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Global Network of Sex Work Projects
Promoting Health and Human Rights

ADVANCING SEX WORKERS' SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

A Toolkit for Inclusive Programming

Contents

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Introduction

Sexual and reproductive health and rights (SRHR) are not only an integral part of the right to health but also necessary to enjoy many other human rights. Sex workers, like all people, are entitled to access sexual and reproductive health (SRH) care free from stigma, discrimination, coercion and violence. However, due to widespread criminalization, stigma and discrimination, sex workers are often excluded from essential SRH services, exacerbating vulnerabilities and violating their fundamental human rights. Furthermore, the healthcare available to sex workers is seldom informed by the community's needs and preferences.

Who are sex workers?

Sex workers include cisgender female, male, transgender and gender-diverse adults (age 18 and older) who receive money or goods in exchange for sexual services, either regularly or occasionally.[1] The global sex worker rights movement defines sex workers as people aged 18 and over in line with the UN Convention on the Rights of the Child, which recognizes children under 18 who sell sex as victims of sexual exploitation.[2]

Sex work refers to the consensual provision of sexual services between adults, which takes many forms and varies between and within countries and communities. Sex work is work. It may vary in the degree to which it is "formal" or organized.

The terms "prostitute" and "prostituted women" are used by opponents of sex work to deny sex workers' capacity to act, think and decide for themselves, and to portray them as victims of exploitation. These highly stigmatizing terms are rejected by sex workers and their allies.[3]

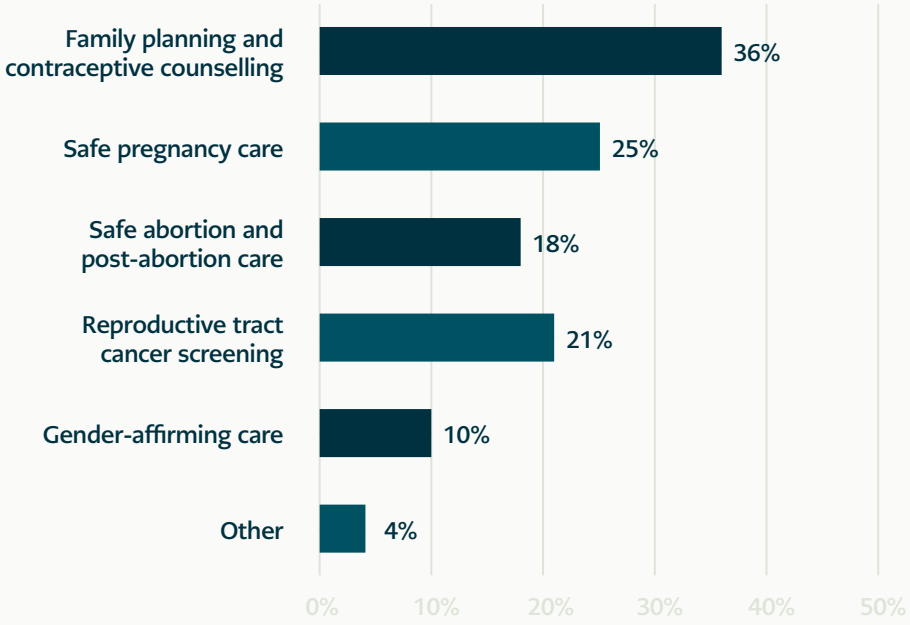
Sex workers' unmet SRH needs and heightened vulnerability to poor health outcomes have been extensively documented by academic and community-led research. Sex workers, gay and bisexual men and other men who have sex with men, people who inject drugs, trans people and people in prisons and other closed settings are defined by UNAIDS as "key populations" due to their increased vulnerability to HIV and disproportionate burden of disease. In 2022, the relative risk of acquiring HIV was nine times higher for sex workers than the wider adult population globally.[4] Sex workers across different settings are also particularly affected by sexually transmitted infections (STIs)[5] and violence, which are fuelled by criminalization and repressive policing practices.[6]

1.1 Scope of unmet sexual and reproductive health needs

Many services for sex workers remain focused on HIV and STI interventions, driven by a public health paradigm that frames sex workers as "vectors of disease."[7] This narrow, stigmatizing view has resulted in systems that routinely neglect the broader spectrum of sex workers' SRH needs. These gaps are shown by recent data. A 2022 community-led study with sex workers in 27 countries found that 61 per cent of participants did not have, or were unsure if they had, SRH coverage under national health insurance. Even among those who reported some level of access, the services available were rarely comprehensive. Screening for reproductive tract cancer, safe abortion and post-abortion care and gender-affirming care were particularly scarce across regions.[8]

1 WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP (2013) Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions. Available at: https://www.who.int/publications/i/item/9789241506182
2 UN (1989) Convention on the Rights of the Child and NSWP (2016) Policy Brief: Young Sex Workers. Available at: https://www.unicef.org/child-rights-convention/convention-text and https://www.nswp.org/resource/nswp-policy-briefs/policy-brief-young-sex-workers
3 NSWP (2024) Let's Talk About Sex Work – A Terminology Statement and Guide. Available at: https://www.nswp.org/resource/nswp-publications/lets-talk-about-sex-work-terminology-statement-and-guide
4 UNAIDS (2024) The Urgency of Now: AIDS at a Crossroads. Available at: https://www.unaids.org/en/resources/documents/2024/global-aids-update-2024
5 Whelan J, Abbing-Karahagopian V, Serino L, Unemo M (2021) Gonorrhoea: a Systematic Review of Prevalence Reporting Globally. BMC Infect Dis.21:1152. Available at: https://link.springer.com/article/10.1186/s12879-021-06381-4
Poteat T et al (2021) Characterising HIV and STIs Among Transgender Female Sex Workers: A Longitudinal Analysis. Sex Transm Infect. 97(3):226–31. Available at: https://pubmed.ncbi.nlm.nih.gov/32366602/
6 Platt L et al (2018) Associations Between Sex Work Laws and Sex Workers' Health: A Systematic Review and Meta-Analysis of Quantitative and Qualitative Studies, PLoS Med 15(12). Available at: https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002680
7 NSWP (2018) Briefing Paper: Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services. Available at: https://www.nswp.org/resource/nswp-briefing-papers/briefing-paper-sex-workers-access-comprehensive-sexual-and-reproductive
8 NSWP (2024) Global Findings on Sex Workers' Access to Social Protection and Sexual and Reproductive Health and Rights. Available at: https://www.nswp.org/sites/default/files/social_protection_srhr_english.pdf

Figure 1: Availability of SRH services through national health insurance



Source: NSWP (2024) Global Findings on Sex Workers' Access to Social Protection and Sexual and Reproductive Health and Rights

Stigma, discrimination and risks of legal repercussions in mainstream healthcare settings lead many sex workers to prefer community-led services. Accordingly, sex workers and other key populations have consistently called for scaling up and investment in community-led programming. At the same time, they have emphasized the need for stronger partnerships and sensitization within mainstream health systems to expand options for care.[9]

Much like the broader population, sex workers are a heterogeneous group with diverse health needs shaped by factors such as age, gender identity, sexual orientation, HIV status, type of work, drug use, migrant status and other overlapping identities. These factors also influence how sex workers experience discrimination and legal oppression, which in turn affects their access to SRH services. Therefore, there is no "one-size-fits-all" solution to addressing sex workers' SRH needs – instead, intersectional, person-centred approaches are required.[10]

9 WHO (2022) Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations. Available at: https://www.who.int/publications/i/item/9789240052390

10 IPPF (2025) International Medical Advisory Panel (IMAP) Statement on Sex Worker-Centred Sexual and Reproductive Health Services. Available at: https://www.ippf.org/resource/imap-statement-sex-worker-centred-sexual-and-reproductive-health-services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About this toolkit

2.1 Foundational guidance

This toolkit is grounded in international guidance and frameworks on sex workers' health and human rights. It builds directly on Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions (2013). This publication centres rights-based, inclusive health services for sex workers, anchored in community empowerment and meaningful involvement.

The toolkit also draws on WHO's Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations (2022),[11] developed in consultation with networks led by sex workers and other key populations. In addition, it builds on vital components from IPPF's IMAP Statement on Sex Worker-Centred Sexual and Reproductive Health Services (2025).[12]

2.2 Approach

This toolkit is based on a qualitative, community-led approach, drawing on multiple studies on sex work and SRHR conducted by NSWP. In 2025, NSWP conducted a global consultation with its membership to collect data on SRHR barriers, needs, priorities and best practice examples. The online survey gathered 61 responses, and key informant interviews were conducted with representatives of regional sex worker-led networks across the world.

The toolkit also draws on evidence from NSWP's previous studies on sex work and SRHR conducted in 2018,[13] and in 2022, in which data were collected across 27 countries from 1,411 participants.[14] While this toolkit does not analyse these findings in depth, they have informed the framing, context and identification of needs, priorities and gaps.

2.3 Scope, objectives and audience

This toolkit consolidates key principles, best practices and clinical guidance into a practical resource tailored to the needs of sex worker communities. In addition to outlining comprehensive SRH services, this resource aims to provide tools for designing and delivering rights-based SRH programmes in collaboration with sex workers. Informed by the lived experiences of sex workers, it centres meaningful involvement, inclusivity and sustainability in partnerships with sex worker-led organizations, thereby increasing its effectiveness among this population.

The toolkit is intended for healthcare providers, programme managers, sex worker-led organizations, civil society actors, policymakers and others involved in SRH programming and advocacy.

11 WHO Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations.
12 IPPF IMAP Statement on Sex Worker-Centred Sexual and Reproductive Health Services.
13 NSWP Briefing Paper: Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services.
14 Ibid.

3

Understanding structural barriers

Access to comprehensive SRH services is an essential component of a rights-based approach to health. However, the full scope of sex workers' SRH needs is often overlooked in policy and public health programmes. Structural barriers – including criminalization, stigma and discrimination – drive inequitable access to SRH services while increasing sex workers' vulnerability to HIV, STIs, violence and unintended pregnancy.[15]

The widespread conflation of sex work with exploitation and human trafficking reinforces these barriers.[16] Some international funding mechanisms impose restrictions that inhibit rights-based programming for sex workers. For example, US global health funding has required international organizations to oppose "prostitution" in order to receive aid. More recently, US policy restrictions, including the reinstated, expanded Global Gag Rule, as well as executive orders targeting diversity, equity and inclusion and LGBTQI+ rights, have further constrained the ability of organizations to provide inclusive SRH services. These conditions restrict funding for programmes that support sex workers, LGBTQI+ communities and other marginalized groups, undermining community-led services, advocacy and rights-based approaches. Such requirements severely limit the design and delivery of comprehensive, rights-based SRH services for sex workers and contribute to the chronic underfunding of sex worker-led interventions.

3.1 Criminalization and legal barriers

The criminalization of sex work remains one of the greatest barriers to sex workers realizing their SRHR. It is also an underlying cause of violence, discrimination and HIV transmission.[17] Sex workers may be criminalized through laws prohibiting:

- The sale and/or purchase of sexual services
- Soliciting and advertising services
- Managing, organizing or "facilitating" sex work
- Sharing premises with other sex workers
- Living off the proceeds of sex work.

Laws can also be used to criminalize clients, third parties, family members, partners and friends.[18] The term "third parties" refers to managers, brothel keepers, receptionists, cleaning staff, drivers, landlords, hotels who rent rooms to sex workers and anyone else who is seen as "facilitating" sex work.

Intersectional criminalization

Sex workers also face other forms of criminalization based on their overlapping identities and activities. These may include:

- Anti-LGBTQI+ laws criminalizing same-sex relations and/or non-conforming gender identities
- Laws criminalizing HIV exposure, non-disclosure and transmission
- Laws criminalizing abortion
- Laws criminalizing drug use and possession
- Anti-migration policies that limit sex workers' access to legal migration channels
- Laws requiring partners or parents to be notified, present and/or consent to access services.

Impacts of criminalization

All forms of criminalization undermine sex workers' access to health services and commodities while making their working conditions more dangerous. Globally, many sex workers are reluctant to access healthcare due to fear of legal repercussions, including fines, arrest, detainment, child custody loss, or in the case of migrant sex workers, deportation.

