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STUDENT ESSAY

A Human Rights Case Study on Access to Pre-exposure Prophylaxis for Female Sex Workers in South Africa

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Abstract

This paper examines the extent to which access to HIV preventive medicines such as pre-exposure prophylaxis (PrEP) are ensured under the International Covenant on Economic, Social and Cultural Rights. There is a lack of human rights-focused research on access to HIV preventive medicines for vulnerable populations such as female sex workers in HIV-endemic countries. To help fill this gap, I utilized a case study approach to critically examine the rollout of PrEP for female sex workers in South Africa, drawing on the country's Bill of Rights, health care policies, and PrEP implementation. My analysis found that (1) PrEP rollout was largely physically and economically *inaccessible* for female sex workers outside of urban centers; (2) the dissemination of PrEP information specific to female sex workers was limited both virtually and in clinics, reducing the medicine's *acceptability*; and (3) South Africa's overburdened public health care system and continued criminalization of sex work limited the *accessibility* and *quality* of HIV prevention services, contributing to weak uptake of PrEP among female sex workers. To remedy these issues, state leaders should prioritize PrEP counseling and socially acceptable information dissemination; expand comprehensive, coherent, and coordinated sexual health services for female sex workers; increase the financial resources available for programs specific to female sex workers; and decriminalize sex work.

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Introduction

A human rights lens, particularly regarding the universal right to health, is useful to understand and address complex global public health problems. A human rights-based approach to health is one that acknowledges and aligns with the universality of human rights, recognizes and facilitates the agency of vulnerable populations, and holds states and other institutional powers accountable for the achievement and protection of human rights.[1] Article 25 of the Universal Declaration of Human Rights (UDHR) states that "everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family."[2] Similarly, article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) asserts the universal right of all people to the "highest attainable standard of physical and mental health."[3] States that have ratified this international covenant have committed to taking deliberate steps to progressively realize the right to health for people both within their country using maximum available resources, and globally through international cooperation.[4] However, states must also contend with limited resources, conflicting sociopolitical agendas, and ongoing epidemics, all of which threaten the progressive realization of the right to health.

HIV is an ongoing epidemic that continues to pose significant health and human rights risks globally, particularly for members of disempowered and marginalized populations in HIV-endemic and hyperendemic countries, where the virus maintains a consistently high presence among the adult population.[5] Female sex workers are an especially vulnerable population for HIV as a result of factors such as gender-based violence, substance use, fear of discrimination from health care providers, and difficulties negotiating condom use with sexual partners for fear of violence or disincentivizing business, as well as structural issues such as poverty, the criminalization of sex work, and police harassment.[6] The criminalization of sex work in particular prevents female sex workers from accessing health and social services for fear of imprisonment or assault, thereby worsening health outcomes and infringing on their right to health.[7] As a result, the United Nations has called on states to protect and ensure access to sexual and reproductive services for sex workers.[8] Some states, including South Africa, have specifically identified female sex workers as a priority population for HIV prevention and treatment services through national policies and strategic plans.[9] Human rights-based analysis, which rigorously examines the impact of state policies and systems on the health of members of vulnerable populations, is an important tool in challenging the HIV epidemic.[10]

Human rights-based approaches to HIV are historically rooted in ensuring access to HIV treatment, clinical services, and education on behavioral prevention strategies such as condom use through civil engagement and legal action.[11] New biomedical HIV preventions tools, particularly oral pre-exposure prophylaxis (PrEP), evidence a shift in the global response to the HIV epidemic. PrEP is a combination of antiretroviral medications, most commonly taken as a once-daily pill containing emtricitabine and tenofovir disoproxil, which can prevent the sexual transmission of HIV by up to 99% when taken with high adherence by a person who is HIV negative.[12] Alternatives to oral PrEP, such as long-lasting injectable cabotegravir and the dapivirine vaginal ring, are under review or have been approved for use in South Africa, although their rollout is still being piloted.[13] PrEP is an increasingly significant HIV prevention tool globally; however, given its relative recency, there is an absence of human rights-based research regarding access to PrEP. This lack of rights-based analysis is particularly concerning given the precarity of priority populations at risk of HIV who could benefit from increased access to PrEP, including female sex workers.

