

**The Framing of Sex Work and its Impact on Health Outcomes: A Comparative Analysis of
Canada, Australia and Sweden**

MRP FINAL COPY

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ABSTRACT

Canada's prostitution laws have created a legal paradox whereby sex work itself is not illegal, but facilitating acts are. Research has shown that such a criminalization frame has increased risks to both the safety and health of sex workers in Canada. Furthermore, despite having access to a universal healthcare system, sex workers continue to experience worse health outcomes when compared to the general population. The objectives of this major research paper are to explore how framing sex work along the legal spectrum impacts/creates barriers to accessing healthcare and healthcare outcomes, and to provide best practice policy recommendations for Canada. To achieve this, the paper will present a comparative analysis of three case studies: Canada (criminalization); Australia (legalization) and Sweden (neo-abolitionist). The impact of these three varying framing/legal approaches on health outcomes of sex workers was evaluated by completing a literature review on three health indicators: HIV transmission/rates; intravenous drug use (IDU) and post-traumatic stress disorder rates (PTSD). The research within this MRP draws three main conclusions based on the findings. First, how sex work is framed in policy and legislation has an extending impact on accessing health care services due to the fact that related health and social policies, programs and promotions must align with legislation on sex work. Secondly, the Australian state of New South Wales provides the most successful best practices in improving the health outcomes of sex workers. Finally, despite a lack of information and monitoring of sex workers' health in Canada, the case of INSITE Vancouver demonstrates there is significant potential for the Canadian healthcare system to reduce HIV transmission and IDU risks through needle exchange programming.

INTRODUCTION

A recent Ontario Superior Court ruling has placed Canada's prostitution laws in a delicate limbo, which has the potential to bring about significant and historical amendments to Canada's criminal laws. In 2012, the Ontario Superior Court ruled in *Bedford v. Canada* that two of the three provisions that former sex workers Terri-Jean Bedford, Amy Lebovitch and Valerie Scott were contesting were in fact unconstitutional: owning, managing or occupying a common bawdy house (brothel) and living off the avails (profits) of prostitution. The third provision brought before the court, communicating in public for the purpose of prostitution, was not deemed unconstitutional and therefore the activity remains illegal. The Canadian government made the decision to appeal the ruling and *Bedford v. Canada* is expected to go before the Supreme Court of Canada in the summer of 2013 to defend the its prostitution laws as constitutional legislation.

Contrary to Canada's position there are several countries that have taken a decriminalization-regulation approach to their prostitution policies/laws. These alternative approaches vary from full to partial decriminalization and typically involve some degree of regulation; for example, prostitution may be regulated via taxation, licensing requirements, area/city restrictions, inspections and mandatory reporting. In looking at these other countries, what becomes evident is that how these governments frame prostitution and its issues largely determines what laws, policies and regulations are put into place. Furthermore, they will also influence what consequences or benefits prostitutes will experience. As it currently stands, Canada's position criminalizes prostitution, thereby labeling it and its participants as criminal. The case brought before the court by Bedford and her co-plaintiffs raises some of the concerns often highlighted in debates on the Canadian approach, such as concerns over the risks to sex workers' and clients' health and safety when being criminalized. If the Supreme Court agrees that the prostitution laws are unconstitutional, the government would be forced to amend the laws to align with the Supreme Court's ruling since the Supreme Court is the highest, final and binding court on Canadian law. Given that the Canadian government may be facing significant changes in the realm of sex work, the goal of my major research paper is to propose regulatory approaches and best practices which could guide the restructuring of policy; moreover, a new legal/policy approach to sex work in Canada will need to incorporate the rights protected in

Charter, as well as the concerns of the sex worker community (as expressed through the Bedford case).

There are five identified regulatory frameworks for sex work/prostitution in Barnett, Casavant and Nicol's (2011) review of prostitution legislation in various countries: prohibitionism, decriminalization, legalization, abolitionism and neo-abolitionism. Prohibitionism attempts to eliminate prostitution by criminalizing all aspects of it; this approach frames sex work as a violation to human dignity and utilizes law and law enforcement and the predominant tools to reduce prostitution. Decriminalization is an approach that removes all prostitution-related laws. Legalization on the other hand is when a government regulates prostitution or sex work as an occupation, often using some form of legislation to establish controls over who participates and circumstances of the work. Abolitionism contains elements of prohibitionism and legalization; proponents argue that prostitution is immoral but accept that individuals may choose to enter into it nonetheless. They propose that government should allow prostitution, but in places where it does not negatively affect public order or safety (i.e., prohibit public solicitation). Lastly, there is neo-abolitionism. Neo-abolitionism views prostitution as a human rights violation and posits that sex workers do not have free choice in participating in the sex trade. As such, they do not seek the criminalization of prostitutes themselves, but those who procure their services.

The hypothesis that my major research paper put forwards is that how a government frames sex work and prostitution in policy (i.e., an occupation, crime, violence against women, etc.) will affect sex workers' access to healthcare services. If access to health care services is affected, then framing could therefore could create barriers to health services and impact health outcomes of sex workers. In order to determine whether this is the case for the health outcomes of sex workers I will examine Canada's, Australia's and Sweden's policy approaches to sex work and the health of sex workers. The research question I will seek to answer for the conclusion of my MRP is as follows: in comparing the health outcomes of the Australian (decriminalization-regulatory) and Swedish (neo-abolitionism) models, would either of them be a best practice for Canada to pursue? I have selected Australia and Sweden as the comparative studies to Canada mainly because their policy differing approaches and framing of sex work provide a contrast to Canada and one another and therefore allows me to provide somewhat of a spectrum of policy options in criminalizing or regulating sex work. Moreover, different policy

approaches and frames would also allow me explore whether or not different models can yield the same health outcomes. Australia has decriminalized sex work and proceeded to regulate it using a combination of health policy and legislation. Sweden, like Canada, does not criminalize sex work itself but does criminalize certain aspects of it. Sweden has made legislative changes so that frames purchasing sexual services are criminal. In presenting these two opposing models it will be possible to explore what policy options and outcomes Canada might have regarding sex work if the Supreme Court of Canada should come to a ruling that the present laws are unconstitutional and must be amended.