Criminalization also increases violence against sex workers by creating a culture of impunity in which perpetrators (which can include law enforcement officials) feel empowered to commit abuses without repercussions. As a result, sex workers who experience violence and abuse are often denied justice and avoid vital services, care and support.[19]

15 Shapiro A, Duff P (2021) Sexual and Reproductive Health and Rights Inequities Among Sex Workers Across the Life Course. Springer Nature. Available at: https://link.springer.com/chapter/10.1007/978-3-030-64171-9_4
16 NSWP (2019) Policy Brief: The Impact of Anti-trafficking Legislation and Initiatives on Sex Workers. Available at: https://www.nswp.org/resource/nswp-policy-briefs/policy-brief-the-impact-anti-trafficking-legislation-and-initiatives-sex
17 Shannon K et al (2015) Global Epidemiology of HIV Among Female Sex Workers: Influence of Structural Determinants. The Lancet 385 (9962): 55–71. Available at: https://pubmed.ncbi.nlm.nih.gov/25059947/
18 NSWP (2016) Policy Brief: The Decriminalisation of Third Parties. Available at: https://www.nswp.org/resource/nswp-policy-briefs/policy-brief-the-decriminalisation-third-parties
19 NSWP (2017) The Impact of Criminalisation on Sex Workers' Vulnerability to HIV and Violence. Available at: https://www.nswp.org/resource/nswp-policy-briefs/the-impact-criminalisation-sex-workers-vulnerability-hiv-and-violence

Punitive policing and surveillance further push sex workers into isolated or unsafe areas to avoid detection, heightening their vulnerability to abuse. Additionally, criminalization, including the criminalization of clients, has been found to reduce sex workers' ability to negotiate condom use and implement safety measures, such as screening clients.[20] In certain contexts, police may also confiscate condoms as "evidence" of sex work, discouraging sex workers from carrying essential prevention tools.[21]

3.2 Stigma and discrimination

Stigma and discrimination towards sex workers arise from broader societal norms surrounding gender, sexuality and respectability as well as from biases and misconceptions about sex work itself. These include conflating sex work with trafficking and exploitation, framing sex workers as "vectors of disease" and portraying sex workers as "deviants" or criminals. Such ingrained biases shape how sex workers are treated within health systems and affect their willingness to access care. They may also lead to internalized stigma and diminishing feelings of self-worth, causing some sex workers to feel undeserving of, or too ashamed, to seek care.

> ***"I went to the ER with a lot of abdominal pain and was denied services because I was a sex worker. They told me they had to finish with the rest of their patients first before providing me with assistance."***
>
> Female sex worker, Peru

Sex workers consistently report high levels of stigma and discrimination in SRH care settings. Those sex workers facing multiple, intersecting forms of marginalization, such as male and transgender sex workers, sex workers who use drugs, migrant sex workers and those living with HIV, experience even higher levels of discrimination. Stigma and discrimination are most frequently reported in public healthcare facilities, where staff are seldom sensitized to sex workers' needs. However, sex workers also report stigma and discrimination in other healthcare settings, contributing to a broader reluctance to access services.[22]

The table below provides examples of how stigma and discrimination towards sex workers can manifest in healthcare settings. These examples were gathered through community-led consultations conducted by NSWP and have also been documented by regional sex worker-led networks.[23]

20 Krüsi A et al (2014) Criminalisation of Clients: Reproducing Vulnerabilities for Violence and Poor Health Among Street-Based Sex Workers in Canada – A Qualitative Study. BMJ Open. 4(6):e005191. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC4054637/

21 Open Society Foundations (2012) Criminalizing Condoms. Available at: https://www.opensocietyfoundations.org/reports/criminalizing-condoms

22 NSWP Briefing Paper: Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services.

23 European Sex Workers' Rights Alliance (2023) "Two Pairs of Gloves": Sex Workers' Experiences of Stigma and Discrimination in Healthcare Settings in Europe. Available at: https://www.eswalliance.org/two_pairs_of_gloves_sw_experiences_stigma_discrimination_healthcare_europe

Table 1: What do stigma and discrimination look like in healthcare settings?

Type of discrimination	What it can look like
Verbal abuse or judgement	Insulting or moralizing comments, name-calling, shaming, judgements about sex workers being "immoral," "careless," or undeserving of equal care; blaming sex workers for their health problems
Hostile or unfriendly environment	Negative body language, gossip, visible discomfort among staff when sex work is mentioned
Breaches of privacy and confidentiality	Forcing sex workers to disclose their sex worker status without consent, lack of private spaces for service provision, insufficient data protection
Lack of informed consent	Refusing to provide sex workers with full information due to assumptions that they don't need or won't understand something
Excessive focus on sex work	Asking intrusive or irrelevant questions about sex work, even when they are unrelated to the reason for the visit
Treating sex workers as "dirty" or "contaminated"	Double-gloving, excessive handwashing or using a separate set of equipment for sex workers
Gatekeeping services or "exit" requirements	Requiring sex workers to exit sex work in order to access services
Denial of care	Refusing to provide services to sex workers due to their sex worker status

Stigma and discrimination significantly affect sex workers' experiences in SRH care settings and overall access to care. They can also have wider, community-level impacts: when one sex worker encounters stigma and discrimination in a clinic, other sex workers who witness or hear of the discrimination may be discouraged from accessing services.[24]

To avoid or reduce experiences of stigma and discrimination in healthcare settings, sex workers may adopt various coping strategies, including:

- Concealing their occupation in healthcare settings
- Missing follow-up appointments or discontinuing care due to prior negative experiences
- Delaying or avoiding care altogether
- Relying on self-medication or informal services provided by non-health professionals, including informal and unsafe abortion services.

These practices limit sex workers' ability to access tailored, quality SRH services and increase their vulnerability to preventable complications and poor health outcomes. The negative impacts are felt most acutely by sex workers who face multiple, overlapping forms of marginalization, deepening existing health inequities. [25]

24 Oneko T (2015) Impact of Stigma on Utilization of Health Services Among Sex Workers in Kenya. 10.13140/RG.2.1.5062.0888. Available at: https://www.academia.edu/65190418/Impact_of_Stigma_on_Utilization_of_Health_Services_Among_Sex_Workers_in_Kenya

25 NSWP Briefing Paper: Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services.

3.3 Violence in healthcare settings

Stigma and discrimination can also escalate into emotional, physical and sexual violence against sex workers in healthcare settings.[26] This constitutes a violation of sex workers' fundamental human rights and bodily autonomy as well as a serious breach of medical ethics.

Such violence is not only interpersonal; it is often systemic, enabled by unequal power dynamics, lack of accountability and ingrained prejudice within health institutions. Violence against sex workers in healthcare settings is not a set of isolated incidents, but a sign of deeper structural inequalities. These intersect with racism, transphobia, homophobia and stigma related to drug use, migration, HIV status and other factors, compounding vulnerability. Examples include:

- **Physical violence**, including the use of physical force that may cause injury, harm or death[27]
- **Emotional and psychological violence**, including insults, degradation or humiliation, threats of harm and controlling or coercive behaviour[28]
- **Sexual harassment or abuse** perpetrated by healthcare providers or staff, sometimes under the guise of medical care or advice[29]
- **Forced or coerced procedures**, such as sterilization,[30] abortion[31] and mandatory HIV or STI testing,[32] conducted without informed consent or under pressure.

26 WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions.
27 WHO (2002) World Report on Violence and Health. Available at: https://www.who.int/publications/i/item/9241545615 UNFPA, APNSW and UNDP (2015) Sex Work, Violence and HIV in Asia – from Evidence to Safety. Available at: https://asiapacific.unfpa.org/en/publications/sex-work-violence-and-hiv-asia-evidence-safety
28 NSWP Briefing Paper: Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services.
29 European Sex Workers' Rights Alliance "Two Pairs of Gloves": Sex Workers' Experiences of Stigma and Discrimination in Healthcare Settings in Europe.
30 IPPF (2022) Technical Brief: Fulfilling the Sexual and Reproductive Rights of Women Living with HIV, Preventing Coerced and Forced Sterilization. Available at: https://acr.ippf.org/resource/technical-brief-fulfilling-sexual-and-reproductive-rights-women-living-hiv-preventing
31 International Community of Women Living with HIV (2024) Confronting Coercion: A Global Scan of Coercion, Mistreatment and Abuse Experienced by Women Living with HIV. Available at: https://www.wlhiv.org/reproductivejustice
32 NSWP (2015) HIV and STI Testing and Treatment Policies. Available at: https://www.nswp.org/resource/nswp-publications/hiv-and-sti-testing-and-treatment-policies

4

Sex workers' sexual and reproductive healthcare needs

Sex workers, like everyone else, require comprehensive, respectful and person-centred SRH services. This chapter outlines the core components of SRH services for sex workers of all genders and includes issues that should be considered to meet the diverse needs of different groups within sex worker communities.

4.1 Principles of rights-based care

All SRH and other health services provided to sex workers must be grounded in respect for human rights and adhere to core principles of ethical, evidence-based service delivery. The meaningful participation of sex workers in the design, delivery, implementation and monitoring and evaluation of SRH services is essential: this is explored further in Chapters 5 and 6.

Table 2: SRH services for sex workers should uphold the following standards

1. Availability	A comprehensive range of SRH interventions must be available to sex workers. Services should be adequately staffed and resourced to function effectively.
2. Accessibility	Services must be physically and logistically accessible. This includes convenient service locations and operating hours that match sex workers' schedules; reasonable waiting times; and options for mobile, outreach or co-located services, such as through a "one-stop-shop" model. Services should be available to sex workers regardless of their immigration status or documentation.
3. Acceptability	Services must be delivered in ways that are safe, non-judgemental, culturally appropriate, trauma-informed and gender-affirming. Healthcare providers must be trained and sensitized to respect sex workers' diverse identities, experiences and needs.
4. Confidentiality and privacy	Clients' information, records and personal identifying data must be protected. Sex workers should be allowed to access services without providing their legal or birth name, government identification or biometric data. Private and discreet intake procedures, consultation spaces and follow-up procedures must be ensured.
5. Voluntary and informed consent	Clear, accurate and easy-to-understand information must always be provided so that sex workers can make informed decisions about their health. Sex workers must always be able to refuse any examination, test or treatment without threats, coercion or pressure. Mandatory HIV and STI testing and treatment should never be implemented.
6. Affordability	Services for sex workers should be free or low-cost. Since many sex workers lack access to health insurance, sick leave and other social protection benefits, affordability is essential to ensuring equitable care.
7. Quality	SRH services for sex workers must be appropriate to their needs and of high quality. This means that services must be evidence-based, timely, person-centred and in line with international health standards and best practices, delivered by non-judgemental healthcare providers.

These standards are aligned with international guidance,[33,34] which emphasizes the importance of rights-based care, informed by communities' needs and lived experiences.

4.2 Comprehensive sexual and reproductive health services for sex workers

Like all people, sex workers require access to comprehensive SRH services to meet their

33 WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions.
34 WHO Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations.

diverse needs across the life course. The list below represents the core SRH components that should be routinely available to sex workers in various settings. These components have been informed by global best practice guidelines, including the WHO Consolidated Guidelines on HIV, Viral Hepatitis and STIs for Key Populations; Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions; and IPPF's IMAP Statement on Sex Worker-Centred SRH Services.

Comprehensive SRH services for sex workers

- **HIV and STI prevention, testing and treatment**
- **Contraceptive counselling and services**
- **Safe and respectful pregnancy care**
- **Abortion and post-abortion care**
- **Fertility care**
- **Reproductive tract cancer screening (e.g. cervical, ano-rectal and prostatic cancers)**
- **General gynaecology and management of reproductive tract infections**
- **Gender-affirming care for trans and gender-diverse sex workers**
- **Clinical care and psychological support for survivors of sexual and gender-based violence**
- **Mental health services**

4.2.1 HIV and STI prevention, testing and treatment

HIV and STI services are a core component of healthcare for sex workers, including as part of SRH care. These services often receive the most attention in health programming for sex workers, and are frequently delivered as standalone interventions, rather than within an integrated package of care. Despite overall progress in HIV prevention and treatment globally,[35] sex workers continue to be disproportionately affected by HIV and STIs, exacerbated by inadequate access to rights-based services.[36] Reports consistently show that sex workers are at higher risk of acquiring HIV compared to the general adult population – nine times higher in 2022 – while also experiencing lower coverage of antiretroviral therapy and combination HIV prevention services.[37]

Essential components of care:

- Voluntary, confidential HIV and STI testing offered in multiple settings and channels (e.g. community-led services, mobile outreach, clinic-based options and self-testing)
- Pre-exposure prophylaxis (PrEP) to prevent HIV, including long-acting injections
- Post-exposure prophylaxis (PEP) to prevent HIV and STIs
- Consistent access to high-quality condoms and lubricants
- Immediate antiretroviral therapy (ART) initiation for people who test positive for HIV, regardless of their CD4 cell count
- HIV and STI treatment, follow-up and adherence support
- HIV/STI counselling and psychosocial support
- Peer navigation and referrals to other services as needed.