To address this gap in knowledge, I use a case-study approach to examine the extent to which access to HIV preventive medicines such as PrEP is ensured under international human rights law for priority populations in HIV-endemic countries. This analysis focuses on access to PrEP for female sex workers in South Africa, given the country's rich history of human rights-driven HIV prevention and treatment policies.[14] Female sex workers

were selected as the primary population for this case study because they face significant barriers to health care access and have been explicitly identified as a priority population for PrEP in existing literature and government documents.[15]

This analysis examines the current status of female sex workers in South Africa, details the right to health in South Africa and the country's national PrEP policies and strategic plans, and concludes with a critical analysis of the de facto rollout of PrEP for female sex workers in South Africa to answer the following questions:

1. To what extent does the right to the highest attainable standard of health, as enshrined in article 12(1) of the ICESCR, include preventive health measures such as PrEP for HIV-negative female sex workers in HIV-endemic countries?
2. How are human rights frameworks currently guiding the implementation of PrEP delivery for female sex workers in South Africa?

The status of female sex workers in South Africa

South Africa faces one of the world's highest HIV burdens, with a reported HIV prevalence rate of approximately 19% among adults, an HIV incidence rate of approximately 6.9 per 1,000 adults, and approximately 7.5 million people living with HIV in 2019.[16] As of 2019, South Africa had a population of approximately 59 million people across nine provinces. Over 67% of the population lives in urban areas and cities.[17] The health system in South Africa is organized under a unified National Department of Health, which manages the nine provincial departments of health and municipal and local health authorities.[18] Approximately 14% of South Africa's government spending was on the health care sector in 2020 and 2021; however, the country continues to experience lagging health outcomes resulting from poor infrastructure and an overstrained health care system.[19]

Health care in South Africa is delivered through both public health facilities and the private sector. The public system is funded primarily by the South African government and international funding bodies such as the US President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria and provides services to uninsured patients, while the private system is funded through out-of-pocket payments and insurance premiums.[20] The public health care system in South Africa is being increasingly decentralized, with authority being transferred to local clinics, hospitals, ward-based outreach teams, and rural home-based care organizations.[21] Approximately 84% of South African citizens access their health care through public clinics and hospitals.[22] However, an overwhelming majority of doctors in South Africa work in the private sector and provide services to the 16% of South Africans with private health insurance.[23] Approximately 50% of national health care expenditures is spent on those with private health insurance.[24] This inequitable public-private split presents a concerning dichotomy of health care access, leading to many South Africans struggling to receive necessary care and treatment within an overburdened public health system.

Sex workers are recognized by the South African government as a key and vulnerable population for HIV prevention services.[25] Sex work in South Africa is immensely complicated, and not all people who engage in sex work may consider themselves to be sex workers.[26] Human Rights Watch reports that the majority of sex workers in South Africa are female, black, and living in poverty.[27] Sex work can take place in both urban and rural settings, though the majority of health care services targeted toward female sex workers are based in major cities such as Johannesburg. Such services are provided through sex worker clinics, mobile clinical outreach vans, and targeted clinical services delivered in hotels and brothels where sex workers operate.[28] Access to clinical services in rural areas is limited, including access to HIV prevention and treatment services specific to female sex workers. As a result, women who engage in sex work in rural areas may be at higher risk of HIV infection due to a lack of available services.[29] This lack of rural access to clinical services may also negatively affect young women engaging in transactional sex or "blesser-blessee"

relationships, in which an older, typically male, partner provides money, goods, or services to a younger partner in exchange for sex.[30] While transactional sex is considered distinct from sex work, both practices present significant HIV risk, and young women who rely on transactional sex may be more likely to engage in sex work in the future.[31]

The right to health and the right to the benefits of science in South Africa

The Republic of South Africa was readmitted to the United Nations General Assembly in 1994, following the end of Apartheid. This readmittance was followed by an amalgamation and domestication of human rights elements enshrined in the UDHR into the country's Bill of Rights in 1996, under the leadership of the newly elected African National Congress.[32] The country later ratified the ICESCR in 2015.

