Creating Safe Spaces:

EVALUATION OF THE RED UMBRELLA SEX WORK PROGRAMME

By Impact Consulting for NACOSA and SANAC

Creating Safe Spaces: Evaluation of the Red Umbrella Sex Work Programme

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PARTNERSHIP IN ACTION

As principal recipient for the Global Fund to Fight AIDS, Tuberculosis and Malaria, NACOSA worked with partners to build the capacity of community organisations, scale up prevention programmes for the most at-risk populations, increase the coverage and uptake of HIV counseling and testing, increase access to services for people living with HIV and strengthen support for orphaned and vulnerable children.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
CAPRISA	Centre for the Aids Programme of Research in South Africa
CBO	Community-Based Organisation
CPC	Centre for Positive Care
CV	Curriculum Vitae
DAC	District AIDS Council
DVD	Digital Versatile Disc
DoH	Department of Health
DSD	Department of Social Development
EPWP	Expanded Public Works Programme
GARPR	Global AIDS Response Progress Reporting
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IEC	Independent Electoral Commission
IUD	Intrauterine Device
LGBTI	Lesbian, Gay, Bisexual, Trans and Intersex
M&E	Monitoring and Evaluation
MSAT	Multi-Sectoral Action Team
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NACOSA	Networking HIV/AIDS Community of South Africa
NGO	Non-Governmental Organisation
NHLS	National Health Laboratory Service
NSP	National Strategic Plan for HIV and AIDS, STIs and TB 2012-2016
OI	Opportunistic Infections
OSS	Operation Sukuma Sakhe
PAC	Provincial AIDS Council
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHRU	Perinatal HIV Research Unit
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PrEP	Pre-Exposure Prophylaxis
PSH	Partners in Sexual Health
RU	Red Umbrella
REC	Research Ethics Committee
SADC	Southern African Development Community
SANAC	South African National AIDS Council
SANCA	South African National Council on Alcoholism and Drug Dependence
SAPS	South African Police Service
SMS	Short Message Service
SR/SSR	Sub-Recipient / Sub-Sub-Recipient
STI	Sexually Transmitted Infection
SWAG	Sex Work Advocacy Groups
SWEAT	Sex Workers Education and Advocacy Taskforce
TB	Tuberculosis
TG	Transgender
ToC	Theory of Change
UN	United Nations
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV/AIDS
WBOT	Ward-Based Outreach Team
WHO	World Health Organisation
WLC	Women's Legal Centre
WRHI	Wits Reproductive Health and HIV Institute

1. EXECUTIVE SUMMARY

Background

Sex workers in South Africa

Sex workers can be defined as individuals who use the exchange of sex as a source of livelihood, with terms negotiated by the sex workers, and with the choice to accept or reject the transaction (SWEAT strategy development process, 2015).

Using the definition of people who self-identify as sex workers, the current working figure for the number of female, male and transgender sex workers is 153,000 (SANAC, 2013a; Konstant et al., 2015); however, this figure is very likely an under-estimation. With cognisance of the artificial constructs around gender classification, it is estimated that most sex workers are female, with a 4% and 5% estimate for the number of transgender and male sex workers respectively (Konstant et al, 2015).

Sex workers are a diverse population, with variations in sex work in terms of client and sex worker sexual orientations and genders, client and sex worker sexual preferences (Richter et al, 2012), locations in which sex work takes place, payment arrangements and livelihood strategies, and in terms of where sex workers come from. Given this range of variables, there is little that can be concluded about a *typical* sex work setting, and the needs and conditions and vulnerabilities of sex workers are as variable as their contexts. Those involved in sex work programming do not classify trafficked individuals or those who are doing sex work involuntarily as "sex workers". Sex workers do however include national and international migrants.

Rights, access to justice and criminalisation of sex work

South Africa's Constitution enshrines human rights, freedom and dignity, and South Africa has signed numerous international covenants and agreements that include or encompass the protection of sex workers. Despite this, current South African law criminalises consenting adult sex under certain conditions. The Sexual Offenses Act of 1957, which continues to be applied under the current South African Constitution, states that "*unlawful carnal intercourse or act of indecency with any other person for reward commits an offence*". In 2007, the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 came into force, criminalising clients who engage the services of sex workers.

In many cases of arrest, the sex workers have not committed the offence in question (Manoek, 2012). Even when the sex worker is guilty of an offence, the correct procedure for implementing laws is not usually followed. Sex workers frequently report that the violence, harassment and abuse of the law that they suffer from police are one of the most difficult aspects of their lives (Impact Consulting/SWEAT, 2012; Impact Consulting/SWEAT, 2014; Manoek, 2012; Sonke and Partners, 2014; SWEAT, 2013a).

Decriminalisation

Decriminalisation of adult consensual sex work has been recommended as a route to substantial reduction in HIV infection rates, modelled to avert 33-46% of new HIV infections over the next 10 years (Shannon et al, 2015). It is a critical step towards ameliorating the full range of health and human rights limitations experienced by sex workers (Richter, 2009). The Global Commission on HIV and the Law states that all countries should repeal laws that prohibit consenting adults to buy or sell sex (UNDP 2012), and decriminalisation is a UN target for all countries (UNAIDS, 2013). However, it is a politically contested proposition, and will require concerted and continued advocacy efforts.

Stigma, discrimination and violence

Globally, sex workers' early mortality rates are six times that of the general population, with murder being a significant contributor (SWEAT, 2009; Gould and Fick, 2008; Scorgie 2013a; Sonke and Partners, 2014). For sex workers, the vulnerabilities of poverty are exacerbated by the criminalisation of their work, the intimate and dangerous nature of their work, the lack of protection by the law, and the social stigma attached to the sex work industry (Abrahams et al, 2013; Jewkes et al, 2009). Various studies show that sex workers experience high levels of stigma, discrimination and violence in South Africa – from the police, by clients, by their partners and by each other, with minimal recourse to protection or justice (Richter and Chakuvinga, 2012; Mac AIDS, 2015; Sonke and partners, 2014; Richter and Chakuvinga, 2012).

Men who have sex with men (MSM) and particularly transgender sex workers experience double discrimination; homophobia compounds sex work discrimination (Scorgie et al, 2013b; Fick, 2006; Boyce and Isaacs, 2011). International migrant sex workers are more vulnerable to harassment, violence and abuse than locals (Crago and Arnott, 2008).

Sex workers and HIV prevalence

The risk of contracting HIV, and poor health care, are some of the consequences of the severe levels of stigma, discrimination and violence experienced by sex workers in South Africa (Richter and Chakuvinga 2012, Scorgie et al. 2013b). Sex workers face particular vulnerability to disease because of the nature of their work, and the challenges regarding consistent safe sex practices. Research shows that (outdoor-based) female sex workers are 13 times more likely to become infected with HIV than other women of reproductive age in low- and middle-income countries (Baral et al, 2012) and modelled data shows that annual new infections associated with sex work are as high as 20% (Richter et al, 2013). The global HIV response recognises that sex workers' behavioural vulnerability to HIV is compounded by limited access to rights and justice.

Sex workers are currently prioritised for accelerated and intensified HIV and human rights interventions by global agencies, as well as in the South African National Strategic Plan on HIV, STIs and TB 2012-2016 (SANAC and NDOH, 2012), and The South African National Sex Work HIV Plan 2016-2019. Sex workers who are also members of other key populations (in particular, MSM, transgender women and drug users who inject themselves) face further increased risks of contracting HIV. Key populations also experience reduced access to services, which leads to severe gaps in treatment and support, and they are therefore prioritised for the provision of health service coverage (GFATM, 2013). HIV strategies should also take account of the structural and social drivers that create vulnerability, increase risk of infection, and reduce resilience, including, among others, gender-based violence, sex worker stigma and discrimination and criminalisation (GFATM, 2013).

Connecting and mobilising sex workers

As a response to the stigma, criminalisation and social exclusion that they face, sex workers can become focused on survival strategies, drawing on individual resources and sometimes on informal peer networks (Scorgie et al., 2013a). Sex worker social movements have been a valuable resource in addressing sex worker concerns in South Africa and could continue to be central to harm reduction, realisation of rights and decriminalisation movements. The Sisonke Sex Worker Movement was established for the purpose of social mobilisation, to create solidarity and to provide peer support for and by sex workers.

The Red Umbrella Programme

The Global Fund / SANAC National Sex Worker Programme, which has been branded the 'Red Umbrella National Sex Work Programme', seeks to mobilise female, male and transgender sex workers to play a key role to collectively address HIV/AIDS, while promoting sex workers' rights and wellbeing. It is the first sex work programme in South Africa to provide HIV prevention, care and support to adult sex workers on a national and

coordinated scale[1]. The programme has achieved an approximately 10-fold increase in the number of peer educators and sites since the Global Fund Phase I grant. NACOSA – the Principal Recipient for the grant agreement with the Global Fund – provided leadership, monitoring and evaluation (M&E), grant management, and ultimate responsibility for delivery of the programme, with 18 implementing partners, called sub-recipients (SRs), who provide services at 70 sites across all nine provinces of South Africa.

The programme's complex response is summarised into four broad areas that interact with each other:

1. Advocacy for a legally and politically enabling environment
2. Sensitisation of service providers
3. Constituency involvement
4. Access to rights and services.

Aligned with national priorities, the programme aims to[2]: stabilise HIV prevalence among sex workers; increase access to HIV-related services (through sensitising and mobilising gatekeepers); increase access to emergency and psychosocial support for sex workers; improve coverage and access to sex work-focused HIV prevention, treatment, care and support; increase the capacity of government, CBOs and NGOs to implement sex worker programmes; increase coordination of sex work programming; reduce violence experienced by sex workers; and progress towards the decriminalisation of sex work in South Africa.

Key programme interventions include:

- Comprehensive prevention services through peer-based outreach and education, distribution of condoms, assistance with accessing services, creative space/risk reduction workshops, providing HIV Counseling and Testing (HCT)
- Sensitising and mobilising "gate-keepers"
- National response call centre
- SANAC Sex Work sector supported as a platform for collective engagement.

Evaluation overview

Evaluation aims and design

Initially, this evaluation aimed to assess the effectiveness of the programme (mainly the outcomes) to inform programme improvement for the next phase of the Global Fund grant. However, shifts in Global Fund strategy during the evaluation led to major changes in the plans for Phase III of the project, prior to the release of the evaluation. This report now serves as a documentation of Phase II achievements, with recommendations based on the learning from Phase II towards the new Phase III strategy and for other sex work programmes.

The study was participatory, theory-based, constituency-based, inclusive, and based on "realist" principles. A theory of change was explicated at the beginning of the study, and has been used as the framework for this report. The evaluation used mixed methods (i.e. both qualitative and quantitative), including desktop research and participatory planning, interviews, focus groups, a mobile phone-based survey with sex workers (administered by peer educators), a survey with peer educators, outreach visits and participatory analysis and recommendations sessions.

[1] NACOSA (2105) Terms of Reference, Red Umbrella Programme evaluation.
[2] Please note that these goals will not all be measured during this evaluation.

Participants

A total of 22 of the 70 programme sites across all nine provinces were sampled, with at least one site for each participating partner, and a further three sites to ensure that all provinces were represented. A total of 1699 participants participated across all the evaluation methods, 1410 of whom were non-peer educator sex workers. 1244 sex workers completed the sex worker survey. All participants were over 18 years of age.

Description of participating sex workers

Participating sex workers were mainly between 18 and 45, with more than half being between 26 and 35 years old. Most (88.6%) were female, 8.1% were transgender individuals and 3% were MSM individuals. Most were South African, with 17% from mostly neighbouring countries. Interestingly, the vast majority were not mobile and had resided in the area they were interviewed in for two years or more. More than half (52.9%) of the sex worker survey respondents had been working as sex workers for between two to five years and only 9.1% of the sample are "new" sex workers who have been in the industry for a year or less.

All sex workers participating in the study reported that they have become involved in the sex work industry because of poverty combined with a lack of skills and very few employment opportunities. Most sex worker respondents work full time, and for the majority (81.5%), sex work is their main source of income. A third of sex workers (33.5%, n=1180) work seven days per week, 21% work five days a week and smaller percentages work less than five days a week. The vast majority of survey respondents (88.4%, n=1213) service up to 30 clients a week, with 8% servicing between 31 and 50 clients per week and 3.5% seeing over 50 clients per week. Rates for services range from R50 to a few hundred rands, to a few thousand rands. While most participating sex workers only accept cash, a minority occasionally accept goods and services.

Sex workers mostly work independently, although a small percentage of survey respondents claimed to work for a manager or controller (7.8%). Participants work across various locations. Almost all the survey respondents (96.7%, n=1230) had heard about and/or interacted with the Red Umbrella programme. Therefore, findings from this study relate to Red Umbrella programme participants, and not the general sex worker population.

Young people engaged in selling sex (also known as victims of commercial exploitation of children)

Sex workers under the age of 18 are excluded from programming since sex work is not recognised for minors, and were excluded from the study. When encountered they were referred to social workers, but were generally lost to follow-up since neither they themselves nor their controllers (who may be their parents) have any desire for interference. This is an obvious human rights, programming and HIV response gap.

Although this evaluation excluded sex workers under the age of 18, it does provide an indirect estimate of the ratio of underage sex workers in need of support. Subtracting the survey results for time in sex work from current age reveals that around 8% of survey respondents began sex work before the age of 18. Of these, 63% were 16 or 17. The remainder were 15 or younger, with the youngest beginning sex work at the age of 11.

Description of participating peer educators

Peer educators across the sample sites are mostly female (85.5%, n = 165), with less than 10% being transgender and only 5% being male. Most peer educators are experienced part-time staff: almost two thirds (62.2%, n=193) have been working as a peer educator between one to three years, with 20% working for less than a year, and 17.6% working for more than three years. Almost three quarters (72%) of peers continue to do sex work whilst being a peer educator.

Data analysis and dissemination

Data was analysed using the theory of change as a framework, as well as looking for unexpected outcomes and any emerging trends and patterns. Data was also collectively interpreted with NACOSA staff to some extent, and recommendations workshopped with the steering committee. Results will be disseminated to staff and sex workers through a dissemination strategy being devised by the steering committee in formats appropriate to the various audiences.

Research ethics

The study has been granted official ethics approval from the Human Sciences Research Council (HSRC) Research Ethics Committee (REC).

Limitations

A key limitation in the study was the lack of reliable health knowledge and behaviour questions. Timeframes and budget restrictions also limited the effectiveness of the piloting of tools, which affected both content and administration to some degree. Most importantly, the timeframes of the evaluation did not match the project cycles, which has meant that the findings of this study will not inform the next phase of the programme.

Findings

Programme models and processes

The programme's package of services towards "comprehensive prevention of HIV" is outreach-based and peer educator-led to deliver the following:

- Condoms and lubrication distribution
- Information, education and communication
- Human rights advice and referrals
- Referral to services for health, substance abuse, and other support services
- Risk reduction workshops (known within the programme as Creative Space workshops)
- Accessible HCT, and training of peer lay HCT counsellors.

In addition, SWEAT was contracted to train peers, site coordinators, human rights defenders and HCT counsellors, sensitise sex work stakeholders, run the SWEAT helpline, hold sex work sector conferences.

It was found that all sampled sites are conducting the minimum required activities of conducting HCT and Creative Space workshops, and distributing condoms and lubricant. All sites also assist sex workers to access legal, health and psychosocial services, to varying levels of success and by using various models of delivery.

Almost all peer educators engage in outreach activities (99.5%), distribute condoms, refer sex workers to health care and services (99.5%), and are involved in HIV testing. Most are involved in Creative Space workshops (90.7%). In terms of providing human rights support, 59.1% of peer educators are assisting sex workers in this way. Peer educators are also highly involved in the sex worker movement – with 61.1% of peer educators engaging in advocacy events and 72.5% participating in Sisonke activities.

Finances

Almost all sampled sites were fully dependent on the Global Fund grant to run their sex work programmes. Most programmes will stop when the grant ends. Even the larger organisations would have to scale down their operations and services due to withdrawn funding. This will lead to thousands of sex workers being left without essential services.

Programme components: successes and challenges

The programme implementation has been mostly successful, with some room for improvement in the next phase.

Creative Spaces

These workshops are hugely successful as they effectively fulfill multiple functions of education, skills development, networking, HCT, psychosocial support, and sensitisation of key stakeholders (who can be invited to participate or observe). Workshops work best when the content is driven and they are facilitated by the peers and sex workers, when they include other local stakeholders, and when they utilise community dialogue and mobilisation practices and interactive methodologies. There is reportedly a high demand for these workshops across the board, but the limited resources that have been made available have not allowed the need to be met.

Outreach

Peer-based outreach is extremely effective, especially if done discreetly and naturally. A very effective model is when mobile clinics accompany the peers so that specialised health services are made available during outreach. Some partners do outreach by going door-to-door to sex workers' homes rather than just visiting their work places. HCT is sometimes done during outreach – either by HCT-trained peers or by nurses in mobile units. Peers also refer sex workers to health, legal and psychosocial services.

In order for the well-received peer-based model to be truly effective, it is essential that peers are imparting correct information. The study showed that knowledge of HIV was generally high amongst the peers, although additional training is still required. Human rights knowledge was not as widespread, and this should be addressed. The implemention of outreach faced many challenges during this programme phase, for example, a lack of transport or resources for transport, insufficient funding for management staff, and high staff turnover (also due to low stipends for peers).

Assisting with access to health services

In addition to the standard package of services which involves providing health information (through outreach and creative space workshops), condoms and HCT, and referring sex workers with health issues to health care facilities, some sites have additional funding to provide mobile clinic services, non-judgmental specialised clinics for sex workers, in-house nurses at site offices, "peer navigators"/"health mentors" who track sex workers to ensure linkage to care, healthy eating programmes, and general health programmes. In many areas, peers distribute both Red Umbrella branded condoms and lubricant, as well DoH Choice condoms and femidoms.

Foreign national sex workers struggle to access health care as some do not have formal documentation and nurses will not serve them without this. Peers are working to address this at some sites. The selection and management of peer educators to be trained in HCT could also have been better managed as the process was not fair and these peers end up doing additional work without additional pay. Doing HCT in the streets also has challenges in terms of follow up and ensuring that sex workers take up referrals if found positive. Sex workers also have other health issues, and the programme's focus on HCT means that these can be neglected. Sites do

not have adequate information education communication (IEC) material that is specialised for sex workers, nor are there are enough Red Umbrella condoms. There is also an issues because Red Umbrella condoms are only allowed to be distributed to the sex workers, and peers report a demand from clients that they are unable to meet, though client use of condoms should be just as equally encouraged. The lubricant sachets are also messy and wasteful, and a tube should be considered in the future. There is also a need for additional effective support mechanisms for sex workers living with HIV.

Assisting with legal services

None of the grant sub-recipients (SRs) are legal organisations. Access to legal services is provided by referring sex workers with issues to partners, teaching sex workers about their rights (to varying degrees), Sex Worker Advocacy Groups (SWAGs), peers providing court support where necessary, sensitisation training done with police to enhance sex workers' access to police services. This element of the work needs to be strengthened as the selection process for peers to become paralegals was not as effective as it could have been, and there is a need for more targeted and more regular training. Peers still need much capacity building in this area. Knowledge about human rights amongst sex workers can generally be informed, with many not knowing that they need legal assistance even though they report abuse, theft and rape. The SWEAT helpline is reported to be of some help, but there were also some complaints about the availability of this service and the ability of staff to follow up on cases.

Psychosocial services

Psychosocial services for sex workers are very limited. A few SRs provide their own counseling services because this is part of what the organisation already has on offer. For example, Lifeline Kimberley is providing counselling and psychosocial services to sex workers and in addition has a call line which sex workers can access. On the whole though, the emotional wellness of sex workers is not catered for. Creative space workshops play some role in this support (*"We are able to talk about our problems, knowing it never gets out of the safe space",* sex worker focus group discussion), as well as support groups at some sites. Sex workers also find comfort and support from the non-judgmental, accepting and caring attitudes of the peer educators.

As most sex workers suffer from untreated psychological trauma, there is a great need for more psychosocial support and care. DSD social workers also need to be sensitised so that sex workers can access social services. This is particularly important with immigrant sex workers, who are often harassed by social workers who are trying to deport them.

Additional services

Some SRs offer additional personal development or skills training for sex workers, including training in self-defense, positive living, life skills, income generation, as well as opportunities to go back to school and learn skills about being in a professional environment.

Creating an enabling environment for sex work

SRs have been involved in the following activities to create a more accepting environment for sex workers, where stigma and human rights violations are reduced:

- **Public awareness and sensitisation** activities such as local radio shows, public information sessions, participation in community awareness campaigns, working with community and faith-based leaders.
- **Sensitising service providers and key stakeholders** in sex work through formal sensitisation training provided by SWEAT and Sisonke or more informal activities such as involving stakeholders in programme activities and engaging with them regularly about sex worker issues.
- **Working with clients** to teach them about HIV and sex workers' rights is challenging as they want to remain secret, but this is an important and effective activity where it is achieved.

- **Multi-stakeholder forums and dialogues** which have been extremely effective – whether the SR convenes these or participates in existing forums and/or dialogue sessions.
- **Educating sex workers** about how to conduct themselves within their environment so that they become more accepted, for example not exposing themselves in the street during the day.

Despite sensitisation, sex workers are still reluctant to report crimes committed against them to the police. Very high gender-based violence levels are still driving HIV, and this needs to be addressed in general and with clients in particular. Innovative programmes to reach clients of sex workers need to be rolled out. One idea was to work within employee wellness programmes, for example with transport and mining companies and other companies that hire mobile or migrant men.

Networking and mobilising sex workers (Sisonke)

Sisonke is the national sex worker movement in South Africa. Although more than 70% of sex worker survey respondents (n=1168) know about Sisonke, only 37.8% have participated in a Sisonke activity (n=1169), and even less are members – only 21.6% of the respondents. Study participants noted that Sisonke has been helpful by helping peers to deal with under-age sex workers, sensitising police, arranging sex worker marches, assisting in legal cases, and providing human rights information to sex workers and empowering them to take these up. However, there was also some negative feedback. For example sex workers felt that activities were too centralised and urban. There are Sisonke branches in all provinces, despite there being members in all provinces, which leads to these members being sidelined.

Creating partnerships

A key good practice intervention of the programme is the establishment of partnerships with local stakeholders, both governmental and non-governmental, to assist sex workers to access services, realise their rights, and reduce violence and stigma against sex workers. During Phase II, partnerships have been forged with:

- South African Police Services (SAPS) and legal services
- Department of Health (DoH)
- other NGOS
- Department of Higher Education (DHE) to a lesser extent
- Department of Social Development (DSD)
- brothels.

Approaches to delivering the sex work programme

SRs approach the programme differently based on their organisational missions and values. Approaches include: holistic participant-focused approach, positive psychology approach, comprehensive health services focus, rights-based approach, partnership approach.

What works? Successful elements of current model

The success of the model used by SRs depends strongly on the context. Some of the key elements that have been shown to be successful in sex work programme implementation include: flexibility to implement according to context; creative space workshops which serve multiple programme purposes; employing a holistic and human rights focus; the peer-based approach; ensuring that sex workers are treated caringly and non-judgementally; having national reach; being able to distribute condoms to sex work hotspots; "peer navigator" model to monitor and mentor sex workers with their health; and integration of the various programme components; as well as integration of the programme into the other programmes of the SRs, building relationships and partnerships.

Outcomes

The Red Umbrella Programme has been successful in that it has contributed to all the outcomes in the theory of change, to varying degrees.

Outcomes on the sub-recipients

The sub-recipients of the Red Umbrella programme grant have benefited from the project in terms of growing and strengthening their organisations (for example, by opening new offices, purchasing equipment, developing better systems and policies, increasing their financial turnover), increasing their staff complements, building the capacity of their staff, reaching more sex workers, increasing their social capital and visibility, and expanding their focus (most have now mainstreamed human rights into their organisations too).

Overall vulnerability of sex workers

Vulnerability is highly variable among sex workers, and takes a variety of forms, such as low knowledge of health and rights, problems of access to condoms and services, drug and alcohol abuse and multiple sources of violence. Older sex workers and those who have been in the industry longest, transgender sex workers, small town sex workers and migrant sex workers have several sources of vulnerability. Overall vulnerability cannot, however, be pinned to a particular style of sex work or context, with each context presenting different challenges. Programming that is client-centred and needs-based, and offers a selection of engagement patterns and services, is demonstrated to be essential if it is to be effective.

Outcomes on the broader environment

Violence

In the last 12 months, 44% of sex workers reported experiencing violence, the majority (70%) of which was perpetrated by clients. There is a substantial decrease in total violence since the survey conducted at the end of Phase 1 (NACOSA and Impact Consulting, 2013)[3].

Survey data shows significant correlations between some of the major sources of violence and sex worker vulnerability:

- Sex workers who have been in the industry longest are most vulnerable to violence
- Older sex workers experience more violence (24% among those under 21 years old, compared with 43% among sex workers over 45 years old)
- Sex workers who work in the street are most vulnerable to violence
- Sex workers in small towns are more vulnerable to violence than those in metros
- Transgender sex workers experience more violence[4]
- Sex workers who have been arrested experience significantly more other sources of violence (or sex workers who have experienced multiple sources of violence have been arrested significantly more)
- Sex workers who are regularly at risk through drugs and alcohol are more vulnerable to violence

[3] Not statistically or directly comparable, but the difference in results in police violence are substantial
[4] A substantial difference, but small sample sizes prevented statistical significance

Sex workers who have experienced more violence are significantly more likely to have noticed STI symptoms, implying reduced condom use.

The reduction of violence from police is a major programme impact, with the programme clearly contributing to changing police attitudes. Police violence was reported by 55% of respondents in the 2013 Phase I survey, and only 23% of the Phase II survey participants. Lower total violence against sex workers is entirely attributable to a decrease in police violence, as there has been no meaningful reduction in other sources of violence. Only two out of the sample of 22 sites continued to have severely problematic police relationships (Brits and Rustenburg). Across other sampled sites, sex workers and SRs and police reported substantial improvements in police attitudes and behaviour, reduced arrests, better legal compliance by the police and more friendly police relationships with sex workers:

"They used to beat us but not anymore." (Peer educator)

"There is almost no more violence from police" (Sex worker)

"In the past the police … hated us, now they understand the programme" (Peer educator)

"It has been two years since the last sex worker arrest. The police are our friends" (Staff member).

Where police violence continues, it is often perpetuated by individual officers, rather than the systematic violence that used to take place in the past. Police arrests, rape and abuse do still take place in programme areas, but at a far lower rate.

Although arrests are reported to have decreased, 31% of sex workers have still been arrested in the last three years. Sex worker arrest is statistically significantly correlated with substance abuse, violence, immigrant sex workers, and with sex workers who have been in the industry the longest.

This achievement provides valuable good practice lessons and a strong indicator for the ability to work constructively with the police and other public servants. The key reasons reported for the positive outcomes are:

- sex workers' increased knowledge and their ability to clearly articulate their rights if arrested
- access to legal and paralegal support by professional legal NGOs, Sisonke and SRs against the police, and police knowledge that they could be sued, as well as intervention by agencies when sex workers are arrested
- Personal relationship building, engagement and advocacy, police participation in programme activities, and sometimes (but not necessarily) formal sensitisation training for the police
- Participation by both police and sex workers in community forums.

Changes in attitudes and discrimination (particularly at health services) - There has been a shift at some health facilities in the sample towards more positive, professional and inclusive treatment of health workers. Sex workers reported that they are better able to access health facilities where discrimination against them has decreased, and they are no longer humiliated when visiting these facilities. This is not, however, universal: *"The attitude in clinic staff has changed dramatically in the last three years but there is still a long way to go"* (Peer educator FGD).

Sex workers are most likely to face abuse and poor services when they report STIs or when they ask for post-exposure prophylaxis (PEP) after a broken condom or rape. At some facilities, there are improved and effective services, but in others they are physically abused and often humiliated: *"When you go to the clinic with an STI, they will humiliate, mock you and interrogate you about where you got it, all the time talking loudly so that everyone will hear"* (SW). Transgender and male sex workers are most severely subjected to abuse.

Access to services

Reporting crime and legal services – Although police harassment has clearly decreased, access to police services for sex workers remains limited. Access to justice is relevant both for sex workers who have been arrested, and for sex workers reporting crimes perpetrated against them. Sex workers in most sites remain reluctant to report crimes against them, and examples were shared of the police not regarding rape or even gang rape as a crime relevant to sex workers, and dismissing charges. Of the sex workers who had been arrested, 32.4% received some form of legal help. Legal services are only available with the presence of organisations such as Sisonke, Women's Legal Centre (WLC) and Legal Aid, and sometimes through legal services provided by the police and justice systems. Focus groups and interviews suggest extremely poor access to legal services, along with ignorance among sex workers that they need legal support, despite them reporting violence against them.

Psychological services – Professional psychological services are virtually non-existent, either for sex workers or other community members. Lifeline is the primary appropriately trained counselling service offering services to sex workers. In this vacuum, the non-professional Risk Reduction Workshops (or equivalents) and peer motivators became the only space in which to debrief, be heard and find encouragement. The skills shortage in mental health is severe, and clinical services for psychological or psychiatric illness are a major service gap.

Outcomes for sex workers

Increase in wellbeing and health-seeking behaviours

***Accessibility, openness, confidence and engagement* -** Many sex workers have come out of hiding in programme areas. They are less defensive and aggressive, more willing to engage with services, and as a result more available to receive support and information, and much more likely to seek health and legal services. The change in accessibility of sex worker, and engagement by them, has been dramatic: "*One of the most visible impacts is that sex workers are coming forward. There is a drastic change in health seeking behaviour"* (SR Management).

***Condoms* –** Uptake of the very popular Red Umbrella condoms has been massive, and interview results suggest that condom use has increased as a result of the programme. The evaluation focused on programme participants, and 94% of respondents get condoms from the programme. Many no longer need to go to the clinic for condoms (only 42% sometimes get condoms from the clinic). Sex workers in metros generally struggled to access condoms more than their small town counterparts.

While Red Umbrella condoms have been a success, there are sustainability concerns. The programme has demonstrated that bulk distribution of condoms into workplaces and directly to sex workers is necessary and appropriate, and that the branding and qualities of the condoms are of importance to a discerning group of customers. Having created this demand and changed the patterns of condom access, it would be unwise to either reduce access or change branding without intensive testing and marketing of new brands.

Female condoms - Acceptance of female condoms has increased at several sites, although male condoms continue to be the primary form of protection. Female condoms tend to be used discreetly when clients are reluctant to use condoms, when the sex worker has her period, or anally by male and especially by transgender sex workers. The survey revealed that use of female condoms is significantly higher among sex workers who had experienced symptoms of STIs.

***Lubricant* -** Lubricant is increasingly used and appreciated, particularly by male and transgender sex workers, but also substantially by female sex workers. Respondents confirm that lubricant reduces genital injuries. Clients orgasm more quickly and dryness or pain are less problematic, meaning that more clients can be serviced, and therefore income from sex work increases. The main problem with the Red Umbrella lubricant, and a reason for many sex workers refusing to accept it, is the impractical and messy packaging – one sachet can be used three to four times but the pack cannot be resealed. Tubes of lubricant would be more cost effective and better accepted, with interest already well-established.

HCT - As a core driver in the programme HCT has been strongly promoted, and 91% of respondents stated that they had taken an HIV test in the last 12 months and knew the result. Many sex workers have now tested repeatedly. Reach and HCT rates, and evaluation discussions, suggested that current size estimations remain an under-estimate of sex worker population. In addition, there is a continuous stream of new sex workers entering the industry while others exit (9% of respondents had been in sex work for less than a year). Unreached groups of sex workers, new sex workers and sex workers who are HIV negative will continue to need HCT services.

Literature and HCT results suggest that between 50% and 70% of sex workers are living with HIV. The programme's HCT drives began in the sample areas three to six years ago. However, 91% of respondents state that they have tested or retested in the last year. As regular testing is unnecessary for those who are HIV positive, this results shows that there is either a bias towards desirable reporting or a high level of repeat testing for people living with HIV. More rationalised, targeted HCT is recommended in the next phase.

The blanket promotion and pressure for HCT is only a constructive HIV prevention strategy in the first year or two at a new site. Thereafter, it is recommended that a more targeted and less wasteful system is implemented. At one site, an effective system has been through an SMS reminder system: After a first test, a confidential, computerised system sends personalised messaging depending on HIV and treatment status for either repeat testing (HIV negative), immunity monitoring (HIV positive, not on treatment) or medication dates (HIV positive, on antiretroviral treatment – ART). The system is also used to share dates for meetings and campaign announcements. Testing is easily accessible at workshops, mobile clinics and/or the SR premises, by a nurse or lay counsellor who also advises on other health or psychological concerns.

ART and adherence support **-** because of ethics and confidentiality restrictions, survey data has limited use for ascertaining HIV status, and enrolment in ART or pre-ART care. Qualitative results suggest that more sex workers have been initiated onto ART than previously. Follow up into care has been shown to be most effective either where a peer mentor supports the sex worker, or in situations where the SR has the capacity from other funding sources to initiate and monitor treatment. Treatment is least likely if the sex worker is given a result and referred to the clinic without follow up: *"Sex workers are also sometimes not disciplined. They miss their clinic dates and default on their treatment. They often do not want to go the clinic and complain about being humiliated. Yet when peer educators offer to accompany them to the clinic, they still won't go, this only puts them more at risk."* (peer educator FGD).

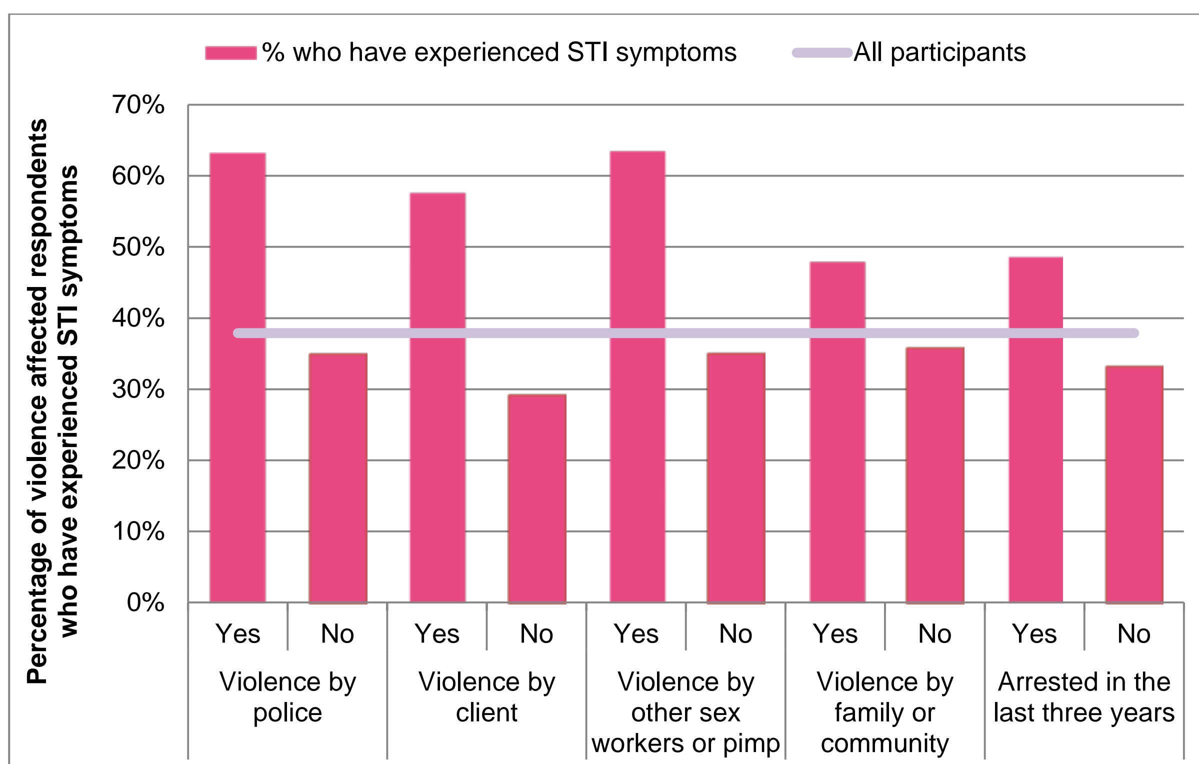
ART initiation, stabilisation and adherence are poorly understood for sex workers, and inconsistently implemented. Given very high HIV prevalence in this key population, this should be a major area of focus. Support into care should revolve around peer mentorship, defaulter follow up and community-based, integrated chronic medication dispensing and adherence clubs in close partnership with the DoH.

STI rates and treatment **-** As discussed above, sex workers reporting STIs regularly face poor services and humiliation in the health system. Since STIs are a direct, obvious and essential service entry point for sex workers who have high risk lifestyles, this is a key area for attention, both by programme partners and by DoH.

STIs are also the only available objective proxy for condom use and sexual safety, and have provided this evaluation with a valuable indicator of impact and vulnerability, with data showing highly informative patterns around STIs, and inferred condom use:

- There is no relationship between STIs and the number of clients seen per week or access to condoms
- Sex workers who pick up clients at a combination of places (street and/or bars and/or phone) experienced more STIs
- Male respondents more often stated that they did not know what an STI was, while this was a rare response among female and transgender respondents
- More sex workers who placed themselves at risk by using drugs and alcohol had STIs

- Sex workers subjected to violence or arrest by the police were significantly more likely to have suffered from STI symptoms (figure below), or in other words have sex without condoms. Qualitative data confirms that police often force sex workers to have sex without condoms. This statistically significant relationship suggests that arrests and harassment by the police increases sexual risk behaviour (and therefore increases the risk of HIV spread), which provides some evidence to support the global decriminalisation movement.



