly through protection action. These issues are discussed in the following sections.

If people who engage in selling or exchanging sex consider that they are doing so without being forced or coerced by another person, then from a human rights perspective – which endows every individual with agency – their decision to sell sex has to be respected. The goal of the protection sector/cluster is not to prevent people from engaging in these practices.⁹⁶ Rather, protection actors need to prevent violence against people who sell or exchange sex and support them in knowing and claiming their rights to assistance, safety and dignity. It is essential for humanitarian actors – especially protection actors – to understand the factors that contribute towards violence against people who sell or exchange sex, including stigma, marginalization, broader gender-based and interpersonal violence, and criminalization of sex work. Actors need to recognize these precipitating factors and take them into account when providing support and responses for people who sell or exchange sex.

At all times, humanitarian action should include an active effort to reduce stigma and negative attitudes towards people selling or exchanging sex. Stigma is one of the largest drivers of violence and discrimination against people who sell sex and fosters an environment in which further violence and discrimination are tolerated. Action to reduce stigma includes opening dialogues, values clarification and recognizing and responding to specific needs. Dialogue is required at all levels: between humanitarian actors, with health-care providers and protection staff, with community leaders and in communities, and with sex workers and their families. Structured ways to explore values and attitudes can help different actors to recognize how their own values, attitudes and unconscious biases influence their actions (or inaction) regarding people who sell or exchange sex.

⁹⁶ As noted in the introduction, a longer-term goal of humanitarian aid is to address the structural drivers of scarcity, inequity and violence in humanitarian settings, which influence people’s decisions to sell and exchange sex. Global and national policy change is needed to facilitate forcibly displaced individuals’ access to resources and opportunities, so that nobody who does not wish to has to rely on selling sex to meet their basic needs.

2.5.1. MINIMUM INITIAL PROTECTION MEASURES AND ACTIONS

Information on legal provisions, rights and protection

All interactions with people who sell or exchange sex should be used as an opportunity to provide information on legal provisions and protection, including a person's rights, how to claim these, how to act when detained and whom to contact. Information should be developed in a way that is contextually appropriate and accessible to different groups of people who sell or exchange sex (e.g. consider language, formats and media).

Vulnerability mapping

It is useful to identify additional characteristics of people who are selling or exchanging sex in humanitarian settings to further tailor services that meet their specific needs. People who sell or exchange sex may include:

- Gay, bisexual or other men who have sex with men, who may experience additional challenges as a result of criminalization of same-sex relations;
- Transgender people including both trans men and trans women (trans women who sell sex often have higher HIV rates than non-trans sex workers);
- Sex workers with disabilities – many people with a disability encounter barriers to securing other forms of work. Humanitarian actors often do not realize that people with disabilities may be selling sex (owing to unconscious biases about persons with disabilities);
- Unaccompanied and separated children, minors and youth;
- Older women who sell sex (including those who are married or are widows);
- Persons from ethnic minorities including displaced indigenous people.

When people who sell or exchange sex access services, they can be invited to share their circumstances, characteristics and preferences for care. Visits may also be made to locations where people sell or exchange sex to strengthen further dialogue. Having mapped the different vulnerabilities of people who sell sex, further specific efforts are possible to address their specific needs.

Advocacy for harm reduction

Harm reduction measures for people who sell or exchange sex involve a number of interventions to minimize the health and security risks associated with selling sex. The above health section focuses on health interventions, including the provision and promotion of the use of condoms, HIV and other STI testing, the provision of PrEP, PEP and ART, and ensuring access to contraception. This section on protection highlights another set of actions for reducing security risks of people who sell or exchange sex, including awareness-raising, safe working practices and learning specific skills, such as how to negotiate with clients.

There are multiple possibilities for harm reduction. However, a harm reduction approach must include and ensure non-judgemental support for people who have chosen activities or behaviours that involve particular risks, including selling sex. Harm reduction aims to minimize these risks rather than to change the risky behaviour. It is a rights-based, person-centred approach that meets people “where they are”, rather than directing them “where to go”. The key to a harm reduction approach is thus to understand people’s situation and the threats they face, and to identify measures that reduce the risks associated with these threats.

Advocacy for harm reduction on a protection level requires knowledge of local laws, policies and practices that increase vulnerability of people selling or exchanging sex. Specific vulnerabilities may include:

- Lack of support or assistance. Lack of basic food and livelihood needs can drive people to sell or exchange sex. Shortcomings in humanitarian assistance need to be continuously monitored and highlighted. It is the responsibility of all humanitarian actors to advocate to improve food and livelihood assistance and compliance with international standards;
- Camp security activities that present a threat. Harassment and abuse of people who sell or exchange sex are discriminatory actions that need to be identified and addressed. “Gathering points” for people who sell or exchange sex are sometimes bulldozed or otherwise dismantled to scatter people, thus increasing their isolation and vulnerability. Actors need to identify these potential threats and advocate for reforms by discussing solutions with camp managers. Security personnel and the police need to be informed of and sensitized to the rights of people who sell or exchange sex. There is a need to align and harmonize camp operating and security procedures and practices with harm reduction measures for people who sell or exchange sex.

2.5.2. COMPREHENSIVE PROTECTION MEASURES AND ACTIONS

Based on UNHCR’s operational protection experience, the needs of forcibly displaced persons engaging in sex work are best addressed through tailored and integrated comprehensive packages of health and protection services. Health and protection programmes for people who sell or exchange sex need to be flexible and adapted to the specific needs and constraints of each humanitarian context. For example, in camp situations, response services may be required both inside and outside camps. Key to the success of the response is to ensure a service continuum for people who sell or exchange sex. Once immediate vulnerability to violence and discrimination are addressed, further harm reduction approaches can be built up over time in more protracted or stabilized settings. These approaches are drawn from key population programming in broader development settings and include: (1) community empowerment; (2) community-led outreach and peer education; (3) establishing safe spaces/DICs; and (4) advocating for rights and harm reduction.

Community empowerment

Community empowerment is an essential part of rights-based programming with and for people who sell or exchange sex. It involves building the knowledge, capacity, skills and confidence of people who sell or exchange sex, so that they can make informed decisions and better care for themselves and their peers. A set of core approaches for guiding community empowerment are given in **Annexes 6, 7 and 8**. There is no set formula, but key elements of a community empowerment programme, plus various peer-led empowerment models, have been implemented in both camp and urban humanitarian settings. UNHCR provides further specific guidance on community-based protection in refugee and other forced displacement situations.⁹⁷

Community-led outreach and peer education⁹⁸

Community-led outreach and peer education are two key, field-tested, interrelated elements of a community empowerment programme.⁹⁹ Community-led outreach and education are often delivered together by the same individuals, commonly those who themselves sell sex, and who are often employed or managed by a local community-based NGO. Training is provided on topics, including: (1) sexual health; (2) condom distribution, demonstration and negotiation skills; (3) safety in selling sex; (4) peer counselling; and (5) referral pathways. Outreach workers and peer educators share this knowledge and distribute resources through one-on-one or small-group activities. There is a two-way flow of information, from the NGO or other service provider to outreach workers and then on to community members, and from the community to the service provider, about the lived reality of persons selling or exchanging sex, their skills, resources and needs to further improve collaboration and programming.

Steps for developing community-led outreach and peer education programmes include:

- Map the outreach areas;
- Recruit and train community outreach workers and peer educators applying an AGD-sensitive approach to ensure they will be able to meaningfully reach diverse groups in the community;
- Remunerate outreach workers and educators (they are giving up potential earning time);
- Foster leadership opportunities to identify individuals who can take a lead role;
- Ensure documentation of experience and dialogue with and between peers, debriefing and identification of PSS needs (e.g. through regular team briefing and exchange sessions);
- Supervise, mentor and support outreach workers;
- Tailor outreach in different settings – for example, considering recipients of different ages, genders, languages, religions and ethnic groups.

⁹⁷ UNHCR, *Guidance on Community Based Protection*, 2013 (Geneva, UNHCR).

⁹⁸ Find more information and resources regarding peer education in **Annex 8**.

⁹⁹ SWIT, chapter 3: “Community-led services”.

Safe spaces and drop-in centres¹⁰⁰

Safe spaces for people who sell or exchange sex are places where individuals can socialize, form a sense of community or a peer network and hold group activities. Individuals can also seek shelter here and be counselled, for example if they have experienced violence or assault, or if they have specific protection needs. In humanitarian settings, they are a main venue for interactions between programme and protection staff, outreach workers, peer educators and beneficiaries. Safe spaces can also be used to:

- Share information with and between individuals who sell sex;
- Provide condoms, lubricant and clinical services;
- Discuss the risks, discrimination and violence faced by individuals who sell sex;
- Discuss specific protection needs (e.g. the need for identification/documentation and legal advice);
- Plan and review outreach activities and responses;
- Hold educational sessions, including training sessions for peer educators and outreach workers;
- Provide specialized services such as MHPSS and GBV case management.

The location and set-up of a safe space will vary with local situation, context and resources. Choice of location should consider discreetness, such as its visibility to others including the broader community. Safe spaces can be established exclusively for individuals who sell or exchange sex; however, this may risk attracting attention and exposing people. Alternatively, a part-time or multipurpose area can be designated as a safe space at certain times and on certain days. A part-time DIC could be established in a health clinic or women's centre, making it less visible as a place for people selling or exchanging sex to meet and discuss issues and challenges.¹⁰¹

Remote access to psychosocial, legal and other support services

Establishing remote access to support services can increase information dissemination and uptake of services. Remote support has to comply with guiding principles, including specific attention to ensuring confidentiality. Decisions on how to provide remote access should be based on the preferences of the local population, as well as an assessment of access and connectivity for different groups. Infrastructure for providing remote support may already exist in some host communities, such as a phone hotline for local sex workers. Even in camp settings, it may be possible to establish a hotline that people can call for immediate support, advice or referrals – for example, in response to violence, arrest, loss of ID/documents, unprotected sex or other crises they may have experienced. Links to web-based resources for sex workers, including safety materials, can also be given to individuals or uploaded to social media sites used by refugees or internally displaced persons.¹⁰²

100 This section is adapted from SWIT, Chapter 3, Community-led services, **Section 3.3**, Safe spaces (drop-in centres), pp 62–65.