In order to evaluate the health outcomes of sex workers, these countries will be compared across three health indicators: HIV, intravenous drug use (IDU) and post-traumatic stress disorder (PTSD). These three indicators have been selected based on preliminary readings and literature reviews. There is a vast body of research that suggests sex workers are at a higher risk of HIV infection due the high frequency of sexual encounters and also the risks associated with intravenous drug use –also seen at a high prevalence among sex workers. According to the 2012 United Nations World AIDS Day Report, women who are engaged in sex work are 13.5 times more likely to become infected with HIV, and its estimates found that approximately 1 in 4 sex workers in capitals cities are living with HIV (UNAIDS, 2012). In a Canadian study on sex workers' access to HIV treatment in Vancouver, Shannon, Bright, Duddy and Tyndall (2005) found high rates of IDU among their sample and that of the sex workers who have HIV, only 9% were accessing treatment for the infection. Moreover, the National Collaborative Centre for Disease's (2001) report on STI and HIV intervention found that between 2001 and 2006, 62% of HIV infections were obtained through sexual contact and 32% were IDU related. Farley, Cotton, Lynne, Zumbeck, Spiwak, Reyes, Alvarez and Sezgin (2003) conducted a study on PTSD in sex workers, and noted that traumatic events and violence typically precede entrance into prostitution and sex work. Furthermore, experiencing or witnessing sexual violence (from clients, pimps) continues while in the sex industry. Farley et al. (2003) argue that for many women, exposure can then result in PTSD symptoms. There is a knowledge gap regarding the health and well-being of sex workers both in their work and home contexts; however, PTSD is a frequent psychological problem for sex workers and prevalence rates surpass that of the general population (Jackson, Bennett and Sowinski, 2007). In finding these to be some of the more significant health concerns for the sex worker population, and seeing that that they are relevant to

the Canadian context, I selected them to be used as the health indicators and I will be discussing to what extent they are prevalent in the other two case studies.

One of the Canadian policies and commitments that are internationally recognized is to equal access of universal health care. The Canadian health care system is structured in such a way that health services are available via clinics and hospitals without cost so long as the individual presents a provincial health card (indicating their residency status in the province). The system and services provided are funded utilizing public funds from federal taxes. Shifting the cost of the health care from the individual upfront and onto the provincial/federal governments is meant to remove income (and therefore occupational/employment status) as a barrier to health care. It rests upon the value and principle that those who are in the lowest socioeconomic strata are equally entitled to quality health (care) as those who are in the highest socioeconomic levels. This is of particular importance to my evaluation of Canada's policies and approaches in this MRP. Although the Canadian policy has the overarching goal of ensuring access, the issue of health care needs is also relevant. Different groups within the population may have different health needs and risk as compared to the general population (due to their occupation, genetic predispositions, environments, accidents, natural disease occurrence, etc.) which may require special or specific health policy provisions that fall as a responsibility to governments because of the way the system is structured. The research presented on Canada (and the other two case studies) will illustrate that sex workers comprise part of the Canadian population which has different health care needs and risks where access to services is of critical importance but may be prevented by various barriers not associated with their income range.

Methodology

In order to complete my comparative case study and analysis I will conduct a literature review on all three countries, focusing on the historical political/social context of sex work and legislation, HIV policies, intravenous drug statistics and policies and research on post-traumatic stress disorder. Most of the sources that I will be using are government reports, criminal code provisions, non-governmental reports and academic articles. Government reports include those that are general government publications, as well as ones from more specialized government departments and/or agencies (such as departments of justice and health agencies). Reports and publications from case study governments are utilized in order to present the government's

position on sex work and the health indicators in general, and also to provide context by using the official statistics they have collected and published; for example, how many sex workers are known to be living with HIV or to be IDU. I recognize that sourcing government reports on sex work, or any political or legal issue, can present a methodological or argumentative weakness in my research due to the fact that government publications can demonstrate a bias toward representing only the government's position on the issue. For this reason, having additional sources from NGOs and academic articles has been an important part of the literature review because academics and NGOs provide evaluations, criticisms and alternative perspectives on official government policy or reports on sex work and health. Moreover, the literature review has shown that they also are able to conduct research at various levels (local, regional, multi-regional) and with access to populations that the governments does not have or does not pursue.

Limitations to the Research Methodology

While conducting the literature review I encountered some limitations to my research on the case studies –particularly where the health indicators were concerned. My literature review revealed that when the government or government departments/agencies are the predominant collectors of information and statistics related to sex workers and their health status, the scope and type of information available is heavily influenced by what the government considers worthy of monitoring, research or attention; that is, how they frame these health issues in relation to sex workers effects what they focus on, if anything, in their data collection. For example, since the Canadian government holds a strong criminalization frame there is a focus on collecting data on prosecution, arrests and offending sex workers and less focus on the details of their health risks. Furthermore, the lack of focus on sex workers' health meant that my research had to rely on non-governmental sources for information on the health indicators as opposed to the Public Health Agency of Canada, for example. This trend was consistently present across the other two case studies. Australia's occupational focus resulted in more data about the industry and health statistic, whereas Sweden's client focus generated more information about arrests/prosecutions and effects on clients. Additionally, the literature review on PTSD for each case study country did not yield as much research as I expected and made it difficult for me to draw any concrete conclusions about framing and sex workers' health relating to PTSD.

In light of the nature of the limitations, it becomes evident that framing plays a role in what governments will focus on or monitor in their research and statistics where sex work and health are concerned. By extension, this will ultimately affected what can be discussed in research papers on these topics and what sources will be required to capture a more accurate context of the issues.

The organization of the MRP will be as follows: Chapter 1 will present the case study on Canada and its criminalization approach. Furthermore, I will summarize the arguments in the Bedford case as well as the criticisms to Canada's approach. Chapter 2 will then present the Australian case, also outlining the legal and policy framework and what the implications have been for sex workers and their health outcomes. The third chapter will then present the neo-abolitionist model of Sweden, and discuss what the implications of criminalizing clients has on sex workers and their health. The fourth chapter will provide an analysis and recommendation of best practices for Canada before closing with a conclusion. Each chapter will follow a comparable layout as each will provide some political and social context for the development of the current legislation and framing of sex work in the country. Additionally, I will also summarize the criticism of the framing and legislation in the literature, where applicable. The chapters will summarize my research on policies, programs and statistics related to HIV, IDU and PTSD in general, and then also as they relate to sex workers. This contrast will allow me to demonstrate if and where sex workers are treated differently or the same as the general population in relation to the health indicators and where they are given special consideration in public health policy/programs.

