

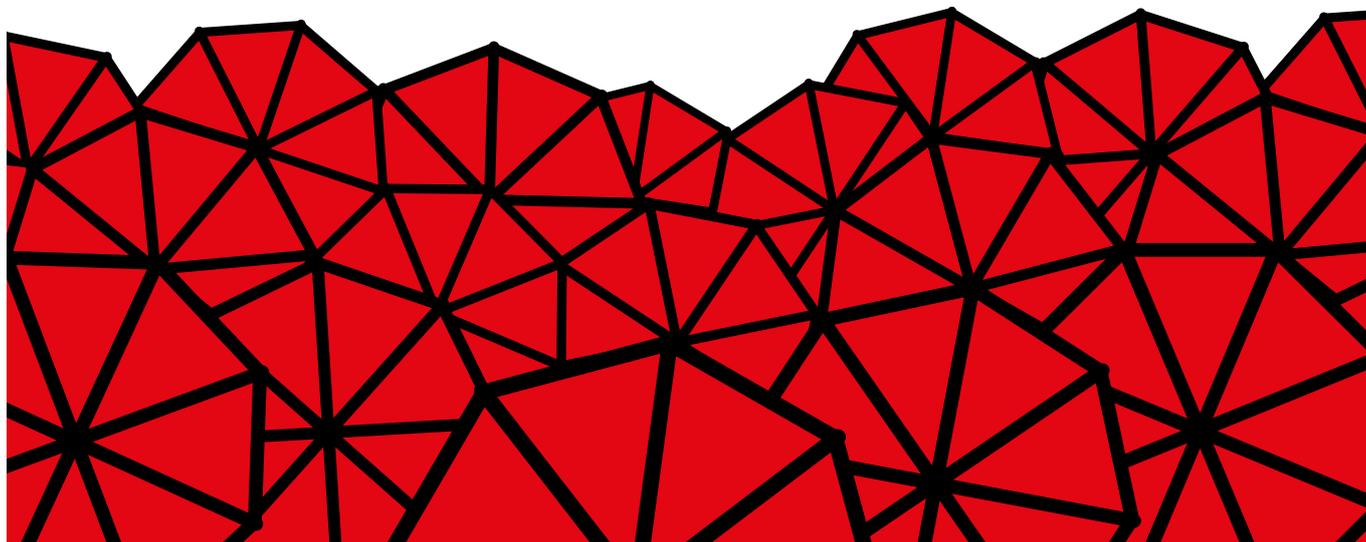


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Global Network of Sex Work Projects
Promoting Health and Human Rights

**BRIEFING
PAPER**

Sex Workers' Access to Comprehensive Sexual and Reproductive Health Services



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Introduction

Access to comprehensive sexual and reproductive health services – from STI prevention to post-natal care – is an essential component of a human rights-based health approach. However, public health programmes and

Due to abolitionist approaches and popular connotations of sex work with human trafficking, SRH services for sex workers may even be excluded from national and international HIV and health funding.

policy-makers have seldom addressed the comprehensive sexual and reproductive health (SRH) needs of sex workers. Due to abolitionist approaches and popular connotations of sex work with human trafficking, SRH services for sex workers may even be excluded from national and international HIV and health funding. The Global Gag Rule, which was reinstated and expanded upon in January 2017, prohibits international non-governmental organisations that perform, provide

information about, or promote the decriminalisation of abortion, from receiving U.S. global health funds. PEPFAR's Anti-Prostitution Loyalty Oath, which requires international organisations receiving HIV funds to oppose prostitution and human trafficking, is another funding policy that creates a barrier to sex workers' access to SRH services.

Even where sex workers are not explicitly excluded from utilising SRH services, pervasive structural barriers such as criminalisation, stigma and discrimination impede their access to comprehensive, rights-based care. Within the public health paradigm, the framing of sex workers as 'vectors of disease' has reinforced stigma while prioritising narrow HIV and STI interventions at the expense of their broader SRH needs. In the NGO sector, inadequate funding for both service provision and community empowerment initiatives has forced sex workers to rely on public health care, which is often inaccessible, disjointed and discriminatory. As a result, there are critically few SRH services available to sex workers that are both comprehensive and compassionate. These shortcomings are compounded for male and transgender sex workers, who are largely excluded from SRH programming, further increasing their vulnerability and marginalisation.

Sex workers of all genders, including those living with HIV, are entitled to the same SRH care as everyone else. However, sex workers globally attest to widespread inadequacies in SRH coverage and treatment, resulting in violations of their human rights.

This Briefing Paper discusses the obstacles sex workers face when accessing SRH services across multiple settings. It examines the quality of available SRH services, as well as the different needs of female, male and transgender sex workers. Finally, practical examples and recommendations are given for improving the accessibility and acceptability of SRH services for sex workers.

International SRH Rights Frameworks

The right to SRH is a fundamental human right. Although no human rights instrument is dedicated specifically to SRH, these rights are protected in numerous international, regional and national frameworks, and are connected to other civil and political rights.