101 See **Annex 11** for an example of a safe space layout. For an example of a safe space for female sex workers in a camp setting, see Good Practice Box 1 in **Annex 12**. Further guidance on establishing safe spaces can be found in SWIT, Chapter 3, Community-led services, **Section 3.3**, Safe spaces (drop-in centres), pp 62–65.

102 Additional information can be found in NSW's *Smart Service Provider's Guide to ICT and Sex Work* (Edinburgh, NSW, 2016).

Strengthening advocacy for rights and harm reduction in humanitarian settings

In the long term, there is a need to further address deeper structural drivers, such as scarcity of resources, inequity, gender inequalities, discrimination and violence in humanitarian settings, all of which influence people's decisions to sell and exchange sex. Policy change is needed at national and global level to increase displaced persons' access to resources and opportunities, so that people can make further choices about whether or not to rely on selling or exchanging sex to meet the needs of themselves and their dependants. Dialogues may be held with host states to encourage local responsibility for more comprehensive threat reduction, to reduce harassment by local law enforcement officers and to ensure the provision of rights-based programmes and services for people who sell or exchange sex.¹⁰³

Safety training, information and skills-building

Over time, more in-depth support programmes can be developed for people selling or exchanging sex in the following areas.

Identifying risks (vulnerability mapping)

Work with people who sell or exchange sex (through focus groups and one-on-one discussions) to identify and mitigate the risks they face. Risks may include harassment and arrest by law enforcement officers, violence from clients and other community members, loss of confidentiality in host and affected communities and discrimination by service providers. There may be certain hotspots or danger zones where people who sell or exchange sex are particularly vulnerable to attack. Consultations can also be conducted with host community sex workers and service providers to identify further local risks.

Identifying community-led strategies to reduce vulnerability

A variety of guidance is available¹⁰⁴ and can be adapted to the local context. Measures that could be applied may include:

- Improve lighting and organizing security patrols;
- Disseminate safety information and tips;
- Implement working in pairs or groups;
- Practice condom negotiation with peers;
- Promote safety and security in workplaces such as bars, lodges and hotels;
- Encourage the maintenance and sharing of lists of aggressors;
- Conduct safety and self-defence training.

103 Amnesty International, *Policy on State Obligations to Respect, Protect and Fulfil the Human Rights of Sex Workers* (London, Amnesty International, 2016).

104 A number of tools on safety in sex work exist and can be adapted for people who sell sex in specific humanitarian contexts. AidsFonds, for example, has published a training-of-trainers manual for peer educators called *Health, Rights, Safety* (2017). Practical guides developed by sex workers around the world also contain much practical advice that forcibly displaced individuals in camps and cities may find helpful. One example is *Keeping Safe: Safety Advice for Sex Workers in the UK*, published by the UK Network of Sex Work Projects. For more information about safety strategies, see SWIT Chapter 2, Addressing violence against sex workers, **Section 2.2.5**. Promoting the safety and security of sex workers, p. 30.

Document violence faced by people who sell sex in humanitarian settings

Violence can be directed at persons who sell or exchange sex, as well as at their families and dependants.

Documenting violence can be a powerful tool, building evidence to advocate for increased resources that can be used to increase security, to implement further support programmes for people who sell or exchange sex, to increase livelihood support or to fund interventions to address further identified risks faced by people who sell or exchange sex. Documentation can also be used to advocate for changes in local policing practices and community attitudes that cause violence against people who sell sex or against their families and dependants. Documentation can also be used to change local practices that grant immunity to perpetrators of violence. When documenting or sharing instances of violence, a range of ethical and safety issues must be considered and addressed.¹⁰⁵

Economic empowerment of people who sell sex

Economic empowerment of sex workers is essential. Vulnerability and risks related to sex work can be reduced through economic empowerment. People who sell or exchange sex should be accorded the same rights as all other informal workers, i.e. the rights to safe and fair working conditions, to education and skills training and to access to bank accounts and fair credit programmes. The aim is to expand options and reduce vulnerability, for example a sex worker who is economically empowered may be in a better position to refuse sex without a condom, be strengthened in their ability to negotiate with clients, and be at a reduced risk of violence and/or abuse. With more economic options, vulnerable individuals will be in a better position to meet their needs and those of their families without taking unnecessary risks.

The main reason economic empowerment interventions fail is because they do not meaningfully involve sex workers in the design, implementation, monitoring and evaluation of the programme. Programme implementers and staff members should not make assumptions or judgments, or impose their views on sex workers and should consult with sex workers to identify their needs and preferences. Programmes that do not conduct market research to establish if there is demand for specific goods or services often fail. Furthermore, many programmes fail because of inadequate funding and lack of resources needed to sustain the initiative longer than the pilot period.¹⁰⁶

105 WHO, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* (Geneva, WHO, 2007), p. 17/42: "Eight safety and ethical recommendations".

106 NSWP, *Stepping up, Stepping out Project - Economic Empowerment of Sex Workers - Regional Reports Summary* (Edinburgh, NSWP)

Options for economic empowerment include:

- Integration and inclusion in social protection schemes;
- Microcredit and loans services;
- Cash assistance and livelihood programmes;
- Access to bank accounts;
- Literacy training;
- Financial literacy training;
- Vocational training;
- Skills-building classes;
- Setting up community-run collectives and cooperative schemes.

Dos and don'ts of economic empowerment

Do	Don't
<ul style="list-style-type: none"> ● Consult with people who sell sex in a respectful and meaningful way; ● Involve those selling sex in the design, implementation, monitoring and evaluation of programmes; ● Undertake market research to establish if there is a demand for goods and services; ● Include economic empowerment as a component of a comprehensive programme aimed at meeting health and protection needs; ● Where possible, include people who sell sex in existing economic empowerment initiatives. 	<ul style="list-style-type: none"> ● Undertake economic empowerment as a means to “rehabilitate” or “rescue” those selling sex; ● Offer economic empowerment on the condition that people leave sex work; ● Impose views on those selling sex; ● Undertake activities in ways that stigmatize those selling sex.

3. Assessment, monitoring and evaluation

It is critical to develop an assessment, monitoring and evaluation framework to track progress of all interventions with people who sell or exchange sex. The framework needs to be tailored to determine if the needs of people who sell or exchange sex are being met. Is the programme meeting the objectives – that is, do the allocated technical inputs, funding, human resources and consumables (the programme inputs) produce activities and services (outputs)? What are the outcomes (i.e. benefits of these services)? What is the overall impact (is the programme achieving its goals)?

The monitoring and evaluation framework should be developed in collaboration with individuals who sell sex, humanitarian responders and in-country partners. Monitoring should be built into broader humanitarian monitoring systems and utilize existing frameworks and monitoring approaches. Below is a summary of the assessment and monitoring and evaluation techniques available.¹⁰⁷

Further guidance and resources can be found in the *Monitoring Guide and Toolkit for Key Population HIV Prevention, Care and Treatment Programmes*.¹⁰⁸



3.1. Periodic assessments

Apart from an initial assessment during the planning phase, assessments can be repeated at intervals during implementation to gauge how well a programme is responding to identified needs and challenges, and examine how well it is meeting programme objectives. A wide variety of assessment techniques are available, including:

- Rapid assessments – collection of basic information on numbers of people, service providers, resources, supplies and financing;
- Desk review – more detailed examination of available published reports, data and communications;
- Situational analysis – review of the contextual environment – for example legal, political, socioeconomic and cultural factors affecting the affected population;
- Key informant interviews – one-on-one discussions with persons with first-hand knowledge of the situation;
- Focus group discussions – small group discussions of key stakeholders – separately for affected populations and providers;
- Participatory methods – engaging the community through civil society organizations to gather data and qualitative information;
- Health facility/service assessments – review of a service’s functioning, quality and delivery;
- Mapping – geographic identification of hotspots, danger zones and location of infrastructure and service providers;
- Surveys – quantitative, population-level collection of data from representative samples of people – both providers and recipients.

107 Inter-Agency Working Group on Reproductive Health in Crises, *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (Geneva, Inter-Agency Working Group on Reproductive Health in Crises, 2019).

108 FHI360, *Monitoring Guide and Toolkit for Key Population HIV Prevention, Care, and Treatment Programs* (Durham, North Carolina, FHI360, 2016).

There are several steps for conducting any assessment. Firstly, confirm it is needed and will provide useful information. The assessment needs to be designed – using one or more of the above techniques – ensuring validity and quality of the collected data and information. AGD considerations should be incorporated into the assessment design. Consultation is needed with individuals who are selling or exchanging sex, together with policymakers, humanitarian actors and service providers. Thought should be given to any potential adverse consequences, and plans made to avoid or mitigate any possible harm arising from the assessment. Consent is required from those engaged in selling or exchanging sex prior to participation and efforts made to protect identity and confidentiality. Participants' understanding of the methods and objectives of an assessment should be checked, they should be made aware of the limitations of an assessment, that is in and by itself, it will not change or improve a situation. It is also important to update participants on how the collected data and findings are being used, and any developments arising from the assessment.



3.2. Monitoring

Ongoing monitoring usually makes use of existing data collection processes and systems, for example in a health-care service, or as part of a broader humanitarian data system. Collation of data routinely collected during service delivery can be used to review and examine many aspects of service delivery. What are the trends in uptake of services? How many cases of HIV or other STIs are being diagnosed? What are the demographics of people accessing services? What service quality and client satisfaction measures are routinely collected?

Age and gender disaggregated data should be collected. A variety of routine data sources can be reviewed, again with the need to protect client identity and maintain confidentiality, for example:

- Individual patient records and charts (e.g. clinic intake forms, antenatal cards and contraception cards);
- Daily registers and tally sheets (e.g. birth registers and antenatal tally sheets);
- Laboratory forms (e.g. HIV testing or syphilis screening results);
- Maternal and perinatal death review forms;
- Near-miss reviews;
- Community-based health worker/outreach worker and peer educator reports;
- Weekly and/or monthly reporting forms;
- Repeated surveys (a useful source of SRH monitoring data when repeated over time);
- Sentinel surveillance;
- Commodities/supplies inventories.