CHAPTER 1: CANADA

THE DEBATE ON SEX WORK IN CANADA

The debate on sex work in Canada gained momentum after 1978 when a Supreme Court ruling placed limitations on the police's ability to arrest sex workers for solicitation. The Canadian government appointed a committee in 1980, known as the Fraser Committee, to investigate the social and economic determinants of prostitution. In their report, the Committee recommended that Canada partially decriminalize sex work in order to recognize the distinction between commercial and street-level sex work. The government responded by changing the solicitation law to the law against communicating in public (section 213) in 1985 (Sex Trade Advocacy and Research, 2006). The most recent committee appointed to explore the issues surrounding the Canadian sex trade was the House of Commons Subcommittee on Solicitation Laws from 2003-2006. This was the fourth inquiry established on sex work since 1980 and despite directly acknowledging and documenting the negative impacts and increased risk the current laws have created for sex workers, who are engaging in a *legal* activity, the inquiry's recommendations was criticized for lacking leadership (Jeffrey, 2009). The criticism stemmed from the hypocrisy of prostitution being legal and a lack of initiative to take responsibility for or initiative to correct the subsequent harms and risks to health and safety created by the legislation (Jeffrey, 2009). Since then government has been seen to persistently endorse its framing of sex work, positing that if women were deterred from prostitution, it will end. It would appear then, that making sex work riskier for health and safety is a means of deterring women from participating in it.

Most recently, the Ontario courts have heard one of the most successful and high profile constitutional challenges to the prostitution laws, *Bedford v. Canada* (2012). This case was brought against the government by three women who have worked as sex workers; the three plaintiffs argued that three of the prostitution provisions (bawdy house, avails and communicating) violated their constitutional rights to freedom of expression and life, liberty and security of the person. Originally, the Ontario Superior Court ruled in favour of Bedford in 2010, stating that the three laws were unconstitutional because they were too broad, jeopardized the safety and security of sex workers and violated principles of fundamental justice. The case moved onto the Ontario Court of Appeal where judges ruled unanimously that the provisions on

common bawdy houses (section 210) and living off the avails of prostitution (section 211) violated principles of fundamental justice, therefore striking them down (Pacey & Sigurdson, 2012). The judges concluded that the bawdy house law violated principles of fundamental justice because it does not fulfill the purpose of the legislation; the provision was originally intended to safeguard neighbourhoods, public health and safety. However, as it stands, it is overbroad and prevents prostitutes from working within their premises. The judges reasoned that sex workers would have more control in their premises, making it the safest place to sell sex and therefore meeting the objective of the provision (Canada (Attorney General) v. Bedford, 2012 ONCA 186). Similarly, the provision on avails violated principles of fundamental justice because it too missed the objective of the law. This provision was intended to prevent exploitation via pimping, but it also is too broad because it could be mistakenly applied to non-exploitative commercial relations with landlords, family and friends (Canada (Attorney General) v. Bedford, 2012 ONCA 186). The Court upheld the law prohibiting communicating in public, but only with a three-judge majority; their decision stated that despite negative effects to the safety of sex workers, the purpose of diminishing public nuisance outweighed the negative effects (Pacey & Sigurdson, 2012). The case will go before the Supreme Court of Canada in the summer of 2013.

According to the House of Commons Subcommittee on Solicitation's final report (2006), the Canadian government's position on the debate is characterized by a belief that sex work victimizes women and exploits their bodies, is harmful to society and coercive. The government also questions whether consent is ever genuinely given out of volition or out of necessity. Moreover, the government does not believe that it is possible to create conditions where consensual exchange of sexual services for money can occur without harming others (Subcommittee on Solicitation Laws, 2006); however, the following section of the chapter, which discusses the impact of the current legislation, will show that the government's laws are also liable in preventing a safe environment for sexual transactions. Despite the fact that the government concurs that the status quo regarding enforcement of the laws is "unacceptable", it sees decriminalization as "voluntarily degrading" society (Subcommittee on Solicitation, p.90-91, 2006). The report's summary of the government's position shows that sex workers are perceived as victims who lack agency, autonomy or free will that should be protected through deterrence. However, for the government to suggest that a lack of agency or autonomy should or will deter women from sex work and motivate them to leave is an oversimplification of their

circumstances (addiction, poverty, violence, arrests) and also works to avoid the government's responsibility to minimize the harm the laws place on sex workers engaging in a legal occupation. Nonetheless, from this stated position, it becomes evident how this framing of prostitution has come to influence the laws. Women are seen as victims of exploitation and must be protected, therefore the government avoids directly criminalizing prostitution as it would be equivalent to criminalizing the victim. The government does not believe that consensual sexual transactions can occur without degrading society, and therefore the conditions that facilitate sex work are criminalized. The following section will discuss the laws in greater detail, as well as their observed consequences.

SEX WORK IN CANADA: THE LAWS AND THEIR CONSEQUENCES

In Canada, sex work exists in both indoor commercial markets and in an outdoor "street" market. Indoor commercial sex work often refers to escort agencies, massage parlours and in-call (where the clients come to the establishment) and out-call (where the sex worker comes to the client) services. Statistically, 80% of women in the sex trade work in the commercial market; whereas street-level prostitution is estimated to account for 5-20% of the sex trade (Indoor article, Subcommittee on Solicitation Laws, 2006). It should be noted that escort agencies and massage parlours are legal in Canada and not considered brothels as long as they do not advertise for or publicly communicate/arrange sexual services; these establishments are regulated by both municipal by-laws and provincial laws (Lewis & Maticka-Tyndale, 2000). In fact, all sex work and services are legal in Canada, and therein lies the Canadian prostitution paradox: Canada's prostitution laws have often been criticized for being unconstitutional and responsible for creating a bizarre legal/policy contradiction that only further endangers the lives of sex workers. The paradox stems from the way in which Canada applies the criminalization model: prostitution itself is not illegal, but in an effort to deter people from engaging in sex work (especially street-level sex work), several acts associated with prostitution are illegal.

Within the Canadian Criminal Code, sections 210 to 213 outline the acts related to prostitution that are illegal (Minister of Justice, 2012): **Section 210** states that it is illegal to keep a common bawdy house (brothel), meaning that it is illegal for one to work in or be found in a common bawdy house or knowingly allow someone to use a place as a common bawdy house. Subsequently, **section 211** of the Code makes it illegal to transport or direct someone to a

common bawdy house. **Section 212** states that it is illegal to procure (coerce) for the purpose of prostitution or live off the avails (profits) of prostitution. And lastly, **Section 213** makes it illegal to communicate in public for the purpose of prostitution; that is the negotiation of price, location, services, conditions, or stopping cars in public areas.

