THE SISTERS WITH A VOICE PROJECT - BUILDING A RESILIENT SEX WORK COMMUNITY IN ZIMBABWE IN THE CONTEXT OF HIV AND AIDS

DOCUMENTATION OF A DIFFERENTIATED HIV PREVENTION AND CARE MODEL

Submitted by CeSHHAR Zimbabwe to IAS

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Overview

The Centre for Sexual Health HIV and AIDS Research, CeSHHAR Zimbabwe, established the Sisters with a Voice programme in 2009 with the aim of fostering an empowered and resilient sex work community fully engaged in HIV prevention and care cascades. It is a comprehensive programme that takes a rights-based approach and aligns with UNAIDS/WHO guidance on programming for key populations (1, 2). Programming is evidence driven, benefitting from a strong research base to understand the size, characteristics and needs of female sex workers (FSW), who are typically marginalised, poor, and stigmatised (including within health services). The programme has informed extensive research including randomised controlled trials of new interventions (3), formative qualitative work and policy analysis (4, 5), and assessments of enablers and barriers to FSW service uptake (6, 7).

The programme has scaled up from an initial five sites to 10 static and 26 outreach sites, nested within public sector facilities to reach the sub-population of FSW engaged in full- or part-time sex work throughout Zimbabwe. Outreach is inclusive of urban, peri-urban and rural areas with emphasis on hotspots such as border posts and major transport routes. By mid-2018 the Sisters with a Voice (Sisters) clinics had seen 65,000 women, and are thought to be accessible to 75-85% of the estimated 45-49,000 active FSW in Zimbabwe (1.23% of the adult female population) (8). HIV prevalence in FSW is estimated at 58%, with annual incidence of 7-10% (9). Around one-third of HIV positive female sex workers have a viral load >1000 copies/ml and thus have potential for onward sexual transmission (8). Sisters has tested over 31,000 FSW for HIV, and linked over 7,500 to ART and around 2,000 HIV negative women to PrEP.