Sex worker self-esteem, knowledge and confidence

Raised self-esteem and confidence have resulted in sex workers presenting themselves in a more socially acceptable manner. They have raised standards of hygiene, dress and public behaviour. Solidarity, social mobilisation and community forming, motivated through the programme, have contributed to raised self-esteem. Social cohesion is also reported to increase safety as sex workers look out for each other, record the vehicle registrations of clients' cars in which their colleagues go, or keep the upfront fees of their colleagues when they go off to do business, so that clients cannot steal these back after they receive the services.

As with many peer or volunteer initiatives, the immediate and direct beneficiaries are the volunteers themselves. Sometimes seen by funders and programmers as 'units of production', these members of the target community are those most intensively involved in transformation and upliftment. Peers in the Red Umbrella Programme have raised their capacities, confidence, professional profiles and status in the community through being seen, treated and trained as employees. Whether this is sustainable or not, will depend on the extent to which this cadre continues to be respected and included in the mainstream economy, with a role as experts in a critical niche in the rights and HIV response.

Negative outcomes

Programme sustainability after only three years of implementation in most sites is the most concerning source of negative impact. For many sites this has been the first formal sex worker programme, and has found fertile ground and achieved substantial impact. Not dissimilar to an ART roll-out, relationships with key populations cannot be seen as temporary. Once built, there is a national responsibility, and a responsibility among programmers, to ensure that they are sustained in these sites, and for these communities.

The two key factors behind achieving impact are trust and the sense of 'humanisation' experienced by sex workers. Should support for sex workers disappear and trust be destroyed, the inevitable hurt and cynicism will result in future programmes having far more difficulty gaining traction. Profound negative impact is also likely should sex workers come to realise that their experienced sense of humanity and respect were illusions, and that national programming sees them less as human than as 'a site'. A major lesson in working with key populations is, by definition, their sensitivity and vulnerability. Cavalier treatment of trust and humanisation are therefore strongly condemned.

Recommendations

A summary of key recommendations is as follows:

- The programme should be continued at the sites in which it is being run, and expanded to new areas.
- Partnerships must be built with the government and other funders to ensure sustainability of the programme.
- Health services for sex workers should be strengthened by replacing blanket HCT with a more targeted approach, focusing on ART roll-out and adherence support for sex workers, conducting further work on sensitising health facilities and health providers.
- Achievements in popularity and uptake of Red Umbrella condoms must be sustained.
- Wide-spread professional mental health services for sex workers and programme staff must be provided.
- Better legal services and access to justice must be achieved, by extending legal rights education for sex workers, and continuing engagement with the police and the decriminalisation movement.
- Clients and the community must be sensitised and programmes must be developed to work with them purposefully.
- The popular Red Umbrella brand should be built on.
- Key programme elements must be adequately resourced, and flexibility in implementation must be encouraged.
- Ongoing training for programme staff must be provided on a regular basis.
- Ensuring the safety of programme staff must be built into the programme.
- Programme funding must include programme administration, management, financial management and monitoring and evaluation costs.
- The NACOSA/Global Fund funding cycle should be better aligned to the implementation cycle of the project so that evaluations could be used as evidence to inform the new phase of the programme.
- Evaluations should be better managed and funded from the PR side.
- Getting participation in planning processes, and ensuring that information and feedback is not only received from the SRs and sex workers, but also goes back down.
- Sisonke strategy should bear the feedback from the evaluation in mind when designing a new strategy that will assist them to maximise the funding that they have received.
- The sex worker programme must be integrated with GBV programmes, and have elements of GBV programming mainstreamed.

2. INTRODUCTION

The Red Umbrella programme seeks to mobilise sex workers (male, female and transgender) to play a key role to collectively address HIV/AIDS, while promoting sex workers' rights and wellbeing. It is the first sex work programme in South Africa to provide HIV prevention, care and support to adult sex workers on a national and coordinated scale[5].

The purpose of the evaluation study is to assess the extent of the outcomes that the programme is achieving, and how the implementation context affects the achievement of these outcomes. A sample of 22 of the 70 implementation sites were included in this mixed methods study.

3. BACKGROUND TO SEX WORK IN SOUTH AFRICA: A RAPID LITERATURE REVIEW

This review outlines the findings from a selection of major publications on the sex work industry in South Africa, and provides an overview of some of the pertinent issues and topics under discussion in the sex work discourse. Much of the discussion has been informed by a series of consultations with the Sex Worker Education and Advocacy Taskforce (SWEAT) on the current sex work context. SWEAT has been working closely with South African sex workers, and in various aspects of the sex work industry, for 20 years, and has a nuanced and detailed grasp of current issues, underlying assumption and trends with regards to this industry. We therefore acknowledge the intellectual input of SWEAT in this review, although the review is not endorsed by SWEAT, and does not necessarily reflect their views.

A key observation from the consultations with SWEAT is that much of the available literature on the sex work industry in South Africa positions sex workers as victims of violence; as prone to substance abuse; as vulnerable to HIV, and as nodes of HIV transmission. While these positions do have truth, the literature does not recognise sex workers as adults who are to be respected for their choices and strategies, who have holistic needs, and who have the same dreams, hopes, gifts, relationships, pasts and futures as any other group of working people.

In this review, sex worker definitions are considered. Secondly, criminalisation and human rights violations are discussed – as factors that affect all sex workers and that form the basis for much of the vulnerability that faces many of those working in the industry. Finally, emerging from the human rights framework, we discuss access to services, vulnerability to HIV and strategies for supportive prevention and sexual safety.

3.1 Definitions and size estimations of sex workers in South Africa

3.1.1 Definition of sex work

Sex work has been defined as "female, male and transgender adults who receive money or goods in exchange for sexual services, either regularly or occasionally" (WHO, 2011).

[5] NACOSA (2105) Terms of Reference, Red Umbrella Programme evaluation.

This broad definition applies to a wide range of decisions around sexual relationships with non-primary sexual partners involving a transaction in some form (SALRC, in Richter, 2012). In South Africa, where transactional sex is a complex social issue, the broad definition is not very helpful for practical application. The distinction that most usefully defines sex workers is based on how sex workers perceive themselves; self-identifying as professionals and regarding their sex work income as a form of employment (WHO, 2011).

A more useful working definition of a "sex worker", therefore, would not be a person who exchanges sex for goods or services, but refer to a person who uses the exchange of sex as a source of livelihood, with terms negotiated by the sex workers, and with the choice to accept or reject the transaction (SWEAT strategy development process, 2015). Consultation is ongoing with regards to finding a working definition that is inclusive of occasional sex workers, but that excludes all forms of transactional sex with someone who is not a primary partner.

A controversial aspect of the sex work industry, which is mostly avoided in the literature, is that of the selling of sex by young people under the age of 18. This is an area that requires critical attention, both in terms of research and interventions.

3.1.2 Estimating the number of sex workers in South Africa

Size estimation studies in South Africa have been related to specific locations, or based on assumptions generated in other countries. These were used to develop extrapolation assumptions for the South African National AIDS Council (SANAC)-funded rapid size estimation study of 2013 (SANAC, 2013a; Konstant et al, 2015), which provided the current population size figures that are being used by those working with sex workers in South Africa.

Using the definition of people who self-identify as sex workers, the rapid size estimation study of 2013 (SANAC, 2013a; Konstant et al., 2015) estimated that there are between 132,000 and 182,000 female, male and transgender sex workers in South Africa. Agencies and organisations engaging with sex workers currently use an intermediate working estimate of 153,000.

This size estimation process used a small sample and a rapid methodology. While the method used remains valid, the sample of reliable estimates from which to extrapolate national population estimates is very small for an accurate national estimate. Another limitation is that while the study looked at all the major internet sites to estimate indoor sex worker numbers, an unknown number of sex workers operate privately, discreetly, and under indirect banners such as escorts and masseuses.

Despite the limitations, this estimate is the best available figure. More recent size estimation research has not yet been published.

3.2 Description of sex work and sex workers in South Africa

There are variations in sex work in terms of client and sex worker sexual orientations and genders, client and sex worker sexual preferences (Richter et al, 2012), locations in which sex work takes place, payment arrangements and livelihood strategies, and in terms of where sex workers come from.

Given this range of variables, there is little that can be concluded about a *typical* sex work setting, and the needs and conditions and vulnerabilities of sex workers are as variable as their contexts.

3.2.1 Sex work and gender

With cognisance of the artificial constructs around gender distinctions, sex workers are generally categorised as being male, female or transgender. Most sex workers are female, with population estimation models using a 4% and 5% estimate for the number of transgender and male sex workers respectively (Konstant et al, 2015). Although there are some similarities in terms of working conditions, there are variations in working conditions for the three groups as they tend to work from different locations, have different clientele and have different marketing strategies.

A common factor is that men who have sex with men (MSM) and transgender sex workers experience double discrimination; homophobia compounds sex work discrimination (Scorgie et al, 2013b). It was found that transgender sex workers are particularly severely abused, face higher levels of violence, humiliation and harassment than other genders, and are targeted by police, society and clients both for sex work and for their overt expression of gender identity (Fick, 2006; Boyce and Isaacs, 2011).

Research among brothel and street-based sex workers in cities shows that 20% of female sex workers reported receiving some form of financial support from a committed partner, compared with only 3.7% of male sex workers and none of the participating transgender sex workers (Richter et al., 2013). In the same study, it was found that more male sex workers had completed secondary school than female or transgender sex workers. More female sex workers reported having a regular partner, and fewer transgender sex workers were in committed relationships.

3.2.2 Sex work locations and hotspots

Sex work is conducted in a wide range of locations: from outdoor/street-based sex work (with its severe challenges), through working from small to large brothels (which offer some collective support and security), to better protection and status which is enjoyed by high-class escorts (WHO 2011).

Sex worker population estimates and engagement strategies have used the concept of 'hotspots' (SANAC 2013a, SANAC 2013b, SANAC & NDoH 2012, WHO 2013), which are locations in which there are a high concentration of sex workers. Some of the predictors for finding hotspots include: the level of urbanisation (cities, towns or rural areas) and the presence of *mobile men,* i.e. men who are away from their community or family, for example contractors, mine workers and truck drivers, and people in ports and border towns (Konstant et al, 2015). *Mobile men* constitute the most typical clients of sex workers.

Within a town or area in which sex work is concentrated, 'hotspots' refer to the specific places where sex workers and their clients meet and gather, such as truck stops and/or brothels, and the informal 'red light' districts known in all major cities (Konstant et al, 2015). Some sex work is located in clients' workplaces, such as truck stops and mining hostels. These 'hotspots' are prioritised as points of intervention for customised services for sex workers.

It is argued that the working location of sex workers reflects their context. For example, a study of sex workers who operated from daily-rate hotels, apartments, informal settlements and the streets, found that most respondents were from severely disadvantaged backgrounds, were poorly educated, and lacked the skills for formal employment (Wechsberg et al, 2006). Most sex workers from urban streets or brothels who have participated in research have never been employed before (Richter et al, 2013).

3.2.3 Payment and livelihood strategies

Sex workers may operate independently and directly receive and manage their income, or they may be managed by a controller (usually a pimp or a brothel owner) who handles their income and controls their movements, and provides them with certain services in exchange. Sex work may also be full-time or part-time, and could be supplemented by other livelihood strategies.

Sex work programming discussions have highlighted critical distinctions between voluntary sex work and human trafficking for sex. Interventions that provide sex worker support do not cater for or work in situations where sex work is involuntary and exploitative (SWEAT 2013b). Although controllers may exert considerable force on sex workers and limit some of their choices, the definition of sex work is that it is being undertaken by an adult who chooses to be in that situation (although working conditions may be difficult). To be appropriately supportive, organisations that work with sex workers should respect the capability of people to make and expand their choices, to devise solutions to improve their situations, and to ask for help to do so. The role of sex work programming is to facilitate the help and support that is required without infringing on participants' self-determination and capabilities as adult workers (SWEAT strategy, 2015).

3.2.4 Sex workers and migrancy

A high proportion of sex workers are national and international migrants. Scorgie (2013a) found that in sites in Hillbrow and Limpopo, 60% of study participants were cross-border migrants. Richter (2013) recorded that only 15%, 20% and 29% of male, female and transgender sex workers, respectively, were local to the area. Most migrant female sex workers were cross-border migrants, and most migrant MSM sex workers were national migrants from other areas in the country, while transgender sex workers were evenly drawn from inside and outside the country.

International migrant sex workers are more vulnerable to harassment by the police for documentation, and they have less legal recourse or access to health care and services (Crago and Arnott, 2008). This makes them more vulnerable to violence and abuse than locals. These conditions are exacerbated for male and transgender migrant sex workers, who are subjected to all three forms of discrimination – xenophobia, homophobia and discrimination for being a sex worker.

3.2.5 Bias in sex worker research

The great variability in terms of types of sex work, sex work locations, the nature and level of discrimination in local norms and policing, and the characteristics of clientele (WHO, 2015) impacts on the levels of marginalisation, access to protection and vulnerability of sex workers. It also has an impact on research sampling, with the most accessible sex workers for research being those who work in the streets, in bars and in brothels. Sex worker research seldom includes those who work from their homes, from exclusive escort agencies, from upmarket clubs or strip clubs, within the formal tourist industry, online, and otherwise discreetly (such as university students supporting themselves through sex work).

There is bias in available research studies towards sex workers who are from deprived backgrounds. The severe difficulties faced by these sex workers (in terms of their living conditions and risks) do not, therefore, only relate to vulnerabilities because of sex work, but would be in line with the challenges faced by those from the same socio-economic background who do not do sex work (SWEAT strategy development process, 2015).

3.3 Rights, access to justice and criminalisation of sex work

3.3.1 Legal and justice framework regarding sex work in South Africa

A summary of the legal and justice framework relating to the sex work industry in South Africa can be found in Appendix 1, which was compiled by Stacey-Leigh Manoek, an attorney at the Women's Legal Centre. The various laws that pertain to sex work are in contradiction to one another. Laws that protect sex workers and their rights are:

- The **South African Constitution** provides for dignity, equal protection under the law, and non-discrimination on any grounds. It also specifically confers the right to people who are in detention, including rights to trial, and freedom from violence, cruelty, and degradation.
- The **International Covenant on Economic, Social and Cultural Rights of 1966** states that people have the right to earn a living by work which is chosen and accepted, and to have just working conditions.
- The **African Charter on Human and People's Rights of 1986** and the **2005 Protocol on the Rights of Women** confirm that states protect women from all forms of violence, and guarantees all individuals equality, dignity and work.
- Multiple **conventions** commit countries to eliminate discrimination against women and all forms of gender-based violence.
- The Convention on the **Elimination of All Forms of Discrimination against Women of 1967** specifically highlights the need for sex workers to have equal protection against rape and gender-based violence under the law.
- Internationally, South Africa has signed the **International Covenant on Civil and Political Rights of 1966,** which protects people from arbitrary arrest, confers equal protection under the law to all.

However, the following laws maintain the criminalised nature of sex work:

- The **Sexual Offences Act 23 of 1957** makes prostitution, brothel-keeping, solicitation, indecent exposure, and knowingly living from the proceeds of sex work illegal.
- In 2007, the **Criminal Law (Sexual Offences and Related Matters) Amendment Act 32** came into force, criminalising clients who engage the services of sex workers.
- Sex workers are most often detained in terms of various **municipal by-laws**, although the regulations around by-laws are seldom followed. Under by-laws, offenders should receive written notices and fines, which they have the opportunity to contest, and should only be arrested as the only resort to ensuring appearance in court.

3.3.2 Law enforcement behaviour and recourse to justice

The Sexual Offences Act of 1957, which continues to be applied under the current South African constitution, states that "*unlawful carnal intercourse or act of indecency with any other person for reward commits an offence*". However, the criminalised act of prostitution is difficult and time-consuming to enforce, and can often only be practically achieved through 'entrapment' – the posing of undercover police officers as clients. Therefore, sex workers are most frequently arrested and harassed under municipal by-laws – under the charge of 'loitering' in particular (Scorgie et al, 2013a). In many cases of arrest, the sex workers have not actually committed the offence in question (Manoek, 2012), and even when the sex worker is guilty of that offence, the correct procedure for implementing by-laws (see Appendix 1) is not usually followed.

Sex workers frequently report that the violence, harassment and abuse of the law that they suffer from police are one of the most difficult aspects of their lives (Impact Consulting/SWEAT, 2011; Impact Consulting/SWEAT, 2014; Manoek, 2012; Sonke and Partners, 2014; SWEAT, 2013a). In a survey by Gould and Fick (2008), 47% of sex workers reported being threatened by police with violence, 12% reported having been raped by police, and 28% had been asked for sex by policemen in exchange for release from custody. The SWEAT (2013a) survey of 1136 sex workers across the country revealed that 55% of sex workers who had experience violence in the previous year, had experienced violence from the police. Examples of police brutality experienced by sex workers include murder and attempted murder, rape, gang rape, violence, arrests, neglect in prisons and police stations, regular harassment, as well as police directly obstructing HIV prevention by confiscating condoms, and by using the possession of condoms as evidence of intention for sex work (Scorgie, 2013a, 2013b).

Since police officers are often perpetrators of violent crime against sex workers, sex workers are hesitant to attempt to access legal or police services (Scorgie, 2013a, 2013b). On the rare occasions that sex workers do seek recourse for justice, they generally report a negative experience and secondary trauma due to humiliation and abuse suffered at the police stations.

Police attitudes and practices have great influence on health and sexual risk outcomes. Where police are supportive of sex workers, condom use can increase, and violence and HIV infection among sex workers can decrease (UNDP, 2012). In addition to enhancing sex workers' access to their rights, police cooperation with sex workers enhances security, which is in the interests of both sex workers and law enforcement.

3.3.3 Decriminalisation

The criminalisation of sex work is described as 'irrational and fuzzy', particularly as the definitions of illegal sex work can be ambiguous when one looks at the wide range of transactional sexual practices and sexual interactions within consensual adult sexual relations (Scorgie et al. 2013a). In South Africa, the law that criminalises consenting adult sex for 'reward' is difficult to define, justify or enforce. It is essentially a morality-based vehicle for the victimisation of those culturally identified as 'prostitutes', and in South Africa dates back to the oppressive censorship of the apartheid era.

Convened to specifically address the global stance on criminalisation, the Global Commission on HIV and the Law states that all countries should repeal laws that prohibit consenting adults to buy or sell sex (UNDP 2012). Decriminalisation, therefore, is a UN target for all countries (UNAIDS, 2013), although it is often politically unpalatable.

Despite a concerted South African sex work movement for decriminalization, the establishment of the South African Law Reform Commission on Adult Prostitution (SALRC, 2009) and the precedents of a liberal constitution, the 2012 UNAIDS report (SANAC 2013b) described the outcomes of the decriminalisation movements as follows: "*Efforts to change government policy regarding sex work/law reform have shown no progress*." Decriminalisation is a critical step towards ameliorating the full range of health and human rights limitations experienced by sex workers (Richter 2009). SANAC and the sex work sector expressed intense frustration when commitments to end criminalisation were removed from the National Strategic Plan for HIV and AIDS without sufficient consultation (Meji, Buthelezi and Yingwana, 2011).

3.4 Stigma, discrimination and violence

For sex workers the vulnerabilities of poverty are exacerbated by the criminalisation of their work, the intimate and dangerous nature of their work, the lack of protection by the law, and the social stigma attached to the sex work industry (Abrahams et al, 2013; Jewkes et al, 2009).

Sex workers experience high levels of stigma, discrimination and violence in South Africa (Richter and Chakuvinga, 2012). Street-based sex workers deal with harassment, abuse and vigilante verbal and physical assault. In a study in Port Elizabeth, 60% of sex workers reported having been subjected to verbal abuse by the public, and this abuse extended to the harassment and victimisation of their children (Mac AIDS, 2015).

One result of the discrimination faced by sex workers is that they tend to work away from their communities and usually keep their occupation secret. If they are exposed to be sex workers, they face contempt, rejection and the social exclusion of their family, community and religious institutions (Scorgie et al, 2013a).

Sex workers are physically abused by the police, by clients, by their partners and by each other, and they have minimal recourse to protection or justice in these instances (Sonke and partners, 2014; Richter and Chakuvinga, 2012). Scorgie (2013a) describes the sex worker "*experiences of unlawful arrests and detention, violence, extortion, vilification and exclusions… profound exploitation and repeated human rights violations.*"

Globally, the literature reports that up to 50% of sex workers experience violence in the workplace (Deering et al, 2014). These results are in line with South African research, with over 50% of sex workers (street, bar and brothel based) in a survey of 1129 sex workers reporting having experienced violence by police and/or clients (SWEAT 2013a). In a sample of 410 sex workers in Port Elizabeth, 62% had been physically abused and 38% had been raped (Mac AIDS, 2015).

Globally, sex workers' early mortality rates are six times that of the general population, with murder being a significant contributor (SWEAT, 2009; Gould and Fick, 2008; Scorgie 2013a; Sonke and Partners, 2014). A qualitative study in four countries, including South Africa, found that most sex workers had at some point been beaten, gang raped by clients, and/or assaulted by police (Scorgie, 2011).

3.5 Sex workers and HIV

3.5.1 HIV prevalence amongst sex workers

It is acknowledged that poor health care and the risk of contracting HIV are some of the consequences of the severe levels of stigma, discrimination and violence experienced by sex workers in South Africa (Richter and Chakuvinga 2012, Scorgie et al. 2013b). Sex workers face particular vulnerability to disease because of the nature of their profession and the challenges and power dynamics regarding consistent condom use. Research shows that (outdoor-based) sex workers are 13 times more likely to become infected with HIV than other women of reproductive age in low- and middle-income countries (Richter et al, 2013). Therefore, it is unsurprising that sex workers bear the highest HIV burden of all key populations in South Africa.

As discussed, most research studies about HIV prevalence of sex workers focus on those sex workers who are working in the streets, at truck-stops, at brothels and at bars (i.e. those who are based "outdoors"). These are the least privileged sex workers, and therefore, the research findings should only be applied to these particular sex work contexts and not be taken as indicative of the whole population. This applies to most of the current available research, including figures relating to testing rates, education and knowledge, and condom use.

Richter reports HIV prevalence rates among different female sex worker groups ranging from 46% to 69%, based on studies from 1998. The currently reported UNAIDS (SANAC 2013b) official rate of 59.6% is based on a CAPRISA study of 775 women at high risk in Durban, the great majority of whom were sex workers. HIV prevalence is highly variable across sex worker areas and groups, and is seldom compared with local prevalence in the surrounding area, to ascertain whether the rate is indeed higher because the sample are sex workers, or because they are living in particular conditions.

In a sample of 173 sex workers working along the N3 corridor (UCSF, 2014), a terrifying HIV prevalence rate of 90.6% was found among female sex workers over 25 years old. In a study of over 2100 sex workers in the three largest metros (Lane et al, 2015): Johannesburg, Cape Town and eThekwini, sex workers returned HIV prevalence rates of 72%, 40% and 54% respectively, compared with 29%, 20% and 38%, respectively, for these cities among antenatal women aged 15-49 (i.e. women recently exposed to unprotected sex) (NDoH, 2012).

Although there is a high level of variability, the research overall shows that sex worker HIV prevalence appears to be far higher than the general population, which is reported as 30% of women aged 15-49 in 2010 (South African Government 2012). Richter et al (2013) quote modelled data showing that annual new infections associated with sex work are as high as 20%. Of these, around 6% are directly associated with sex workers, and 14% are associated with sex workers' clients and partners of their clients. Because of findings such as these, sex workers have been prioritised in the HIV response as a *key population*.

3.5.2 Sex workers as a 'key population' for HIV

The global HIV response recognises that vulnerability to HIV is partly a human rights issue, as the vulnerability is a consequence of groups' limited access to rights and justice. The global agenda also specifically targets these populations, aiming to reduce their HIV rates as a means of reducing transmission into the general population.

The South African National AIDS Council (SANAC) defines a key population for the purposes of HIV as "*a group of individuals that are most likely to be exposed to HIV and transmit it*" (SANAC & NDoH 2012). Key populations are seen as "vectors of disease". WHO (2006) combines the *vector* and the *rights* paradigms for key populations as follows: "*Key populations tend to have a higher prevalence of HIV infection than that of the general population because (i) they engage in behaviours that put them at higher risk of becoming infected and (ii) they are among the most marginalised and discriminated against populations in society. At the same time, the resources devoted to HIV prevention, treatment and care for these populations are not proportional to the HIV prevalence — a serious mismanagement of resources and a failure to respect fundamental human rights*."

The Global Fund, in its strategy for key populations (GFATM, 2013) considers key populations in relation to AIDS, TB and malaria to meet three criteria:

1. High epidemiological impact due to a combination of biological, socioeconomic and structural factors
2. Reduced access to services meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility
3. The group faces human rights violations, systematic disenfranchisement, social and economic marginalisation and/or criminalisation.

As they meet these criteria, sex workers are currently prioritised for accelerated and intensified HIV and human rights interventions by global agencies, as well as in the South African National Strategic Plan on HIV, STIs and TB 2012-2016 (SANAC and NDoH, 2012). Sex workers who are also members of other key populations (in particular, MSM, transgender women and drug users who inject themselves) face further increased risks of contracting HIV, with multiple factors increasing their vulnerability to infection.

3.5.3 South African national HIV policies and strategy for sex workers

In attempts to balance the provision of treatment alongside preventing new infections, Hecht et al. (2010) describe how *hard choices* need to be made for prevention. They argue that only the most cost-effective prevention interventions can be supported, focusing on the sub-populations with the highest infection and transmission rates (Aids 2031, 2010). Because key populations experience reduced access to services, there are more severe gaps in treatment and support for these groups than for the general population, and the provision of health service coverage is a priority for these groups (GFATM, 2013).

The Global Fund also maintains that HIV strategies should take account of the structural and social drivers that create vulnerability, increase risk of infection, and reduce resilience. For a sustainable response to HIV, the underpinning drivers of the epidemic must be addressed. These include, among others, gender-based violence, sex worker stigma and discrimination and criminalisation (GFATM, 2013).

The two main national plans that relate to sex workers are:

- The National Strategic Plan on HIV, STIs and TB 2012-2016 (NSP)[6]
- National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers.

[6] SANAC & NDoH (2012) South Africa's National Strategic Plan on HIV, STIs and TB. Online at http://www.sahivsoc.org/upload/documents/National_Strategic_Plan_2012.pdf

3.5.3.1 National Strategic Plan on HIV, STIs and TB 2012-2016 (NSP)[7]

The NSP has specific objectives relating to sex worker and key populations under each of its Strategic Objectives, as captured in the following relevant extracts:

Strategic Objective 1: Addressing social and structural drivers of HIV and TB prevention, care and impact, including continued negotiation around decriminalisation.

Strategic Objective 2: Preventing new HIV, STI and TB infections, which focuses prevention efforts in high-transmission areas and on key populations and is likely to have the greatest impact, while simultaneously sustaining and expanding efforts in the general population:

- "Combination prevention is a mix of biomedical, behavioural, social and structural interventions. Different combinations of interventions will be designed for the different key populations"; and
- "A comprehensive national social and behavioural change communication strategy with a focus on key populations aims to increase the demand and uptake of services, promote healthy behaviours, and address norms and behaviours that put people at risk for HIV, STIs and TB."

Strategic Objective 3: Sustaining health and wellness

Intervention 3.1.2: Targeted programmes of HIV, STI and TB screening and support for key populations. The NSP specifies for sex workers: "*Treatment programmes targeting HIV, STIs and TB as part of a broader health and prevention package should be developed where there is a high concentration of brothel- and street-based sex workers. An enabling legal framework, healthcare worker sensitisation and sex-worker involvement is imperative for the effectiveness of this intervention*."

Strategic Objective 4: Ensuring protection of human rights and improving access to justice, including the rights of key populations.

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

In order to ensure accountability, and support the coordination of interventions for sex workers, the sex work sector under SANAC has drafted a National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers[8] (SANAC 2013). The Sex Work NSP is geared to addressing three core goals:

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

These are supported through the four key objectives of the sex worker NSP:

1. "To reduce social and structural barriers to HIV, STI and TB prevention, care and impact among sex workers"
2. "To reduce the sexual transmission of HIV among sex workers, their clients and sexual partners by at least 50% using combination prevention approaches"

[7] SANAC & NDoH (2012) South Africa's National Strategic Plan on HIV, STIs and TB. Online at http://www.sahivsoc.org/upload/documents/National_Strategic_Plan_2012.pdf

[8] South African National AIDS Council. National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers. (2013). Pretoria, South Africa

3. “To sustain health and wellness in the sex work setting”
4. “To strengthen the health system for National Sex Work Programme implementation”.

3.5.4 Good practices in reducing HIV amongst sex workers

To reduce HIV amongst sex workers, there are some good practice strategies that should be employed. These include:

- decriminalisation
- holistic participant-centred support
- sex workers’ HIV knowledge
- encouraging health-seeking behaviour
- access to integrated health services
- HIV counseling and testing (HCT)
- access to and use of condoms and femidoms
- prevention of mother to child transmission
- access to and proper use of anti-retroviral treatment
- dealing with substance abuse issues.

3.5.4.1 Decriminalisation

Decriminalisation has been demonstrated as a route to substantial reduction in HIV infection rates, modelled to avert 33-46% of new HIV infections over the next 10 years (Shannon et al, 2015). Decriminalisation is, however, a politically contested proposition that is currently not on South Africa’s national agenda, and will require concerted and continued advocacy efforts.

3.5.4.2 Holistic, participant-centred support

Prevention programmes that are comprehensive and context-appropriate have been shown to result in increased condom use and decreased HIV and STI rates (WHO, 2011). Interventions need to be tailored to local conditions in the sex work industry, for example they must cater for the type of sex work in that area (street, brothel, truck or club-based) (Wechsberg, Parry and Jewkes, 2010). Programmes should also take account of the multiple risks facing sex workers who are also members of other key populations.

HIV prevention is merely one aspect of meeting the holistic needs and rights of sex workers. Effective programmes should address the integrated needs of sex workers, rather than focusing on disease prevention only. The rights-based assumption is that educating and assisting people to realise their human rights will lead to them being able to make healthier choices, of which HIV prevention is only one (SWEAT, pers comm).

3.5.4.3 Sex workers’ knowledge

Sex workers with some or substantial exposure to peer education are shown to be more knowledgeable about HIV than the general population (Government, 2013; GARPR). At programme sites with intensive outreach and education work (SWEAT 2013a), 48% of female and 41% of transgender sex workers answered four standard questions correctly. Male sex workers’ knowledge was lower, with only 28% answering all questions correctly. The MSM sex workers’ knowledge was in line with the general male population, 30% of whom answered all questions correctly.

3.5.4.4 Encouraging health seeking behaviour

The IBBS study of 173 sex workers along the N3 (UCSF 2014) found that around 50% had accessed healthcare of some form in the last year, most frequently using the health system to access antenatal care.

Lane et al (2015) found that, on average in the three largest metros, 79% of sex workers who are aware of their HIV positive status had sought care, despite their fear of being victimised and identified (Mac AIDS 2015) as a result of high levels of discrimination, humiliation and neglect by healthcare workers (Scorgie 2013b). Therefore, there is a strong link between knowing one's status and health seeking behaviour.

3.5.4.5 Access to integrated health services

One of the key reasons why sex workers are not able to access integrated health services is because of prejudice towards sex workers (usually based on moral judgement) from healthcare workers (Richter and Chakuvinga, 2012). Sex workers describe aggressive and discriminatory attitudes and public humiliation from healthcare workers, and breaches of confidentiality about both their sex work and their health status, including their HIV status (Mac AIDS, 2015; Richter and Chakuvinga, 2012). Even clinics specifically designed for sex workers are sometimes criticised for stigmatisation. When health services are sought, sex workers tend not to divulge their professional involvement in sex, and are, therefore, not upfront about their sexual health risks.

It has been found that having access to non-discriminatory health care and to supportive services has a positive impact on sex workers' health behaviour. Richter et al (2013) found that sex workers operating near a sex-work-friendly clinic in Hillbrow were substantially less likely to have unprotected sex than those in other sites.

Without access to non-discriminatory health services, sex workers suffer from a lack of access to:

- diagnosis and treatment of STIs
- regular HCT
- PEP or PrEP
- contraception or emergency contraception
- other forms of maternal and sexual and reproductive health
- diagnosis and treatment of TB
- drug and alcohol addiction support
- psychological care

Not having access to the above constitutes a contravention of human rights, and contributes to exacerbating the HIV/TB epidemic (WHO 2013). Sensitised, trained and competent service providers and sex-work specific clinics have been shown to correlate with higher rates of condom use, and reduce HIV transmission (Richter et al, 2013).

Research and statistics regarding STI prevalence, ART adherence, TB/HIV integration, emergency care and psychological health for sex workers is not readily available, and neither is research regarding health access for sex workers (aside from the SWEAT/Impact Consulting studies, 2011 and 2014).

3.5.4.6 HIV counseling and testing (HCT)

National data on HCT do not provide disaggregated figures of HCT for key populations (UN GARPR, 2012). The available data is from sites where active outreach and programmes are running, and where testing uptake is likely to be higher than elsewhere. In the study of sex workers along the N3 highway (UCSF, 2014) it was found that 97% of female sex workers had tested for HIV, but only 59% had tested in the past year. In the SWEAT study, which surveyed approximately 1200 sex workers at its programme sites, it was found that 88% had tested in the past year, with 18% stating that they had received an HIV test directly from SWEAT. Intensive

outreach efforts seem to have had an effect on the general population of sex workers in these areas, as evidenced in these high HCT rates. These results can be compared with the national figure of 32% uptake of HCT in the last year for the general population aged 15 to 49, ranging from 23% uptake in Gauteng to 41% uptake in Limpopo (HST 2015).

3.5.4.7 Access to and use of condoms, femidoms and lube

Sex workers' use of condoms varies greatly depending on whether they are having sex with long-term or short-term clients, or with clients versus non-paying partners, or with casual versus long-term non-paying partners (see box). In the N3 sex workers study (UCSF 2014), 91% of female sex workers reported using condoms at last sex with paying partners, and 53% with non-paying partners. Only 14% had ever used lube, and only 21% even knew about water-based lube. In Richter's (2013) study of almost 1800 sex workers in four urban sites, about 8% of women, 33% of men, and 25% of transgender people had had unprotected sex with their last two clients.

Condom use with:

Last new client	98%
Last regular client	86%
Last casual non-paying partner	50%
Last long-term non-paying partner	30%
Use lubricant	36%

(Mac AIDS 2015)

Although sex workers universally support condom use and report high levels of condom use at last sex, qualitative discussions frequently dwell on the difficulties of consistent use of condoms (Impact Consulting/SWEAT 2014). The high rates of new infections in sex workers, reflected in an estimated 60% prevalence rate, suggest that current condom use is not sufficient to protect sex workers from HIV infection.

Femidom use:

	Always	Sometimes	Never
Female	15%	29%	54%
Male	30%	10%	59%
Transgender	12%	16%	71%

(SWEAT, 2013a)

Unequal power relations underpin many of the circumstances that make using condoms difficult, and often impossible, for sex workers (Richter and Chakuvinga, 2012). Although many sex workers hold a policy of 'no condom, no sex', they are challenged in practice due to financial desperation and client insistence. Some sex workers are able to adhere to a strict condom policy, even in the face of danger, cost and resistance (Scorgie 2013a). However, most do not manage to always have protected sex for the following reasons (Mac AIDS, 2015; Richter et al, 2013; Scorgie 2013b):

- complacency with familiar sexual partners
- intoxication
- refusal or reluctance by clients, which often leads to violence if the sex workers insist on a condom
- sabotage of condoms by clients
- clients who offer to pay more for skin on skin
- police harassment
- rape

Uptake of female condoms (femidoms) has been low, and lower than anticipated. There was a surge in use by female sex workers during the run up to the 2010 World Cup, who successfully used them without their clients' knowledge (Richter et al, 2013). SWEAT (2013a) found that femidom use was higher among male sex workers for anal sex, than among female sex workers for vaginal sex (see box). Regular femidom use was lowest among

transgender sex workers. Sex workers in SWEAT's programme areas used femidoms far more than sex workers in four major sex work centres in 2010 (Richter 2013), where 9%, 21% and 44% of male, transgender and female sex workers had ever used a femidom.

Femidoms are more difficult to access than male condoms. While only 9% of sex workers reported not being able to access male condoms during the SWEAT survey, 59% of respondents stated that they cannot always get femidoms. The National Department of Health distributed around 5 million female condoms in 2010/11 – only 1% of the half-a-billion male condoms that were distributed (Richter et al, 2013).

3.5.5 Prevention of Mother to Child Transmission (PMTCT) of HIV

A total of 59% of the sex workers who were interviewed in Port Elizabeth (Mac AIDS, 2015) reported having had an unwanted or unplanned pregnancy. This is comparable to the general population, where in a cohort of pregnant women on ART, 62% of these pregnancies were unplanned (Day and Gray 2012). More than half of the participants (53%) in the Mac Aids study (2015) used a hormonal form of birth control, had an IUD, or had undergone a bilateral tubal ligation. About three quarters of female sex worker respondents in the IBBS survey (UCSF, 2014) reported using a contraceptive at the time of the study.

The IBBS study (UCSF, 2014) along the N3 truck route showed that 96% of sex workers who had been pregnant in the five years prior to the study had used public sector antenatal care, including PMTCT where needed. In the Mac AIDS study in Port Elizabeth (2015), 85% of HIV positive women who had been pregnant had received PMTCT, more than the UNAIDS target of 80% MTCT coverage. This study also reported that 8% of participants in Port Elizabeth had at least one child who had also tested positive for HIV.

In 2013/14, national statistics for PMTCT show that 2.2% of affected infants are HIV positive [around 0.7% of all infants] (HST 2014), and the figure for MTCT was below 4% in 2012 (SANAC 2013b). The 8% rate for sex workers suggests that PMTCT services are relatively equitably available to sex workers.

3.5.5.1 Access to and proper use of anti-retroviral treatment (ART)

While 79% of sex workers who knew their HIV status in three major metros had sought healthcare, only 46% on average of these had been initiated onto ART (Lane et al, 2015).

