PEER-LED HIV AND SRH SERVICES FOR SEX WORKERS

Experiences from Médecins Sans Frontières in Malawi

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OVERVIEW

In Malawi, where poverty and unemployment remain high, many women turn to sex work – offering sexual services in exchange for payment of some sort – to support themselves and their communities. Malawi has one of the world’s highest rates of HIV at 8.9%. Prevalence is even higher among sex workers (SWs) at almost 63%, and HIV/AIDS remains the most common cause of death, with an estimated 13,000 AIDS-related deaths a year.

Although the country has made huge strides in fighting the epidemic, female SWs remain extremely exposed. With much lower access to health information and health care than others in the community, female SWs are over 13 times more likely to contract HIV than others and face much higher risks of unwanted pregnancies and sexually transmitted infections (STIs).

Female SWs are often criminalised; subjected to social rejection, stigma, discrimination, and violence. Too often, they are effectively excluded from government health services. Once on treatment, increased mobility and structural violence create challenges for them to access and remain in effective care.

This Médecins Sans Frontières (MSF) SW program started in 2013 and focused on health challenges associated with but not limited to HIV, beginning with a focus on SWs and long-distance truck drivers along the Mozambique-Malawi transport corridor. The emphasis became more site specific over time, and the project shifted to focus on the local female SW communities from 2017.

Following the World Health Organisation key population (KP) recommendations, a package of services was developed resulting in a SW-friendly and peer-led HIV, TB and comprehensive sexual and reproductive health (SRH) package of care. When seeking to engage with SWs, employing and training those who themselves have experienced the challenges and dangers associated with sex work, had an impact on uptake of service.

Based in the semi-urban towns of Dedza, Mwanza, Zalewa and rural remote Nsanje, the project evolved to become a peer-led, patient-centred, “one-stop” HIV, TB and SRH service delivery model for SWs, integrated into the Ministry of Health (MoH) clinics, with additional services delivered in the community, alongside the MoH services.

SW empowerment and health education, as well as supported navigation to MoH services and awareness training for MoH staff ensured that many SWs were able to increase access to health services and improve follow-up care.

MSF collaborated with the MoH and partners in Malawi to support the implementation of client-centred models of differentiated service delivery along with sensitisation of all staff to SW-friendly approaches. The project saw progressively reduced levels of stigma against SWs in these sites, as well as a positive impact on SWs’ access to HIV and SRH care.

Recognising that adolescents who sell sex face even bigger challenges in accessing health care, dedicated activities to improve engagement and service provision for this highly vulnerable group were implemented in 2019, with promising results.

By December 2020, almost 7,000 SWs had enrolled in MSF’s Malawi SW project since inception, of which 756 were aged < 18 years.

Approximately half of all enrolled SWs were HIV-positive, and in the last year, 1,365 had remained active in MSF-supported care. Thanks to the treatment they received, by the last quarter of the program we reached 86.9% Viral Load suppression among all women who had a viral load done (318 of 366 women), meaning that the women were able to take their treatment well, they were more likely to stay healthy and less likely to transmit the HIV virus in the event of unprotected sex.

As the project prepared to exit, the community component was partially taken over by the newly formed female sex worker community-based organisations (CBOs). Sex Workers Empowerment Alliance Dedza (SWEAD) and Tikondane in Zalewa site became operational and engaged with the MoH to take responsibility for service provision to support female SWs in their communities. These opportunities to continue building ownership among beneficiaries show how much female SWs have been empowered over this period.

With MSF-Belgium’s departure from Malawi, this document aims to capture lessons learned and share the experience of providing peer-led KP services.
In the design of healthcare services for female SWs, MSF found the following core principles to be essential:

**Peer-led service delivery**
Access and delivery of care to female SWs and other excluded populations is critically dependent on a trained, paid, peer cadre working with sensitised healthcare workers.\(^{10}\)

**Providing ‘One-Stop’ services**
A package of care including HIV, TB and SRH services should be provided at the same site, on the same day, ideally by the same healthcare worker. Each additional venue a female SW must visit to access all their health needs represents an additional barrier.

**Strategic mix of MoH and NGO/CBO services**
The provision of “friendly” MoH-led services where SWs can access care along with the general population is essential. However, such services are often far from the reality. While moving towards integration into MoH services, fully-funded, community-based services specifically for SWs, which are run in parallel with MoH services, need to be facilitated through effective community engagement. The sustainability of such services is a major challenge and should be prioritised.

**Advocacy and activism to enable sustainable access**
The creation of an enabling environment for equitable access to health care for SWs is an essential component of effective programming. This entails support to local civil society organisations (CSOs) in challenging criminalisation of these populations and societal efforts to change attitudes. Moreover, offering tools to build community-based organisations (CBOs) and facilitating relationships with other SW affiliations should be initiated early on.\(^{11}\)

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10 Refer to topic: The Importance of Peer Leadership, p7
11 Refer to topic: Sex Worker-Led Community Building, p12

An MSF nurse mentor along with another MSF staff member engage with a group of sex workers during an outreach clinic in Nsanje. Photo © Isabel Corthier/MSF
What Services Were Provided?