Service providers can extract relevant data from data sources, for collation, usually conducted by supervisors. Data should be reported at least monthly. A list of potential data points is given in **Annexes 9 and 10**.

Part of the monitoring process is to identify activities and services that are avoided and underused, which may reflect poor quality of care – for example because of negative attitudes of providers or breaches of confidentiality.

Methods for this purpose include:

- follow-up of referrals by peers, to ensure that information related to the referral is captured
- regular focus groups with people who sell or exchange sex to help to build a qualitative understanding of the challenges they face and solutions they propose.



3.3. Evaluation

Longer-term goals of a programme are assessed through one-off, end-stage and, sometimes, mid-term evaluations. Evaluation is more in-depth than ongoing monitoring of routine data, and involves both quantitative and qualitative review of how well the programme has met its goals by looking at the overall results of the intervention. The following are typical questions considered during an evaluation:

- What were our goals?
- What was our theory of change and logic frame?
- What did we do?
- What did we achieve?
- Did we achieve what we intended?
- What worked and why? What beneficiaries did it work best for and why?
- What didn't work and why? What beneficiaries did it work least for and why?
- What lessons have we learned?
- What else is needed to achieve our desired impact?

It is useful to employ an objective third party who is not involved in the delivery of the programme to conduct the evaluation to ensure impartiality. Age, gender and diversity considerations should be incorporated into the evaluation's design.

Annexes



Annex 1**WHO-recommended antiretroviral therapy protocols for post-exposure prophylaxis**

Adults and adolescents \geq 40 kg

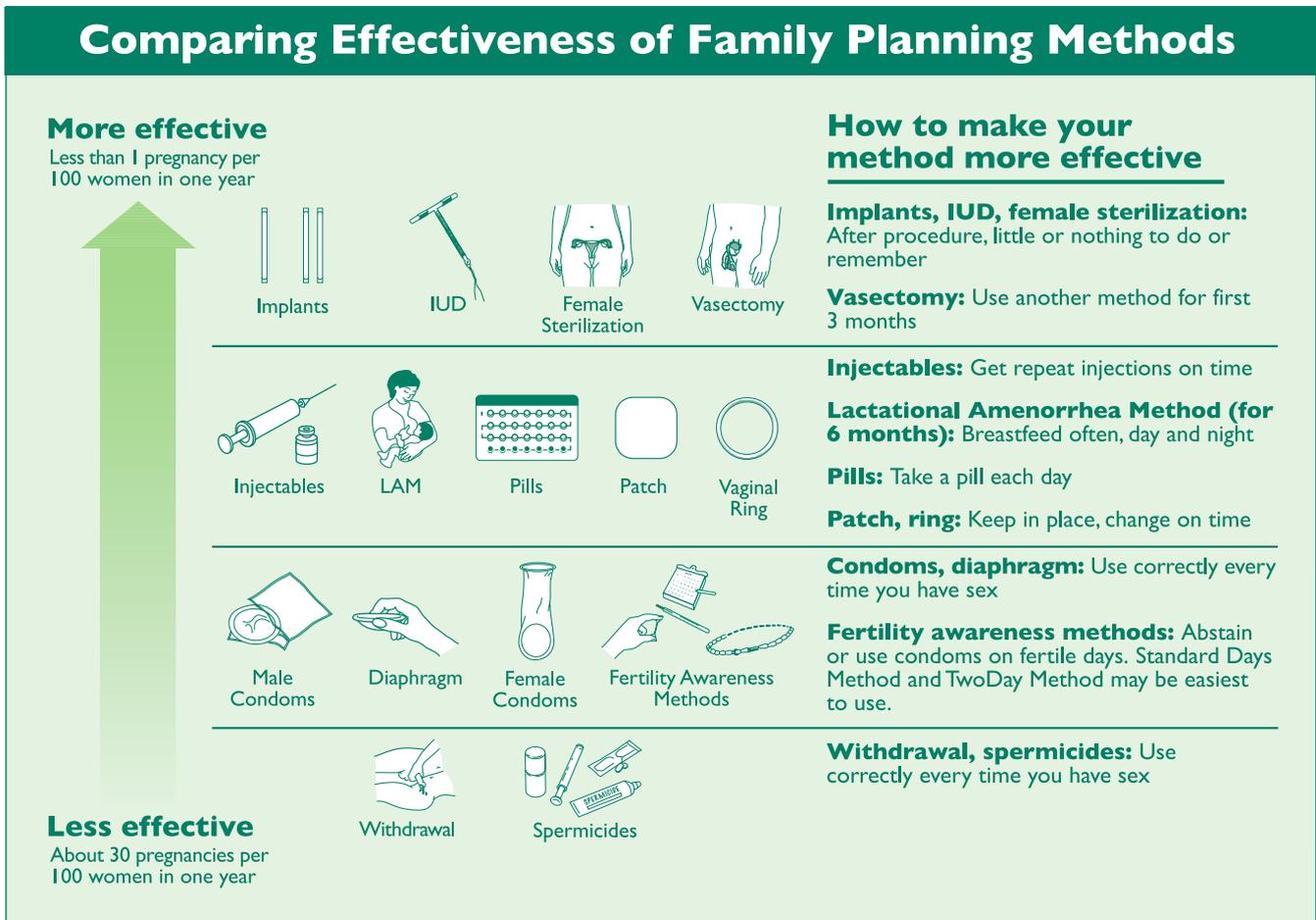
- Backbone regimen (two ARVs): tenofovir and lamivudine or emtricitabine
- Recommended third drug: lopinavir/ritonavir or atazanavir/ritonavir
- Where available, consider raltegravir, darunavir/ritonavir or efavirenz as alternative options.

Children < 40 kg

- Two ARVs: zidovudine and lamivudine
- Dosage varies according to the weight of the child; the formulations can be syrup or tablets/capsules.

Annex 2

Overview of the effectiveness of birth control methods¹⁰⁹



109 WHO, Johns Hopkins Bloomberg School of Public Health, USAID. *Family Planning: A Global Handbook for Providers, 3rd Edition.* (Geneva, WHO 2018).

Annex 3.1

Example patient intake file (UNFPA)

Unique N°: F | Allergies: | Date 1st visit: | Age at 1st visit:

Medical history (at first visit)

Number of live births		Caesarean Section (yes/no)	
Number of children still alive		Ever received blood transfusion (Yes/no)	
Number of children living under the same roof		Ever had surgery (specify)	
Age of youngest child		Affected by a chronic illness (specify)	
Currently breast Feeding (yes/no)		Ever treated for STI (specify when and what)	
Number of still births/ miscarriages/abortions		Ever tested for HIV (date of last test)	

Risk Assessment

	Date	Initial	3 mths	6 mths	1 yr	1 ½ yr	2 yrs	3 yrs
In the past week:								
Have you had penetrative sex with a client without a condom?								
Have you used condoms systematically with your boyfriend / husband?								
Have you used condoms systematically with regular clients?								
Have you used condoms systematically with casual clients?								
Have you had a condom failure?								
Have you had a client with urethral discharge or burning urines?								
Have you done sex work under the influence of alcohol?								
Have you done sex work under the influence drugs?								
Have you done extra sex work to be able to buy alcohol or drugs?								
How many clients do you have in a typical day of sex work?								
How many days do you work in a typical month?								
Do you practice vaginal douching?								
Do you introduce objects or substances in your vagina for "dry sex"?								
Do you have sex during your menses?								

Counselling

	Date							
HIV pre-test counselling								
HIV post-test counselling								
Condom promotion and demonstration								
Discouragement of vaginal douching								
Family planning								
Negotiation skills								
Substance abuse								
Post-GBV								
Referral (specify)								

Investigations

	Date							
Syphilis VDRL								
Syphilis RDT								
Wet mount yeast								
Wet mount Trichomonas V.								
Bacterial vaginosis (clue cells > 20%)								
N. Gonorrhea/Chlamydia T. rapid test								
Cervical cancer screening								

Family Planning

	Date							
COC (3 months supplies)								
Depo-Provera								
Implant								
Other (specify)								

Consultation date: _____ **Reason: quarterly visit** ; **or complaints** ; **or contact**

If quarterly visit: in time early by more than a week late by more than a week

If complaints specify (e.g.: abnormal vaginal discharge, pain,rape...): _____

History:

Examination

Vaginal discharge <input type="checkbox"/>	Genital warts <input type="checkbox"/>	Vulval rash, oedema <input type="checkbox"/>	IF cervical erythema <input type="checkbox"/> OR pus from cervix <input type="checkbox"/> Then treat for NG/CT
Dysuria <input type="checkbox"/>	Genital ulcer <input type="checkbox"/>	Pruritus <input type="checkbox"/>	
Dyspareunia <input type="checkbox"/>	Contact bleeding <input type="checkbox"/>	Lower abdominal pain <input type="checkbox"/>	

Other (specify: e.g. lice, injuries...) _____

Investigations Results

Non STI Diagnosis Healthy Candidiasis BV Other (specify) _____

STI Diagnosis Gonorrhoea(NG) Chlamydiais (CT) Trichomoniasis Pubic Lice
Warts Herpes PID Syphilis stage _____

Treatment

Referrals

Date of next quarterly visit: _____

Consultation date: _____ **Reason: quarterly visit** ; **or complaints** ; **or contact**

If quarterly visit: in time early by more than a week late by more than a week

If complaints specify (e.g.: abnormal vaginal discharge, pain,rape...): _____

History:

Examination

Vaginal discharge <input type="checkbox"/>	Genital warts <input type="checkbox"/>	Vulval rash, oedema <input type="checkbox"/>	IF cervical erythema <input type="checkbox"/> OR pus from cervix <input type="checkbox"/> Then treat for NG/CT
Dysuria <input type="checkbox"/>	Genital ulcer <input type="checkbox"/>	Pruritus <input type="checkbox"/>	
Dyspareunia <input type="checkbox"/>	Contact bleeding <input type="checkbox"/>	Lower abdominal pain <input type="checkbox"/>	

Other (specify: e.g. lice, injuries...) _____

Investigations Results

Non STI Diagnosis Healthy Candidiasis BV Other (specify) _____

STI Diagnosis Gonorrhoea(NG) Chlamydiais (CT) Trichomoniasis Pubic Lice
Warts Herpes PID Syphilis stage _____