In Port Elizabeth (Mac AIDS 2015), although 82% of sex workers were aware of their positive HIV status, only 39% of sex workers who were positive were on ART. Of those that were not on treatment, half were eligible for ART, and none of the HIV positive pregnant women were virally suppressed. In the third reviewed study, the IBBS along the N3 (UCSF 2014), 79% of people living with HIV (PLHIV) knew their status; but only 57% were linked to care and slightly more than 33% were on ART.

Research with the general population indicates that the majority of PLHIV who are eligible under the criteria of CD4<350 have been initiated onto ART, and around 60% of those eligible under the current expanded eligibility criteria (Bekker et al, 2014). Although viral suppression is achieved in many patients, there are still major challenges to viral suppression and treatment outcomes across the general population. Challenges include inability to follow up with clients, low adherence, drug stockouts, food insecurity, and disrupted environments. There is a greater gap in the delivery of ARTs for sex workers than in the delivery of PMTCT, although the exact reasons for this are not known.

3.5.5.2 Dealing with substance abuse issues

There is a common prejudiced assumption that sex work and drug and alcohol consumption are linked. This assumption does not take into account the levels of drug and alcohol consumption in the communities from which the sampled sex workers are drawn. For example, we do not have data for comparison with the general population in the drug and alcohol profile reported in the Mac AIDS (2015) study in Port Elizabeth, where 1% of the sampled sex workers reported previously injecting drugs, 25% had used non-injection drugs, 47% drank

alcohol more than twice a week, most reported drinking more than four times a week, and approximately 10% of respondents in the study drank 6 or more drinks at a time on a daily or almost daily basis. The data does not provide information on whether these high levels are related specifically to sex work or are in line with the general population's habits in the area.

In four sex work centres across South Africa, 44% of female sex workers, 65% of male sex workers, and 67% of transgender sex workers were daily or weekly binge drinkers[9], (Richter et al, 2013). Many sex workers report the social use of drugs and alcohol as a requirement by clients (Impact Consulting/ SWEAT, 2014; Boyce and Isaacs, 2011). Sex workers also report using drugs and alcohol to lower their inhibitions and to enable them to do their work more easily (Wechsberg et al, 2006; Wechsberg Parry and Jewkes, 2010).

In excess, drugs and alcohol affect negotiation for condom use (Wechsberg et al., 2006; Wechsberg Parry and Jewkes, 2010; WHO, 2011), and unprotected sex is reported as more than twice as likely among daily or weekly binge drinkers (Richter et al, 2013).

Impact Consulting/SWEAT (2011) found that some sex workers were given 'advance payment' by controllers in the form of drugs. These controllers were described as violent and threatening drug lords, who had drawn sex workers into addiction. The sex workers remained trapped in sex work to repay regular drug purchases. These situations were the exception, and not widespread across the research sites, but they are the reality of sex work conditions in some areas. In the Port Elizabeth study, 53% of sex workers drank less than twice a week (Impact Consulting/SWEAT, 2011). And SWEAT interviewers in central Johannesburg met sex workers who make no use of drugs or alcohol, finding that their work is safer and more efficient without substances.

3.6 Connecting and mobilising sex workers

As a response to the stigma, criminalisation and social exclusion that they face, sex workers can become inwardly focused on survival strategies, drawing on individual resources and sometimes drawing on informal peer networks (Scorgie et al. 2013a). Many sex workers connect with each other in order to become stronger against day-to-day risks in their work and environment, and in order to mobilise against abuses and human rights violations.

The Sisonke Sex Worker Movement was initiated for the purpose of social mobilisation, to create solidarity and to provide peer support for and by sex workers. Sex worker social movements have been a valuable resource in addressing sex worker concerns in South Africa and could continue to be central to harm reduction, realisation of rights and decriminalisation movements.

[9] More than 6 alcoholic drinks at a session

4. RED UMBRELLA PROGRAMME OVERVIEW

4.1 The Red Umbrella programme

The Global Fund / SANAC National Sex Worker Programme seeks to mobilise sex workers (male, female and transgender) to play a key role to collectively address HIV/AIDS, while promoting sex workers' rights and wellbeing. It is the first sex work programme in South Africa to provide HIV prevention, care and support to adult sex workers on a national and coordinated scale[10]. The name 'Red Umbrella National Sex Work Programme' was collectively chosen by the 18 sub-recipient organisations, aligning the programme with the global sex workers' rights movement, for which the red umbrella is the symbol.

There has been a shift in HIV funding over the last five years, which has intensified focus on key populations. With the GFATM/NACOSA Sex Worker Programme, this has impacted profoundly on the response, with massive growth in the number of implementation sites, implementing agencies, activities, interventions, staff, peer educators, and sex worker involvement. NACOSA data reports that the programme currently reaches 40 000 sex workers per quarter, or 25% of the national estimate. There has been around a 10-fold increase in the number of peer educators and sites, and more than double the numbers of implementing partners are now funded under the Global Fund grant. This constitutes substantial and rapid progress towards the WHO recommended target of 60% reach for sex workers by national programming[11].

The Red Umbrella Programme is a cooperative venture of 18 partners working across the country in implementing sex worker support interventions. NACOSA provides the leadership, monitoring and evaluation (M&E), grant management, and ultimate responsibility for delivery of the programme, in its role of Principal Recipient for the grant agreement with the Global Fund.

The Red Umbrella Programme follows a model outlined in the World Health Organisation Sex Worker Implementation Tool (SWIT), using a multi-pronged set of interventions[12] to address the causes, context and service requirements of a sex work response[13].

4.2 Programme components

The programme's complex response is summarised into four broad areas:

1. A legally and politically enabling environment
2. sensitisation of service providers
3. constituency involvement
4. access to rights and services.

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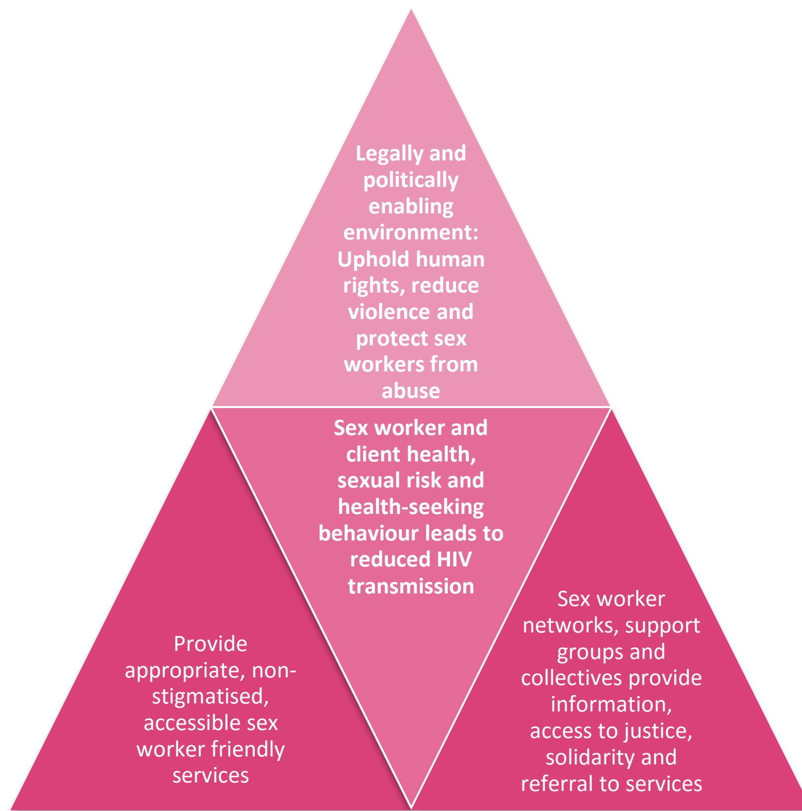
[10] NACOSA (2105) Terms of Reference, Red Umbrella Programme evaluation.
[11] Cited in THE GLOBAL FUND(2011) Monitoring And Evaluation Toolkit: HIV, Tuberculosis, Malaria and Health and Community Systems Strengthening, Part 2 HIV. http://www.theglobalfund.org/en/me/documents/toolkit/
[12] WHO (2013) Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions
[13] Shannon, K., Strathdee, S. A., Goldenberg, S. M., Duff, P., Mwangi, P., Rusakova, M., & Boily, M. C. (2015) Global epidemiology of HIV among female sex workers: influence of structural determinants. *The Lancet* 385(9962):55-71.

The interplay is summarised in Figure 1:

Figure 1. Four major components in a multi-pronged approach to sex worker support interventions



4.2.1 A legally and politically enabling environment

A decriminalisation advocacy agenda is a long-term programme element. Advocacy for legal reform is an ongoing and long-term project, with steady progress and step-wise achievement reported each year.

4.2.2 Sensitisation of service providers

Changes to law and policy are time-consuming. Pragmatic interventions with sex workers are being provided by Government, SANAC and the Red Umbrella programme despite formal criminalisation. The Red Umbrella programme focuses on sensitisation and education of service providers (particularly police, courts and health workers) to the realities, needs and rights of sex workers[14], as it is theorised that sufficient education and sensitisation should *de facto* lead to many of the expected positive impacts of full legal reform.

[14] SANAC (2013) National Strategic Plan for HIV Prevention, Care and Treatment for Sex Workers. Pretoria, South Africa.

4.2.3 Constituency involvement

Constituency involvement means that sex workers participate in all aspects of programming[15]. Social mobilisation has been a key component in the design and implementation of sex work programming[16,17]. Involvement has been led by the Sisonke Network of Sex Workers, an organisation that has grown both in size and institutional capacity in recent years.

4.2.4 Access to rights and services

A major thrust of the Red Umbrella programme involves direct interventions with sex workers providing sexual and reproductive health services and information, facilitating support structures and networks, and helping to negotiate for rights with police and legal structures.

4.3 Outcomes and goals of the programme

Aligned with national priorities, the programme has the following high level goals[18]:

- stabilisation of HIV prevalence among sex workers
- increased access to HIV-related services (through sensitising and mobilising gatekeepers)
- increased access to emergency and psychosocial support for sex workers
- improved coverage and access to sex work-focused HIV prevention, treatment, care and support
- increased capacity of government, CBOs and NGOs to implement sex worker programmes
- increased coordination of sex work programming
- reduction of violence experienced by sex workers
- progress towards the decriminalisation of sex work in South Africa.

While the goals are, to varying extents, beyond the direct influence of the programme, they serve as a touchstone for contribution to a national comprehensive response which should improve the three key population factors cited by the Global Fund: HIV vulnerability; access to services; realisation of human rights.

[15] NSWP, Sex Worker Implementation Tool.
[16] SAT / THE GLOBAL FUND(2015) Our Stories Statistics Solutions: A Supplement to the South African Civil Society Priorities Charter, Written by Key Populations
[17] WHO (2013) Implementing Comprehensive HIV/STI Programmes with Sex Workers.
[18] Please note that these goals will not all be measured during this evaluation.

4.4 Sex work programme interventions

Programme goals are achieved through the following main interventions:

Table 1. Intervention areas and related services

Main intervention area	Package of services
1: Comprehensive prevention	560 part-time sex worker peer educators and 56 site coordinators Outreach as a strategy for all interventions Condoms and lubrication distribution Information, education and communication Paralegal services Referral to services for health, substance abuse support services Creative Space risk reduction workshops, counseling, training Accessible HCT, and training of peer lay HCT counsellors
2. Sensitise and mobilise "gate-keepers"	Two-day capacity building workshops for organisations and individuals
3. National response call centre	SWEAT helpline, staffed and managed by trained sex worker lay counsellors
4: SANAC Sex Work Sector supported as a platform for collective engagement	Two-day Sex Work Sector conferences in 2014 and 2016 Good Practice Guide developed and trained, for sex worker programmes, including information on services, rights, biomedical services for sex workers

4.5 Programme partners and provincial presence

The Red Umbrella programme has grown substantially since its initiation in 2010. In the last three year phase, the programme has been implemented through 18 sub-recipients in all nine provinces of South Africa. Table 2 outlines the distribution of partners and programming:

Table 2. Implementing partners, geographic areas and scales of intervention

Partner	Provinces[19]									Participating sex workers in Q7[20]	# sites
Centre for Positive Care (CPC)			GP		LP	MP		NW		5370	10
GRIP						MP				2533	7
Hoedspruit Training Trust, Hlokomela Project					LP	MP				1473	3
Khethimpilo	EC			KZ						1761	4
Lesedi-Lechabile Primary Care (LLPC)		FS								1535	3
Lifeline Durban				KZ						1851	4
Lifeline Freestate		FS								604	1
Lifeline Northern Cape							NC			778	2
Lifeline Zululand				KZ						395	1
Munna Ndi Nnyi (MNN)					LP					780	1
Nqobile Women			GP							1591	2
Oasis Faithworks			GP							1856	2
PHRU			GP							1573	1

[19] EC=Eastern Cape KZ=KwaZulu Natal FS= Free State GP=Gauteng LP=Limpopo MP=Mpumalanga NC= Northern Cape NW=North West WC=Western Cape
[20] March to June 2015

Partner	Provinces[19]									Participating sex workers in Q7[20]	# sites
Partners in Sexual Health (PSH)							NC		WC	1049	2
Qholaqwe Advice Centre		FS								2630	5
SWEAT								NW	WC	3539	14
TB/HIV Care Association	EC			KZ						2319	4
WRHI			GP							7574	4
18 partners in total	9 provinces									39 211	70

5. EVALUATION OVERVIEW

5.1 Brief rationale and background

The evaluation took place at a time when sex worker programming and policy-making, both in South Africa and internationally, was rapidly evolving. In Phase II of the Red Umbrella programme, the programme has been actively implemented in new areas, among new groups of sex workers and their communities, offering new services and interventions. With many sites and partners in their first cycle of intervention at this level, there has been a great deal of learning. Unintended negative effects have also been identified and learnt from in the design of the next phase.

5.2 Primary aim

The purpose of the evaluation when it was initiated was to assess the effectiveness of the programme to inform programme improvement for the next phase of the Global Fund grant, which will commence in April 2016.

However, shifts in Global Fund strategy took place during the evaluation, which led to major changes in the plans for Phase III of the project – many of which are counter to what the evaluation has found and would recommend. The evaluation, therefore, serves as a documentation of Phase II achievements, with recommendations based on the learning from Phase II towards the new Phase III strategy.

5.3 Specific objectives of the evaluation

- To formalise and document the implicit Theory of Change (ToC)
- To evaluate programme outcomes (what difference has the programme made: including changes in social, behavioural and other risk and protective factors on sex workers) using a realist evaluation[21] approach
- To evaluate a variety of programme implementation models in different contexts in terms of programme effectiveness and efficiency
- To provide data that serves as additional descriptive data about sex workers and their access to services and lived experiences in the country (to add to data from the SWEAT/Impact Consulting data from 2013).

5.4 Methodology

5.4.1 Evaluation principles and approach

The following principles guided the evaluation approach, and defined the manner in which the research was conducted:

- The evaluation had a **human rights** focus.

[21] An introduction to realist evaluation including a downloadable chapter from Pawson and Tilley (1997) (reproduced with permission from the authors) www.communitymatters.com.au/gpage1.html

- The evaluation was based on **'realist' principles (Pawson and Tilley, 1997)** – not only looking at *"what works?"* and *"what doesn't work?"*, but *"what works for whom, in what contexts, and how."* Additional information about this theoretical framework is included in Appendix 2.
- As with all realist evaluations, the evaluation was **theory-based** – it tests the draft **theory of change** (Figure 2) as well as emergent outcomes. The theory can be revised based on the study findings.
- The evaluation was **participatory** and there was engagement with sub-recipients and the project steering committee through all phases.
- The evaluation was **constituency-based** and engaged peers as researchers, informants, site hosts and gate openers.
- The evaluation was **inclusive** in terms of both external and internal stakeholders.
- The evaluation is **utilisation-focused** – it aims to be directly useful to the programme.

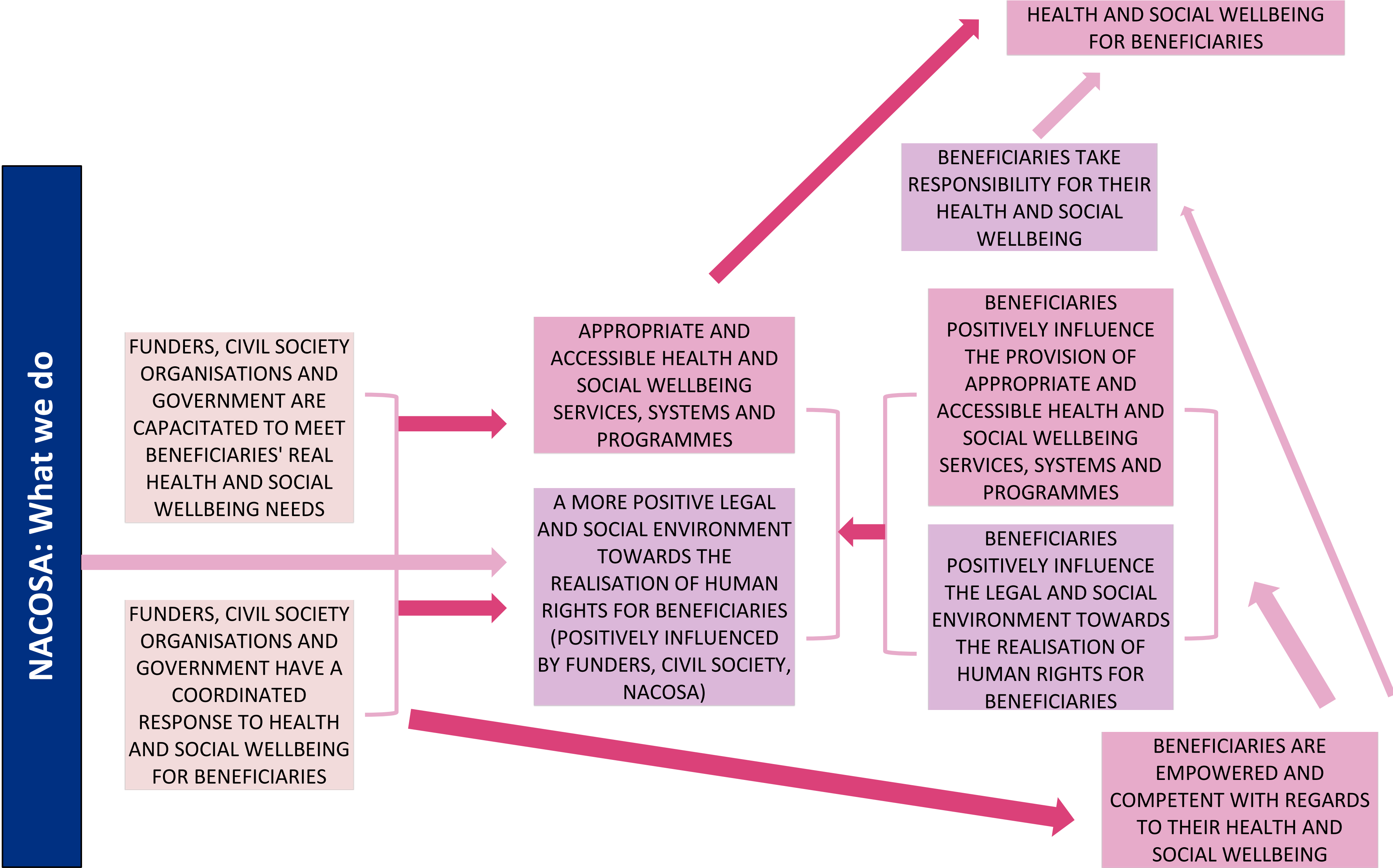
5.4.1.1 Red Umbrella Theory of Change

Part of the realist evaluation approach is to develop a ToC that guides the evaluation framework. The programme theory describes how the intervention is expected to lead to its effects and in which conditions it should do so. The evaluation uses this programme rationale as its conceptual underpinning, testing the assumptions of cause and effect outlined in the strategic rationale.

For this study, the ToC was developed at the beginning of the study (Figure 1) to guide the investigation, in consultation with a range of stakeholders and in line with NACOSA's overall organisational ToC. The evaluation specifically tests to what extent these outcomes are being realised on the ground, and looks for emergent outcomes/consequences/effects. Outcomes findings are reported according to this theory.

The theory of change can be found below (note that 'beneficiaries' in this instance refers to sex workers):

Figure 2. Theory of change as an analytical framework for evaluation of causal relationships in programme outcome



5.4.2 Evaluation methods

The evaluation used mixed methods (i.e. both qualitative and quantitative), including:

- desktop research and participatory planning
- national interviews
- site visits to 22 sample sites at which the following was conducted:
  - surveys with peer educators
  - surveys with a sample of sex workers (data was collected by trained peer educators using a mobile app that was developed by Dure Technologies).
  - focus groups with peer educators
  - focus groups with sex workers
  - interviews with management staff
  - interviews with external key informants
  - outreach visit observations
- participatory analysis
- participatory recommendations and conclusions.

5.4.3 Constituency involvement in the evaluation process

An important value and principle of implementing sex work programmes is that sex workers are integrally involved in all activities. This evaluation study upheld these values in the following ways:

- sub-recipients have been involved in the design and review of the research protocol, evaluation approach and evaluation tools, and they set up the fieldwork at each site
- a sex work programme steerimg committee, which includes representatives of sub-recipients and the sex worker network, guided the evaluation
- provincial managers of the programme all attended an evaluation design, planning and orientation meeting and liaised with the sampled sites in terms of their involvement in setting up and participating in the data collection
- peer educators (who are sex workers themselves) were trained on the mobile survey app and survey questions, and they administered the survey to sex workers, after being supervised in the field by the research team
- peer educators and sex workers participated in focus groups, acted as guides for outreach, and were involved in all logistical aspects of the study.

Although possible biases may occur from the close participation of peer educators, the principles of NACOSA and the Sex Work movement are based on participant involvement and, therefore, they were an integral part of this participatory evaluation. In research terms, the benefits of using peers to administer the survey far outweighed the risks in terms of getting accurate and valid data, for the following reasons:

- peers know how to find sex workers and are familiar with their working environments (in terms of safety, hidden spots, hotspots etc.)
- peers know how to talk to sex workers, particularly since they have already been trained to do outreach and engage with sex workers and have specific requisite skills

- sex workers will be more likely to agree to complete the survey if representatives of an organisation that they are familiar with are making the request
- sex workers are less likely to be dishonest about their answers for reasons of social desirability with their peers – sex workers have expressed to the research team and to peers that they would be more likely to fake positive with a stranger who is not a sex worker
- the process of conducting an evaluation provides insights and information, which become directly useful and relevant to the programme where peers are involved.

5.5 Site sample

A total of 22 of the 70 programme sites were sampled. The sample permitted at least one site for each participating partner, and a further three sites to ensure that all provinces were represented, weighting the sample for sites and partners with the most participating sex workers. The sampling was purposive to a degree, with stratification to ensure representation of:

- ***Provinces***: At least one site from every province is selected
- ***Partner organisations***: Sites were chosen to ensure that every partner organisation is included in order that each of their models is reviewed
- ***Typology of sites***: In terms of being a sex work hotspot (e.g. mining towns, towns on major truck routes, border towns etc.) / metro versus large to small service town / rural versus urban versus peri-urban[22]
- ***New sites vs old sites***: Sites that had been implementing services for sex workers during Phase I (8) versus those where sex work programmes which were introduced in Phase II (62). Seven of the eight original sites were included in the study.

Thereafter, a random sampling process was used to choose the remaining sites in each province.

The sampled sites are described in Table 3 below (* indicates that they were in Phase I):

Table 3. Sample sites

Prov	Sites	Place type / factors	Sub-recipient
EC	Makana	Regional centre	Khethimpilo
	East London*	City (metro, transport)	SWEAT
FS	Welkom	Regional centre (mining, transport)	Lesedi-Lechabile
	Bloemfontein	City (metro, transport)	Lifeline Freestate
	Bethlehem	Regional centre (transport)	Qholaqwe LAC
GP	Sedibeng, Emfuleni	City region (transport)	Nqobile Women's Development
	City of JHB, Randburg	City (mining, transport)	Oasis Faithworks
	City of JHB Soweto	City (mining, transport)	PHRU
	Hillbrow* and TG site	City (metro, mining, transport)	WRHI
KZN	Port Shepstone*	Regional centre (tourism)	Lifeline Durban
	Richards Bay	Regional centre (mining, transport, port)	Lifeline Zululand
	Ethekwini	City region (metro, transport, port)	TB/HIV Care
LPO	Musina*	Service town (border, transport)	CPC
	Makhado	Regional centre	Munna Ndi Nnyi
MP	Ngodwana	Local town (transport)	GRIP
	Bushbuckridge	Service town	Hlokomela

[22] Reference CSIR town typologies

Prov	Sites	Place type / factors	Sub-recipient
NC	Kimberley	Regional centre (mining, transport)	Lifeline NC
NW	Madibeng/ Brits	Regional Centre (mining, transport)	CPC
	Rustenburg*	Service town (mining)	CPC
WC	Beaufort West*	Service Town (transport)	PSH
	George*	Regional Centre (mining, transport)	SWEAT

5.6 Description of evaluation participants

A total of 1699 participants across 22 sites in nine provinces were involved in the evaluation, as shown in the table below:

Table 4. Total number of participants

Participant group	Number of participants
Sex workers	1410
Peer educators	193
Site managers	51
Key informants	45
Total	**1699**

Of the 1410 non-peer sex workers who participated, 1244 were survey respondents.

The peer educators were located as follows:

Table 5. Number of peer educators per sampled site

Sites	# of peers	Sites	# of peers	Sites	# of peers
Beaufort West	14	Ethekwini	8	Port Shepstone	10
Bethlehem	1	Hillbrow	14	Randburg	6
Bloemfontein	15	Kimberley	7	Richards Bay	11
Brits	9	Makana	5	Rustenburg	10
Bushbuckridge	11	Makhado	9	Soweto	9
East London	5	Musina	8	Welkom	19
Emfuleni/Sedibeng	9	Ngodwana	13		
Total	**193**				

5.6.1 Eligibility to participate

The following eligibility criteria applied to participants, who had to volunteer their participation and provide voluntary informed consent prior to participating in the study.

Table 6. Inclusion criteria for evaluation participants

Participant group	Inclusion criteria
All participants	• Over 18 years of age • Provide informed consent to participate
Sex workers	• Actively selling sex as a source of livelihood
Peer educators	• Currently contracted to the sub-recipient, routinely engaged in outreach work, and experienced as a sex worker communicator • Has worked for the partner organisation for more than six months

Participant group	Inclusion criteria
Key informants	• Has knowledge, insight or experience of the Red Umbrella programme, sex worker experiences, rights, services, welfare, concerns, access, health, HIV prevention and services, or any other area relevant to the evaluation.

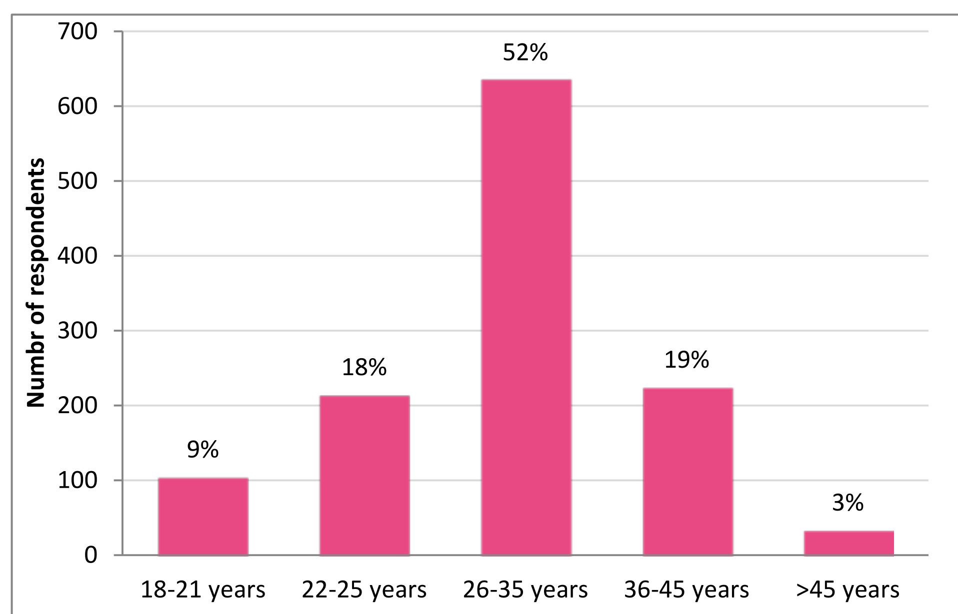
5.6.2 Description of participating sex workers

5.6.2.1 Age

Sex work and peer educator participants who were involved in the qualitative and quantitative aspects of the study were primarily between the ages of 18 and 45, with a smaller group of participants who were older than 45 years of age.

In terms of the sex workers who responded to the survey (n=1244), more than half (52%) were between the ages of 26 and 35 years old. Only 3% were over the age of 45.

Figure 3. Ages of sex worker survey respondents (n=1244)



5.6.2.2 Gender

Table 7. Gender of survey respondents (n=1239)

Gender	Frequency	Percentage
Female	1098	88.6
Male	37	3.0
Transgender	100	8.1
Other	4	0.3
Total	1239	100.0

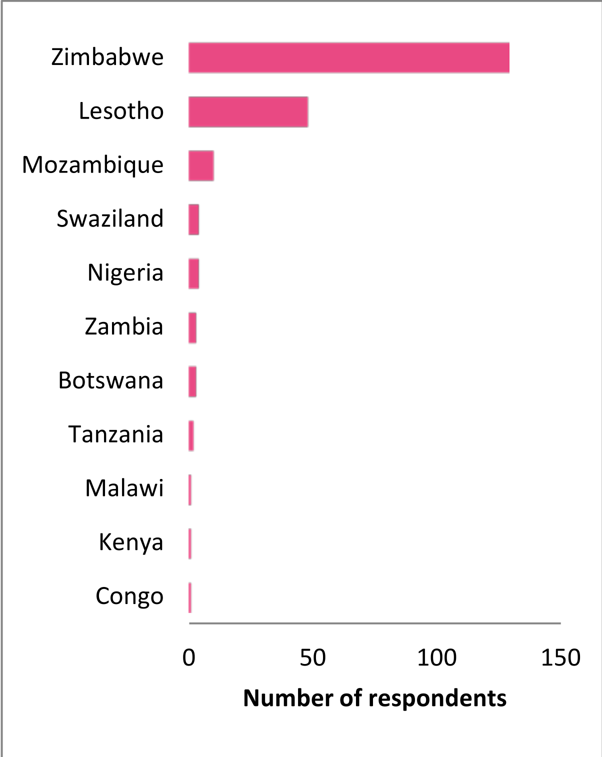
Sex worker participants in qualitative and quantitative aspects of the study were mainly female, with transgender individuals making up less than 10% of the sample and MSM individuals comprising about 3%.

In terms of the sex worker survey respondents in particular, 88.6% were female, 8.1% were transgender and 3% were male:

5.6.2.3 Nationality

The majority of sex worker respondents were born in South Africa (83%). Of the remaining 17% who are foreign nationals – 62.6% are from Zimbabwe, 23.3% from Lesotho, 4.9% from Mozambique, 1.9% from Nigeria and 1.9% from Swaziland, (1.9%), 1.5% from Botswana and 1.5% from Zambia, and 1% or less from other sub-Saharan African countries. This is illustrated in the figure below:

Figure 4. Nationality of sex worker survey respondents (n=206)



5.6.2.4 Sex worker mobility

The majority of sex workers who participated in the survey were not mobile (n=1232), with the vast majority (78%) having resided in the same area for over two years, and less than 7% having been in the area for less than six months.

Table 8. Sex worker mobility: time living in current area (n=1232)

Time	Frequency	Percentage
Less than a month	7	0.6
1 to 6 months	71	5.8
6 months to 2 years	192	15.6
More than 2 years	962	78.1
Total	**1232**	**100.0**

5.6.2.5 Time in the sex work industry

More than half (52.9%) of the sex worker survey respondents (n=1209) have been working as sex workers for between two to five years, more than a quarter (27.6%) for six to ten years, and more than 10% for over a decade. Only 9.1% of the sample are “new” sex workers who have been in the industry for a year or less.

Table 9. Time in the sex work industry (n=1209)

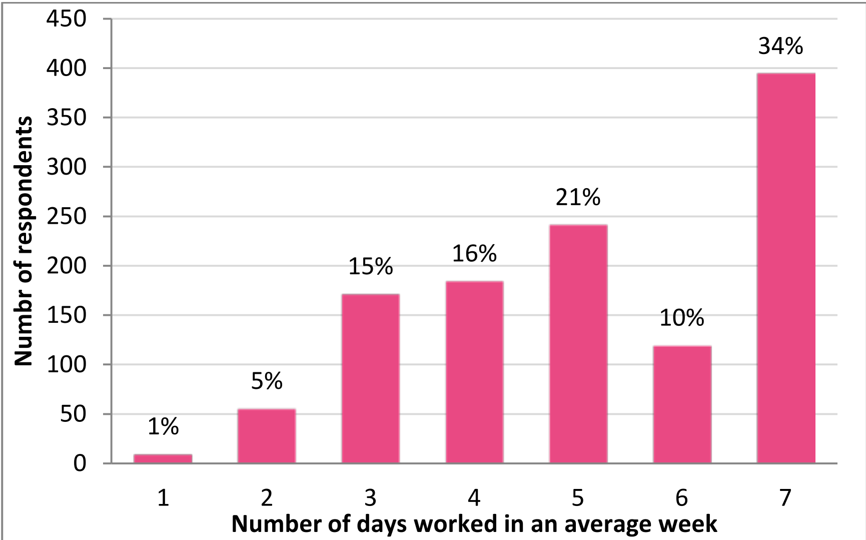
Time	Frequency	Percentage
1 year or less	110	9.1
2 to 5 years	640	52.9
6 to 10 years	334	27.6
More than 10 years	125	10.3
Total	**1209**	**100.0**

5.6.2.6 Economic situation

Sex workers participating in the study report that they have become involved in the sex work industry because of poverty combined with a lack of skills and very few employment opportunities. Almost all reported that sex work was a last resort for sex workers to support themselves and their families. Most sex worker respondents work full-time, and for the majority (81.5%), sex work is their main source of income, though some participants work in salons, as domestic workers or as street vendors to supplement their income.

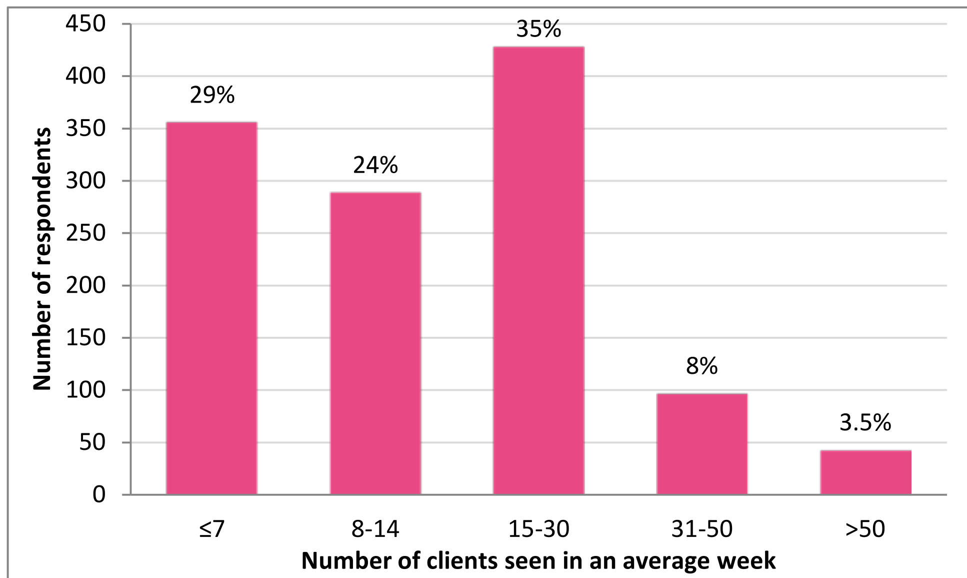
A third of sex workers (33.5%, n=1180) work seven days per week, 21% work five days a week and smaller percentages work less than five days a week.

Figure 5. Number of days worked in an average week (n=1180)



The vast majority of survey respondents (88.4%, n=1213) service up to 30 clients a week, with 8% servicing between 31 and 50 clients per week and 3.5% seeing over 50 clients per week. It is important to note that there could be multiple sexual encounters with each of these clients and, therefore, the number of sexual acts per sex worker per week is probably higher. Many participants noted that they service regular as well as once-off clients.

Figure 6. Number of clients seen in an average week (n=1213)



For the majority of peer educators (71.9%, n=193), their peer educator stipend is supplemented with income obtained through sex work.

Rates for services vary greatly and can range from anywhere between R50 to a few hundred rands, to a few thousand rands. However, sex workers in some areas accept as little as R20 a round if they are desperate. While sex workers mostly work for cash, participants indicated that they sometimes engage in transactional sex for alcohol or electronic items such as cell phones, laptops and DVDs. Some will trade sexual acts for tuition fees, or for doctor's payments.