All HIV and STI services must be voluntary and based on autonomous, informed choice. Mandatory testing and treatment violate sex workers' bodily autonomy and right to self-determination, while increasing distrust of health systems. In addition, periodic presumptive treatment of STIs is not recommended for sex workers due to concerns regarding antimicrobial resistance, health risks associated with repeated antibiotic use and the way it reinforces stereotypes of sex workers as "vectors of disease."[38] Instead, sex workers and sex worker-led organizations have called for increased access to evidence-based STI testing and prevention options.[39]

4.2.2 Contraceptive counselling and services

Sex workers have diverse values, preferences and goals related to contraception, yet evidence shows high unmet needs and inadequate access to services and options.[40] Beyond their work lives, many sex workers have private partners with

35 UNAIDS (2025) Global AIDS Update 2025. Available at: https://www.unaids.org/en/UNAIDS-global-AIDS-update-2025
36 WHO Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations.
37 UNAIDS The Urgency of Now.
38 WHO Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations.
39 Ibid.
40 Birger L, Peled E and Benyamini Y (2024) Stigmatizing and Inaccessible: The Perspectives of Female Sex Workers on Barriers to Reproductive Healthcare Utilization – A Scoping Review. *Journal of Advanced Nursing*, 80, 2273–2289. Available at: https://onlinelibrary.wiley.com/doi/10.1111/jan.16010

whom contraceptive needs vary. Therefore, sex workers should have access to the full range of contraceptive options and adequate information to make informed decisions.

Essential components of care:

- Comprehensive counselling on contraception, including information on correct usage, method effectiveness, side effects and health risks and benefits
- Access to the full range of contraceptive methods, including condoms, oral contraceptives, injectable methods, emergency contraception, long-acting reversible contraceptives (e.g. intrauterine devices and implants) and permanent contraception (vasectomy, tubal ligation)
- Support for switching methods and managing contraceptive side effects.

Forced or coerced contraception or sterilization constitute serious violations of human rights and are never acceptable. As such violations have been documented across diverse groups of marginalized women, providers must take particular care to ensure that their approach to contraceptive services is based on voluntary, informed consent and respect for sex workers' autonomy.

4.2.3 Safe and respectful pregnancy care

Sex workers must be provided with access to information and services to promote safety and wellbeing at all stages of pregnancy, from pre-pregnancy counselling to post-natal care. However, bias and stigma often reinforce the myth that sex work is incompatible with parenthood, leading many providers to overlook or dismiss sex workers' reproductive and family planning goals.[41] In reality, many sex workers are parents or wish to become parents in the future, underscoring the need for attentive, non-judgemental pregnancy care and support.

Essential components of care:

- Pre-pregnancy counselling and treatment
- Pregnancy testing and early pregnancy counselling
- Antenatal care, including routine screenings and management of pregnancy-related conditions and screening (and referral) for high-risk pregnancies
- Prevention of parent-to-child (vertical) transmission for HIV-positive sex workers
- Safe labour and delivery services, including emergency obstetric and newborn care
- Post-natal care, including breastfeeding support, mental health screening and linkages to other services as needed.

More details on providing pregnancy care services can be found in IPPF's Client-Centred Clinical Guidelines.[42]

4.2.4 Abortion and post-abortion care

Unsafe abortion is a leading – yet preventable – cause of maternal mortality and morbidity.[43] Access to safe abortion and post-abortion care is an essential component of SRHR, however, significant barriers remain worldwide. For sex workers, these barriers are compounded by reduced access to contraception, vulnerability to sexual and gender-based violence and difficulties negotiating condom use, which can increase the risk of unintended pregnancy.[44]

Evidence shows that abortion is common within sex worker communities, and a significant proportion occur without clinical supervision, which increases the risk of complications.[45] In line with international human rights and public health guidance, abortion should be fully decriminalized and accessible to all people, including sex workers.[46] In settings where restrictions remain, sex workers should be supported to obtain the safest possible care that is available within existing legal frameworks.

41 NSWP (2018) Policy Brief: The Impact of Stigma and Discrimination on Key Populations and Their Families. Available at: https://www.nswp.org/resource/nswp-policy-briefs/policy-brief-the-impact-stigma-and-discrimination-key-populations-and
42 IPPF (2022) Client-Centred Clinical Guidelines for Sexual and Reproductive Healthcare. Available at: https://www.ippf.org/cccg
43 WHO (2025) Abortion. Available at: https://www.who.int/news-room/fact-sheets/detail/abortion
44 Ampt FH, Willenberg L, Agius PA et al (2018) Incidence of Unintended Pregnancy Among Female Sex Workers in Low-Income and Middle-Income Countries: A Systematic Review and Meta-Analysis. *BMJ Open*;8:e021779. Available at: https://bmjopen.bmj.com/content/8/9/e021779.long
45 Khezri M et al (2023) Global Epidemiology of Abortion Among Female Sex Workers: A Systematic Review, Meta-Analysis, And Meta-Regression. *Ann Epidemiol* 85: 13-37. Available at: https://cdpe.org/wp-content/uploads/2024/07/Global-epidemiology-of-abortion-among-female.pdf
46 WHO (2022) Abortion Care Guideline. Available at: https://www.who.int/publications/i/item/9789240039483

Essential components of care:

- Clear, evidence-based information on abortion options and non-judgemental counselling
- Access to and choice of safe abortion methods (including medical and surgical, and clinic-based and self-managed, where legal and appropriate)
- Comprehensive post-abortion care, including treatment of complications, psychosocial support and voluntary contraceptive counselling
- Referrals to additional SRH services as needed.

4.2.5 Fertility care

Fertility care is an important aspect of SRHR for sex workers who wish to have children now or in the future. Fertility care is not only about managing infertility, but also about providing information, counselling and options to support the reproductive goals of sex workers of all genders. Sex workers living with HIV or those who are in sero-discordant relationships also require equal access to fertility care, free from stigma or discrimination. All fertility care must be inclusive and non-judgemental, respecting the rights of all sex workers, regardless of their gender identity, sexual orientation, health status or family structure.

Essential components of care:

- Management and treatment of infertility
- Information and counselling on fertility preservation for trans and gender-diverse sex workers who are using or planning to use hormone replacement therapy
- Pre-pregnancy counselling and safer conception services for sex workers living with HIV or in sero-discordant relationships, integrated with HIV prevention, treatment and care
- Access or referral pathways to assisted reproductive care (such as intrauterine insemination or in vitro fertilization, where available)
- Referrals to specialists as needed (e.g. gynaecologists, urologists and endocrinologists).

4.2.6 Reproductive tract cancer screening

Sex workers face elevated risks for reproductive tract cancers, yet remain under-served in screening programmes.[47] Studies shows high rates of human papilloma virus (HPV) among cisgender female sex workers, alongside lower uptake of routine cervical screening, reducing the likelihood of early detection.[48] Sex workers who engage in anal sex also face a higher risk of anal HPV and related cancers. However, ano-rectal screening is rarely offered, and may require disclosure of sexual practices. This creates additional barriers where same-sex relations or anal sex are stigmatized or criminalized. Information on prostate cancer should be available to sex workers with a prostate, with screenings offered in a non-judgemental, inclusive manner.

Essential components of care:

- Cervical cancer screening using HPV DNA testing as the preferred method (every five to ten years starting at age 30 or three to five years for people living with HIV); cytology or visual inspection with acetic acid may be used where HPV DNA testing is unavailable (performed every three years); self-sampling should be offered as an additional option[49]
- Information on ano-rectal cancer and its risk factors for all sex workers; screening should be offered without requiring disclosure of sexual practices
- For sex workers with a prostate, information and counselling on prostate cancer risk, with testing offered based on individual risk factors.

4.2.7 General gynaecology and management of reproductive tract infections

General gynaecology addresses health concerns related to the vulva, vagina, cervix, uterus, fallopian tubes or ovaries. These concerns can affect any sex worker who has these organs, regardless of their gender identity. However, sex workers report consistent challenges in accessing respectful and holistic gynaecological care that considers their

47 Vimpere L, Sami J, Jeannot E (2023) Cervical Cancer Screening Programs for Female Sex Workers: A Scoping Review. *Front Public Health*.11:1226779. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10570451/
48 Ibid.
49 WHO (2021) WHO Guideline for Screening and Treatment of Cervical Pre-Cancer Lesions for Cervical Cancer Prevention. Available at: https://www.who.int/publications/i/item/9789240030824

broader healthcare needs beyond HIV and STIs.[50] In many settings, limited access to services and user-friendly information may contribute to delayed care-seeking for common gynaecological needs.

Essential components of care:

- Counselling, information and care on menstrual health, hygiene, prevention of reproductive tract infections, support for other menstrual health conditions and access to hygiene products
- Gynaecological examinations
- Symptomatic testing, treatment and follow-up for candidiasis, bacterial vaginosis and other reproductive tract (including sexually transmitted) infections
- Diagnosis and management of underlying gynaecological conditions associated with pelvic pain, abnormal bleeding and other concerns.

4.2.8 Gender-affirming care for transgender and gender-diverse sex workers

Trans and gender-diverse sex workers frequently encounter discriminatory and degrading treatment in SRH care settings. Multiple layers of stigma, including transphobia, homophobia and judgement around sex work intensify barriers to care and increase vulnerability to violence as well as poor health outcomes.[51] Due to the lack of targeted, rights-based and gender-affirming services, some trans sex workers may self-medicate with hormones and other gender-affirming treatments, risking their health.[52]

Since trans and gender-diverse sex workers share many of the same health needs as cisgender sex workers, all services should be delivered in ways that are gender-inclusive by default. At the same time, trans and gender-diverse sex workers may have additional needs related to hormone therapy, gender-affirming procedures and fertility.

Essential components of care:

- Gender-inclusive contraceptive counselling, including information about the possibility of pregnancy and interactions between hormones and other medications
- Comprehensive counselling on hormone therapy, including the benefits, risks and impacts on fertility
- Initiation, monitoring and management of gender-affirming hormone therapy
- Access and referrals to gender-affirming surgeries or procedures
- Counselling on fertility and referral to fertility preservation services for those who may want to have children now or in the future.

Below are recommendations for providers on strengthening services that are gender-affirming, inclusive and respectful for trans and gender-diverse sex workers. More detailed guidance can be found in IPPF's Technical Brief: Designing and Delivering Inclusive, Rights-Based Sexual and Reproductive Healthcare to Transgender and Gender Diverse People.[53]

50 Shapiro A, Duff P (2021) Sexual and Reproductive Health and Rights Inequities Among Sex Workers Across the Life Course. *Springer*. Available at: https://www.ncbi.nlm.nih.gov/books/NBK585697/

51 NSWP Briefing Paper: Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services.
Ganju D, Saggurti N (2017) Stigma, Violence and HIV Vulnerability among Transgender Persons in Sex Work in Maharashtra, India. *Cult Health Sex*.19(8):903-917. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC6176758/

52 NSWP Briefing Paper: Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services.

53 IPPF (2025) Technical Brief: Designing and Delivering Inclusive, Rights-Based Sexual and Reproductive Healthcare to Transgender and Gender Diverse People. Available at: https://www.ippf.org/resource/technical-brief-designing-and-delivering-inclusive-rights-based-sexual-and-reproductive

Figure 3: Providing services to trans and gender-diverse sex workers: do's and don'ts

Do's	Don'ts
✓ Ask for a client's pronouns and chosen name and use them consistently, even if they differ from official documents.	✗ Misgender clients or use the name printed on their identification documents when they have provided another.
✓ Include representation of diverse gender identities in intake forms, health records and informational materials.	✗ Force clients to choose between "male" and "female," representing limited gender expressions.
✓ Provide gender-affirming care that respects autonomy, bodily diversity and different transition pathways.	✗ Question, challenge or invalidate a client's gender identity or transition decisions.
✓ Use gender-neutral language based on anatomy, function and form (e.g. "internal condom," "external condom").	✗ Use gendered terms like "male condom" or "female reproductive system".
✓ Protect client confidentiality, including details about transition status and gender assigned at birth.	✗ Disclose a client's gender identity or transition history to staff or others without explicit consent and medical need.
✓ Focus on anatomy only when it is medically relevant to the care being sought.	✗ Focus on or inquire about a client's genitalia when it is medically unnecessary.
✓ Collaborate with trans sex worker-led organizations to co-design and implement SRH programmes for their communities.	✗ Design or implement programmes for trans sex workers without meaningfully involving them.

