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Global Network of Sex Work Projects

Promoting Health and Human Rights

GLOBAL BRIEFING PAPER:

The impact of non-rights-based HIV programming for sex workers around the world

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The impact of non-rights-based HIV programming for sex workers around the world

Introduction

Sex workers constitute a key group affected by HIV, with multiple factors contributing to their vulnerability. Around the world, much HIV programming falls short of taking these factors into account and actively working towards their reduction. This failure can only result, at best, in temporary respite which privileges some sex workers over others, rather than serving to empower the sex worker community as a whole, enabling them to work safely and protect themselves.

Sex workers are put at risk of exposure to HIV by criminalisation; violence; unsafe working conditions; violations of their human rights; stigma, discrimination and social marginalisation; drug and alcohol use; unequal access to appropriate health services (WHO et al., 2013); minimal access to HIV prevention tools (such as safe sex supplies and safer injecting equipment); barriers to negotiation of safe sex with clients; offers of higher fees for unprotected sex; and an absence of HIV-related information targeted at sex workers, due to insufficient funding for rights-based and sex worker-led programming.

Strategies currently in place in many countries to ostensibly protect sex workers (and/or the general public) from HIV are counterproductive in that, besides failing to take into account sex workers' human rights, they actually put sex workers' health at risk. Prime examples are mandatory and coercive testing for HIV and sexually transmitted infections (STIs), as well as line testing and '100% Condom Use Programmes'. These approaches are discussed in greater detail below.

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Effects of criminalisation

Criminalisation of sex work and/or related activities may target sex workers themselves, their clients, and/or third parties profiting from sex work, such as managers, receptionists and even taxi drivers. Regardless of the ideology behind criminalisation, or the party or parties ostensibly targeted by the laws, the result is frequently that sex workers are on the receiving end of police harassment and violence. Fear of arrest and police abuse drives sex workers underground, forcing them to work in more risky environments in order to avoid police attention, disrupting their support networks, exposing them to violence, and depriving them of the ability to sufficiently screen clients or negotiate condom use (Shannon et al., 2009). Repressive legislation can make it impossible for sex workers to work both safely and legally, forcing them to choose between one or the other (Stella, 2013). The practice among many police forces of confiscating sex workers' condoms to use them as evidence of sex work also negatively impacts sex workers' ability to practise safe sex (Wurth et al., 2013).

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Anti-trafficking measures, particularly where vague definitions of trafficking overlap with consensual sex work, additionally put sex workers at risk through police raids on sex work venues which can lead to supposedly 'rescued' migrant sex workers being subjected to months of detention (Open Society Institute, 2008), or police abuses such as arbitrary detention, extortion, physical violence or sexual harassment of sex workers (Global Commission on HIV and the Law – Secretariat, UNDP, HIV/AIDS Practice, 2011a).

Laws against vagrancy, same-sex sexual behaviour, crossdressing and drug use particularly impact street-based sex workers, male sex workers, transgender sex workers and sex workers who use drugs, respectively.

HIV non-disclosure, exposure and transmission are criminalised in many parts of the world. In several US states, engaging in sex work with knowledge of one's HIV-positive status is specifically criminalised – even if condoms have been consistently used or less risky sexual behaviour has been practised with clients – and is a felony for brothel-based sex workers in Nevada. Even in states where this is not the case, sex workers may face higher penalties if they are found to be HIV-positive when convicted for sex work-related offences.

A climate of criminalisation deters sex workers from reporting violence to the police, for fear that it will not be taken seriously, or for fear of being arrested themselves for engaging in sex work. Furthermore, they may be deterred from accessing health and social services for fear of the nature of their work being shared with the authorities (Kurtz et al., 2005). Repercussions may include loss of child custody or deportation. Those who are known to be sex workers may be prohibited from entering or immigrating to numerous countries (UNIFEM, 2007).