5.6.2.7 Work setting

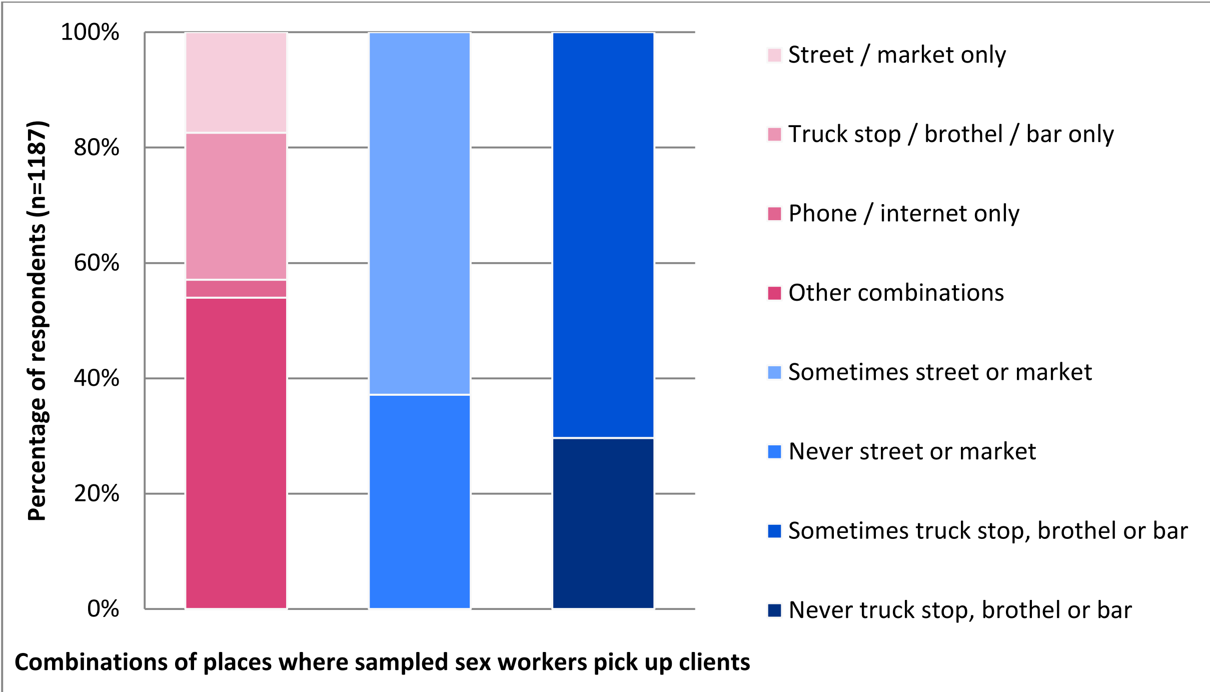
Sex workers mostly work independently, although a small percentage of survey respondents claimed to work for a manager or pimp (7.8%).

Street-based sex work (selected as an option by 61.7% of respondents) and working from within a bar/shebeen/club/casino (selected as an option by 52.6% of respondents) is most common. Almost 20% of respondents sometimes work from a truck stop at some point during their work, and almost a third (31.7%) connect with their clients using the phone. Only 7.6% market themselves online.

Table 10. Pick-up locations

Options	Option selected	
	Count	%
Street	735	61.7%
Bar/shebeen/club/casino	627	52.6%
Phone	378	31.7%
Brothel	255	21.4%
Truck stop	236	19.8%
Internet/online	91	7.6%
Market/shopping centre	72	6.0%
Any other	27	2.3%

Figure 7: Where sex workers pick up clients



Other pick up and service sites include hotels, motels, parks, public toilets, clients' cars, schools, derelict and unoccupied buildings and offices (accessed through paying the security guards of the buildings).

Almost all the survey respondents (96.7%, n=1230) had heard about and/or interacted with the Red Umbrella programme. Therefore, findings from this study relate to Red Umbrella programme participants, and not the general sex worker population.

5.6.3 Description of peer educators in the study

Peer educators across the sample sites are mostly female (85.5%, n = 165), with less than 10% being transgender and only 5% being male. Most peer educators are experienced part-time staff: almost two thirds (62.2%, n=193) have been working as peer educators between one to three years, with 20% being "new" (working for less than a year), and 17.6% working for more than three years. The majority of sex workers (80%, n=190) work between 12 and 20 hours a week. Less than 5% work less than 12 hours and 15% work between 20 and 40 hours a week. 72% of peers continue to do sex work whilst being peer educators.

5.7 Data analysis

As a theory-based analysis, the ToC forms an analytical framework, and data is used to test the theory. The analysis explores the evidence of enablers and constraints to realisation of the ToC, and the contextual elements within which the programme operates that bear relevance to its level of success. The ToC and programme implementation models (theory of action) will be reviewed and recommendations will be made for maximising impact.

5.7.1 Quantitative analysis

The surveys are the source of quantitative data, and have been analysed using appropriate procedures (both bivariate and multivariate) to detect relationships between the full range of available variables.

5.7.2 Qualitative

Programme processes, context and outcomes (as defined in the ToC) are the themes of the focus group discussions and the key information interviews. Interview and focus group notes have been analysed using Atlas.ti qualitative analysis software to organise results according to coded themes, and to establish patterns and relationships between themes. Descriptive information and causal information is considered so that we can reach an understanding not only of what occurred but why and in what contexts.

5.7.3 Collective interpretation workshop

Quantitative and qualitative findings were shared with relevant project stakeholders in a workshop format. In this participatory session results were presented, and a heuristic discussion was facilitated to make meaning of the data. The steering committee, which includes Sisonke member sex workers and partner representatives, were asked to give input in terms of interpretation of results, the implications of results for practice, and feasible appropriate recommendations.

5.8 Dissemination of results

The Red Umbrella programme will disseminate the study findings to its staff and to the sex workers it serves through a dissemination strategy which is being prepared by the Provincial Managers. NACOSA and the Steering Team have undertaken to convert the report into a range of appropriate products to the target audience, to include the results into meetings with Provincial Managers, and Sub-recipient, and to provide them with visual material to conduct dissemination sessions at province, sub-recipient and site levels.

Inputs from the Red Umbrella community will be collated by NACOSA M&E in a longer term follow through and recommendations development process.

5.9 Research ethics

The study has been granted official ethics approval from the Human Sciences Research Council (HSRC) Research Ethics Committee (REC).

In a sensitive and criminalised context, anonymity and confidentiality are essential. Names were not recorded for focus groups, interviews or surveys involving sex workers. Responses were coded using a fictional coding sequence, not related in any way to respondent identity. Any reference to the results in publications will use an unrelated, anonymous code name. Focus group participants have also remained anonymous. All raw data is in electronic format only, and is securely stored in Impact Consulting’s secure cloud storage facility. Electronic survey data, which is anonymous, is stored on Dure Technologies’ secure servers.

Informed consent is a fundamental ethical principal, which has been fully upheld and promoted in the evaluation through processes of carefully providing all relevant information to participants, and obtaining express written consent from every evaluation participant.

5.10 Limitations

A key limitation in the study was the lack of reliable health knowledge and behaviour questions. To be able to assess the results against the previous study, the UNAIDS Global Aids Response Progress Report (or GARPR, formerly known as UNGASS) HIV questions were used. Although these are “approved” internationally, the results are not reliable as respondents’ answers were not consistent between questions, which indicates that they may not have answered truthfully. For example, while many reported having had an STI in the last 12 months they also reported that they consistently use condoms. In order to truly assess health behaviour and condom use, the only question in the survey that was able to be used to assess condom use was the question *“Have you experienced symptoms of an STI in the past 12 months”.* The lack of valid and reliable questions was confounded by the tight timeframes of the project, which meant that the questions were not adequately tested in the field. A pilot was held, but it was rapid. A full pilot would have involved both the data collection as well as the analysis of the test data to check the questions properly. This also meant that there was wasted effort in data collection, as responses that were collected were not able to be used.

While the aim of the evaluation was to inform Phase III of the evaluation, the grant management cycle does not, in fact, allow the findings to inform Phase III as the concept note for Phase III was actually written before the evaluation terms of reference were released. Phase III was being rolled out while the study was being concluded. This is disappointing as the next phase of the programme does not clearly respond to the findings from the evaluation.

6. FINDINGS

6.1 Programme models and processes

6.1.1 Required programme activities and processes

Based on the objectives of the programme and the findings from the Red Umbrella good practice workshop (run by SWEAT)[23], effective programmes for sex workers should be holistic and address:

- the provision of (or ensuring access to) information, health, legal and psychosocial services
- the creation of an enabling environment in terms of reduced stigma and violence (including decriminalisation of sex work)
- empowering and networking sex workers to engage in positive health and pro-social behaviour to enable wellbeing (and reduce HIV).

This is in line with the theory of change for the programme.

The overall activities for the programme include:

1. advocating for a legally and poliltically enabling environment, including advocacy for decriminalisation
2. sensitising service providers, particularly police, courts and health workers to the realities, needs and rights of sex workers so that sex workers' rights are realised
3. involving the constituency in the programme
4. promoting access to rights and services, including providing sexual and reproductive health services and information, facilitating support structures and networks, and helping to negotiate for rights with police and legal structures.

The interplay is summarised in the programme description section.

The programme's package of services towards *"comprehensive prevention of HIV"* is outreach-based and peer educator-led to deliver the following:

- condoms and lubricants
- information, education and communication
- paralegal services
- referral to services for health and substance abuse support services
- Creative Space risk reduction workshops, counseling and training
- accessible HCT and training of peer lay HCT counsellors.

[23] SWEAT Good Practice Guide

The Global Fund grant administered by NACOSA only requires the sub-recipients to report on the following:

- HCT: the number of tests done and number of sex workers who know their results (either tested by peers or referred)
- The number of sex workers reached on outreach
- the number of risk reduction workshops hosted and number of sex workers attending these
- distribution of condoms.

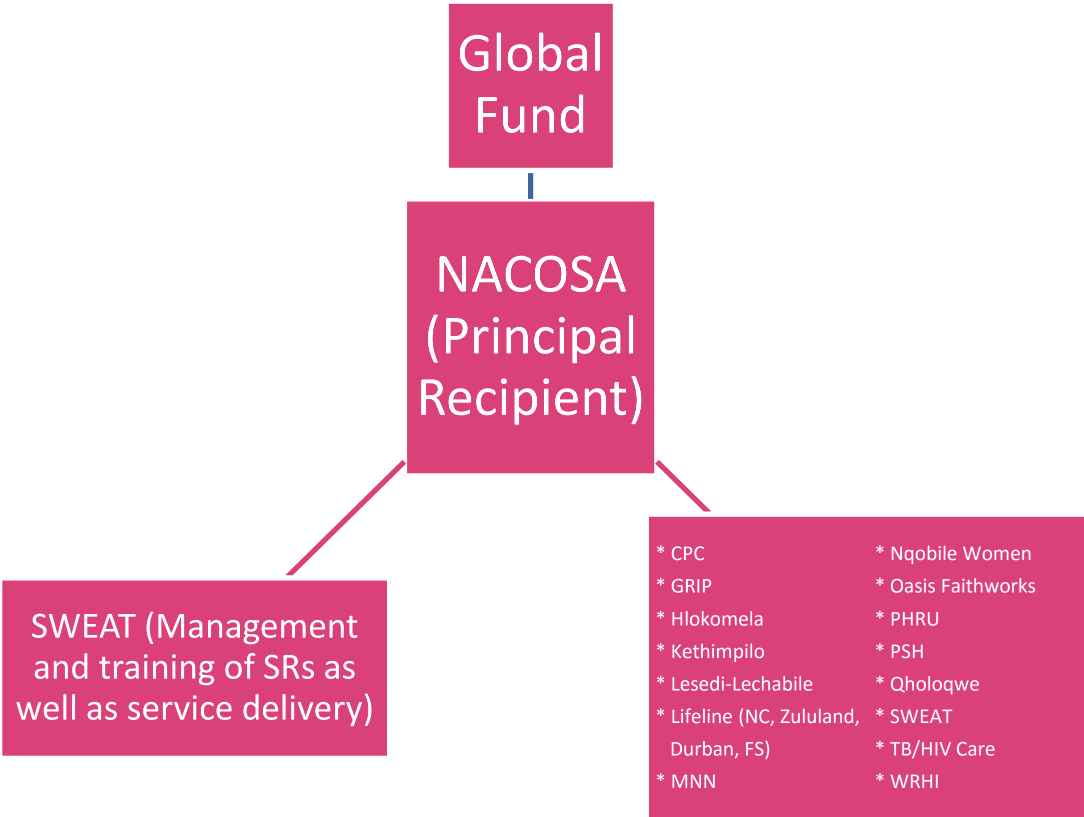
In addition, SWEAT was contracted to:

- provide capacity building training for peers, coordinators, paralegals and HCT peers (initial training and refresher courses)
- sensitise sex work stakeholders through two-day capacity building workshops for organisations and individuals
- provide trainer workshops for sensitisation training so that sites could continue to run them as needed
- run the SWEAT helpline, staffed and managed by trained sex worker lay counsellors
- design and host two-day sex work sector conferences in 2014 and 2016

6.1.2 Structure of the grant

In Phase II, the Red Umbrella programme was structured as follows:

Figure 8: Structure of the Red Umbrella programme



6.1.3 Delivery against requirements

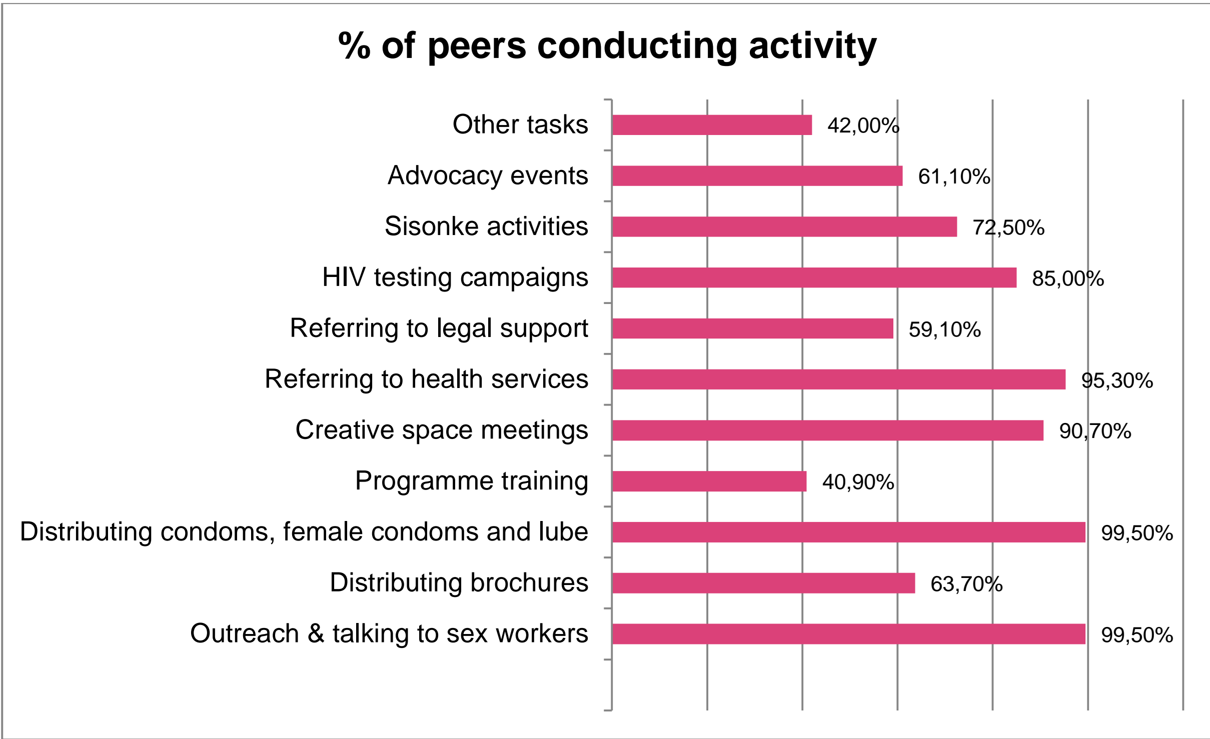
All sampled sites are conducting the minimum required activities of conducting HCT, outreach and risk reduction workshops (usually called Creative Space workshops), and distributing condoms and lubricant. All sites also assist sex workers to access legal, health and psychosocial services, to varying levels of success and by using various models of delivery.

There are three funding models that correlate to the implementation models for delivering a sex worker programme:

1. Funded by RU only and delivering the basic required package of services (HCT, outreach, CS, referral to other services)
2. Funded by RU only and delivering a basic package plus other services
3. Funded by RU and other donors and delivering a basic package plus other services.

In the section below, delivery of the various programme components are described, as well as a discussion of the successes and challenges associated with each of these. Peer educators are involved in all activities. In the peer educator survey, peers reported that they are involved in the following activities:

Figure 9: Activities undertaken by peer educators



Almost all peer educators engage in outreach activities (99.5%), distribute condoms, refer sex workers to health care and services (99.5%), and are involved in HIV testing campaigns. Most are involved in Creative Space workshops (90.7%). In terms of providing legal support, 59.1% of peer educators are assisting sex workers in this way. Peer educators are also highly involved in the sex worker movement – with 61.1% of peer educators engaging in advocacy events and 72.5% participating in Sisonke activities.

7. PROGRAMME MODELS AND PROCESSES

7.1 Finances

Almost all sampled sites were fully dependent on this grant to run its sex work programme. Most programmes will stop when the funding stops. Even the larger organisations would have to scale down their operations and services if the funding were to be withdrawn. PEPFAR and Gates Foundation funding is the additional other funding which some organisations have access to.

7.2 Creative space workshops

Creative Space workshops are funded to cater for 25 people, but there can be up to 80 participants. While some sites are strict about the 25 person maximum, others do not turn sex workers away and there can be up to 80 people in attendance. Creative Spaces are held monthly at most sites, twice a month in some and once a month in others. This is despite funding being provided for monthly meetings of 25 persons only, which means that SRs are stretching their funds to provide more services or funding additional workshops from other funding sources. Workshops usually last three hours, but some sites report that they can easily go on for up to five hours. They are hosted onsite at the SR's office, or offsite (for example, in brothels or at the local clinics) and some SRs move the workshops around so sometimes have them onsite and sometimes offsite. At one site, the workshops are held at a popular tavern which has rooms at the back for sex work to take place. The security guard at the tavern reported that he locks all the sex workers into the room during the Creative Space workshop so that they are all present and there are not one or two unfairly benefitting from having access to all the clients during that time. SRs provide HCT during Creative Space workshops, which they report help them to meet their HCT targets.

Good practices include:

- sex workers setting the themes based on need
- sex workers and peer educators facilitating the sessions
- inviting local stakeholders (such as the police or health care staff or municipal officials) to attend, and sometimes to give input
- utilising community dialogue and mobilisation practices
- using interactive methodologies, such as playing games, role-plays etc.

Creative Space workshops are reported to achieve the following:

- **networking/social cohesion/building a movement of sex workers**: *"They [peer educators] taught us to work together and treat each other like friends"* (Sex Worker FGD). Through Creative Spaces sex workers have gotten to know each other and feel accepted: *"There is freedom of speech. Sex workers experience connection with others and feel supported"* (Sex worker FGD).
- **meeting psychological needs and assisting to heal trauma**, for example sex workers acknowledge that they receive psychological support: *"You leave your place depressed by your experiences and the things that happened to you, you get to the Creative Space sessions, you get to hear people talking about worse things than you have been through… you say to yourself 'if they went through this and they are still alive and living, why should I feel ashamed and depressed?' I am going to pressa, phanda and pusha for life, it goes on…"* (Sex worker FGD). *"I come here in tears, but when I leave here I'm myself again"* (Sex worker FGD).

- providing education, including information about:
    - health (HIV and general)
    - hygiene
    - rights
    - reducing risks (e.g. to contracting HIV, being vulnerable to violence)
    - substance abuse
    - job-seeking
    - financial management
- providing personal development and personal behaviour skills.

7.2.1 Challenges with Creative Space

The Creative Space workshops are an extremely successful programme component. One site felt that some more structure through the year, perhaps through thematic guidance month by month, would be beneficial. Most, however, appreciated the freedom and ability to respond to sex workers' needs with the workshops. The only real challenge that was expressed was the high demand for the workshops and the limited resources available, which makes it difficult for sites to meet the demand.

7.3 Outreach activities

Outreach refers to peer educators going to visit sex workers at their places of work and providing information (verbally and distributing IEC materials), distributing condoms and recruiting sex workers to join Creative Space workshops. Effective outreach is when the work is done discreetly and naturally:

> ***"Over years of experience peers have found that an outreach style that is discreet and natural is important: when we go to taverns and clubs, we go to the bar manager and talk to them – we know the managers. We go to the bar and get a drink, so that you don't look like a researcher. It keeps people comfortable. The style is approachable. We also don't wear the SWEAT t-shirt, only the Red Umbrella t-shirt which doesn't say anything about sex work" (Management interview).***

Outreach is done during the day or at night, or both at some sites – depending on the context of sex work in the area and the capacity of the partner. For example, in eThekwini outreach is conducted during the day and at night; in Soweto, sex workers work at night but a lack of adequate transport funds prohibit the peers from conducting night outreach.

At some sites, a mobile clinic is available during outreach (in some cases the clinic belongs to the SR or sometimes the mobile clinic is a DoH one). When the mobile clinic belongs to the SR, they receive additional funding from other donors to provide this service. Other partners do outreach by going door-to-door to sex workers' homes rather than just visiting their work places. HCT is sometimes done during outreach – either by HCT-trained peers or by nurses in mobile units.

To varying extents, referrals are made during outreach based on the needs of the sex workers. These referrals can be for:

- more comprehensive health services (usually to the local clinic, or a specialised clinic, or to a hospital)
- legal assistance, for example to the SWEAT helpline or to Sisonke or to partners such as the Women's Legal Centre (WLC) (if peers have received paralegal training, they would be more able to make these referrals)

- psychosocial services, for example to DoH clinics for mental health services, to DSD for assistance with documentation or social grants or substance abuse issues. For example CPC in Rustenburg refers sex workers to DSD for assistance with getting their legal documents or accessing grants (child grants in particular). In addition, peers and sex workers participate in DSD's mental health programme.

CASE STUDY

The PSH outreach model involves door-to-door visits and HCT, condom distribution, pamphlet distribution, as well as education on different topics each month (HIV, breast cancer, hygiene, and smart decision-making) (Beaufort West, Peer Educator FGD)

HCT is provided by regular medical staff at Risk Reduction Workshops, but more effectively by trained medical staff in door-to-door outreach: "We test at risk reduction a bit, but we don't push, that doesn't work for us. Door-to-door is better." This option has greatly increased uptake of HCT, and also provides a more permanent relationship for follow-up to care (Beaufort West, KI interview)

One SR works with sex workers, but also educates and provides outreach for clients, such as truck drivers. Other SRs have noted that they realise that working with clients is important and that not working with them is currently a gap. However, they report that they have struggled to find an effective way to engage clients because clients want to remain secret.

7.3.1 Peer-based education model

The peer-based model is a core element of the South African National Sex Worker HIV Plan 2016-2019, and is based on international and local best practice in sex worker programming. Using sex workers as programme staff is also in line with the best practice principle of sex work programmes involving their constituency: *"nothing about us without us"*. The peer-based model has been very effective in this programme, and is lauded as one of the critical success factors by all participant groups.

"It was very very hard [for a non-peer to access sex workers]. They thought I was disturbing business and chasing clients. We started recruiting peers, and they [now] educate their peers and clients on prevention" (Key informant interview).

During outreach the peer educators interact with sex workers: "Women who are new in sex work get advice and quickly feel at home. The peer educators listen to our problems and are willing to assist us at all times. There's a feeling of sisterhood…like you are with your own people." (Sex worker FGD)

"They always advise us on how to ensure that our lube lasts. E.g. pouring all contents from the lubricant sachets into a bottle that you can close, unlike the sachets which cannot seal after use so the remainder gets wasted." (Sex worker FGD)

"When testing positive the peer motivator [educator] does psycho social support and goes the extra mile, they even visit the homes of sex workers." (District management interview)

"The peer educators are committed to being there for us 24/7." (Sex worker FGD)

In order for the peer-based model to be truly effective, it is essential that the peers are imparting the correct information during their outreach. In the evaluation, peer educators at the sampled sites were tested in terms of basic HIV and human rights knowledge.

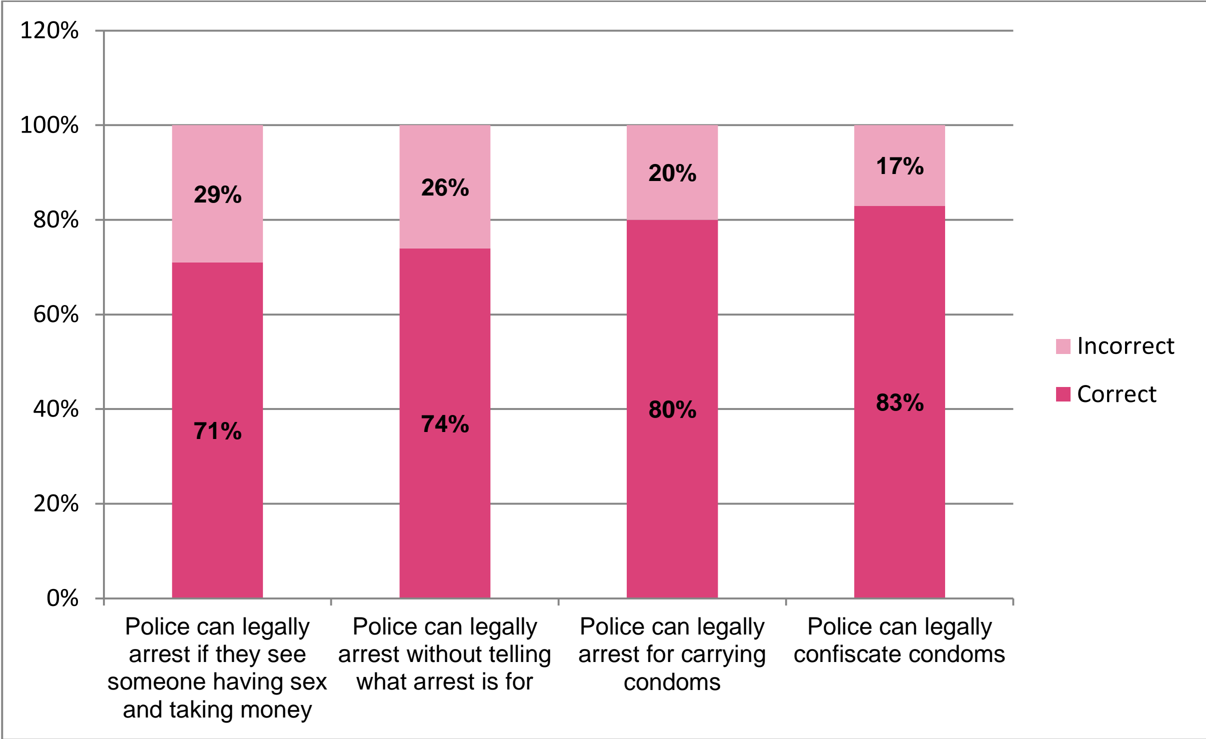
7.3.1.1 Health knowledge of peers

Knowledge of HIV was generally high amongst the peers. However, it is worrying that 8.6% did not know that using a condom reduces risk of HIV and 6.3% did not know that a healthy looking person can have HIV – this is basic health knowledge and gaps in this knowledge should be addressed immediately.

7.3.1.2 Knowledge of human rights

Peer knowledge was not as strong with regards to human rights as about health.

Figure 10: Peer educator knowledge of human rights



7.3.2 Challenges with outreach

7.3.2.1 Not enough resources towards necessary programme staff

Remuneration of programme staff was cited as a challenge by almost all sites. It was felt that there was an inadequate human resource budget provided for management, M&E and administrative support staff on the programme. Peer educator stipends, which are covered, are very low, and it is reported that this leads to a high turnover of staff, which reduces the quality of the service provided. Training of new staff is not always readily available, which might also account for some of the gaps in peer educator knowledge.

> ***"…there was also a shortage of resources for the programme and the peer educators are really volunteers, Red Umbrella is still a Mickey Mouse programme…[the SR] needs to be assisted with resources to take the programme forward [at this site] as it is [assisted] in the more structured provinces, to take the programme to the next level in all districts" (Management interview).***

7.3.2.2 Not enough training provided for first time employees

At some sites, peer educators need more skills in terms of the work environment and how to be a professional member of staff:

> ***"There is just not enough time to capacitate peers to be effective peers… For example, they need to be taught better the balance between being a sex worker (especially the street-based ones) and being part of an organisation. For example, we have peers coming to work drunk, not understanding the rigid structure of being in an organisation and being professional rather than working in the informal sector. The problem is not specific to sex work, it is just the formal versus informal sector" (Management interview).***

7.3.2.3 Insufficient transport budgets

The transport budget allocation for peers is far too low, and the blanket amount per site does not cater for the context, i.e. the long distances that need to be covered in rural areas versus closer proximity in metros. Most sites explained how the transport budget is quickly used up, which leads to sites that are further afield not receiving the same service as closer ones:

> ***"Although peer educators can walk to some hotspots which are close by, they need transport to get to the sites further away. The budget is usually used up in the first few days of the month and then the further away sites are neglected. Funds from donors are used to try to address this issue, but it remains a challenge" (Management interview).***

At some sites the limited resources means that outreach cannot be done at night (night outreach usually requires one's own transport for safety and availability reasons).

The peers themselves often have to travel from far away to get to work, with high associated transport costs. Their stipends are very low, and no additional funding is provided for them to get to work:

> ***"The terms and conditions for peers are found to be difficult, especially with regards to the travelling for the peer educators who do not live and work in [the town] itself, but are based in the outlying areas, some of which are up to 70 kilometres away" (Management interview).***

Finally, peer educators report that they struggle to work in the rainy season as the work is often outdoors or they are on foot a lot, but there are no umbrellas or raincoats provided with their uniform.

7.3.3 Assisting with access to services

7.3.3.1 Health

The standard package of services involves providing health information (through outreach and Creative Space), condoms and HCT, and referring sex workers with health issues to health care facilities. HCT at the sampled sites is currently done at:

- sex workers' homes (door-to-door outreach)
- local clinics (peers refer sex workers and sometimes accompany them)
- SR's own fixed clinics
- SR's own mobile clinics
- DoH mobile clinics
- sex workers' work places by HCT peers

- the site office (using in-house nurses who work from the site office and who also go on outreach with peers)
- HCT tents/gazeboes that some sites set up in the community.

In addition to the standard package of care, additional health services include:

- a mobile clinic service which provides HCT and basic SRH services to sex workers and clients onsite, can treat STIs, initiates and dispenses ART, and prescribes and dispenses contraception
- non-judgmental specialised clinics for sex workers – that offer a high level of service, are sex worker friendly and sensitised. Services provided include immediate HCT results, same day CD4 results, and immediate ART initiation if appropriate, with monthly monitoring in a social and supportive environment.
- in-house nurses at site offices
- peers who track sex workers and make sure they get the health care that they need, who also follow up on treatment adherence and the status of referrals to clinics ("health mentors")
- healthy nutrition programmes (for example one site explained that HIV positive sex workers sometimes eat a lot to get fat so that they appear to be healthy, but that this can lead to all sorts of other serious health issues like diabetes
- general health programmes: "The sex workers have learnt about and know about 'my health' and if someone asks for something they are not sure of, they refuse to do it. The sex workers have received sexual education on safer sex practices and realise that they have rights" (Management interview).

In almost all instances where expanded health services are provided, this is due to other funding that the SR is receiving. At one site, the SR (who does not have funding for the programme other than the Red Umbrella funding) has established a relationship with the local DoH who have a mobile clinic. The mobile clinic with DoH nurses (who have been sensitised) goes to sex worker hotspots accompanied by peer educators. This is a best practice model which should be encouraged in other areas, particularly as DoH has been mandated to provide mobile health services, and should be rolling out this programme from 2014.

Peers distribute condoms to sex workers in all their various sex work venues weekly (TGMSM): "We are deeply grateful to the peer educators who walk distances to our homes, in the heat, on foot, to listen to our problems, to support and to make sure we get tested and we have condoms" (Sex worker FGD).

An innovation in providing health services is an SMS communication system being used by one of the SRs. Sex workers are alerted about events coming up (for example Creative Space meetings), HIV-positive sex workers are reminded to take their treatment and HIV negative sex workers are reminded to go for a test every three months.

CASE STUDY: IMPROVING ACCESS TO HEALTH THROUGH PEER-BASED OUTREACH WITH A MOBILE CLINIC AND IMMEDIATE REFERRAL

A good practice model that was seen during the study is where peers provide outreach services, focusing on prevention, and supported by mobile clinics. Peer navigators distribute condoms, provide information and provide immediate referral for services and health checks. A direct link to care by a peer/nurse/counsellor teams means that follow up into care is more easily achieved in this model. With a group approach, people known to be living with HIV who were not in care can be referred for a broader wellness package, and allocated a peer navigator as mentor, with their consent. Key informants confirmed the value of this service: *"They have community health workers (peer navigators) who are tracking them (sex workers on ART) and making sure they take treatment. They brought two cases who were defaulting"* (Clinic External Key Informant Interview).

In addition to defaulter tracing, mentorship and emotional support, peer navigators also fast-track their clients through the health system, their presence providing a kind of screening for services which would normally require waiting in a queue: *"If they come with a community health worker (peer), they are given first priority. We support the health workers."* (Clinic External Key Informant Interview)

This relationship with the clinic extends to adherence and referral follow up. Since sex workers seldom submit referral forms, peers visit the clinics regularly: "They used to come monthly, now there are more peers, so they come every week". Using names and date of birth from ART referral forms, the peers and facility staff attempt to determine whether sex workers have arrived for treatment initiation, and to identify high risk defaulters.

7.3.4 Challenges with accessing health

7.3.4.1 Treatment denied without legal documentation

One of the issues that came up in a few provinces is the DoH policy of not treating patients who do not have the correct legal documentation. This affects many of the foreign national sex workers. In eThekwini, Zimbabwean sex workers explained how they have been unable to access treatment in the area: *"Without proof of address and ID, the DoH does not serve us*" (Sex worker outreach interview). The mobile clinic run by the SR in the area is able to take bloods for viral load monitoring and provide diagnosis and screening services to anyone; however, they are only mandated to dispense drugs to patients approved by DoH, so they cannot provide medication for undocumented foreign nationals. Therefore, a large proportion of sex workers is not able to access treatment and treatment after hours unless they travel to those working from the brothel. With discussion, it was revealed that non-resident sex workers need to travel to municipality health facilities to receive services.

"[The local] clinic does not service foreign sex workers, they demand ID, or passport and proof of residence". Key informants were clear that "it is against their rights to be denied treatment and will lead to defaulting on their medication".

7.3.4.2 No specialised clinic services for MSM and transgender sex workers

There is currently no clinic that caters specifically for MSM or transgender sex workers. There are LGBTI clinics and sex-worker friendly clinics, but not one with the combination. *"They [MSM and transgender sex workers] have different STIs, for example, anal and oral STIs and different psychosocial needs – we still need that special package."* (Management interview).

7.3.4.3 Peer knowledge

If peers do not have the correct knowledge, this is dangerous as they are then spreading incorrect information with authority.

7.3.4.4 HCT peers

The selection and management of HCT peers needs to be re-considered. *"It was not a fair process – organisations were asked to select, rather than there being an application process. And then those who got trained have to meet targets and do the testing with no more pay"* (Provincial manager interview). Peers noted that conducting HCT in the street is not always effective because the sex workers who test positive need to go to the clinic to get their CD4 counts anyway and it is difficult to track and support them to do this. *"Follow-ups in general are difficult because sex workers change their phone numbers often"* (Peer educator FGD).

Sex workers also noticed that the Red Umbrella activities *"focus[es] a lot on testing us for HIV, we believe there are other important things, an example – warts are everywhere in sex workers, on that one there is no improvement and information".* At sites where the local clinics have not been sensitised, referring sex workers there *"is like throwing a sex worker under the bus"* (Peer educator FGD).

7.3.4.5 Lack of appropriate IEC material

IEC material is not provided by the Red Umbrella programme. While some sites attempt to get material from other clinics and from DoH, they find that this information is too general, and not specific information that sex workers need. While SWEAT was funded to reprint its sex worker-focused IEC materials, it was not funded to distribute these materials to other sub-recipients.

7.3.4.6 Condoms and lubricant

Many participants noted that the Red Umbrella lubricant packaging was unsatisfactory. Sex workers can use the contents about three times and there is, therefore, wastage as the packet does not store well, and can make a big mess in their bags if left open. Some sex workers use the extra lubricant as body cream. It would be better to have a tube or some form of packaging that is easier to re-use.

The allocation of 30 Red Umbrella condoms per sex worker per week was too few in many sites. Because some brothel managers try to sell free condoms to the sex workers, the peers are instructed to give the Red Umbrella condoms directly to the sex workers. They explained that there is a demand for the Red Umbrella condoms from clients as well, who want to use them during other sexual encounters. However, the programme prohibits them from distributing these to clients, although condom use is a behaviour that should be encouraged and supported to stop HIV spread.

7.3.4.7 Need to support HIV positive sex workers

The needs of HIV-positive sex workers were not catered for in Phase II. The team feels that there is potential to extend support groups to the Adherence Club model (non-medical site health services and drug dispensing as well as treatment support and literacy) (Management interview).

7.3.5 Legal

None of the SRs are legal organisations. Access to legal services is provided by:

- referring sex workers with issues to the SWEAT Helpline, Sisonke, the Women's Legal Centre (although they only take on impact cases), or partnering private lawyers or legal NGOs who assist the sex workers pro bono.
- most SRs teach sex workers about their rights, but to greatly varying degrees – this is done through Creative Space workshops and through outreach (if there are trained paralegals at the site)
- Sex Worker Advocacy Groups (SWAG) are run in one of the sampled sites, where they teach sex workers about their human rights and encourage them to take this knowledge to their peers. *"We taught them to look at the name of the police officer and the licence number plate of the police car so that they can report them."* (Management and KI interview).
- some peer educators go to court with sex workers to provide support
- Sensitisation training done with police has resulted in sex workers being able to access police services at some sites. However, this is not always the case and many sex workers complain that even when they are taken seriously enough to open a case, the dockets go "missing", cases get dropped or it is not prioritised or investigated until it goes cold.