Articles 25 and 27 of the UDHR and articles 12 and 15 of the ICESCR encompass the universal and inalienable right to health and the right to participate in and benefit from scientific progress. Article 25(1) of the UDHR declares that "everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing, and medical care and necessary social services."[33] Article 27(1) notes that everyone has the right "to share in scientific advancements and its benefits."[34] Meanwhile, article 12 of the ICESCR recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, while also noting that steps to achieve the highest attainable standard of health must include the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases.[35] Article 15(1)(b) of the ICESCR recognizes the rights of everyone to enjoy the benefits of scientific progress and its applications.[36]

The Committee on Economic, Social and Cultural Rights oversees state parties' implementation of the ICESCR by monitoring the progressive realization of rights and by releasing general comments. General comments are recommendations to guide the implementation, interpretation, and monitoring of specific provisions within international treaties. The committee's General Comment 14 notes that the realization of the right to health is dependent on a public health system or program meeting the required conditions of *availability, accessibility, acceptability, and quality*.[37] *Availability* refers to the presence and quantity of health care-related facilities, goods, and services, and also takes into consideration underlying determinants of health such as safe drinking water and housing.[38] *Accessibility* refers to nondiscrimination, which means ensuring that health programs are physically and economically accessible and that related information is presented in a way that can be understood by all.[39] *Acceptability* relates to the cultural appropriateness of health care programs, alignment with medical ethics, and level of respect and sensitivity provided to the needs of marginalized communities.[40] *Quality* refers to the quality and medical soundness of a health care program and requires the presence of skilled health care staff, safe drugs, and adequate and sanitary health care facilities.[41] The presence of these qualities is dependent on the available resources of the state, but they are necessary to achieve the progressive realization of the right to health.

General Comment 14 notes that the realization of article 12(2)(c) of the ICESCR requires "the establishment of prevention and education programmes," particularly relating to epidemics such as HIV/AIDS.[42] The control of diseases is also dependent on the individual and joint efforts of state parties to ensure the availability of relevant technologies.[43] The realization of article 12(2)(d)—the right to health facilities, goods, and services—requires access to basic preventive, curative, and rehabilitative health services, as well as the provision of essential drugs. PrEP has been included in the World Health Organization's (WHO) Model List of Essential Medicines since 2017.[44]

General Comment 22 on the right to sexual and reproductive health notes that essential medicines should be made available for the prevention and treatment of sexually transmitted infections (STIs) and HIV.[45] It also emphasizes that state parties should take measures to fully protect persons

working in the sex industry against all forms of violence, coercion, and discrimination and to ensure that such persons have access to the full range of sexual and reproductive health care services.[46] States should act to ensure universal access to nondiscriminatory sexual and reproductive health services, particularly for members of disadvantaged and marginalized groups. Finally, General Comment 22 notes the importance of ensuring access to quality technologies, personnel, equipment, and medicines, including generic medicines based on the WHO Model List of Essential Medicines.[47]

General Comment 25 on the right to enjoy the benefits of scientific progress and its applications declares that the right to benefit from scientific progress is instrumental in realizing the right to health.[48] New medicines and health care services should be made available to everyone, especially members of the most vulnerable populations, and particularly as "means for the prevention, control and treatment of epidemic, endemic, occupational and other diseases."[49] States should also promote scientific research and ensure that everyone benefits from the findings of this research.[50] Elements of the right to participate in and enjoy the benefits of scientific progress and its applications include *availability, accessibility, quality,* and *acceptability*. *Availability* refers to the enaction and dissemination of scientific progress; *accessibility* refers to equal access to participate in and benefit from scientific progress; *quality* refers to advanced and verifiable science; and *acceptability* refers to the dissemination of scientific findings and technologies in different social and cultural contexts.[51]

The right to health is enshrined in the South African Constitution and Bill of Rights, and policies that seek to increase equitable access to health care for persons disadvantaged by unfair discrimination have been gradually adopted following the end of Apartheid in 1994.[52] The domestication of policies that embrace the right to health and nondiscrimination suggests a strong commitment from the government of South Africa to apply and enforce international human rights law within the country's borders.[53] Notable articles in the South African Bill of Rights relating to the right to health include the following:

- article 10: the right to human dignity
- article 11: the right to life
- article 27(1)(a): the right to have access to health care services, including reproductive health care
- article 27(2): the state's duty to take legislative and other measures within available resources to achieve the progressive realization of these rights[54]

As recognized by the Constitutional Court of South Africa, the progressive realization of rights requires the state to strive to the maximum extent possible within available resources, increasing access for vulnerable populations over time.[55]