4.2.9 Clinical care and psychological support for survivors of sexual and gender-based violence

Sexual and gender-based violence (SGBV) violates human rights and has a major impact on the health and wellbeing of those subjected to it. Women and girls are disproportionately vulnerable to SGBV, however, it can affect individuals of all gender identities and sexual orientations.[54] Sex workers are particularly impacted due to stigma, discrimination and criminalization, which foster an environment of impunity for perpetrators.[55] These risks are heightened for sex workers who face overlapping forms of marginalization.[56]

Although violence amongst sex worker communities has been widely documented, access to sensitive, trauma-informed SGBV services remains limited. Many sex workers report discriminatory or dismissive treatment in public health facilities, including victim-blaming. In contrast, services and accompaniment provided by sex worker-led organizations are associated with safer, more respectful and more positive experiences of care.[57] All services for survivors of SGBV should be integrated into broader SRH care to support continuity of care and follow-up for health issues that may arise due to violence.[58]

Essential components of care:

- First-line support, including practical care and responses to immediate emotional,

54 IPPF (2020) IMAP Statement on Sexual and Gender-based Violence. Available at: https://www.ippf.org/resource/imap-statement-sexual-and-gender-based-violence
55 Platt L et al Associations Between Sex Work Laws and Sex Workers' Health: A Systematic Review and Meta-Analysis of Quantitative and Qualitative Studies.
56 NSWP (2017) The Impact of Criminalisation on Sex Workers' Vulnerability to HIV and Violence. Available at: https://www.nswp.org/resource/nswp-policy-briefs/the-impact-criminalisation-sex-workers-vulnerability-hiv-and-violence
57 NSWP Global Findings on Sex Workers' Access to Social Protection and Sexual and Reproductive Health and Rights.
58 IPPF Technical Brief: Designing and Delivering Inclusive, Rights-Based Sexual and Reproductive Healthcare to Transgender and Gender Diverse People.

physical and safety needs, such as through safe emergency shelters. Providers should follow the LIVES approach: **L**isten, **I**nquire about concerns, **V**alidate, **E**nhance safety and **S**upport[59]
- History taking and physical examination
- Emergency contraception
- Post-exposure prophylaxis (PEP) for HIV and STIs
- Psychological counselling and support
- Referrals to other services (e.g. medical, legal, social, community-based protection) as needed.

4.2.10 Mental health services

Mental healthcare is vital to enhance sex workers' wellbeing and is a critical component of SRHR. Sex workers experience high rates of depression, anxiety and post-traumatic stress.[60] This is not because sex work is inherently harmful or traumatizing, but rather due to criminalization, stigma, discrimination and violence, coupled with the lack of legal and social protections. Stigma within healthcare settings amplifies barriers to mental health and can discourage sex workers from seeking care and support.[61]

While acknowledging these structural factors, healthcare providers should focus on identifying and treating mental health symptoms and conditions with care and compassion, without seeking to determine their exact cause.

Essential components of care:

- Routine, non-stigmatizing mental health screenings integrated into SRH consultations
- Psychological counselling and psychosocial support, including peer-led models
- Integrating psychological support into SGBV services
- Crisis support and safety planning
- Trauma-informed care delivered by providers who have been trained by sex worker-led organizations
- Referral pathways to sex worker-friendly mental health specialists.

Why does mental health matter for SRHR?

Mental health affects vulnerability: stress, trauma and depression can reduce sex workers' ability to negotiate safer sex and maintain boundaries.

Poor mental health is a barrier to care: mental health challenges can make it harder to seek out, access and navigate SRH services – especially within complex or unwelcoming systems. This can lead to missed appointments, delayed care or trouble adhering to treatment.

Healthcare settings can be harmful: systemic stigma, discrimination, abuse and neglect within healthcare settings can traumatize sex workers and deepen mistrust.

Violence is common: given sex workers' disproportionate vulnerability to SGBV, integrating trauma-informed care and psychological support into SRHR programming is critical.

4.3 Service delivery models

Because sex workers face numerous barriers to accessing healthcare, SRH services must be flexible and responsive to their lived realities. Different models of service delivery should be promoted to provide more accessible alternatives to standard facility-based care, adapting the way that services are organized and delivered. All models and approaches should be designed and implemented in partnership with sex worker-led organizations.

4.3.1 Integrated care and the "one-stop-shop" model

Sex workers' diverse healthcare needs are often interrelated. But in many settings, comprehensive SRH services are not integrated and offered in a single facility, requiring sex workers to travel to multiple locations. This fragmentation can lead to loss to follow-up or force sex workers to prioritize

59 WHO (2014) Health Care For Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook. Available at: https://www.who.int/publications/i/item/WHO-RHR-14.26

60 Beattie TS, Smilenova B, Krishnaratne S, Mazzuca A (2020) Mental Health Problems Among Female Sex Workers in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis. *PLoS Med* 17(9): e1003297. Available at: https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003297
Martín-Romo L, Sanmartín FJ, Velasco J (2023) Invisible and Stigmatized: A Systematic Review of Mental Health and Risk Factors among Sex Workers. *Acta Psychiatr Scand*.148(3):255-264. Available at: https://onlinelibrary.wiley.com/doi/10.1111/acps.13559

61 Brunswig F, Desbuleux-Rettel J, Kratzer L et al (2026) Sex Work Stigma and Psychological Distress – A Mixed-Methods Analysis of an International Sample of Sex Workers. *Sex Res Soc Policy* 23, 182–190. Available at: https://link.springer.com/article/10.1007/s13178-025-01133-4

certain services over others due to financial, logistical or time constraints.[62]

Where possible, multiple SRH services for sex workers should be integrated and offered in one location, also known as the "one-stop-shop" model of care. This allows sex workers to address various, holistic needs in a single location, reducing logistical barriers to service uptake while promoting more comprehensive care. WHO has recommended integrating HIV, viral hepatitis and STI services for sex workers, in addition to integrating other clinical services for SRH, mental health and parent and child health in one setting, where possible.

Good practice example: "one-stop-shop" model – SWING clinic, Thailand

The community-based organization, SWING (Service Workers in Group Foundation), operates three health clinics for sex workers of all genders in Bangkok and Pattaya, Thailand. Sex workers are employed to deliver peer-led services. The clinics offer comprehensive HIV prevention, testing and treatment, STI and hepatitis C screening, gender-affirming care counselling and holistic support for physical, mental and social wellbeing. Operating as a one-stop-shop model, SWING estimates that its services reach between 20,000 to 30,000 sex workers each year.[63]

4.3.2 Digital and online services

Delivering SRH services via digital platforms, online or "telemedicine" is becoming increasingly widespread. This can help people find out about services, access health information and counselling, and schedule and attend medical appointments virtually. While digital health interventions offer several advantages, such as convenience and increased access to information and services for those using these technologies, they also present numerous challenges and risks for sex workers as a criminalized and marginalized population.

One of the main concerns surrounding digital or online services for sex workers is around data protection and privacy. Online or digital health services may require the collection of sensitive data, including personal identifying information, HIV and STI status, or information that may identify a person as a sex worker. Existing data protection policies and systems do not always adequately protect this information, putting sex workers at risk of legal repercussions.

In addition, the spread of health services that are online only or require the use of digital technologies may reinforce existing inequities among sex workers. Due to marginalization, poverty and the global digital divide, many sex workers have unequal access to the digital technologies and stable internet connections needed to take advantage of online health services. In some contexts, these barriers may be compounded by lower levels of digital literacy, making it more difficult for sex workers to use online or digital services safely and effectively.[64]

For these reasons, digital health interventions should be offered alongside in-person services – not as a replacement.[65] To increase access to information and expand service delivery options, IPPF recommends a hybrid SRH service delivery model that integrates in-person care with digital health interventions.[66] All digital health interventions must be designed with meaningful involvement from sex workers, with attention given to ensuring safety, transparency and equity.

4.3.3 Differentiated service delivery

Differentiated service delivery (DSD) refers to models of care that are adapted and streamlined to better meet clients' needs while reducing burdens on health systems. This is achieved by adjusting where, when, how and by whom services are delivered. Originally developed for HIV services, DSD approaches are also highly relevant for SRH care for sex workers.

DSD can include arrangements that allow sex workers to take on a range of roles as community health workers, in line with national policies. This can include provisions that allow trained sex workers, under the supervision of a clinician, to dispense certain medications, such as PrEP, ART or

62 NSWP Briefing Paper: Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services.
63 SWING. Available at: https://www.swingthailand.org/en/swingstory
64 Mokhwelepa LW Sumbane GO (2026) Digital Health Interventions as a Catalyst for Change: A Narrative Review of the Roles of Digital Health in Enhancing Well-Being and Reducing Public Health and Social Issues among Sex Workers. Digital Health;12. Available at: https://journals.sagepub.com/doi/10.1177/20552076251382056
65 WHO Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations.
66 IPPF (2022) IMAP Statement on DHI for SRHR. Available at: https://www.ippf.org/resource/imap-statement-dhi-srhr

oral contraception. DSD approaches allow services to be shifted away from central health facilities to more accessible settings, such as community health clinics, local primary health centres and mobile or outreach spots. DSD can also include measures to increase the flexibility of clinic hours and reduce frequency of visits for clients who are medically stable. These adaptations can address both logistical barriers to healthcare as well as reduce exposure to stigma and discrimination. More information on how DSD models can be integrated as part of a community empowerment approach can be found in Chapter 5.

4.4 Practical and logistical considerations

Beyond service delivery models, there are many day-to-day factors that can determine whether services are accessible and acceptable to sex workers in practice. Many sex workers face significant logistical, financial and bureaucratic obstacles that may not be obvious to SRH care providers, yet which powerfully shape their access to care. Below are common barriers to health services reported by sex workers during consultations, along with strategies that can be used to address them:

Table 4: Service access barriers and strategies

Area	Barrier	Strategies
Operating hours and scheduling	Sex workers often work during the night and rest during the day, making standard clinic hours inaccessible. Irregular and unstable schedules may also make it more difficult for sex workers to access services when there are long waiting times or when multiple visits are required.	✓ Offer services during the evening, night or weekend. ✓ Offer flexible, walk-in and same-day appointments to increase uptake and reduce loss to follow-up. ✓ Arrange dedicated clinic hours or time slots for sex workers, which can enhance privacy and reduce stigma.
Location	Services are often located far from where sex workers live or work, which requires additional time and transportation arrangements. This can be particularly challenging for sex workers who are in mobile or unstable housing.	✓ Offer services in community-based locations, including drop-in centres, work venues or sex work "hotspots". ✓ Invest in mobile outreach, satellite clinics and/or pop-up SRH services in collaboration with sex worker-led organizations. ✓ Integrate and co-locate services to reduce the burden of having to travel to multiple locations.
Cost and affordability	Many sex workers are excluded from national health insurance schemes or avoid public health systems due to stigma and discrimination. This reality makes many sex workers reliant on private or NGO-run services for SRH care. However, even small fees for health services in these settings can be prohibitive for sex workers. In some cases, sex workers may also be illegally charged for services, which are meant to be free.	✓ Ensure all SRH services are free or heavily subsidized for sex workers. ✓ Establish a transparent fee structure to reduce the likelihood of sex workers being charged illegally. ✓ Advocate for the inclusion of sex workers in national health insurance schemes to expand their access to public health services.
Bureaucracy and documentation	Lack of legal identification, health insurance, proof of residence or mismatching names and gender markers on documents can create significant barriers to access to SRH services. These barriers disproportionately affect sex workers who are trans or gender-diverse, migrants and/or undocumented.	✓ Remove requirements for documentation wherever possible. ✓ Allow clients to access services anonymously or using pseudonyms. ✓ Partner with sex worker-led organizations to establish referral pathways that can reduce paperwork and bureaucracy.


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5

Community empowerment and community-led services

Community empowerment plays a central role in promoting sex workers' agency, self-determination and capacity-building within SRH programming. While service delivery models determine how care is structured, community empowerment shapes who holds power within those systems. It enables sex workers to take control of their own health and healthcare for their communities. Supported by a robust body of evidence, community empowerment has been identified by WHO as an essential component of sex worker interventions, which should be led by sex workers themselves.[67]

This chapter explores what community empowerment means in the context of sex workers' SRHR and the different forms community-led SRH interventions can take. It also outlines guiding principles for SRH programmes to support community empowerment and meaningful involvement, which form the backbone of effective, rights-based partnerships.

5.1 Community empowerment

Community empowerment is the process of sex workers taking ownership of programming for their communities, including addressing structural barriers to their health and human rights. It is not a fixed set of activities, but rather an approach that treats sex workers as active partners, leaders and implementers, instead of passive recipients or beneficiaries.

By definition, the process of community empowerment must be led by sex workers themselves. However, SRH care providers and advocates can play an important role in facilitating and making space for community empowerment initiatives and ensuring that sex workers play meaningful roles in the design, delivery, and monitoring and evaluation of SRH programming.

Figure 2: Key elements of community empowerment

Source: WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP (2013) Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions

67 WHO (2012) Prevention and Treatment of HIV and other Sexually Transmitted Infections for Sex Workers in Low- and Middle-Income Countries. Available at: https://www.who.int/publications/i/item/9789241504744;
WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions;
WHO Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations.