Although prostitution itself is legal, it is clear then that the social and environmental settings, which can facilitate sex work, are illegal, thereby making it difficult or near impossible for sex workers to carry out their work in a manner that allows them to protect their safety, health and agency in the first place (Pacey & Sigurdson, 2012, Shannon, Kerr, Allinot, Chettiar, Shoveller & Tyndall, 2008). Originally, the laws on prostitution were intended to address the public nuisance associated with sex work and have since been reframed as a means to deter people from engaging in sex work and decrease the incentive to do so. The reality of their consequences has been very different and has fueled the debate on the constitutionality of these laws and the rights of sex workers.

Research on sex work in Canada reveals that there is an unequal enforcement of the laws in two respects. First, a vast majority of charges laid are for street sex work (over 80%), while commercial sex work is often not pursued by police for enforcement (Lewis & Maticka-Tyndale, 2000). Second, women are disproportionately represented in the charges in comparison to their male clients (Canadian HIV/AIDS Legal Network, 2005). Over a 30-year span, Statistics Canada found that sex workers receive harsher penalties than their clients when convicted under section 213 (Canadian HIV/AIDS Legal Network, 2005). When compared to their male clients, women receive prison sentences more often, with longer sentences; they do not receive probation as often but when they do the length of probation is twice as long; and women are not offered prison sentence alternatives, such as diversion programs that use education or probation-style requirements, as often (Canadian HIV/AIDS Legal Network, 2005). Since 1985, when the law which prohibits communicating for the purpose of prostitution was added to the Code, more than 90% of the charges for incidents related to sex work have been under the communication provision (section 213) (Canadian HIV/AIDS Legal Network, 2005, Subcommittee on Solicitation Laws, 2006). Statistics from 2003-04 further illustrate the gender disparity in the criminalization of sex work: 68% of women charged were found guilty of violating section 213, whereas 70% of charges against men were stayed (ceased) or withdrawn for the same provision (Subcommittee on the Solicitation Laws, 2006). Of those who were sentenced to prison for

violating the communication law, 92% of those were female (Subcommittee on Solicitation Laws, 2006). The high rate of charges under section 213 is likely due to the fact that in comparison to the other acts, communicating for the purpose of prostitution in public is much more visible and easily identifiable by police and complainants (Jeffrey,2009), as well as easier and faster to set-up in an undercover operation as is common police practice (Duchesne, 1997).

The consequences and implications of the laws for sex workers are not confined to arrest or sentencing rates and have extended into issues of safety, health and the rights of sex workers. The bawdy house laws prevent sex workers from working in safe indoor locations because virtually any place where services are communicated or sex work regularly occurs can be labeled a bawdy house (Subcommittee on Solicitation Laws, 2006, others, Canadian HIV/AIDS Legal Network, 2005). Whereas the law on living off the avails has been criticized for being overbroad because it includes people in sex workers' personal and professional lives, such as dependents, roommates, and family and friends (Subcommittee on Solicitation Laws, 2006). The law prevents sex workers from hiring personnel to improve security and can be a barrier for housing and services if their occupation is known (Pacey & Sigurdson, 2012). Scholars, advocates and sex workers have argued that the communication provision has the most negative and dangerous impact as it removes sex workers from a position of agency and control over their transactions, and places them in a weakened bargaining position to negotiate services, prices, location and screen clients hastily (Subcommittee on Solicitation Laws, 2006, Shannon et al., 2008). Furthermore, it has forced sex workers to operate in more isolated areas, increasing both opportunity and rates for violence (Sex Trade Advocacy and Research, 2006, Jeffrey, 2009). Combined, these laws create a setting where sex workers are at increased risk of exploitation, abuse, violence, and poor health outcomes. The social stigma of sex work is reinforced and pushes workers into dangerous areas to avoid police harassment (Canadian HIV/AIDS Legal Network, 2005), and in treating sex work as if it were illegal, it becomes part of actual illegal markets such as drugs (Canadian HIV/AIDS Legal Network, 2005, Subcommittee on Solicitation Laws, 2006). As mentioned in the previous section, detailing the Canadian debate on sex work, the framing of prostitution as both violence against women and degrading to society has influenced the laws that the Canadian government created to address prostitution.

These findings in the literature review discuss the consequences these laws (and therefore the frame) have for sex workers. Moreover, in my opinion these findings establish a trend of

negative or detrimental impacts on these women. I would like to draw attention to these findings for two reasons. First, they present a contradiction in the framing of the issue because the government argues that these women are victims in sex work who require protection, and yet the research demonstrates that they are further isolated. Secondly, if a trend of negative consequences in the lives of sex workers is already identifiable, it is reasonable to expect the same for their health outcomes because the laws are seen to push these women away from resources and safe environments. At this point in the chapter I have discussed the framing of prostitution that underpins the laws regarding sex work in Canada. In the next half I will focus on the health indicators to examine what (if any) impact the laws have had on access to healthcare and health outcomes.

BARRIERS TO HEALTHCARE ACCESS AND HEALTH OUTCOMES: HIV, SUBSTANCE ABUSE AND PTSD

As the focus of the debate in Canada is shifting, so too is the focus of the research on sex work. The health outcomes of sex workers has increasingly become a focus in research on the sex trade and public health because of the connection between the risks of sex work, health and access to healthcare. Empirical studies are consistently demonstrating that not only do sex workers experience awful health outcomes, but criminalization of sex work moves sex workers into isolated settings away from health and social support (Shannon et al., 2008) –therefore exacerbating the problem. Despite living in a country that offers a universal healthcare system, sex workers in Canada still experience barriers to accessing healthcare services. Some of the most commonly identified barriers to healthcare for sex workers in Canada are concerns for privacy and disclosure, “restrictive office hours at health facilities, lack of women-specific services and limited means of transportation to service locations” (Lazarus et al., p.146-7, 2012).

The literature also supports occupational and social stigma as being one of the most significant social and structural barriers for accessing health services in Canada, which has been created by how we criminalize sex work (Shannon et al., 2008, 2005, Canadian HIV/AIDS Legal Network, 2005,). In their work on occupational stigma, Lazarus, Deering, Gibson, Tyndall and Shannon (2012) demonstrate the impact of social stigma on sex workers’ access to healthcare within the Canadian context. The results of their study of street-based sex workers revealed a high incidence of occupational stigma, and nearly half of the sex workers reported it as an

immediate barrier to accessing healthcare (Lazarus et al., 2012). Women hide their status as sex workers due to the associated stigma they feel; even when contact with health professionals occurs frequently, sex workers still will not disclose their status due to fear of arrest, negative past experiences and embarrassment (Lazarus et al., 2012). Women's healthcare needs are then compounded by stigma as not only a barrier to seeking services, but also to full occupational disclosure; consequentially, health professionals remain unaware of all the women's healthcare needs and risks and cannot provide complete care (Lazarus et al. 2012). Some of the most significant health concerns and risks that sex workers in Canada, and around the world, face is HIV infection, substance abuse and post-traumatic stress disorder. What follows is an overview of these selected health indicators in the Canadian context.