One-Stop Clinics
The comprehensive package of care provided at the one-stop clinic was in line with the MoH recommended minimum package of care, and included: HIV prevention and treatment services, viral load monitoring, TB and STI screening and treatment, comprehensive SRH services, including response to sexual and gender-based violence (SGBV). However, MoH guidelines at the time did not allow for pre-exposure prophylaxis (PrEP) provision, which is an essential service for KPs according to WHO.

Community Outreach
Through community outreach, peers provided health education on topics including safer sex, HIV, TB and STI prevention, SGBV, hygiene, contraception, prevention of unsafe abortion, and cervical cancer. SWPEs conducted regular sessions in the community or in female SWs’ homes. They also provided female SWs with male and female condoms, lubricant, emergency contraception, initial doses of post-exposure prophylaxis (PEP) and navigation to the clinic for HIV testing and access to care, pregnancy testing, contraceptive care and as first responders for sexual violence providing psychological first aid and referrals to related services.

SWPEs are an essential link for female SWs to access medical and psychosocial care, legal and social services, as well as helping to ensure follow-up and tracing of beneficiaries.

In the community, Nurses along with Counselor Educators (CEs), were formally trained by MoH to provide and ensure HIV testing services (HTS), and assisted with beneficiaries’ enrolment and collected routine data. SWPEs were not allowed to conduct HTS because the MoH requires a specific level of education to access the training.

More recently, a task sharing exercise was implemented for SWPEs to recruit new beneficiaries, providing HIV self-tests (HIV-ST) in the community as well as conducting basic data collection. Data from Dedza demonstrated that peer-led delivery of HIV-ST improved reach and uptake of HIV testing and increased enrollment of SWs in the program.

Figure 1: Engaging Sex Workers across the HIV Cascade

HIV Testing
- Reaching and mobilising peer group clients to be tested
- Supporting HIV testing

HIV Prevention
- Mobilising and linking HIV negative clients to prevention services
- Providing condoms, lubricants and health education
- Tracing clients on PEP who are lost to follow up

HIV Treatment
- Linking and/or navigating HIV-positive clients to ART services
- Adapted ART delivery within ART group and other models
- Tracing clients on ART who are lost to follow up
- Treatment literacy and addressing stigma and discrimination
- Ensuring client’s viral load is done and results understood

Sex workers receive condoms and lubricant during a health promotion session conducted discreetly at a hotspot in Nsanje. During sessions, health workers distribute supplies of lubricant and male and female condoms, which become precious commodities for sex workers in protecting themselves from HIV and other STIs. Photo © Isabel Corthier/MSF
In the community, MSF hired SWPEs to deliver and link SWs to HIV and SRH rights-based services (SRHR). They were supported in the delivery of community services by MSF Counsellor Educators (CEs).

At the one-stop clinics, MSF clinical officers (COs) and Nurses provided medical services. The major institutional partner of the program was the MoH, and clinical staff, MoH Nurses, CEs and COs were available to fill the gap and support activities when needed. In Nsanje, outreach clinics were often done with a mixed MoH and MSF team.

SWPEs were engaged across the HIV cascade and played an important role as activists and advocates. Ongoing capacity building were important to ensure that messages were owned and passed within the female SW communities.

SWPEs were identified and recruited from the local areas based on their motivation, ability, talent, and knowledge of the vulnerabilities faced by SWs. SWPEs received a three- to five-day training workshop and spent time shadowing medical teams and Nurses providing comprehensive HIV/TB and SRH services.

WHO PROVIDED SERVICES?

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The one-stop services were provided at a static clinic in dedicated rooms within MoH premises in Dedza, Mwanza and Zalewa (District Hospitals and health centres). In Nsanje, services were delivered through outreach clinics that were hosted either on MoH facilities or in a rented space (like hotels, lodges, or private empty houses) usually located near SW hotspots. These places varied according to context and SWs’ specific needs and preferences.

The choice of where to provide medical services for SWs was decided with participatory consultation and mapping with both SW beneficiaries and healthcare workers. Options included:

- Mobile outreach clinic in the community or sites selected seasonally, run by an NGO or private provider alone or with the MoH.
- Standalone/parallel fixed site clinics run by an NGO or private provider.
- Existing MoH ART or SRH clinic with sensitised staff for female SWs.

WHERE WERE SERVICES PROVIDED?

SWPEs, CEs and Nurses or COs provided services in the community, such as bars, bottle stores, rest-houses, SW’s houses and residences.

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WHEN WERE SERVICES PROVIDED?

SWPEs were available daily (24/7), and with their healthcare teams during adapted working hours to suit SW schedules.

The one-stop services at static clinics were available during working days and adapted working hours. The one-stop clinics via outreach were conducted bi-weekly.