South Africa's health care policies and national strategies

Oral PrEP was approved for use in South Africa in 2015. Both brand-name and generic versions of PrEP can be purchased at cost from the private sector. South Africa has historically gone to great lengths to ensure affordable or free access to generic medicines through policies such as the 1996 National Drug Policy, which established a nondiscriminatory pricing system, and the implementation of the 2004 Single Exit Price Policy, which further regulated the cost of imported pharmaceuticals.[56] Since June 2016, PrEP has been offered free to female sex workers through select public health clinics, mobile outreach vans, and fixed facilities in select urban centers such as Cape Town, Durban, Johannesburg, and Hillbrow, eventually expanding to clinics across the country.[57] In order to access services specific to female sex workers, however, the women must disclose their sexual activity, which may prevent many eligible PrEP users from accessing the medication for fear of stigma or arrest.[58]

The South African Guidelines for the Provision of PrEP to Persons at Substantial Risk of HIV Infection notes that PrEP provision must be com-

bined with existing sexual and reproductive health services, with PrEP clients receiving a minimum package of services, including HIV testing and antiretroviral therapy initiation for those diagnosed with HIV, syndromic STI diagnosis and treatment, tuberculosis screening, pregnancy screening, mental health counseling, contraception, and condoms and lubricants.[59] The guidelines advise that PrEP users undergo an HIV test, STI screening, and counseling one month after PrEP initiation, and every three months after.[60]

South Africa's PrEP policies for female sex workers

South Africa has recognized the need to expand HIV prevention and treatment services for female sex workers. The country's 2016 National Policy on HIV Pre-exposure Prophylaxis (PrEP) and Test and Treat (T&T) follows WHO guidelines recommending the provision of daily PrEP to members of priority populations at substantial risk of HIV infection in order to reduce HIV incidence over time.[61] The objectives of this policy are to expand prevention options such as PrEP, increase access to treatment, integrate PrEP and T&T into existing health care systems, and ensure high-quality and well-communicated community-based strategies.[62] The National Department of Health has further clarified the implementation of PrEP and T&T for female sex workers through the publication of the *Guidelines for Expanding Combination Prevention and Treatment Options for Sex Workers: Oral PrEP and Test and Treat (T&T).* This document advises that PrEP should be offered to female sex workers at high risk of HIV, along with a combination prevention package, including the provision of condoms, risk reduction counseling, and immediate initiation of antiretroviral therapy if a patient tests positive for HIV.[63] The guidelines also call for the integration of PrEP programs into existing sexual and reproductive health programs and family planning services and for capacity-building and sensitivity training for health care providers.[64]

Female sex workers are identified as a key population for PrEP under South Africa's 2017–2022 National Strategic Plan on HIV, TB and STIs, particularly under goal 1, which concerns prevention to reduce new HIV and tuberculosis infections and STIs.[65] Objective 1.14 of this strategic plan calls for the provision of PrEP to identified risk populations, including sex workers. It also calls for the expansion of combination HIV prevention, which combines human rights-based and evidence-informed behavioral, biomedical, and structural strategies, including PrEP.[66]

Implementation of PrEP policies in South Africa

Following the passage of the National Policy on HIV Pre-exposure Prophylaxis (PrEP) and Test and Treat (T&T), the government began a phased rollout of PrEP. The rollout initially targeted female sex workers at select public health care centers across the country and was then expanded to include facilities providing services to men who have sex with men, and finally to students at select university campuses, before being offered at primary clinics in 2018.[67] Although female sex workers were the first population to be targeted for PrEP rollout, their uptake compared to other populations has been relatively low.[68] As of 2018, approximately 4,109 female sex workers had initiated PrEP, representing only 13% of those who had been offered PrEP clinically.[69] Further, only 66% of female sex workers who tested negative at a clinic were offered PrEP.[70] Female sex workers were initiating PrEP at significantly lower rates than men who have sex with men, approximately 54% of whom initiated PrEP upon offer.[71] In a study on clients attending clinics for female sex workers and men who have sex with men in South Africa, over half of the clients who had never initiated PrEP attributed this to having never been offered PrEP.[72] This evidences a serious gap in PrEP implementation and information accessibility. Many clients also expressed that they stopped adhering to PrEP as a result of early side effects of the medication, suggesting that counseling on side-effect management was not regularly provided.[73]

To increase the dissemination of information

about PrEP, the government of South Africa has created a publicly accessible website, www.myprep.co.za. However, the website makes no mention of PrEP services for sex workers, asks no questions about sex work in the self-assessment survey, and does not provide information on free or publicly funded PrEP. Female sex workers in South Africa face difficulties accessing sexual health information due to stigma and judgment within clinic settings.[74] A non-stigmatizing website containing PrEP information and resources would help close this information gap.

