

HIV AND SEX WORKERS

OVERVIEW

Sex workers are disproportionately affected by HIV. In 2022, the relative risk of acquiring HIV was nine times higher for sex workers than for people in the wider population globally, declining from 12 times higher in 2010 (1).

In sub-Saharan Africa, annual numbers of sex workers with newly acquired HIV dropped by 50% between 2010 and 2022 according to new modelled estimates. Numbers of new infections among sex workers remain the same outside sub-Saharan Africa and are increasing in some countries (1).

Criminalization of any aspect of sex work, other punitive laws, interpersonal and institutional violence, and stigma and discrimination remain significant barriers to achieving social justice and equality for sex workers, and ensuring health for all through access to and uptake of HIV and sexual and reproductive health services (2–4). A median of 26% of sex workers have reported experiencing violence in the past 12 months (20 reporting countries)¹.

¹ Unless otherwise specified, the source for all quantitative data is Global AIDS Monitoring, 2024 (<https://aidsinfo.unaids.org/>) or UNAIDS epidemiological estimates, 2024 (<https://aidsinfo.unaids.org/>).

In 10 countries in sub-Saharan Africa, the odds of living with HIV were seven times higher for sex workers in countries that criminalize sex work compared with sex workers in countries that have partially legalized sex work (5).

Sex workers face many intersecting forms of discrimination and structural barriers, including those based on sexual orientation, sex, gender identity and expression, migrant status, race, incarceration or criminalized behaviour (e.g. if they are also people who inject drugs), which can significantly impact on their vulnerability to violence and their ability to access services and protect their health (6).

Sex workers include people of all genders, including cisgender men and women, transgender people and gender diverse people. In Thailand, for example, among the estimated population of sex workers in 2023, 62% were female, 13% were male and 25% were transgender. Intersecting forms of stigma and discrimination based on gender identity and expression and structural barriers can increase the risks of acquiring HIV.

KEY MESSAGES

- Antiretroviral therapy coverage among sex workers is low. A high number of sex workers report avoiding accessing health services due to stigma and discrimination. Overall, condom use has consistently been higher among sex workers than among people from other key populations, but access to HIV prevention for sex workers is well below the target in some countries. National responses should align their HIV prevention programmes to address the distribution of new infections among people from key populations, including sex workers. Complacency is a danger, and HIV services need to be scaled up to achieve sustained declines in numbers of new HIV infections and testing and treatment targets.
- Sex workers, like all other workers, have a right to safe working conditions, access to social protection, bodily autonomy, and autonomy over their sexuality, without discrimination (7). Countries should implement evidence-informed responses to HIV and sex work that reduce inequalities and protect and promote human rights and public health. These responses include ensuring access to HIV services that are free from stigma and discrimination, supportive legal environments to enable sex workers to protect their health and well-being, and removal of structural barriers in full partnership with sex worker-led organizations. Critical actions include ending the criminalization of all aspects of sex work, including the purchase, sale and management of sex work; extending labour protections; protecting sex workers against state and private actor violence; and ending stigma, discrimination and gender-based violence. Sex workers report being significantly affected by humanitarian crises due to structural barriers and intersecting forms of oppression, which increase their vulnerability to violence, economic hardship and human rights abuses, and programmes need to better take their situations into consideration (8).

- Sex worker-led organizations are effective in reaching the marginalized members of their communities who have been left behind by other health services. Peer-led responses should be prioritized to deliver prevention services for sex workers and to support linkages to treatment for sex workers living with HIV. Based on their lived experiences, sex worker-led organizations are able to quickly identify barriers and emerging challenges affecting people in their communities and work in coordination with governments and health facilities to bridge those gaps (9, 10).
- Programmes for people from key populations, including sex workers, are under-resourced. Only 40% of domestic funding is dedicated to prevention programmes for people from key populations, highlighting the dependency on international financing. Core funding and institutional support have played an essential role in the development and success of networks of sex workers. Globally, however, funding for sex worker and key population programming remains insufficient, including within the category of HIV funding, with 0.6% of total HIV spending from 53 reporting countries allocated for prevention interventions among sex workers. (11). Increased, more sustained funding for sex worker-led organizations to deliver HIV services, advocate for sex workers' rights, and conduct community-led monitoring and research is needed.
- Community-led organizations play essential roles in ensuring delivery of good-quality services to sex workers. Example of best practice include the Peruvian organizations Casa Trans Zuleymi, Miluska Vida y Dignidad and Trans Organización Feminista, which play roles in addressing the systemic issues faced by sex workers. These organizations are part of a comprehensive plan with the Peruvian Ministry of Women and Vulnerable Populations to combat violence against sex workers. They organize training for police officers, designed and facilitated by cisgender and transgender sex workers to instil knowledge about human rights, stigma and discrimination, and the essential role of police officers as guarantors of justice and enablers of a human rights-based approach (12, 13).