During this time, SWs were also encouraged to access medical services through the standard MoH service provision system, or through private clinics, such as as Catholic Hospitals in Nsanje District.

The timing of HIV testing and ART services were adjusted to the beneficiaries’ preference in both clinics and outreach services.

Enabling Continuous Treatment

Although Malawi is shifting towards 6-month ARV refills, this service often remains inaccessible for SWs because long-term enrollment in a cohort is put as a condition for access, ignoring the fact that this population tends to be quite mobile.

Funding, Costs and Continuity

MSF’s experience of providing SW services has demonstrated that care can be delivered in a collaborative way with the MoH, community-based organisations and SW communities themselves. Still, more needs to be done. Comprehensive health services adapted for SW needs must be fully funded and scaled up if the UN stated ambition to “leave no one behind” is to be more than just a slogan.

12 Refer to topic: The Importance of Peer Leadership, p7
The human resource (HR) structures that were set up in MSF Malawi are best viewed in two phases: Phase 1 (2014-2016) during which the project was focused on the Corridor, and Phase 2 (2017-2020), during which the project was more focused on the needs of local female sex workers.

The project sites had initially been conceived of as independent entities during the Corridor period, but over time they became more connected to the managerial team in the capital city, and the medical team became progressively more specialised, with the addition of dedicated positions such as Project Medical Referent (PMR), Patient Support Activity Manager (PSAM), and a Midwife, with direct technical and hierarchical links between the dedicated Project Coordinator (PC) and site managerial team.

The community teams were composed of Sex Worker Peer Educators (SWPE) employed as Community Health Workers (CHW), with a Patient Support Supervisor (PSS), Counsellor Educator (CE), and Nurse or Clinical Officer (CO) in each site. The inclusion of a Social Worker into the multidisciplinary team in 2018 was done to ensure referral of at risk and vulnerable cases to partners for social and legal support and to expand sexual and gender-based violence (SGBV) awareness and response.

In the earlier phase, the HR set-up was characterised by a “light approach”, with fewer managerial resources and a highly mobile staff that was shared between Mozambique and Malawi. HR structures progressively grew to shift the role and capacity towards increasing number of SWPEs, while reducing the number of CEs and other cadres. The significant increase in SWPEs and growing recognition of the importance of peer leadership is at the crux of the success of the project.14

“My relationship with fellow sex workers is good because when I go to the hotspot they don’t see me as MSF staff, but as a fellow sex worker as we are usually together at night... They look at me as their helper because we counsel and guide each other, and share the problems we are facing. [W]hen there is need to go to the hospital I accompany them.”

Sex Worker Peer Educator

**DEDICATED QUALITY STAFF**

- Direct and consistent involvement of SWPEs is essential as they know the local community and retain the institutional memory.
- The designation of dedicated medical managerial team positions can give a clearer medical direction to the project.
- The addition of a Social Worker to the project team improved linkages to advocacy and social support networks and helped expand SGBV awareness and care.
- Ensuring equal opportunities for all staff, together with continuous education, is key to creating a “safe” environment where staff with fewer formal qualifications also feel comfortable to share opinions and have a voice.
- When working with vulnerable populations as beneficiaries and staff, tools for sensitisation and awareness about harassment, abuse and discrimination are essential from the start and must be revisited periodically for all MSF staff. Transparent policies need to be in place, and material that is created together with and tailored to the specific audience should be available. Accessible channels for reporting of harassment and abuse should also be in place.
- Staffing policies should be taken into account, such as gender specificities and the vulnerabilities of the target population, ensuring an understanding of the context for female SWs and the power imbalances.

**Recruiting Sex Worker Peer Educators**

Female SWPEs are the essential part of a successful program. Identifying good candidates, recognising talent and interest, and mentoring those who show initiative can help create a formidable cadre. Key characteristics to look for include:

- **Social networks**: be living in the area for some time, be well connected with SW social networks, and demonstrate knowledge about local context and culture
- **Reliability**: be self motivated, easy to reach and dependable
- **Interactive skills**: have good communication skills, be a good listener and be able to show empathy
- **Organisation skills**: be able to plan ahead and execute tasks
- **Basic literacy**: be able to speak, read and write local language

Sex worker peers are the key to ensuring we hear their voices and speak out about the circumstances of SW’s lives, while ensuring we support their human rights awareness and empowerment, as well as linking with national and international sex worker networks, and thereby nurturing their individual and independent development.

**Peer Educator Training**

The training curriculum for outreach activities must be consistent, standardised and updated. Most training is likely to be on-the-job by Counsellors and/or Nurses, depending on the need. The investment in peer-to-peer education promotes trust and allows for ‘walking the talk’ language which can enhance understanding through experience.

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14 Refer to topic: The Importance of Peer Leadership, p7
Sex Worker Peer Educators (SWPEs) are the centrepiece of the program and, employed as Community Health Workers (CHWs), they are essential in engaging with their SW networks, identifying needs and providing links to services. SWPEs can best understand barriers to care and are critical for building trust and empowerment between the target population and MSF.