According to the report submitted on behalf of the Canadian government to the United Nations General Assembly Special Session on HIV/AIDS, Canada does not collect indicators on HIV and sex workers at the national level (Public Health Agency of Canada, 2012). As a result, Canada does not have national-level data on the percentage of sex workers who are living with HIV, what percentage of sex workers are reached by prevention programmes or how many have had an HIV test and are aware of their status (Public Health Agency of Canada, 2012). As a result, my ability to discuss national averages for HIV infection in sex workers is limited; however, in order to provide some context I will use Vancouver as an example instead. Studies on sex workers in Vancouver report an HIV infection rate ranging between 23-26%, with the overall prevalence in Vancouver being approximately 1.21% (six times the national average) (Shannon, Bright, Duddy & Tyndall, 2005, Fayerman, 2009). Due to a lack of national and provincial statistics on sex workers it is difficult to determine whether Vancouver's high rate is an anomaly, but what is apparent is that sex workers in Canada can have an HIV rate of up to 6 times the national average. According to statistics published by the Public Health Agency of Canada, the number of people with HIV in Canada in 2011 rose to 71,300, approximately 0.21% of population (Public Health Agency of Canada, 2012). When specifically looking at the female population, the Public Health Agency of Canada (2012) reported that the main routes of transmission are drug use and heterosexual sex; a study published on sex workers in Vancouver found these two to be the same routes of transmission in their sex worker subpopulation (Fayerman, 2009). Furthermore, the highest rates of infection were in Ontario, followed by Quebec and British Columbia (Public Health Agency of Canada, 2012).

The prevalence of HIV infection among female sex workers in Canada is an increasing trend and therefore also an emerging public health concern (Fayerman, 2009). The literature on Canadian sex workers and HIV reveals that HIV transmission is a public health concern for two reasons (in addition to the primary reason that it is a detriment to the well-being and lifespan of sex workers): 1) the relationship with substance abuse and the high risk of transmission from and to clients, and 2) the barriers to receiving HIV treatment and healthcare. During its investigation on the solicitation laws, the Subcommittee on Solicitations Laws (2006) heard testimony from witnesses who are in or somehow interact with sex workers in their occupation (health professionals, police) describe the relationship between sex work and drug use as intertwined. Sex workers who are most at risk for HIV infection are those who engage in intravenous drug use (IDU), have a history of IDU or have high-risk sexual partners in their personal lives (National Collaborating Center for Infectious Disease, 2010, Public Health Agency of Canada, 2010). When interviewing sex workers at a Vancouver drop-in Shannon, Bright, Duddy, and Tyndall (2005) found that 57% of sex workers reported IDU, 97% used non-injection drugs, 85% of the women were polysubstance users and 13% reported sharing drugs injectable drugs with clients; in particular they identified a high rate of daily crack cocaine use (80%) among the women. In a report on HIV in Canadian women, the Public Health Agency of Canada (2010) also found a high correlation between crack cocaine use and sex work. Further corroborative research on the use of drugs among Canadian sex workers was found by Spittal, Bruneau, Craib, Miller, Lamothe, Weber, Lee, Tyndall, O'Shaughnessy and Schechter (2003) who studied women in Montreal and Vancouver and found that 56% of their sample were IDUs, while 90% were active crack cocaine smokers. Spittal et al. (2003) study also found support for the association between IDU and high risk of HIV transmission in female sex workers, as have findings published by the Public Health Agency of Canada. As an example of innovative harm reduction strategies, which targets both HIV and IDU, we can look to Canada's one and only needle exchange program, INSITE in Vancouver, British Columbia. Since illicit drug use or supplying paraphernalia is illegal in Canada, INSITE and the Vancouver Coastal Health Authority had to receive a three exemption from the *Controlled Drugs and Substances Act* before the program could commence (Fafard, 2012); IDU and HIV transmission became a significant health and political issue for British Columbia in the 1990s, and an innovative and drastic measure was deemed necessary. When the Conservative government stated it would only briefly

renew the exemption, INSITE's operation was threatened and a constitutional challenge was taken all the way to the Supreme Court; where the Supreme Court would rule in favour of the site remaining open (Fafard, 2012). The latest research on INSITE demonstrates that HIV infection rates, IDU and needle sharing have all declined due to the support and services offered in the program. This research will be further discussed in the Chapter 4 under Best Practices.

Canadian studies on HIV transmission between clients and sex workers often identify stigma and the section 213 law prohibiting public communication as the aggravating environmental and institutional factors that increase this risk for sex workers. As a result of the displacement and isolated working conditions sex workers are forced into because of section 213 and the fear of arrest, the ability of sex workers to bargain, negotiate and control their work has diminished (Subcommittee on Solicitation Laws ,2006); subsequently, this prevents sex workers from better appraising their clients and establishing safe sex and health conditions for the transaction. Sex workers interviewed by Shannon et al. (2008) reported that the current laws function as a direct structural barrier to preventing HIV because of the reduced level of control and negotiation capabilities; these findings offer empirical support to the testimony heard by the Subcommittee on Solicitation Laws in 2006. Moreover, women will be paid more by clients if they agree not to use condoms (Fayerman, 2009). Despite these enlightening findings on the context of client-sex worker HIV risks, my literature review has shown that overall, Canada is lacking a sufficient quantity of research and literature into to dynamics and structural and institutional factors that increase HIV transmission risk when sex workers engage with clients.

Similarly, there is a lack of research on the experience of post-traumatic stress disorder (PTSD) in sex workers in Canada. Although there are various articles (news citation) and reports from advocacy groups which discuss stress and PTSD experience by sex workers, the academic and empirical literature is scarce. Of the one study that I did find included Canada is an study of sex workers in nine countries. Farley, Cotton, Lynne, Zumbeck, Spiwak, Reyes, Alvarez and Sezgin (2003) examined samples of sex workers and their responses to questionnaires in order to determine how many of them were suffering from or met the criterion for PTSD. The average across all nine countries was 68%, with 74% of sex workers in Canada meeting the criteria (Farley et al. 2003). From the limitation I encountered in conducting research on PTSD in sex workers in Canada it is evident that Canada-focused research has significant potential to develop.

