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Sex Work, Criminalization, and HIV: Lessons from Advocacy History

If you have—voluntarily or involuntarily—spent time watching Sesame Street on television, you probably remember hearing “one of these things is not like the others.” It’s a catchy little tune used to teach children to categorize, and it was going through my head at the International AIDS Conference in Vienna last July. It started during the opening plenary, as Yves Souteyrand, a health economist from the World Health Organization (WHO), described the populations most at risk for HIV infection in various countries and regions.

Souteyrand said that, globally, men who have sex with men (MSM) have 19.3 times greater risk of being infected with HIV than people in the general population, and that their risk is arguably greatest in the more than 80 countries in which homosexual activity is criminalized.

He noted that laws in 40% of countries currently limit access to HIV services for injection drug users (IDUs). Souteyrand highlighted Ukraine's progress in scaling up evidence-based prevention and treatment interventions for IDUs: After steadily climbing for a decade, new HIV infections in that country are now starting to decline. The HIV prevalence among Ukrainian IDUs, estimated at 30% in 2004, is now down to about 11%. Good news!

But Souteyrand concluded his talk without presenting data on the impact that criminalization and marginalization have on sex workers and their HIV risk. He omitted this group even though his WHO data showed that sex workers account for an equal or higher percentage of new infections in sub-Saharan Africa (home to more than two-thirds of all people living with HIV), compared with the other two populations he had been discussing. Wait a minute!

Upon reflection, I realized that this omission is actually common in discussions about the causal links between criminalization, marginalization, and increased HIV transmission. We talk a lot about the effects of this dynamic on men who have sex with men, injection drug users, and people living with HIV—as we certainly should—but not about sex workers. Why is this group not like the others?

WHAT DO THE DATA SAY?

Comparative discussions are difficult given the frustrating dearth of accurate data on the impact of the AIDS epidemic on each of these populations in various regions. The *Global HIV Prevention Progress Report Card*

2010 notes that, of the 169 countries reporting epidemiological data to the Joint United Nations Programme on HIV/AIDS (UNAIDS) in 2008, only 38% had survey-based estimates of HIV prevalence among female sex workers, 31% had estimates on MSM, and only 26% had data on prevalence among IDUs.

The data that do exist are spotty and incomplete, especially with regard to MSM—a category not even recognized in many regions. Mozambique, for example, estimates that sex work contributed directly or indirectly (via clients to their regular partners) to 19% of new HIV infections in 2007. They attribute 3% of new cases in the country to injection drug use and 5% to sex between men. In Uganda, sex work is cited as accounting for 10% of new infections, while MSM and IDUs together accounted for less than 1%—figures that are neither credible nor surprising in light of the Ugandan government's tendency to deny the presence of homosexuality and injection drug use in that country.

The Kenyan government, by contrast, is now gathering much more accurate data and preparing to roll out its first HIV prevention campaign targeted to MSM. A national survey recently conducted by the Kenya Medical Research Institute reported that 15% of all new HIV infections were occurring among MSM, and 14% among sex workers and their clients.

The U.S. Centers for Disease Control and Prevention (CDC) now describes several major U.S. cities as having “generalized” HIV epidemics that are primarily associated with poverty and affect populations outside of the major at-risk groups.

The CDC confirms that the majority of new infections in the U.S. are still occurring among MSM, and estimates that injection drug use accounts for 12% of the country's new HIV infections each year. But the agency provides no parallel estimate of the number occurring among sex

workers. This gap is surprising, given that the CDC has funded and participated in sophisticated research to assess the rate of new infections among sex workers in many other parts of the world.

SCIENTIFICALLY SOUND BUT POLITICALLY UNPALATABLE

The worldwide lack of accurate reporting on real HIV incidence among the most marginalized and at-risk groups is connected to the paltry funding set aside for HIV prevention. According to UNAIDS, 4.7% of all global HIV prevention spending in 2008 was allocated to programs targeting IDUs, 3.3% for MSM programs, and 1.8% for programs reaching sex workers.

These shockingly low funding levels also correlate with the fact that all three populations are characterized by behavior that is criminalized, one way or another, in most countries. The Global HIV Prevention Working Group notes that “sex work is illegal in at least 110 countries, consensual sex between adults of the same sex is criminalized in more than 80 countries, and substitution therapy with methadone and buprenorphine is allowed in only 52 and 32 countries, respectively.”

This political dynamic has far-reaching effects: Criminalization leads to marginalization and invisibility; invisibility masks the need for adequately funded, effective services. As the late gay African American writer James Baldwin once observed, “you cannot fix what you will not face.” With regard to governments, this translates into, “you do not have to fix what you do not face.”