7.3.6 Challenges with legal support

7.3.6.1 Human rights defenders/paralegal training

A provincial manger noted that the selection process for the human rights defenders training was flawed and organisations were asked to identify relevant peers to become human rights defenders. This worked well in areas where Sisonke was already active, and peers had some understanding of legal issues. However, in areas where there was not already an activist movement, peers attended *"a four day training on a huge thick manual in English. And some came with no basics. And then they were left without the managers being trained so no one could support them. It is not a reporting requirement so there has been no follow up training and no support or mentoring. And not enough resources, for example organisations who do not allow human rights forms to be printed because it is not in the budget"* (Provincial manager interview). In Gauteng, the SWEAT provincial office would provide these forms out of their own budget.

Participants noted that the trained peers are not always well equipped to deal with legal issues: *"There was a case at the casino where a sex worker was beaten by a client and we called the peer educators. They did not seem to know what to do about the matter and promised to revert back after consulting with others"* (Sex worker FGD). Site coordinators at another site reported that while the human rights defenders may be trained on paralegal content and are able to take down statements, there is no system to enable recourse to justice, and no consistent follow-up or action taken (Site coordination team FGD).

The generally low level of knowledge about human rights leads to many issues not being taken up. For example, although sex workers at a few sites stated that they cannot report rape or other crimes committed against them, they also described themselves as *"not really having legal issues"* (Sex worker FGD). This contradiction suggests that sex workers are not able to clearly identify instances where legal help would be appropriate and, therefore, do not seek it.

Although the SWEAT helpline is used as a referral, there were some complaints:

> ***"Most of the girls are arrested on the weekend and the SWEAT helpline does not offer proper services on the weekend" (Management interview).***
>
> ***"A sex worker is raped by a police officer. Where is SWEAT or Sisonke? We always have to follow up. We use the helpline number, we have direct numbers for people in Cape Town, we talk to Sisonke in Cape Town, but legal support doesn't come through. Or if it does we don't know about it. Our peers who were trained as paralegals have cases, but don't know where to refer these cases. Then the next time you meet the sex worker the trust is broken – you have promised legal support and it hasn't happened. We call Sisonke for legal support, and she switches off her phone and doesn't come, and we are left standing there at the police station" (Management interview).***

Aside from the SWEAT Helpline, Sisonke and WLC (who only take on impact cases in certain areas) there are almost no legal services for sex workers.

Finally, sex workers who engage in crimes make the working relationship with police difficult: *"Some sex workers are not helpful in building this relationship, with sex workers involved in mugging of clients and drug dealing, and tense relationships with the police. Some sex workers also don't respect the work of the police"* (Sex worker FGD).

7.3.6.2 Psychosocial

Psychosocial services are very limited. Some SRs provide their own counseling services and one SR has its own helpline because this is part of what the organisation already has on offer. For example, Lifeline Kimberley is providing counseling and psychosocial services to sex workers and in addition has a call line which sex workers can access. The merging of the Red Umbrella and Lifeline programmes closes the gap in the RU programme, which relates to sex workers' emotional wellness. The establishment of support groups for sex workers, which were initially for HIV-positive sex workers but have been extended to all sex workers, is a very effective

psychosocial element of the programme. The site is also known for regular Creative Space workshops at the offices and regular peer outreach (Management interview).

Sex workers noted that the most appreciated inputs have been advice and support with drug abuse, delivered with non-judgmental, accepting attitudes (Sex worker FGD).

PSH's direct provision of professional health services providing for linkage to care is also a major strength. Once tested HIV positive, for example, counseling includes peer support and accompaniment through the health care process: *"From there we walk the road with that person."* (Management interview). However, these services are not funded by the Red Umbrella programme. Aside from these few instances, psychosocial support is provided through:

Creative Space workshops where sex workers do find some relief and healing from psychic pain: "We are able to talk about our problems, knowing it never gets out of the safe space" (Sex worker FGD)

Debriefing sessions for regular attendees are held during Creative Space workshops: "We attend Creative Spaces which provides us with the personal support and also addresses some personal challenges through some counsellors." (Sex worker FGD)

- adherence support clubs at some sites
- peers who have been trained as lay counselors
- outreach where sex workers find solace from peers expressing an interest in them and listening to them
- the SWEAT helpline, which is staffed by lay counselors
- referrals to DSD social workers or DoH programmes.

One of the SRs reported that the peers and coordinators buy food with their personal funds when sex workers are in desperate need.

7.3.6.2.1 Challenges

Adequate psychosocial services for sex workers are not available in general. These are greatly in need as sex workers are often highly traumatised. One example of a gap is when women - who have been hospitalised after being subjected to violence - face poor attitudes and are not given access to counseling and psychological support: *"Often these women do not have anyone to talk to and this continues the cycle of abuse when they go back home. The hospital staff often make them feel like it's their fault that they were beaten"* (Sex worker FGD).

There is reluctance to refer cases to DSD as the social workers have not been sensitised and are also discriminatory to sex workers. In addition, *"DSD is not always supportive of sex workers as sometimes they are working to deport those who are immigrants, especially those who are on drugs"* (Management interview).

7.3.6.2.2 Additional services

Some SRs offer additional personal development or skills training for sex workers. These include training in:

- self defense
- sewing
- positive living
- life skills
- income generation.

In addition, peers are supported and encouraged, to go back to school, finish their matric, and are offered personal development opportunities to learn how to fit into a professional environment.

7.3.7 Creating an enabling environment for sex work

One of the key outcomes of the programme is to create an enabling environment for sex work. In the long term, this means decriminalisation of sex work. In the short term, the various SRs engage in various activities that have been effective in creating a more positive environment for sex workers.

7.3.7.1 Public awareness and sensitisation

The SRs provide information and sensitise the public through using local radio and public information sessions. In some cases, during community awareness campaigns about other topics, SWEAT would join in on these public information sessions to highlight sex workers' rights: *"We go into communities with banners and music, we explain how sex workers use condoms a lot, and that anyone can be infected with HIV, and that it is non-sex workers who are more likely not to have condoms."* (Management interview). Some also host or participate in campaigns in the community, for example DoH campaigns, or World AIDS Day events, or general community events.

Working with community leaders has also been effective, such as pastors and other faith-based leaders:

> ***"When government called for a strategic plan for HIV prevention with sex workers, we took these stakeholders to the meeting and they advocated well for sex workers, especially a church leader who asked for people to not judge. After that, the tone of the meeting changed and we could actually work. We ended up with a draft document. The involvement of stakeholders is very important, it has made a huge difference." (Management interview)***

7.3.7.2 Sensitising service providers and key stakeholders in sex work

To sensitise key stakeholders such as police, health care staff and pimps, there is formal sensitisation training that was provided by SWEAT in Phase II of the programme, but SRs also conduct various other ongoing activities that are highly effective in reducing stigma and discrimination and ill-treatment of the sex workers in the area. For example, SRs engage the police through meetings, by inviting them to Creative Space, and by continuously going and discussing sex worker issues and rights with them. The police also invite SRs to their police forum meetings. In addition, some SRs will assist sex workers who are arrested, and will document their experiences of the arrest in the presence of the police. At one particular site there is a police officer who is known for harassment and abuse. The SR informs SAPS management and makes sure that he is kept in line to provide *"reasonable and dignified policing"* (Management interview).

> ***"When we visited the police station, we were wearing the t-shirts. We are starting to work hand-in-hand, to change attitudes and share information and are willing to help each other with the aim of making this a better work place for sex workers." (Peer educator FGD)***

> ***"We often invite police [and] health staff to engage them positively into changing their attitude toward the sex workers, thus minimising the discrimination and stigma towards sex workers. It helps dispel the belief that 'because I am a sex worker, I automatically have HIV/AIDS', and encourages the sex workers to test and be certain of their status" (Peer educator FGD).***

7.3.7.3 Working with clients

Although SRs realise that it is important to work with clients to teach them about HIV and sex workers' rights, this is challenging as clients are generally unwilling to engage in programme activities because they want to remain secret. A few SRs have managed to do some work with clients, particularly truck drivers.

7.3.7.4 Multi-stakeholder forums and dialogues

An extremely effective model is for the SR to either set up or to participate in multi-stakeholder forums, or dialogue sessions. At these sessions, which ideally involve sex worker representatives, involved parties are given information about sex work and exposed to the lived experience of sex workers, so as to advocate for better treatment of these sex workers. An example is a small multi-stakeholder committee that was established in the North West and is made up of representatives from police, DoH, churches, and the local AIDS council. The committee meets once per quarter to discuss and get involved in sex worker issues and this is having some positive benefits.

Another way in which the SRs have created a more enabling environment is by educating sex workers about how to conduct themselves within the broader environment to improve social acceptance. For example, a common complaint across various sites was that sex workers used to indecently expose themselves in public at all hours of the day. Community members were particularly upset about this because their children were being exposed to sex workers in very skimpy clothes or to sex workers flashing as they walked or drove past. This would lead to complaints to the police, who then had to take action, even if they had been sensitised and were not harassing sex workers. Through the programme, negotiations have been completed with sex workers and they understand that such behaviour should be restricted to times when there are generally no children around, for example after dark at one site and after 21h00 at another site. This has led to less harassment of the sex workers at these sites.

One SR, Nqobile Women's Development, approached community leaders about the stigma and violence against the sex workers after *"a group was beating up sex workers."* They found, that in this instance, the community were upset because the sex workers were standing naked in the streets at 19h00 when children were still outside. This was addressed with sex workers who agreed to wear decent clothing before dark (Management Interview). This kind of engagement has worked well to reduce the levels of stigma: *"Since we have started, the community is starting to open up and they see this work as a good thing. That society is being protected by us doing this work, by keeping HIV rates down"* (Interview with partner).

7.3.8 Challenges with creating an enabling environment

- Despite sensitisation, sex workers do not easily report cases with the police as they still do not want to disclose their work because of police raiding brothels and arresting them
- There is a serious need to address the issue of gender-based violence in the areas in which sex workers do business as this has a huge impact on HIV infection
- It is difficult to work with clients as they do not want to participate in programmes.

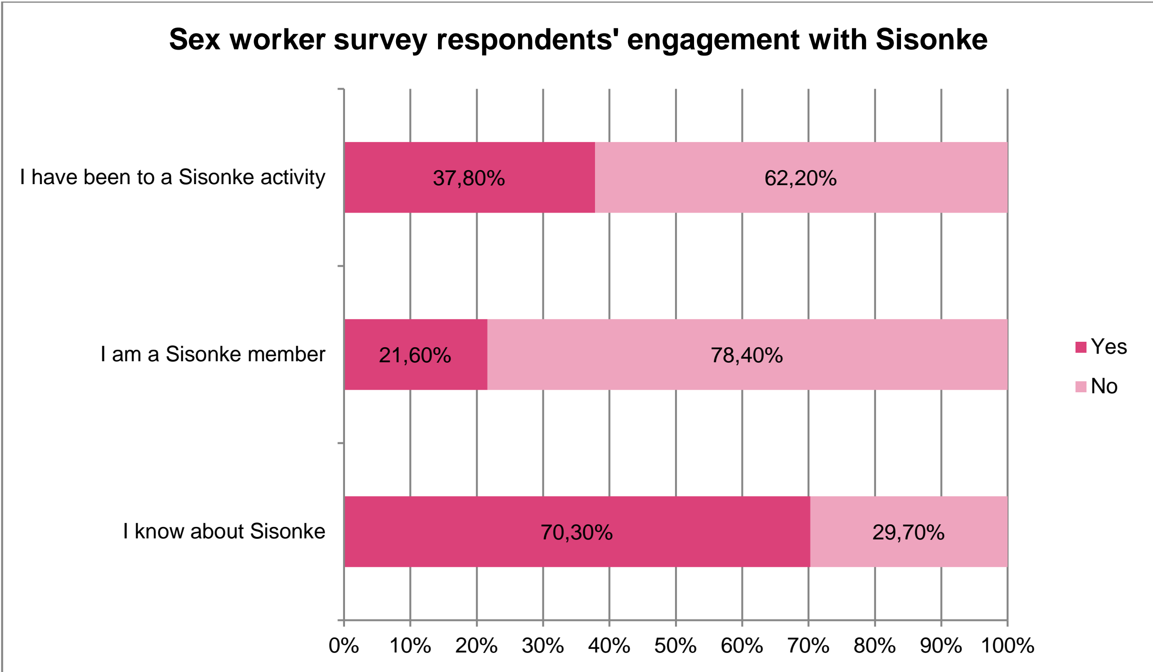
7.3.9 Networking and mobilising sex workers (Sisonke)

Sisonke is the national sex worker movement in South Africa. "Sisonke is a movement of sex workers, by sex workers. It has offices in four provinces, based in partnership organisations, and its primary focus is on mobilising sex workers to speak out on issues of importance to them"[24].

As the figure below shows, although more than 70% of sex worker survey respondents (n=1168) know about Sisonke, only 37.8% have participated in a Sisonke activity (n=1169), and even less are members – only 21.6% of the respondents.

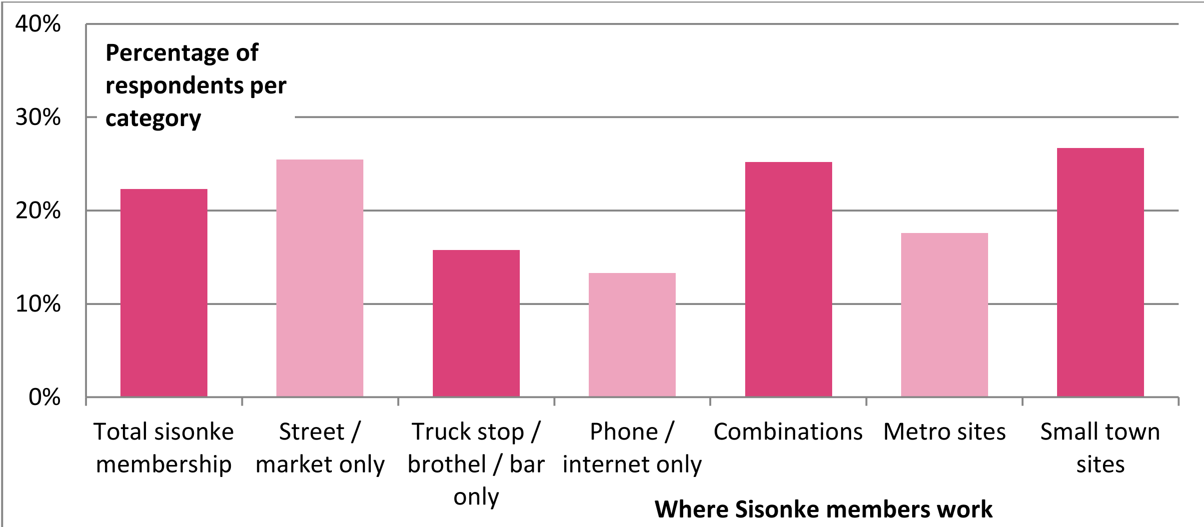
[24] www.nswp.org/members/africa/sisonke

Figure 11: Sex workers in the survey who engage with Sisonke



Sisonke members work in a variety of settings, as shown in Figure 12 below, which is useful to understand in terms of knowing how to effectively reach and provide services for them.

Figure 12: Where Sisonke members work



Sisonke received some positive feedback from study participants, who noted that Sisonke has been effective in some of the following ways:

- sensitising police: *"The sensitisation training that was done by Sisonke, SWEAT and WRHI and a Sisonke sex worker march have played a huge role in alleviating abuse and harassment from police"* (Management interview)
- arranging sex worker marches
- assisting in legal cases

- providing human rights information to sex workers (for example, thorough awareness events) and empowering them to take these up: “They [sex workers] know that they are also human beings and should be treated with respect” (Management interview); *“Some sex workers attended a workshop by Kheth’impilo and Sisonke in 2015...we learnt about our rights. Some of the sex workers registered as members”* (Sex worker FGD).
- dealing with under-age sex workers that peer educators come across

There was also some negative feedback regarding Sisonke. Some sites explained that although sex workers participate in events, these are often held in central locations in metros, and they are often given short notice to join. *“Sisonke is not doing enough…and they should be closer than they are to the sex workers [in different areas, not just the big towns]”* (Peer educator FGD).

In the North West, there is no Sisonke coordinator and the sex worker community is not able to access Sisonke services. The peer educators encouraged the sex workers to join the movement and pay their membership fee and this is now impacting negatively on their relationship with the sex workers:

> ***“Sex workers associate Sisonke with fighting for the rights of sex workers and providing protection services to sex workers… but they have not had any direct services from Sisonke to date…we want protection by Sisonke… but we did not get much from joining – just a T-shirt, but the sex workers have not ever gotten any assistance from Sisonke” (Sex worker and peer educator FGDs).***

There is currently no Sisonke coordinator based in the North West, and it is reported that neither the national office nor the Gauteng office assist in the North West: *“They [sex workers] are not getting any help from the Sisonke person in Gauteng and have been referred to the National Office [in Cape Town], but then Cape Town refers us back to Gauteng”* (Management interview). The lack of service and engagement from Sisonke has damaged the relationship, between the area’s SR and sex workers, to a degree. This is because the SR actively mobilised the sex workers to join Sisonke - when the sex workers receive no services and no contact they blame the peers *“that they took their money and received nothing. We have not had any luck with trying to get these services”* (Management interview).

In the Eastern Cape, participants mentioned that they receive infrequent communication from or about Sisonke (Sex worker FGD). Management interviews perceive that *“even though the sex workers belong to the Sisonke movement, Sisonke is not as visible as the unions”* (Management interview).

> **“Sisonke needs to up its game otherwise we are going to demand our R50.00 back. We still don’t have membership cards, all we have are T-Shirts *(Peer educator FGD).***

7.3.10 Creating partnerships

A key best practice of the programme is the establishment of partnerships with local stakeholders. *“When dealing with sex workers, we need to deal with them holistically. So we have to address human rights violations and violence, and so we need to forge partnerships with the organisations that provide these services, for example SWEAT, Sisonke, the Women’s Legal Centre…”* (Management interview).

SRs have successfully established relationships with government and non-governmental partners to assist sex workers to access services, realise their rights, and reduce violence and stigma against sex workers.

7.3.10.1 Partnerships with brothels

Brothel owners are engaged and they support the programme by encouraging the sex workers who work there to attend meetings and to talk to peers. Some offer up space in the establishments for Creative Space workshops to be held and for HCT to be done. An interesting example of a partnership is one of the SRs which negotiated with hotels in the area to allow sex workers to conduct business in their hotel rooms for free.

7.3.10.2 Partnerships with SAPS and legal services

Some SRs have established relationships with lawyers who provide legal services to sex workers pro bono. Partnerships with the police have been very effective.

> ***"[The SR] is not regularly asked for legal support, however they have established a relationship with SAPS to which sex workers go directly now if they have to lay a complaint or a charge" (Management interview)***

> ***"The substantial changes in the attitudes of the police in [the site] are largely attributed to [the SR's] work in creating relationships, clarifying rights and ensuring that both sex workers and the police are well-informed on legal rights and correct procedure" (Key informant interview).***

SRs also participate in community policing forums, and invite police and forum members to Creative Spaces.

7.3.10.3 Partnerships with DoH

Some examples of partnerships with DoH include:

- obtaining and distributing condoms on behalf of DoH
- referring patients to receive appropriate treatment and services at clinics
- delivering mobile services to sex workers: "This is the first sub district in the whole district to offer mobile clinic services – it is very brilliant. It is a mandate to provide this mobile service to high transmission areas, it should have been rolled out to all sub districts by 2014. But [the SR] is helping to drive this at DoH and make it happen." (Key informant interview)
- receiving quality control on HCT tests from NHLS
- participating in DoH campaigns and using these to raise awareness of sex work and sex work issues.

7.3.10.4 Partnerships with other NGOS

In Gauteng, Red Umbrella sub-recipients, together with the assistance of the SWEAT Provincial Manager, have been in regular contact and work together to develop ideas on how to provide the best services. In Kimberley, the programme is reported to have established and strengthened relationships with other NGOs in the area: *"There is an integrated relationship between NGOs who refer to each other in terms of needs of the sex worker"* (Key informant interview).

The Women's Legal Centre and the SWEAT helpline are partnerships that provide ***legal assistance*** to sex workers. The service from the SWEAT helpline has had some mixed reviews, for example:

> ***"The SWEAT helpline really helps us with our rights in conjunction with the Women's Legal Centre" (Peer educator FGD)***

> ***"People call the helpline, and there is no feedback, and no referrals, and no intervention with a case is achieved". (Management interview).***

SWEAT has provided a huge amount of human rights training and support, and *"their booklet on human rights has helped a lot, and there is more information now"* (Peer educator FGD).

Partnerships are also formed to deliver improved ***health education and services***, for example:

- with other sex worker-friendly specialised clinics
- ANOVA provides health training
- NGOs provide home based care in the community for sex workers who need these services.

Some of the more general and psychosocial partnerships include:

- partnering with an NGO who provides a shelter for abused, battered women and rape victims (one particular SR) (management interview)
- some of the sex workers *"need the basics – housing and clothes".* One NGO partnership resulted in sex workers earning money by cleaning up the streets in an Expanded Public Works Programme (EPWP)
- an NGO offers their venue to the Red Umbrella programme for the purpose of weekly coordinator meetings.

7.3.10.5 Other partnerships

SRs also mentioned that they work with DHE to get sex workers into further education programmes and DSD for mental health programmes, as well as for assistance with substance abuse.

7.3.11 Approaches to delivering the sex work programme

Although the contracted services are the same across the SRs, the various SRs implement the programme with different approaches based on their organisational missions and values. Although an ideal programme would have all of the following elements, organisations usually combine a few of the approaches outlined below:

1. A holistic participant-focused approach: approaching sex workers first as people and providing holistic services that include lifeskills and support to sex workers' families
2. A positive psychology approach in which personal development and self-esteem are seen as the key drivers of change for sex workers
3. A comprehensive health services focus - ensuring that sex workers receive the full range of health care services and treatment that they need
4. A rights-based approach which aims to empower sex workers to take responsibility for their own lives by exercising their rights
5. A partnership approach to ensure that the sex work programme is embedded in the community and that local stakeholders know about it and contribute to it in some way.

7.3.12 What works? Success/effectiveness of current model / enabling factors

As one of the SR managers pointed out: *"The success of the model depends strongly on context. The CAG / peer / mobile service combination is highly successful in [a metro] where sex work is free, open and concentrated in dense populations around large brothels or sex work districts. The model is more difficult to apply in Port Elizabeth, for example, where sex work is strongly managed by controllers, and there are high levels of substance abuse in the sex work sector. In places where sex workers are more vulnerable, and in greater need of services, they are also less accessible"* (Management interview).

7.3.12.1 Flexibility to implement according to context

One of the successes of the programme is that there is a level of flexibility in it. Although budget cost categories are reported to be fairly rigid (i.e. SRs reported that they are not able to use funding for salaries), how the SR uses the allocated activity amount is up to them. For example, an amount of money is provided for Creative Spaces – based on 25 attendees once per month. Despite this, some SRs run Creative Space more often by stretching this budget so that they are able to accommodate more sex workers in this activity.

7.3.12.2 Creative Space workshops

The Creative Space workshops are a very successful activity within the programme. They meet multiple objectives and have multiple outcomes, including:

- networking, movement building and building social capital
- psychological support and personal development
- providing information to sex workers
- learning about sex workers needs
- building partnerships and relationships, for example by inviting local stakeholders to participate in the programme.

> **"Creative Space is like their own space, where they can be open, vulnerable, and show emotions. They see each other as family. They enjoy the messages at each session. It has boosted their self-confidence" *(Peer educator FGD).***

7.3.12.3 Holistic and human rights focus

Although the programme's main goal is to prevent HIV transmission, the programme has been particularly successful because of its more holistic focus, and particularly its human rights lens. Even organisations which have a medical approach have come to realise that the disease is not just biological, but also social and that protecting sex worker rights are essential to reducing HIV.

7.3.12.4 Peer-based approach

The peer-based approach is a critical success factor for this programme. *"There is a lot of support from peer educators. The fact that they are also sex workers makes us comfortable with them because they can relate to our problems"* (Sex worker FGD). The peers have become respected role models in their communities on the whole. There has been huge value for them in being employed and gaining skills and this has shown other sex workers that it is possible for them too.

> ***"The peer motivators are the key to the whole programme. The Red Umbrella programme was not just a harm reduction programme, but gentle and nurturing" (Key informant interview).***

7.3.12.5 Caring and non-judgmental approach

Respondents consider the model's success to be as much due to the way in which the programme is delivered as the range of services: *"It is more than services alone. The approach leads to connection, validation and a family atmosphere. When we introduce the programme, we first take a personal interest in the person. How are you? Your home situation? Your needs? Then we do Creative Space marketing. Peers are trained in this approach"* (Management interview). To enable the correct attitudes, reception of sex workers and relationships – which are key to the programme's success – the recruitment of the right peers is very important so as to ensure an accepting, friendly and non-judgmental atmosphere across the organisation, to make sure that *"there is no one looking down on [the sex workers]"* (Management Interview).

> ***"…it takes a lot for a sex worker to tell you they are a sex worker, but [the SR] manages to work with the sex workers very well and get them to be free, they have this Ubuntu and attracting people to them and even when they are working in the mining area they suddenly have a full house for services…. they have found all the sex workers – they know so many of them, even those who are working in the streets. They are reaching most of them because their peer educators are also sex workers so they can recruit their peers."***

7.3.12.6 National reach

Study participants felt that a major success factor was the fact that the programme has had national reach, with programme offices located in the provinces and support from provincial managers. *"District offices means that there is visibility of sex worker issues, and that sex worker programmes are there which is good. That means that sex workers can be reached on a more frequent basis because everything is there"* (Provincial manager).

7.3.12.7 Ability to distribute condoms to sex work hotspots

The Red Umbrella condoms have been very popular, and they are also delivered directly to sex workers at their places of work. This takes away some of the barriers to condom use that sex workers face.

7.3.12.8 Peer navigators: monitors and mentors of sex workers' health

A very successful model to promote the health of sex workers has been peer educators acting as navigators through the health system for the sex workers. They carefully collect data and monitor whether individual sex workers are accessing the treatments that they need. The accumulation of data and use of an operational research lens has allowed the SR to make progress in gathering difficult variables such as adherence rates (Management interview).

7.3.12.9 Integration of programmes

The integration of the different aspects of the programme have worked well: *"All participants know about and have been part of Outreach, Creative Space, HCT, condom and pamphlet distribution"* (peer and sex worker FGDs). There has also been internal referral among programmes in larger organisations, which have allowed comprehensive care and an integrated service to be provided to sex workers.

Some examples of good practice models follow:

PSH offers, in addition to its sex work and truck driver HIV and SRH programmes:

- a victim empowerment project for both men and women who have been subjected to violence or are at risk of abuse as either victims or perpetrators. Eight sex workers currently participate, and the curriculum covers cycles of abuse, relationships, decision-making, human trafficking, and options for preventing abuse.
- Teen parenting skills: a programme for in and out of school youth and a youth-friendly clinic. Young sex workers were referred into the youth programme and were less visible at truck stops since this time (Management interview).

Lifeline has merged their counseling and support programme with the Red Umbrella programme for sex workers "once we had identified the gap in the Red Umbrella programme including emotional wellness for sex workers. In addition our counsellors go to the sex workers to offer counseling – on the streets and in their homes." (Management interview).

7.3.12.10 Building relationships and partnerships

The programme has major outcomes when stakeholders such as the police, pimps, brothel owners, health care staff and the community are engaged and sensitised. The building of partnerships is vital to its success.

> ***"Some sites don't have ART drugs but have links with the clinics where people can be initiated onto treatment" (Key informant interview)***
>
> ***"The programme has improved the way that sex work organisations work with government and SANAC, it is much more collaborative than it used to be. There used to be a more confrontational relationship, but it has become more collegial and developed into strong partnership and you can see how government through SANAC is trying to assist the sex work community through decriminalisation efforts and engagement with the Department of Justice" (Key informant interview).***

8. OUTCOMES

8.1 Outcomes on the sub-recipients

The sub-recipients of the Red Umbrella programme grant have benefited hugely from the project in terms of building the capacity of their staff, growing and strengthening their organisations, reaching more sex workers, increasing social capital, and expanding their focus. New site offices were opened because of the programme. Sites also purchased resources such as laptops and computers from the programme funding.

RELATES TO THE OUTCOME:
Funders, civil society organisations and government are capacitated to meet sex workers' real health and social wellbeing needs

8.1.1 Increase in staff complement

The Red Umbrella programme has increased the staff complement at many sites. Many organisations have increased their number of peer educators or have hired peer educators for the first time. A few sites have also hired coordinators and managers, and one site hired an M&E officer and a data capturer (although there was, reportedly, a fair amount of negotiation with NACOSA before they were able to achieve this).

8.1.2 Building staff capacity

The most significant change for organisations has been in terms of the capacity that the programme has built for the peers and site coordinators.

Training content has included:

- HCT
- Condom use and condom negotiation
- Human rights
- Legal training
- Facilitation skills
- Training to run Creative Space workshops
- Workshop processes
- Counseling
- Financial literacy
- Financial management
- Monitoring and evaluation
- Data capturing
- Report writing
- Administration
- Computer skills
- Leadership
- Becoming role models.

The capacity building has allowed staff to build their CVs and start building a career: **“**In Gauteng, we have over 100 peers who were sex workers who now have more on their CV than just sex work. Some have become site coordinators elsewhere” (Provincial manager). Sex worker peers have been promoted across the country, either within their organisations, or they have moved to other sites to become site coordinators.

Roles have been professionalised within the partner organisations because of this increased capacity. One example is that sex workers have learnt not to use alcohol or substances during work:

“They do not go to work drunk anymore” (Sex worker FGD).

“If you drink on the job or are totally hungover on the next day, you get called in and then get referred to SANCA for counseling, and they have to bring letters to say that they were present there every week. If you are caught drinking again, then you are out. We are very strict about this as it undermines the team. We function within an elite research house. We can’t have high and drunk staff – you have to be professional staff” (Management interview).

For some organisations, the employment of peer educators for the Red Umbrella programme is a new component. They express that “we were initially nervous about having sex workers as staff, but we realise that they are so capable and grateful for the opportunity, and they have amazing links with the stakeholders. They take the lead and run with the partners on the ground now. They are able to account for the money that they are in charge of – it’s such huge skills development. Some even did not have computer skills and now they are totally competent” (Peer educator FGD). Peers in Hillbrow “can really manage on their own, we only have to supervise a little and provide small support in terms of validating info (for example doing site checks) and helping with building partnerships” (Peer educator FGD).

Alongside the content and technical skills, peer educators and coordinators have gained soft skills and personal development skills as well. These include:

- leadership skills
- communication skills: “the programme has given me the skills to listen”
- self-discipline
- increased empathy for others
- the ability to consider and work with others: “I’m from the streets and have been a sex worker for many years. Being a peer educator is the first stable job I have ever had, and I am learning to work closely with others. I was very selfish before, rude, and I only watched out for my own needs”
- taking responsibility

In Gauteng, it is reported that increased capacity of the site coordinators has resulted in “many…sitting in AIDS council spaces…the programme now has buy-in from national players and therefore they [the coordinators] have more leverage in those spaces” (Provincial manager).

At some organisations, peers and coordinators have been exposed to additional training that is outside of the Red Umbrella programme. In Welkom, the programme is working with ANOVA and DoH to receive additional training in health care, particularly about STIs and other sexual health issues, and psychiatric health (KI interview - DoH). At the Soweto site, the peer educators have been trained to become researchers because they are collecting data for both the programme and for the programme director’s PhD, which is a bio-behavioural and psychosocial research study looking at violence and trauma that will feed data back into the project (Management interview). Peers at this site are also assisted in their efforts to complete their matric, or to study further.

Skills development for peer educators is done very purposefully at one of the sites, to enable peers to learn additional skills through the programme. Peers at this site are involved in all aspects of the programme and not just on outreach and Creative Space activities. They complete administrative work, work with client files, write reports, and attend team meetings where they learn about meeting processes, amongst other responsibilities.

8.1.3 Better systems and processes and policies

Sub-recipients reported that the strict requirements for grant management from NACOSA have improved their systems, processes and policies. In particular, they have better financial, operational and reporting systems (Randburg, Bethlehem, Sedibeng) and are better able to collect data and identify impact (Randburg, Bethlehem, East London, Rustenburg). This means that they are able to be more accountable and honest (Randburg).

The programme has encouraged some organisations to develop new policies *"which protect the organisation better"*. In Bloemfontein, there has been a new procurement policy developed so they now know how to manage condoms, and in Soweto new Human Resources policies and processes have been developed, particularly in terms of recruiting suitable peers (for example, tests have been developed to assess ability, competence, willingness to learn and taking initiative).

New posts, particularly at management level, have enabled sites to work more effectively and efficiently: *"We now know how to follow protocol, and we know what direction to go in. We know who to communicate what to where, and the channels that are in place"*.

8.1.4 Financial outcomes

The Red Umbrella programme has increased the turnover of all of its sub-recipients. In addition, it has assisted organisations to cover their operating costs because the Red Umbrella funding provides for this: *"We don't struggle to buy stationery anymore. It is so nice to work with Red Umbrella as with [other donors]...it is sort of abuse – they won't buy stationery and ink and paper, they don't care, but they want their report on the first [of the month]"*. Some funds are also provided by the programme for management, administration, financial administration and M&E.

8.1.5 Human rights mainstreaming/focus

A significant outcome that the Red Umbrella programme has achieved is that many of the sub-recipients have introduced, expanded or mainstreamed a human rights focus in their work. Some examples follow:

In Randburg: *"SWEAT has given us Human Rights training and there are human rights watchers/monitors in each area. Through WLC we have had lots of training and the peers and site coordinators will get more of this soon. This lens has impacted on the organisation – it requires us to respond to certain issues (for example if someone gets arrested we have an idea of how to respond to this), but we would need much more capacity to deal with the issues properly – right now we work with SWEAT and WLC to address these issues."*

In Hillbrow, assisting with human rights violations is a new service that WRHI is able to offer because of the Red Umbrella programme; previously, they only provided health services.

In Rustenburg and Brits, CPC has transformed "*from being just a service delivery organisation but now we've become advocates too"*. The director's time is mostly spent on advocacy activities.

In Soweto, PHRU staff have undergone sensitisation training to become more aware of the human rights issues associated with sex work.

In Welkom, one staff member said *"I used to have an attitude, judgement towards sex workers because of my religious beliefs, I saw nothing wrong with discrimination against them in the work and in the community. Now I am more informed about human rights, my attitude has changed to be more accepting."*

8.1.6 Relationships with sex workers

Sex workers are a difficult-to-reach population as most sex workers attempt to keep their work secret. The focused Red Umbrella programme has enabled SRs to build trust with the sex workers: *"Being able to give the RU condoms has improved our relationship with them – they trust us now and they know we are bringing them things, supporting them"* (Management interview).

8.1.7 Building partnerships and social capital

In Rustenburg, Brits, Sedibeng and Hillbrow, management staff report that they are more visible because of the programme – both with partners as well as with sex workers:

> ***"We are known around the area – people know that if they want help with sex workers, even the DoH, then you must go to Nqobile"***
>
> ***"We have built a partnership with SAFAIDS due to increased visibility"***

Some sub-recipients have experienced that they are better able to work with other organisations and partners since the funding. In Musina, the SR expressed that *"the programme has also established and strengthened relationships with other NGOs in Musina"*. In Soweto, there has been social capital built *"much more, we have friends and support now"*. WRHI in Hillbrow reported that *"the Red Umbrella programme has served to unify sex workers and the various civil society organisations that provide services to sex workers. Red Umbrella sub-recipients in Gauteng, with the assistance of the SWEAT Provincial Manager, are in regular contact and work together to develop ideas on how best to provide the best services…When dealing with sex workers we need to deal with them holistically. So we have to address human rights violations and violence so we need to forge partnerships with the organisations that provide these services, for example SWEAT, Sisonke, WLC."*

8.2 OUTCOMES ON THE BROADER ENVIRONMENT

RELATES TO THE OUTCOME:	RELATES TO THE OUTCOME:	RELATES TO THE OUTCOME:
Funders, civil society organisations and government have a coordinated response to health and social wellbeing for sex workers	Appropriate and accessible health and social wellbeing services, systems and programmes	Beneficiaries positively influence the provision of appropriate and accessible health and social wellbeing services, systems and programmes

8.2.1 Stigma and discrimination

The programme has shifted community perceptions of sex work - sometimes slightly, and sometimes substantially. Peer community outreach, sensitisation of the police, health and wellness campaigns involving DoH and the municipality which focus on sex work, sensitisation of churches in some communities, and greater confidence and sophistication among sex workers, have all resulted in improved visibility of the programme and gradually reducing stigma. Beginning within the self-stigma of sex workers, supported by the open messaging of the programme, there have been changes in many sites in the image and social standing of sex workers. Sex workers reported reduced discrimination in some communities, and greater tolerance, understanding and acceptance in some communities.

"The attitude towards sex work is more tolerant. Maybe because people understand the poverty situation. People are not judging the sex worker as much now" (KI interview).

"Before the programme stigma was bad. Since the programme there is less stigma." (Management interview).

"People are now used to sex workers and they have started to accept sex work. A security guard … said that he has observed us giving away condoms to sex workers, and said 'I also look out for them, when I see robbers approaching them, I go and dismiss the robbers'." (Peer educator FGD)

In a powerful statement of rights and dignity, the police marched with sex workers in a public campaign titled 'No Violence Against Sex Workers' in George in December 2015. The event communicated not only police support for sex workers' human rights, but also provided a powerful message to the community around stigma and discrimination against sex workers.

While peers and managers are often under the impression that community stigma has reduced, sex workers continue to experience severe community abuse at other sites.