Arrest and incarceration may interrupt sex workers' treatment for HIV or other health issues, and condoms and safer injecting equipment may not be available in prisons. Criminal records and/or being listed as sex offenders may cause difficulties for sex workers in accessing housing and even low-wage, menial work (BPPP et al., 2010), forcing them to continue to engage in criminalised activities.

The clandestine nature of sex work under regimes of criminalisation prevents sex workers from organising collectively. Without sufficient support from rights-based organisations, sex workers may be unable to empower themselves and challenge the unjust laws that put them at risk.

Deterrents to accessing HIV services

Many of the barriers which obstruct sex workers' access to HIV services are connected to stigma and repressive legal measures. Those who do access services may avoid revealing their occupation or other relevant information, due to fears of receiving unfavourable treatment and/or of being outed to the authorities or other parties. This withholding of health-related information has the potential to severely undermine diagnostic accuracy, effectiveness of care procedures and prescribed treatment regimes.

STIGMA AND MORAL JUDGEMENT

A common fear among sex workers, often based on past experience, is of discrimination, open hostility or patronising attitudes from staff. This may be reflective of individual staff beliefs or of institutional policy, with sex workers variously constructed as morally impure, as victims with no agency, and/or as 'vectors of disease'. Sex workers may be pressured to cease engagement in sex work, or to answer intrusive and irrelevant questions about their work merely to satisfy staff members' curiosity. Problematic attitudes are widespread, indicating an overall lack of knowledge among service providers of the realities of sex work and a reliance on harmful myths and stereotypes.

PRACTICAL BARRIERS

Many HIV services lack flexible hours which would more realistically meet sex workers' needs, and may have inconvenient locations (Sex Workers Project at the Urban Justice Center, 2005). Sex workers may be deterred from accessing services due to recognition that they are of low quality, fragmented or subject to delays.

LACK OF HEALTH INSURANCE

The right to use health care services can itself be complicated by states' refusals to recognise sex work as work. This can prevent sex workers from obtaining the medical insurance that would grant them access to health and social services in accordance with labour rights. International migrants (who comprise 65% of sex workers in Western Europe) are unable to obtain work and residence visas as sex workers. Internal migrants in Eastern Europe and Central Asia, who may migrate within their own countries in order to preserve anonymity or to seek better work opportunities, are impacted by legal regulations which tie their access to services to residence in a particular region.

LACK OF CONFIDENTIALITY

A principal fear among many sex workers is that they will be reported to the authorities for their engagement in sex work, immigration status, HIV status and/or drug use, leading them to face repercussions such as criminal charges, loss of child custody, or deportation (PAHO, 2011; Global Commission on HIV and the Law – Secretariat, UNDP, HIV/AIDS Practice, 2011b). Breaches of confidentiality are not unknown, with health care services in Europe and Central Asia reported to have shared sex workers' personal details with third parties such as police, authorities, family members, clients and other sex workers. Practices of forced testing by police lead sex workers to further distrust health services.

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REPRESSIVE MEASURES IMPACTING SEX WORKERS WHO USE DRUGS

Some organisations impose requirements that service users cease drug use before receiving treatment or support (Harm Reduction International, 2013), and some, as reported by sex workers in Canada, may call the police or bar people for using drugs. Those who seek drug treatment in Kazakhstan, Kyrgyzstan, Russia and Ukraine are placed on 'drug user registers', which can result in the denial of driver's licences and certain jobs, and even the removal of child custody (UNDP, Global Commission on HIV & the Law, 2011; Eurasian Harm Reduction Network, 2011).

REPRESSIVE MEASURES IMPACTING HIV-POSITIVE SEX WORKERS

Although Ecuador has no law preventing HIV-positive people from engaging in sex work, health cards are removed immediately from sex workers testing HIV-positive, in order to ban them from working. This confiscation of health cards is a violation of procedure, but the framework of human rights is not honoured in practice. Sex workers may as a result stop visiting health services and move to other cities to engage in sex work.