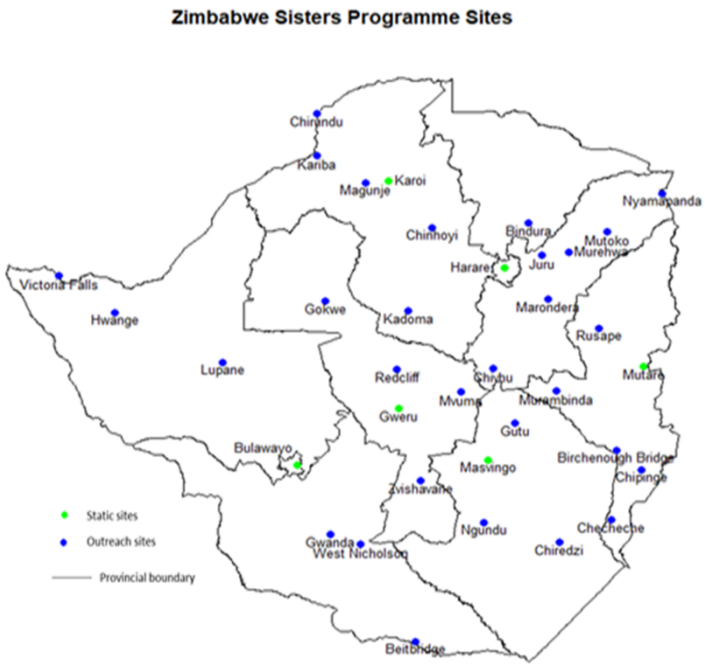

Figure 1; Map of Sisters Clinics across Zimbabwe

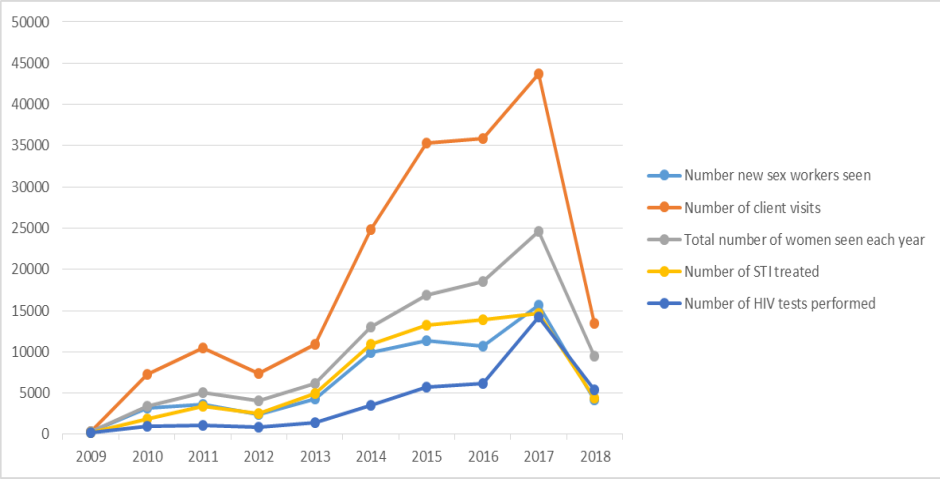

Figure 2; Female sex workers reached by the Sisters Program from 2009 up to June 2018

> '*I take my meds (ART) every day, no difficulty taking them. I am an empowered lady, I am an empowerment worker - there is no message I can preach if I am not taking mine*.'
>
> Peer educator

Crucial to the success of the programme has been the engagement and training of sex workers themselves as peer educators who are supervised, mentored and supported by outreach workers. Attitudes of all staff are non-judgemental and friendly, and therefore build trust. Also crucial has been the nesting of Sisters clinics with Ministry of Health and Child Care (MoHCC), city and district health facilities providing ART and OI treatment, and that there was government initiation and buy in from the start.

Figure 3; Peer Educators having a discussion outside the Sisters clinic

These factors promote long-term sustainability and government ownership, as does training and mentoring public sector nurses within Sisters clinics to be sex worker friendly, providing them with skills to expand the service to government services.

Figure 7; The Sisters clinic is collocated with the City Health Clinic as well as an OI Clinic at Mbare Hostels.

'*The fact (sex workers) can come to a clinic as a citizen and human being not a victim, is a real achievement*.'

Outreach worker

'(You) need to recognise quite how empowering their work has been, Zimbabwe is ahead of the region in national sex work programming; others have centres of excellence but nothing nationwide.'

NAC stakeholder

Other key government partners include the Department of Social Welfare, the National AIDS Council and the Police Victim Friendly Unit. Civil society partners include Population Services International (PSI) through New Start centres, and organisations for legal and human rights and social protection. They have been critical to bringing about reform in terms of sex workers legal rights (10).

'*Violence is not such a big problem now, with police support.*'

FSW

There is need to widen and strengthen partnerships further to support the full range of needs of female and other sex workers in the challenging socio-economic environment of Zimbabwe.

Services and staffing

The programme is designed to empower FSW regarding their health-seeking behaviour (and rights in general), including access to PrEP and ART, to negotiate safer sex, and to raise self-esteem within a community of support. Services provided at the Sisters' static and mobile clinics include syndromic management of sexually transmitted infections (STIs), male and female condom programming, water-based lubricants when available, HIV testing with piloting of self-testing, referral to pre-exposure prophylaxis (PrEP), antiretroviral therapy (ART) and treatment of opportunistic infections (OIs), counselling, and community based adherence support through the Adherence Sisters Programme. The clinics also

Figure 11; Women waiting to access services at the Sisters Clinic

provide family planning methods including injectables and pills, and basic primary health care and health education. Services are user-friendly, free and accessible, and the clinics have become informal meeting places for socialising and mutual support. In addition, a drop-in centre has been established in Harare, with a second one soon to open in Bulawayo, the second largest city.