"Stigma and discrimination continues to exist, you cannot say it is better. … We get evicted by stand owners (landlords) as tenants once they get to know that we are o'magosha. Maqhwetsa (Xhosa men) always chase after us at shebeens, especially at the mines. We are hurled with insults by passing cars. Boere women don't want to see us, they once poured us with water…or what we believed was water…this water was so itchy we had to undress on Hystek Street" (Sex worker FGD).

"The most painful incident was when my child clashed with a neighbour's child and the mother intervened and insulted my child, telling my child that 'his mother is a whore who sells herself for money'. I hate that my children had to go through this but I am proud of what I do. I believe it's a job and I am able to put food on the table for my family." (Sex worker FGD).

Male and transgender sex workers also have particularly severe stigma to overcome, with community attitudes shifting more slowly.

8.2.2 Access to health services

8.2.2.1 Attitudes and quality of engagement by the public health service

Approximately half of surveyed respondents (54%) stated that they rely entirely on public sector health services. The public health service is broadly considered capable of delivering appropriate and comprehensive services: "*They [sex workers] receive the necessary services with no hassles*" (Peer educator FGD).

There are, however, accounts of this not being the case, and the public health sector is often a challenging space for sex workers, with major implications on their health:

"I went to the clinic because I needed PEP. They would not give me because I was apparently not raped but a condom had burst. I got no help. I reported at the Dept of Health and they said the clinic was supposed to have given PEP because my case was an emergency." (Peer educator FGD).

"At the Marikana clinic, it was reported that the only medicine that sex workers can access is a Panado." (Peer educator FGD).

Sex workers are aware that "*nurses have attitudes to everyone, not just sex workers*" (Sex worker outreach interview), acknowledging that nurse manners vary towards all clinic clients and that this can sometimes be unpleasant.

Complaints continue to some extent, particularly around stigma and discrimination, a lack of confidentiality, abuse and poor treatment, as well as public humiliation. As a result of stigma and discrimination, however, services are not consistently accessible and relevant to sex workers.

"I was referred to Jabulani Clinic after developing complications from STI's which included infection in my womb. The night shift [nursing] staff refused to give me pain killers. They said what did I expect to come out me giving my body to men of Joburg" (Sex worker FGD).

"We get medical attention if the clinician doesn't know that we are the sex workers or if we meet a nice health care worker. Sometimes when we have an STI we end up saying the work that we do and they would discriminate us." (Sex worker FGD).

"When you go to the clinic with an STI, they will humiliate, mock you and interrogate you about where you got it, all the time talking loudly so that everyone will hear" (Sex worker FGD).

"A TG sex worker with anal warts had a nurse insert a spatula into the anus, poking the warts so forcefully that the pain caused the sex worker the faint." (Peer educator FGD).

"A nurse once screamed at me, 'your face is a woman's but you have a body of a man, you are cursed by nature', I would rather die than go to that clinic". (Sex worker FGD).

"A girl said yesterday that she ended up leaving the clinic without being helped because she just could not handle the humiliation. This is one of the causes of people defaulting." (Peer educator FGD).

Nevertheless, in many sites sex workers have access to a clinic where they are able to receive better quality services. DoH health services were reported to have greatly improved in the last two to three years at some sites. This is often a result of the SR building relationships with the DoH, and formally or informally sensitizing health workers.

"At the clinic the nurses were refusing for us to do HCT. Our managers told them that it is our right." (Sex worker FGD).

"There is one nurse at the local clinic who is very good – they (nurses) have been sensitised and so they (sex workers) are free and get good service there." (Peer educator FGD).

"[The SR] has taught us a lot about our rights, and the attitude of the clinic staff has changed for the better. In the past we would be humiliated when we went to clinics. We would be insulted for having STIs. All of us would be painted with one brush of being HIV positive when they did not even know our status." (Sex worker FGD).

"We refer them to the clinic, and don't have a problem. They are treated decently. It never was bad, but now it is very good." (Management interview).

"We saw a change in attitudes in these facilities … The way they treated those people has changed. Sensitisation has changed our staff." (Key informant interview).

"The clinics around here treated transgendered and gay sex workers with contempt as if we were the disease itself, I won't even repeat the words nurses said to me in 2013 in February when I had a rectum problem. She called everyone, I was called all names you can think of in the book of insults…but I can happily say I get my treatment there today, and when I have a health problem I do not pause for any moment going there" (Sex worker FGD).

Sex workers rapidly gravitate towards clinics and individuals where they are *"treated with dignity"* (Sex worker FGD).

Problems that continue in some, although not all sites, include breaches of confidentiality, and identification of people living with HIV through continued use of different coloured folders and waiting areas.

A health practice which is challenging for sex workers is the practice of encouraging partner testing, and the probing questions that health workers are likely to ask: *"In 2014 we used to be discriminated [against] in the clinic by nurses and asked to bring our partners*." (Sex worker FGD).

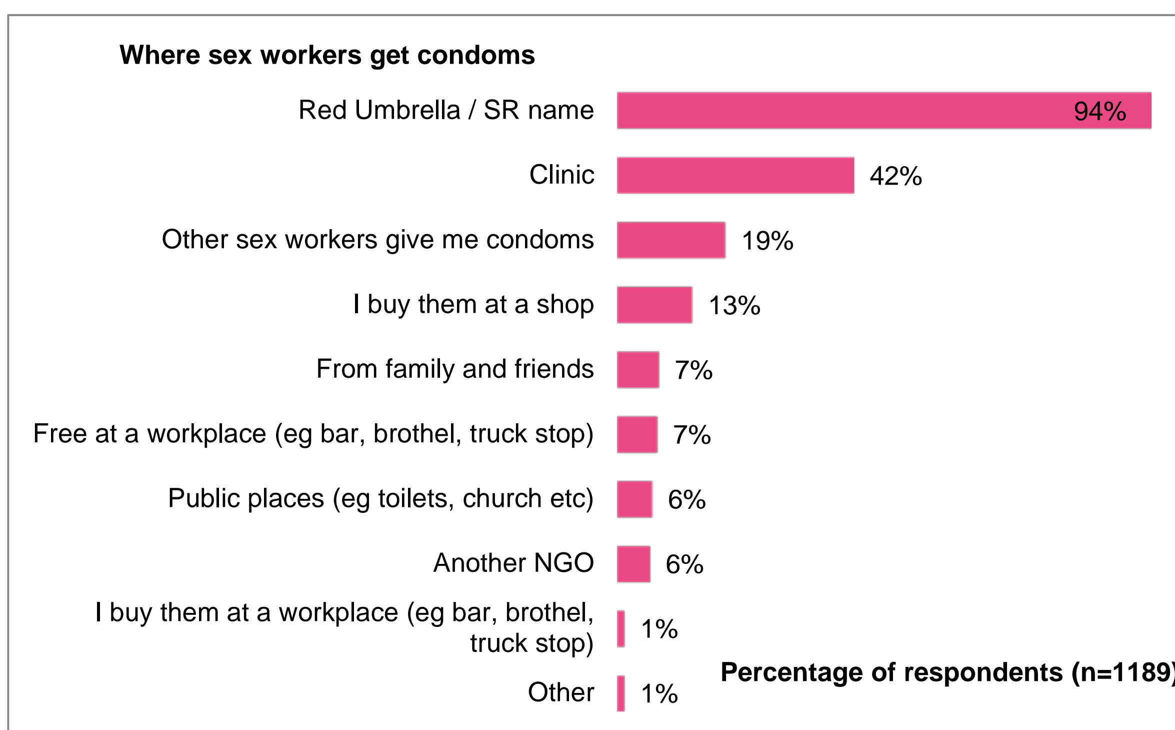
Overall, there has been progress in health service provision, however, not to an extent where sex workers readily and openly access health care across all sites.

"The attitude in clinic staff has changed dramatically in the last 3 years but there is still a long way to go" (Peer educator FGD).

8.2.2.2 Public sector availability of condoms and femidoms

Virtually all of those surveyed were programme participants, and 94% of participants regularly receive Red Umbrella condoms from the programme. Many (42%) also use the public health facilities for condoms (Figure 13).

Figure 13: Responses to "Where do you get condoms?" with multiple answers permitted.



This is a marked change from the 2013 Phase I evaluation in which only 61% of participants received condoms through the programme (Choice condoms), but 74% went to the clinic for condoms. While Red Umbrella condoms have clearly been a success, there are sustainability concerns. If regarded as a pilot exercise, the programme has demonstrated that bulk distribution of a vast amount of condoms into workplaces and directly to sex workers is necessary and appropriate, and that the brand and qualities of the condoms are of great importance to a highly discerning group of customers.

Whether as a result of the success of the Red Umbrella condom or not, the DoH decision to introduce scented condoms under the Choice brand has been widely welcomed, and it is recommended that the principle of bulk distribution outside of medical facilities be continued. Key informants in various sites were interested in attempting to arrange that Red Umbrella condoms continue to be supplied in their areas.

8.2.2.3 Psychosocial and professional psychological services

Programme elements have provided risk reduction spaces for debrief and support, adherence support groups in a few cases, personalised peer support, and greater community support among sex workers. In a context where psychological support is virtually non-existent, these have been a revelation and have transformed the lives of participating sex workers.

> ***"When you have a problem here you can speak without worrying about judgment. We share stories and there's confidentiality." (Sex worker FGD).***

Professional counseling and psychological support is only offered by the various Lifeline SRs, where properly trained counselors are part of their teams. Some SRs were also part of the GRATM/NACOSA GBV Programme, and as such, provided psychosocial support to rape survivors at Thuthuzela Care Centres. Generally sustainable, systematic, accessible, and professional counseling does not exist for sex workers, as it is for the general population. Similarly, professional psychiatric services are not easily found or accessed and are a major gap in the service package for sex workers. This is also a concern for many other public health care users.

8.2.2.4 Violence and vulnerability and access to related services

8.2.2.4.1 The implications of pick up locations

The survey probed various indicators of vulnerability, several of which were significantly related to sex work patterns. The survey asked sex workers where they picked up clients, and categorised these into:

- streets or markets – open public areas
- bars, brothels or truck stops – closed or indoor public areas
- phone or internet contact, or home-based sex work, for indoor private settings
- combinations of any two or more of these location types.

Several variables were significantly related to where sex workers pick up clients.

Figure 14 Relationship between pick-up location and measure of vulnerability

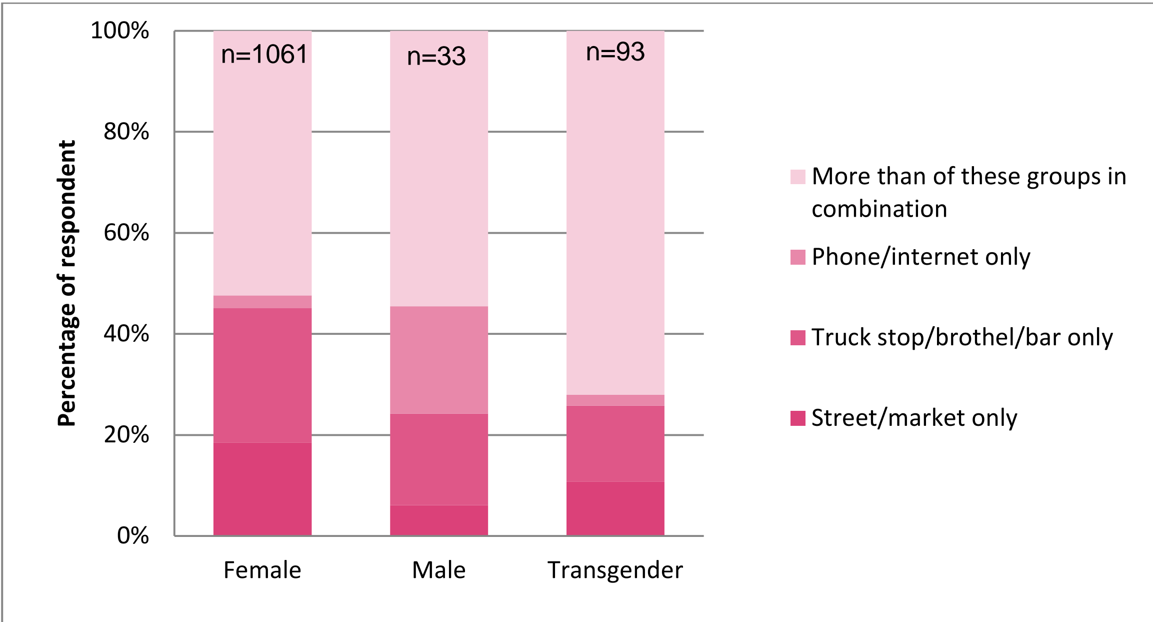


Table 12. Shows the relationships between pick-up locations and vulnerability

	Where people pick up clients				
	OUTDOOR Street/market only	**INDOOR PUBLIC Truck stop / brothel / bar only**	**HOME-BASED Phone/internet only**	**COMBINATION More than one of these places**	**AVG**
N	194-207	284-310	35-36	611-644	1158
Low HIV knowledge	8.5%	**5.5%**	8.6%	**13.6%**	10.5%
Replies 'False' or 'Don't know' to the question "A healthy looking person can have HIV"					
Low rights knowledge	**19.3%**	16.3%	13.95	**11.8%**	14.3%
Correct answers to none, one or two out of four policiing and rights questions					
Access to condoms	10.8%	**20%**	**22.2%**	13%	14.7%
Can only sometimes or never get enough condoms					
High substance related risk	35%	**33.6%**	40%	**51.2%**	43.6%
Reports often or sometimes being in a risky situation due to drugs or alcohol					
Violence in the last 12 months	**53.4%**	31.5%	34.3%	48.6%	44.7%
Intimate partner violence	4.4%	8.2%	**14.3%**	**15.8%**	11.8%
No significant relationships with violence by police (average 10.3%) or clients (average 31.4%)					

These tables and figures provide patterns around significant links between vulnerability and sex work location.

Street-based sex workers (only working in the street)	Have good access to condoms and below average substance abuse risk, but have very **poor knowledge of their rights**, are **younger**, and are most at risk of **violence**.
Sex workers who only work in brothel, bar or truckstops	Have good HIV knowledge, low substance related risk, and least risk of violence, more often female, but have **difficulty accessing condoms**
Home and internet based sex workers	Have **difficulty accessing condoms**, and have lower overall violence, but most **intimate partner violence,** and are more often **male**
People who work at a combination of places	Have multiple sources of vulnerability, including **low HIV knowledge**, high **substance related risk**, highest rates of intimate partner **violence,** are **older,** more often **transgender,** but better rights knowledge than most

Some of the reasons for vulnerability lie in the conventions and rules associated with different work spaces, others relate to the level of protection, isolation or exposure in different areas.

"The mini-forests, open fields, being in a car of a stranger (client) and the streets are typically high risk situations for assault, rape, and other forms of physical violence. In order to not think of what might be on the negative experiences, we use drugs. Some of us will not go into the streets or work spots without having a three or four pints of cider or beer. We have those of us who smoke dagga. We continue working and in most cases we are successful in putting a plate of food on the table and get kids to school, clean and with all required stationery…even though we know sometimes that we might not return home, we might go to a mortuary or hospital." (Peer educator FGD).

"Some of the rules in taverns are no stealing from clients, stick to agreements made with clients, no use of drugs, seeking health treatment immediately if there are any sexual health issues. Clients are kicked out of the club if they do not honour the sex work agreements, for example a position other than agreed or refusal to use condoms. If clients do not like the rules at the tavern, they find sex workers on the streets. (Peer educator FGD).

"We are worried with the high incidence of sexual assault to sex workers in hostels and in various places outside the known controlled paces such as houses and rooms offered and used in some taverns and shebeens". (Peer educator FGD).

"Some of us have been injured many times and we will never again get into clients cars. At least in the brothels we do get some form of protection from the security guys, but it is never for free. On top of paying for your room, you are constantly harassed by the bouncer for money. Sometime you are even threatened with eviction when you don't pay up" (Sex worker FGD).

"I work in Makhado, sometimes I meet the robbers when I work, and they want money from me and from the client." "I work in the bush in the weeds and trees. The tsotsis come and demand money to rent the street." (Peer educator FGD).

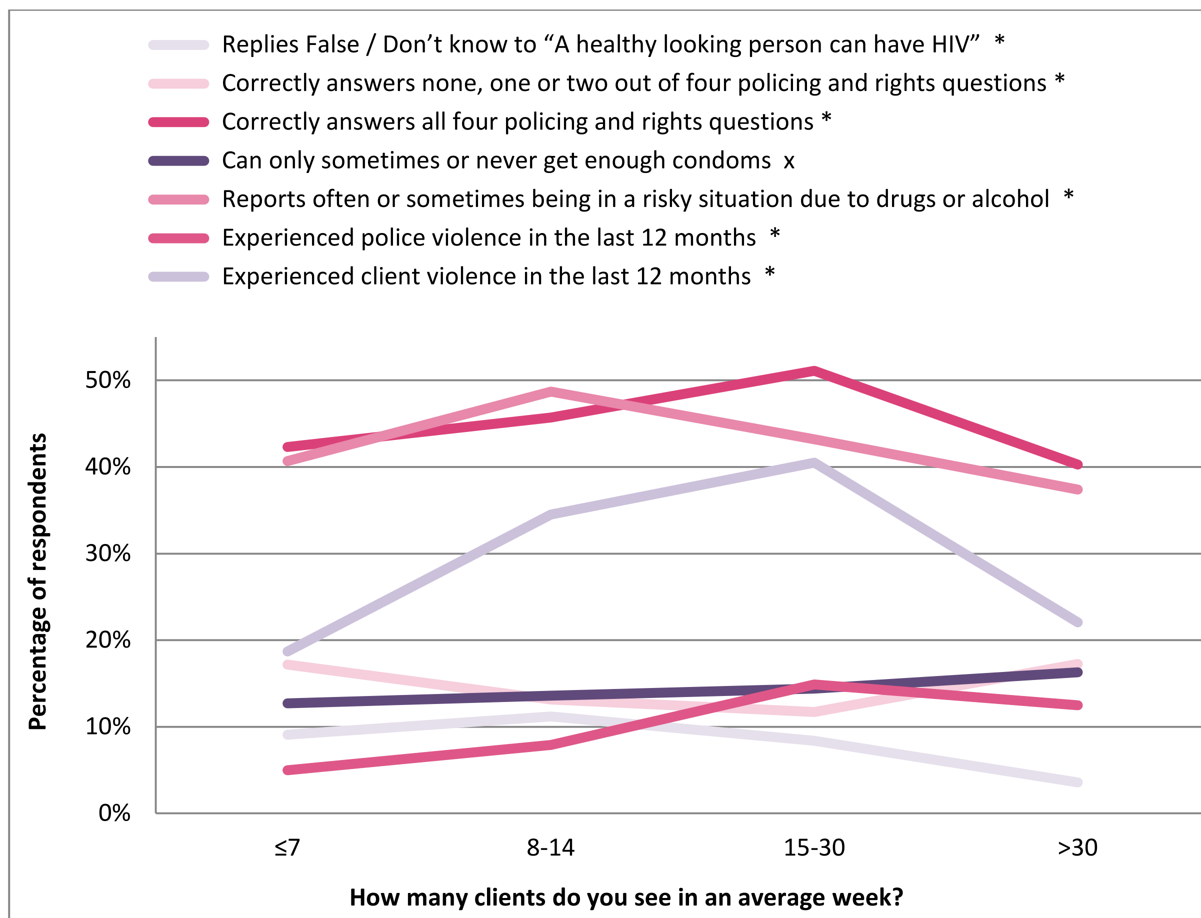
8.2.2.4.2 The implications of clients seen per week

In the survey, sex workers were asked to estimate the number of different clients they saw in an average week. Age and gender are both significantly related to their responses (Figure 16). Younger sex workers see fewer clients in a week. Sex workers between the ages of 36 and 45 see the highest number of clients. Female sex workers see significantly more sex workers per week than male and transgender clients.

Figure 16. Relationship between age and gender, and the number of clients seen per week

Migrant sex workers, who were not born in South Africa, see significantly more clients per week than those born in South Africa, with 23% of non-South Africans seeing more than 30 clients a week, compared to 9% of South African born sex workers. The number of client seen per week is also significantly related to other measures of vulnerability (Figure 17).

Figure 17. Significant relationships between sources of vulnerability and number of clients seen per week



* Significant relationship between two variables (p>0.05)

x No significant relationship between two variables (p>0.05)

Client activity therefore relates to vulnerability as:

Sex workers who see fewer than 8 clients a week	Have least rights knowledge, many are younger, and male or transgender **and least substance abuse and least violence**
Sex workers who see between 8 and 15 clients a week	Have least HIV knowledge, and most substance abuse, **but reasonable rights knowledge**
Sex workers who see between 16 and 30 clients a week	Are most vulnerable to both police and client violence, many are aged 36-45 and female and a larger proportion are non-South African, **but have most knowledge of their rights**
Sex workers who see more than 30 clients a week	Have least rights knowledge and a high level of police violence, and a larger proportion are non-South African, **and most HIV knowledge, and least substance abuse and low client violence**

8.2.2.4.3 The implications of small town and metro contexts

The survey sample was evenly distributed across metros and small towns. In various measures of vulnerability the survey shows significantly greater vulnerability in small towns compared to metros, with the only more severe challenge for metros being access to condoms (Table 13). In small towns, HIV knowledge is lower and violence is higher. There is no significant difference in STI rates or substance abuse.

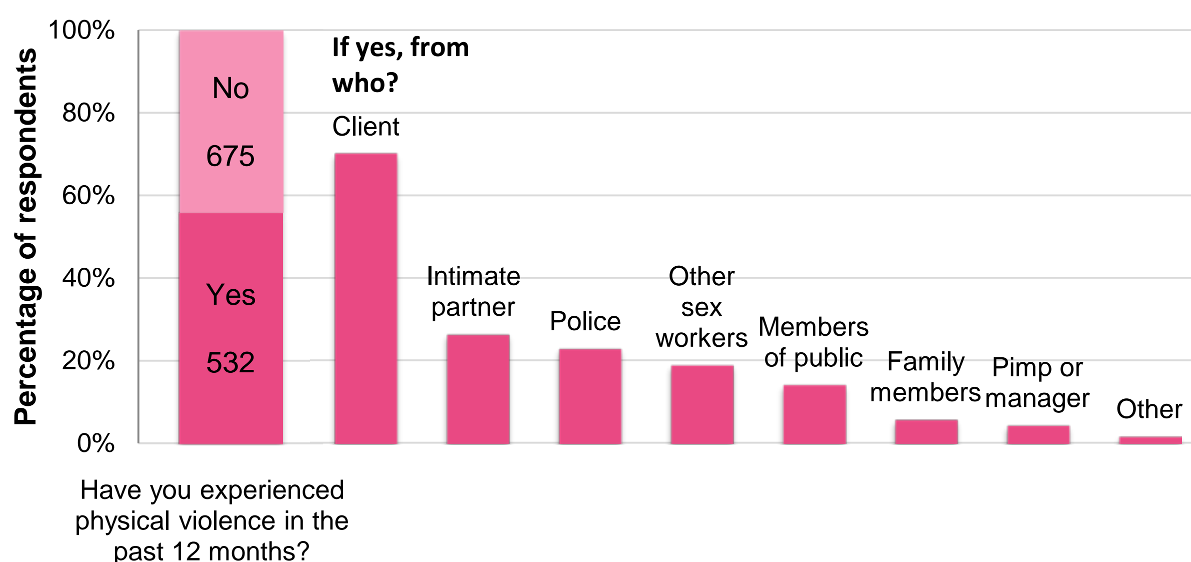
Table 13. Relationships between metro / small town sites and measures of vulnerability

	METRO SITES	SMALL TOWN SITES
Low HIV knowledge	5.2%	**11.5%**
Replies 'False' or 'Don't know' to the question "A healthy looking person can have HIV"		
Low rights knowledge	No significant difference (average of 8%)	
Correct answers to none, one or two out of four policing and rights questions		
Access to condoms	22.4%	12.6%
Can sometimes or never get enough condoms		
High substance related risk	No significant difference (average of 44.8%)	
Reports often or sometimes being in a risky situation due to drugs or alcohol		
Violence in the last 12 months	40%	**47.2%**
Police violence	8.9%	**13.9%**
Violence among sex workers or by controllers	8.2%	**14.2%**
Violence by community or family members	13.6%	**23.5%**
No significant relationships with violence by clients or intimate partners		
Access to legal assistance	21.6%	43.5%
Answers yes to "Did you receive any legal help from anywhere?"		

Significant relationship between two variables ($p<0.05$)

The metros have demonstrated the value of a central clinical service - which is well marketed - and the potential for expanding reach using peer marketing across a large metropolitan area:

Figure 18. Rates and sources of violence experienced by sex workers



“We have gone to sites that we have never been to before and to new hotspots … people know about it (the Esselen Str Clinic) far afield and they use it now” (Management interview).

8.3 Violence

In the last 12 months, 44% of sex workers had experienced violence (Figure 18), the vast majority of which was perpetrated by clients (70% of those who had experienced violence, had been subjected to client violence).

The number of years a person has been involved in sex work is significantly related with violence of all types (Figure 19).

Figure 19. Relationship between years in sex work and violence

In summary, the statistically significant vulnerability factors around overall violence, most of which is perpetrated by clients include:

- **Where people pick up clients:** Most for **street-based** and for people who work in a **combination** of different types of pick places, e.g. street and bar.
- **The number of clients seen a week:** Most in the upper-middle of the range – **16-30 clients/week**.
- **Time in sex work:** Most for people who have been doing sex work for **longest**.
- **Small town or metro:** More in **small towns** than metros.

- **Age:** Small samples in some categories means that the difference is not significant, but markedly more for **older sex workers**.
- **Gender:** Small samples in some categories means that the difference is not significant, but markedly more for **transgender sex workers** across all perpetrators of violence. The focus groups confirmed that gay and transgender sex workers are increasingly experiencing homophobic attacks in some sites.
- **Police arrests:** Violence by all perpetrators is most for sex workers who have been **arrested** in the last 3 years.
- **Drugs and alcohol:** Violence if most for sex workers who are in risky situations due to **drugs or alcohol sometimes or every day**.
- **STIs:** People subjected to violence by police, clients or other sex workers are **far more likely to have had STI** symptoms in the last 12 months, implying lower condom use.

8.3.1 Community violence

Sex workers are out late at night in isolated areas. They are highly vulnerable to generalised violence, as well as violence related to sex work stigma and hate crime.

> ***"'abogila' (abo 'gila' - criminals who pretend to be clients) - you find them anywhere - in the streets, online, in clubs, shebeens, taverns, on Facebook. The bastards always know when we have made money and they know where to search in our bodies." (Sex worker FGD).***

> ***"There is a notion that when you are a sex worker you are an easy target for rape, and even the police would take the side of the rapist once they say you are a sex worker." (Sex worker FGD).***

> ***"Community uprising is happening against sex workers. There is a growing hatred by women in Soweto against sex workers, such that attacks have happened at our private homes where they came in, burned our furniture and torched our rooms and homes." (Sex worker FGD).***

There is a perception that even general violence against sex workers has decreased, despite national trends of high rates of gender-based violence. This seems to be related to greater community coherence, *"looking out for each other"* and perhaps also to raised personal confidence and presence.

> ***"Although sex workers still experience muggings after midnight, there is a strong feeling that the streets are safer now than they were three years ago." (Sex worker FGD).***

> ***"There have been less murders of sex workers by clients since Red Umbrella program. In the past, clients would kill a sex worker and dump their body in the river." (Peer educator FGD).***

8.3.2 Client violence

Clients are the main perpetrators of violence against sex workers, with approximately 30% of all sex workers reporting client violence in the last year. Refusal to pay, beatings, rape, gang rape, stabbings, being thrown from moving vehicles, being driven far away from town and left somewhere desolate at night, being forced to perform sex acts with a dog, being forced into unwanted sexual positions, and kidnappings are amongst the range of abuses that sex workers continue to experience. Murders have also occurred within recent years at several of the RU sites.

> ***"We experience a lot of violence from clients not wanting to pay and wanting to take out the condom and have sex without it." (Sex worker FGD).***

"I had sex with a client outside the car. When I went around to fetch my pants, he hit me, took my pants and left me there naked. I got help from a security guy who took me to his workplace, let me wash the blood off - and I wrapped my shirt around like a skirt." (Sex worker FGD).

"Sometimes they ask you for impossible sex styles and want to enter you from behind (anal sex) and once you refuse, some of them just blow up and if you cannot fight, you might end up dead or in hospital". (Sex worker FGD).

"They threaten sex workers with guns, forcing them to do what they want, like anal sex, blowjobs without condoms, fingering, ejaculating inside the mouth." (Peer educator FGD).

"[Some of the things that have happened include] being stripped naked, tied to a tree, leaving you lying on the street, locking you in the boot." (Peer educator FGD).

"A friend and I were thrown out of the moving car. We learnt later that he always does that." (Sex worker FGD).

"*The client kept driving until they got into Vanderbijlpark where the client stopped at a party. The sex worker was taken into the house and into a room at the back where four men entered and gang raped her and beat her up. She was kicked out of the house without her clothes and left to walk naked in the streets."* The police refused to open a case, however, legal proceedings by SWEAT and Women's Legal Centre are underway.

"In 2015 a sex worker I stayed with was killed by a client who threw her out of a flat in town." (Sex worker FGD).

Although the data are variable, and there are no strong trends around age of sex workers for other sources of violence, there is a marked difference in client violence against sex workers of different ages :

Table 14. Age and percentage of sex workers in each age group to have experienced client violence in the last 12 months

18-21 years	22-25 years	26-35 years	36-45 years	>45 years
24.3%	31.0%	29.1%	**35.7%**	**43.3%**

Variable data, not statistically significant

Transgender sex workers are also particularly vulnerable to violence:

"The big one is with those clients thinking that you are a girl…this always leads us to serious trouble, it is how we represent ourselves that's more of a danger" (Sex worker FGD).

"A client asked me … after I got into the car and we are at the park in Zoo Lake, 'are you a she-male?' Before I could answer he took out a knife, and stabbed me badly. I fought and came out, when I ran into the road on Jan Smuts I was assisted …. This client drove away and … we gave the police his plate numbers." (Sex worker FGD).

Respondents described cases where sex workers are "dumped in remote places, clients refusing to pay after being serviced, or being raped and/or abused" as rare (Sex worker and peer educator FGDs).

In some settings, police support and sex worker vigilance and assertiveness have both resulted in a reported decrease in client violence, and there are sites where client violence is described as rare.

8.3.3 Violence by other sex workers

Most sites reported far greater awareness of their own community and facilitation for solidarity and mutual support. Qualitative data suggest that sex worker rivalry has decreased substantially.

"Many sex workers died three years ago. We used to be violent ourselves and now this SR has helped us to respect each other." (Sex Worker FGD).

Although relations between sex workers have improved, rivalry and jealousy between sex workers at some sites does continue to be a source of conflict and sometimes violence. The main causes for conflict include territory, under-cutting prices, newcomers to an area, fighting over clients or fighting when drunk. There was one account of female and male sex workers harassing transgender sex workers, with female sex workers exposing transgender sex workers as 'male'.

"A sex worker would spike another's drink so that she passes out and they would then steal her client." (Sex worker FGD).

"At times when a sex worker is seen to be in demand, other sex workers set thugs to rob her of her money." (Peer educator FGD).

"I was confronted by two sex workers after a client chose me over them. I fought back and refused to leave the spot. Later when I was drunk I got my friends and we went to fight them back. We found one of them and beat her up." (Sex worker FGD).

"There's an older woman who used to be sex worker, but now just spends her time bullying, intimidating and demanding daily payments from sex workers who have had clients. She carries a huge knife, takes drugs and sniffs glue and even some clients are scared of her." (Peer educator FGD).

"The problem with the hostility and tension among the sex workers is that they are unlikely to help if one is in trouble." (Peer Educator FGD).

There were noticeably more accounts of both client and sex worker violence for Bloemfontein than any other sites.

8.3.4 Police harassment and violence

A major programme impact has been the consistent reduction in police violence and police harassment across almost all sites. This is borne out by a comparison with the Phase I survey, although not directly comparable or statistically testable, in which 55% of Phase I respondents reported police violence compared to 23% of Phase 2 survey participants.

"The relationship with the police has improved. They used to beat us but not anymore." (Peer educator FGD).

"There is almost no more violence from police" (Sex worker FGD).

"In the past, we used to get arrested and driven around for 4 hours and then dropped off without being told the reason for being arrested. These days they [police] don't do that." (Peer FGD).

"The police are fine now. In the past years they were quite violent and arresting the sex workers. They used to handle the sex workers roughly and throw them in the vans." (Peer FGD).

"In the past the police wanted to arrest us, they hated us, but now they understand the programme" (Peer FGD) …"It has been two years since the last sex worker arrest. The police are our friends" (Site coordinator team interview).

"Police now are friends with sex workers, they just greet them on the streets now, they don't harass them anymore" (Management interview).

Rapid outcomes and shifts in police attitudes and behaviour have been achieved across the programme. Police staff have been increasingly amenable to more constructive relationships and open to quickly adjusting their approaches. The process is described well by a SAPS respondent:

> ***"Previously SAPS had no contact with the sex workers and there was a friction. Then Lifeline Kimberley came on board and invited us to meeting and we became part of the programmes and understood our role, especially with regards to – social crime prevention. We educated the sex workers about their rights and we acknowledge that they were mostly being mistreated by our police shifts, but now the patrols check on the sex workers re their safety. The relationship between Lifeline Kimberley and SAPS is providing positive results, we have meetings and there is a community police forum meetings for all stakeholders." (SAPS Interview).***

A level of police ill-treatment does exist, but fewer cases seem to be occurring than in the past. Rather than systemic violence perpetrated against sex workers, individual members of the police may continue to violate sex workers, with transgender sex workers still the most likely to be abused. In general, sex workers are far safer from the police than they were before the programme was implemented. At some sites (a minority) police moderation is primarily due to understanding that legal rights for sex workers exist, and that they "*can be sued*", rather than a genuine shift in attitude.

Several key reasons are given, and give guidance on good practice:

- Sex workers knowledge and ability to articulate their rights
- Access to legal and paralegal support by professional legal NGOs, Sisonke and SRs against the police
- Personal relationship building, engagement and advocacy, which might or might not include formal sensitization training for the police
- Participation by both police and sex worker in community forums

Police and sex worker relationship building through community forums has been particularly constructive and is the main reason for improved sex worker conditions at some sites: *"The police have been invited to risk reduction workshops as guest speakers, have met sex workers, answered questions, correct procedures for arrests have been shared and affirmed by both the police and sex workers.*" (Peer educator FGD).

The most effective model seems to be legal rights education for sex workers and the police, followed by institutional support, and by contact in community forums in particular, with a backstop of legal intervention if necessary.

> ***"Most sex workers know their rights, they participate in [various NGOs] activities and training sessions, and this has led to police harassment and brutality coming down drastically over the past three years." (Peer educator FGD).***

> ***"A month after receiving SWEAT training on legal rights in 2014 the police arrested them (the peer educators). They were released with an apology 30 minutes later, and no sex worker arrest has been reported since." (Management interview).***

> ***"Once they raided and arrested 75 sex workers. We [SR] were called. We kept asking the police to give the reasons for the arrests. They were rapidly processed and released at two in the morning." (Management interview).***

> ***"There was a recent case of a policewoman taking money and condoms from sex workers. We dealt with her and she is not doing it anymore." (Management interview).***

> ***"There are still some places where they [police] are not amazing, but if they are in contact with [the SR] then they find that the police become more amenable. There is no police violence." (Management interview).***

One site reported that some of the police remove their name tags when harassing sex workers, however, that they generally move on if the sex worker pointedly takes note of their vehicle registration number.

Although reducing conflict and increasing understanding has been achieved, police relations continue to be challenging within the context of criminalisation. In the last three years, 32% of sex workers surveyed had been arrested. Of these a far higher proportion were working on the streets (40%), although indoor sex workers are also subjected to arrests (25%). Patterns for arrests include:

- significantly more sex workers who regularly use drugs or alcohol (45%) who have been arrested, compared with 22% of those who state that they are never at risk due to using substances
- people who have been doing sex work for longer are significantly more likely to have been arrested (28% for 2-5 years, 36% for 6 or more years of sex work)
- migrant sex workers are more likely to be arrested: 43% of non-South Africans, compared with 29% of South African born sex workers
- people who have been involved in or subjected to violence are also more likely to have been arrested.

While there are encouraging signs in many areas there are a few sites where police abuse continues to be severe and destructive, most notably in Brits (although a shift in attitude is beginning to be seen) and in Rustenburg:

"Also, sometimes they (police) rape the sex workers when they arrest them." (KI interview).

"…the shutting down of the brothels by police and authorities is a problem because now we are forced to do sex in bushes and this leaves us vulnerable to rape and even death by clients and criminals..." (Peer educator FGD).

"There is harassment of clients by the police and robbery by the police, they steal our money point blank." (Peer educator FGD).

"The police have recently shut down one of the main brothels in Brits CBD, which has left many sex workers without a safe space to do their work." (Peer educator FGD).

"The sex workers in Brits are not able to work freely. They are not fine. They are harassed by the police, who chase them from the taverns and streets, and they will close taverns down if they find sex workers in them." (KI interview).

Arrests and harassment do take place – though these are less common in other areas - and the police occasionally continue to deter and obstruct sex work. In several cases physical and sexual abuse was reported, including sex workers being raped in the cells after being arrested.

"In 2015 October I was arrested in town while I was off duty for 'showing cleavage'." (Sex worker FGD).

"One policeman is known to have favourites and targets and arrests you if don't have sex with him. He takes their clothes and even beats us. We've reported him a couple of times, station commander says street work is illegal so there's no case." (Peer educator FGD).

"They also put their finger in our vaginas saying they are looking for drugs." (Sex worker FGD).

8.4 Professional legal services

> **RELATES TO THE OUTCOME:**
> A more positive legal and social environment towards the realisation of human rights for beneficiaries (positively influenced by funders, civil society, NACOSA)

Of sex workers who had been arrested, 32.4% received some form of legal help. Sex workers aged 26-35 most frequently received legal assistance (38%), but only 18% of sex workers over 45 received legal support. Also significant, 35% of South Africans received legal support, compared with 24% of sex workers not born in South Africa.

