HIV prevention, criminalization, and sex work: Where are we at?

By Dr. Kate Shannon

Sex workers experience a disproportionately high burden of HIV in Canada and globally, in large part driven by structural factors (such as criminalization, physical and sexual violence, stigma, lack of access to services) that impact sex workers’ vulnerability to HIV. There is growing international evidence of the social and health-related harms that the criminalization of sex work causes. This has increased calls for sex work to be decriminalized in Canada and elsewhere. This article looks at some of the approaches in Canada and globally that help improve sex workers’ access to HIV prevention and care services in a criminalized environment. Combination HIV prevention approaches, which include structural and community-led responses, have been shown to be critical to an effective HIV response.

Global HIV burden amongst sex workers

Sex workers – consenting adults who exchange sex for money – experience a disproportionate burden of HIV both in Canada and globally due to structural factors (criminalization, violence, stigma, poor working conditions) that limit sex workers’ ability to engage in HIV prevention including the consistent and correct use of condoms. In Canada, HIV burden is highest among street-involved sex workers, and often acquired through non-commercial intimate partners.

Sex workers represent a diverse population. Although most are women who are serviced by male clients (sex buyers), there are also sizable populations of male and trans (transgender, transsexual and two-spirit) sex workers in Canada and most settings globally. Sex workers may work either independently (for example, self-advertising online or in newspapers, or the street) or through a third party (such as a manager, book keeper, escort agency) in a variety of locations:

- formal sex work establishments and in-call venues (for example, massage parlours, health enhancement centres, brothels);
- entertainment venues (such as bars, clubs);
- out-call, home-based, or other informal indoor venues (for example, hotels, saunas);
- on the street or in public spaces (such as alleys, parks).

A 2015 comprehensive review of all HIV and sex work research over the last six years identified that individual biomedical and behavioural prevention interventions alone have only had modest impact in shifting the course of the HIV epidemic among sex workers. Instead, the review found that structural factors (those that are external to the individual) have been consistently shown to play the largest role in affecting HIV transmission risks in sex work. This review was part of a special sex work and HIV series in the medical journal The Lancet that was launched at a special session of the AIDS 2014 conference in Melbourne, Australia, and includes a diverse team of academic and
sex work co-authors and editors.  

**Structural determinants: Barriers and facilitators of HIV prevention**

**Criminalization of sex work**

Research has consistently demonstrated that the criminalization of sex work and the police response to it continues to force sex workers to move to more hidden street and indoor locations; reduces their ability to screen prospective clients and to negotiate terms of sexual transactions, such as condom use; and limits access to health services including HIV care. Police harassment and enforcement have been independently linked to increased violence, refusal of clients to use condoms, and fear of sex workers to carry condoms.

**Physical and sexual violence**

In Canada, as in other settings where sex work is criminalized, there are alarmingly high rates of workplace physical and sexual violence against sex workers by clients, individuals posing as clients, police, exploitative managers and others. Such physical and/or sexual violence has been one of the strongest drivers of HIV risk for sex workers. Violence or threats of violence have been shown to reduce the control sex workers have over transactions with their clients, including their ability to negotiate sexual risks and the use of condoms.

Violence and fear of violence have also been linked to reduced access to health and social services and police protections, particularly for more criminalized and visible sex workers including Indigenous, immigrant, migrant and other racialized sex workers.

In Canada, the current and ongoing violence toward sex workers and the failure of police and services providers to respond have led to a deep-rooted mistrust of health, social and police services.

**Stigma**

Stigma has been shown to significantly increase the HIV risks for sex workers by isolating sex workers from the HIV continuum of services (prevention, testing, treatment, care and support). In Vancouver, sex work stigma, fear of disclosure as a sex worker, and discrimination by health providers are among the strongest institutional barriers to care reported by sex workers. Stigma disproportionately impacts the most marginalized and criminalized, including Indigenous, immigrant, migrant and gender and sexual minority sex workers. Trans and male sex workers experience stigma associated with transphobia, homophobia, and perceptions of transgressing gender norms.

**Lack of access to services**

Sub-optimal access to HIV prevention, treatment and care among sex workers remains a major concern across diverse settings globally. Evidence suggests these gaps in access and coverage can only be met alongside changes in structural and community-led efforts.

For example, in Mombasa, Kenya, large scale-up of outreach and programming led by sex workers was compromised by police targeting of service providers and the use of condoms as evidence for arrest. Of concern, there is also limited research in both developing and developed countries that documents sex workers’ lived experiences, and their interest in and the barriers they face accessing biomedical interventions, particularly HIV treatment and pre-exposure prophylaxis (PrEP).

Available evidence suggests that many of the same structural drivers of increased HIV risks, including criminalization, policing, violence and stigma, impact sex workers’ access and retention in sexual and reproductive health and HIV care services.