Mandatory testing

Compulsory HIV and STI testing of sex workers takes place under two main sets of circumstances. In the first, it is enforced by police during raids and sweeps, and in the second, it is required in order to legally engage in sex work in countries and areas where sex work is regulated. Compulsory testing is generally conducted with no counselling or confidentiality, and results may be released without consent to health authorities and the general public (Global Commission on HIV and the Law – Secretariat, UNDP, HIV/AIDS Practice, 2011b). There is a scarcity of evidence that compulsory screenings are effective in reducing the incidence of HIV or STIs (Nitschke et al., 2006; Samaranayake et al., 2009; Wilson et al., 2010), and sex workers highlight that this practice is a repressive and degrading form of exercising control over them. It undermines sex workers' empowerment and sense of professional responsibility, and perpetuates their stigmatisation as 'vectors of disease' and 'core transmitters', framing them as entirely accountable for the spread of HIV and other STIs. Its creation of dangerously strong links between the authorities and health services causes sex workers to distrust medical personnel. Through the practice of compulsory testing, discrimination against sex workers, especially those living with HIV, is reinforced in the eyes of health care providers, law enforcement and the general public.

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MANDATORY TESTING AS ENFORCED BY POLICE

Twenty US states permit compulsory HIV testing of individuals arrested for or convicted of prostitution, solicitation or pandering (Global Commission on HIV and the Law – Secretariat, UNDP, HIV/AIDS Practice, 2011b). Forced HIV and STI testing of arrested sex workers, as well as a few cases of hospitalisation for compulsory treatment, has been reported in Armenia, Georgia, Russia, Tajikistan and Uzbekistan (CEEHRN, 2005), and over 30% of Kyrgyzstani sex workers and 25% of sex workers in Ukraine have been subjected to it.

In 2008, seven sex workers in Macedonia were arrested, forcibly tested, and diagnosed with hepatitis C, upon which they faced criminal charges for allegedly transmitting an infectious disease (UNDP, Global Commission on HIV and the Law, 2011; SWAN, 2009). In a much publicised 2011 case in Greece, 29 women were arrested and subjected to non-consensual testing, with the threat of criminal charges if they tested positive; the media released their images and identities without consent.

The threat of forced testing and criminal charges for the alleged transmission of HIV and other STIs enables police officers to engage in extortion of sex workers or demand sexual (or other) services for free (SWAN, 2009). As such, whether forced testing is carried out or merely threatened, sex workers are exposed to human rights violations.

MANDATORY TESTING AS A CONDITION OF ENGAGEMENT IN SEX WORK

In Latvia, sex workers are required by law to attend for tests monthly, and to carry a health card when working; failure to comply with either of these conditions results in an administrative fine, and criminal charges may be brought if there are several breaches within one year (TAMPEP, 2009; SWAN, 2009). Similarly, sex workers in some provinces of Mexico face fines or two days in jail if they do not get tested or carry their mandatory health licences – although the fees for testing can in some cases outweigh the fines.

Sex workers may be required to undergo unnecessarily frequent testing, without benefit to the individual (Jeffreys et al., 2012). Sex workers in Austria, who are in some provinces expected to attend for tests weekly, report humiliating experiences with testing carried out by insensitive and overworked staff (Sex-Worker Forum of Vienna, Austria, 2013).

Mandatory testing's sole focus on sex workers absolves clients of responsibility for safe sex practices. Where sex workers are compelled to get tested regularly, clients may assume that their own risks are low and pressure sex workers for unprotected sex (Sex-Worker Forum of Vienna, Austria, 2013; TAMPEP, 2009).

Until 2012, mandatory screenings for registered sex workers in Hungary entailed the provision of a document which identified them as 'prostitutes' (SZEXE, 2013). Testing positive for HIV can lead to criminal charges for sex workers in Austria (Sex-Worker Forum of Vienna, Austria, 2013), and exclusion from work in sex work venues for those in northern Mexico. With such pitfalls, it is no wonder that many sex workers are deterred from registering in the first place. Tying compulsory testing to registration forces them underground and drives them away from services (ibid.).

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Line testing

India's National Aids Control Organization (NACO) recently implemented line testing as a means of tackling HIV among sex workers – an approach which falls considerably short of human rights standards.