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The right of all persons to the highest attainable standard of health is enshrined in numerous mandates, including the Universal Declaration of Human Rights¹, the International Covenant on Economic, Social and Cultural Rights², and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)³. Article 16 of CEDAW further affirms the right of women to access health care services, including those related to family planning.

The 1994 International Conference on Population and Development (ICPD) in Cairo confirmed that SRH rights were already protected within existing national and international documents. The ICPD Programme of Action articulated the right “to decide on the number, spacing, and timing of their children, have information and means to do so, and the right to attain the highest standard of sexual and reproductive health” as well as the right to make reproductive decisions “free of discrimination, coercion, and violence.”⁴ The Beijing Declaration and Platform for Action⁵ and the Amman Declaration⁶ reinforced states’ commitment to protecting and promoting SRH.

The UN’s 2030 Sustainable Development Goals, such as reducing global maternal mortality, ending HIV/AIDs, and ensuring universal access to SRH services,⁷ promise that SRH will continue to occupy a prominent place on the international agenda. Sustainable Development Goal 5’s inclusion in the ICPD Programme of Action and the Beijing Platform for Action also promises future attention to SRH.⁸ Goal 5 encompasses achieving gender equality, empowering all women and girls, and ensuring universal access to SRH and reproductive rights.

The UN has specifically acknowledged sex workers’ right to SRH. In 1999, the CEDAW Committee called for special attention to be given to the health needs and rights of women belonging to vulnerable groups, including those ‘in prostitution.’⁹ In 2016, the Committee on Economic, Social, and Cultural Rights recommended:

“States parties should take measures to fully protect persons working in the sex industry against all forms of violence, coercion, and discrimination. They should ensure that such persons have access to the full range of sexual and reproductive health care services.”¹⁰

1 UN General Assembly, 1948, “Universal Declaration of Human Rights, 15.1”

2 UN General Assembly, 1966, “International Covenant on Economic, Social and Cultural Rights,” 12.

3 UN General Assembly, 1979, “Convention on the Elimination of All Forms of Discrimination against Women,” 10h, 11, 12, 16.

4 UN Population Fund, 2014, “Programme of Action adopted at the International Conference on Population and Development Cairo, 5–13 September 1994: 20th Anniversary Edition,” 7.3.

5 Fourth World Conference on Women, 1995, “Beijing Declaration and Platform for Action,” 93–97.

6 Eleventh International Conference of the International Coordinating Committee of National Institutions for the Promotion and Protection of Human Rights, 2012, “Amman Declaration and Programme of Action,” 25–28.

7 UN General Assembly, 2015, “Transforming our world: the 2030 Agenda for Sustainable Development,” 3.1, 3.3, & 3.7.

8 Ibid., 5.6.

9 UN Committee on the Elimination of Discrimination Against Women, 1999, “CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health),” 6.

10 UN Committee on Economic, Social, and Cultural Rights, 2016, “General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social, and Cultural Rights), 32.”

International Guidelines for Sex Worker SRH Services

In consultation with sex worker organisations, UN Agencies have developed several guidance documents to help governments and policymakers fulfil their commitments to universal SRH. In 2013, WHO, UNFPA, UNAIDS, NSWP, the World Bank, and UNDP produced *Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions*, also known as the “Sex Worker Implementation Tool” (SWIT).

The SWIT defines the vision for comprehensive SRH services for sex workers as part of a community-led, human rights-based approach to addressing HIV and STIs.

The SWIT defines the vision for comprehensive SRH services for sex workers as part of a community-led, human rights-based approach to addressing HIV and STIs. According to the SWIT, in addition to STI and HIV programming, clinical SRH services for sex workers should include:

- Family planning and contraceptive counselling.
- Safe pregnancy.
- Abortion and post-abortion care.
- Reproductive tract cancer screening.
- Clinical care for sexual assault survivors; and
- Hormonal and other gender enhancement therapy and counselling for transgender sex workers.¹¹

Membership Consultation

This Briefing Paper was informed by in-depth research in ten countries and a global e-consultation with NSWP member organisations. National Key Informants conducted in-depth interviews and focus groups with sex workers using a standardised questionnaire and produced national case studies in the Bahamas, Canada, El Salvador, Peru, Austria, Kyrgyzstan, Indonesia, Nepal, Namibia and Rwanda. A global e-consultation with NSWP member organisations using the same questionnaire was conducted simultaneously.

In total, 171 male, female and transgender sex workers, including migrant sex workers, sex workers living with HIV, and LGB sex workers participated in in-depth focus groups and interviews. An additional 13 NSWP member organisations replied to the e-consultation.

¹¹ WHO, UNFPA, UNAIDS, NSWP, World Bank & UNDP, 2013, “Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions,” 125.

The State of SRH Services

Limited Service Provision

The common view of sex workers as 'vectors of disease' within public health systems (indicated by their emphasis on HIV and STI interventions) has reinforced stigma and impeded the development of comprehensive SRH programmes. While sex workers believe condom and lubricant programming and voluntary HIV and STI testing and treatment are important, many participants found that these programmes alone do not address their broader SRH needs.