**Peer-Led Provision Increases Access to Care**

Successful provision of Post Exposure Prophylaxis to HIV (PEP) first doses in the community and navigation to clinics for testing and continuation can be attributed to SWPEs (Figure 3). Good acceptability of the distribution of HIV-self testing in the community is also due, in large part, to the role of fellow sex workers. SWPEs have also helped increase provision of integrated, free HIV and sexual and reproductive health (SRH) preventive services since 2015: offering pregnancy tests (4,668) and emergency contraception, distributing condoms (1,468,729 male condoms and 25,585 female condoms) and lubricants, and offering psychological first aid (PFA) to almost 100% of reported sexual and gender-based violence (SGBV) cases. In Dedza, when responsibility for enrollment and data collection shifted from CEs to SWPEs, new enrollments more than doubled.

**Peers Need Training & Empowerment**

SWPEs may have varying levels of literacy and education, but high levels of motivation. They not only form the essential core of each pillar of the program, but they also hold the institutional memory in a context with high turnover of the rest of the MSF staff (both national and international).

Projects could further increase their capacity by offering a standardised orientation, curriculum and mentorship plan along with on-going education. Routine PFA and systematic debriefings as well as regular refresher trainings should be offered, along with regular on-the-job coaching of SWPEs for active case identification and management. Topics of SGBV, health promotion, SRH rights along with HIV treatment access should be included.

In Malawi, SWPEs are not allowed to do HIV testing that involves taking blood samples, or to monitor ART as they do not have HIV Testing Services (HTS) accreditation. This requires a certain level of education that SWs often do not have, and it is expensive. An excellent next step would be to find ways to mentor and encourage the improvement of SWPE skills and broaden the services they provide so that they are eventually recognised by the government. Defining what SWPEs’ core knowledge is and what their “scope of practice” should be can also help with replicability.

**Encourage SW Peer Participation & Ownership from Program Inception**

A critical aspect for the sustainability of peer-led models is grassroots-level community building, networking and the formation of collectives to share knowledge and empower organisations.

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16 Refer to topic: Human Resources, p6
17 Refer to topic: Sex Worker-Led Community Building, p12
From 2013, MSF implemented adapted models of care to address the specific needs of female sex workers (SWs) by providing access to one-stop, HIV, TB and sexual and reproductive health (SRH) services. These adapted services were provided at Ministry of Health (MoH) facilities or conducted as outreach clinics along with daily, 24/7 services in the community with Sex Worker Peer Educators (SWPEs).

An essential minimum package of de-medicalised service provision by female SWPEs was crucial and, depending on the site, included: PEP first 3 daily doses and link to clinic for HIV testing and treatment continuation, condom and lubricant distribution, services for SGBV cases, pregnancy tests and emergency contraception, HIV self-test (HIV-ST) distribution in the community, TB and STI screening and referral and contraceptive care.

SWPEs helped navigate beneficiaries to access the clinic for medical services covering HIV and viral load (VL) monitoring, PEP, ART initiation and refills, as well as STI screening and treatment, contraception, cervical cancer screening and referral for treatment. Peers could also offer SWs referrals for social and legal support.

Over the final two years, the project developed dedicated services for adolescents who sell sex, a particularly hard to reach and hard to engage with group among an already highly vulnerable and at-risk population.

“A sex worker doesn’t want her customers to see her on a queue leading to the STI room. [It] discourages these women from utilising these services... A lot of girls will prefer to be assisted at the MSF clinic because there they are not exposed. So it is basically the lack of privacy in the health system that discourages them to seek these services.”

Sex Worker Peer Educator

Table 1: Models & Packages of Care

<table>
<thead>
<tr>
<th>Organisation</th>
<th>One-Stop Medical Service</th>
<th>Community Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inside MoH facility, clinical officer (MSF staff)</td>
<td>HIV testing services,* contraceptive care, pregnancy tests, emergency contraception and related SRHR services</td>
<td></td>
</tr>
<tr>
<td>Priority to sex workers (open to all)</td>
<td>STI diagnosis and syphilis test and treatment</td>
<td></td>
</tr>
<tr>
<td>One-stop service (integrated HIV/SRH)</td>
<td>Navigation and linkage to care in one-stop clinic (integrated HIV/SRH)</td>
<td></td>
</tr>
<tr>
<td>Hours: Mon-Fri 7:30am-4:30pm</td>
<td>VL by protocol</td>
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<tr>
<td></td>
<td>PEP provision-continuation</td>
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<tr>
<td></td>
<td>TB screening and referral</td>
<td></td>
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<tr>
<td></td>
<td>Contraceptive care</td>
<td></td>
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<tr>
<td></td>
<td>STI screening</td>
<td></td>
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<tr>
<td></td>
<td>Condom and lubricant distribution</td>
<td></td>
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<tr>
<td></td>
<td>Medical care for SGBV</td>
<td></td>
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<tr>
<td></td>
<td>Cervical cancer screening</td>
<td></td>
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<tr>
<td></td>
<td>Hepatitis B vaccine</td>
<td></td>
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<tr>
<td></td>
<td>1st dose PEP (3 days) with TDF-3TC-DTG and referral to one-stop for testing and initiation if positive</td>
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<tr>
<td></td>
<td>TB screening for beneficiaries on ART</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Condom and lubricant distribution</td>
<td></td>
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<tr>
<td></td>
<td>Psychological first aid for ART</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Condom and lubricant distribution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referral for social and legal services</td>
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</tbody>
</table>