Treatment

Referrals

Date of next quarterly visit: _____

Annex 3.2

Example clinic enrolment and contact forms (Ministry of Health, Kenya)

Clinic Enrolment Form¹¹⁰

Name of County: _____ Sub-county: _____

Ward: _____ Implementing partner: _____

Date of enrolment (DD/MM/YYYY): ____/____/____ MFL code: _____

KP unique identifier code: _____

KP type (Tick appropriate): FSW MSM MSW PWID PWUD Transman Transwoman

1	Name of KP: _____
2	Have you been contacted by a peer educator for any health services? 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
3	Do you have a regular non paying sexual partner? 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
4	a. Which year did you start sex work Year: _____ b. Which year did you start having sex with men (MSM only) Year: _____ c. Which year did you start using drugs (injecting or smoking) Year: _____
5	Have you ever experienced physical/sexual violence? 1= Yes <input type="checkbox"/> 2= No <input type="checkbox"/> (If yes, specify Physical / Sexual / Both) _____
6	a) Have you ever been tested for HIV? 1= Yes <input type="checkbox"/> 2= No <input type="checkbox"/> If NO, skip to Q10 b) The last time you received HIV testing, how did you test? <input type="checkbox"/> Rapid HIV testing <input type="checkbox"/> Self-test
7	Would you like to share your LAST test result with me? (circle the number) 1= Yes, I tested positive <input type="checkbox"/> 2= Yes, I tested negative <input type="checkbox"/> 3= I do not want to share <input type="checkbox"/>
8	If POSITIVE, are you receiving HIV care? 1= Yes <input type="checkbox"/> 2= No <input type="checkbox"/> (If NO refer to CARE)
9	If Yes (receiving care), ASK for the following; Facility Name: _____ CCC number: _____ Viral load test: 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> _____ Date of VL result: _____
10	Are you willing to be tested for HIV? 1= Yes <input type="checkbox"/> 2= No <input type="checkbox"/> If No, indicate reason _____
11	In case you are due for clinical services, could we contact you through: Phone 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Peer educator 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Outreach worker 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Clinician/HTS Counsellor 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Treatment buddy 1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> Name of the treatment buddy _____ Telephone number of the treatment buddy _____ Signature /Thumb of the KP _____ Completed by: _____ Date: _____

Key Population Contact Form¹¹¹

Name of County: _____ Sub-county: _____

Ward: _____ Implementing partner: _____

Date of first contact: (dd/mm/yyyy): ____/____/____

Name of peer educator/health care worker: _____

KP unique identifier code: _____

KP type (Tick appropriate): FSW MSM MSW PWID PWUD Transman Transwoman

1. What is your name? (All three names) (Please add the nickname)	
2. Sex (circle appropriate) 1= Male; 2= Female	
3a. Date of Birth (DD/MM/YYYY):	3b. Age:
4. Contact Phone No:	5. Alternative contact person and phone number:
6a. Have you been contacted by a peer educator?	1. Yes 2. No
6b. If yes, which programme do you receive services from?	
7a. Where do you MOSTLY operate/hangout/conduct sex work/Inject/meet your clients or partners? (Write down name and physical address of the Hotspot MOSTLY frequented)	
7b. Type of spot MOSTLY frequented 1= Street, 2= Injecting den, 3= Uninhabitable building, 4= Parks, 5= Homes, 6= Beach, 7= Casino, 8= Bar with lodging, 9= Bar without lodging, 10= Sex den, 11= Strip club, 12= Highways, 13= Brothel, 14= Guest house/Hotels/Lodgings, 15= Massage parlor, 16= Chang'aa den, 17= Barbershop/Salon, 18= Virtual Space, 19= Other(Specify)	
8. a. Which year did you start sex work?	Year: _____
b. Which year did you start having sex with men (MSM only)?	Year: _____
c. Which year did you start using drugs (injecting or smoking)?	Year: _____
9. On average, how many sex acts do you have PER WEEK?	
10. On average, how many anal sex acts do you have PER WEEK?	
11. On average, how many times do you inject drugs per day? (only for PWID)	

111 Republic of Kenya, Ministry of Health. Contact Form.

Annex 3.3.

Example clinic enrolment and contact files (FHI360 Linkages across the Continuum of HIV Services for Key Populations Affected by HIV Programme)

TOOL #9A: MSM/TG CLINIC ENROLMENT FORM

Name of Implementing Partner: _____ Date: ____ / ____ / ____

District: _____ Location: _____ Hotspot: _____

Staff Outreach Supervisor: _____ Peer Outreach Worker: _____

Name of KP: _____ Sex: Female Male TG

Date of Birth: ____ / ____ / ____ Program ID: _____

Contact Address: _____

Phone Number: _____

1	How old were you on your last birthday? (Age in completed years)		
2	Where do you MOSTLY cruise/meet your clients or partners? CIRCLE ALL THAT APPLY	Name of hotspot (s):	
		<input type="checkbox"/> Bar with lodging	<input type="checkbox"/> Bar without lodging
		<input type="checkbox"/> Sex den (brothels)	<input type="checkbox"/> Strip club
		<input type="checkbox"/> Streets/highways	<input type="checkbox"/> Home
		<input type="checkbox"/> Casino	<input type="checkbox"/> Beach
		<input type="checkbox"/> Lodgings/guesthouse/ Rest house/hotels	<input type="checkbox"/> Massage parlors
		<input type="checkbox"/> Parks	<input type="checkbox"/> Beer tavern
	<input type="checkbox"/> Public toilets	<input type="checkbox"/> Others	
3	On average how many penetrative sex acts (anal) do you have?	Per day	Per week
4	Have you ever visited any DIC/clinic/wellness centre for any services in the last 6 months?	Yes	No
5	If Yes, which DIC did you visit?		
6	Have you been contacted by a peer outreach worker from the HIV prevention program?	Yes	No

SEXUALLY TRANSMITTED INFECTIONS			
7	In the past 6 months have you ever had any of these symptoms? PLEASE READ ALL	<input type="checkbox"/> Genital/anal ulcer disease <input type="checkbox"/> Foul smelling penile/anal discharge <input type="checkbox"/> Painless growth in anal/penile area <input type="checkbox"/> Itch in genital/anal area <input type="checkbox"/> Rash in genital/anal area <input type="checkbox"/> Bubo <input type="checkbox"/> Dysuria <input type="checkbox"/> LAP <input type="checkbox"/> Others	
8	Where did you receive treatment for the above mentioned symptoms you had in the past 6 months?	<input type="checkbox"/> Pharmacy <input type="checkbox"/> Private doctor <input type="checkbox"/> Government clinic <input type="checkbox"/> Herbalist <input type="checkbox"/> NGO/ program clinic <input type="checkbox"/> Other _____ <input type="checkbox"/> Did not receive treatment	

SEXUAL HISTORY AND RISK ASSESSMENT			
9	At what age did you first have sexual intercourse?		
10	In the past 3 months have you had sex with another man?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11	In the past ONE WEEK, how many male partners did you have?		
12	What type of sex do you have in most sexual encounters?	<input type="checkbox"/> Anal penetrative <input type="checkbox"/> Anal receptive <input type="checkbox"/> Oral <input type="checkbox"/> Other _____	
13	Did you ever receive cash or goods in exchange for sex with a man?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14	If yes, at what age did you start sex work? (only for MSW)		
15	In the past ONE WEEK, from how many men did you receive cash or goods in exchange for sex? (only for MSW)		
16	In the past ONE WEEK, how many men did not pay you cash or goods in exchange for sex? (only for MSW)		
17	Did you use a condom last time you had sex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18	Did you use lubricant last time you had anal sex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19	During the past one month how often have you consumed drinks containing alcohol?	<input type="checkbox"/> Never <input type="checkbox"/> Most days	<input type="checkbox"/> Sometimes <input type="checkbox"/> Every day
20	Have you ever used/consumed a drug for non-medical purpose?	EVER	LAST MONTH
		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
		LAST WEEK	<input type="checkbox"/> Y <input type="checkbox"/> N

SEXUAL AND GENDER-BASED VIOLENCE			
21	In the last 3 months have you ever experienced violence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22	If yes, which type? Tick all mentioned	<input type="checkbox"/> Harassment <input type="checkbox"/> Physical violence <input type="checkbox"/> Sexual violence <input type="checkbox"/> Discrimination <input type="checkbox"/> Other	
23	Who perpetrated the violence?	<input type="checkbox"/> Community pressure groups <input type="checkbox"/> Local leaders <input type="checkbox"/> Police <input type="checkbox"/> Military <input type="checkbox"/> Pimps <input type="checkbox"/> Bar managers and owners <input type="checkbox"/> Local gangs <input type="checkbox"/> Fellow employee <input type="checkbox"/> Magistrate/judiciary	<input type="checkbox"/> Government officials <input type="checkbox"/> General community <input type="checkbox"/> Family members <input type="checkbox"/> Religious groups <input type="checkbox"/> Regular partner <input type="checkbox"/> Clients <input type="checkbox"/> Health care provider <input type="checkbox"/> Employer <input type="checkbox"/> Other (Specify) _____
24	Did you seek help?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25	If yes, where did you seek the help? MARK ALL MENTIONED	<input type="checkbox"/> Medical/hospital <input type="checkbox"/> Legal/police <input type="checkbox"/> Family <input type="checkbox"/> Peers <input type="checkbox"/> Friends <input type="checkbox"/> Religious leader <input type="checkbox"/> Chief/village elder <input type="checkbox"/> Other _____	