5.1.1 Foundations for partnering with sex workers

True meaningful involvement requires intentional, sustained engagement with sex workers as well as creating structures that support their ongoing participation. These efforts must be grounded in respect for sex workers' lived experiences, knowledge and priorities, reflecting a commitment to shifting power dynamics and challenging the status quo.

What is meaningful involvement?

Meaningful involvement means that sex workers:

- Choose how they are represented and by whom
- Choose how they are engaged in the process
- Choose whether to participate
- Have an equal voice in how partnerships are managed
- Are actively involved in all levels of programming.[68]

Five fundamental principles for partnering with sex workers

The following principles draw from broader community empowerment frameworks. While not exhaustive, they offer a foundation for building respectful, collaborative partnerships with sex workers based on a community empowerment approach.

Table 5: Five fundamental principles for partnering with sex workers

1. Build trust intentionally	Many sex workers have experienced harm or exclusion from health systems and people in positions of power. Rebuilding trust requires time, consistency, humility and an openness to learn. It is important that partners take time to meet with and listen to sex workers to understand their needs, priorities and lived experiences, without imposing an agenda.
2. Recognize sex workers as experts	Sex workers are the foremost experts in their own lives and work. They are uniquely aware of the structural, legal, institutional, socioeconomic and cultural barriers that affect their access to rights and healthcare. Sex workers' lived experiences should be treated as valuable expertise that informs all levels of decision-making.
3. Prioritize co-design and collaboration	Meaningfully involving sex workers goes beyond just consulting them. It requires a commitment to shared decision-making at every stage of programming. Sex workers should be actively invited to participate in the design, implementation and evaluation of services, and should be compensated fairly for their time, knowledge and labour.
4. Create structures for ongoing participation	Sex workers' meaningful participation must be built into programming and health systems, not added as an afterthought. This can include: • Employing sex workers directly in staff and leadership roles • Establishing sex worker advisory boards • Institutionalizing feedback mechanisms for community input. These structures help ensure that sex workers' involvement remains embedded as a core component of programming over time, thereby promoting sustainability.
5. Adapt to local contexts	Sex worker communities are not homogeneous. Their health needs, risk factors and priorities are shaped by the different legal, political, social and economic environments in which they live and work. These differences must be accounted for in all programming and partnerships. Partners should always start by engaging with existing sex worker-led groups or organizations, regardless of how formal or developed they may be.

68 WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions.

Good practice example: the Sonagachi Project, India

The Sonagachi Project in Kolkata, India is a leading example of community empowerment approaches in action. It began as a public health initiative focused on HIV and STI prevention and has since evolved into a comprehensive community-driven model.

To improve service acceptability and build trust, the project recruited sex workers as peer outreach workers who distributed STI medications, inquired about community health concerns and encouraged follow-up. Simultaneously, clinic staff received ongoing trainings to shift attitudes and promote the acceptance of sex workers as peers. This mutual process of building trust and collaboration laid the groundwork for shared governance and sex worker leadership. Over time, sex workers were promoted to leadership positions within the programme, working in full partnership with clinic staff. This transfer of power to sex workers is considered a key factor in the programme's long-term success.[69]

Today, the programme is run by the Durbar Mahila Samanwaya Committee, a sex worker-led organization, which was formed by the peer outreach workers in Sonagachi. The project now spans SRH care, legal and economic empowerment, literacy programmes and political advocacy, employing sex workers in diverse roles and partnering with healthcare providers and other stakeholders. The project has led to increased condom use among local sex workers, supporting low HIV prevalence while fostering collective empowerment.[70] It shows what can be achieved when health programmes invest in community empowerment and promote community ownership over time.

Avoiding tokenistic involvement

Efforts to engage with sex workers often fall short of fostering empowerment, with sex workers reporting that their involvement in health programming is frequently tokenistic or symbolic, rather than meaningful.[71] In some cases, this stems from deliberate exclusion driven by stigma and discrimination. In other cases, it can arise from subconscious biases, limited understanding of sex worker communities or outdated systems that inadvertently prevent sex workers from participating meaningfully.

Table 6 highlights examples illustrating how tokenistic involvement can look within SRH programming and offers alternative approaches that promote meaningful involvement.

Table 6: Tokenistic vs. meaningful involvement of sex workers in SRH programming

Tokenistic involvement	Meaningful involvement
Sex workers are treated as beneficiaries or passive recipients of services.	Sex workers are equal partners in programme design, development, implementation and monitoring and evaluation.
One or two sex workers are invited to "represent the community."	Diverse sex workers are engaged, with attention paid to gender identity, sexual orientation, age, HIV status, migration status, drug use and other factors.
Sex workers are not given enough time or clear information to meaningfully engage.	Sex workers are given clear, timely and accessible information to engage, including support with translation and interpretation, where needed.
Sex worker involvement is unpaid or underpaid.	Sex workers are fairly and equally compensated, on par with other workers.

69 Jana S, Basu I, Rotheram-Borus MJ, Newman P (2004) The Sonagachi Project: A Sustainable Community Intervention Program. *AIDS Educ Prev*.16(5):405-14. Available at: https://pubmed.ncbi.nlm.nih.gov/15491952/

70 Basu I et al (2004). HIV Prevention Among Sex Workers in India. *J Acquir Immune Defic Syndr*. 36(3):845-52. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC2826108/

71 NSWP (2017) Briefing Paper: The Meaningful Involvement of Sex Workers in the Development of Health Services Aimed at them. Available at: https://www.nswp.org/resource/nswp-briefing-papers/briefing-paper-the-meaningful-involvement-sex-workers-the-development

Tokenistic involvement	Meaningful involvement
Sex workers are only consulted with after decisions have already been made.	Sex workers are involved from the outset in decision-making processes as co-designers.
Engagement is one-off or short-term.	Ongoing roles for sex workers are built into structures for planning, governance and monitoring and evaluation.
Sex workers are limited to peer or outreach roles.	Sex workers are hired and trained for diverse roles and are promoted to leadership positions.
No mechanisms for feedback or accountability exist.	Systems exist for sex workers to raise concerns, support accountability and shape improvements.

Meaningful involvement is not a one-off intervention that can be implemented and then set aside – it requires continuous attention, accountability and reflection across all levels. Even when individuals' or institutions' intentions are well-meaning, missteps can still happen. For that reason, it is essential to maintain ongoing dialogue with sex workers to assess how partnerships are functioning and make changes as needed.

5.2 Community-led sexual and reproductive healthcare models

For many sex workers, community-led healthcare models offer safer, less judgemental and more accessible alternatives to mainstream healthcare settings. Evidence shows that community-led services have not only improved health outcomes,[72] but are also preferred by many sex workers.[73] As part of a community empowerment approach, community-led services help ensure that SRH care is grounded in sex workers' lived experiences and delivered in ways that are inclusive and rights-based.

Community-led SRH care models can take various forms. Their implementation may vary depending on local resources, capacity and legal environments. The following section provides an overview of different sex worker-led SRH service models, including examples of good practices.

5.2.1 Peer outreach, education and support

Around the world, sex workers lead outreach, education and support services for their peers. These efforts can create entry points into broader health systems and empowerment initiatives while promoting community cohesion. Examples of peer outreach, education and support initiatives can include:

- Sharing information on SRHR, including safer sex practices
- Peer-to-peer distribution of condoms, lubricants, hygiene products and harm reduction supplies
- Referrals and peer accompaniment (navigation) to services for HIV, STIs, contraception, pregnancy care and broader SRH needs
- First-line, holistic support for sex workers, including survivors of SGBV
- Support following HIV and STI testing as well as support with treatment adherence and follow-up appointments
- Providing linkages to other community care and resources.

72 Kerrigan D et al (2014) A Community Empowerment Approach to the HIV Response Among Sex Workers: Effectiveness, Challenges, and Considerations for Implementation and Scale-up. *Lancet*; 385(9963):172-85. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC7394498/

73 WHO Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations.

Good practice example: peer-led awareness-raising of SRHR in Ethiopia

Since 2010, the sex worker-led organization, Nikat Charitable Association, has engaged in a range of activities to raise sex workers' awareness of SRHR and increase access to rights-based care. Run by former and current sex workers, the organization disseminates information on SRHR to sex workers and operates community drop-in centres. They have trained 189 sex workers as peer educators[74] and have established a referral system with the Family Guidance Association of Ethiopia to refer sex workers to targeted, stigma-free SRH care.[75] In 2020, they launched The Right to Safe Sex Work project in partnership with the Danish Family Planning Association, reaching over 4,000 women with SRHR information and education. At the same time, through capacity-building initiatives, Nikat supported the creation of 12 new community-based organizations across three regions.[76]

5.2.2 Community-led mobile and fixed services

SRH services can be offered in a range of community settings under the leadership of sex workers. Some services can be provided directly by trained peers, while others may be offered in partnership with clinicians. These services are most effective when they are located close to where sex workers live and work and offered at times that suit sex workers' schedules (e.g. evenings, nights and weekends). Examples include:

- Mobile units, brigades and pop-up clinics that travel to brothels, bars, red-light districts and other hotspots
- Fixed services providing on-site HIV and STI testing, pre- and post-test counselling, condoms and lubricants, contraceptives (including emergency contraception) and first-line support for survivors of SGBV
- Community drop-in centres and safe spaces that facilitate inclusive access to care and support.

Good practice example: sex worker-led mobile van, Kyrgyzstan

In 2016, a sex worker-led organization in Kyrgyzstan launched a mobile van unit to offer HIV and STI testing to sex workers at convenient times and locations. The van primarily operated in the evenings and at night, informing sex workers in advance of when and where services would be available.

The unit employed a peer outreach worker, HIV counsellor and nurse. Services included free HIV testing (with pre- and post-test counselling), STI testing via vaginal swabs, and counselling to support treatment adherence. Blood and swab samples were taken to a partner laboratory, which cooperated closely with the community. Outreach workers returned to sex workers with test results and provided support for follow-up care, as needed. Through their outreach (including the mobile unit), the organization estimates that they have reached as many as 90 per cent of all street-based sex workers in Kyrgyzstan.

5.2.3 Community-public health partnerships

Sex worker-led services can be successfully integrated into public health systems. This can amplify their reach, increase access to commodities and create new opportunities for sex worker roles in health systems. These partnerships can also support the scale-up of effective community models, however, ongoing community leadership and oversight are essential to ensure quality and safety. Some collaborations may take place under differentiated service delivery models, while others may be less formalized.

Examples of community-public health partnerships include:

- Peer-led dispensing of medication (including PrEP, ART and contraception) under the supervision of a clinician
- Mobile SRH units, staffed by sex workers but operating as satellites of public health services
- Task shifting, where sex workers are trained to provide specific SRH services in line with national protocols

74 Nikat Charitable Association. Available at: https://www.nswp.org/members/africa/nikat-charitable-association
75 International HIV/AIDS Alliance (2016) Case Study: Ethiopia – Voices of Young Women Who Sell Sex. Available at: https://frontlineaids.org/resources/case-study-ethiopia-voices-of-young-women-who-sell-sex/
76 NIKAT. Available at: https://nikatca.org.et/index.php/key-achievements/

- Referral systems between community-led initiatives and public health clinics that offer sex worker-friendly services
- Sex worker or key population focal persons at government health facilities
- Community-led data collection and monitoring to inform health responses and assess progress and effectiveness.

Good practice example: Red Stiletto Project, Germany

The Red Stiletto Project (*Roter Stöckelschuh*) was launched in 2017 by the German sex worker-led organization, Berufsverband erotische und sexuelle Dienstleistungen e.V. (BesD). The initiative delivers community-led sensitization trainings to health professionals and has established a national network of providers offering comprehensive, non-judgemental SRH care.

Initially focused on gynaecology, the project later expanded to include other areas, including primary care and psychotherapy. Providers who have completed sensitization trainings can display a red stiletto sticker at the entrance of their practice to signal their commitment to sex worker-friendly care.

To increase accessibility, BesD created an online database of sex worker-friendly providers. Providers can register on the platform, and sex workers can submit recommendations for doctors or clinics where they have had positive experiences. The directory allows users to filter by location, speciality and other features, and includes both public and NGO-affiliated SRHR providers.[77]

Wherever possible, sex worker-led services should remain autonomous, with full community ownership. At the same time, exploring ways to integrate community-led services into broader health systems can foster long-term sustainability, access to resources and continuity of care – particularly in the context of unstable funding for civil society organizations.

5.2.4 Advocacy and sensitization

Advocacy is an essential component of community empowerment for sex workers to foster an enabling environment and reduce structural barriers to health and human rights. Advocacy not only targets law reform – such as campaigns to oppose criminalization and other harmful laws – but also includes efforts to reduce stigma and discrimination in healthcare settings and improve quality of care. Key activities can include:

- Advocacy with parliamentarians and government officials, public health authorities, NGOs working on SRHR and human rights more broadly, healthcare professional organizations, UN agencies and others
- Sensitizing health workers and other stakeholders on sex workers' rights, lived experiences and health needs
- Creating tools and best practice guidelines on how to provide respectful, non-discriminatory care to sex workers.