Countries routinely use this approach to avoid uptake of public health strategies that are, in the words of Paula Akugizibwe of the AIDS and Rights Alliance for Southern Africa, “scientifically sound but politically unpalatable.” So let's look at how advocates for IDUs and MSM have

dealt with this neglect, and see if it tells us anything about why sex workers have yet to command the attention and broad-based public support among HIV/AIDS and human rights advocates that their evident risk level warrants.

PEPFAR AND NEEDLE EXCHANGE

The President's Emergency Plan for AIDS Relief (PEPFAR), a massive funding bill created to implement the 2003 Global AIDS Act, was first funded in 2004 and reauthorized by Congress in 2008 with a significant funding increase.

While it represents a step forward in terms of overall investment in HIV/AIDS efforts, PEPFAR has some major limitations. For example, it failed to allow support for harm reduction programs, including syringe exchange, which has been shown to help IDUs limit their risk of acquiring or passing on HIV and other blood-borne diseases. Instead, PEPFAR funding could only be used for work with IDUs already living with HIV. Until December 2009, the U.S. government refused to fund harm reduction programs, either domestically or internationally, that involved syringe exchange.

In 1985, the first evidence of the effectiveness of needle exchange was published in Amsterdam. The following year, an HIV prevention pioneer named Jon Parker started exchanging used needles for clean ones in the U.S., getting arrested and inspiring activists across the country—and organizations like San Francisco AIDS Foundation—to follow his example.

Four years later, use of U.S. federal funds for needle exchange services was officially banned. One stipulation of the 1989 federal ban was that it could not be lifted unless the President or the U.S. Surgeon General could certify that needle exchange lowered HIV transmission rates without increasing drug use. But the National Institutes of Health was explicitly forbidden to evaluate needle exchange programs, and researchers interested in conducting such evaluations were told that these proposals could not be considered for federal funding. No evidence generated, no way to certify the effect, no way to lift the ban!

Working with activists, dedicated epidemiologists (mostly supported by their academic institutions) persisted in gathering, analyzing, and publishing evidence that needle exchange works.

A decade—and uncounted lives—later, the U.S. Secretary of Health and Human Services reported that solid scientific evidence showed that the two conditions required to lift the ban had been met. In 2000, the Surgeon General formally concurred with this finding. Yet the ban remained in place.

Since 2000, clean needles have become more widely available in the U.S. through a variety of mechanisms, including prescription-free pharmacy access, state and local health departments' needle exchange programs—since states are empowered to make their own policies on this issue—and, in some areas, “decriminalized” exchanges which are technically illegal but tolerated by law enforcement.

By this time, however, the U.S. was the only country in the world that explicitly banned the use of federal funds for needle exchange services. Approximately five million injection drug users live in 13 PEPFAR-supported countries across Eastern Europe, Asia, and Africa. So U.S. policy was withholding HIV prevention tools from domestic IDUs and those in PEPFAR-recipient countries.

After long years of HIV-prevention and harm reduction advocacy—including expert testimony before Congress on the effectiveness of syringe exchange—President Obama lifted the domestic needle exchange funding ban on December 16, 2009. Six months later, the U.S. Department of Health and Human Services (DHHS) issued new policy guidance for PEPFAR that allows funding for needle exchange programs and medication-assisted therapy (treating opioid dependence with substitution drugs, including methadone and buprenorphine).

The guidelines stipulate that these programs can be funded only in areas where they comply with local laws and regulations, but the U.S. government is no longer refusing to support these urgently needed strategies. As former International AIDS Society President

THE VIENNA DECLARATION

In the summer of 2010, advocacy groups worldwide began circulating the Vienna Declaration, a statement “seeking to improve community health and safety by calling for the incorporation of scientific evidence into illicit drug policies.”

Spearheaded by the International AIDS Society, the International Centre for Science in Drug Policy, and the British Columbia Centre for Excellence in HIV/AIDS, the declaration was formally launched at the International AIDS Conference in Vienna. It has been endorsed by more than 18,000 people to date, including such influential advocates as Michel Kazatchkine, Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria; former United Nations Special Envoy on AIDS Stephen Lewis; and several Nobel laureates in biochemistry, economics, medicine, virology, and other fields.

Framed in the language of human rights, the declaration explicitly calls for governments to reduce drug-related harm by supporting needle exchange and opiate substitution programs rather than harsh criminalization policies. To read the declaration, visit www.viennadeclaration.com.

Julio Montaner declared in Vienna, “there is no successful intervention for HIV that does not include a comprehensive prevention package for IDUs. That is non-negotiable.”