KEY DATA²

Size estimate

A total of 137 countries have ever reported population size estimates for sex workers. Among these, only 27 countries reported a recent (past five years) national empirically derived estimate that could be used for current programme planning.

HIV incidence

In 2022, the relative risk of acquiring HIV was nine times higher for sex workers than for people in the wider population globally. Annual numbers of new HIV infections among sex workers decreased by 35% from 2010 to 2022 (1).

HIV prevalence

The global median HIV prevalence among sex workers is 3.0%, ranging from 0% to 62% (72 reporting countries). This is higher than the 0.7% global prevalence in the total adult population aged 15–49 years. Most countries do not report data to UNAIDS for prevalence of HIV among cisgender male or transgender sex workers. Countries that do report transgender sex workers data (26 countries since 2013) show higher levels of HIV among transgender sex workers than female sex workers, when gender disaggregation is included. A total of 38 countries have reported data on HIV prevalence among male sex workers since 2011 through Global AIDS Monitoring, and 12 have reported these data in more recent years (2019–2023), nine of which show HIV prevalence is higher among male sex workers than female sex workers.

Recent data are very limited for cisgender male and transgender sex workers. Reported HIV prevalence among transgender sex workers in the past five years in countries with available data (Belgium, Indonesia, Nigeria, Peru) is reported at a median of 18%.

HIV services

The coverage and use of combination HIV prevention among sex workers was low globally, with a reported median of 50% receiving at least two prevention services in the past three months (32 reporting countries).

Among people from key populations, condom use at last sex with a client tends to be more common among sex workers (over 90% in 27 of 64 reporting countries), although it remains concerningly low in some places. In five reporting countries (Democratic Republic of the Congo, Honduras, Sierra Leone, South Sudan, Zambia), less than 50% of sex workers reported condom use at last sex with a client.

Antiretroviral therapy coverage is low among sex workers, with a global median of 66% (32 reporting countries). Coverage is lower among young sex workers aged under 25 years, with a median of 55% of sex workers living with HIV on treatment. Coverage among older sex workers reported a median of 72% (seven reporting countries).

A median of 80% of sex workers globally either had taken an HIV test and received the results in the past 12 months or had previously tested positive for HIV (69 reporting countries).

Laws and policies

As of June 2024, 170 countries had punitive laws that criminalized some aspect of sex work.

2 Unless otherwise specified, the source for all quantitative data is Global AIDS Monitoring, 2024 (<https://aidsinfo.unaids.org/>) or UNAIDS epidemiological estimates, 2024 (<https://aidsinfo.unaids.org/>). See also references in Laws and Policies Scorecard figures in regional factsheets.