In this chapter I have presented the recent and historical context for how Canada frames prostitution in its criminalization approach. I have also detailed the laws that function as a representation of the Canadian frame and the consequences they have for sex workers. In order to understand the impact these two elements might be having on health outcomes, I provided a summary of research on HIV, IDU and PTSD in sex workers. In my discussion of the literature on HIV in Canada's sex workers I was able to identify that transmission of the infection to and from the sex worker population is a concern; however, there is a lack of national strategy to address the needs of and risks to sex workers, even as they are identified as an at-risk group. Furthermore, in discussing the IDU among sex workers I have demonstrated that IDU is a significant concern (particularly among street workers) and is a risk factor for HIV transmission in sex workers; thereby linking the health outcomes in HIV and IDU for sex workers in Canada. Lastly, my literature review on PTSD has found that in one study focusing on Canada, a high proportion of women experience PTSD. I have sought to draw out the policy considerations for the best practice recommendations to be discussed in Chapter 4. The next chapter will focus on Australia's regulatory system and the impact it has on the health outcomes of sex workers there.

CHAPTER 2: AUSTRALIA

THE STATUS OF SEX WORK IN AUSTRALIA

Australia's earliest prostitution laws were predominately influenced by the English abolitionist system at the turn of the 20th century; the focus of this approach being the eradication of undesirable activities associated with sex work, e.g., organizing and receiving direct financial profit from sex work (Banach and Metzenrath, 2000). Changes to prostitution and sex work legislation over the last 30 years have been motivated by a desire to control the perceived impact of sex work on the wider community, as well as to mitigate offensive stereotypes of the work (Banach and Metzenrath, 2000). More specifically, the Australian government and communities became concerned over public morality, organized crime, illegal drugs, protecting minors, local planning issues, public health (particularly in regards to STIs) and violence towards women who work in the sex industry (Banach and Metzenrath, 2000).

In present day Australia, prostitution (street sex work) and sex work is regulated through criminal laws, which fall under the jurisdiction of each state and territory. Although each state and territory supports some degree of decriminalization of sex work (Jeffrey, Matthews and Thomas, 2010), some variation across the country does exist. According to a New South Wales (NSW) Parliamentary Briefing Paper (Smith, 2003) prostitution is illegal in Southern Australia and Tasmania; in the Northern Territories, brothels are legal but prostitution is not; Victoria, Queensland and Western Australia have implemented regulatory systems which require town planning permission and licensing for brothels; in NSW, brothels only need town planning permission to establish their businesses.

For this chapter on Australia, I have chosen to specifically focus on information and regulations within the state of New South Wales, Australia. The main reason for this decision is that the regulatory framework in NSW has been internationally praised as the most successful best practice model for decriminalizing sex work. Moreover, the model in NSW provides a better contrast to the Canadian and Swedish systems. It should be noted that the Australian Capital Territory (ACT) has some of the most liberal laws in Australia as well, however due to its small geographical scale (the only city there being the capital, Canberra) and that it is part of NSW, NSW seemed like a more appropriate comparison.

SEX WORK IN NEW SOUTH WALES

NSW's process of establishing the most liberal sex industry laws in Australia began in 1979 when the Labor government decriminalized sex work and street solicitation (Banach and Metzenrath, 1999, Better Regulation Office, 2012, Donovan, Harcourt, Egger, Smith, Schneider, Kaldor, Chen, Farley and Tabrigi 2012, Sullivan, 1990). However, soon afterwards, in 1983, there was an increase in public concern over the visibility of street prostitution in residential areas; consequentially, the government made amendments to the law in 1988 which made it illegal to solicit sexual services near a church, dwelling, school or hospital (Banach and Metzenrath, 1999, Donovan et al., 2012, Sullivan, 1990).

Further changes to laws came in 1995 after a Royal Commission completed an inquiry into the NSW Police Force (Smith, 2003). In 1995, The *Disorderly Houses Amendment Act (DHAA) 1995* was passed and amendments were made to the *Summary Offences Act 1988 (SOA)*: it became legal to own/operate brothels, to work in a brothel or privately at home, and to live off the earnings of sex work- street solicitation remained illegal, as did living off the earnings of street prostitution according to the SOA 1988 (Smith, 2003, Donovan et al., 2012). Similarly to Canada, NSW faced an issue with the provisions regarding living off the avails of prostitution. Prior to the DHAA 1995, living off the avails was illegal; although it was generally understood that this provision was intended to address pimps of street sex workers, the SOA 1988 was nonetheless clarified that owners/operators of brothels were exempt from this provision under the new law (Donovan et al., 2012). However, the issues of misapplying the law to family, friends, dependents and landlords of sex workers has remained unclear in the law and persists as a concern for NSW sex workers (Donovan et al., 2012). Additional amendments were made in the late 1990s to include roads as illegal public places for solicitation and laws targeting "kerb crawlers" (clients who drive slowly down a road to try to discretely solicit sexual services on the street) (Smith, 2003).

In order for brothels to legally operate, they must receive local council planning permission; as mentioned earlier in this section, the sale of sexual services cannot occur near a dwelling, church, hospital or school. As such, the local council must approve of a brothel's location. With local councils becoming the authority that determines where brothels operate, the police have been removed as the monitoring authorities so that issues of police corruption and discrimination could be addressed (Smith, 2003). The DHAA 1995 provides local councils and

individuals with two mechanisms with which to close illegal brothels through the *Environmental Planning and Assessment Act 1979* (Donovan et al., 2012). According to NSW laws, local councils can file an application with the Land and Environment Court to close an illegal brothel, but in order to file the application for consideration two criteria must first be met (Briefing Paper 2003). According the NSW Briefing Paper (Smith, 2003) the local council must receive sufficient complaints from residents of or occupiers of areas or premises near the brothel, and the reason stated for the closure must be one of the reasons outlined in the Act (see Annex 1).