* HIV testing services in the community: all CE providing testing and re-testing, one site HIV self-testing

18 Refer to topic: The Importance of Peer Leadership, p7
19 Refer to topic: Adolescents Who Sell Sex, p10
Testing and Linking to Treatment

Monitoring linkage to care from community HIV testing to ART services is always challenging, and arguably more so amongst SWs who tend to be mobile and, when criminalised, may have an increased need to remain anonymous. Of 525 female SWs newly diagnosed with HIV, we could confirm linkage to ART services for 335 or 63.8%.

Quality health talks and counselling were shown to enhance acceptance of VL testing and results and overcome denial, fear, and stigma. An organised strategy, more staff and time is required to help with follow-up and monitoring.

Viral Load

A peer-based community mobilisation campaign was organised to enable transitioning to Dolutegravir (DTG). This was shown to be effective in rapidly increasing coverage of VL testing among SWs on ART, from 45% to 64%. The observed percentage of VL suppression (87%), indicates the need to remain focused on achieving the 90-90-90 target.

Contraception

Contraceptive uptake among female sex workers in the program has risen to 71.4% among active beneficiaries with at least two visits, compared to only 49% of beneficiaries using contraceptive methods at enrolment. Awareness of and quality consultations about a range of contraceptives increased access considerably once they were made available.

STI Screening and Treatment

STI screening was conducted in the community by either CEs or SWPEs, and referrals were done to the one-stop clinics for treatment. This supported the treatment of over 1,600 STIs. However, linkage was a challenge and not well documented. It is worth considering whether, periodic presumptive treatment could have been implemented.

SGBV services

Sex workers frequently experience sexual violence but rarely report it. Despite this under-reporting, a recent study in Nsanje found that over a quarter of SW had experienced sexual violence in the previous month, often from police.

SWPEs were trained to identify and respond to SGBV cases in their communities, provide PEP first doses, emergency contraception and psychological first aid and refer survivors to further service provision – either medical care through MSF, MoH or other providers, and for social and legal support. A social worker position was added to the team in 2018 to enhance linkages with available support initiatives and increase SGBV awareness and response.

OUTCOMES

An MSF community health worker provides a health promotion session to sex workers at Dedza hotspot as part of MSF outreach activities conducted under MSF’s sex worker project. Photo © Isabel Cortelier/MSF

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20 MSF Annual Report 2020
21 MSF Annual Report 2020
From the inception of the project, we encountered many vulnerable adolescents who sell sex with major unmet health and socio-economic needs. We noticed HIV prevalence rates were really high and rates increased by age group in adolescents who sell sex, so engagement for HIV prevention needed to start earlier. According to the MSF-Epicentre Study in Nsanje District, 47% of the enrolled female sex workers reported having started sex work between 13 and 19 years of age.\textsuperscript{24} They represent 18.4% of the female sex workers (SWs) ever enrolled in the program.\textsuperscript{25}

**Adolescents Are Extremely Vulnerable**

Adolescents who sell sex are even more vulnerable than their adult counterparts, with greater challenges in terms of access to health care.\textsuperscript{26} Adolescents are less aware of or empowered to protect themselves and have an extremely high incidence of HIV,\textsuperscript{27} STIs, SGBV, and unplanned pregnancy.

Services needed, as with adult female SWs, include a comprehensive HIV and SRH rights-based medical one-stop package combined with health education and condom and lubricant distribution. Additional adolescent-oriented services are also required.

To adequately engage with adolescents who sell sex, activities should be adolescent- and SW-friendly in a way that is:
- non-judgemental
- provided in a private and confidential space
- delivered through an edutainment approach, with a mix of fun and learning with music and other tailored education materials
- offered in collaboration with adolescent peer educators

**Adolescent Peer-Led Mobilisation**

In 2019, a set of teen activities (TAs) were launched in Mwanza site. These were designed to provide a comprehensive, one-stop, one-shot package of health services that included information and medical care in an attractive, appropriate and acceptable environment for adolescents who sell sex, within an existing model of care for adult female SWs. Two groups were targeted and it was found that an adolescent peer-led mobilisation approach, which was employed for the second group, was far more effective in engaging adolescents who sell sex compared to the adult peer-led group.