Good practice example: sex worker-led sensitization trainings for SRHR organizations

As part of the IPPF Sex Work Consortium, NSWP developed an online values clarification for action and transformation training to sensitize IPPF Member Associations to the unique needs, priorities and lived experiences of sex worker communities. The training, delivered by NSWP to consortium partners, encourages SRHR organizations to challenge their beliefs about sex work, outlines fundamental human rights principles, and shares best practices in providing inclusive, non-judgemental and comprehensive SRH care to sex workers.

77 Roter Stöckelschuh. Available at: https://roterstoeckelschuh.de/


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International Planned Parenthood Federation
Australian AID
স্বাস্থ্য সেবা অধিকার ও ন্যায্যতা নিশ্চিতে
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6

Developing inclusive programmes and partnerships

Ensuring sex workers' access to comprehensive, rights-based SRH services cannot be achieved in isolation; it requires intentional, inclusive partnerships based on mutual respect and shared power.

This chapter provides practical guidance for SRH care providers, sex worker-led organizations and other stakeholders on how to work together in real-world settings. It outlines best practices across the programme lifecycle – from building relationships through to programme design, implementation and monitoring and evaluation. Rooted in the principle of community empowerment, it highlights ways to ensure that sex workers are meaningfully involved at every stage.

There is no one-size-fits-all model for partnerships between sex worker communities and SRH stakeholders. Approaches must remain flexible and responsive to local contexts. With this in mind, this chapter outlines key elements and practices that support more inclusive, equitable and sustainable collaboration, rather than prescribing one approach. The chapter is organized around four stages of programming:

1. Building foundations
2. Co-design and development
3. Implementation
4. Monitoring and evaluation.

Figure 3: Stages of sex worker-inclusive SRHR programming

6.1 Building foundations

Because many sex workers have experienced harm, discrimination, or exclusion from health systems and civil society spaces, building relationships requires time and consistency. In the early stages of collaboration, the focus should be on creating spaces for listening, learning and defining shared values and priorities.

6.1.1 Key practices for building strong foundations

Map and connect with existing sex worker networks

SRH partners should begin by mapping sex worker-led groups, collectives, organizations and networks that are active in their area. It is important to approach sex worker organizations that already exist – regardless of their registration status – rather than attempting to create new ones. Once initial contact is established, sex worker-led organizations can support by identifying other trusted groups and networks within the SRHR landscape as well as areas of shared interest and priorities.

Create space for listening, learning and understanding

Early engagements should focus on building trust, rather than immediately planning activities. Meetings should be organized collaboratively, with sex worker-led organizations selecting locations that are safe and accessible for their community members. Where needed, support such as interpretation, transportation and childcare should be provided.

Initial meetings are an opportunity for SRH partners to listen and learn about sex workers' needs and priorities, and for sex worker-led organizations to assess the potential for partnership. Rather than bringing a fixed agenda, SRH partners should let sex workers shape the tone, focus and format of early conversations.

Agree measures for mutual respect

SRH partners and sex worker-led organizations should take time to jointly define what respectful engagement looks like in practice. This may include expectations around communication, time commitments and recognition of expertise. These discussions also provide an opportunity for partners to agree how sex workers will be compensated for their contributions and establish shared commitments around confidentiality, safety and accountability.

Lay the groundwork for shared decision-making

Shared decision-making begins with sex worker-led organizations determining how and by whom they will be represented. This autonomy should be respected from the outset. Once representation

is agreed, partners can jointly establish clear structures for collaboration, including how decisions will be made, how input will be gathered and how power and responsibility will be shared across the partnership.

6.2 Co-design and development

Once foundations have been established, sex worker-led organizations and SRH partners can move into co-planning, designing and developing programmes. This phase must be grounded in the expertise, leadership and lived experiences of sex workers to ensure that programmes reflect community realities, rather than assumptions made on their behalf.

6.2.1 Key practices for co-design and development

Ensure inclusive community representation

Sex workers are diverse. In co-design processes, sex worker-led organizations should determine who represents their community and how they will participate. Together, partners should strive to reflect community diversity, including across gender, sexual orientation, age, HIV status, migrant background and types of sex work. This helps ensure that programmes respond to a wide range of needs and do not reinforce exclusion or inequity.

Facilitate community consultations

Community consultations provide opportunities to identify community priorities, service gaps and barriers to access that may not be immediately visible. SRH partners and sex worker-led organizations should jointly choose consultation approaches that are appropriate for their context.

Because sex workers are experts in their own lives and have existing ties within their communities, they are best placed to lead consultations. Community-led approaches are particularly important for reaching individuals who are marginalized, excluded or distrustful of formal systems. SRH partners can support this process by providing technical input as well as logistical, financial or other support.

Consultations should allow sufficient time for sex workers to meaningfully participate – at least one month is standard. Methods such as peer-led focus group discussions, mapping exercises and surveys can help ensure that the process remains community-driven and participatory.

To support safety, comfort and accessibility, consultations should be held in spaces chosen by the communities. Participants should also be informed of how their input will shape programme design. As participation may require time away from work or caregiving, sex workers should be fairly compensated for their contributions.

Co-develop proposals and budgets

Developing proposals and budgets are critical steps that determine not just what the programme does, but how power and resources are distributed. However, sex workers are frequently sidelined from these processes due to harmful misconceptions about their capacity or are included only tokenistically to meet donor requirements or improve funding prospects.[78]

Equitable partnerships require sex workers' involvement from the outset. Sex workers must be invited to collaborate in drafting proposals and budgets – not brought in to approve documents that are already written.

To support meaningful engagement, all relevant materials, including donor guidelines, application documents and budget templates, should be shared as soon as they are available. Where feasible, time for multiple rounds of input and revision should be built in to strengthen both the quality of the proposal and promote shared ownership.

Establish transparent structures to share power

Sharing power is central to forging equitable partnerships. Yet too often, sex worker-led organizations are included as programme implementers while being excluded from decision-making spaces. Without explicit commitments and structures for sharing power, sex workers risk being overlooked as programmes evolve and resources shift.

Partners should jointly agree how decisions will be made, documented and communicated, including how sex workers will be represented in governance structures. This may include paid staff roles, advisory bodies, or steering committees, formalized through clear terms of reference.

78 NSWP (2020) Briefing Paper: Shrinking Spaces and Silencing Voices. Available at: https://www.nswp.org/resource/nswp-briefing-papers/briefing-paper-shrinking-spaces-and-silencing-voices

Programme management structures, evaluation processes and data monitoring systems should also be co-designed, with mechanisms in place to regularly review and adjust arrangements as needed. While specific structures may evolve or change over time, the principle of power-sharing should remain constant.

Check-in questions

Partners can use the following questions to reflect on whether programmes are being designed equitably and with meaningful involvement from sex workers:

- What is the programme model? Whose priorities does it reflect?
- Which interventions and services are planned? And how were they chosen?
- How will the programme be coordinated and managed by partners?
- What roles will sex workers play in each stage of the programme?
- How will programme data be collected, analysed and used to improve systems?
- What structures are in place to support sex workers' ongoing involvement and co-ownership?

6.3 Implementation

Even well-designed programmes will fall short if sex workers are excluded from implementing activities or if power imbalances are not addressed. At this stage, sex worker-led organizations must serve as co-leaders in managing and delivering programmes – not just as beneficiaries or "add-ons." Implementation also provides important opportunities to build capacity, strengthen systems and address structural barriers to SRHR, while progressively shifting power and ownership to communities themselves.

6.3.1 Key practices for programme implementation

Invest in sex workers' leadership and capacity-building

Sex workers bring unique expertise to SRH programming and should therefore be empowered to take on roles across all levels. When sex workers are limited to peer-led roles, paid less than non-sex worker staff or are excluded from decision-making, programmes risk reinforcing the very structural inequalities they seek to address.

Sex workers should be recognized as core team members, with equal pay, formal contracts and full participation in decision-making. This should be accompanied by opportunities for training, mentorship and professional advancement, with clear pathways into supervisory and leadership roles. To promote long-term sustainability, partnerships should identify areas where decision-making and operational responsibilities can be transferred to sex worker-led organizations over time.

In some settings, national task-sharing policies allow non-clinical staff, including trained sex workers and other community health workers, to provide specific health services under clinical supervision. Examples of these roles and services are outlined in Table 7.

Table 7: Tasks for sex workers in delivering SRH services

Clinical tasks *(where policy and training permit)*	**Non-clinical tasks** *(across contexts)*
• Conducting HIV testing and counselling • Conducting pregnancy testing • Collecting STI test samples • Dispensing medications (e.g. ART, PrEP, oral contraceptives and emergency contraception, under clinician supervision) • Administering injectable contraceptives • Triage support • Conducting basic clinical reviews	• Supporting HIV/STI self-testing and distribution • Distributing condoms and lubricants • Providing counselling on safer sex and contraception • Providing information and referrals to safe abortion services • Supporting adherence to PrEP and ART • Providing psychosocial support to survivors of violence • Referring and accompanying peers to services • Peer navigation • Leading peer and community education on SRHR • Conducting home visits • Providing administrative support in clinical settings (e.g. registration and records) • Supporting self-care for health and wellbeing

Deliver services led by and centred on communities

Effective SRH programmes for sex workers must be grounded in sex workers' priorities and led by the community. Services should be delivered in settings chosen by sex workers, such as drop-in centres, mobile units or community safe spaces, at times that align with sex workers' schedules.

Because peer-led services are preferred by many sex workers, they can boost service uptake while also fostering community empowerment. As needs and circumstances evolve, programmes should remain flexible, adapting their locations, schedules and approaches through ongoing dialogue with community members.

Ensure safety, confidentiality and dignity

Sex worker-led and SRH organizations should work together to ensure that all programmes and services prioritize safety, protect confidentiality and uphold dignity. Sex workers should lead the process of setting standards for safety protocols, data protection, informed consent and confidential service delivery. SRH partners should commit to minimizing the collection of personal identifying information and co-managing data systems with sex worker-led organizations. Reporting mechanisms, such as IPPF's SafeReport,[79] should be implemented to ensure that any programme staff or volunteers can confidentially report concerns.

To promote safer and more acceptable services, all staff, including clinical, administrative and security personnel, should complete sensitization trainings designed and delivered by sex workers. Services should be offered in private, welcoming spaces that have been vetted by the community, with preference given to community settings.

Check-in questions

- How are sex workers involved in day-to-day operations, service delivery, coordination and decision-making?
- Are services being offered in ways, locations and times that sex workers consider convenient?
- What measures are in place to ensure privacy, confidentiality and safety?
- Have staff been trained in how to provide non-judgemental care to sex workers?
- Do sex workers have an equal say in how the partnership and activities are managed?

6.4 Monitoring and evaluation

Monitoring and evaluation systems are not only tools for tracking health outcomes and service uptake; they can also be used to assess the quality of partnerships and the extent to which programmes promote sex workers' agency and collective power. When designed and used well,

79 IPPF SafeReport. Available at: https://www.ippf.org/ippfsafereport

monitoring and evaluation helps ensure that SRH programming remains responsive to sex workers' evolving needs.

Sex workers should lead and participate meaningfully across all stages of monitoring and evaluation, from defining measures of success to collecting and interpreting data. When implemented collaboratively, monitoring and evaluation becomes more than just a reporting requirement – it also supports accountability, learning and community ownership.

> *"Numbers alone do not convey the complex interaction of factors that define empowerment."* [80]

6.4.1 Key practices for monitoring and evaluation

Fund and leverage community-led monitoring

Community-led monitoring (CLM) is an evidence-based approach to strengthening health systems and empowering affected communities.[81] It is widely practised by sex worker-led organizations to support programming, advocacy and accountability. For example, many sex worker-led organizations systematically document violence and human rights violations in healthcare settings and then use this evidence to inform advocacy with governments and other stakeholders. Data collected from CLM can also be used to demonstrate the effectiveness and value of sex worker-led interventions.[82]

SRHR programmes should integrate and fund CLM as a core programme component. When sex workers are trained, supported and fairly compensated to lead data collection and service monitoring, all partners benefit. Sex workers' existing connections within their communities can help facilitate broader and more meaningful participation, ensuring that data accurately reflects everyday realities.

All data gathered through CLM should be analysed jointly to identify what is working, what needs to be changed and how programmes can better respond to communities' priorities. Findings can be leveraged to support advocacy efforts, scale up evidence-based programming, advance policy reform and attract greater investments in community-led initiatives.