Sexual and reproductive health and rights services

Stigma and discrimination

Violence

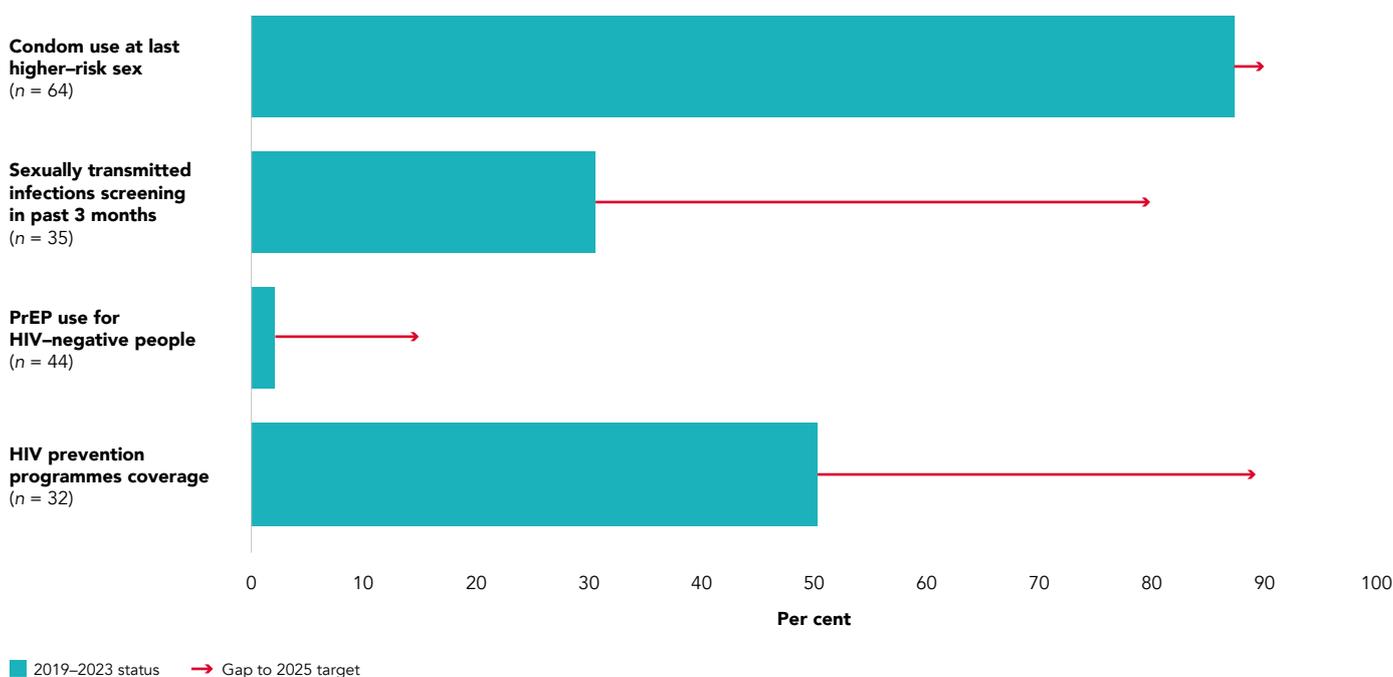
Sex workers report facing multiple challenges in accessing the services they need. Sexual and reproductive health services are rarely integrated for different health issues (e.g. HIV, sexually transmitted infections, reproductive health services). Inadequate contraceptive access, difficulties negotiating condom use, and vulnerability to sexual violence make access to sexual and reproductive health services essential (6, 14).

A median of 26% of sex workers have experienced stigma and discrimination in the past six months (20 reporting countries). A median of 14% of sex workers have avoided accessing health-care services due to stigma and discrimination in the past 12 months (34 reporting countries).

A median of 21% of sex workers have experienced violence in the past 12 months (31 reporting countries).

Figure 11.3.

Gap to achieve combination prevention targets among sex workers, by intervention, global, 2019–2023



Source: Global AIDS Monitoring, 2020–2024 (<https://aidsinfo.unaids.org/>); UNAIDS special analysis, 2024.

Note: The methods used are described under the section “Calculation of pre-exposure prophylaxis (PrEP) coverage for HIV-negative people” in the Annex.

The graph shows median coverage among countries reporting except for PrEP use.