The common view of sex workers as 'vectors of disease' within public health systems has reinforced stigma and impeded the development of comprehensive SRH programmes.

The pervasive lack of services and referrals to family planning and contraceptive counselling, pregnancy care, safe abortion, reproductive tract cancer screening, and hormonal therapy show

that existing SRH programmes fall short of standards outlined within international guidelines.

A review of SRH programmes for female sex workers in Africa confirmed the limited scope of SRH services in both the private and public sectors. While almost all of the 54 programmes reviewed addressed HIV and STIs, only 6 offered pregnancy testing and only 2 offered HPV sub-type testing. Cervical cancer screening and treatment was available in only 3 of the 28 countries represented.¹²

In El Salvador, the Ministry of Health's Clínicas de Vigilancia Centinela de ITS programme (Sentinel Surveillance Clinics for STIs), aimed at providing essential prevention, diagnosis, and treatment services to key populations (including female sex workers and LGBT people) is unpopular due to significant shortcomings.

"There are no condoms to provide as samples. There are not enough medications for STIs, and HIV testing consultations are not given. There is only discrimination against female sex workers and LGBTI people."

ASOCIACIÓN DE MUJERES TRABAJADORES SEXUALES LIQUIDAMBÁR, EL SALVADOR

Scattered Services; Segregated Care

WHO guidelines and community research agree that offering health services in one location (health services integration) increases the acceptability, accessibility, and uptake of care for key populations.¹³ Yet SRH services are rarely offered together, forcing sex workers to travel to multiple locations to address different health needs. The segregated nature of SRH care can subsequently lead to problems with uptake and adherence, in addition to income loss.

"A very small percentage of [sex workers] referred to HIV testing centres from general clinics will actually arrive there at the end of the day."

AVENIR JEUNE DE L'OUEST, CAMEROON

12 Ashar Dhana et al., "Systemic Review of facility-based sexual and reproductive health services for female sex workers in Africa," *Globalization and Health* 10:46 (2014).

13 World Health Organization, 2014, "Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations."

Segregated services not only complicate access to individual services, but also prevent important issues from being addressed.

“Since SRH and STI services are offered in different places, questions of consultation and family planning, such as using condoms with long-term partners, are not addressed.”

TAIS PLUS, KYRGYZSTAN

Lack of SRH and HIV service integration can be particularly harmful for pregnant sex workers. Where all SRH services are not available at the same place, female sex workers may not have access to HIV testing and antiretroviral therapy during pregnancy, which can increase mother-to-child transmission (MTCT). Lack of SRH and HIV service integration also contributes to reduced prevention awareness, as noted in a study of female sex workers in Karnataka, India, in which only 24.7% of female sex workers reported knowledge of MTCT prevention methods.¹⁴

In regions such as Sub-Saharan Africa, heightened mortality rates related to pregnancy and HIV are compounded by a lack of integrated maternal and child health services. Lack of integration not only impedes the fulfilment of Sustainable Development Goals, but also further marginalises sex workers and their children.¹⁵

Contraception, Abortion and Sterilisation

Sex workers do not have access to adequate contraception in many regions. In Nepal, focus group participants reported that the low quality of freely available condoms often caused pain and discomfort, making these condoms unpopular in the local community. Sex workers' access

to non-barrier methods such as contraceptive pills and intrauterine devices is further limited and depends on health insurance coverage, the availability of NGO family planning services and other factors.

In 66 countries – concentrated in Latin America, Africa, the Middle East, and Asia-Pacific – abortion is entirely prohibited or is only permitted in

extreme cases, such as to save a woman's life.¹⁶ For female sex workers, limited access to contraceptives, difficulties negotiating condom usage, and vulnerability to sexual violence can result in unintended pregnancy,¹⁷ making access to safe abortion and post-abortion care an essential SRH need. Where abortion is prohibited, illegal service providers may be used, increasing the risk of mortality and long-term health issues.

“In Nicaragua ... any type of abortion is punishable, and if sex workers want to obtain one, they must go to clandestine clinics where they put their lives and health at risk.”

ASOCIACIÓN DE MUJERES LAS GOLONDRINAS, NICARAGUA

In Brazil, where abortion is largely prohibited, a study of female sex workers who had illegal abortions revealed high rates of haemorrhaging, infection, and hospitalisation. Although the spread of Misoprostol (a pill used for abortion where abortion is prohibited) has decreased the use of more dangerous and invasive methods, half of the participants surveyed who had obtained an illegal abortion needed hospitalisation to conclude their abortions.¹⁸

Where abortion is prohibited, illegal service providers may be used, increasing the risk of mortality and long-term health issues.

14 Marissa Becker et al., “The Intersection between Sex Work and Reproductive Health in Northern Karnataka, India: Identifying Gaps and Opportunities in the Context of HIV Prevention,” *AIDS Research and Treatment* 2012 (2012).

15 Brian Willis et al., “Health of female sex workers and their children: a call for action,” *The Lancet* 4:7 (2016): e438–e439.

16 “Questions & Answers: Understanding the World's Abortion Laws Map,” World Abortion Laws.