In sites where organisations like Sisonke, WLC and Legal Aid are active, sex workers report that they are better able to access professional legal help when they need it. At a number of sites sex workers had also found that the sex worker helpline had been of assistance (Peer educator FGD).

Some SRs provide legal support, but not professional legal services. In one example, a sex worker who had assaulted a client who refused to pay was arrested. She obtained support from a Legal Aid lawyer, and was represented in court, and acquitted on grounds of self-defence. (KI interview).

In another case, a focus group participant related her story of a client who ejaculated too quickly and wanted more sex by force. He hit her with a blunt iron object on her head, after which she lost consciousness and woke up a day later in hospital. Fortunately, she knew him very well and traced him. He was arrested and they appeared in court. The family has offered her R4000 to drop the charges because they are worried that he will lose his job, as he is a breadwinner with two children of his own. The SR has advised the sex worker not to drop the charges. The sex worker is determined to press on with the case (Sex worker FGD).

Overall, however, provision of professional legal services further away from the two largest metros is extremely poor. Even without access to legal services, however, the rights and legal training received by sex workers has resulted in a greater willingness (in some areas) to report crimes and lay charges.

8.5 Policing services for sex workers

> **RELATES TO THE OUTCOME:**
> Beneficiaries positively influence the legal and social environment towards the realisation of human rights for beneficiaries

At many sites, police have shifted from main sources of violence and harassment to providing a security presence and a level of protection during their patrols.

With knowledge of their rights and a far friendlier police presence, sex workers are more willing to report crimes, and at some sites the police have become more willing to open cases. In Makana the police open and follow up on rape cases reported by sex workers. In Welkom the police accompanied a sex worker to demand payment from a client.

"In town white kids threw eggs and lit firecrackers at us… There was a police car behind them when it happened. They were arrested." (Sex worker FGD).

In an example of advocacy leading to action in the Western Cape, the Beaufort West SR advocacy team succeeded in persuading the police station to provide a dedicated cell for transgender sex workers, in line with policy supported by the province. As a result, abuse of transgender women in male cells has been prevented.

However, "not all policemen treat you the same…and access to police service appears [to be] a continuing challenge" (Sex worker FGD).

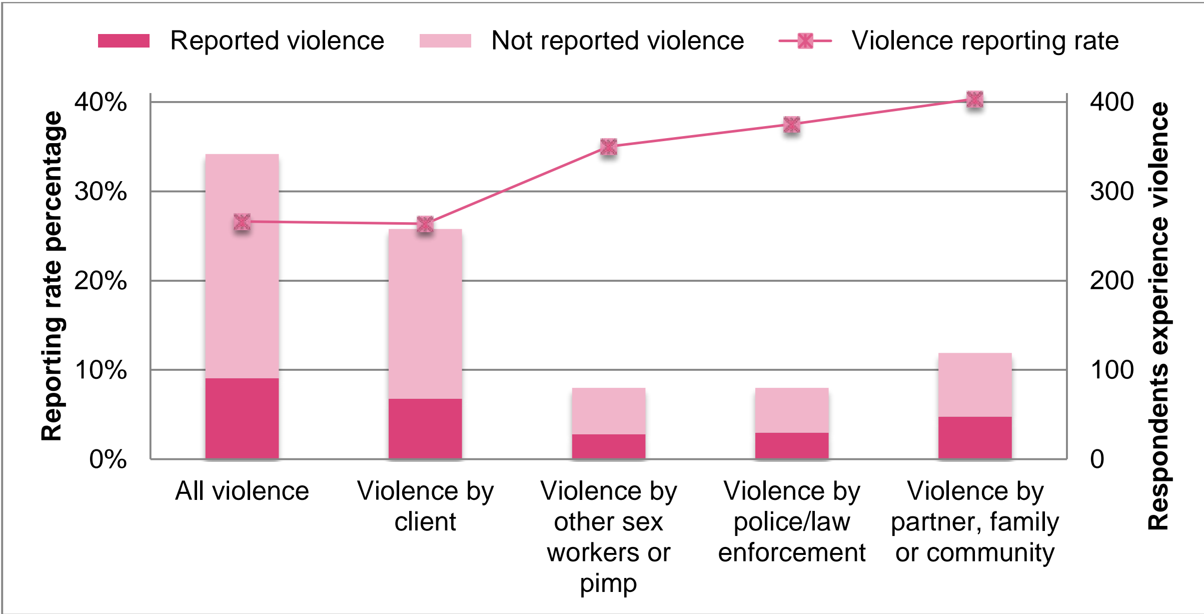
At several sites protection services extend to police giving sex workers a lift from clubs late at night, sometimes for a R10 tip, to help avoid violence.

8.5.1 Reporting crime, and demanding human and legal rights

Shifts in violence, stigma, health services, police and legal services in the community are strongly attributed to the Red Umbrella programme.

> ***"Participants all agree that the programme is the reason why the violence and discrimination against sex workers has decreased. Sex workers know their rights now and have a place to go for help." (Peer educator FGD).***

Figure 20. Rates of reporting for violence



There is still a sense, however, that sex workers avoid contact with law enforcement, and are reluctant to report crime. Less than 30% of violence is reported (Figure 20), with the high rate of client violence being least reported. Domestic and community violence is most frequently reported, and sex workers are relatively non-averse to reporting police violence.

> ***"There is a reluctance on the part of sex workers to report incidents of violence that they experience, due to sex work being viewed as a criminal act." (KI interview).***

Many respondents are reluctant to report crimes against them. This is mostly due to disinterested police rather than a concern about sex work being illegal.

> ***"I didn't go and report because police humiliate us sex workers. I once tried to go report and they said they waste work time on someone like me." (Sex worker FGD).***

> ***"It seems they have doubts on what I was saying to them when I get raped by four men after being picked by a client. It is like I am telling them a story that makes them not believe me because they were not there: they thought I had agreed to an orgy with multiple clients, at least that's how they made me feel." (Sex worker FGD).***

8.5.2 Crime by sex workers

Sex workers are aware of criminal elements in their midst, describing sub-groups or locations where sex workers and 'boyfriends' collaborate to rob clients. It is also not unusual for sex workers to spike a client's drink and rob him. Police raids and arrests in some areas are a reaction to criminal activity, rather than to sex work itself.

"Most if the time when sex workers go to court it is for shoplifting and not necessarily for sex work itself" (Peer educator FGD).

"What we do, when we are drinking, we use eye gene on the glass of the person who is like a client and they pass out, and we rob them. We also use brake-fluid or snuff. When they have a bonus they buy a lot of alcohol and have a lot of money. Then we rob them." (Peer educator FGD).

"We have one [sex worker] who gets violent and kicks the windscreens of the car. She often robs the clients of their phones, bank cards, money etc." (Sex worker FGD).

"They (truck-stop sex workers) are unruly, aggressive, destructive, many of them under-aged, and indecently dressed. Many of them operate with their boyfriends who are well known criminals. They work together with them to rob clients or sell drugs". (Sex worker FGD).

"Die tik koppe and prostitutes pimp mekaar af" (tik-heads and sex workers sell each others services). They steal tyres and fuel. They will steal the light bulbs to get tik." (Truck stop KI interview)

8.6 Other sources of vulnerability

8.6.1 Legal documentation

At some sites receiving health services is difficult for sex workers, or any individual, without identity documents, proof of residential address or legal immigrant status. Where mobile or DoH services refuse these patients, they might be accepted at municipal clinics. This has shifted in programme sites, where SRs have assisted sex workers to gain access to treatment, even when their documents are incomplete. Although many sex workers may not have documentation, this particularly affects foreign nationals working in South Africa.

8.6.2 Migrancy and sex work

Sex workers who are not born in South Africa follow significantly distinct work-life patterns in a number of respects (Table 15). Most frequently, they pick up clients at bars, truck stops and brothels, and less frequently in the streets or home-based locations. A large proportion are resident in metropolitan areas, where they each see significantly more clients on average than South African born sex workers.

Table 15. Where and how often migrant sex workers work

<table>
<tr><th rowspan="2">Migrancy</th><th colspan="20">Where people pick up clients</th></tr>
<tr><th colspan="5">OUTDOOR
Street/market only</th><th colspan="5">INDOOR PUBLIC
Truck stop / brothel / bar only</th><th colspan="5">HOME-BASED
Phone/internet only</th><th colspan="5">COMBINATION
More than one of these places</th></tr>
<tr><td>Born in SA</td><td colspan="5">18.6%</td><td colspan="5">22.1%</td><td colspan="5">2.7%</td><td colspan="5">56.6%</td></tr>
<tr><td>Not born in SA</td><td colspan="5">11.7%</td><td colspan="5">41.0%</td><td colspan="5">4.9%</td><td colspan="5">42.4%</td></tr>
<tr><td rowspan="2"></td><th colspan="20">Site type</th></tr>
<tr><th colspan="10">METRO</th><th colspan="10">SMALL TOWN</th></tr>
<tr><td>Born in SA</td><td colspan="10">45.8%</td><td colspan="10">54.2%</td></tr>
<tr><td>Not born in SA</td><td colspan="10">61.6%</td><td colspan="10">38.4%</td></tr>
<tr><td rowspan="2"></td><th colspan="20">Number of clients seen per week</th></tr>
<tr><th colspan="4">≤7</th><th colspan="4">8-15</th><th colspan="4">16-30</th><th colspan="4">31-50</th><th colspan="4">>50</th></tr>
<tr><td>Born in SA</td><td colspan="4">32.3%</td><td colspan="4">24.7%</td><td colspan="4">33.6%</td><td colspan="4">6.4%</td><td colspan="4">3.0%</td></tr>
<tr><td>Not born in SA</td><td colspan="4">14.9%</td><td colspan="4">18.8%</td><td colspan="4">43.6%</td><td colspan="4">16.3%</td><td colspan="4">6.4%</td></tr>
<tr><td rowspan="2"></td><th colspan="20">Police intervention and legal support</th></tr>
<tr><th colspan="10">ARRESTED:
Have been arrested in the last three years</th><th colspan="10">LEGAL HELP:
If arrested, received legal support</th></tr>
<tr><td>Born in SA</td><td colspan="10">28.6%</td><td colspan="10">35.4%</td></tr>
<tr><td>Not born in SA</td><td colspan="10">42.7%</td><td colspan="10">23.5%</td></tr>
</table>

Significant relationship between two variables ($p<0.05$)

Foreign sex workers deal with denial of medical treatment at clinics, police harassment and xenophobia. When arrested, migrant sex workers have less access to legal support than South African born sex workers.

Sex workers in Brits, one of the most disadvantaged sex worker communities in the sample, felt strongly that there is a need to *"address the plight of foreign sex workers - we have seen some dying and some going back to their homes to die."* (Sex worker FGD).

> ***"Madibeng Clinic does not service foreign sex workers. They demand ID, or passport and proof of residence". …. "it is against their rights to be denied treatment and will lead to defaulting on their medication." (KI interview).***

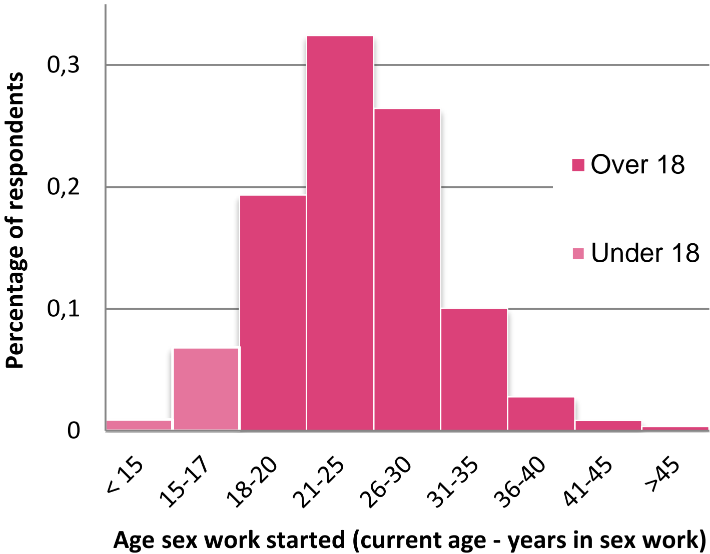
> ***"The police have xenophobia. Sometimes they will arrest all of us, but if you don't speak Setswana or Afrikaans, others who speak Setswana are left to go home, but you get kept in the van, then they ask for passport, work permits and demand sex or money.'' (Peer educator FGD).***

> ***"(A policeman who is a regular client) threatened a new street worker from Lesotho who was with a client and demanded sex. She had to consent because she had no papers and was scared of being sent home." (Sex worker FGD).***

8.6.3 Underage sex work

By subtracting current age from years in sex work, the survey reveals that 8% of respondents started sex work before the age of 18 (Figure 21).

Figure 21. Age when respondents started sex work (calculated)



Young people under the age of 18 who sell sex (categorised in South African law as victims of commercial sexual exploitation of children or CSEC) are excluded from programming and from the evaluation in line with ethics and legislation around child protection and child abuse.

When encountered, underage sex workers were referred to social workers, or at one site to Sisonke. They were generally lost to follow-up since neither they themselves nor their controllers (who may be their parents) have any desire for interference. This is an obvious human rights, programming and HIV response gap.

Young gay and transgender individuals were found to be especially vulnerable to becoming sex workers at a young age, as it is not unusual for them to be thrown out of their family homes once their sexual orientation/identity is discovered.

This gap in education, legal services, and relevant engagement is a programme challenge in the next round. Research ethics processes for children, while well-meaning, also create a major obstacle to information on the situation of young people who sell sex, mapping of populations and needs analyses. Excluding young people who sell sex from services is problematic.

8.7 Outcomes on sex workers

8.7.1 Sex worker empowerment and influence

RELATES TO THE OUTCOME:
Beneficiaries are empowered and competent with regards to their health and social wellbeing

Recognition and inclusion of sex workers in community forums and formal local coordination committees have been reported for many sites. As a national mandate for addressing key populations is rolled out, peers and sex workers as informants and participants become an asset, providing information and credibility that is valuable to local programme coordinators.

"One of the peer educators was invited by DoH to be an advocate during reduction week." (Management interview).

8.7.2 Sex worker knowledge and skills

Outcomes in both legal and health access have been strongly supported by increased knowledge.

> ***"Sex workers are now empowered. You can ask them about their health and STIs, and they know about health rights and human rights and how to access services and how to challenge bad attitudes from other health staff." (Management interview).***

Challenges of measuring health knowledge were highlighted in the survey, where all GARPR questions were found to no longer be valid (e.g. Have you been tested in the last 3 months and know your status – where HIV prevalence is between 50 and 70%), and additional health questions have become common knowledge (e.g. Is it safe to share eating utensils).

Discussions were useful in identifying more current health misconceptions, many of which the programme has helped to resolve. These included:

- the idea that two condoms are better than one
- that if you and your sexual partner are both HIV positive protection is no longer necessary
- "We now know that if you have been raped, you can ask for PEP" (Sex worker FGD)
- "If you are on ARVs, you can have raw sex (nyama to nyama) because your medication will help you not to be sick." (Peer educator FGD).

8.7.3 Uptake of health services and health behaviour

8.7.3.1. Uptake of health services

RELATES TO THE OUTCOME:
Beneficiaries take responsibility for their health and social wellbeing

SRs throughout the programme report increases in sex workers accessing health services, knowing their status and using prevention.

One key factor which has enabled this is where peers accompany sex workers to the clinic and provide consistent and continuous mentorship through the early stages of their health care process. The capacity to provide this service exhaustively is, however, beyond the resources of the SRs.

> ***"One of the most visible impacts is that sex workers are coming forward. There is a drastic change in health seeking behaviour" (Management interview).***

> ***"There is an increase in the number of sex workers referred to clinics, for testing and other medical reasons". (KI interview).***

> ***"There is an increase in clinic attendance and taking up referrals for full screens and pap smears." (KI interview).***

Another administrative obstacle that SRs have helped to resolve is ensuring that sex workers have registered at local clinics, transferred their files if necessary, and resolved any documentation concerns. Having overcome administrative barriers, sex workers have improved access to clinical services.

8.7.3.2 HCT

HCT has been a programme focus for the last three years. Most respondents (91%) stated that they had had an HIV test in the last 12 months and knew the result. For some sex workers the HCT drive in the programme was their first experience of testing, and for many the first time they learnt of their status.

"Most SW started testing when they came to Creative Space." (Peer educator FGD).

Having been intensively encouraged to test and retest over the programme period, sex workers are *"no longer scared of testing."* (Sex worker FGD).

"People say that they want to test, that they have tested four times. They know that who is testing will not judge you if you are positive. People come - we have budget for 30 people and 60 come." (Provincial manager interview).

For new sex workers entering the industry, HCT remains highly relevant as a core initial offering. At virtually all sites, easily accessible sex workers may have entered the programme, and targets have generally been met for HCT. The 2013 size estimation has been observed to be a under-estimate at many sites. At some sites current population size estimates could easily be doubled as programmes reach more effectively into the sex work community. Sex work is also increasing in some areas, as stigma and police harassment decrease, and economic difficulties intensify. HCT, therefore, continues to be relevant: *"There are a lot of sex workers in Makhado who want to know their HIV status."* (Peer FGD).

One anomaly in the results is that testing began in these areas more than 12 months ago. For many sites testing has been part of SR services for years, and for others it started intensively 3 years ago. Although most sites anecdotally report having lower HIV prevalence, between 50% and 70% of sex workers are living with HIV, many of whom have known their status for far longer than a year. For 91% to state that they have tested or retested in the last year, there is either a bias towards desirable reporting or a high level of repeat testing for people living with HIV.

The programme focus on prevention, HIV and HCT in Creative Spaces has been driven by HCT targets, but has not always been constructive.

"There is a feeling that peer educators test to reach targets not to increase awareness and prevention." (Peer educator FGD).

"People are reluctant to come because we are going to focus on testing, and they think they might not get the money if they don't test. The pressure is too much. HIV is just one of our focus points. We do not look away from it – but we do not look too into it all the time." (Management interview).

Driving first time HCT and encouraging individuals who are HIV negative to test regularly is important, however, these needs are difficult to separate from the majority of people, who have already tested, and who know their status to be positive. Blanket promotion and pressure for HCT is only constructive in the first year or two at a new hotspot. Thereafter, a system that is less wasteful and more respectful would be better. An SMS reminder system has been piloted at one site. Only the system manager knows the identities of those in the database, and this is an office based person with a strong confidentiality contract. A computerised system sends personalized messages depending on HIV and treatment status for either repeat testing, immunity monitoring or medication dates. The system is also used to share dates for meetings and campaign announcements with everyone. Testing is then easily accessible at Creative Spaces, mobile clinics and/or the SR premises and is provided by a nurse or trained lay counselor who can also advise on other health or psychological concerns.

8.7.3.3 ART uptake and adherence

ART roll-out, uptake and adherence support for sex workers has been a major service gap:

"Die meeste is oorlede." (most have passed away) (Peer educator FGD).

This has been somewhat addressed through the programme, especially where mobile clinics or sex worker friendly clinics have been able to offer CD4 monitoring and chronic dispensing sites. At some sites respondents report that many more sex workers are on treatment and belong to adherence clubs. Some sites have managed to roll out test-and-treat, which has further raised community health.

One factor which has enabled treatment to be successful is greater trust, community and social solidarity, and reduced HIV stigma, meaning that sex workers are less fearful of disclosure.

"It is different to before where you could not talk about HIV. It is easier to talk about it now and have discussions with them." (Peer educator FGD).

"For us as sex workers we used to laugh at each other, and then when we got tested we were free to talk about our HIV status and which medication we take." "I am no longer shy to disclose my status." (Sex worker FGD).

In being more open about HIV, friends and peers become more available to provide reminders for treatment. At several sites, peers offer personalized adherence support and defaulter tracing, in combination with local primary health, which has been a critical service for those at risk of defaulting and those at treatment initiation stage.

"They don't default anymore, they take their treatment" (Management interview).

"We are seeing much less people getting sick and the death rate has been decreased" (KI interview).

Despite improvements, there are "still too many not on treatment and defaulting because people are not brave enough to go to the clinic [alone]" (Management interview).

"Sex workers are also sometimes not disciplined. They miss their clinic dates and default on their treatment. They often do not want to go the clinic and complain about being humiliated. Yet when peer educators offer to accompany them to the clinic, they still won't go, this only puts them more at risk." (Peer educator FGD).

Referral follow up was a major challenge mentioned widely by respondents. Appointing a personal peer mentor to ensure that sex workers in need of treatment followed through on referrals to the clinic, was the strategy that seemed to work most effectively. Both manpower, and in some cases approaches to confidentiality, meant that this strategy could not be consistently employed. There is, therefore, very little data on whether HCT does in fact lead to treatment initiation, adherence and better health outcomes.

"They test here (SR) and get referred to the clinic to start treatment, but there is no way of tracking if they do take treatment. Next thing you meet the person and they look like a skeleton." (Peer educator FGD).

The quality of care received by sex workers at clinics affects whether referrals are followed, and affects the outcomes of treatment and ART adherence. One site managed to follow through on referrals in a paper-based referral and reply system, which relied on a very good relationship with health facility staff.

"I was given grief when I transferred from another clinic… They sent me from pillar to post, to the point where I almost gave up and went home without the treatment." (Peer educator FGD).

"The attitudes of health care workers leads to reluctance to test, disclose their status, access HIV monitoring, enrol in treatment, and accept nutritional support to enable adherence." (Management interview).

Once treatment has been initiated, community-based adherence clubs which include chronic medication dispensing, were recognised as a key service needed for sex workers. Virtually all sites reported that better treatment adherence support was needed as a key programming recommendation. Integrated treatment, particularly incorporating STI and TB care was also highlighted as a gap. Given very high HIV prevalence in this key population, this is a major area of focus, and should revolve around peer mentorship, defaulter follow-up and community-based integrated chronic medication dispensing and adherence clubs in close partnership with the DoH.

"There are adherence clubs being rolled out by the DoH since August where participants get treatment. Sex workers need adherence clubs." (Management interview - District).

8.7.3.4 Condom uptake and use

A large proportion of respondents (90%) stated that they had used protection (condom, femidom and/or dental dam) with their last client sexual partner, and 88% with their last non-client. The majority (86% and 85%) of respondents stated that they used a condom with clients and non-clients respectively, and some stated that they had used multiple prevention methods. This is similar to self-reported data from the previous phase. Given that condom use is acknowledged to be far greater with clients than non-clients, and sex workers themselves acknowledge that they over-report condom use, further analysis of condom use data has not been undertaken.

All sites report an increase in uptake of both male and female condoms as a direct result of peer education campaigns, which have included distribution during outreach, as well as using brothels as distribution points. Sex workers who might previously have expected the client to provide a condom, are now more likely to provide their own.

> ***"They take hundreds (of condoms) sometimes. I get messages on Whatsapp asking me to bring condoms". (Peer educator FGD).***

> ***"We have brothel managers calling us when they run out. We are developing a stock management system to deliver as they run out". (Management interview).***

> ***"In my area I even use a wheelbarrow to deliver condoms." (Peer educator FGD).***

In areas where sex workers receive an allocation of 30 condoms per month, there were requests to increase this number to align more closely with real needs.

The convenience of flooding sex work sites with condoms, which are accessible, convenient and easily available has been one factor in this uptake.

> ***"When you fetch condoms at clinics, nurses will interrogate you, ask a lot of questions in front of people about what you are doing with so many condoms. That's why sex workers are grateful for Lifeline/Red Umbrella because they just fetch them from the office." (Peer educator FGD).***

Another key reason for this is the universal popularity of Red Umbrella male condoms.

> ***"Red Umbrella condoms smell good, are of a high standard and it give me the power to charge high because my client can see I use a quality condom." (Sex worker FGD).***

> ***"RU condoms smell good, even if you haven't washed. They are strong and safe. They don't have excess oil and lubricant helps prevent cuts due to dryness and clients who do not want foreplay. No more itchiness that is caused by Choice." (Sex worker FGD).***

> ***"The Red Umbrella condom is preferred than Choice, because it is strong but thin. It makes one feel like it's skin to skin." (Sex worker FGD).***

Another important reason for increased uptake and use of condoms has been the relaxed and open approach with which peers demonstrate and train on condoms and their use: *"We are visible and we are not embarrassed to demonstrate condom use in the community. People say 'why we are going to be afraid to go and take condoms when these people are not even shy to show us how to use condoms'."* (Peer educator FGD).

Some respondents stated that they always insist on a condom. In several sites the concept of the right to refuse to have sex without a condom was new for sex workers, who had previously believed that they had no option but to accept the client's preference.

> ***"The programme has helped us to know that we can refuse to have sex with clients without a condom" (Peer educator FGD).***

"We didn't know that we can refuse to have sex without a condom. We know how to use protection." (Sex worker FGD).

"Risky behaviour has come down because we refuse to have sex without a condom. Even when a client is offering more money for sex without a condom we can tell him to keep his money instead of risking our lives." (Peer educator FGD).

Condom use has historically been driven down by client reluctance, and by offers of more money, and this does continue to be a factor for many: *"We have extensive knowledge … we were part of many training sessions … and have participated in TAC's treatment literacy programmes. Even though that is the case, the devil is the money, because when the money is bigger and better, condom use and health risky behaviour knowledge get out of the door".* (Sex worker FGD).

"Condom use has increased since the programmes, although some clients still refuse to wear a condom and give all kinds of excuses." (Peer educator FGD).

"Mostly we use condoms with clients, but when the money is offered for a clean round, we do not use a condom but we don't allow them to cum inside". (Sex worker FGD).

There are sex workers who have become adept at using condoms and femidoms inconspicuously.

There seems to be consensus that rates of condom use have increased, but that condoms are not used every time.

"No one will lie and say they use condoms every time, we might do it with most clients, but if a client will pay me R1000 just for one round without, I won't hesitate because I have rent to pay, kids at home with my mom that are in school and I need to support. We need to be empowered and supported so that we can take ownership of AIDS and avoid compromising situations." (Sex worker FGD).

Focus groups stated that condoms are less likely to be used with long-term partners than with clients: "*We use condoms with clients always, but with our 'qondile' (friends) we don't"* (Sex worker FGD).

"I'm passionate about sex work, but my heart bleeds for our lies, we lie a lot just so that we are seen as better, one example, do we use a condom with our "regtes" (boyfriends) the answer is a BIG NO!" (Sex worker FGD).

Clients frequently request Red Umbrella condoms during outreach, although SRs have only been permitted to distribute them to sex workers: *"Some guys (truck drivers) drive far in search of Red Umbrella condoms and they were under the assumption [that] the trucking wellness programme provided the Red Umbrella condoms and lube."* (KI interview).

Condom distribution is assisted by networks of sex workers, where those most involved in the Red Umbrella programme naturally become distribution hubs to others, readily sharing condoms among friends.

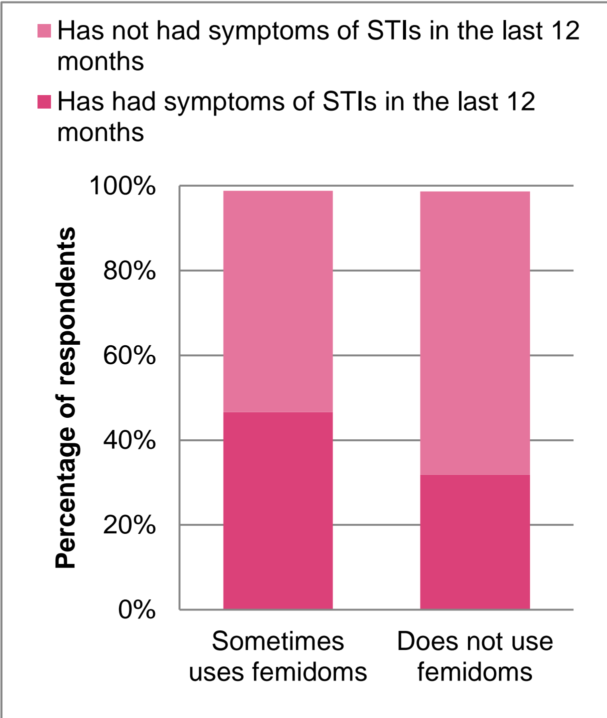
8.7.3.5 Female condom

DoH female condoms have been distributed and their use encouraged through the programme. Some respondents (39%) stated that they sometimes use femidoms. In some cases female condoms may be preferred over male condoms, particularly during a sex worker's period, or when a client is reluctant to use a condom. Transgender sex workers find female condoms particularly useful for anal sex (Peer educator FGD).

"People are trying femidoms and finding them to be better." (Site coordination team interview).

"They are taking a lot of female condom, and haven't complained." (Management interview).

Figure 22. Relationship between femidom use and STIs



Despite, or perhaps resulting in, a high interest in femidoms, 47% of sex workers who experienced STI symptoms in the last year sometimes used femidoms, which is significantly more than the 32% who had experienced STIs but did not try femidoms (Figure 22).

An important benefit of female condoms is the option of using them without a client's knowledge.

> ***"When client does not want to use a condom I pretend to go to the toilet and quickly insert the femidom and have sex without him knowing I am protected." (Sex worker FGD).***

> ***"I like it because they can fool clients who don't want a condom." (Peer educator FGD).***

Although steadily increasing in popularity, for many people female condoms remain less popular than male condoms, and many sex workers do not use them at all. Some remain suspicious of the design and find it complicated and disconcerting.

A misconception was mentioned in Hillbrow that should be rapidly corrected, namely that female condoms cause illness.

The survey revealed that, of those who use femidoms, 61.1% can always get enough for their needs (compared with 85.4% for male condoms). Female condoms are least available for street-based sex worker. Femidoms are most popular among sex workers who move between venues, a group of sex workers shown to be most vulnerable in several respects.

8.7.3.6 Lubricant

With a few exceptions, lubricant is appreciated and used by all, and particularly by male and transgender sex workers. Before the programme was implemented, awareness of lubricant had been much lower. Since the programme, knowledge as well as uptake have increased.

In one site female sex workers did not use lubricant at all, although male and transgender sex workers did.

> ***"It really helps when you have a client with a big penis" (Peer educator FGD).***

Lubricant also has a direct financial benefit to sex workers, making clients climax more quickly, and increasing the number of clients they can service without pain or injury.

At some sites, sex workers would have liked to have taken more of the lubricant that was being provided, but they did not because of the sachet packaging. The sachet contains far more than is needed for each condom, and it cannot be resealed. It is messy and sex workers would prefer to receive a tube.

8.7.3.7 STIs

The topic of STIs is linked to reproductive health care and rights, but has two further implications. Firstly, the most commonly mentioned reason for sex workers to visit a clinic is for STIs. The treatment they receive and the attitudes of health facility staff to STIs profoundly affect their engagement with the health care system, and their willingness to use services and remain healthy. Multiple responses indicated that sex workers are routinely humiliated and abused for reporting to health facilities with STIs.

The second reason for particular interest in STIs is that it is the proxy indicator selected here for effective condom use. Condom use is known to be over-reported. Experiences of STIs are analysed here to gain an impression of the factors that influence consistent and effective condom use as reflected in the survey.

A total of 38% of sex workers had experienced symptoms of STIs in the last 12 months. There is some dissent as to whether STI rates really have decreased, with some sites stating that despite increased condom uptake, STIs and unplanned pregnancies are still common.

In other settings, an impact on STI rates has been noticed:

> ***"The incidence of STIs and pregnancies is also on the decline due to increased condom uptake." (Management interview).***

> ***"Since the Red Umbrella programme started, they no longer see me at the local clinic". (Sex worker FGD).***

Part of the educational process has been informing sex workers on systems and early detection of STIs, and encouraging early treatment. This knowledge is empowering, and helps sex workers to take greater responsibility for their health.

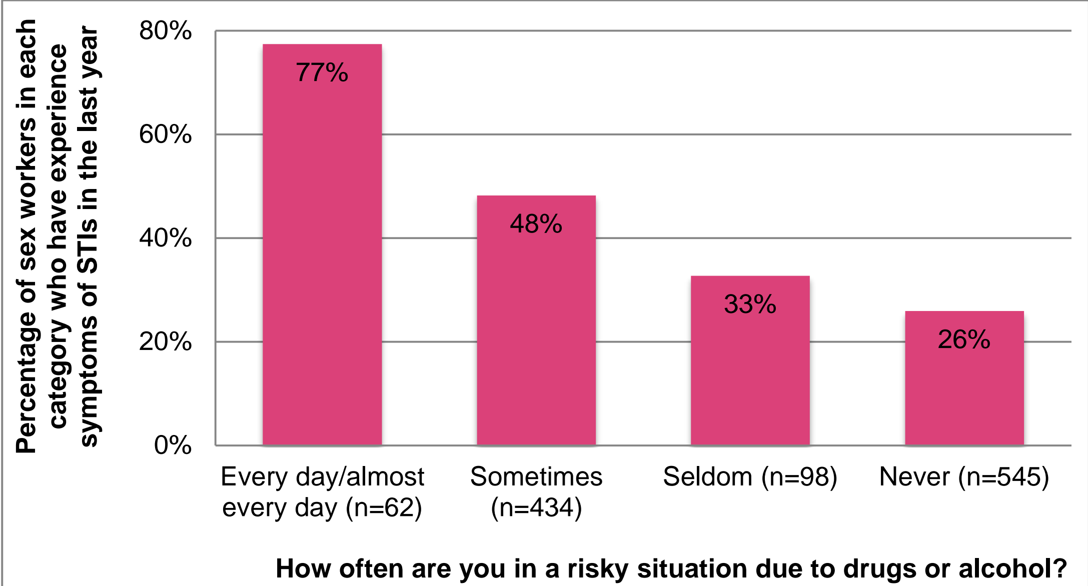
> ***"I can note signs of STIs. We also do TB and cervical cancer screening." (Sex worker FGD).***

Interestingly, and counter-intuitively, there is no significant relationship between STI symptoms and number of clients seen per week or age. There are also no significant trends around access to condoms and STIs. Whether a person can get enough condoms to meet their needs, or whether or not they get condoms from the clinic.

Far more males stated that they did not know what an STI is (9%, compared with 1% female and transgender), and more of both females (38%) and transgender (40%) respondents reported experiences of STIs than male sex workers (26%). STI symptoms are most commonly experienced in mobile sex workers who use a combination of pick up areas. Least at risk to STIs are sex workers who are home- or internet-based.

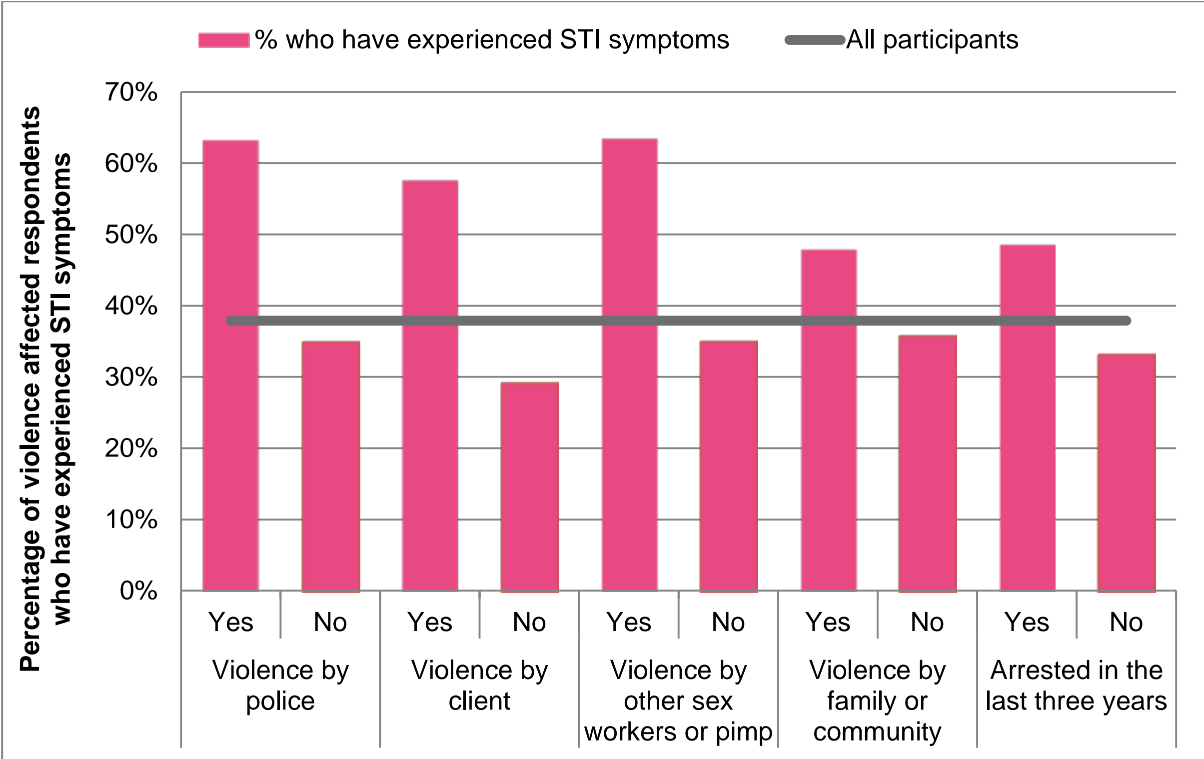
The survey also shows a clear relationship between drug and alcohol risk and STIs, as an indicator of consistent condom use (Figure 23). 77% of daily substance users and 48% of moderate users had experienced STI symptoms.

Figure 23: Relationship between STI symptoms and risk to safety as a result of drugs and alcohol



Finally, STI rates - and presumably effective HIV prevention - are significantly correlated with every form of violence, including arrest by the police. The UNAIDS position, that the criminalisation of sex work is a direct driver of HIV prevalence, is supported by the data in this survey (Figure 24).