**Adapted Services Are Needed for Adolescents Who Sell Sex**

Adolescents who sell sex may have reduced ability to negotiate consensual safe sex with boyfriends and clients and this increases their exposure to high risk sex and, consequently, health harms.

Health seeking behaviors are affected by age, especially among adolescents who may have low self-confidence, experience stigma around condom use and HIV status, and be misinformed about SRH rights.\textsuperscript{26} Mobility is an additional challenge that reduces access to health and other services even further, and reduces the already poor social support and networking possibilities.

To further scale-up adapted services, we need to:
- Adapt age-appropriate education for self-care and protective behaviours
- Offer services at suitable times and places
- Ensure adolescents who sell sex are a priority for PrEP
- Heighten awareness of adolescent pregnancy and motherhood needs, including Prevention of Mother To Child transmission of HIV (PMTCT)
- Develop dedicated services including referral to social welfare with consent, psychological support, and linkages to paralegal support
- Work with relevant ministry-funded services to help prevent exploitation

### Table 2: Mwanza Intervention for Adolescents

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Group 1 (led by adult peers) Feb-Apr 2019</th>
<th>Group 2 (led by adolescent peers) Jul-Oct 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled</td>
<td>40</td>
<td>77</td>
</tr>
<tr>
<td>New to MSF SW program</td>
<td>31.6%</td>
<td>75.6%</td>
</tr>
<tr>
<td>(77 girls were enrolled. Of these, 75.6% were new beneficiaries to the Mwanza SW program.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal education</td>
<td>2.8%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Age &lt; 19 yrs</td>
<td>28.9%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Age 19-24 yrs</td>
<td>57.5%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Age &gt; 25 yrs+</td>
<td>15.0%</td>
<td>0%</td>
</tr>
<tr>
<td>HIV status: negative</td>
<td>42.5%</td>
<td>77.6%</td>
</tr>
</tbody>
</table>


\textsuperscript{25} MSF Annual Report 2020


\textsuperscript{28} PEPFAR. 2015. Malawi Gender Assessment Report.
The question of whether we should define this key population as adolescents who sell sex or sexually-exploited minors has legal and health promotion ramifications. Understanding the country-specific legal framework alongside the international UN Convention on Rights of the Child is essential when working with adolescents who sell sex. To bridge these gaps, there is a need for dialogue and understanding. At a minimum, we should seek to ensure access not only to health care, but also include a social package. In addition:

- Do not involuntarily refer minors engaged in selling sex for services, as this may drive them underground and away from much-needed health care and is, therefore, inconsistent with their “best interests”.
- Work directly or in close collaboration with other actors/stakeholders if they are present.
- Push partners to recognise the existence of adolescents who sell sex and understand the range of influences that shape the girls’ (forced) choices.
- Break down judgmental perceptions that often work against health interventions.
- Seek a balance between protection requirements, recognition of adolescents’ evolving capacity and right to participate, and identify situations where interventions to reduce risks and to guarantee access to health may be required.

MSF community health worker Rozi (not her real name) follows a sex worker to the MSF-run ‘one-stop’ clinic at Mwanza district hospital. Photo © Isabel Corthier/MSF

An important legacy of peer empowerment has been the development of three community-based organisations (CBOs), lead by female SWs themselves – Sex Workers Empowerment Alliance in Dedza (SWEAD), Tikondane in Zalewa, and Mgwarizano Sex Worker Group in Bangula. Efforts to further build their capacity are essential and on-going.

The biggest lesson learned is that community-building initiatives must be supported from the inception of a sex worker (SW) project so that capacity and sustainability can be planned.

**Significance of Sex Worker Associations**

During the course of the project, SWs were introduced to national and international alliances. Of particular relevance is the Female Sex Workers Association for Malawi (FSWA), an umbrella body to whom other local SW organisations report, and Sex Workers Education and Advocacy Task Force (SWEAT), a South Africa-based organisation that works to educate and advocate for SWs’ rights in the region.

The aim of fostering alliances is to not only advocate for and monitor access to essential health services, but also to sustain the specific health promotion services provided by SW communities themselves and to promote leadership and ownership and advocacy programs.

**Catalysts for Community Building**

It is essential that communities and beneficiaries are owners of their community building initiatives. In addition, forging partnerships and sharing knowledge with other SW organisations is invaluable for solidarity and support.

One of the greatest leaps forward in community building during the project was inspired by a training for Sex Worker Human Rights Defenders, carried out by representatives from SWEAT in 2019. Through this workshop, participants gained a hands-on understanding of how to come together and what goals can be accomplished in a collective.

The newly formed SW CBOs are in the process of formalising, and will need support from MSF or other NGOs to become sustainable. But their roles may be limited due to lack of funding and/or precarious structures in their early stages. However, they have demonstrated their resilience as they begin to achieve formal recognition and engage with MoH and other structures to share their collective vision and goals.

