The health effects and moral imperative of funding sex worker programmes

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The modelling study, published in *The Lancet Global Health*, by Loveleen Bansi-Matharu and colleagues,[1] adds to the literature on key populations by drawing attention to the potential effect on HIV incidence and cost-effectiveness of programmes targeted specifically to sex workers. The findings provide the necessary backing for relevant policymakers to reconsider their stance on funding programmes for key populations such as female sex workers (FSWs). Current socio-economic and geopolitical constraints, coupled with pressure from the recent COVID-19 pandemic, have placed immense strain on existing programmes. High budget cuts and the reallocation of funds to other priority health areas[2] have resulted in many programmes permanently closing after years of delivering services. Programmes that were at the cusp of, if not already, achieving international targets set by UNAIDS,[3] and that provided necessary services to an often overlooked, over-stigmatised, and in most countries criminalised population are no more.

This study reports that a high-intensity programme (which should be the minimum offered in areas with an HIV epidemic) between 2023–2030 was predicted to considerably lower HIV incidence amongst FSWs, and consequently the general population. This is crucial when taking into consideration data from a South African study showing that sex between FSWs and their clients contributed 7% of new HIV infections, while sex between the clients of FSWs and their non-paying partners contributed 42%.[4] Therefore, the funding of key population programmes to continue providing HIV prevention and treatment services is crucial for ensuring general population health.

The investment of $US 34 million, the maximum cost calculated by Bansi-Matharu and colleagues of implementing a high-intensity programme, on FSW-specific health programmes is no small request, especially considering the varied health burdens and health system challenges of countries across East, Central, and Southern Africa.[5] However, the consequences of funding FSW programmes on HIV incidence has a cost-saving potential that could then be reinvested to address other unmet health and health care delivery needs.[1] As a vulnerable population, sex workers are prone to extreme levels of violence and higher incidences of rape compared with the general population, alongside higher levels of substance use and mental ill health.[6,7] Their basic survival needs are far greater than simply the provision of a biomedical response to HIV (eg, condom distribution, provision of antiretroviral therapy, HIV testing, and counselling). Programmes that have adapted to provide additional services such as legal aid and human rights, gender-based violence, and trauma containment, alongside mental, sexual, and reproductive health were linked to a greater uptake of HIV services.[3] The more we invest in people based on their individual needs, the higher the return on investment.

Sex as a transactional act sits upon a behavioural continuum, which includes non-paying partnership, transactional sex, informal sex work, commercial sex work, and sexual exploitation.[8] It is challenging to draw clear distinctions between sex work and transactional sex, with multiple different terms used to define each practice, sometimes used interchangeably to describe a set of behaviours which increase or decrease the risk profile of individuals and populations who engage in them, but who might not self-identify with the label of a sex worker. Once we acknowledge the complexities of what drives people to engage in sex work and better understand the continuum, it is not uncommon to find men who have sex with men, transgender people, and adolescent girls and young women engaging in sex work.[9] Sex worker programmes that traditionally would have catered to a specific cohort of sex workers (cisgender women, aged >18 years and engaging in sex work) are expanding their delivery services to meet a broader range of needs, despite the funding pressures across this sector. Taking this into consideration, it would be crucial to understand the full reach of sex work programmes and their associated effects and cost-effectiveness. Additionally, lessons learned from running sex worker programmes (such as identifying and retaining hard-to-reach populations) should be translated to guide the implementation of HIV programmes for the general population.

The current biomedical model places a large burden of the responsibility to avoid or manage HIV status

on the sex workers. However, existing programmes have the potential to include other, often overlooked priority populations, such as male clients of sex workers. In recent years, we have seen a growing interest in including men in the response to HIV, and one of the first studies of its kind was undertaken in South Africa and successfully enrolled male clients of female sex workers as its primary population (unpublished). Preliminary findings showed that while the men had lower HIV prevalence compared to FSWs, and there was also low condom use and high exposure to both perpetrating and receiving violence, especially sexual violence, among male clients of FSWs.

The renewed investment in sex work programmes is not only a moral imperative but a strategic necessity for global public health. Given their significant role in the HIV epidemic, including male clients of sex workers in intervention programmes is crucial to address the broader dynamics of HIV transmission. Costing studies are essential to understanding the costs and benefits of investing in key populations such as FSWs, demonstrating that funding such programs is not only cost effective but vital for the improvement of health outcomes among both key and general populations. By highlighting the health returns of investing in comprehensive and inclusive programs, we enable a stronger case to be made for continued and expanded support for specialised sex worker programmes.

We declare no competing interests.

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