> '*That women come in for a test is a success. Many assume they are positive because they are sex workers, and there is nothing to do but enjoy life while it lasts*.'
>
> Outreach worker

Each static site is staffed by a minimum of three qualified nurse counsellors, three outreach workers, a clinic clerk and a driver. The programme has trained 270 sex worker peer educators to lead empowerment activities and community outreach and mobilisation. Close to one-quarter have received paralegal training to assist in cases of abuse and to organise referrals and support as needed, and around half have received training to provide lay child protection services. Peer educators are supervised and mentored by outreach workers, predominantly social workers, who also undertake monitoring, record keeping and follow up with clients identified as at higher risk. The programme also currently employs six sex workers as junior outreach workers in line with the vision of gradually building a network of sex workers to do all community mobilisation and advocacy activities.

Figure 12; a woman taking an HIV self-test

> '*Everyone is trained to be non-judgemental and you can't tell the difference (at the clinic) between staff, outreach workers and sex workers, so we demonstrate friendliness and equality. We are much less formal than other clinics, interactions are informal and very open*.'
>
> Outreach worker

The Sisters' with a voice Differentiated HIV model

The Sisters model is providing a differentiated care model for both HIV positive and HIV negative sex workers. Table 1 below shows the building blocks of the differentiated HIV testing which is provided at three locations – at the Sisters static clinic, at mobile/ outreach clinics and as self-test kits in the communities. The testing model includes a provider initiated as well as a client initiated approach. When a woman test they are linked on the same day to the most appropriate intervention. The peer educators and outreach teams mobilise sex workers to access HIV testing and treatment. Table 2 shows the building blocks of a differentiated ART delivery model, where Sisters nurses ensure active referral for sex workers to be initiated on ART and then the service providers (either public sector of PSI) refer the sex workers back to Sisters for adherence and psychosocial support.

Table 1: The building blocks of differentiated HIV testing

	Mobilization	**Testing**	**Linkage**
WHEN	Continuously for individual sex workers through peer education and microplanning. During day or night outreach	Every three months for all HIV negative sex workers	Referral continuous from Sisters' clinic to on site public sector clinic. Mobile clinics visit each public sector clinic weekly or fortnightly Same day initiation PrEP or ART Weekly follow up after initiation on PrEP or ART, then monthly
WHERE	SW hotspots e.g. bars, the street, flat or residence, truck stops, border posts, drop-in centre (Harare) and one opening in Bulawayo.	At the 10 static sites in cities and main border posts At the 26 mobile outreach clinics on the highways of the country, (previously 30 but 4 became static sites at border posts). At mobile outreach sites in and around the 6 major towns of Zimbabwe (Harare, Bulawayo, Mutare, Masvingo, Gweru and	Refer to public sector clinic on site of static clinic or to PSI New Start site (5 in main cities). Most mobile clinics operate at public sector clinics

		Karoi)	
WHO	270 trained peer educators supported by outreach workers 50 peer educators who have become empowerment workers for microplanning and self-help groups 6 junior outreach workers	Nurse counsellors and outreach workers	Nurse counsellors, outreach workers and peer educators. Sensitised and FSW friendly staff in public clinics and PSI
WHAT	Encouragement to attend health services and prompts for scheduled appointments, participatory activities to build resilience and social cohesion, mobilisation for regular HIV testing. In microplanning and self-help groups, keep hotspot diary and assess vulnerability with risk assessment score. Young Sisters Programme (15-24) with community mobilisation and delivery of community empowerment materials by trained and younger peer educators (18-24)	HIV testing with supported referral for i) PrEP - PSI clinics; CeSHHAR clinics and public sector clinics starting in 2018 ii) ART in public sector clinics and PSI New Start centres Scaling up self-test kits (oral Oraquick HIV Self-Test Kit, with clear instructions in the three main languages) Often used while waiting at the clinic; can take home for self and/or partner also Confirmatory testing	Referral and accompaniment as requested. Outreach workers do follow up by mobile phone to see if referral is acted on. Unique identifier number for referral from Sisters' clinic. Make links with FSW and health services for referral beyond Sisters clinics to on site public sector clinic or PSI New Start centre