From my literature review I have been able to identify two overarching reasons for the amendments to the laws on sex work and prostitution, which can be broadly categorized as protecting society and mitigating negative consequences of illegal sex work. A NSW Government Issues Paper discussing the regulation of brothels (Better Regulation Office, 2012) identifies protecting residential amenity, safeguarding public health and protecting sex workers as objectives of the new regulatory system; however, there were also concerns over police corruption, organized crime, discrimination, autonomy of sex workers and difficulties in executing health and welfare outreach plans in an industry that was illegal (Egger and Harcourt, 1991). Despite fears of what consequence would transpire from decriminalization, the prevalence of commercial sex has not increased in the state (Donovan et al., 2012). As a result of decriminalization, the local authorities which are now part of sex industry regulation in NSW are local councils, the NSW Ministry of Health, Work Cover NSW (the NSW health and safety authority) and, to a lesser extent, the police (Better Regulation Office, 2012). The Better Regulation Office (2012) published statistics on the NSW industry indicating that there are approximately 10,000 sex workers in NSW; 60% of whom work in the commercial sex business and the remainder working on the streets or privately (at home). Since the new laws have been in place, the majority of charges that go before the courts have been for street solicitation; one-third of those prosecuted are male clients (Donovan et al., 2012). Interestingly, Donovan et al., (2012) also point out that there has been a 95% decline in the number of street solicitation charges since the 1970s- 4,288 in 1972 down to only 53 in 2006.

NSW has chosen to address concerns for the negative byproducts of sex work (illegal criminal organizations, police corruption, public health) and the public concern over visibility/location through legislation that identifies where brothels can operate, criteria to be satisfied, means by which to close them and the approving authority for their establishment.

These various components of NSW's regulatory system suggest that sex work is framed as an occupation or form of employment that ought to be regulated and standardized, as a business would be. In the following section I will not only be discussing the impact NSW's regulatory approach has on access to health services and outcomes for sex workers, but I also intend to show that this approach has created occupational health and safety standards through HIV prevention and IDU harm reduction.

HIV HEALTH IN AUSTRALIA AND NSW SEX WORKERS

Overall, the prevalence of HIV among female sex workers in Australia is very low (Government of Australia, 2012). At the national level, 25, 166 people were estimated to be living with HIV and 30, 486 HIV infection cases diagnosed in Australia at the end of 2010, for an overall prevalence of 0.1 percent (Government of Australia, 2012). The 2012 Global AIDS Country Report submitted by the Australian government provided sex worker-specific data which showed that 99% of sex workers reported using condoms with their most recent client; 59.6% had an HIV test and knew their status within the last 12 months and that 0.04% of sex workers were living with HIV- lower than the national rate (Government of Australia, 2012).

Despite a low prevalence of HIV, sex workers have been considered a risk population for several decades due to the high number of sexual encounters in their occupation. During the 1980s a number of initiatives were implemented in order to improve public and sex workers' health, and since then the health of sex workers has and continues to improve (Donovan et al., 2012). These initiatives focused on health promotion by providing education, advocacy and support through community-based organizations; improving sexual health services by allowing STIs tests from private doctors to be rebated through Medicare; changing sexual behavior to increase condom use with clients and decrease STIs through HIV prevention programs and recognizing reproductive nursing as a specialty in order to increase the number of nurses who specialists in sexual and reproductive health matters. (Donovan et al., 2012). Moreover in professionalizing reproductive nursing, these specialists have become consultants and advocates for sex workers in their client population and also a resource for health authorities on the health of sex workers.

In addition to this shift in public health, Australia also implemented a National HIV Strategy, the Sixth National Strategy was approved for 2010-13. The HIV Strategy is one of five

developed by the government to address the risk of blood borne viruses (BBVs) and sexually transmissible infections, the other strategies include: the National Hepatitis Strategy; the Second National Sexually Transmissible Infections Strategy; the Third National Hepatitis C Strategy and the Third National Aboriginal and Torres Strait Island Blood Borne Virus and Sexually Transmissible Infections Strategy (Department of Health and Ageing, 2010). The Sixth National HIV Strategy published in 2010 outlines the goals of the strategy as being to 1) sustain low rates among priority groups, 2) continue investment in and monitoring of prevention programs for these groups, and 3) monitor research in order to inform policy and program development of innovation prevention technology (Department of Health and Ageing, 2010). The main vehicles through which these objectives are achieved are peer education, outreach and innovative healthcare access through community-based development with sex workers' organizations and all-level government coordination (Department of Health and Ageing, 2010, Government of Australia, 2012). Australia's successful approach has been globally acknowledged and is due to the fact the government and healthcare professionals realized early on that they would not only need to engage HIV-affected communities and groups but also that a response would require complex education and the help of sex workers organizations to address occupational health and safety concerns (Department of Health and Ageing, 2010 Government of Australia, 2012, Jeffrey, 2009).

The NSW government also implemented measures to protect the health of sex workers and the public, however it comes in the form of legislation as opposed to a policy or strategy. In using legislation for health, the government has created legal incentives for clients, sex workers and brothel operators to be consistent with and promote safe sexual behaviour. The *Public Health Act 1991* outlines what sex workers and clients are legally obligated to disclose regarding STIs status. If an individual has a STI which the laboratory is legally required to report to the Director-General of the Ministry of Health (i.e., a scheduled STI such as HIV, syphilis, hepatitis, Chlamydia, gonorrhoea), they must disclose the risk of contraction before sex and the partner must then voluntarily accept this risk (Sex Workers Outreach Program, n.d., New South Wales Government, 2010). A sex worker cannot use the client or partner's lack of inquiring on their status as a defence if they are charged. Owners/operators of brothels also have a legal obligation to prevent sexual services from being provided if they are aware that a sex worker or client a) has an STI and b) does not disclose/acquire informed consent. Sex workers are only required to

reveal their HIV status specifically if sexual intercourse is part of the services they provide. Under the NSW Crimes Act, an individual who intentionally infects or attempts to infect another may be sentenced to 25 years in prison; reckless behaviour (e.g., not using a condom when infected) where the partner does not contract HIV can receive up to 10 years in prison; suspecting one has HIV and not being tested is considered negligent transmission and can receive up to two years imprisonment (Sex Workers Outreach Program, n.d.). The *Public Health Act 1991* also includes provisions for “certificates of attendance”, which are certificates sex workers receive when they attend sexual health services and checkups and can be requested by employers (Sex Workers Outreach Program, n.d.); the certificates simply include the date that the worker visited the clinic and which, but does not reveal any testing results. Lastly, there are public health orders which can be issued by physicians if discussing safe sex practices does not alter a sex worker’s or client’s risky sexual behaviour. Interventions under the orders can range from counseling to detention; orders have been issued to sex workers and clients in a small number of instances (Sex Workers Outreach Program, n.d.).