GAY MEN: FROM “VECTORS” TO A VOICE AT THE TABLE

HIV has, without question, elicited overt and covert homophobic reactions all over the world. The U.S. has progressed substantially on this front since the 1980s, when AIDS was widely regarded as a “gay disease” undeserving of any significant federal response. In 1988, Senator Jesse Helms (who, on television, advocated quarantining people with HIV) personified this widely shared disdain by introducing a federal budget amendment prohibiting use of tax dollars for AIDS prevention materials that “promote or encourage homosexuality.”

To illustrate the need for this language, he showed fellow senators a gay-themed comic book, produced by Gay Men’s Health Crisis, that used explicit HIV prevention language and images to reach men among whom HIV incidence was skyrocketing. Known colloquially as “*no promo homo*,” Helms’ amendment was eventually replaced with language stipulating that federal funds could not be used for materials that could be “objectionable to the American public.”

The growing visibility of HIV/AIDS service organizations led largely by gay men and their allies helped to discourage the overt expressions of homophobic attitudes. Gay Men’s Health Crisis (and its Institute for Gay Men’s Health), the Gay Men’s Health Summit, the Black Gay Men’s Network (a project of the Black AIDS Institute), and the Global Forum on MSM and HIV (an international coalition based in the U.S.) are just a few of the groups formed by advocates and service providers determined to highlight the specific needs of this population and demand that those needs be addressed.

Their success is evident in the “Young MSM of Color Initiative,” created in the Ryan White CARE Act under Special Programs of National Significance; the inclusion of MSM as an eligible category for grant applications within the Minority Substance Abuse/HIV Prevention Initiative; and in the President’s MSM Initiative, which provides CDC funding in fiscal year 2011 to address the disproportionate impact of HIV on MSM.

Meanwhile, overt homophobic and transgender-phobic responses to HIV are still gaining traction in several African and Asian countries, where existing stigma is exacerbated by the worsening pressures of the epidemic. A report released at the Vienna conference by the United Nations Development Programme and the Asia Pacific Coalition on Male Sexual Health indicated that sex between consenting adult men is criminalized in 19 Asian countries and police frequently use these laws to target MSM and transgender people in ways that drastically hinder their access to HIV prevention services and educational programs.

The report goes on to note that, while HIV prevention services are currently reaching only 9% to 20% of MSM in the Asia-Pacific region overall, the highest rates of access and uptake of these services by MSM are occurring in the eight countries in the region that *prohibit* discrimination against them.

Recent efforts to increase criminal penalties against MSM in Uganda and Rwanda have particularly commanded public attention, as the media has presented us with pictures of politicians and church leaders openly endorsing homophobic violence. Yet while some African countries are debating enhanced penalties for MSM, others are making progress in the opposite direction.

Joel Nana, Director of African Men for Sexual Health and Rights (based in South Africa), told press at the Vienna conference that “we now have 14 countries out of 54 that

include men who have sex with men in their national HIV strategic plans. It doesn’t mean the services will be delivered to those populations, but it is an acknowledgment. That’s a first step.”

CRIMINALIZING HIV EXPOSURE AND TRANSMISSION

Many countries are also criminalizing HIV transmission itself, possibly as a surrogate for persecuting the groups to whom they attribute such transmission. A report by the International Planned Parenthood Federation points out that 58 countries have passed laws that specifically criminalize HIV transmission or have in place non-HIV-specific laws with which to prosecute people accused of spreading the virus. Another 33 countries are reported to be considering similar legislation.

In sub-Saharan Africa alone, more than 20 countries have passed legislation ranging from mandatory HIV testing and disclosure to criminalizing exposure to or transmission of HIV. Similar laws are in place or pending in parts of Asia, Latin America, and the Caribbean, according to the ATHENA Network, an organization dedicated to combating HIV through advancing human rights and gender equity.

In the U.S., 36 states have explicitly criminalized HIV exposure or transmission, despite the fact that pre-existing laws against assault, rape, and endangerment are sufficient for prosecution in the rare instances in which people *deliberately* attempt to transmit HIV. Carefully applied, the non-HIV-specific laws already on the books can address these situations without violating public health principles.

Criminalizing HIV transmission specifically opens the door to all kinds of human rights violations—and creates a huge disincentive for HIV testing, since ignorance of one’s HIV status may be the safest way to avoid being accused of deliberately trying to transmit the virus.

The U.S. leads the world in the number of people convicted of willfully exposing others to HIV: 205 convictions as of 2009, according to the Global Network of People Living with HIV. Many more have been accused and, as the Center for HIV Law and Policy puts it, “singled out for irrational, exceptionalist treatment and punishment solely on the basis of their known HIV status.”