17 Rishan Weldegebreal, et al., “Unintended pregnancy among female sex workers in Mekelle city, northern Ethiopia: a cross-sectional study,” *BMC Public Health* 15:40 (2015).

18 Alberto Pererira Madeiro and Debora Diniz, “Induced abortion among Brazilian female sex workers: a qualitative study,” *Ciencia & Saude Coletiva* 20, 2 (2015): 587–93.

However, even in countries where abortion is legal, the high cost of abortion and government and international donor restrictions on abortion-related funding makes abortion inaccessible to many sex workers. For incarcerated sex workers, the right to decide whether and when to have children is denied to an even greater extent.

“In prison it is not possible to obtain an abortion, however women who have been sexually assaulted by Corrections Officers and gotten pregnant as a result have been forced to abort their unborn child.”

SWOP BEHIND BARS, U.S.A.

Additionally, forced and coerced sterilisation remains a problem. In Tehran, Iran, in early 2017 there was a call from an official to sterilise female sex workers and homeless women who use drugs.¹⁹ Forced and coerced sterilisation/pregnancy termination violates the right to make reproductive decisions “free of discrimination, coercion, and violence,” as protected in the ICPD Programme of Action.

The Needs of Male Sex Workers

Male sex workers face double stigmatisation due to both their work and perceived deviation from masculinity norms. In 72 countries, the criminalisation of same-sex relationships increases discrimination and discourages male sex workers from accessing care due to fear of punitive consequences. Even in less punitive contexts, male sex workers' broader SRH needs are seldom acknowledged, as demonstrated by the lack of epidemiological data available and the frequent conflation of this group with MSM (gay men and other men who have sex with men).²⁰ As a result, most SRH programming available to male sex workers remains limited to HIV and STI testing and treatment services targeted towards MSM or the general population, which often excludes rectal STI screening.²¹

Homophobia, stigma, and isolation make male sex workers particularly vulnerable to HIV; but they may also experience other, unaddressed SRH issues such as infertility, erectile dysfunction, prostate and anal cancers, and anorectal STIs. Since many of these health issues occur more often among men living with HIV, integrating HIV services with broader SRH services could greatly increase community awareness of health risks and service uptake. However, most health care systems do not adequately address the broader needs of men, let alone male sex workers, within their programming.

“In SRH services, we male sex workers have no type of access ... because we are not considered within the health care system We are struggling to be included in health care programmes specific to our work activities and our masculinities. We can only access health care as MSM, and only from a pathologised approach in HIV/AIDS, not in an integrated way.”

ASOCIACIÓN GOOVER, ECUADOR

...the criminalisation of same-sex relationships increases discrimination and discourages male sex workers from accessing care due to fear of punitive consequences.

19 “Iran Official Calls for Sterilization for Sex Workers, Homeless Drug Addicts,” Radio Free Europe, 1 January 2017.

20 Global Network of Sex Work Projects, 2014, “The Needs and Rights of Male Sex Workers.”

21 GNP+ and NSWP, 2010, “Advancing the Sexual and Reproductive Health and Human Rights of Sex Workers Living with HIV,” 5.

Due to the widespread lack of public SRH services for men – and consequently, male sex workers – this population frequently seeks care through NGO programmes. Participants reported that even these services may be poor, especially when they are primarily directed towards women. In Latin America, it was reported that male sex workers are commonly required to take so-called ‘voluntary’ HIV tests to receive free condoms from service centres. Coercive practices like these not only undermine the concept of voluntary testing and foster negative attitudes towards health services; they also restrict male sex workers’ access to critical HIV and STI prevention supplies.

While most male sex workers provide sexual services primarily to men, their personal identities, relationships and interactions are often diverse, reflecting a range of socio-cultural nuances.²² As a result, health programmes for MSM do not meet the specific needs of male sex workers. At the same time, intersecting whorephobia and homophobia further exclude this population from health care aimed at the general public. Accordingly, male sex workers rarely disclose their work and sexual orientation in health care settings.

Lacking access to appropriate medical advice and treatment, male sex workers may self-medicate for issues such as sexual dysfunction, which carries long-term health risks.

The Needs of Transgender Sex Workers

Transgender sex workers face very high levels of stigma and discrimination. They experience particularly high rates of sexual violence, which is linked to increased HIV and STI vulnerability.²³

However, very few trans-specific SRH services exist worldwide, and

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transgender people remain under-represented in national HIV strategies, in spite of their heavy HIV burden.²⁴ Exclusion of transgender individuals from HIV surveillance estimates – where they are often incorrectly categorised as ‘MSM’ – exacerbates this problem. While transgender and cisgender sex workers’ SRH needs overlap in many ways, the SWIT has identified counselling, therapy, and referrals related to hormone therapy and other gender-affirming treatments as essential, transgender-specific SRH services.

Consultation participants consistently reported insufficient SRH services and commodities for transgender sex workers, compounded by high levels of provider stigma and discrimination. Several participants added that many transgender individuals enter sex work to pay for gender-affirming treatments and procedures, indicating how essential, yet inaccessible these services remain.

“Transgender needs are not met at [public health care] clinics.”