TOOL #9A: MSM/TG CLINIC ENROLLMENT FORM *continued*

HIV TESTING AND COUNSELING		
26	Have you ever been tested for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to question 33)
27	If yes, how long ago?	<input type="checkbox"/> Within 3 months <input type="checkbox"/> Within 6 months <input type="checkbox"/> Within 1 year <input type="checkbox"/> Above 1 year
28	If yes, would you like to share your test result with me?	<input type="checkbox"/> Tested positive <input type="checkbox"/> Tested negative <input type="checkbox"/> Results unknown <input type="checkbox"/> I do not want to share
29	If positive, have you disclosed your HIV status to anyone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
30	If Yes, to whom?	<input type="checkbox"/> Boyfriend <input type="checkbox"/> Regular client <input type="checkbox"/> Friend/relative
31	If positive are you receiving HIV care?	<input type="checkbox"/> Yes (specify duration) If yes, duration _____ <input type="checkbox"/> No
32	If receiving care, which facility is giving you care (address of the facility)?	
33	Could we contact you by phone (including SMS) for services related to STI/FP/HIV testing/HIV care/GBV or other services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
34	Could we contact you through your peer outreach worker /staff outreach supervisor for services related to STI//HIV testing/HIV care/GBV or other services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Signature/thumb print of the KP _____
35	Name of Service Provider:	Signature _____ Date _____

Annex 4

WHO treatment protocols for sexually transmitted infections in adults

Reference: Guidelines for the management of people with symptoms of Sexually Transmitted Infections; WHO (2021 forthcoming)

Note: Refer to the guidelines for treatment of pregnant or breastfeeding women and patients under 16 years old

STI	Treatment options	Dose	Remarks
Neisseria gonorrhoea	Ceftriaxone PLUS Azithromycin	250 mg IM, single dose 1 g orally, single dose	First choice. Use dual therapy where antimicrobial resistance has not been determined. Azithromycin not required where susceptibility to Ceftriaxone is proven
	Cefixime PLUS Azithromycin	400 mg orally, single dose 1 g orally, single dose	Use dual therapy where antimicrobial resistance has not been determined. Azithromycin not required, where susceptibility to Cefixime is proven
Chlamydia trachomatis	Doxycycline	100 mg orally, twice daily for 7 days; (14 days for PID)	First choice. Contraindicated in pregnancy
	Azithromycin	1 g orally, in a single dose	Also active against incubating syphilis (within 30 days of exposure)
	Erythromycin	500 mg orally, 4 times daily for 7 days; (14 days for PID)	
	Ofloxacin	200–400 mg orally, twice daily for 7 days	
Chlamydia trachomatis in pregnant or breastfeeding women	Erythromycin	500 mg orally, 4 times daily for 7 days	First choice.
	Azithromycin	1 g orally, in a single dose	Also active against incubating syphilis (within 30 days of exposure)
Syphilis (Early): (Primary, secondary and early latent, i.e. <2 years since infection)	Benzathine penicillin	2.4 million IU, intramuscularly, single dose	First choice. Can give as 2 injections in separate sites
	Doxycycline	100 mg orally, twice daily for 14 days	Contraindicated in pregnancy
	Erythromycin	500 mg orally, 4 times daily for 14 days	Can be used with pregnant women, but does not cross the placental barrier. Treat new born infant(s) soon after delivery
Syphilis (Late): (Late latent and tertiary infection)	Benzathine penicillin	2.4 million IU, IM, once weekly for 3 weeks	First choice. Can give as 2 injections in separate sites
	Procaine penicillin	1.2 million IU, IM, daily for 20 days	
	Doxycycline	100 mg orally, twice daily for 30 days	For patients allergic to penicillin, but contraindicated in pregnancy.
Syphilis (Late) in pregnant and breastfeeding woman	Erythromycin	500 mg orally, 4 times daily for 30 days	This antibiotic is also active against chlamydial infection

STI	Treatment options	Dose	Remarks
Trichomonas vaginalis	Metronidazole	2 g orally, single dose OR 400 mg or 500 mg orally, twice daily for 7 days	First choice. Ideally avoid during first trimester of pregnancy (see below)
	Tinidazole	2 g orally, single dose OR 500 mg orally, twice daily for 5 days	
Trichomonas vaginalis in pregnant women (2nd and 3rd trimester)	Metronidazole	200 mg or 250 mg orally, 3 times daily for 7 days OR Gel (0.75%), 1 full applicator (5 g), twice daily for 7 days	Ideally avoid during first trimester of pregnancy, unless benefit outweighs the risks
Mycoplasma genitalium	Azithromycin	500 mg orally, day 1; 250 mg orally, days 2-5	
Genital herpes (Primary infection)	Acyclovir	400 mg orally, 3 times daily for 10 days OR 200 mg orally, 5 times daily for 10 days	First choice. During pregnancy, only use Acyclovir when the benefit outweighs risks
	Valaciclovir	500mg orally, twice daily for 10 days	
	Famciclovir	250 mg orally, 3 times daily for 10 days	
Genital herpes (Recurrent infection – episodic therapy)	Acyclovir	400 mg orally, 3 times daily for 5 days OR 800 mg orally, 2 times daily for 5 days OR 800 mg orally, 3 times daily for 2 days	First choice. Use same treatment for pregnant/ breastfeeding women
	Valaciclovir	500 mg orally, twice daily for 5 days	
	Famciclovir	250 mg orally, twice daily for 5 days	
Genital herpes (Recurrent infection – suppressive therapy)	Acyclovir	400mg orally, twice a day	Suppressive therapy is recommended for persons having 4+ episodes per year, severe symptoms, or episodes causing distress. Increased dosage or duration is needed for people living with HIV
	Valaciclovir	500 mg orally, once daily	
	Famciclovir	250 mg orally, twice daily	

For other STIs, and treatment of people under 16 years, refer to the WHO guidelines.

Annex 5

Counselling for HIV testing services¹¹²

Preparation

Appropriate preparation for delivering HTS includes building community awareness and demand, training providers, selecting locations and times to deliver services, and procuring supplies.

Community awareness and building demand for voluntary HIV testing services

- Community members should be informed about the benefits of knowing one's HIV status and about the availability of treatment if they are infected with HIV. Even with awareness-raising activities for the general public or key populations, sex workers may not know about services that are respectful of sex workers or that are provided by trained and qualified peer sex workers;
- As part of awareness-raising campaigns, sex workers should be informed of their right to confidentiality and consent and their right to refuse HIV testing if they choose.

Training providers and community outreach workers

- Training in HTS should follow national and international standards (see **Section 2.4.2**);
- Training for counsellors who will provide HTS to sex workers should include additional training on:
 - Their duty to be respectful and non-judgemental;
 - Specific needs of sex workers;
 - The absolute requirement to maintain confidentiality not only about HIV results, but also about any other information provided during the counselling session, including about engagement in sex work.

Location and timing of services

- Both the location and the timing of voluntary HTS should be responsive to the needs and requests of sex workers. In some settings, this might mean providing services during evening hours or at weekends, such as "moonlight HTS", which has been provided in a number of countries;
- Community settings may be more attractive than health-care institutions.

How often should HIV testing be offered?¹¹³

- Sex workers who test HIV negative should be advised to return for repeat testing after four weeks. They should also seek retesting at best three-monthly or be offered retesting at least annually as recommended by WHO for persons at higher risk;
- Repeat HIV testing should also be offered whenever there is a new STI diagnosis.

112 WHO, Implementing Comprehensive HIV/STI Programmes with Sex Workers – Practical Approaches from Collaborative Interventions (Geneva, WHO, 2013).

113 SWIT, chapter 5 Clinical and Support Services.

Annex 6

Dos and don'ts of providing health and protection services for people selling or exchanging sex

Do	Don't
<p>Use reflective listening and make supportive, open-minded statements</p> <p><i>Examples</i> “You are not alone in doing this” “You have nothing to be ashamed of”</p>	<p>Make judgemental statements</p> <p><i>Examples</i> “What would your children think of you?” “You know our religion prohibits this. God does not approve”</p>
<p>Ask non-judgemental questions to try to understand a person's health and protection needs</p> <p><i>Examples</i> “Do you have access to condoms and lubricants?” “Have you been forced to have sex without condom?” “Have you been hit by someone while selling sex?”</p>	<p>Make any assumptions about why someone is selling/ exchanging sex, when they began, or how they feel about it</p> <p><i>Examples</i> People who sell sex have experienced some trauma; People who sell sex are bad people; All people who sell sex are forced to do it.</p>
<p>Offer to refer someone to designated service(s) that have been verified as adequate (i.e. professional, sensitized, confidential, adequate quality of care)</p> <p><i>Examples</i> Inform the person of the referral option(s); Ask if they are willing and interested to attend; Request their consent before contacting a provider.</p>	<p>Refer someone to a provider without verifying the provider is aware, non-judgemental and supportive</p> <p><i>Examples</i> Referring to a health provider who is not trained on the specific needs of persons engaging in selling/ exchanging sex; Referring a person to a livelihood initiative without discussing whether they are interested because of own perception or assumption that this is best for the person.</p>
<p>Use language that is non-judgemental and rights based</p> <p><i>Examples</i> Describe the service provided as “selling or exchanging sex” Use the terms “sex work” or “people engaged in sex work”</p>	<p>Use language that removes a person's agency from their decision to sell or exchange sex</p> <p>Use terminology that implies selling sex is inherently coercive or violent</p> <p><i>Examples</i> Refer to selling or exchanging sex as “survival sex” Describe selling/exchanging sex as “negative coping strategy” Use the term “prostitute”.</p>
<p>Present a full range of referral options, and provide information and assurance to ensure informed consent</p> <p><i>Examples</i> Give details of all available service providers; Explain procedures and any side effects or risks; Offer to accompany a person if they would like this.</p>	<p>Make assumptions about what type of support or referrals someone is looking for</p> <p><i>Examples</i> All people who sell sex need STI treatment; A woman who sells sex wants to be rehabilitated or rescued; If a person who sells sex receives support (e.g. expanded livelihood options and food and non-food aid) they will stop.</p>
<p>Create a welcoming environment for people of diverse sexual orientations and gender identities</p> <p><i>Example</i> “I use she/her/hers. What pronouns do you prefer?”</p>	<p>Make assumptions/gossip about someone's sexuality or the type of sex they are having</p>
<p>Provide compassionate care</p> <p><i>Example</i> “What can we do to help you today?”</p>	<p>Insist on the need for specific types of care and support</p> <p><i>Examples</i> Order a range of STI tests without consulting or consent; Prescribe contraception without consulting or consent.</p>
<p>Support individual agency</p> <p><i>Examples</i> Ask a person how they think they can protect themselves when they are selling or exchanging sex; Ask a person what support they need when they sell or exchange sex.</p>	<p>Assume that a person selling or exchanging sex needs rehabilitation</p>
<p>Maintain professional standards of ethics and respect for human rights – including maintaining privacy and confidentiality, and ensuring non-discrimination during care and support</p>	<p>Discuss or reveal the identity of someone who sells sex, or release any information that would identify them, without their explicit and informed consent</p>