As the convener of the Positive Justice Project, the Center has proposed innovative strategies for pushing states to eliminate these laws, including the possibility of tying Ryan White CARE Act funding and other federal HIV-related state funding to state-wide elimination of laws and policies that criminalize HIV transmission or otherwise discriminate against people with HIV.

The Obama administration’s new National HIV/AIDS Strategy discourages states from adopting laws that criminalize HIV transmission. Although it does not call directly for their repeal, the strategy directs the U.S. Department of Justice to examine and report on how such laws are being implemented.

Resistance to the global trend toward criminalization was widely evident at the Vienna AIDS Conference, with the theme “Rights Here, Right Now.” UNAIDS leaders spoke out forcefully against it, and data on criminalization trends presented at conference sessions underscored a consensus that criminalization is both ethically wrong and disastrous to public health efforts to stop the spread of HIV. More than 15,000 conference participants and local residents marched through the streets of Vienna on July 20 as part of the “HIV and Human Rights March,” demanding that action to uphold human rights be recognized and supported as a fundamental part of the global response to HIV/AIDS.

SEX WORKERS: THE “OTHER” MOST AT-RISK POPULATION

Although sex workers are generally the at-risk group mentioned last after MSM

and IDUs, the three are obviously not exclusive categories. People at high risk for HIV may belong to one, two, or all three of these of these populations at various points in their lives. People in these groups are at high risk in part *because* they are stigmatized, vilified, or ignored whenever possible in most countries.

However, not everyone is clear on exactly who sex workers are. Cheryl Overs, co-founder of the global Network of Sex Work Projects (NSWP), started off a presentation at the Vienna conference by saying that sex workers are younger, older, indigenous people and migrants, female, male, and transgender, etc. What sex workers are *not*, Overs continued, are children or people in slavery.

Confusion on this point is a major hurdle in sex workers’ rights advocacy today. Anti-trafficking advocacy has blurred public understanding of the vital distinction between voluntary, consensual adult sex work and the labor of women and children who have been trafficked into sexual slavery.

Sex workers’ rights advocates are just as opposed to human trafficking and the sexual exploitation of children as anyone else. Except for their criminalized status, in fact, sex workers are ideally positioned to work with law enforcement in fighting trafficking and getting help to trafficked individuals. As Meena Seshu of SANGRAM/VAMP, an Indian sex workers’ rights organization, pointed out, “it is the sex workers who are in contact with new ‘girls’ in the community and who can speak to them about their rights.”

The NSWP and its member organizations worldwide hold the position that voluntary, adult sex work is simply *work* and that sex workers deserve the same rights as other workers. Some sex workers choose their profession over other available jobs, while many do it because the pay and the hours are better than those offered by any other work available to them.

Andrew Hunter, current president

of NSWP, observed, “saying that sex work is ‘work’ doesn’t mean you think it’s a great job. We all agree that clothing manufacturing is work, but no one says that working in a sweatshop is fabulous. And no one argues that sweatshop workers don’t deserve labor rights.”

Currently, the legal status of sex work varies widely from country to country and even among states in the U.S. In 2003, New Zealand became the first country to completely decriminalize sex work. Their Ministry of Justice reports that this has caused no increase in the number of people engaged in sex work, and it has improved sex workers’ health and safety, particularly by enabling them to report violent crimes.

In some places (Nevada and Amsterdam, for example), sex work is legalized, meaning that sex workers can operate within specific areas, with police registration and monitoring. Legalization and decriminalization are quite different in that legalization generally favors big business (e.g., brothel owners). Individuals in these regions who prefer to work in small collectives or on their own still risk arrest if they go to the police to report being robbed or assaulted. They also remain highly vulnerable to police extortion (for money or sex) when they are caught.

Despite the patchwork of laws, sex work is generally regarded as “illegal” everywhere, and those who suffer most as a result are street-based sex workers. Whether female, male, or transgender, street-based sex workers are at greatest risk of violence from clients and the police. They are most likely to be impoverished, homeless, and/or addicted, and they have the highest risk for HIV. Because they can be arrested at any time, negotiations regarding price and condom use are often hasty and agreements unenforceable.

THE PROBLEM WITH PEPFAR

Public promotion in the U.S. of the view that all sex workers are either

criminals or trafficked victims in need of rescue paved the way for the introduction of the PEPFAR anti-prostitution pledge. The 2004 PEPFAR language stipulated that no funds “may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking,” or be used to “promote, support, or advocate the legalization or practice of prostitution.”