TRANSGENDER SEX WORKER, THE BAHAMAS

22 Stefan Baral et al. “Male Sex Workers: Practices, Contexts, and Vulnerabilities for HIV Acquisition and Transmission,” *The Lancet* 385,9964 (2015): 260–273.

23 Deepika Ganju and Niranjana Saggurthi, “Stigma, violence and HIV vulnerability among transgender persons in sex work in Maharashtra, India,” *Culture, Health & Sexuality* 19, 8 (2017): 903–917.

24 UNAIDS, 2014, “The Gap Report 2014: Transgender People.”

Focus group participants from The Bahamas reported that the national public health system does not include hormone replacement therapy and counselling for transgender individuals. NSWP members in El Salvador, Rwanda, Namibia, Kyrgyzstan, Canada, Indonesia, Peru, Montenegro, Belgium, Mexico, Ecuador and Nicaragua also reported inadequate services for transgender people, demonstrating the global scale of unmet transgender SRH needs.

While some comprehensive public health programmes for transgender people have been established worldwide, they are the exception. Transgender sex workers usually access SRH services aimed at the general population. Where they are available, they may access services aimed at cisgender sex workers. However they frequently encounter degrading treatment using both services. Such negative experiences may discourage them from following through with treatment or seeking future care.

"... The doctor ... lifted up my pullover and noticed that I had no breasts. She started telling me that my lifestyle was wrong. I was born a man and thus I should be a man. I shouldn't wear skirts or use makeup ... After that incident I am really scared of going to a clinic."

TRANSGENDER SEX WORKER, KYRGYZSTAN

Lacking targeted, affordable and accessible SRH services, many transgender sex workers self-medicate.

"Because I don't have the money, I always get my female friend to get contraceptives from the clinic [for me], which I take as hormones."

TRANSGENDER SEX WORKER, NAMIBIA

"We, trans women ... have to buy syringes used by veterinarians so that we can inject hormones, since in our country, in our region, there is no hormone treatment."

TRANSGENDER SEX WORKER, PERU

Hormone therapy administered without proper medical supervision can cause serious side effects, including thromboembolism, liver dysfunction, breast cancer, and coronary artery disease.

Hormone therapy administered without proper medical supervision can cause serious side effects, including thromboembolism, liver dysfunction, breast cancer, and coronary artery disease.²⁵ HIV and Hepatitis C transmission risks also increase when injection supplies are reused and shared.

While some countries' Ministries of Health, such as that of Peru, have recently developed protocols to address the health needs of transgender people (most often transgender women), their primary focus on addressing HIV epidemics does little to ensure a holistic, rights-based response.

25 See footnote 11 at 125.

Barriers to Accessing SRH Services

NSWP's member consultation confirmed that apart from HIV and STI interventions, the majority of SRH services available to sex workers are those offered to the general population in public health care settings. While most participants preferred NGO-led services, due to a lack of funding, they are typically referred to government clinics where they may encounter provider-based stigma and sub-par treatment. While private clinics often offer higher quality SRH care, their high costs make them inaccessible to most sex workers.

SRH Literacy

In some settings a lack of basic SRH knowledge was reported, indicating a crucial need for educational programming for sex workers. 97% of 217 female sex workers surveyed by LIQUIDAMBÁR, El Salvador, stated that they "had no familiarity" with the topic of SRH. This lack of knowledge can negatively impact sex workers' health, particularly in contexts of concentrated HIV epidemics.

"[Many] female sex workers think that cervical cancer cannot be detected in advance and are not very aware of treatment for cervical disease ... They have seen that many female sex workers have died because of cervical cancer."

JAGRITI MAHILA MAHASANG, NATIONAL NETWORK OF FEMALE SEX WORKERS, NEPAL

Some focus group participants added that low SRH literacy across the general population often burdens sex workers with the task of educating their clients on safe sex practices, highlighting the need for increased SRH educational programming among the broader public.

Criminalisation

The direct and indirect criminalisation of sex work remains one of the greatest barriers to sex workers' SRH access, as well

as a structural determinant of violence, discrimination, and HIV transmission.²⁶

Additional laws, such as those related to HIV exposure, non-disclosure, and transmission; same-sex sexual activities, and sodomy, can further deter sex workers from seeking critical SRH care for fear of legal reprisal.

...criminalisation of sex work remains one of the greatest barriers to sex workers' SRH access...

"Late one night, I was arrested by two police officers who asked me to have sex with them in case I wanted to be set free. When I refused, one of them forced himself on me and raped me. I had nowhere to report [the rape] since sex work is illegal under the Rwandan penal code. Because of this, I couldn't even get post-exposure prophylaxis that is offered to all rape victims. Thankfully, I didn't get pregnant ... But I tested HIV-positive."

FEMALE SEX WORKER, RWANDA

Other impacts of criminalisation, such as the confiscation of condoms as evidence of sex work by police, similarly discourage the utilisation of SRH services while increasing sex workers' vulnerability to HIV and STIs. For example, in Kyrgyzstan, persistent, unsanctioned police raids have forced many street-based sex workers into hiding, resulting in a two-fold reduction of SRH service uptake for this population.