Besides learning how to advocate for continued access to the essential package of care for SWs, there are other organisational skills that still need to be gained: how to manage institutional dynamics, how to fundraise and generate income, how to manage risks and finances and be accountable to donors as well.

The lessons of how to move from community building into a CBO should be shared in peer-to-peer learning formats with other SW groups across Malawi and elsewhere.

**Preparing for MSF Exit**

Increasingly, MSF in Southern Africa is recognising the importance of community engagement, empowerment and leadership, particularly among marginalised and excluded populations. Unfortunately, there tends to be a lack of timely support to strengthen these groups while MSF is present, and sometimes these groups are inadvertently instrumentalised towards MSF priorities, which means they risk collapse or reduced capacity when MSF exits.32, 33, 34

Supporting SW community building is important to ensuring greater longevity of interventions. It is essential to help build these relationships from the beginning and to frame these as partnerships. Linking sex worker CBOs with MoH and others, such as police and social welfare providers, through the implementation of routine activities helps build trust and legitimacy.

33 https://evaluation.msf.org/sites/evaluation/files/involving_communities_0.pdf
Experiences from Médecins Sans Frontières in Malawi

GAPS & RECOMMENDATIONS

After seven years in Malawi working with sex workers (SWs), we reflect back not only on what was accomplished, but also on what recommendations we can make to fill the gaps that were identified.

EXPANDING THE MEDICAL PACKAGE OF CARE

**PrEP & PEP:** HIV incidence remains extremely high among SWs, indicating that HIV prevention based on condom use and PEP is insufficient. Condoms are not always used and not always available in the community. PEP, when available, can be underutilised. In 2020 PrEP was recognised within Malawi guidelines, but rollout was not yet effective.

**Recommendations:** PEP should be offered whenever a person is at risk of HIV exposure due to unprotected sexual intercourse, without regard to circumstances. In 2020 PrEP was recognised within Malawi guidelines, but rollout was not yet effective.

**Mental Health, Substance Use:** Common risk factors such as alcohol, violence and poverty can exacerbate the risks of HIV infection as well as mental health disorders in SWs. The use of alcohol and recreational drugs can be quite common in the sex work industry, resulting in addiction or dependency and further associated health risks.

**Recommendations:** A variety of interventions including access to support groups, workshops in safe spaces as well as screenings and referrals to mental health or substance use specialists should be implemented to tackle these challenges.

**Expanding the medical package of care**

**Mother and Child Health:** Since most of the project’s enrolled female SWs are mothers, prevention of HIV in pregnancy and prevention of mother-to-child transmission (PMTCT) should receive more focus.

**Recommendations:** Specific interventions to address health and social care for the children of SWs need to be clearly signposted and seen as a priority. Inclusion of children could increase the engagement with SWs in health care because it enables them to attend to care for themselves and their children simultaneously.

**Sexual Partners of SWs:** A major challenge has been the lack of focus on engagement with sexual partners for STI screening and treatment as well as for other key preventive activities, which undermines the chances of a bigger impact.

**Recommendations:** Interventions for SWs’ clients and partners need to be implemented. Minimum male sexual health services, to prevent and treat STIs and HIV care as well as tracing and follow-up treatment, must be ensured. However, they require male sexual health tailored approaches separate from the female SW services.

**Expanding the medical package of care**

**Mental Health, Substance Use:** Common risk factors such as alcohol, violence and poverty can exacerbate the risks of HIV infection as well as mental health disorders in SWs. The use of alcohol and recreational drugs can be quite common in the sex work industry, resulting in addiction or dependency and further associated health risks.

**Recommendations:** A variety of interventions including access to support groups, workshops in safe spaces as well as screenings and referrals to mental health or substance use specialists should be implemented to tackle these challenges.
SUSTAINABILITY & REPLICABILITY

Community Building & CBOs: Each project site has developed an effective health promotion and delivery of services outreach model based on the central role of sex worker peer educators (SWPE). The continuation of these activities will, however, rely not only on MoH support but also on the presence of an NGO to assist CBOs with operations, funding and staffing. The process of community building requires time, resources and expertise.

Recommendations: Encourage and nurture grassroots SW groups at the inception of sex worker programming. Assist by linking with partners and experts, supporting basic organisational structures, and offering alternative trainings in economic literacy, financial management or Village Savings & Loans. Organise regular exchanges and workshops for SWs so that they can share skills and experiences.

Maintaining a SW-Friendly Environment: It is important to have a sensitised team and staff, as underlying stigma, discrimination and resistance needs to be overcome. When there is high turnover of staff in MSF or among stakeholders, there is a continuous need to reinforce what SW peer-led and SW-friendly services mean.

Recommendations: Maintaining the sector networks and having an MSF pool of national, regional and international staff experienced in working with key populations like SWs would be helpful. Their skills would include standard HIV and TB care, along with a rights-based approach to SRH, social work, and an awareness of SW-friendly policies. Regular SW-friendly service delivery trainings for different sectors should be part of the routine to ensure that a wider range of partners are sensitised to the challenges being faced by SWs. This would also create more opportunities for networking for referrals and support.