Annex 7

Key elements of community empowerment and core values for empowering communities



Source: *Implementation of Comprehensive HIV/STI Programmes with Sex Workers (SWIT)*

Annex 8

Community-led outreach and peer education – additional information

Core values for empowering communities

- 1. Empathic** – make sustained efforts to understand the situation, needs, wants, limitations, opportunities and aspirations of all peers, beneficiaries, partners and responders.
- 2. Inclusive** – include all affected people in the identification of problems and challenges, design of solutions and implementation of these responses, openly sharing all ideas and solutions.
- 3. Trustworthy** – enter into all relationships with goodwill, honesty and integrity, in the same way that one would want others to do in return.
- 4. People-focused** – consider the desired changes and goals of peers/beneficiaries over the short, medium and long terms.
- 5. Intentional** – be thoughtful and careful of the impact of actions on peers and others, including efforts to try to foresee and avoid unintended consequences.
- 6. Dignified** – treat peers with the honour, dignity and respect that they have earned and deserve.
- 7. Collaborative** – build partnerships with peers, service providers, responders and others in ways that leverage individuals' strengths and mitigate weaknesses, so that everyone involved has the opportunity to both add value and derive benefit.
- 8. Accountable** – hold oneself, peers, partners and responders responsible for ethical performance, thus building a sense of ownership for both successes and failures of all stakeholders in the value chain.
- 9. Innovative** – strive to solve problems and overcome obstacles for peers through creative ways that have never been tried before.
- 10. Enduring** – offer and create opportunities, services and products of the highest quality, and that are resilient and sustainable.
- 11. Practical** – focus not on ideology, but on common sense and actionable contributions for achieving goals effectively and efficiently.
- 12. Catalytic** – seek to create and implement processes and solutions that have positive and high-velocity multiplier effects.

Adapted from Community Empowerment Solutions:

<https://www.cesolutions.org/our-core-values-approach>

Community empowerment of people who sell or exchange sex can occur in any humanitarian context including in acute emergencies and resource-poor settings, and wherever individuals sell sex. Face-to-face peer education can be offered during community outreach or in DICs, or remotely through mobile phone messages and social media. Peer educators may carry out a wide range of information and skills-building activities. When a peer educator recommends a particular service or provider, this may be the only reason a person trusts and accesses that service.^{114, 115} Examples of peer educator activities include:

- Meet regularly (e.g. monthly), One-on-one, with peers who sell sex, at an assigned, safe location;
- Assess each individual's needs for HIV/STI prevention, care and support;
- Develop a plan with health sector/cluster focal points to address these needs;
- Assess the need for condoms/lubricant of each person, based on their usual sexual activity;
- Distribute enough condoms and lubricant to last until the next visit;
- Promote and encourage attendance at safe spaces (DICs) for people who sell sex;
- Promote and refer individuals to designated and trusted clinics or health-care workers for:
 - STI check-ups and management – diagnosis, treatment, counselling, risk assessment, behaviour change communication and condom promotion;
 - HIV testing and ART services, plus support and adherence monitoring for people diagnosed with HIV;
 - GBV treatment, care and PSS;
 - Further SRH care including contraception and cancer screening;
 - Drug and alcohol harm reduction and counselling services;
 - Tuberculosis and viral hepatitis testing and treatment services.

Note: peer educators can explain and describe services, refer people as needed, reassure and accompany people if requested and facilitate access:

- Provide safety tips and advice on how to:
 - Deal with law enforcement, camp authorities and other security personnel;
 - Negotiate safe sex and condom use;
 - Perform self-defence, work in pairs, deal with aggressive clients or those known to be violent;
 - Access legal and PSS.
- Report and provide feedback on activities to health/protection focal points/ programme managers:
 - Summarize community outreach and peer education activities – such as the number of people seen, information and commodities provided and referrals made;
 - Report specific risks identified for individuals selling sex – for example risky locations, times, individuals and activities;
 - Suggest approaches for mitigating risks and improving relations with law enforcement/ security personnel, community leaders and humanitarian responders;
 - Report on the quality of care provided (e.g. by health workers, protection staff and other humanitarian actors).

114 See SWIT, chapter 3.2: “Community-led outreach”.

115 This list has been adapted from the SWIT, chapter 3.2.1: “What community outreach workers do”.

Community-led outreach and peer education can be self-contained, for example within a camp setting. However, where possible, these activities should link to host community sex worker networks. Supplemental activities can be organized, for example inviting host community sex workers to speak to a gathering of individuals selling sex, or group activities can be organized at a safe space, based on common interests or concerns. In some settings, virtual/remote peer education may be set up – ensuring that good practices are followed and new dangers avoided, as summarized in Global Network of Sex Work Projects' *Smart Service Provider's Guide to Information and Communication Technologies and Sex Work*.¹¹⁶ These activities should be supplemental to, not a substitute for, in-person peer outreach activities. Examples of peer education and peer outreach in various settings, and in collaboration with local or national sex worker organizations, are given in Good Practice Boxes 1-4 in **Annex 12**.

116 NSWP, *Smart Service Provider's Guide to ICTs and Sex Work* (Edinburgh, NSWP, 2016).

Annex 9 Minimum Initial Service Package checklist¹¹⁷

FIGURE 3.2: SAMPLE MISP CHECKLIST

GEOGRAPHIC AREA:		REPORTING TIME PERIOD: __/__/20__ TO __/__/20__	START DATE OF HEALTH RESPONSE: __/__/20__	REPORTED BY:	
1. SRH lead agency and SRH Coordinator					
				YES	NO
1.1	Lead SRH agency identified and SRH Coordinator functioning within the health sector/cluster				
	Lead agency				
	SRH Coordinator				
1.2	SRH stakeholder meetings established and meeting regularly:			YES	NO
	National (MONTHLY)				
	Sub-national/district (BIWEEKLY)				
	Local(WEEKLY)				
1.3	Relevant stakeholders lead/participate in SRH Working Group meetings			YES	NO
	Ministry of Health				
	UNFPA and other relevant UN agencies				
	International NGOs				
	Local NGOs				
	Protection/GBV				
	HIV				
	Civil Society including marginalized (adolescents, persons with disabilities, LGBTQIA people)				
1.4	With health/protection/GBV/sectors/cluster and national HIV program inputs, ensures mapping and vetting of existing SRH services				
2. Demographics					
2.1	Total population				
2.2	Number of women of reproductive age (ages 15 to 49, estimated at 25% of population)				
2.3	Number of sexually active men (estimated at 20% of population)				
2.4	Crude birth rate (national host and/or affected population or estimated at 4% of the population)				
3. Prevent sexual violence and respond to the needs of survivors					
				YES	NO
3.1	Multi-sectoral coordinated mechanisms to prevent sexual violence are in place				
3.2	Safe access to health facilities				
	Percentage of health facilities with safety measures (Sex segregated latrines with locks inside, lighting around health facility, system to control who is entering or leaving facility, i.e., guards or reception)				%
3.3	Confidential health services to manage survivors of sexual violence			YES	NO
	Percentage of health facilities providing clinical management of survivors of sexual violence (Number of health facilities offering care/all health facilities) x 100%				%
	Emergency contraception				
	Pregnancy test				
	Pregnancy				
	PEP				
	Antibiotics to prevent and treat STIs				
	Tetanus toxoid/Tetanus immunoglobulin				
	Hep B vaccine				
	Safe abortion care				
	Referral to health services				
Referral to safe abortion services					
Referral to psychological, social support services					

¹¹⁷ Inter-Agency Working Group on Reproductive Health in Crises, *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (Geneva, Inter-Agency Working Group on Reproductive Health in Crises, 2019).

3.4	Number of incidents of sexual violence reported to health services		
	Percent of eligible survivors of sexual violence who receive PEP within 72 hours of an incident (Number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100%		%
		YES	NO
3.5	Information on the benefits and location of care for survivors of sexual violence		
4. Prevent and respond to HIV			
4.1	Safe and rational blood transfusion protocols in place		
4.2	Units of blood screened/all units of blood donated x 100		
4.3	Health facilities have sufficient materials to ensure standard precautions in place		
4.4	Lubricated condoms available free of charge:		
	Health facilities		
	Community level		
	Adolescents		
	LGBTQIA		
	People with disabilities		
	Sex workers		
4.5	Approximate number of condoms taken this period		
4.6	Number of condoms replenished in distribution sites this period (specify locations)		
4.7	ARVs available to continue treatment for people who were enrolled in ART prior to the emergency including PMTCT		
4.8	PEP available for survivors of sexual violence?		
	PEP available for occupational exposure?		
4.9	Co-trimoxazole prophylaxis for opportunistic infections		
4.10	Syndromic diagnosis and treatment for STIs available at health facilities		
5. Prevent excess maternal and newborn morbidity and mortality			
5.1	Availability of emergency obstetric and newborn care (EmONC) basic and comprehensive per 500,000 population	YES	NO
	Health center with basic EmONC five per 500,000 population		
	Hospital with comprehensive EmONC one per 500,000 population		
5.2	Health center (to ensure basic EmONC 24/7)	YES	NO
	One qualified health worker on duty per 50 outpatient consultations per day		
	Adequate supplies, including newborn supplies to support basic EmONC available		
	Hospital (to ensure comprehensive EmONC 24/7)	YES	NO
	One qualified service provider on duty per 20-30 inpatient beds for the obstetric wards		
	One team of doctor/nurse/midwife/anesthetist on duty		
	Adequate drugs and supplies to support comprehensive EmONC 24/7		
	Post-abortion care		
	Coverage of post-abortion care (PAC) (number of health facilities where PAC is available/number of health facilities) x 100%		
Number of women and girls receiving PAC			
5.3	Referral system for obstetric and newborn emergencies functioning 24/7 means of communication (radios, mobile phones)	YES	NO
	Transport from community to health center available 24/7		
	Transport from health center to hospital available 24/7		
5.4	Functioning cold chain (for oxytocin, blood screening tests) in place		