Table 2: The building blocks of a differentiated ART delivery model

	ART refills	**Clinical consultations**	**Psychosocial support**
WHEN	Monthly then three monthly after stabilised (based on clinical observation and reported history)	Clinical consultation when collect ARVs and drop in to address any health concerns	Depending on individual risk assessment, weekly (high risk), biweekly (medium risk) or monthly (lower risk/stable)
WHERE	Public sector ART facilities and PSI New Start centres in 5 cities. With viral suppression aim to transfer stable FSW to government services	Public sector facilities PSI New Start centres Sisters clinics (except for ARVs or OIs)	In community through Adherence Sisters Programme, Sisters static and mobile clinics, PSI New Start centres
WHO	Led by physician in PSI New Start sites, led by	Nurse at Sisters clinics, nurse or physician at PSI	Adherence Sisters Programme in community: peer educators and

	physician or nurse in public sector ART sites	and public sector facilities	outreach workers PSI nurse counsellors ART clinics
WHAT	Supply of antiretrovirals for PrEP or ART Viral load testing not always available	Clinical examination as needed and provision of family planning, STI syndromic management, OI treatment and other services PSI services also integrate screening for cervical cancer	Adherence Sisters Programme in the community for FSW on PrEP and ART meeting together, health talks, community dialogue, building sisterhood for adherence support, individual contacts Young Sisters Programme Individual follow up with microplanning peer educator Self-help group intervention to build financial literacy, resilience including psychosocial support and social cohesion MoHCC guidelines used by public sector ART clinics

Microplanning an innovative, peer led, data guided, community outreach approach tailored for the individual needs of FSW was developed by the Avahan India AIDS, is being piloted in Harare to assess acceptability and utility. Fifty of the sex worker peer educators have been trained to identify and cover 50 geographic 'hotspots' for sex work in and around Harare. They enumerate local FSW and undertake individual risk assessment using a simple score card, tailoring support to each sex worker's level of social and clinical vulnerability. For those FSW assessed at higher risk, outreach workers undertake close follow up, tracking referrals and promoting service uptake. Reassessment is undertaken as indicated.

In Harare, self-help groups with an average of 10 FSW are being developed to help build social cohesion between FSW, who tend to distrust and compete with one another, and to assist with microfinancing and skills building for small businesses. Women may join a group and also visit the drop-in centre whether or not they have health needs or have attended a Sisters clinic, thus widening the potential pool of FSW who know of the service.

'*We now look out for each other, check that we know car number plates, and if someone has gone for a short- or long-time session. If one person is victimised or beaten, we share the information so that others can avoid (the client).*'

FSW member of self-help group

A major challenge for the programme has been reaching adolescent and young women selling sex, who are at high risk for infection and who may not self-identify as sex workers.

> '*They (sex workers) are very different from me, you can tell them by how they walk, talk and dress - and that is not me.*'
>
> '*Sometimes I use condoms, it depends on the client not me. I depend on the money and accept if they offer more with no condom. I know the risk, but whatever happens happens. When I think deeply about it, it frightens me.*'
>
> 17-year old newcomer to Sisters clinic

The Young Sisters Programme, started in 2014, has increasingly brought in adolescent girls and young women, however, reaching over 19,500 young women 15-24 by mid-June 2018. Younger trained peer educators undertake outreach and referral. Service delivery is differentiated for young women, with age-specific demand creation and community outreach and adherence support. Efforts are also made to secure financial assistance (e.g. from the Department of Social Welfare or through special grants to subsidise school fees). In 2016, CeSHHAR became a DREAMS implementing partner in the six DREAMS programme districts. This involved mobilising women 15-24 who were selling sex for the comprehensive package of biomedical and social interventions provided through DREAMS partners (school subsidies, family cash transfers and other benefits).

Figure 13; a young woman being interviewed at the Drop in Centre in Harare

Since April 2018, the remit of Sisters clinics is expanding to include male and transgender sex workers. Partners of sex workers are also invited to attend the clinics for HIV testing and support but, to date, few have taken this up.