²⁶ Kate Shannon, et al., "Global epidemiology of HIV among female sex workers: influence of structural determinants," *The Lancet* 385, 9962 (2015): 55–71.

Documentation and Health Insurance

Since most of the SRH services that are available to sex workers are offered within public health care systems, the requirement of possessing official residency and valid national health insurance further reduces access to SRH, particularly for migrant sex workers. In criminalised contexts, it is almost impossible for sex workers to provide the necessary proof of income or employment to obtain health insurance. In Kyrgyzstan, where many sex workers do not have passports and registration documents, gynaecological services and pregnancy care are routinely denied by medical staff. As a result, many sex workers only seek SRH care in cases of emergency. As explained by the sex worker organisation Juventas, Montenegro:

“Around 50% of sex workers are illegally living and working in Montenegro ... Thus, they do not have any right to use health care services, except for in an emergency. They do not have health insurance in their mother countries either, and do not have the possibility to obtain health insurance for foreigners.”

Mandatory Testing and Treatment

Mandatory HIV and STI testing and treatment policies (present in many countries globally where sex work is legalised or criminalised) further violate sex workers' human rights and foster distrust of health care

systems. Research has shown that mandatory and coerced testing does not reduce HIV transmission among sex workers or the general population.²⁷

In Austria, in order to work legally, sex workers must undergo weekly STI and quarterly HIV tests at state-run medical centres. Failure to comply with these regulations can result in administrative fines, loss of registration, or in the case of migrant

workers, deportation.²⁸ Even where national legislation surrounding mandatory testing is absent, sex workers may still be subject to these practices. In the border regions of Peru for instance, mandatory health screenings for individuals from neighbouring countries affect migrant sex workers. In Canada, it was noted that some indoor working spaces additionally require health check-ups as a pre-condition to employment.

Focus group participants unanimously considered mandatory testing to be a control mechanism, not a supportive SRH service, and also felt that such policies perpetuate stigma and intensify fears of obtaining a positive diagnosis. Sex worker focus group participants in Canada agreed that the absence of mandatory testing legislation in their country imbued them with a sense of agency over their own sexual health.

Consent and Notification Laws

Laws requiring partner or parent notification, presence, and consent further restrict the autonomy and privacy of sex workers when accessing SRH services. In Rwanda, for instance, health care providers often require both partners to be present for family planning services. Parental consent requirements similarly discourage young people under the age of 18 who sell sex from accessing vital SRH prevention supplies, HIV tests, examinations, and abortion services, as many minors who sell sex are estranged from their families or simply do not wish to reveal their activities.²⁹

Mandatory HIV and STI testing and treatment policies further violate sex workers' human rights and foster distrust of health care systems.

27 Elena Jeffreys, et al., “Mandatory Testing for HIV and Sexually Transmissible Infections among Sex Workers in Australia: A Barrier to HIV and STI Prevention,” *World Journal of AIDS* 2 (2012): 203–211.

28 Sex-Worker Forum of Vienna, Austria, 2013, “Shadow Report on Persistent and Systemic Violations of Article 6 CEDAW by Austria.”

29 Global Network of Sex Work Projects, 2016, “Young Sex Workers.”

Logistical Barriers

Many sex workers consulted also cited inflexible opening hours, inconvenient locations, long waiting times, and a dearth of free services as additional obstacles to accessing state-run SRH services. These barriers are exacerbated for individuals residing outside of major cities, and in contexts with fewer resources. In Cameroon for instance, it was noted that some health facilities possess only rudimentary medical equipment. In other cases, clinics may be poorly designed, resulting in breaches of confidentiality. As one sex worker in Indonesia described:

“I receive my results in the corner of the room and I’m scared that the others will hear something about me ... when we do VCT [voluntary counselling and testing] in this facility they should partition the room... not give us our results in the corner of an open room where others can listen.”

FEMALE SEX WORKER, INDONESIA

Stigma and Discrimination

“There are no sexual and reproductive services that provide non-judgemental and compassionate care to people involved in the sex industry.”

COYOTE RHODE ISLAND, U.S.A.

Due to society’s attitudes towards sexuality, family planning, and parenthood, accessing SRH services may be broadly stigmatised and expose individuals to discrimination. In rural Kyrgyzstan for example, it was noted that many female sex workers are afraid of being seen going to the local gynaecologist for fear of social repercussions.

“If a single woman visits the gynaecologist, it means that she is having sexual contact outside of marriage, which is judged based on religious and patriarchal beliefs.”

TAIS PLUS, KYRGYZSTAN

Respondents in this consultation also reported pervasive stigma associated with their status as sex workers – as well as provider-based discrimination – as additional obstacles to accessing SRH services. Sex workers facing multiple levels of marginalisation, such as male and transgender sex workers, sex workers who use drugs, migrant sex workers, young sex workers, and those living with HIV, encounter even greater levels of stigma and discrimination.