5.5	Proportion of all births in health facilities (Number of women giving birth in health facilities in specified period/expected number of births in the same period)			%
5.6	Need for EmONC met (Number of women with major direct obstetric complications treated in EmONC facilities in specified period/Expected number of women with severe direct obstetric complications in the same area in the same period)			%
5.7	Number of caesarean deliveries/number of lives births at health facilities x 100%			%
5.8	Supplies and commodities for clean delivery and newborn care			
5.9	Clean delivery kit coverage (Number of clean delivery kits distributed where access to health facilities is not possible/estimated number of pregnant women) x 100%			%
5.10	Number of newborn kits distributed including clinics and hospitals			
5.11	Community informed about the danger of signs of pregnancy and childbirth complications and where to seek care			
6. Prevent unintended pregnancies				
6.1	Short-acting methods available in at least one facility	YES	NO	
6.2	Condoms			
6.3	Emergency contraception (progestin-only pills)			
6.4	Oral contraceptive pills			
6.5	Injectables			
6.6	Implants			
6.7	Intrauterine device			
6.8	Number of health facilities which maintain a minimum of 3 month's supply of each			NUMBER
	Condoms			
	Emergency contraception (progestin-only pills)			
	Combined oral contraceptive pills			
	Progestin only contraceptive pills			
	Injectables			
	Implants			
	Intrauterine device			
7. Planning for transition to comprehensive SRH services				
7.1	Service delivery	YES	NO	
	SRH needs in the community identified			
	Suitable sites for SRH service delivery identified			
7.2	Health workforce	YES	NO	
	Staff capacity assessed			
	Staffing needs and levels identified			
	Training(s) designed and planned			
7.3	Health information system	YES	NO	
	SRH information included in health information system			
7.4	Medical commodities	YES	NO	
	SRH commodity needs identified			
	SRH commodity supply lines identified, consolidated and strengthened			
7.5	Financing	YES	NO	
	SRH funding possibilities identified			
7.6	Governance, leadership	YES	NO	
7.7	SRH-related laws, policies, and protocols reviewed			

Annex 10

Key contraception service indicators

FIGURE 7.2: KEY INDICATORS

INDICATOR	DEFINITION	DATA SOURCE	COMMENTS
FACILITY INDICATORS			
Number of clients who start a modern contraceptive method at this facility, by method	Number of clients who begin using a contraceptive method, by method <ol style="list-style-type: none"> a. IUD b. Implants c. Tubal ligation d. Vasectomy e. Daily oral contraceptive pill f. Injectables g. Condoms (male or female) h. Emergency contraception <ol style="list-style-type: none"> 1. EC pills 2. IUD as EC 	Facility registers	Please include any client who starts a modern method, including those switching from another method You must define how long a client stops a method before re-starting; e.g., if a client has stopped using a method for 6 months (i.e., missed her last appointment for 6 months), she should be counted as re-starting
Integration	<ul style="list-style-type: none"> • Percentage of contraceptive clients also counseled about sexually transmitted infections • Percentage of contraceptive clients also referred to source of ongoing contraceptive method 		
Method mix	Numerator: Number of contraceptive clients who start each method Denominator: Number of clients who start a modern contraceptive method at this facility	Facility registers	
PROGRAMMATIC INDICATORS			
Number of contraceptive service delivery points that had no stock-outs of methods in previous month	Number of contraceptive service delivery points that had no stock-outs (for more than 1 day) of methods in previous month	Stock registers	It is important to check stocks of all methods that are provided by the facility (e.g., OCPs, injectables, IUDs, implants, EC)
Number of providers with technical competence to provide contraception	Number of providers with technical competence, as measured using a checklist, to provide contraceptive methods, by method	Program or supervision records	Supervisors should observe providers' competence using a checklist with each method periodically (for example, twice a year)

Annex 11

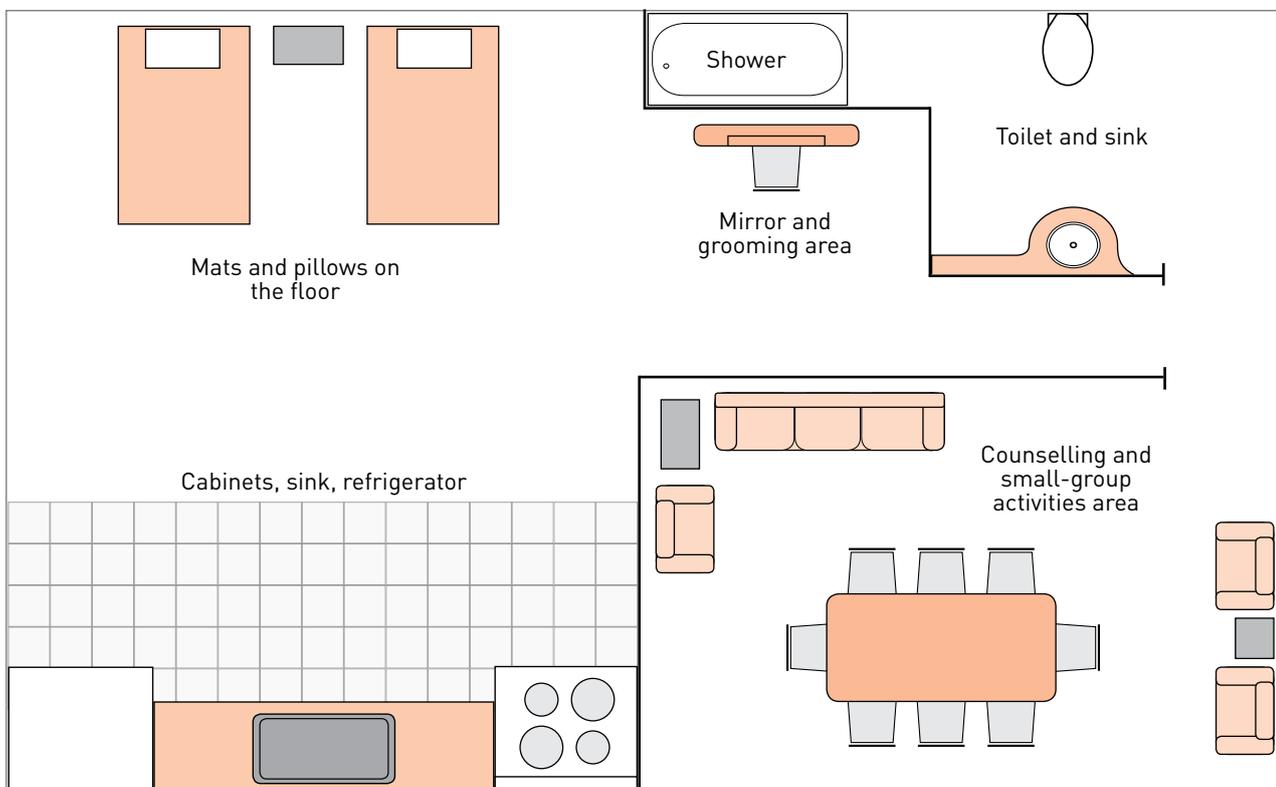
Example of a drop-in centre floorplan

Safe spaces for people who sell sex – also known as DICs – are places where individuals can socialize, form a sense of community or a peer network and hold group activities. Individuals can also seek shelter here and be counselled, for example if they have experienced violence or assault. In humanitarian settings, they are a main venue for interactions between programme staff, peer outreach workers and beneficiaries. They can provide a refuge for someone who has been attacked or raped and also serve as a location to:

- Share information with and among individuals who sell sex;
- Provide condoms, lubricant and clinical services;
- Discuss the risks, discrimination and violence faced by individuals who sell sex;
- Plan and review outreach activities and responses;
- Hold educational sessions, including training sessions for peer educators and outreach workers.

The location and set-up of a safe space will vary by local situation and context. The chosen location should be discreet, i.e. its purpose should not be apparent to others, including members of the broader community. Safe spaces are sometimes used only for the provision of services to individuals who sell sex. However, this can sometimes attract unwanted attention, and it can be helpful to use a multipurpose space on a part-time basis, i.e. at certain times or on certain days. A part-time DIC might, for example, be set up in a health clinic or women's centre, making it less visible as a place used by people who sell sex.¹¹⁸ An example layout of a dedicated safe space is given in the figure below. For an example of a safe space for female sex workers in a camp setting, see Good Practice Box 1 (see **Annex 12**). More operational guidance on establishing safe spaces can be found in the *Implementation of Comprehensive HIV/STI Programmes with Sex Workers (SWIT)*, chapter 3.3.

Figure 3.9 Example of a safe-space floor plan



¹¹⁸ Locating a safe space in an existing women's centre is likely to create access barriers for male or transgender individuals who sell sex.

Annex 12

Examples of good practice in health and protection programmes

Good Practice Box 1

Peer education and “drop-in” centre for women who sell sex in Kakuma refugee camp [International Rescue Committee, Kenya]

The International Rescue Committee has partnered with Kenya’s national Ministry of Health and the United Nations High Commissioner for Refugees to implement a targeted health and social services programme for women who sell sex in Kakuma refugee camp. One pillar of the programme is peer-led empowerment and education. Women who volunteer to become peer leaders receive training in a variety of health and safety topics, from how to use condoms to the importance of cervical cancer screening. They also learn strategies for providing peer support, distributing condoms and lubricant, referring peers to trusted providers and accompanying peers to check-ups. Peer leaders conduct outreach in different camp hotspots, and each receives a small incentive for their efforts. The peer education programme is linked to a host community sex worker organization, whose members facilitate peer training sessions.

Another aspect of the programme is a holistic DIC located in the camp referral hospital. Four trained staff, working in teams of two, run the centre to ensure that it is “open all hours”, and that visitors have access to friendly and knowledgeable support whenever they arrive (no appointment is needed), in addition to a range of voluntary clinical services. The DIC also hosts regular meetings of peer leaders and community get-togethers among women who sell sex.