Jointly establish expectations, indicators and milestones

Sex workers rarely set expectations and indicators. Metrics are often determined by donors without community input, resulting in reporting challenges and measures that do not accurately reflect successes. For this reason, sex workers and SRH partners should collaborate from the outset to develop a shared understanding of how, what and when data will be collected and how it will be used.

Sex workers should lead the process of setting both short- and long-term indicators and targets to ensure they are relevant, achievable and underpinned by community priorities – not just those of donors. Monitoring and evaluation systems should also be practical, easy to use and respectful of people's time and capacity.

Broaden measures of success

While quantitative indicators are important for public health reporting and advocacy, they rarely capture the full impact of community-led, rights-based programming. Quantitative data on service uptake and health outcomes should therefore be complemented by qualitative indicators that reflect progress in community empowerment, leadership and meaningful involvement.

Structural factors – including legal, social and economic barriers that affect access to services – should also be tracked. However, achieving systemic change requires time and sustained effort. For example, it is unrealistic to expect a country to decriminalize sex work within a short-term project cycle. Nonetheless, tracking incremental progress towards achieving longer-term goals is essential for demonstrating momentum, sustaining advocacy and holding decision-makers accountable.

Table 8 provides examples of key areas of change that can be monitored, alongside suggested indicators and tracking methods.

80 WHO, UNFPA, UNAIDS, NSWP, World Bank and UNDP Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions.
81 UNAIDS (2023) Community-Led Monitoring in Action: Emerging Evidence and Good Practice. Available at: https://www.unaids.org/en/resources/documents/2023/community-led-monitoring-in-action
82 NSWP (2025) Policy Brief: Sex Worker-Led Organisations and the Sustainability of the HIV Response. Available at: https://www.nswp.org/resource/nswp-policy-briefs/policy-brief-sex-worker-led-organisations-and-the-sustainability-the-hiv

Table 8: Measures for tracking change and progress

Area of change	Examples of indicators	How to track them
Community empowerment	• Sex workers' confidence in navigating SRH care and asserting their rights • Formation of new sex worker-led collectives and organizations	• Peer-led surveys, interviews or focus group discussions • # of new sex worker-led collectives or organizations formed
Sex worker leadership	• Sex worker leadership in decision-making and programme operations • Access to mentorship, training and career growth as part of programme activities	• # of sex workers in supervisory, management or leadership roles • Sex workers' reflections on inclusion and leadership opportunities and barriers
Meaningful involvement	• Sex worker involvement in the design, delivery and monitoring and evaluation of programmes	• # of sex workers hired and trained as programme staff • Case studies and qualitative reflections from sex workers
Safety	• Experiences of violence, harassment and abuse • Perceptions of safety in SRH care settings	• # of incidents documented by sex workers • Qualitative reflections on safety
Stigma reduction	• Sex workers' experiences of stigma and discrimination in SRH care settings • Providers' attitudes towards sex workers	• # of incidents of stigma reported in SRH care settings • # of sensitization trainings conducted by sex workers • Pre- and post-training surveys and reflections from participants • Community reports on stigma and discrimination e.g. scorecards
Structural factors	• Shifts in legal, social or economic conditions that impact sex workers' access to SRHR	• Policy tracking logs • Recognition of sex work and/or sex workers in national policies, programmes and strategies • Cost and reported affordability of SRH services for sex workers

Check-in questions

- Who was involved in deciding what data will be collected, how it will be collected and how it will be used?
- Do sex workers feel that the monitoring and evaluation system is accessible and realistic?
- Are the outcomes being tracked achievable within the programme's timeframe?
- Do the indicators include both quantitative data (e.g. service uptake numbers) and qualitative insights (e.g. sex workers' experiences and reflections)?
- How will the findings be used to improve programme design and delivery?
- How will the findings support advocacy efforts? And how will they promote sustainability?


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Advocacy, systems change and funding

Increasing sex workers' access to comprehensive, rights-based SRH care depends on more than just isolated services and interventions. Sustained efforts must be made to address underlying structural barriers and exclusionary systems that foster inequalities. As described in Chapter 3, criminalization, stigma and discrimination limit sex workers' access to services and perpetuate inequities and vulnerability. Criminalization and legal barriers discourage many sex workers from even attempting to access services, while widespread stigma and discrimination – coupled with ingrained biases in health systems – mean that sex workers routinely experience judgement and poor treatment in SRH care settings.

Sex worker-led organizations and their allies all play vital roles in challenging these barriers and advancing sex workers' SRHR. This chapter explores strategies for joint advocacy to promote structural change, including advocacy for sustainable funding.

7.1 Structural drivers of change

Structural barriers to sex workers' SRHR persist across legal, institutional and social levels, often reinforcing one another. Addressing these barriers requires coordinated and sustained interventions at every level, with sex workers' leadership at its heart. This section outlines key advocacy areas that sex worker-led organizations and their allies can pursue, including the fight for decriminalization and strategies to address violence, stigma and discrimination across each level.

Decriminalization and legal reform

The criminalization of sex work, along with other intersecting forms of legal oppression, significantly undermine sex workers' health and human rights. While a range of legal models have been promoted to address these harms, many exacerbate, rather than improve, health outcomes and rights violations. The full decriminalization of sex work is the only legal framework that has been shown to effectively reduce violence, stigma and discrimination, while improving sex workers' access to rights, including the right to health.

What is decriminalization?

The decriminalization of sex work refers to the removal of *all* laws and regulations that criminalize and/or penalize various aspects of sex work, including its sale, purchase, advertisement and the involvement of third parties. Rather than introducing new laws to regulate or restrict the sex industry, decriminalization treats sex work like any other form of labour, covered by existing occupational health and safety laws. It should be noted that the decriminalization of sex work strictly applies to activities between consenting adults (aged 18 years and older).[83]

Decriminalization is often confused with other legal frameworks, such as legalization and the Nordic Model (also known as the "Swedish" or "End Demand" model). Understanding the differences between these distinct models is critical, as they each have vastly different implications for sex workers' health, safety and human rights.

83 NSWP (2024) Decriminalisation vs. Legalisation: Understanding Key Differences in Sex Work Legislation. Available at: https://www.nswp.org/resource/nswp-publications/decriminalisation-vs-legalisation-understanding-key-differences-sex-work

Table 9: Legal models and their impacts on SRHR

Legal model	What it means	Impacts on SRHR
Decriminalization	Criminal and administrative penalties for all aspects of sex work are removed. Sex work is treated like any other form of labour, governed by the same occupational health and safety standards that apply to other industries.	✓ Removes legal barriers to access to SRH services. ✓ Reduces vulnerability to violence by improving access to legal redress. ✓ Upholds bodily autonomy and agency, encouraging sex workers to take control of their own health. ✓ Promotes trust and collaboration between sex workers, health systems and healthcare providers.
Legalization	Sex work is permitted under strict conditions (e.g. mandatory registration, compulsory HIV and STI testing and treatment, zoning restrictions). Those who cannot comply with regulations – often most sex workers – remain criminalized.	✗ Creates a two-tiered system that excludes many sex workers (particularly migrants, trans and undocumented workers) from working legally. ✗ Violates bodily autonomy through mandatory health procedures. ✗ Fosters distrust of public health systems and drives sex workers away from care. ✗ Reinforces stigma and stereotypes by treating sex workers as "vectors of disease."
Nordic Model	Selling sex is legal, while its purchase is criminalized. Third-party involvement is also criminalized.	✗ Drives sex work underground, increasing risks of violence and abuse and reducing sex workers' ability to negotiate safer sex. ✗ Fuels stigma and poor treatment in healthcare settings by treating sex workers as victims, rather than as workers and rights-holders. ✗ Criminalizes sex worker support networks. ✗ Promotes programmes that pressure sex workers to exit sex work as a condition to accessing services.

Why decriminalization matters for sexual and reproductive health and rights

Decriminalization is an essential intervention for sex workers to realize their SRHR. It fosters an enabling environment for sex workers to access the full spectrum of SRHR without fear or coercion. When sex work is decriminalized, sex workers are recognized as legitimate workers, enabling them to access national health insurance and employment-based social protection measures, thereby increasing access to vital SRH care.

New Zealand was the first country to fully decriminalize sex work in 2003. Since then, sex workers have reported improved working conditions, power to negotiate safer sex and increased confidence in asserting their legal and employment rights.[84] They have also reported improved relationships with law enforcement and a greater likelihood of reporting incidents of violence to the police.[85] It is estimated that decriminalizing sex work could reduce HIV infections by 33-46 per cent over the next decade through its combined effects on reducing violence, promoting safer work environments and increasing condom use.[86]

84 Abel G (2014) A Decade of Decriminalization: Sex Work 'Down Under' But Not Underground. *Criminology and Criminal Justice* 14. 580-592. Available at: https://www.researchgate.net/publication/280445933_A_decade_of_decriminalization_Sex_work_'down_under'_but_not_underground

85 New Zealand Ministry of Justice and Victoria University of Wellington Crime and Justice Research Centre (2007) Key Informant Interviews: Review of the Prostitution Reform Act 2003. Available at: https://nzpc.org.nz/research/

86 Shannon K et al Global Epidemiology of HIV Among Female Sex Workers: Influence of Structural Determinants.

Decriminalization aligns with international human rights standards and the core principles of SRHR: bodily autonomy, informed consent and non-discrimination. It is the legal model most widely supported by sex worker-led organizations worldwide as well as leading global health and human rights bodies, including Amnesty International, Human Rights Watch, IPPF, UNAIDS, UNFPA and WHO many others.[87] Crucially, decriminalization reframes sex workers as rights-holders and partners in building inclusive, equitable health systems, rather than as "problems" to be managed.

Recognizing sex work as work

The legal recognition of sex work as a legitimate form of labour is another vital step towards upholding sex workers' SRHR. This recognition offers sex workers the same access to labour rights and social protection entitlements that are afforded to other workers. It allows sex workers to be protected under standard occupational health and safety laws, helping to ensure safer, healthier working conditions. By holding employers that violate these standards accountable, these protections can help reduce sex workers' vulnerability to violence, coercion and exploitation.

Good practice example: Belgium's sex work labour law

In Belgium, where sex work was decriminalized in 2022, the sex worker-led organizations UTSOPI, Violett and Espace P worked with the Ministries of Labour, Health and Justice to co-develop a dedicated labour law for sex work. Passed in 2024, the law ensures that sex workers with employment contracts can access the full range of social protections, including health insurance, pension, unemployment benefits, parental leave and more.

The law also enshrines five key labour rights specific to sex work: the rights to refuse a client, refuse a specific sexual act, interrupt a sexual act at any time, perform a sexual act in any manner they wish and refuse to advertise their services. None of these actions can be considered a breach of contract. In addition, sex workers can end their contracts at any time, without losing eligibility for unemployment benefits.[88] These protections help ensure that sex workers are not compelled to endure unsafe or exploitative conditions out of fear for dismissal or loss of benefits.

The Belgian labour law shows what is possible when governments work directly with sex worker-led organizations as experts in their own lives and work. It demonstrates how meaningful engagement with communities can result in policies that address sex workers' realities, embed tailored safeguards and advance both health and labour rights.

7.2 Addressing violence

Addressing violence is central to promoting sex workers' SRHR, upholding bodily autonomy and supporting equality. Experiences of violence – whether from law enforcement, clients or in healthcare settings – undermine sex workers' health and safety. In addition, fears of violence and revictimization may deter sex workers from attempting to access essential services. Addressing violence against sex workers requires SRH care providers to reframe their role not only as those who treat the impacts of violence, but as agents of change who, in partnership with sex worker-led organizations, can proactively foster safer and more supportive environments.

Comprehensive responses to addressing violence include:

- Integrating safe, confidential violence reporting mechanisms into SRH care models
- Training SRH care providers to offer non-judgemental, trauma-informed care that upholds sex workers' bodily autonomy, consent and dignity
- Supporting rapid-response mechanisms to address violence
- Documenting incidents of violence to demonstrate how violence hinders access to SRHR
- Advocating to address the underlying drivers of violence and eliminate barriers to rights-based care.

87 See NSWP Decriminalisation vs. Legalisation: Understanding Key Differences in Sex Work Legislation for a list of organizations that call for the decriminalization of sex work.

88 IPPF (2024) Belgium: A Transformative Law for Sex Workers' Rights. Available at: https://www.ippf.org/featured-perspective/belgium-transformative-law-sex-workers-rights;
Human Rights Watch (2024) Belgium Adopts Historic Law Against Sexual Exploitation. Available at: https://www.hrw.org/news/2024/12/02/belgium-adopts-historic-law-against-sexual-exploitation

Community empowerment is central to these efforts. Globally, many sex worker-led organizations have invested in building their peers' capacity to understand their fundamental rights and seek legal support in the event of violence and abuse. Many also sensitize law enforcement officials to reduce violence perpetrated by the police and improve pathways for legal redress.