In public SRH settings, where most medical personnel have received no sensitisation training regarding sex workers’ health issues, significant discrimination was reported. Following the disclosure (or outing) of their work to health care providers, many sex workers reported changes

in staff attitudes and a decreased quality of care. Disclosing or being outed as LGBT compounds provider discrimination in contexts with widespread homophobia and transphobia.

“Access for me is the same as a non-sex worker, but the treatment/attention given is affected by whether I share my profession or not.”

SEX WORKER, CANADA

Following the disclosure (or outing) of their work to health care providers, many sex workers reported changes in staff attitudes and a decreased quality of care.

“I went to the ER with a lot of abdominal pain and was denied services because I was a sex worker. They told me they had to finish with the rest of their patients first before providing me with assistance.”

FEMALE SEX WORKER, PERU

In other cases, services were withheld altogether. The risk of service denial may be particularly high for sex workers who use substances.

“I was sent back a number of times by the health care providers when I went in for family planning, because most of the time I was drunk and a very well-known sex worker. I was told to change the person I am, and only then can I be helped.”

FEMALE SEX WORKER, NAMIBIA

As a result, few sex workers disclose their profession to medical providers, and some may avoid contact with the health care system altogether. In Rwanda, the majority of focus group participants who did not utilise SRH services revealed that it was out of fear for being termed *indaya* – or prostitutes – “one of the worst insults in local society.”

Community-Led Interventions

Community empowerment models, such as awareness raising, community-led drop-in centres, outreach, and advocacy, improve health outcomes and encourage prevention behaviours. WHO

WHO has deemed community empowerment an “absolutely necessary” measure to improve sex workers’ living and working conditions and redress human rights violations.

has deemed community empowerment an “absolutely necessary” measure to improve sex workers’ living and working conditions and redress human rights violations.³⁰ Participants in this consultation confirmed the importance of sex worker-led interventions as part of a comprehensive SRH response, citing various examples from their local communities.

Sex workers can fulfil numerous roles in community-led SRH interventions, including serving as peer educators and counsellors, developing and implementing trainings, and building referral networks. They may also have experience and qualifications as health care workers and programme managers and should not be limited in the roles they play.

In Nepal, focus group participants credited their SRH knowledge to the presence of local peer educators and counsellors operating through community-based organisations.

“One of the peer educators provided me with information on safer sex and HIV testing and counselling. I felt that I was at high risk, so I went with [her] to the VCT [voluntary counselling and testing] centre. I am so happy that the counsellor provided me with further information regarding safer sex practices. Now I am using condoms ... and I am free from being pregnant and contracting HIV.”

FEMALE SEX WORKER, NEPAL

30 WHO, UNFPA, UNAIDS & NSWP, 2012, “Prevention and Treatment of HIV and Other Sexually Transmitted Infections for Sex Workers in Low- and Middle-Income Countries: Recommendations for a Public Health Approach,” 19–20.

In the face of discrimination from health care providers, outreach workers from sex worker-led organisations can also facilitate sex workers' access to higher quality health care.

"I go to my doctor's appointments with an outreach worker, because they take the outreach worker more seriously than me."

SEX WORKER, CANADA

For sex workers in critical situations, community organisations may serve as a life-line:

"When I was giving birth to my baby, the health care providers didn't want to provide me with services because I was black. So I called the Association of Female Sex Workers so that my baby could be born."

MIGRANT FEMALE SEX WORKER, PERU

Many consultation participants emphasised that sex workers should be meaningfully involved in the training and sensitisation of health care staff to reduce stigma and increase the quality of services. In Kenya,

the Bar Hostess Empowerment and Support Programme regularly conducts trainings for health workers and provides free HIV and STI services through its own wellness centres. They have seen positive outcomes through this work.³¹

In Germany, the sex worker-led organisation Berufsverband erotische und sexuelle Dienstleistungen e.V. (BesD e.V.) collaborated with gynaecologists to develop and launch the "Red Stiletto Shoe" campaign in 2017 to

increase sex workers' awareness of and access to vital services. As part of this campaign, health care professionals offering comprehensive, non-judgmental gynaecological services to sex workers can identify themselves by placing a red stiletto shoe label in the entrance area of their practice.

Several focus study participants added that the more involved sex workers are in clinical operations, the more likely these services are to be accepted by the community. One exemplary case of direct sex worker involvement in health care can be taken from Mysore, India, where Ashodaya Samithi supported 12 sex workers in completing formal nursing training and gaining employment at a local clinic.³²

The Impact of Funding

Since community organisations and other NGOs play a key role in facilitating sex workers' access to SRH services, the availability of funding remains a critical consideration. However, very few resources are invested in achieving sex workers' rights worldwide, and even fewer are granted directly to sex worker-led organisations.³³ Given these constraints, SRH interventions for sex workers are typically localised and small in scale. In order to scale up SRH programming, greater resources and cooperation between community-led organisations, governments, and donors must be ensured.

31 Open Society Foundations, 2016, "No Turning Back: Examining Sex Worker-Led Programs that Protect Health and Rights," 9.

32 See footnote 11 at 121.

33 Red Umbrella Fund, Mama Cash & Open Society Foundations, 2014, "Funding for sex worker rights: Opportunities for foundations to fund more and better."