This language evolved somewhat during PEPFAR reauthorization; the 2010 guidance requires grantees to agree that they are “opposed to the practices of prostitution and sex work because of the psychological and physical risks they pose for women and children.” Tying funding to this inaccurate conflation of practices promotes the invisibility of voluntary consensual adult sex workers.

To comply with this requirement, overseas groups wishing to receive U.S. government funding are required to refrain from doing anything that could be construed as condoning sex work in any way, even if the grantee pays for those activities with other funds. The Obama administration had the opportunity to declare this requirement unconstitutional, but instead directed groups that want to work with sex workers to create entirely new organizations—with separate facilities, management, staff, and signage—to ensure that they keep their PEPFAR funding isolated from those activities.

The anti-prostitution pledge has been challenged in court and a preliminary injunction is currently in place that keeps it from being enforced against U.S. organizations that belong to either the Global Health Council or InterAction, two of the entities that brought the lawsuit (along with Pathfinder and Alliance for Open Society International). The U.S. government has appealed this ruling, and if the injunction is lifted while the suit is pending, all U.S. non-governmental

organizations will be required to comply with the regulations, just as foreign PEPFAR recipients already are.

It is hardly surprising, then, that a central demand of the sex workers’ rights advocates at the Vienna conference was that the U.S. government issue guidance to nullify the anti-prostitution pledge in the same way it had just reversed the ban on needle exchange in PEPFAR.

PEPFAR now funds comprehensive harm reduction programs while effectively deterring organizations that serve sex workers from seeking or receiving U.S. financial support. An analysis presented at the Vienna conference by Melissa Ditmore and Dan Allman captured the essence of how this works.

Because grantees were fearful of being defunded if they complained about PEPFAR, Ditmore and Allman collected confidential data from 25 PEPFAR-funded organizations and projects in Africa, the Americas, Asia-Pacific, and Europe, and used them as the basis for a composite “case story.”

Their narrative is placed in a fictional country, and the made-up organization they describe neither condones sex work nor condemns sex workers. On consulting with their U.S. Agency for International Development (USAID) country office, the organization’s director is advised that, if the group wants to continue to receive U.S. funding, it definitely cannot let sex workers use its drop-in centers.

Rather than police the drop-in centers and deny access to any known or suspected sex workers, the agency closes them altogether. This deprives all clients of access to condoms, lubricant, and peer-based safer sex education. It also deprives homeless clients of their access to bathing and toilet facilities. In the wake of negative community pressure generated by this decision, the agency decides to get out of HIV services altogether and use their resources instead for school-based sex education.

This narrative, while fictional, highlights the real-life experiences of many similarly situated organizations. Agencies report having to stop offering English classes to sex workers (in many countries, a vital step toward getting other employment), curtail their HIV prevention outreach work to women in brothels, and discontinue empowerment programs that train sex workers to serve as peer educators on safer sex, sex workers’ rights, and condom negotiation techniques.

According to current PEPFAR guidance, organizations can continue to offer these services only if they set up entirely separate facilities, staff, management, and equipment to do so. This delineation is simply not feasible for desperately under-resourced organizations and serves as a *de facto* prohibition.

The guidance also states that PEPFAR recipients can continue to provide HIV testing and treatment to sex workers. Because it does not explain what constitutes “promoting prostitution,” however, many organizations choose to abandon their provision of testing, treatment, and services to sex workers rather than risk doing something that might be perceived as violating the anti-prostitution pledge.

In a survey of staff at PEPFAR-recipient agencies, the Center for Health and Gender Equity (CHANGE) found that “19 of the 31 people interviewed in the field reported that they censored themselves or their organizations as a result of the pledge. Almost all contracting agencies reported that they have cleared their websites of references to sex workers or [sex workers’] rights.”

Drop-in centers may be among the biggest casualties. As with any heavily stigmatized and marginalized population, successful engagement with sex workers depends on direct contact, respect, building trust, and becoming a reliable resource. Effective drop-in centers offer sex workers bathroom facilities, snacks, contact with peers,

and a safe place to rest. They provide harm reduction in the form of condom counseling and promotion, and skills-building opportunities that can lead to transitioning out of sex work.

Yet funding for such drop-in centers is slashed when they are perceived as possibly encouraging sex work. In Bangladesh, for example, a drop-in center program that had been recognized as a UNAIDS “best practices” model was defunded and lost 16 out of their 20 centers after the international non-governmental organization that had funded the program signed the anti-prostitution pledge.

OVERCOMING THE ANTI-PROSTITUTION PLEDGE

Herein lies the heart of the problem: It is not possible to simultaneously stigmatize people *and* help them to reduce their HIV risk. A 2007 press release from the Urban Justice Center’s Sex Worker Project summed up the conflict: “The real impact of the anti-prostitution pledge is that people around the world are being denied the healthcare, rights, and services they deserve...The real hypocrisy here is that people who need healthcare and services, and who need their rights protected, are being denounced by those whose mission it is to help them.”