Heavy reliance is placed on the work of peer educators in order to 'map' sex workers. The programme design recognises the need to gain trust in order to obtain sensitive information on sexual behaviours, partners, locations, networks and so on; however, given that this trust is not honoured, the strategy may be perceived as manipulative. Participants in line testing must give their names and addresses, along with other details, to HIV programmes, which are forced to share this information with government agencies (Dey et al., 2010). This infringement of privacy is a bad public health practice (ibid.), and poses a

threat to already marginalised groups, thereby deterring them from HIV programming. Furthermore, it jeopardises relationships between sex workers and peer educators, who have no control over data management or confidentiality of the private details they pass on (Hickok, 2011). As a result, this approach not only discourages sex workers from accessing services, but limits the pool of peer educators, many of whom are uncomfortable with the ethics of the operation.

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Additionally, the data collection required by line testing is burdensome and labour-intensive. NACO's exhaustive requirements for monitoring and evaluation entail extensive paperwork for organisations already working at capacity, undermining the very purpose of the programme. Qualified peer educators may also be excluded due to insufficient literary skills. Though the success of peer education relies on the diversity and relatability of peer educators, reliance on line testing systematically denies opportunities to groups of sex workers.

100% Condom Use Programmes

The 100% Condom Use Programme (100% CUP) was piloted in Thailand in 1989 and has since been implemented in Cambodia, China, Indonesia, Myanmar, the Philippines and Vietnam. It was designed to reduce the spread of HIV among the general population through enforcing condom use among sex workers, and its aim is for condoms to be used "100% of the time, in 100% of risky sexual relations; in 100% of the sex entertainment establishments" (WHO, 2004). Notably, it was created and implemented without any input from sex workers.

Most commonly, 100% CUPs include mapping of sex workers and venues, health outreach, condom distribution and education, and testing and linkage to care (CASAM, 2008). Brothel-based sex workers are required to register with the government, which includes the submission of photographs and personal information (ibid.). Although compulsory testing is allegedly not part of the model (Rojanapithayakorn, 2003), it has been widely reported (CASAM, 2008), with sex workers facing dismissal from brothels if they test positive for HIV or other STIs. This forces them to work in riskier settings (Loff et al., 2003), exacerbating their marginalisation and vulnerability. Unethical and humiliating, compulsory testing also promotes corruption: many brothel owners bribe health officials or hide sick sex workers from inspectors (NSWP, 2003).

The goal of 100% condom use is further compromised by the fact that not all governments consistently fund or adequately subsidise safe sex supplies. Condoms are not always available, and may be very expensive relative to sex workers' earnings (CASAM, 2008). Without an adequate supply, the programme is doomed to failure and sex workers face heavy penalties including loss of livelihood.

A committee of police and other governmental officials oversees enforcement – despite high rates of police harassment and abuse of sex workers across the globe (Shannon & Csete, 2010). Brothels which do not comply with 100% CUP regulations may be shut down (NSWP, 2003), exposing brothel owners to the risk of extortion by police officers.

The effects of 100% CUPs are to stigmatise sex workers, framing them as 'vectors of disease' who threaten to infect the general population. Condom use is left solely the responsibility of sex workers, with no such requirements placed on clients or anyone else. CASAM (2008) reports that sex workers feel targeted and punished. 100% CUPs fail to protect sex workers, both from sexually transmitted infections and from police abuse, and research has been selectively presented to point to their alleged success (ibid.).

Moving to rights-based approaches in HIV programming

In order to adequately tackle HIV, it is crucial that programming takes into account the realities and needs of sex workers, and recognises the diversity of the sex worker community. If they are to be successful, programmes must avoid enforcing compulsory and coercive HIV testing, and ensure access for all (irrespective of occupation, nationality, gender identity, sexual orientation, drug use or documentation) to affordable and effective health care.