Operational costs for Sisters were USD700,000 in 2014, rising to just over two million USD in 2018, with human resources the largest budget head (40%) followed by outreach activities (15%). UNFPA, from the Integrated Support Programme with DfID, IrishAID and Sida, provided

the main funding till 2018, with GIZ funding also till 2015. In 2018 the GFATM became the major donor followed by PEPFAR support received through PSI.

Tracking results

From the start, Sisters with a Voice has closely monitored clinical attendance and referrals for all clients, and measured the programme's output and outcome results. Initially this was done using paper records but in real time electronically since 2013. Each woman is allocated a unique identifier, with coded referral slips to link women confidentially with public service or PSI clinics. Longitudinal data have also facilitated in-depth analysis of programme participants to estimate population HIV incidence and population size.

Data on engagement with the treatment cascade are available from representative population based surveys conducted as part of the SAPPH-IRe trial with data on uptake of testing and ART, retention, viral suppression, preferences and attitudes and show positive results (11). The respondent driven sampling (RDS) surveys found that 67-72% of HIV positive FSW had a viral load below 1000 copies/ml compared with 65% of women in the general population (7, 9). As an example of success, in May 2018, the Mbare Sisters clinic documented reaching 85 new clients who tested positive, of whom 80 were initiated on ART with the remaining five being followed up.

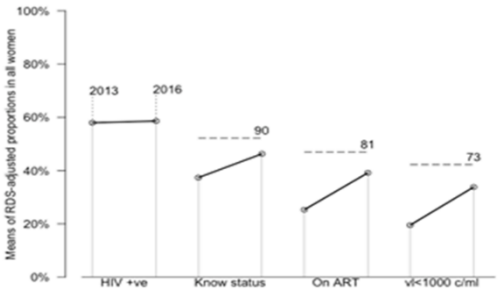

Figure 14; the 90.90.90 treatment cascade for Female sex workers in Zimbabwe

Overall numbers accessing testing have increased year on year and, in a recent RDS survey in Harare, 91% of FSW reported knowing their status (defined as knowing their HIV positive status or having tested negative within previous six months). Many Sisters clinics are facing challenges to meet the growing service demands, and to keep waiting times down so that clients are not deterred from regular follow up. Self-testing is proving a useful additional approach, undertaken either at the clinic or from home.

'Many of the women are now more empowered after contact with the clinic or support groups, and they want to know where they stand and have counselling on what to do. If they test positive they are keen to go for ART. If they are negative they want PrEP as they know these things work. They are not looking back at how they got the virus, they really want to know their

status, whatever.'

Nurse counsellor

The skills building workshop

On the 9th of August 2018 CeSHHAR Zimbabwe held a skills building workshop which was attended by 33 participants representing 8 organisations, 5 of them being CBOs that are sex worker led. The workshop focused on building skills and encouraging replication of the Sisters model with an emphasis on broadening reach to include transgender and male sex workers.

The meeting was well received with participants indicating that the innovations like microplanning and self-help groups can be customised for their constituencies and can be implemented at community level. It was clear from the meeting that male and transgender sex workers were already on board and clearly wanted to tap into these differentiated care models.

Moving forward

The programme already reaches major hotspots for sex work nationwide. It is being developed further in several respects to achieve differentiated service delivery to address the needs of a widening range of sex workers. This includes: widening the key populations served to include male and transgender sex workers; expanding geographical reach to further hotspots, and intensifying outreach through scaled up microplanning to facilitate provision of better targeted, risk differentiated, status neutral support for HIV prevention and care. The programme is also adding PrEP to the clinic care cascade and potentially having outreach workers provide PrEP and ART refills (under discussion with the health ministry). It is intensifying advocacy work primarily through capacity development of emerging beneficiary networks for female and male sex workers and transgender populations.

CeSHHAR will also continue to undertake cutting edge research that provides extensive data for advocacy for sex workers with policy makers, donors and other potential partners. Ongoing research will continue to track the overall benefits of the programme for sex workers themselves, as well as documenting reduced HIV acquisition and transmission risks in this vulnerable cohort.

'This is an excellent model: linking research and implementation together.'

MoHCC stakeholder

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