Let us consider the lessons learned from struggles to overturn policies that blocked the rights of MSM and IDUs to effective HIV prevention and tools specific to their needs. We see an unwavering determination not to back down and be quiet, no matter how long it takes to be heard. We see the crucial importance of developing an evidence base that objectively shows the effectiveness of targeted prevention tools. And we see the importance of not just persuading those in power to meet sex workers’ needs but to get seats at decision-making tables and get these demands entrenched in the language of the larger HIV prevention dialog.

These lessons suggest that advocates now need to highlight the discrepancy between U.S. policy and that of global funders—a publicity challenge directly paralleling that undertaken to legalize syringe exchange. And this struggle cannot be taken on solely by those most directly affected. To be truly effective, it must be on the agenda of mainstream AIDS and human rights activists who see it as a substantial and intolerable injustice. The demand to remove the anti-prostitution pledge needs to be a core part of the message as the HIV/AIDS community presses for adequate PEPFAR, Global Health Initiative, and Global Fund appropriations.

Advocates will have to point out—over and over—that the current PEPFAR guidance defeats efforts to use funding efficiently and effectively to reduce HIV risk among sex workers. And even though U.S.-based organizations are not directly affected by the pledge at this time, American advocates still bear primary responsibility for eradicating this injustice. It is, after all, U.S. money. Americans are ultimately accountable for where and how it is (and is not) disbursed. Just look at anything underwritten by USAID: The tagline “From the American people” always appears right beneath the USAID logo.

Another essential component will be the development of an evidence base showing the impact of using a human rights approach to HIV prevention programming with sex workers. As was the case with syringe exchange ten years ago, almost no research in this area has been funded. In the case of sex work, the issue is further complicated by the fact that sex work is widely seen as synonymous with human trafficking.

The political pressure on the Obama administration to maintain anything associated with anti-trafficking efforts (such as the anti-prostitution pledge) is substantial. The underlying implication is that people

who support sex workers’ rights are, in effect, condoning human trafficking.

The idea that investing enough money in anti-trafficking efforts will eradicate sex work, and hence sex workers’ HIV risk, is illogical and incorrect. But funding, conducting, and publishing the research that will prove the error of this assumption will be exceedingly challenging. That’s all the more reason for advocates from all sectors to push for it to be done.

Don Des Jarlais and others whose work was pivotal to building the evidence base for needle exchange wrote that, “as a profession, epidemiologists need to advocate for openness, even when unpopular, for scientific investigation and evaluation when the root of the issue is protection of the public’s health.” Epidemiologists and social scientists need to step up now with regard to sex workers.

OTHER SEX WORKER ADVOCACY CHALLENGES

Eliminating the PEPFAR anti-prostitution pledge is not the only objective of American advocates for the human rights of sex workers. While U.S.-based organizations are not subjected to PEPFAR regulations, they *are* struggling with myriad challenges and unmet HIV prevention needs of their own.

Minimizing criminalization’s impact on HIV prevention outreach. Law enforcement “crack-downs” on sex workers drive people underground, into more dangerous neighborhoods and settings where they are better hidden from the police—and from health outreach workers. Sometimes police actions directly work against safer sex promotion and HIV prevention. Although there is no legal limit to the number of condoms an individual may carry, law enforcement officers in major cities routinely confiscate condoms from suspected sex workers and may even file them as evidence of prostitution.

In Washington, D.C., the city with the highest HIV prevalence in

the U.S., police are empowered to set up temporary “Prostitution-Free Zones.” People suspected of being sex workers—including those loitering at night and carrying multiple condoms—can be arrested if they refuse to leave the designated area. This use of condom possession as grounds for arrest offers sex workers an untenable choice: protect themselves (or their clients) from HIV, or protect themselves against arrest.

In New York state, where condom possession is currently admissible evidence in prostitution cases, legislation has been introduced that “provides that possession of a condom may not be received in evidence in any trial, hearing or proceeding as evidence of prostitution.” This bill (S1289A) is stuck in a Senate committee and, despite its public health importance, is unlikely to pass without the endorsement of the New York Police Department. Advocates in New York are currently working to get that support.