Having up-to-date data on violence is essential for advocacy. In many contexts, violence against sex workers is significantly under-reported due to fears of stigma and discrimination, legal repercussions or revictimization. When sex workers have safe, confidential channels to report violence, the scale of rights abuses becomes clearer, generating a powerful evidence base for legal change. This data can also reveal ongoing barriers to care and gaps in support to survivors, which can guide SRH actors in improving and tailoring services to meet sex workers' needs.

Good practice example: sex worker-led crisis hotline in South Africa

In South Africa, the sex worker-led organization Sisonke and the Sex Workers Education and Advocacy Taskforce (SWEAT) operate the country's only national 24/7 toll-free hotline exclusively for sex workers. The hotline is sex worker-led, employing trained sex worker counsellors and paralegals to support community members who experience violence, abuse and other emergencies.

As part of its crisis response measures, the hotline strengthens sex workers' access to SRHR by providing referrals to sex worker-friendly medical and counselling services, including post-violence care. Sex workers can also use the hotline to request a state-appointed lawyer. Incidents of violence reported through the helpline are documented in collaboration with the Women's Legal Centre. This bolsters advocacy for legal reform by underscoring the impacts of criminalization on sex workers' health and safety.

7.3 Anti-discrimination measures

Discrimination against sex workers reflects systemic biases and power imbalances embedded across legal frameworks, health systems and social norms. Addressing it requires different approaches across multiple levels, with sex workers' leadership at the centre.

Figure 4: Levels of anti-discrimination interventions

Legal and policy protections

Discrimination is enabled by the criminalization of sex work and the resulting lack of legal protections and redress mechanisms. Under international human rights law, sex workers, like all people, have the right to the highest attainable standard of health, free from discrimination. However, this right is often denied in practice.

Numerous human rights bodies have called for states to repeal punitive laws and adopt anti-discrimination protections that include sex workers.[89] Without this explicit legal recognition, sex workers remain vulnerable to mistreatment, denial of care and exclusion from complaint mechanisms.

Institutional accountability

Even in hostile legal environments, health institutions can take steps to reduce discrimination in healthcare settings. This includes adopting and enforcing institutional codes of conduct that explicitly prohibit discrimination based on sex work and requiring regular sensitization trainings – led by sex workers – for relevant staff.

Institutions should also establish clear accountability mechanisms so that sex workers can safely and confidentially report discrimination. Involving sex workers in the monitoring and

89 WHO Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations.

oversight of these cases can help ensure that complaints are taken seriously and addressed appropriately.

Together, these measures can improve quality of care, accessibility and increase trust towards health institutions. Even though changes in institutional practices are not a replacement for legal reform, they can significantly reduce harm in the meantime.

Shifting norms and attitudes

Discrimination is often rooted in social norms and moral judgements, particularly around sexuality, gender, poverty and power. These attitudes directly affect the way sex workers are treated in healthcare, legal and social service settings.

Sensitization trainings are an important tool for challenging harmful attitudes, but only when they are designed and delivered by sex workers themselves. Effective trainings go beyond providing basic information about sex work to encourage participants to examine how their personal beliefs and institutional cultures influence their work. Such trainings are important for health workers, law enforcement officials and social service providers, who can all play roles in facilitating sex workers' access to SRHR.

Meaningful shifts in attitudes and behaviours require sustained collaborations with sex worker-led organizations and partners. Throughout collaborations, ongoing oversight by sex workers is needed to ensure that interventions to address discrimination do not unintentionally reinforce harmful narratives, myths or stereotypes.

7.4 Sustainable funding

SRHR programming for sex workers has long been underfunded, shaped by a public health paradigm that has prioritized "disease control" and framed sex workers primarily as vectors of HIV and STI transmission. While this framing has reinforced stigma and constrained the scope of programming, international HIV funding has nonetheless been a critical lifeline, supporting many sex worker-led initiatives to deliver rights-based services, including essential SRH care, and creating entry points into broader health systems.

> ***"Protecting and giving priority to marginalized groups, including key populations, is not only a moral imperative but also a pragmatic strategy to control epidemics, reduce onward transmission and save lives."***[90]

But shrinking global resources, coupled with shifting donor priorities and moves to nationalize HIV financing models, heighten uncertainty. When resources are cut or restructured, community-led responses are often the first to be defunded due to misconceptions that they are dispensable or risky investments. These dynamics are exacerbated by widespread criminalization, which may exclude sex worker-led organizations from receiving national funding or partnering in health programmes. As national governments take on greater responsibility for HIV and key population programming, already underfunded SRH initiatives for sex workers may be diluted or erased entirely.

Joint advocacy for funding

As funding landscapes shift and anti-rights movements grow, defending sex workers' SRHR must go beyond protecting services – it must also work towards transforming systems that determine who gets funded, how and why. Advocacy for sex workers' rights must include advocacy for equitable, inclusive funding systems that empower the most affected communities.

Allies in the SRHR movement, including NGOs, donors and service providers, have a critical role to play. Those with established connections to governments or donors can help challenge exclusionary systems and negotiate space for sex workers to meaningfully participate in decision-making. This can include advocating for policy reforms that increase allocations for community-led programming and remove barriers to funding, such as requirements for intermediaries.

Support can also include providing technical and practical assistance to sex worker-led organizations in ways that build their capacity while upholding autonomy. This might involve helping with legal registration processes; strengthening proposal development, financial and governance systems; or identifying opportunities to access new funding streams.

90 WHO (2025) Operational Guidance: Sustaining Priority Services for HIV, Viral Hepatitis and STIs in a Changing Funding Landscape. Available at: https://www.who.int/publications/i/item/9789240112759

Importantly, allies can also support sex workers' advocacy by amplifying their core funding asks, ensuring clear and consistent messaging across spaces where funding decisions are shaped.

Sex workers' core SRHR funding asks

Sex worker-led organizations require funding to advance SRHR that reflects the realities of their work and their communities' needs. Funding must be:

- **Core:** Funds must be usable to cover core operational costs, including staffing, rent and administrative needs. Without this foundation, sex worker-led organizations cannot function, let alone deliver services to their communities or sustain advocacy.
- **Flexible:** Grants must allow organizations to respond quickly to their communities' changing needs and realities, which may include humanitarian crises, political shifts and emerging health concerns.
- **Multi-year:** Significant gains do not happen overnight. Longer-term funding cycles enable sex worker-led organizations to focus on systems change – not just service delivery or one-off projects. Multi-year grants also reduce the burden of having to write frequent grant proposals, freeing up more time for sex workers to do on-the-ground work.
- **Direct:** Funds should go directly to sex worker-led organizations. Partnerships with other organizations can be beneficial when they are expressly chosen by sex workers, rather than imposed as a donor requirement.

7.5 Recommendations

Achieving meaningful and lasting progress for sex workers' SRHR requires action across multiple levels. The following recommendations highlight areas where sex worker-led organizations, SRH care providers, policymakers and other allies can drive change and challenge unjust systems.

Structural and policy change

- **Decriminalize all aspects of sex work (including its sale, purchase, advertisement, brothel-keeping and involvement of third parties).** Criminalization deters sex workers from seeking vital services and reinforces stigma, discrimination and violence.
- **Recognize sex work as a legitimate form of labour.** This recognition increases sex workers' access to fundamental labour rights and social protection benefits, including public SRH services covered by insurance.
- **Implement comprehensive measures to prevent and respond to violence.** These measures should address the relationship between violence and SRHR, including through integrated reporting mechanisms, sensitization trainings for providers and law enforcement, and data collection to inform advocacy.
- **Reduce stigma and discrimination across all levels.** Structural, institutional and interpersonal stigma and discrimination undermine sex workers' access to SRHR. Addressing these barriers requires explicit anti-discrimination policies, codes of conduct, accountability mechanisms and regular sensitization trainings across sectors.

Service delivery

- **Promote comprehensive, rights-based SRH services that go beyond HIV and STIs.** Sex workers, like all people, have diverse SRH needs. Interventions that narrowly focus on HIV and STIs not only leave broader needs unmet but also reinforce harmful stereotypes of sex workers as "vectors of disease."
- **Integrate services in a "one-stop-shop" model to reduce barriers and broaden access.** Co-locating services – such as HIV, contraception, mental health and SGBV support – allows sex workers to address multiple needs in one place, reducing logistical barriers to uptake.
- **Adapt when, where and how services are delivered.** Flexible hours, mobile outreach, community-based settings and peer-led interventions can improve accessibility and acceptability of services.
- **Prioritize interventions led by sex workers.** Peer-led outreach, counselling, accompaniment and direct service provision are often more trusted, tailored and rights-affirming than mainstream health services. Prioritizing peer-led interventions also reinforces community empowerment and ownership over programming.
- **Hire and train sex workers for a wide range of roles.** These roles should extend beyond peer-led or volunteer positions, offering

equitable compensation and opportunities to build skills and develop careers over time.
- **Deliver regular, sex worker-led sensitization trainings for healthcare staff.** These sessions should be mandatory for all relevant staff and be grounded in sex workers' lived experiences to foster more respectful, inclusive environments.
- **Adopt an intersectional approach.** SRH services must account for the diverse needs, priorities and lived experiences of sex worker communities, including migrants, LGBTQI+ people and gender-diverse sex workers.

Partnerships and joint programming

- **Meaningfully include sex workers at every stage of programme design, development, implementation and monitoring and evaluation.** Without this foundation, sex workers' involvement remains tokenistic and programmes often fall short of meeting communities' needs and priorities.
- **Centre all partnerships and programmes in priorities identified by sex workers themselves.** This requires creating safe spaces for building trust, sharing experiences and engaging in meaningful, ongoing consultation with sex workers before decisions are made.
- **Establish clear structures for power-sharing and accountability.** Partners should co-create systems for shared decision-making and leadership with sex workers, which may include paid roles, advisory groups and steering committees. Mechanisms for monitoring and reviewing these structures over time should be included.
- **Invest in sex workers' capacity-building and leadership.** Sex workers bring unique expertise and should be offered opportunities for capacity-building, mentorship and progression into supervisory and leadership roles. Programmes should identify areas where decision-making and operations can be transferred to sex worker-led organizations over time.
- **Embed community-led monitoring and feedback mechanisms.** Sex workers should be directly involved in monitoring and evaluating services and partnerships to identify gaps and improve programming. Communities should be involved in setting indicators to ensure that they are relevant, realistic and reflect sex workers' lives.

Advocacy, funding and research

- **Partner with sex worker-led organizations to identify and amplify advocacy goals.** Sex worker-led organizations must define their own advocacy priorities and messages, which can be amplified through partnerships and alliances.
- **Strengthen alliances across movements.** Sex workers have many intersecting identities and priorities that overlap with other movements' agendas – including migrants' rights, LGBTQI+ rights, women's rights and others. Building strong cross-movement alliances increases visibility, reach and collective power.
- **Mobilize and sustain funding for sex worker-led organizations.** Sex worker-led organizations provide essential services and engage in long-term advocacy, yet remain chronically underfunded. Sex worker-led organizations must be adequately resourced with flexible, multi-year, core funding to sustain and scale up their work.
- **Prioritize sex worker-led research to generate evidence based on lived experiences.** Community-led data collection helps identify SRH service gaps, strengthen programming and challenge harmful narratives. This evidence can also be used to hold governments accountable and strengthen advocacy for rights-based policies and programmes.


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TRABAJO, DIGNIDAD Y AUTONOMÍA
TRABAJO SEXUAL

8

Conclusion

Access to SRHR is a fundamental human right that applies to everyone, including sex workers in all their diversity. Around the world, however, sex workers continue to face persistent barriers – from criminalization to stigmatizing stereotypes – that undermine their access to even the most basic health services. As a result, sex workers' comprehensive SRH needs are seldom fulfilled, reinforcing systemic inequalities.

There is no one-size-fits-all template for ensuring sex workers' SRHR. Solutions must be developed jointly with sex worker communities, based on local realities and responsive to diverse needs and priorities. Interventions must not be prescriptive; they must be tailored, adaptable and informed by communities' lived experiences and expertise.

Because SRHR do not exist in isolation, effective responses must also address broader conditions affecting sex workers' lives, including legal recognition, labour rights and empowerment initiatives.

Sex worker-led organizations have long led efforts to advance their communities' health and rights: delivering essential services, strengthening community cohesion, advocating for reform and demanding accountability. To ensure that these efforts translate into sustained, systemic change, institutions working in the field of SRHR must also shift how they operate. This means moving beyond treating sex workers as passive beneficiaries of services – instead, recognizing them as equal partners and leaders in driving change.