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...without increased investments in community empowerment models, access to comprehensive SRH services for sex workers will remain a distant ideal.

In Kyrgyzstan, support from the Global Fund from 2004–2015 enabled community organisations such as Tais Plus to establish links with sex worker-friendly clinicians and medical units. The services themselves are no longer financed by the Global Fund, however connections with doctors and clinics have been maintained for SRH treatment referrals. While this example highlights the instability of funding arrangements, it affirms the ability of community engagement models to sustain positive change.

On one hand, it is clear that community organisations cannot take full responsibility for ensuring that sex workers' diverse SRH needs are met, particularly given the high demand for specialised clinical services and the widespread exclusion of sex workers from health care professions. On the other hand, it is equally evident that without increased investments in community empowerment models, access to comprehensive SRH services for sex workers will remain a distant ideal.

Recommendations

In the course of this consultation, participants described the following ten recommendations for improving sex workers' access to comprehensive SRH services.

- **Decriminalise sex work, HIV transmission, and same-sex sexual activity, and de-pathologise transgender identities.** Criminalisation and pathologisation not only deter sex workers from seeking vital SRH services due to potential legal repercussions, but also reinforce stigma and discrimination in health care settings.
- **Remove barriers to accessing public health care systems for migrant sex workers, as well as individuals who cannot provide formal proof of income or employment.** These restrictions prevent sex workers from accessing routine SRH services and make them reliant on limited NGO-led programming and emergency-room services.
- **Eliminate mandatory and coercive HIV and STI testing and treatment policies.** These practices violate sex workers' fundamental right to access SRH services free from violence or coercion. They create distrust towards health systems and reduce access to essential prevention and treatment services.
- **Address the stigma and discrimination that female, male and transgender sex workers experience from mainstream SRH services.** When sex workers access SRH services for the general population, they often encounter stigma and discrimination, breaches of confidentiality, and inequitable treatment. Comprehensive, long-term sensitisation and training is required to make SHR services accessible to sex workers. In the meantime, a complaints and redress system should be developed with the sex worker community to effectively address abuses.
- **Increase funding and support for comprehensive SRH services and programmes designed to meet the needs of sex workers of all genders.**

- **Advance a holistic approach to comprehensive SRH services for sex workers that extends beyond HIV and STI testing and treatment.** Comprehensive SRH services, as defined by the SWIT, should be made accessible to sex workers of all genders, taking into consideration divergent priorities and goals associated with work activities and private life. Programmes focused solely on HIV and STIs reinforce the pathologisation of sex workers while diverting attention away from their holistic health needs.
- **Ensure access to safe, legal, and affordable abortion and post-abortion services.** Restrictive abortion policies may force women to employ unsafe, informal pregnancy termination methods at great risk to their health.
- **Integrate SRH care with HIV and STI services in line with a “one-stop-shop” model.** By integrating comprehensive SRH services with existing HIV and STI programmes, a broader spectrum of care can be offered in one location, reducing logistical barriers to service uptake.
- **Promote SRH education programming for sex workers and their clients.** A lack of SRH knowledge endangers sex workers' health and can prevent them from utilising available SRH services. Low SRH literacy among the general population can also burden sex workers with the task of educating their clients on safe sex practices.
- **Prioritise funding for community empowerment models of SRH services.** Beneficial community-led interventions can include outreach programmes, drop-in centres, and sensitisation trainings for medical personnel developed and implemented by sex workers. Sex worker organisations can also partner with health care professionals to form networks of friendly doctors for treatment referrals.

Conclusion

There is no “one-size-fits-all” solution to ensuring sex workers' access to comprehensive SRH services. However, diverse sex workers who participated in this consultation unanimously agreed: the SRH services in their communities do not provide comprehensive, integrated, and non-judgmental care. As a result, sex workers are unable to exercise

their right to SRH – protected in numerous international conventions. Due to widespread discrimination, they may experience further human rights violations by medical professionals.

While NGOs typically offer higher quality, less judgemental HIV and STI care, NGOs cannot compensate for the shortcomings and inequalities sex workers encounter in public health care settings. Therefore, policymakers and government institutions must do more to fulfil their

commitments to universal SRH service access. These efforts must target the structural barriers of criminalisation, stigma, and discrimination, which exclude sex workers from public health systems. Funding for community empowerment interventions (both by international donors and state institutions) is also necessary to increase the quality and uptake of SRH services.

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The Global Network of Sex Work Projects uses a methodology that ensures the grassroots voices of sex workers and sex worker-led organisations are heard. The briefing papers document issues faced by sex workers at local, national, and regional levels while identifying global trends.

The NSWP Secretariat manages the production of briefing papers and conducts consultations among its members to document evidence. To do this, NSWP contracts:

- Global Consultants to undertake desk research, coordinate and collate inputs from Regional Consultants and draft the global briefing papers.
- Regional Consultants to coordinate inputs from National Key Informants and draft regional reports, including case studies.
- National Key Informants, identified by the regional networks, to gather information and document case studies.



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