Sex workers’ groups in other cities are similarly working with police to build bridges and find ways to collaborate on common concerns. In Canada, a Montreal-based university professor working in collaboration with a sex workers’ organization called Stella was funded by the provincial Ministry of Education to develop capacity-building trainings around sex work for police, social workers, and other human services staff. The training was designed to reduce obstacles—identified by Stella members—to accessing non-judgmental health and social services. The curriculum they developed, delivered through team-teaching by the professor and one Stella-trained sex worker, was so well received that it generated demand for additional trainings across the province before funding ran out.

Unfortunately, an anti-prostitution group stepped in and revised the Stella curriculum to relay their own, very different, political agenda. According to Maria Nengeh Mensan, a profes-

sor of social work at the University of Quebec and one of the curriculum creators, “the anti-prostitution feminist movement in Canada is one of the biggest barriers to our work in Canada—and they are really well funded.”

Tensions between the two camps have given rise to an organization called FIRST: Feminists Advocating for Rights and Equality for Sex Workers. FIRST advocates for the decriminalization of sex work in Canada and is dedicated to educating the public about the sharp distinction between voluntary, adult sex work and the situation and needs of people trafficked into sexual slavery.

Preventing the legal status of sex workers from worsening. As discussed previously, MSM, IDUs, and sex workers share the experience of being stigmatized and vilified. In the U.S., the state of Louisiana has taken the vilification of sex workers to a new level by using an 1805 law written to criminalize homosexuality (by banning oral and anal sex as “crimes against nature”) to label sex workers as sex offenders. The *Louisiana Weekly* reported in January 2010 that “sex workers convicted of breaking this law are charged with felonies, issued longer jail sentences, and forced to register as sex offenders. They must also carry a driver’s license with the label ‘sex offender’ printed on it.”

This practice is primarily affecting poor women of color who are already at high risk for HIV, many of whom are drug addicted and cycling in and out of the criminal justice system. Registered sex offenders are often unable to get jobs (because they are barred from certain kinds of employment, and other employers may be unwilling to hire them) and their names are kept on the registry for at least ten years—longer if they violate reporting requirements.

Sex offenders with felony convictions do not qualify for public housing assistance or educational loans in Louisiana and may be ineligible

for food stamps under some circumstances. Thus, the law ironically makes it almost impossible for convicted women to find legal ways to support their families, and increases the likelihood that they will have to continue in the illegal economy, despite fear of re-arrest.

Deon Haywood, Director of New Orleans-based Women with a Vision, has mobilized a coalition of civil rights and health activists dedicated to addressing the excessive and inequitable punitive consequences of conviction under the law. The coalition, called NO Justice, conducts speak-outs and educates the public, while also formulating a legal strategy for challenging the law.

In response to the pressure they have generated so far, the Louisiana legislature passed a new law in July 2010 that reduced a first conviction under the “crimes against nature” law from a felony to a misdemeanor, with a penalty of up to six months in jail, a maximum \$500 fine, or both. A second such conviction, however, is still a felony for which sex offender registration is mandatory (along with five years of prison time and/or a \$2,000 fine).

According to Haywood, this new law is virtually meaningless. Hundreds of women are now registered as sex offenders and stigmatized in a way that only reduces their chances of being able to support themselves in any other way.

Fighting for a seat at the table. The third area of activism centers around demanding representation in the process of making the public policy and funding decisions that directly affect one’s constituency. MSM, as a most at-risk population, took a major (if largely symbolic) step forward in 2002, when President Bush appointed Scott Evertz as the first openly gay man to head the White House Office of National AIDS Policy. Jeff Crowley, appointed by President Obama in 2009, is now carrying this opportunity

forward in a more substantive way. Sex workers have achieved nowhere near this level of representation (or even recognition) in the U.S., although they are gaining some ground in other countries.

Elena Reynaga, a renowned sex workers' rights leader in Latin America, described in her fiery plenary speech at the 2008 International AIDS Conference how the Brazilian Network of Prostitutes worked in collaboration with the Brazilian government on a public health and human rights campaign called "No shame, girl, you're a professional!"

The network won the inclusion of "prostitute" on the list of professions recognized by the Brazilian Ministry of Labor, said Reynaga, and "they even took their fight all the way to parliament, where they pushed for a law that would abolish discrimination against sex workers." Her story sheds light on why Brazil was the only country to refuse PEPFAR funding altogether rather than sign the anti-prostitution pledge.

Advocacy efforts elsewhere have also produced results. In 2009, the South African National AIDS Council (SANAC) opted to admit sex workers as a formal sector of SANAC and created an Intersectoral Working Group on Sex Work. The South African National Plan on HIV and AIDS recommends "an audit of criminal laws [against sex work], and their amendment with a view toward ensuring non-discrimination and harm reduction." The SANAC Working Group issued a report in 2009 strongly recommending decriminalization of sex work in South Africa in advance of the 2010 World Cup games. Although this recommendation was not adopted, the South African Law Commission is expected to produce its report on the matter in February 2011.