Findings from a recent programme evaluation suggest that, since its launch in 2011, the programme has increased access to essential safe sex information and health services among participants, including access to consistent antiretroviral therapy for those who are living with HIV. Over 700 women are enrolled in the programme, with a participant retention rate of 75 per cent. For others looking to implement a similar programme in a camp setting, the International Rescue Committee advises that “integrating [a DIC] into an existing secondary health facility is ideal”, and that programme staff should be chosen carefully to ensure they are “committed and trained specialists, with favourable attitudes” towards people who sell sex. “We can guarantee [positive attitudes] in our DIC because we continuously assess attitudes of staff”, notes the programme director. Acknowledging the need for discretion around the DIC, the International Rescue Committee observes that most people in the camp are not aware it exists: “It’s just like a backdoor into a group of rooms, so it’s not labelled” and “it’s probably only internal [programme] staff who know exactly what happens there, not everybody even in the health system knows”.

Most programme participants (89 per cent) are adult women; however, the programme also works with young women under 18 years who are selling or exchanging sex.

Based on the results of its evaluation – “very little resources, massive impact” – the International Rescue Committee is discussing ways to replicate its targeted approach in other country operations.

For more information, see “Breaking the Barrier – Meeting Sex worker Needs in Humanitarian and Low-resource Settings” (New York, International Rescue Committee, 2017). Available at <https://gbvresponders.org/research-learning/completed-research/> Programme summary above based on International Rescue Committee research brief as well as personal communications.

Good Practice Box 2

Refugee peer educators conduct outreach in camp and urban environments [Reproductive Health Uganda (RHU), Uganda]

Since 2008, RHU, an affiliate of the International Planned Parenthood Foundation, has worked with Ugandan sex workers to enhance their access to sexual and reproductive health information and care. A cornerstone of this work is a programme in which volunteers participate in a five-day training course to become peer educators in their communities. The training is holistic, covering topics ranging from safety in selling sex to human rights, parenting as someone who sells sex, gender-based violence, contraception, interacting with law enforcement, and HIV/STI prevention and treatment. Peer educators then serve as “ambassadors” in their communities, engaging in a variety of activities to inform and support others who sell sex, such as hosting information sessions, distributing condoms, providing referrals and offering peer counselling.

In 2015, RHU worked with the Women’s Refugee Commission to expand its peer education programme to meet the needs of refugees who sell sex. It was the first time RHU targeted refugees for inclusion and adapted its training materials to meet their particular needs and concerns. Through this pilot project, 80 refugee women were trained as peer educators: 50 in Kampala and 30 in Nakivale Settlement. Their positive feedback about the project highlighted the potential for peer education to save lives, by facilitating the dissemination and uptake of critical sexual and reproductive health information and care through trusted peer networks.

For more information on this project, see RHU and the Women’s Refugee Commission, Supporting Refugee Women Engaged in Sex Work Through the Peer Education Model & Bringing Mobile Clinics to Refugee Neighborhoods, (New York, Women’s Refugee Commission, 2016).

Good Practice Box 3

Refugees partner with Kenyan sex workers to access services, empowerment activities [Kenya Sex Workers Alliance (KESWA), Kenya]

KESWA is an organization led by and for Kenyan sex workers. After observing that only “a few empowered” refugees were accessing sex worker-friendly services at a local clinic, KESWA sought to better understand the barriers faced by refugees who sell sex, with the goal of enabling them to access support and including them in outreach work.

KESWA took proactive steps to include refugees who sell sex in “rights empowerment forums”, and to work with them to address particular access barriers, such as Muslim women’s preference to be treated for STIs by female rather than male health-care workers. KESWA also uses its legal assistance networks to come to the assistance of refugees who are detained and harassed by local police for lacking proper documentation and/or selling sex. In addition, refugees who sell sex have been trained as peer outreach workers and as media advocacy volunteers for KESWA.

KESWA hosts the Sex Worker Academy Africa, a learning programme for community empowerment and capacity-building that brings together national teams of sex workers from across Africa. The curriculum is based on the Implementation of *Comprehensive HIV/STI Programmes with Sex Workers* (SWIT). Sudanese and South Sudanese refugees have participated in Sex Worker Academy Africa, where they learned best practices for advancing their safety, health, advocacy skills, peer support networks and rights in-country.

For more information, see KESWA’s website. Available at <https://keswa-kenya.org/>

Good Practice Box 4

Strengthening local capacities to respond to the needs of refugees and migrants engaged with selling or exchanging sex or sex work and mainstreaming a rights approach in an emergency response (Ecuador)

Introduction

According to 2019 data shared by the Ministry of Public Health, there has been an increase of 45 per cent in the number of Venezuelans requesting “a leaflet reflecting prophylactic measures (prophylaxis carnet)” to legally engage in sex work in border areas, and an increase of over 50 per cent in Quito. Most services are not accessible to this population and there has been limited engagement by the humanitarian sector owing to limited funds and capacity.

Implementation

- The United Nations Population Fund (UNFPA), in collaboration with the United Nations High Commissioner for Refugees (UNHCR), sought to improve the existing efforts in the establishment of the Regional Safe Space Networks, the Gender-based Violence Working Group, the Ministry of Public Health, and other key partners in Ecuador, and to strengthen the capacity of local actors to respond to the needs of refugees and migrants engaging in sex work, while mitigating risks regarding sexual exploitation.
- The UNFPA and UNHCR field offices in Carchi and Sucumbíos developed seven training workshops on the Minimum Initial Service Package with the participation of 180 officials from the Ministry of Public Health, UNHCR staff and partners, non-governmental organizations and other agencies working in local humanitarian responses.
- Direct coordination with the Ministry of Public Health was strengthened, allowing for the sustainable delivery of supplies, medical equipment and sexual and reproductive health kits for primary level health units, basic and type C hospitals offering primary and basic secondary care.

Results

- The training led to the formation of multidisciplinary and intersectoral teams with UNHCR, the Ministry of Public Health and the UNFPA, for the implementation of further activities with other interested institutions at the local level.
- The capacity of community-based committees/groups working on gender-based violence prevention and response was enhanced through safety audits.
- The distribution of 1,000 outreach toolkits enhanced engagement and community work with persons of concern engaged in sex work.
- Five workshops on sexual and reproductive health and gender-based violence resulted in strengthened community protection networks and peer support for refugees and migrants engaging in or likely to engage in selling sex.

Continues on next page

Lessons learned

- Inter-agency, intersectoral and inter-institutional coordination, especially on response issues, is essential. While progress is important, it still needs to be strengthened, to avoid duplication and inefficiency.
- Continuous accompaniment of operational units has become a central need and a means to include sexual and reproductive rights, sexual and reproductive health and human mobility approaches in the daily practice, complementing and justifying each other.

Conclusions

By engaging with local organizations the project ensured sustainability by building up the capacity of these actors to mainstream a rights-based approach to sexual health promotion across their interventions while making existing programmes more inclusive to respond to the needs of persons of concern.

Annex 13

Additional resources

Key populations – specific guidance regarding sex work in humanitarian settings

The following resources offer guidance on implementing programmes with people who sell sex and the service providers who work with them. Some of these resources focus on sex work, while others focus on working with other key populations, such as men who have sex with men, transgender individuals and people who inject drugs. Forcibly displaced people who sell sex can also be members of these communities.

- Desmond Tutu HIV Foundation, *Sex Workers: An Introductory Guide for Health-care Workers in South Africa* (Cape Town, Desmond Tutu HIV Foundation, 2012).
- International HIV/AIDS Alliance and LINKAGES. *Safety and Security Toolkit – Strengthening the Implementation of HIV Programmes for and with Key Populations* (Durham, North Carolina, FHI 360, 2018).
- Kenya Ministry of Health, *National AIDS and STI Control Programme – Manual for Peer Educators* (Nairobi, Ministry of Health, 2017).
- LINKAGES, *Violence Prevention and Response Training Curriculum for Peers and Outreach Workers* (Durham, North Carolina, FHI 360, 2019).
- LINKAGES, *LINKAGES Enhanced Peer Outreach Approach (EPOA) – Implementation Guide*. (Durham, North Carolina, FHI 360, 2017).
- LINKAGES, *Law Enforcement Training – Preventing and Responding to Violence against Key Populations to Increase Access to Justice and Strengthen the HIV Response* (Durham, North Carolina, FHI 360, 2019).
- LINKAGES, *A Guide to Comprehensive Violence Prevention and Response in Key Population Programs* (FHI 360, Durham, North Carolina, 2019).
- United Nations Development Programme, *IRGT: A Global Network of Trans Women and HIV*, UNFPA, University of California San Francisco Center of Excellence for Transgender Health, Johns Hopkins Bloomberg School of Public Health and WHO, *Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs – Practical Guidance for Collaborative Interventions (the “IDUIT”)* (Geneva, WHO, 2017).
- WHO, UNFPA, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects and World Bank, *Implementing Comprehensive HIV/STI Programmes with Sex Workers – Practical Approaches from Collaborative Interventions (the “SWIT”)* (Geneva, WHO, 2013).
- WHO, *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update* (Geneva, WHO, 2016).
- WHO, *Technical Brief – HIV and Young People Who Sell Sex* (Geneva, WHO, 2015).

Legal context and rights (HIV and key populations)

- United Nations Development Programme (UNDP), *Know Your Rights, Use Your Laws* (New York, UNDP, 2015). Available at https://www.eurasia.undp.org/content/rbec/en/home/library/hiv_aids/know-your-rights--use-your-laws.html.
- Regional HIV Legal Network (also in Eastern Europe and Central Asia region). Available at <http://hiv-legalaid.org/en/index.php?r=2.1>.

Gender-based violence

- Community Based Protections resources
<https://communities.unhcr.org/communitybasedprotection/en.html>
- Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings (IASC), *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action – Reducing Risk, Promoting Resilience and Aiding Recovery* (New York, IASC, 2015).
- Inter-Agency Standing Committee on Reproductive Health in Humanitarian Settings (IASC), *GBV Case Management Guidelines* (New York, IASC, 2017).
- UNFPA, *Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies* (New York, UNFPA, 2015).
- UNFPA, *Inter-Agency Minimum Standards for Gender-based Violence in Emergencies Programming* (New York, UNFPA Gender-based Violence Area of Responsibility, 2019)

Title:

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Responding to the Health and Protection Needs of People Selling or Exchanging
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