**Promising HIV practices: Toward policy and community-led change**

**International approaches**

In light of strong evidence of the harms of criminalizing sex work, experts around the globe have advocated for the
decriminalization of sex work as necessary for an effective HIV response. New Zealand and parts of Australia have decriminalized sex work, ensuring access to the same occupational health and safety standards for sex workers as other forms of labour. This has resulted in a decrease in sex workers’ safety risks and increased coverage and access to health and social services.\textsuperscript{13}

The first ever international guidelines on prevention, treatment and care of HIV and sexually transmitted infections (STIs) among sex workers were published in 2012 by WHO/ UNAIDS and the Global Network of Sex Work Projects (NSWP). These guidelines call for the removal of all criminal laws targeting sex work (full decriminalization of sex work) as a necessary evidence-based HIV prevention approach.\textsuperscript{1} A decriminalized policy framework is now fully endorsed by international public health and human rights bodies, including the Global Commission on HIV and the Law, UNAIDS, the United Nations Population Fund (UNFPA), the United Nations Development Program (UNDP) and most recently, Amnesty International.

**The Canadian experience**

In Canada, the failure of consecutive governments to address the ineffective and harmful impacts of criminalized sex work laws over decades led to grassroots sex work organizing to challenge the harmful laws through the courts. The Charter challenge (\textit{Bedford vs Canada}) launched by three sex workers (Terri Jean Bedford, Amy Lebovitch and Valerie Scott) led to a landmark and unanimous ruling by the Supreme Court of Canada in December 2013 that struck down Canada’s criminalized sex work laws as violating sex workers’ safety, health and human rights.

The ‘\textit{HIV Coalition}’ (the \textit{Gender and Sexual Health Initiative} [GSHI] of the BC Centre for Excellence in HIV/AIDS, the \textit{Canadian HIV/AIDS Legal Network}, and the \textit{HIV Legal Clinic} of Ontario [HALCO]) was a formal intervener in this case at the Supreme Court based on the overwhelming evidence of the harms of criminalization on the health and safety of sex workers. Unfortunately, in late 2014, the Conservative government introduced new legislation – Protection of Communities and Exploited Persons Act (PCEPA) – that adopts the ‘end-demand’ approach to sex work by criminalizing most aspects surrounding sex work, sex buyers (clients), third parties and self-advertising, while leaving the selling of sex work legal.

Research strongly demonstrates that the decriminalization of sex work could have the largest impact on HIV epidemics in sex work; averting 33\% to 46\% of HIV infections among sex workers and clients over the next decade in Canada, Kenya and India through the removal of violence, police harassment and increased access to safer indoor work spaces. As summarized in an \textit{Open Letter} to the previous Conservative government, which was signed by over 500 Canadian and international researchers and public health experts, this evidence collectively suggests that the current PCEPA legislation in Canada, which targets clients, third parties, and self-advertising spaces, has the potential to detrimentally impact violence and the HIV prevention capacity of sex workers; and limits access to sexual health education, prevention and care initiatives. In fact, research by GSHI in collaboration with Sex Workers United Against Violence (SWUAV) and \textit{Pivot Legal Society} demonstrated that new Vancouver Police Department guidelines to target clients and third parties but not sex workers, which were introduced in 2013 prior to PCEPA, saw no differences in rates of violence against sex workers in the year following the guidelines. There were also similar narratives from sex workers on the harms to their safety and control over their sexual health and HIV prevention.\textsuperscript{14,15} Among men and trans sex workers in Vancouver, loss of Boystown (a ‘street stroll’) in the West End over the last decade has led to a shift to largely online solicitation for the male sex industry. A community-based research study with male and trans sex workers and clients, led by GSHI and \textit{HUSTLE} of Health Initiative for Men and conducted prior to the PCEPA legislation, found that self-advertising online increases safety and HIV protections for sex workers through the use of web cams to screen clients and negotiation of the terms of transactions, including approaches to HIV prevention.\textsuperscript{16}

**Community level approaches**

Community and sex-worker-led interventions (such as sex-worker-led programming, peer support services, mobile outreach, and drop-in spaces) provide a critical window to reach and provide low-threshold support to sex workers by ‘meeting people where they are’.\textsuperscript{1,5} Alongside support services and drop-ins, there are a number of grassroots sex worker-led organizations in Canada that have driven the community advocacy and HIV prevention interventions by and for sex workers over many years, including \textit{Stella} in Montreal, \textit{Maggie’s} in Toronto, \textit{POWER} in Ottawa, SWUAV, \textit{HUSTLE} and \textit{PACE} in Vancouver, and many others. Such interventions have been linked to reduced HIV
risks and increased uptake of HIV continuum of care services, sexual and reproductive health services, and addictions treatment. Given these linkages, and past distrust of health and support services, there exists important evidence-based potential to integrate HIV prevention services within drop-in and sex worker-led services. Culturally tailored health and support services for immigrant, migrant, racialized and Indigenous sex workers are urgently needed that address the unique needs and structural risks (such as stigma, language barriers, immigration challenges) of these populations. Two services (SWAN and Butterfly) provide critical supports to immigrant and migrant sex workers in Canada.