UNAIDS has made some progress in recognizing the importance of sex worker representation, acknowledging in its most recent *Guidance Note*

on *HIV and Sex Workers* that the UN should "support monitoring and review mechanisms that document and hold officials accountable for implementation of rights-based policies" on sex work. The guidelines also note that "representatives of government, sex workers, civil society, private sector and the United Nations should be mobilized to ensure incorporation of strategies and actions on HIV and sex work into National AIDS Plans."

Yet the new U.S. National HIV/AIDS Strategy contains no mention of sex workers. Neither does the CDC's *HIV Prevention Community Planning Guidance*, the blueprint for organizations receiving CDC funding for HIV prevention programs. The *Guidance* does say that the prevention planning process "should include strategies for obtaining input from key populations (e.g., IDUs, MSM, youth, undocumented immigrants, etc.)" but makes no mention of sex workers in any context. Invisibility strikes again.

CONCLUSION

As noted previously, no national survey estimates are available regarding the number of HIV infections among sex workers in the U.S. But the research that has been done in specific cities is telling.

Among street-based, drug-using women selling sex in Miami, 22.4% were HIV positive in a study published in 2006. In a recent study of male sex workers in Houston, 26% tested HIV positive. And the rates among transgender individuals tend to be even higher: In a 2009 study of male-to-female transgender sex workers in Boston, one third had HIV. The CDC reports that HIV infection rates among transgender populations range from 14% to 69%, with the highest prevalence among male-to-female transgender sex workers.

The lack of public health attention to sex workers in the U.S. is clearly not due to the fact that their HIV rates are too low to warrant it. Rather, the

limited available data strongly suggest that this population is, in fact, fundamentally "like the others" and is just as deserving of the attention and dedicated support of HIV prevention advocates as are MSM and IDU.

As always, the most persuasive case is made by those whose story it is. "People are not aware of sex workers and what they go through . . . or why they are in the work that they're in," observed a sex worker named Patricia, who was interviewed for the Sex Workers Project's 2005 report. "When they were growing up, they didn't say, 'Oh, you want to be a ballerina? I want to be a hooker.' It didn't work that way."

Will Rockwell, a sex worker and youth officer for the global Network of Sex Work Projects, told National Public Radio in 2008 that, "[in] a culture in which sex work is criminalized, this sort of work is invisible, and so is the police harassment, the legal abuse, the client violence" that sex workers face. According to Rockwell, sex workers need "affordable housing and health care, along with a legal framework that takes into account reproductive rights, labor rights, [and] immigrant rights—and considers sex workers human beings."

These are not impossible goals if advocates are willing to make the noise, generate the data, and demand the representation to achieve them.

Anna Forbes is a writer, organizer, and women's health activist who has been working full-time in HIV/AIDS since 1985. She is currently an independent consultant and is learning sex workers' rights advocacy from some inspiring teachers.

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HIV Testing and HIV Health Resources

Knowing your HIV status is the first step toward staying healthy with HIV or remaining negative. As a *BETA* reader, chances are you already know your HIV status—but do your friends and family members know theirs? Not everyone knows they may be at risk for HIV, let alone that they may already have the virus. And not everyone knows where and how to get tested, and what to do if they find out they have HIV.

Please take advantage of these resources—all available in English and Spanish—to help keep yourself and those you care about safe and healthy.

The following hotlines offer information and anonymous counseling about HIV testing, transmission, prevention, and health.

California HIV/AIDS Hotline

www.aids hotline.org
1-800-367-AIDS (Toll-free within California)
1-415-863-AIDS (In San Francisco and outside California)
1-888-225-AIDS (TTY for the hearing impaired)
Hours: Monday through Friday, 9 am to 5 pm PT

GMHC Helpline

www.gmhc.org
1-800-AIDS-NYC (1-800-243-7692)
1-212-807-6655 (International)
Hours: Wednesday, 10 am to 2 pm ET; Friday, 2 pm to 6 pm ET

National AIDS Hotline

1-800-CDC-INFO (1-800-232-4636)
1-888-232-6348 (TTY)
Hours: 24 hours a day, 7 days a week

The National Prevention Information Network, part of the U.S. Centers for Disease Control and Prevention (CDC), can help you or someone close to you find an HIV testing site, and can help answer questions about HIV testing and HIV prevention.

CDC National Prevention Information Network

www.hivtest.org/contact.cfm
1-800-458-5231 (U.S.)
1-404-679-3860 (International)
Hours: Monday through Friday, 9 am to 6 pm ET