An essential component of successful HIV programming is the inclusion of sex workers in its design and implementation. While the employment of peer educators can be an effective means of connecting with the sex worker community, to make use of them while excluding sex workers from strategic planning betrays a disrespectful approach towards the target population. Peer educators are most commonly involved as volunteers rather than as paid staff, with no commitment to empowering sex workers as a community. Sex workers should be given a much more prominent role, recognising that they are the experts on what they and their colleagues need, and they should be paid appropriately.

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Services must cease all violations of sex workers' rights to privacy, confidentiality, voluntary HIV testing and counselling (HTC) and informed consent, freedom of choice and autonomy, bodily integrity, and the use of safe sex supplies and drug harm reduction supplies. Such supplies, together with training in the negotiation of condom use with clients and education on occupational health and safety, should be made available to sex workers; presently, some programmes refuse to provide them on the grounds that they are considered to facilitate, promote and legitimise sex work (Levy, 2011). Furthermore, promotion of abstinence and monogamy rather than condom use is unrealistic and ignores the realities of sex workers' circumstances.

Prejudice against sex workers and other marginalised populations must be effectively tackled. Presently, staff and institutions alike often base their interventions on unfounded stereotypes about sex workers and/or a moral opposition to sex work. Sex workers are constructed as individuals to be 'acted upon', as 'beneficiaries' or 'objects' of interventions rather than full actors in matters that directly affect them. Services instead need to recognise them as complex human beings deserving of respect and quality treatment.

Diversion programmes, which are presented as alternatives to sex workers facing criminal charges, are coercive in nature and deny sex workers real choices. Those which collaborate with police in targeting sex workers for arrest (Wahab & Panichelli, 2013) are particularly harmful given that they expose sex workers to police abuses and generate distrust of services. 'John schools', an initiative particularly in the USA to 're-educate' sex workers' clients and convince them to stop paying for sex, are liable to promote myths about sex workers, including framing them as vectors of disease (BPPP et al., 2006), which has harmful repercussions.

HIV programming should not pressure sex workers to leave the sex industry. Whether this pressure is applied by individual staff members or represents institution-wide ideology, it alienates sex workers from attendance and presents them with unrealistic demands which fail to take into account their circumstances and choices. Instead, programmes should recognise, and meet, sex workers' actual needs.

HIV programming which focuses on arbitrarily defined objectives, such as a rise in condom use or uptake of HIV testing – usually pre-determined in funding agreements – fails to take into account sex workers' more immediate concerns. These may include barriers faced by migrants in accessing HIV services, limited availability of ARVs, or unsafe working conditions which affect negotiations of condom use. Programming requires a holistic approach in order to tackle structural oppression. Recognition of the social and legal barriers to sex workers' full enjoyment of health, and a commitment to dismantling those barriers, can result not only in more positive health outcomes but also the empowerment of sex workers.

HIV programming should be integrated with other services relevant to sex workers, such as alcohol and drug harm reduction programmes; information and advice on gender reassignment surgery and hormone replacement therapy; the development of safe spaces for sex workers fleeing violence or facing homelessness; and cultural mediators respectful of sex workers' cultural and linguistic diversity. The provision of safe spaces in which sex workers can socialise, rest, share information and support one another has been shown to reduce isolation among them (WHO et al., 2013).

Funding issues

Although strong sex worker-led organisations can be found around the world, they often operate at limited capacity due to insufficient funding. This is particularly troubling since it is these organisations which have to dedicate precious time, effort and resources to rebuilding sex workers' confidence in, and willingness to access, HIV services after those services have engaged in discriminatory practices against them.

Both public and private funders are frequently difficult to find and sustain for sex worker-led programming (Open Society Institute, 2008). The President's Emergency Plan For AIDS Relief (PEPFAR), a significant donor which contributed 58% of global expenditure on HIV and AIDS programming in 2009, requires that non-US-based recipients of funding sign an anti-prostitution pledge. This has had devastating consequences for programming targeted at sex workers, such as the dissolution of the Guyanese organisation One Love, which had involved peer educators in its approach (Forbes & Ray, 2013).