Community and sex-worker-led strategies, such as engagement with police, health providers, and other stakeholders, which aim to reduce social stigma and health provider discrimination towards sex workers, have been shown to have substantial promise. A number of municipalities in Canada and the U.S. have made some progress through city-wide task forces towards addressing stigma and violence against sex workers (for example, licensing reforms to protect sex workers, public education) including dialogues between police and sex workers. However, there is limited research documenting the impacts and socio-legal barriers faced by cities in enacting safety protections to sex workers, which continues to limit the ability to fully realize and scale-up potential changes.17

Sex worker-led and peer-based occupational health and safety services that are tailored to sex workers with integrated care to address sexual, physical and mental health concerns have been shown to be highly effective at engaging sex workers in HIV prevention and care, and addressing broader individual health issues.18 The St. James Infirmary in San Francisco offers a promising UN/WHO best practice.1 It provides free and confidential medical and social services for current and former sex workers. Services include medical services (such as primary care, and HIV and STI counselling and testing); a needle and syringe program; street and venue-based outreach; and peer education workshops. In addition, they provide general presentations on sex work and in-depth trainings on health and harm reduction approaches for social and medical service providers in the San Francisco area.

Despite substantial community-led programs, large gaps in resources and coverage to scale-up services remain and few sex work support services receive health and HIV funding within Canada.

Ultimately, research suggests that structural and community-led approaches remain most important to addressing the high HIV burden and gaps in access to care for sex workers and are necessary to realizing the health and human rights of sex workers. Supporting community/sex worker-led programming, and acknowledging the local contexts and needs of sex worker communities, is critical to HIV prevention among sex workers both in Canada and globally.

Workplace approaches

Evidence has demonstrated the role of ‘safer work environments’ and supportive housing in reducing violence and HIV risks among sex workers through supportive managerial and venue-based practices.2 Such programs have increased access to harm reduction and prevention resources; referrals to health and support services; and the ability of sex workers to work together. In Vancouver, sex workers working together (for example, measures of trust, mutual aid, connectedness) was the strongest buffer against refusal of clients to use condoms, further highlighting the critical role of sex workers in the HIV response.19 Innovative models of supportive women-only housing in B.C. (Atira Women’s Resource Society and Raincity Housing), have been shown to ensure that the most marginalized sex workers, who were previously working on the street, have access to safer indoor work spaces that provide increased control over sexual transactions, violence and HIV prevention strategies, and the ability to access health, social and police protections.20 Currently, many of these interventions are small and operate in a legal limbo. Resources for the community to scale-up and further implement and evaluate these models are urgently needed.

Looking ahead

We now know that large scale-up of HIV prevention and care services, such as sex worker/peer-led programming, access to condoms, mobile/outreach services, and linkage to HIV care, are challenging, and in some cases near impossible, in jurisdictions where sex workers remain criminalized and stigmatized and are targets of violence and police enforcement.

Ultimately, combination HIV prevention that includes structural and community-led responses remains critical to HIV
prevention in sex work. As the new Canadian government looks to redress the harms of the previous PCEPA legislation introduced in 2014, decriminalization of sex work will be a critical step to ensuring access to HIV prevention and to support the central role of community and sex work-led efforts in protecting the health and human rights of sex workers.

References


About the author(s)

Dr. Kate Shannon is Director of the Gender & Sexual Health Initiative at the BC Centre for Excellence in HIV/AIDS, a Canada Research Chair in Global Sexual Health and HIV/AIDS and an Associate Professor of Medicine at the University of British Columbia. Her research interests include gender and sexual health and HIV/AIDS research and policy among marginalized populations in Canada and globally. She is strongly committed to research that informs policy and practice towards reducing sexual health and social inequities and advancing the human rights of affected populations.
Disclaimer

Decisions about particular medical treatments should always be made in consultation with a qualified medical practitioner knowledgeable about HIV- and hepatitis C-related illness and the treatments in question.

CATIE provides information resources to help people living with HIV and/or hepatitis C who wish to manage their own health care in partnership with their care providers. Information accessed through or published or provided by CATIE, however, is not to be considered medical advice. We do not recommend or advocate particular treatments and we urge users to consult as broad a range of sources as possible. We strongly urge users to consult with a qualified medical practitioner prior to undertaking any decision, use or action of a medical nature.

CATIE endeavours to provide the most up-to-date and accurate information at the time of publication. However, information changes and users are encouraged to ensure they have the most current information. Users relying solely on this information do so entirely at their own risk. Neither CATIE nor any of its partners or funders, nor any of their employees, directors, officers or volunteers may be held liable for damages of any kind that may result from the use or misuse of any such information. Any opinions expressed herein or in any article or publication accessed or published or provided by CATIE may not reflect the policies or opinions of CATIE or any partners or funders.

Information on safer drug use is presented as a public health service to help people make healthier choices to reduce the spread of HIV, viral hepatitis and other infections. It is not intended to encourage or promote the use or possession of illegal drugs.

Permission to Reproduce

This document is copyrighted. It may be reprinted and distributed in its entirety for non-commercial purposes without prior permission, but permission must be obtained to edit its content. The following credit must appear on any reprint: This information was provided by CATIE (the Canadian AIDS Treatment Information Exchange). For more information, contact CATIE at 1.800.263.1638.

© CATIE

Production of this content has been made possible through a financial contribution from the Public Health Agency of Canada.