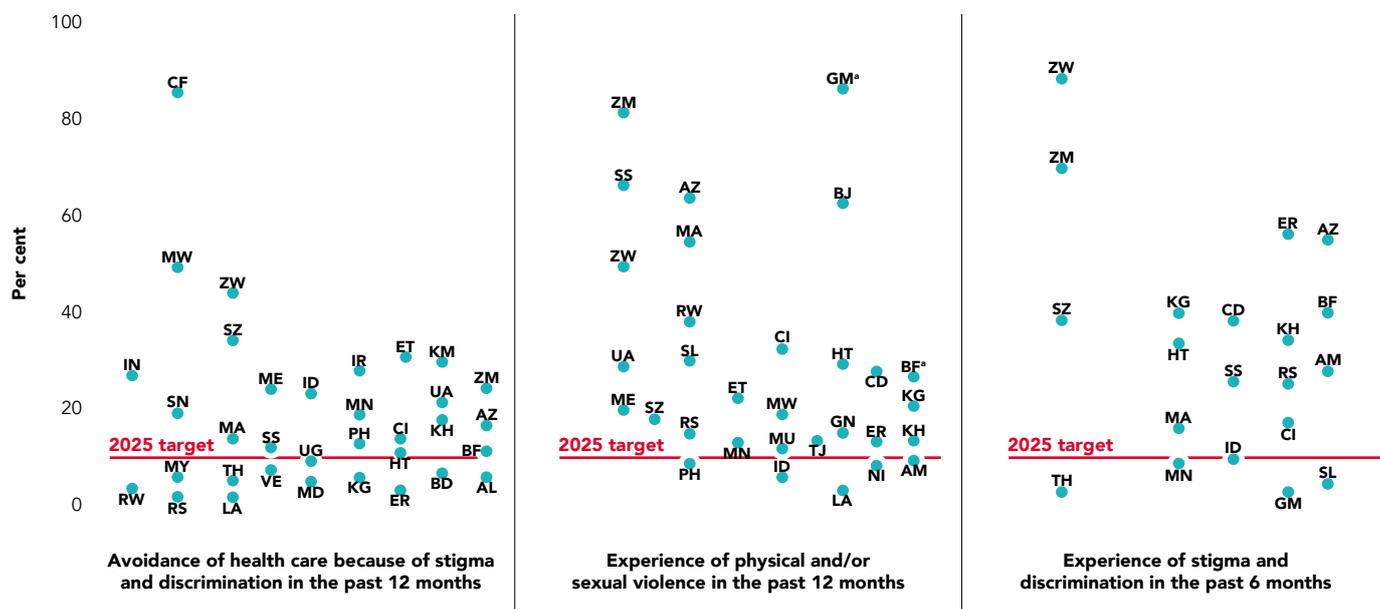
2025 targets are global. Coverage of interventions can be underestimated due to the lack of reporting from some countries.

“HIV prevention programmes coverage” refers to people from key populations who reported receiving at least two prevention services in the past three months. Possible prevention services received for sex workers include condoms and lubricants, counselling on condom use and safer sex, and testing for sexually transmitted infections. Condom use at last higher-risk sex does not take into account people taking PrEP and therefore may be underestimated.

PrEP targets were calculated based on the number of people who would most benefit from PrEP use, those with greatest vulnerability to HIV exposure within each key population. Reported numbers of PrEP users include all users regardless of vulnerability.

Figure 11.4.

Experience of sexual and or physical violence, stigma and discrimination, and avoidance of health care among sex workers, reporting countries, 2019–2023



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| AL: Albania | CI: Côte d'Ivoire | IN: India | ME: Montenegro | TH: Thailand |
| AM: Armenia | CD: Democratic Republic of the Congo | ID: Indonesia | MA: Morocco | UG: Uganda |
| AZ: Azerbaijan | ER: Eritrea | IR: Islamic Republic of Iran | NI: Nicaragua | UA: Ukraine |
| BD: Bangladesh | SZ: Eswatini | KG: Kyrgyzstan | PH: Philippines | UY: Uruguay |
| BJ: Benin | ET: Ethiopia | LA: Lao People's Democratic Republic | MD: Republic of Moldova | VE: Venezuela |
| BO: Bolivia | GM: Gambia | LB: Lebanon | RW: Rwanda | ZM: Zambia |
| BF: Burkina Faso | GE: Georgia | MW: Malawi | SN: Senegal | ZW: Zimbabwe |
| KH: Cambodia | GH: Ghana | MY: Malaysia | RS: Serbia | |
| CF: Central African Republic | GN: Guinea | MU: Mauritius | SL: Sierra Leone | |
| TD: Chad | HT: Haiti | MN: Mongolia | SS: South Sudan | |
| KM: Comoros | | | TJ: Tajikistan | |

Source: Global AIDS Monitoring, 2020–2024 (<https://aidsinfo.unaids.org/>).
 Note: * In the past 6 months

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For additional information and data on HIV and sex workers, see:

2024 global AIDS update. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 www.unaids.org

2024 global AIDS update factsheets. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 www.unaids.org

Key populations atlas. Geneva: Joint United Nations Programme on HIV/AIDS (<https://kpatlas.unaids.org/dashboard>).

New HIV infections data among key populations: proportions in 2010 and 2022. Geneva: Joint United Nations Programme on HIV/AIDS; 2024 (<https://www.unaids.org/en/resources/documents/2024/new-hiv-infections-data-among-key-populations-proportions>).

HIV and sex work: human rights fact sheet series 2021. Geneva: Joint United Nations Programme on HIV/AIDS; 2021 (https://www.unaids.org/sites/default/files/media_asset/05-hiv-human-rights-factsheet-sex-work_en.pdf).