Clinical trials and demonstration projects were also implemented in parallel to the passage of the National Policy on HIV Pre-exposure Prophylaxis (PrEP) and Test and Treat (T&T) to assess the acceptability and effectiveness of PrEP for various priority populations. Only one demonstration project specifically targeted female sex workers: the Treatment and Prevention for Female Sex Workers (TAPS) project, which ran from 2015 to 2017.[75] The primary aim of the TAPS project was to assess whether female sex workers would accept and adhere to a combination prevention and care approach that included PrEP, and whether the South African health care system could handle the additional strain. The study found that female sex workers place significant emphasis on the role of social networks in their acceptance of PrEP. Many workers in the study reported mistrusting PrEP or health care providers.[76] This mistrust was strengthened by participants in the clinical trial not being able to share PrEP with those in their social network who were not enrolled in the TAPS study. However, PrEP was viewed to be a valuable HIV prevention option. The TAPS study recommended that information about PrEP be disseminated widely to increase support among diverse communities, in line with the recommendations of accessibility in General Comments 14 and 25.[77]

Critical analysis of South Africa's PrEP implementation for female sex workers

The government of South Africa has shown that it is willing to take steps to progressively realize the right to health and the right to benefit from scientific progress through the expansion of PrEP services for female sex workers. However, the implementation of PrEP for this population falls short with regard to the realization of both the right to health and the right to benefit from scientific progress.

The right to health

PrEP implementation for female sex workers has not met the standard of *availability* as outlined in General Comment 14.[78] PrEP is available in sufficient quantities in South Africa; however, health care facilities and demonstration sites that disburse the medication and provide counseling on adherence and side-effect management to female sex workers are limited. The location of such services in primarily urban centers limits the *physical accessibility* for female sex workers in rural areas and reduces the *economic accessibility and affordability* of PrEP for female sex workers who cannot access these select public health care clinics. The creation of a PrEP website by the South African government suggests increased *information accessibility*, though the site makes no mention of services for female sex workers. Studies involving South African female sex workers suggest that PrEP information has not been effectively conveyed to this population, nor are health care providers initiating PrEP conversations with female sex workers during clinic visits, further limiting *information accessibility*. There are also limitations to the *acceptability* of PrEP, largely as a result of medical mistrust, poor communication about PrEP, and concerns about the medications' efficacy.[79] However, the *quality* of PrEP has been confirmed by numerous clinical and demonstration trials across the globe.[80] South Africa's PrEP guidelines follow established clinical protocols where resources allow. There are concerns that South Africa's overburdened public health care system may not be capable of providing appropriate or good-quality health care services for female sex workers. This is worsened by the lack of access to social determinants of health such as secure housing and safe and potable water for female sex workers in South Africa as a result of poverty.[81]

Through progressive drug coverage policies

such as the single exit price, which establishes a maximum price at which a medicine can be charged, South Africa has *protected* the right to health for some female sex workers by controlling the financial cost of generic PrEP in the public health sector, but this is not accessible to all female sex workers. South Africa has also committed to *fulfilling* the right to health for these workers through their inclusion in policies and national strategies such as South Africa's National Strategic Plan on HIV, STIs, and TB.[82] The rollout of PrEP has been progressively improving in South Africa. Nonetheless, the government is falling short in the realization of the right to health for female sex workers as a result of harmful policies that criminalize sex work, and the inequitable distribution of public-private and urban-rural health care resources. In particular, the criminalization of sex work in South Africa continues to place female sex workers at risk of violence, harassment, and poor health outcomes. This conflicts with the text of General Comment 22, which calls for full protection for sex workers from violence and discrimination.[83]

The right to the benefits of science

The lack of availability of PrEP for female sex workers across the country fails to meet the call for increased availability of new medicines for vulnerable populations found in General Comments 14, 22, and 25.[84] Regarding ICESCR article 15—the right of everyone to enjoy the benefits of scientific progress and its applications—it appears that the findings of clinical and demonstration trials have not been widely disseminated to female sex workers, reducing *availability*. Further, findings that have been disseminated appear to not be culturally *acceptable* for many female sex workers, largely as a result of a lack of community education about PrEP.[85] *Accessibility* for female sex workers to participate in PrEP-related science has been limited, as there has been only one demonstration trial targeting this group. The unequal distribution of PrEP services for female sex workers across the country has also reduced the *accessibility* of PrEP. However, the *quality* of PrEP-related scientific progress is high and remains verifiable.