Globally, HIV funding is in crisis, with shrinking commitments from international donors, limiting the already small pool of resources to which sex worker-led organisations have access. Governments and donors typically prefer to fund less potentially controversial HIV programming, such as that aimed at youth or the general population – marginalising key affected populations such as sex workers, people who use drugs and men who have sex with men. Their exclusion is counterproductive to the fight against HIV and AIDS.

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Recommendations

For sex worker-led organisations

Sex worker-led organisations should take a human rights-based approach in lobbying and advocacy, and promote community empowerment and solidarity. Sex workers should be empowered to know and understand their rights, analyse policy, form strong community-based advocacy groups, and improve their communication skills.

Training sex workers as paralegals, HTC counsellors and peer educators will enable the provision of services in welcoming environments. Drop-in centres should be established, offering comprehensive HIV prevention services including education, training, counselling, and provision and demonstration of condom use. Sex workers should be educated to (voluntarily) seek screening for asymptomatic STIs, and encouraged to use voluntary HTC services, which will contribute to the elimination of coercive testing. Services should be geographically accessible and testing should be linked to treatment.

For governments and policy makers

In order to remove the barriers faced by sex workers in protecting themselves from HIV, punitive legislation should be repealed, including laws criminalising sex work and related activities; homosexuality; crossdressing; HIV non-disclosure, exposure and transmission; and drug use, as well as laws which permit forced HIV and STI testing, and laws that conflate human trafficking with sex work. Governments should ensure that anti-trafficking legislation is not enforced to prohibit sex work nor disrupt or undermine ongoing HIV prevention and treatment efforts. Sex workers should be meaningfully involved in law and policy reform.

Laws should be developed, and well publicised, to protect sex workers from discrimination, stigma and violations of their rights, guaranteeing them the opportunity to access health services and other social benefits. Violence against sex workers should not be tolerated, and complaints taken seriously.

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Health services should be made appropriate, accessible, and acceptable to sex workers, and engage in no stigmatisation or discrimination. Migrant sex workers' access should be ensured to HIV-related services without fear of their immigration or HIV status being reported to authorities. Health care providers should be educated on sex workers' rights and needs, including the provision of voluntary services, and their right to freedom of choice, confidentiality, and informed consent. Coercive programmes should be rejected, along with services that pressure or require sex workers to leave sex work, reduce their involvement in it, oppose it, or identify as trafficked persons in order to access services. Sex worker-led organisations should be involved in designing, implementing and evaluating health care services offered to sex workers.

Health care providers should be educated on sex workers' rights and needs, including the provision of voluntary services, and their right to freedom of choice, confidentiality, and informed consent.

Governments should support and ensure the accessibility and affordability of psychological health and legal services for sex workers who have experienced violence, and social services to assist sex workers in accessing stable housing. Action should be taken to address structural issues that contribute to HIV vulnerability in the context of sex work, including interventions that aim to reduce poverty and inequality, create and expand employment opportunities, and ensure education for all.

Male and female condoms and lubricants should be provided, and their correct and consistent use promoted. Community-led approaches to their distribution should be supported.

Funding should be provided to sex worker-led organisations, and research supported on sex work and HIV which takes into account the diversity of the sex worker population and is designed in meaningful consultation with sex workers. Sex worker-led programmes should be supported to educate law enforcement officials about sex workers' rights and needs.

Funded anti-trafficking initiatives should be evidence-based, grounded in human rights and have involved meaningful consultation with sex workers.

For health and social service providers

Policies should be developed and training led by sex workers to combat stigma, discrimination and judgemental approaches among staff towards sex workers and other marginalised groups such as LGBT people and people who use drugs.

Sex workers should be recognised and included as essential partners and leaders in designing, planning, implementing and evaluating services aimed at their community.

Services should ensure that their locations are accessible and suitable, that opening times are convenient and that health care is affordable or free.

Access to services should never be made conditional on leaving sex work, reducing involvement in it, opposing it or identifying oneself as a trafficked person.

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