INCREASED FOCUS ON:
SGBV & Social Support

One of the important recurrent responsibilities that SWPEs face is raising awareness regarding human rights and sexual and gender based violence (SGBV). Every SW has her own history of experiencing sexual violence.

There are also challenges when it comes to reporting and documenting abuses, maintaining lines of communication between peer SWs and professional staff, the degree of prejudice and trust in these relationships, and referrals to social welfare or legal service providers. Some SWs continue to feel let down by the very system that is supposed to protect them and, hence, disregard reporting.

Recommendations:
• Sensitise, train and empower SWPEs to become first responders to violence in the community and to monitor and follow up cases until resolved.
• Encourage human rights organisations such as CHREAA to remain active and engaged with the SWPEs in areas they are needed, review and strengthen the referral system.
• Engage all MSF service providers involved in SGBV response in Psychological First Aid and related trainings to ensure that there are no gaps between the multidisciplinary teams.
• Maintain partnerships with other service providers, such as police and municipal / community structures, and ensure SWs are always represented at platforms where stakeholders are meeting.
With commitment, innovation and action, the MSF Malawi female sex worker (SW) project in Mwanza, Zalewa, Dedza and Nsanje, was able to have a big impact. The development of a one-stop model of care, the engagement of and appreciation for sex worker peer educators (SWPEs), and the emphasis on sex worker-friendly services through sensitisation, training and tools for partners and staff enabled the project to make a difference.

HIV, STI and SGBV prevalence remains high among female SWs in Malawi. Access to health care, including contraceptive uptake, is still a significant challenge in light of the high rate of mobility among SWs in the region. Over the course of the project, we reached almost 7,000 female SWs.

One-Stop Clinics Are an Effective and Efficient Approach

The data underscores the importance of taking full advantage of each clinic visit. One-stop clinics are an effective approach to ensure access to health information, HIV prevention and SRH quality treatment in a safe and private space.38, 39

Peer Educators Are the Essential Link

The female SW peer-led model has been shown to raise health awareness and promote linkage to service providers and delivery of a basic medical package that is highly acceptable by fellow SWs, and a successful entry point to care. SWPEs can offer wellness education, distribute condoms and lubricants, identify health needs, provide task-shifted services, and refer for medical and psychosocial care. One-on-one assistance to navigate through the static clinics has been effective. SWPEs also ensure follow-up and tracing of beneficiaries in need of continued care or support.

Sex Worker-Friendliness Provides an Enabling Environment

To be “sex worker-friendly”, a service requires staff who are welcoming, do not stigmatise or mistreat SWs, and are able to gain the trust of the SW community.

One successful initiative took place in partnership with a Malawian lawyer. The project conducted SW-friendliness workshops with key stakeholders and service providers (MoH, police, social welfare and other stakeholders). The objective was to increase awareness about SWs’ vulnerabilities and needs, barriers to access services, the negative impact of stigma and discrimination, and the legal framework concerning sex work in Malawi.

Positive Policy Outcomes

We have seen national policy changes over the years in response to our findings and experiences, along with the general adoption of the model as an appropriate one for Malawi’s MoH to endorse and replicate. We will need SW Community Based Organisations (CBOs) and others to be alert and monitor whether national policy is applied in practice and ensure that access continues.

Internally, the understanding we have gained among MSF staff around SW programming will stand us in good stead as we take the knowledge we have gained into new sites and projects.

The Way Forward

Innovative strategies and further efforts are required to address the needs of sex workers (SWs), and the challenges they face in accessing prevention, linkage to, and retention in service provision:

- Encourage the adaptation of health policies to meet the specificities of the SW population.
- Include a mix of SW-friendly MoH integrated services and parallel community-based alternatives.
- Offer a minimum basic package with HIV, TB, and STI prevention, testing and treatment, as well as contraception within a SRHR frame to include other components such as safe abortion care and long-acting contraceptive choices.
- Provide service delivery in clinics as one-stop consultations with trained SW-friendly and sensitive staff who are known and trusted in the community.
- Strengthen the SWPE model to adapt the workload as needed, ensure training and salaries, and regularly assess the capacity and reach of SWPEs.
- Maintain on-going consultations and discussion with SW communities to determine what their needs are, how the package of care should be adapted, where service provision is better placed, and what their training needs are.
- Encourage advocacy and activism to address violence, criminalisation, stigma and discrimination in healthcare services.
- Boost initiatives aimed at empowering and addressing the needs of SWs, including investment in helping to build female SW-led local collectives that can affiliate with national groups to facilitate long-term relationships, services, and the formation of CBOs.

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Two sex workers head to the bar section after leaving the compound behind a bar in Mwanza. Strong camaraderie exits between sex workers who live closely together. Photo © Isabel Corthier/MSF