Greater efforts must be made to achieve the progressive realization of the right to health and the right to benefit from scientific progress for female sex workers in South Africa, including by expanding comprehensive, coherent, and coordinated sexual health services specific to female sex workers across the country; increasing the financial resources available for programs specific to these workers; and releasing accessible information and educational resources specific to this population.[86]

Limitations

This analysis focused on access to HIV preventive medications such as PrEP under the right to health for female sex workers in South Africa. Future human rights-based research should examine access to HIV preventive medicines for male, transgender, and non-binary sex workers.

Conclusion and recommendations

It is clear that the provision of PrEP for female sex workers in South Africa has been guided by human rights, most clearly evidenced within South Africa's National Strategic Plan on HIV, TB, and STIs.[87] However, the rollout of PrEP has led to some significant gaps in initiation and uptake among female sex workers and has failed to meet the recommended elements and core obligations outlined in General Comments 14 (right to health), 22 (right to sexual and reproductive health), and 25 (right to the benefits of science). Greater work must be undertaken to ensure that PrEP is *accessible, available, acceptable*, and of high *quality* for female sex workers in South Africa. In adopting the ICESCR, the South African government has committed to providing access to health care, safe and healthy working conditions, and socioeconomic factors that can promote a healthy life. The state has committed to expanding PrEP services for female sex workers across the country, suggesting that it will take active steps to ensure the progressive realization of the right to health through a variety of facilities, goods, and preventive health services. The inclusion of female sex workers in South Africa's National Policy on

HIV Pre-exposure Prophylaxis (PrEP) and Test and Treat (T&T), as well as its National Strategic Plan on HIV, TB and STIs, is promising, but more work must be done to ensure an equitable and human rights-driven PrEP rollout for female sex workers.

This analysis clearly shows that the right to the highest attainable standard of health, as enshrined in article 12(1) of the ICESCR, includes preventive health measures such as PrEP for HIV-negative female sex workers in HIV-endemic countries. In order to prevent, treat, and control epidemic and endemic diseases, a wide variety of medical services must be offered. PrEP is a high-quality medical technology that is included in the WHO List of Essential Medicines and can be incorporated into existing health services to help prevent the spread of HIV. Integrating PrEP delivery into existing sexual health and family planning programs bolsters prevention and education services and increases access to relevant HIV-prevention technologies, strengthening that ability of HIV-endemic states to fulfill article 12 of the ICESCR. PrEP has been shown to be a highly effective and acceptable form of HIV prevention for female sex workers in HIV-endemic countries when coupled with counseling services. The use of generic alternatives to PrEP minimizes the cost of PrEP implementation, ensuring that HIV-endemic countries can provide PrEP to vulnerable communities such as female sex workers even in times of resource constraints.

In order to increase the acceptability and availability of PrEP, PrEP programs should prioritize counseling, disseminate information in culturally and socially acceptable ways, and utilize existing social networks among female sex workers to disseminate information and reduce stigma. States should adopt specific legal instruments to ensure access to PrEP for female sex workers, including regulated training for health care providers. By addressing these implementation challenges, the governments of HIV-endemic countries can increase access to HIV prevention measures, essential medicines, sexual and reproductive health resources, and health-related education and information, thereby ensuring entitlements for female sex workers and other vulnerable populations outlined under the right to health. Recognizing that many HIV-endemic countries face resource challenges, the use of generic PrEP and international pharmaceutical assistance is recommended to minimize financial burden and to ensure PrEP access in both urban and rural settings, through both private and public health care systems. Finally, in order to increase the overall health of female sex workers and reduce the rate of HIV infection, it is recommended that HIV-endemic countries address determinants of health for female sex workers, such as ensuring access to health care services and decriminalizing sex work. In particular, the decriminalization of sex work would allow female sex workers to benefit from protection from workplace discrimination and harassment as outlined in General Comment 22 and would increase the *acceptability, accessibility, availability, and quality* of HIV preventive services by reducing harassment and the threat of imprisonment.[88] PrEP is an important tool in the fight against HIV, and PrEP expansion must be aligned with a human rights framework in order to reach the most vulnerable populations equitably and effectively.

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