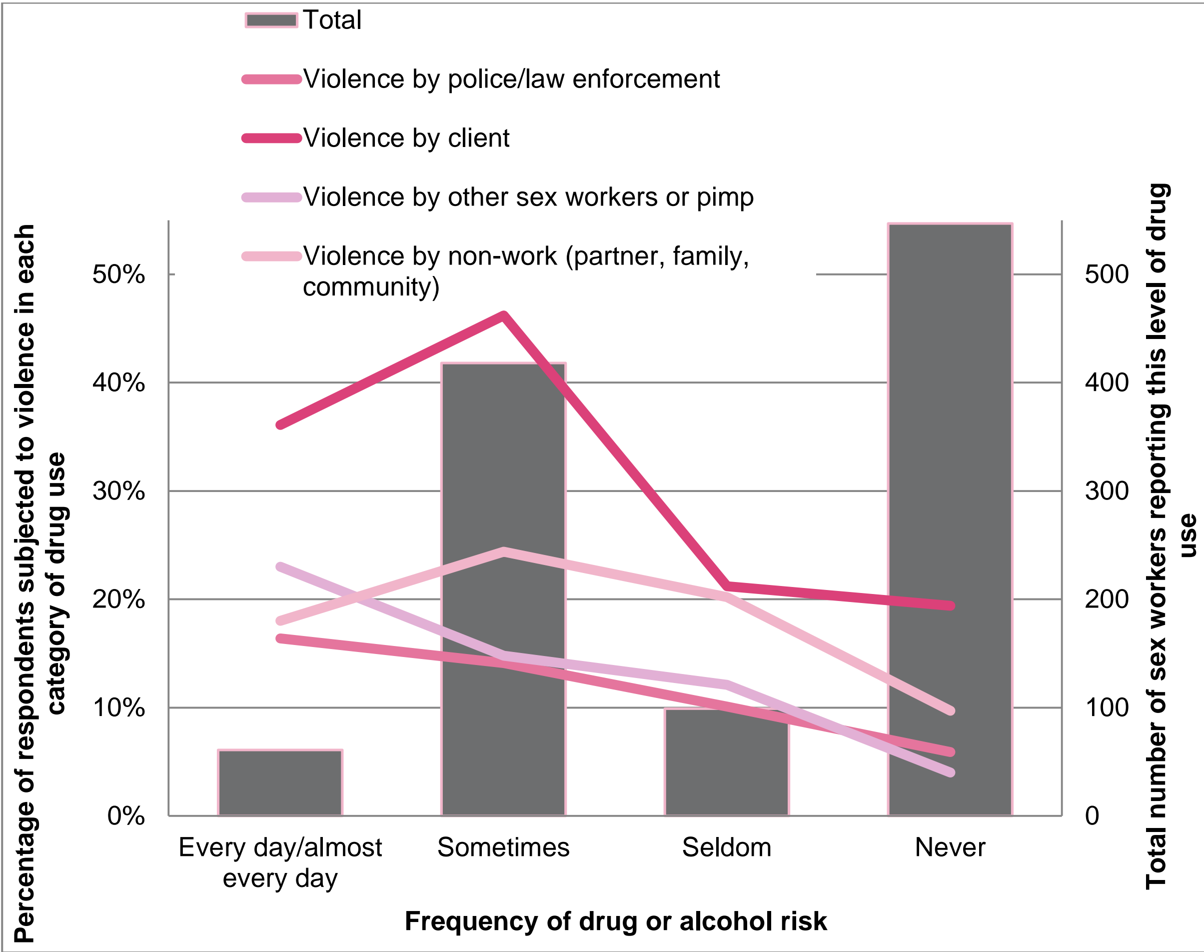
Figure 24: The relationship between STI rates, and violence or arrests



8.7.4 Drug and alcohol use, abuse and exploitation

Drug and alcohol use by sex workers is common, with 43.1% of sex workers stating that they are at risk as a result of using drugs or alcohol every day or sometimes, and at some sites informants estimated that 80% of sex workers routinely use drugs. There are some sites at which the sex work culture does not include substance abuse, and respondents all confirmed that excessive alcohol or drugs were generally not used. The survey clearly confirms the extent of the relationship between drug use and safety (Figure 25), with daily drug and alcohol abusers most at risk from the police and each other, and people who describe themselves as 'sometimes at risk' being most at risk from clients.

Figure 25. Relationship between drugs and alcohol (responses to the question "how often are you in a risky situation due to using drugs or alcohol) and sources of violence



Peers mentioned the common use of alcohol, dagga and cocaine in rural Mpumalanga, and at least one instance of a sex worker's death as a result of drugs (Peer educator FGD). Other substances included:

- CAT/khat/ntash, umgwinyo/FF/ecstasy and herione in Gauteng
- nyaope/whoonga, prescription codeine and cough mixture in North West
- ndanda/mandrax, nyaope and glue in the Free State
- whoonga, ntash, mandrax and tik in the Eastern Cape
- tik in the Northern Cape

Widespread use of tik/methamphetamine is reported in the Western Cape. Transgender and male sex workers mentioned using poppers in association with anal sex.

"Sex workers feel strong when they are on drugs." (Peer educator FGD).

"Almost all the sex workers use drugs and alcohol. When using drugs, the sex workers feel more powerful and think they are able to attract more clients" (Sex worker FGD).

"I do drink alcohol a lot. I feel that when I'm drunk I feel more energetic and not scared. I also take dagga, and some of my clients also smoke. The dagga makes the sex more enjoyable." (Sex worker FGD)

"They will tell you they have to use alcohol and drugs to be able to do the job, as it is hard to do the job." (KI Interview)

"Most of the girls are on drugs in order to be able to numb their emotions to 'perform' our trade. This affects the costs and being paid properly." (Peer educator FGD).

"You just can't work when you are sober. You need bravery derived from something intoxicating so that you disturb your common sense a little." (Sex worker FGD).

"Sex workers use alcohol and/or drugs, otherwise they are not strong enough to deal with the work that they do, so you can drug yourself to work". (Peer educator FGD).

"For them to survive, it's drugs and alcohol…They tell you that they cannot do these things that they don't want to, without being under the influence, so that they do not have to feel this thing that they won't want to be doing…Alcohol and drugs is part of their job." (KI interview).

Drugs are also used to extend working hours: "These women always seem to be on drugs and have little time for sleep as they are often seen to be working all day and all night." (Peer educator FGD).

"It makes us forget about the work that we are doing. Even if we have a flu or fever we can still take the dagga without feeling pain in the chest" (Sex worker FGD).

For people living in severe poverty, drugs are cheaper than food: "Sex workers are not getting food. Drugs are much cheaper than food and take your mind off of hunger, tiredness and discomfort." (Management interview).

In brothels in organized sex work hotspots, specifically in Hillbrow, some prevention of drug abuse is achieved by brothel management prohibiting drugs or sex workers (who are high) from being on the premises.

"The rules are that there is no drinking. It is too dangerous for the sex workers if they are drunk. And no drugs." (Peer educator FGD).

In some sites, drugs are linked to mutual dependency on sex work and drug addiction. Controlled sex workers who work for pimps are "*always high because they are trapped with the drugs by their controllers. They will kill you if you cannot pay the drug money. You don't get money, you just work for the drugs. When you are useless or sick they just throw you away*" (Management interview). A sex worker reported how controllers attempted to trap him, recounting how they keep the sex workers indoors and give them drugs to get them high. They then only let the sex workers out when they know they are hooked.

"Those controlled by pimps usually get paid with drugs and often have to work non-stop. The pimps occasionally buy them clothes but that's all." (Sex worker FGD).

A Creative Space in George, devoted to substances abuse, found all of those present stating that they had first used drugs and then entered sex work. A pattern of exploitation and instigation was described, involving drug merchants engaging under-age youth by persuading them to exchange sex for drugs, and then continuing to demand sexual services for their clients in exchange for access to drugs (KI interview).

In this context sex workers have a dual role as drug carriers, supply chain or client links, and are often part of the local drug supply system providing both sex and drugs to clients.

Used excessively, the livelihood gained by sex work is rapidly lost to substance abuse.

"When you abuse drugs, you never see where your money goes. … we work all night but have nothing to show for it because it all goes to drugs." (Peer educator FGD).

"I had been doing sex work for three years, but because of drugs (CAT) I had no money and no shoes. I was working for drugs." (Sex worker FGD).

"Others are doing it (sex work) because they want to do it, but most of them because they truly need the money - they do transactional sex for drugs (tik, smoking) …. Some of the sex workers are now even doing the sex work just to get the drugs." (Peer educator FGD).

Drugs and alcohol tend to blur the line between transactional sex and sex work. For example, if there is a strong drug culture in the sex work community *"people have sex for a beer and do not see themselves as sex workers. But people might acknowledge that they are sex workers, but might have sex for drugs as an addiction and a need.*" (Management interview).

Exacerbating the existing sense of humiliation and battered self-esteem of many sex workers, SANCA describes how drug addiction is strongly linked to resentment, shame, guilt and fear of judgement. At some sites, there is some referral to rehabilitation services for sex workers, although in numbers that are probably negligible in relation to the level of abuse.

Besides leading to child neglect and severe poverty, drug abuse greatly increases physical risk of all types, including violence, rape, unprotected sex, not being paid, being abandoned and being arrested.

"Drugs have a high impact on sex workers, clients are often high and can be rough." (KI interview).

"I think alcohol and drugs can affect sex workers in condom negotiation. Their judgement can become compromised." (KI interview).

"When sex workers are high or drunk, they misbehave. They expose themselves, flash, and become unruly." (Peer educator FGD).

8.8 Self-esteem, psychological health and social capital

8.8.1 Trust and openness for greater sex worker accessibility

RELATES TO THE IMPACT:
Better health and social wellbeing

As a marginalised, abused, and victimised population, sex workers have historically remained aggressive, hidden, and extremely cautious of contact. This has substantially shifted in all programme sites, and has been a major programme outcome.

"They make time for the peers. Before it was like they want to kill us but now they will engage. It went from 0 to 80%....they have lowered their guard and have higher trust now". (Peer educator FGD).

"At first they could not believe us, as they had been promised things before. There was no trust for anybody." (Management interview).

"We have gained trust from the sex workers, which is very important. They know that they can come here with their problems and be referred to the relevant people. They know now that we are addressing their needs holistically, rather than just the health" (Management interview).

"Sex workers trust us now. They can confide to us." (Management interview).

"Now they are all coming out. All the LGBTI sex workers are coming forward. It is easier to find them through Red Umbrella." (KI interview).

The primary reason for programme success in building trust is the use of a peer-based model.

"It is easy for us to access sex workers because the peers are sex workers themselves." (Management interview).

8.8.2 Sex worker self-esteem, knowledge and confidence

A major step in enabling sex workers to stand tall in the community, to destigmatise themselves, to express self-respect, and to take care of their health, is accepting their work as worthy of respect. Without this respect, 'reckless' behaviour becomes something of a release. This is a major thrust in the programme, and has been important and effective.

"They are proud about belonging to a group. Most have now claimed their identity as a sex worker – there is huge growth now in terms of admitting that they are sex workers and owning their health status and knowing there are opportunities for them." (Management interview).

"Self-esteem has improved because they are treated with respect and care by the peers." (Management interview).

"I used to be ashamed of being sex worker, or being seen with my older client but not anymore" (Sex worker FGD).

Knowledge and affirmation of the importance of this knowledge, and the value of the sex workers who have it, have been a valuable programme outcome.

"There have been a lot of changes. Before Red Umbrella, so many sex workers did not know about their safety, status, condom usage. Peer educators have been taught everything and passed this over to sex workers including not to get drunk on duty, and how to approach not being paid for service." (Management interview).

Sex worker knowledge has directly influenced stigma and created greater respect and acceptance as sex workers expertise in matters of SRH is understood and acknowledged.

"The community used to call us names, but now they want us to teach them. They ask questions when they have discharge. The Red Umbrella program has helped to reduce the stigma and discrimination." (Peer educator FGD).

A direct benefit of confidence has been sex workers' greater ability to demand payment, preferably before providing a service. Non-paying clients are a major challenge for sex workers, and conflicts often lead to violence. Sex worker ability to be assertive for payment up-front has improved their conditions.

"We have rights. In the past we didn't know that we had rights. I demand the money before I give the service." (Sex worker FGD).

8.8.3 Better social acceptance for sex workers

While the police are far more supportive and tolerant around sex work and its manifestations, there are behaviours that their wider community finds difficult to manage, and where the police have conflicting demands. Flashing is commonly mentioned as being difficult for other community members to tolerate. The police invoke the 'flashing by-law', discouraging indecent exposure in public places by sex workers. *"If only they would wear underwear*." (KI Interview).

"They are taking better care of themselves in terms of health and even general hygiene and decency …. After some negotiation with the community, brokered by the SR, sex workers have agreed to stay fully clothed on the streets until after 21h00 when the children are no longer exposed to them." (Management interview).

At virtually all sites there are reports of sex workers uplifting their own hygiene, dignity, self-respect and public image, compromising with regard to social norms around dress codes, and in many cases focusing on dressing smartly, rather than provocatively.

"We have changed the way we look. We don't look like we are from the streets. We look clean, we dress properly, and we don't eat from the dustbins. The people now respect us. We even look better than other people who are not in this business. We use decent, expensive toiletries so that we can feel and smell good. We keep the toilets clean for the municipality cleaners. We let them relax during the day and do the work so that we can be able to use the toilets and keep them clean." (Sex worker FGD).

"They dress up for Risk Reduction. Previously they didn't worry about how they look. Now they look after themselves". (Management interview).

"In 2014 we had a first engagement with the Gauteng legislature where we invited 500 sex workers from all around, and where people were drunk and inappropriately dressed and carrying alcohol. We have done one recently again, and no one could tell that the respondents were sex workers." (Provincial manager interview).

This has brought far greater social acceptance from police and communities.

8.8.4 Solidarity and social cohesion

The programme has been a key instigator and motivator of a greater sense of community, mutual support and solidarity at all sites.

"Things have drastically changed from… when we did not have [the SR]. It was 'is'febe nes'febe bekuwu mazibonela' (every whore for themselves)" (Peer educator FGD).

"There is now more networking, and this brings less fighting among sex workers" (Peer educator FGD).

The main programming element supporting solidarity has been the collective spirit achieved through risk reduction workshops.

"With Creative Space there is more watching out for each other. They are more likely to work together. … A sex worker needs other sex workers. The [SR] family thing has tapped in with the Red Umbrella programme. We aren't talking about 'them and us' – but about all of us" (Management interview).

One of the key outcomes of greater solidarity has been sex workers warning each other against violent or non-paying clients, and taking greater notice of each other's movements and vulnerabilities.

There are a range of other practical and valued benefits to greater community solidarity:

> ***"Now there is more responsibility for one another. They take care of each other and make sure the next person is taken care of if sick. They also work together to send bodies home. They will come with you to court if you get arrested." (Management interview).***

8.8.5 `Skills development, career paths and long-term livelihoods

It is acknowledged that for most sex workers, sex work is an occupation for a phase of their lives. Transition out of sex work might be held by the programme philosophy to be largely irrelevant, but to sex workers themselves, professional progress, livelihoods options and alternatives are of great interest and importance. As for anyone, sex workers have desires to *"grow as people"*. The programme encourages them to *"have dreams"*.

> ***"I got to start my own catering business because of the skills I learnt here that there was more I could do with my life." (Sex worker FGD).***

8.8.6 Impact on peers

One area in which substantial impact has been made is the training of peers, and the contracts and stipends for employees. Many peers left sex work and gravitated entirely into this stimulating, safe, companionable and more pleasant professional life, even if in some cases it involved a decrease in income. They learned skills and gained confidence, and built a CV and a network of professional connections that would have been difficult to achieve for them through any other route. In addition to their peer work, some have started studying or have opened new businesses. To the extent that they continue to have a range of livelihoods options, this will be a concrete and powerful release from severe poverty and a programme impact.

> ***"In Gauteng, we have over 100 peers who were SWs who now have more on their CV than just sex work. Some have become site coordinators elsewhere." (Provincial manager interview).***

> ***"Most peers are leaving sex work for the most part. A few have diversified into other businesses." (Peer educator FGD).***

> ***Peer educators are seen as role models and there seems to be light for them to stop working once they become peers. Now they work to uplift rights of the others – they now have respect of the community – you see a huge change in the peers" (KI interview)***

> ***"Peers can stop doing sex work now if they choose as they are not desperate, and needing the R200 from a jump" (Management interview).***

However, to the extent that they have no alternatives but to return to sex work, this experience is traumatic and dehumanizing.

8.9 Negative outcomes

8.9.1 Safety of programme staff

Due to the clandestine nature of sex work, many of the sex work locations are very dangerous, and frequented by dangerous clients. This means that programme staff place themselves in danger for their work daily. The programme is not well equipped to ensure safety of peers.

8.9.2 Programme closure at sites

The programme closure at the majority of sites constitutes a serious concern, and effective handover to local authorities is essential to avoid negative impact. Trust has been built with dedication, innovation, commitment and delicacy. It can be easily destroyed.

> ***"Take ownership of their spaces and their community. There is a lot more community. This comes from regular contact. They trust that we will be back, so they don't hide anymore." (Provincial manager interview).***

It may be difficult for national and global programme decision makers to identify with the organisational and individual trauma of frequent major changes in priorities and direction.

Sex workers have been profoundly helped in the last three years, have built a sense of dignity, worth and humanity. Humanisation comes through as a powerful theme in building sex workers' capacity to make healthy life choices.

> ***"They know that they are also human beings and should be treated with respect" (Management interview).***

To realise that this sense of humanity was an illusion - and rather than being seen as human, they are seen as a 'site' - has potential for profound negative impact both for participants in this programme and for the process of trust building in programmes to come.

The following exchange highlights the response at one site to hearing news of the programme's discontinuation, having only begun to establish in the last 3 years:

> ***"All of a sudden the site is closed down. We are not going on to the next phase …..***
>
> ***What's going to happen to all of our sex workers and staff members? I don't understand this. You guys were so impressed with how things are going on here …***
>
> ***The sex workers need us – we can't just leave them like this – we have built up hope and now this. ….***
>
> ***I never saw so much tears like today.***
>
> ***One of the peers didn't take it too well and we found her starting to drink pills.***
>
> ***This is what Global Fund causes.I totally give these people doing this to God – he will deal with them."***

And another site:

> ***"The definition of a key population is people who are neglected and forgotten. This is exactly that." (Management interview).***
>
> ***"They stop, and you ask, why did they even start... How do you justify going to Gauteng and leaving us here? There are too many areas not covered, with many many sex workers. … out of the way, who need serious intervention." (Management interview).***

9. RECOMMENDATIONS

The key recommendation is that the programme is continued at these sites. Good traction has been achieved and outcomes and impact are being seen at sites. As the Global Fund is not continuing to fund all sites in Phase III, it is urgent that SRs find other funding, or that NACOSA or SANAC or DoH steps in, to maintain the programme in some way. It is recommended that a working group investigate feasible ways to ensure that the programme's successes to date are not wasted.

Other recommendations follow.

9.1 Building partnerships for sustainability

It is important for SRs and NACOSA to continue to work with government to ensure linkage to care, so that they are able to provide non-discriminatory and friendly services to sex workers. It is vital that these services include comprehensive support to the sex workers and links to GBV services which are also sex worker-friendly. One area which should be explored is a partnership between Red Umbrella peers and the DoH's High Transmission Area mobile clinics that were mandated to be rolled out in 2014. There are examples of very effective partnerships.

9.2 Strengthening health services

9.2.1 Targeted HCT promotion to replace a programme focus on HCT

Instead of a strong drive for blanket HCT after the first year or two of HCT campaigning, a targeted computerised follow-up system is recommended which sends personalised messaging for either repeat testing, immunity monitoring or medication dates, depending on HIV and treatment status. This can also be used to share dates for meetings and campaign announcements with everyone on the system. Testing should then be easily accessible at Creative Space, mobile clinics and/or the SR premises, by a nurse or counselor who can also advise on any health or psychological concern.

9.2.2 ART roll-out and adherence support

Given very high HIV prevalence in this key population, ART is a major area of focus. Programming should focus on peer mentorship after testing to ensure entry into care, defaulter follow-up, community-based integrated chronic medication dispensing, and adherence clubs. Adherence clubs and defaulter tracing are part of the DoH formal practice, and are a valuable entry point for cooperation between sex worker programmes and DoH.

9.2.3 A focus on senisitising health facilities and health providers

Following the good practice achieved with the police, SRs should engage more energetically with the public health sector. This is more sustainable and comprehensive than attempting to create parallel services, and better supports health systems strengthening. The health sector is far less accessible than the police, and engaging with facilities and extremely over-worked health workers is more challenging. Strategies that should be used in a multipronged approach include:

- sex worker education on rights
- health talks in clinics that destigmatise sex work and openly discuss STIs in particular
- accompanying sex workers to clinics

- educating clinic staff in personal engagement
- inviting health care workers to Creative Spaces
- formal sensitisation workshops
- working for community platforms to engage with primarily healthcare clinics, including health care workers in multi-stakeholder dialogues and other forums
- participating in DoH campaigns (e.g. World AIDS Day events) and keeping sex workers' rights on the agenda and raising public awareness during these.

It is noted that STI reporting is a critical entry point, and engagement with clinic staff around attitudes and engagement for patients reporting STIs is the first priority.

9.2.4 Sustaining the Red Umbrella condom achievements

Condoms have been a major programme achievement, but could ultimately produce negative outcomes if the service is stopped. If Red Umbrella condoms no longer flood the workplaces of sex workers, and if condom access habits and routines have been disrupted, access to condoms is likely to relapse. While the programme has shown that flooding the market with popular and well-accepted condoms is effective, provision of Red Umbrella and/or an equally accepted condom (ideally several condom options) into these spaces is critical if the programme's long-term impact is not to be reduced, regarding condom uptake. It is recommended:

- That the principle of bulk distribution outside of medical facilities be continued
- To continue to supply Red Umbrella condoms in abundance across the country, including to clients who request them
- That rebranding of Choice condoms and the inclusion of new flavours is valuable, although the new branding is not as sexy as that of Red Umbrella
- To consider adopting the Red Umbrella logo to endorse other brands as part of national branding
- To change the lubrication packaging so that resources can be used more efficiently.

9.2.5 Mental health professional services

In the absence of sufficient professional psychiatric or mental health services, combined with a highly traumatised and psychologically unhealthy target group, it is recommended that the national network of Lifeline and other appropriately trained psychological support agencies be actively engaged in national programming for sex workers as a rare resource and a nationally scaled service.

Mental health and trauma support services should be extended to programme staff too, as they face the pain of the sex workers daily (peers are mostly sex workers themselves too which means that they face double trauma).

9.3 Better legal services and access to justice

9.3.1 Legal rights education extended

Sex workers have gained excellent knowledge of their rights in the event of being arrested for sex work. There seems to be ignorance, however, of the role of appropriate legal support, and poor access to legal support. There is an opportunity to include legal rights and access processes into training for sex workers on their rights. Legal Aid as a national resource, or a similar national-scale professional and free legal service should be prioritised for partnership in national sex work programming.

9.3.2 Continued engagement with the police and the decriminalisation movement

Police behaviour is clearly shown to directly impact on health and HIV. Ideally, under decriminalisation: full services, rights and removal of tension caused by police would be resolved, and the rights of sex workers would be legislated. In the interim, the evaluation has demonstrated that the police are amenable to more constructive community services, and that engagement with the police in all municipalities in the country would be low hanging fruit, providing relatively easy achievements for massive impact.

9.4 Sensitising clients and community

Creative and innovative programmes to work with clients must be developed. A feasible idea is to work within the employee wellness programmes at mines, transport and trucking companies, farms, and other areas of mobile men. In addition, efforts must continue to be made to engage with clients at taverns and bars and truck stops.

It is important that continuous community engagement is maintained to sensitise the community and to reduce stigma against sex workers. Two key groups to involve, and to gain support from include traditional leaders and faith-based leaders.

9.5 Building on a strong brand

The Red Umbrella brand is used globally and nationally, and has grown to have close connotations with sex worker support. The Red Umbrella Programme has been visible to sex workers and communities, and is associated with broad sex work support. Having built up a strong brand, it is recommended that the national sex work programme as a whole consider adopting the Red Umbrella brand, integrating programmes under the sex work NSP, and diluting the artificial separation between Global Fund programming and the continuum of care that sex workers receive through other funding sources.

9.6 Adequately resourcing key programme elements, and encouraging flexibility in implementation

9.6.1 Further resources

To maximise the impact that the programme has, it is recommended that further resources are allocated to Creative Space workshops and to transport of the peers. Ideally, each outreach team would have a dedicated vehicle with a driver. Creative Spaces need to be extended to meet the demand for them. Peer stipends are also far too low, and need to be raised to value the work of the peers, and to reduce the high staff turnover rate.

Additional focused support groups should be developed, to cater for the specific needs of groups. A support group for PLWHA can serve as an expanded “adherence club”.

9.6.2 Further and ongoing training

Peers and coordinators need to be regularly trained, on an ongoing basis, as HIV knowledge is constantly changing and they need to be up to date. In addition, high staff turnover means that new members arrive regularly and need to be given basic training. Much more paralegal and HCT training is needed.

9.6.3 Ensuring safety of programme staff

It is also important that safety measures are put in place for programme staff as they need to work in dangerous places, frequented by dangerous clients. This should include self-defence training for staff, but each site should also have a safety plan that is suitable to that context.

9.6.4 Encouraging flexibility in implementation

Budgets should be flexible enough to allow SRs to implement the programme in a way that suits their context. Currently, line items are fairly rigid and it is difficult to negotiate to spend budget differently to how it was conceptualised. Targets are also prescriptive, and should be textured according to types and depths of outreach.

9.7 Resources for programme administration and management

It is important that any funder of the programme support programme administration and management costs (high level management to an adequate number of team leaders), including financial management and monitoring and evaluation.

This should include remuneration for intellectual input to the programme from SRs. Currently, any intellectual input is voluntary.

9.8 Funding cycle to follow project implementation cycle

The way that the programme cycle is set up does not allow for the evaluation results and evidence to inform the next phase of the programme. Concept notes for the next phase are currently submitted before the evaluation takes place. Evaluations should be better planned and resourced so that they are more effective and utilisation-focused.

9.9 Better participation and feedback

In line with the good practice principle of “Nothing about us without us”, there should be more participation in the programme from SRs and from sex workers, particularly in the design of the programme and submission of the proposals and concept notes to funders. It is reported that there are many requests for information to go “up” to NACOSA, but very little feedback and information comes back down to the SRs and the sex workers. It is very important that the findings of this evaluation are shared in a user-friendly manner with the SRs and the sex workers that they serve.

9.10 Strengthening sisonke

As Sisonke is receiving formal funding in the next phase, it is important that they are mentored and supported to manage the money and to deliver, as well as to develop a strategy that is attractive to funders but also meets real needs on the ground, and to build and sustain a strong movement. One of the issues that ought to be addressed is the membership fee.

9.11 Integrating programme with gender based violence work

Human rights violations and violence against sex workers will not significantly improve if the sex work continues to be within a context of seriously high levels of gender-based violence (GBV). Therefore, to really make an impact, it is important that GBV is addressed as part of the programme, and that the programme partners with other organisations that work on this issue.

10. CONCLUSION

Phase II of the Red Umbrella programme can be deemed to have been successful. All outcomes in the theory of change have been realised to some degree, some more than others. A significant difference has been the reduction of violence from police. Further engagement with health services and access to legal and psychosocial services should continue to be improved, although some improvements have already been made in terms of accessing services. Sex workers themselves are generally more knowledgeable, empowered and networked, and display increased and improved health-seeking behaviour.

While there are various improvements that could be made to maximise the impact of the programme, it is vital that funding is secured and that partnerships are built to sustain the programme at the sites at which the programme is currently running, so that the enormous progress that has been gained in this phase is not lost. This is particularly important to maintain the hard-won trust that has been gained from sex workers across the country.

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APPENDIX 1

Summary of a detailed overview of laws and human rights instruments relevant to sex workers

Compiled by Stacey-Leigh Manoek at the Women's Legal Centre.

Source	Section	Objective
South African statutes on rights and sexual laws that affect sex workers		
South African Constitution	10	The right to dignity
	9	Right to equal protection and benefit of the law
	9(3)	No discrimination, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth
	12	The right to freedom and security with respect to detention, trial, violence, torture, cruelty, degradation
	35	Detained persons taken to court within 2 days, informed of reasons for arrest, released if in the interests of justice
The Sexual Offences Act 23 of 1957		Prohibits:
	20(1)(aA)	Unlawful carnal intercourse or act of indecency with any other person for reward commits an offence
	2	Brothel-keeping
	10(a & b)	Recruiting a person to work as a sex worker or to work in a brothel
	12A(1)	Knowingly live off the earnings of sex work (e.g pimping)
	19 (a)	Soliciting – direct physical invitation through words, gestures, signs or display
	19(a & b) 20(1)(b)	Indecent exposure in view of the public and public indecency
Amendment Act 32 of 2007	11	Criminal Law (Sexual Offences and Related Matters) Amendment Act 32, criminalises clients, by prohibiting: Engaging services for financial or other reward, favour or compensation for the purpose of engaging in a sexual act, irrespective of whether the act is committed or not
Municipal By-Laws		Prohibit loitering, drunken behaviour and soliciting for the purposes of prostitution. However, by-laws relating to arrest require that: a) A written notice to stop the offending activity be issued OR the person be fined or given a notice to appear in court b) A person who has been fined should have an opportunity to contest the fine c) If a fine has not been paid, a summons to court should be sufficient. Arrest is a last resort to secure attendance in court.
International treaties on rights		
South Africa has signed and ratified many international treaties pertaining to human rights that are relevant to protection of sex workers from violence and abuse. Most focus on respecting, protecting and fulfilling human rights of the most vulnerable people, those who are marginalized by social institutions and subject to human rights abuses		
International Covenant on Civil and Political	Art. 6	The right to life, which must be protected by law
	Art. 9	The right not to be subject to arbitrary arrest or detention
	Art. 26	The right to equality before the law and equal protection under law

Source	Section	Objective
Rights of 1966 (ICCPR)	Art. 2.3	The right to an effective remedy for violations of rights or freedoms, notwithstanding that the violation has been committed by persons acting in an official capacity
International Covenant on Economic, Social and Cultural Rights of 1966 (ICESCR)	Art. 6.1	The right to work, including the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts, with appropriate safeguards for this right
	Art. 7	The right to enjoy just and favourable conditions of work, including a fair wage and decent living, and safe and healthy working conditions
International treaties on the rights of women in particular		
Many references to sex work focus on the rights of sex workers who have been trafficked and are being exploited, and do not protect the rights of those who work voluntarily as sex workers		
Convention on the Elimination of All Forms of Discrimination against Women of 1967 (CEDAW)	Art. 1	Eliminate all forms of discrimination against women
	Art. 6	Take all appropriate measures, including legislation, to suppress all forms of trafficking in women and exploitation of prostitution of women
	General Recomm-endation 19	"Prostitutes are especially vulnerable to violence because their status, which may be unlawful, tends to marginalize them. They need the equal protection of laws against rape and other forms of violence."
Declaration on the Elimination of Violence against Women of 1993		Defines gender-based abuse as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty. Responsible public officials to prevent, investigate and punish violence against women, and should receive training to sensitize them to the needs.
Beijing Declaration and Platform for Action of 1995		Promote "gender mainstreaming" in policies and programmes and undertake other concrete actions in an effort to eliminate all forms of discrimination against women in both public and private life
African instruments		
African Charter on Human and People's Rights of 1986		Guarantees the rights of all individuals to equality, dignity, work under equitable and satisfactory circumstances, health and freedom from exploitation
Protocol to the African Charter on the Rights of Women of 2005	Article 3	Protect women from all forms of violence "particularly sexual and verbal violence."
	Article 4(2)	Enactment and enforcement of laws prohibiting all forms of violence against women "including unwanted or forced sex whether the violence takes place in private or public."
Addendum to 1997 Declaration on Gender and Development by SADC Heads of State of 1998	Para-graph 5	In condemning all forms of violence against women and children, makes specific reference to sexual abuse, sexual harassment and intimidation, trafficking in women and children and forced prostitution
SADC Protocol on Gender and Development of 2008		Empowerment of women, elimination of discrimination and achievement of gender equality
	Article 7	The enactment of legislation to promote and ensure equality for women - including ensuring equality for women in the criminal justice system and addressing gender bias and stereotypes

Source	Section	Objective
Legal national and international analysis on criminalisation of sex work		
SA Law Reform Commission Discussion Paper on "Adult Prostitution"		The current legal position of prostitution needs comprehensive review. Obligation to realise various rights such as dignity, security of the person, equality and equal access to the law and access to health care, as well as to provide effective remedies for violations of rights, must inform the decisions of the legislature.
United Nations Report of the Special Rapporteur[25]		Decriminalisation, and appropriate occupational health and safety regulations, would safeguard the rights of sex workers. Recommends that States repeal all laws criminalising sex work and surrounding practices and establish regulatory frameworks within which sex workers can enjoy the safe working conditions to which they are entitled.
UN High Commission for Human Rights, Annual report		Recommendation that member states reform and monitor laws that impede effective HIV responses, including removing punitive criminal laws used repressively against sex workers.

[25] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, 27 April 2010, page 14, para 46.

APPENDIX 2

Theoretical framework for the evaluation: realist evaluation

In any programme, the context in which the programme operates is vital. This is particularly important when an evaluation has an explicit purpose of determining the effectiveness of the projects. A ***realist evaluation*** approach (Pawson and Tilley, 1997) is being taken to this assignment, asking not only *"what works?"*, but *"what works for whom, in what contexts, and how?"*

Some factors in the context may enable particular change mechanisms to be triggered, while other aspects of the context may prevent particular mechanisms from being triggered. There is, therefore, always an interaction between context and mechanism. This interaction is what creates the programme's impacts or outcomes:

IMPORTANT ELEMENTS AND IMPLICATIONS OF A REALIST EVALUATION ARE:

- Programmes "work" in different ways for different people (ie programmes can trigger different changes in different participants).
- The contexts in which programmes operate make a difference to the outcomes they achieve ("contexts" include features such as social, economic and political structures, organisational context, programme participants, programme staffing, geographical and historical context etc).

Realist Evaluation

Because programmes work differently in different contexts and through different change mechanisms, they cannot be replicated exactly from one context to another with the same outcomes being automatically achieved. Therefore, it is necessary to have a good understanding about "what works for whom, in what contexts, and how in order to identify key principles that can be portable. This is a key task of this evaluation.

A realist approach would make programme theories explicit about how, and for whom, programmes might "work" and then test these theories through the evaluation. This means that the data needed is not only about programme outcomes and implementation processes, but also about the specific aspects of the context that may impact on programme outcomes, and about the specific mechanisms that might be creating change.

Pawson and Tilley (1997) explain that "realist evaluation is a species of theory-driven evaluation", with commonalities to programme theory evaluation, and theories-of-change evaluation. *"In all of these perspectives social programmes are regarded as products of the human imagination: they are hypothesis about social betterment. Programmes chart out a perceived course whereby wrongs might be put to rights, deficiencies of behaviour corrected, inequalities of condition alleviated. Programmes are thus shaped by a vision of change and they succeed or fail according to the veracity of that vision. Evaluation, by these lights, has the task of testing out the underlying programme theories. When one evaluates realistically one always returns to the core theories about how a programme is supposed to work and then interrogates it - is that basic plan sound, plausible, durable, practical and, above all, valid?"* (p 2).

An important component of realist evaluation is to test a programme theory for the purpose of refining it. "Realist evaluations asks not, 'What works?' or, 'Does this program work?' but asks instead, 'What works for whom in what circumstances and in what respects, and how?'" (Pawson and Tilley, 1997, p 2). A realist evaluation has the following underlying understanding:

1. Programmes are **theories**: they are designed from an understanding of problems in society and an idea of how to solve these problems within the social systems in which they occur
2. Programmes are **embedded**: programmes are embedded in social systems and therefore it is important to understand the context and social realities of the programme.
3. Programmes are **active**: effects and change generally requires the active engagement of the programme participants.
4. Programmes are **open systems**: they cannot remain constant as they are situated in a shifting reality, and the programme itself is possibly shifting the reality.

Realist evaluation highlights the following four key linked concepts when it comes to understanding and explaining programmes:

1. *Mechanism:* often hidden, a mechanism is "what it is about programmes and interventions that bring about any effects"; a mechanism can be a step or a series of steps (Pawson and Tilley, p 6)
2. *Context:* the conditions under which the programme operates and their features (not just locality), understanding that certain contexts will support the programme theory whilst others may not
3. *Outcome patterns: "*intended and unintended consequences of programmes, resulting from the activation of different mechanisms in different contexts" (ibid, p 8); assess programmes not just on a pass or fail notion, but understand different patterns according to different contexts.
4. *Context mechanism outcome pattern configuration (CMOC):* bringing together differences in the underlying mechanisms of change and the differences in context to predict and explain differences in outcome patterns.

Realist evaluation empirically develops and tests CMOCs. A good evaluation is deemed to be one which is able to explain complex outcome patterns (Mark et al, 2002). A realist evaluation attempts to find the factors that make a programme successful and sustainable.

Steps in conducting a realist evaluation:

1. explicating the theory of change which is to be tesetd through the evaluation
2. collecting data that investigates the hypotheses
3. analysing the data against various CMOC hypotheses
4. Assessing and interpreting the analysis.

In a realist evaluation, the stakeholders have to play a role in designing the evaluation and in making sense of the data, therefore there is a partnership of sorts – the evaluator does not take a hands-off impartial approach, but has to work closely with the programme stakeholders. Realism rejects the notion of "attribution", "arguing that that programmes are active, and thus it is the operation of particular mechanisms acting in context that brings about change". If one were to attempt to determine whether the programme is bringing about the change, this requires the development and adjudication of rival explanations for the programme outcomes.

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