In NSW, the STI rates among sex workers are comparable to that of females in the general population. In their UN Global AIDS Country Report, Australia includes studies that found a 0.0037% (two individuals) prevalence of HIV infection among 5,413 self-reported sex workers who accessed services at a sexual health clinic in Sydney (Government of Australia, 2012). Moreover, a study commissioned by the NSW Ministry of Health, carried out by the Law and Sex Worker Team (LASH) generated some information about Sydney, Perth and Melbourne (Better Regulation Office, 2012, Donovan et al., 2012). The study completed by Donovan et al., (2012, also known as LASH) found that condom use was reported at 99% with 83% of the sample reporting regular health status checks, and more than half (65.6%) getting checked at least every six months. This combined with the reported 99% condom-usage in the national Global AIDS Report, the fact that the same laws and healthcare access policies are consistent across NSW, and that there are sexual health clinics and community organizations across the state allows me to make some broad generalizations. It does not necessarily permit me to claim these studies as a perfect representation of NSW, but it gives us a good sense of where the HIV prevalence rate likely lies and the sexual health practices among sex workers in NSW; that is, that NSW sex workers have low rates of HIV and utilize safe sexual health practices.

Donovan et al. (2012) found that NSW was the healthiest and best place for sex workers to work when compared to Perth and Melbourne. However, even in what appears to be a superior regulatory framework, sex workers still face and fear discrimination and stigma where HIV is concerned. Donovan et al. (2012) also found that even when working in a decriminalized industry that recognizes their occupational health and safety, sex workers remain hesitant to share their occupation with family and friends because of the associated stigma of their occupation. Similarly, Jeffreys, Matthews and Thomas (2010) found in their research that the “criminalization” of HIV left sex workers feeling stigmatized and discriminated; they feared exposure and that authorities would assume criminality if they knew their HIV status. Scarlet Alliance, an advocacy NGO for sex workers, completed a 12-month consultation with HIV positive workers to assess their health needs (Matthews, 2008). Matthews (2008) also found that the HIV positive workers in his sample felt highly stigmatized even in an accepting environment; participants were also apprehensive to reveal their dual status (HIV, sex worker) and felt stigma still existed in peer organizations. Among these sex workers, there was also a trend to not trust healthcare services (Matthews, 2008). Both Jeffreys, Matthews and Thomas (2010) and Matthews (2008) found that sex workers are frustrated with the weight of responsibility HIV criminalization places on them –in addition to the stigma and discrimination they endure –and both of their samples vocalized a desire to see responsibility for HIV transmission prevention to be more equalized between clients, workers, HIV positive and negative individuals.

INTRAVENOUS DRUG USE AND POST-TRAUMATIC STRESS DISORDER IN NSW SEX WORKERS

The amount of research on intravenous drug users among the sex worker population in NSW is not as extensive as that on HIV, even though needle and syringe programs and harm reduction form an important part of the National HIV Strategy. Sex workers are perceived to be at a higher risk for IDU and substance abuse in general, however, evidence from studies in Australia show that the risk is predominantly among street sex workers and not brothel workers.

In Australia, approximately 7% to 17% of brothel/escort workers reported ever using drugs in one study, and the rates were significantly higher among street sex workers –more than 85% (Donovan et al., 2012). Much like research discussed in the previous chapter on Canada, sex workers are seen as an at-risk population for riskier sexual behaviour or having partners who

are drug users. More specifically, in Australian studies cocaine use has been seen to be associated with an increased risk of risky sexual behaviour and BBVs amongst IDUs (Roxburgh, Degenhardt, Larance, and Copeland, 2005); for that reason, providing safe injection supplies has become part of NSW health services (Donovan et al., 2012). When Donovan et al. (2012) interviewed a sample of workers in Sydney, they found that only 2% had injected drugs in the previous 12 months. In 2005, a study comparing IDUs who were sex workers and non-sex workers also found that street workers were significantly higher IDUs (77%) versus those working in commercial settings (7%) (Roxburgh, Degenhardt and Breen, 2005). Specifically, all except for one sex worker reported heroin as the preferred drug; moreover, a large proportion of sex workers were more likely than non-sex workers to borrow and lend used needles. In their analysis, the authors found that the drug patterns between sex workers and non-sex workers who were IDUs were actually not that different at all (Roxburgh, Degenhardt and Breen, 2005). In a separate study, Roxburgh, Degenhardt, Larance and Copeland (2005) had their research into mental health and drug use among sex workers in Sydney funded by the Australian Department of Health and Ageing. In this sample, the authors found 94% of the sample had ever injected drugs and that there was heavy usage of heroin, cocaine marijuana (one-third of the sample for the latter two). A small proportion of the sample (one-fifth) reported lending out a used needle, however a larger number (two-thirds) reported sharing other injection paraphernalia within the last month (Roxburgh, Degenhardt, Larance and Copeland, 2005). The authors also discovered that within the group which was more likely to sharing injection materials, those who were cocaine dependent were more likely to do so and also less likely to practice safe sex behaviours (i.e., use condoms) during intercourse with clients- thereby establishing a correlating link at least between cocaine users and high risk IDU and sex behaviour. Lastly, two thirds of participants were in drug treatment at the time of the study (Roxburgh, Degenhardt, Larance and Copeland, 2005).

The information on PTSD and sex workers in NSW, although does offer some insight, is also not extensive and arguably more scarce than that on IDUs. The report commissioned by the NSW Ministry of Health found that 10% of sex workers in brothels exhibited psychological distress, which is twice the rate of the general Australia population; furthermore, psychological distress correlated with a higher rate of IDU (Donovan et al., 2012). I was able to find one study that specifically focused on both post-traumatic stress disorder and sex workers within NSW.

Roxburgh, Degenhardt, Larance, and Copeland (2005) studied mental health and drug risks among street sex workers in Sydney and found that 99% of their participants had experienced a traumatic event and a significant proportion, 83%, had experienced multiple traumatic events in their lifetime. The authors also found that half of their participants met the Diagnostic and Statistical Manual IV Text Revised's (DSM-IV TR) criteria to warrant a lifetime diagnosis of PTSD, and one-third were currently presenting symptoms. Interestingly, the authors also questioned the participants' access to mental health services and learned that three quarters of the sample who developed PTSD had spoken to a health professional about their symptoms/experience (Roxburgh, Degenhardt, Larance, and Copeland, 2005). In terms of actual hospital admission, 26% of the sample reported being admitted to a psychiatric hospital-typically for depression or anxiety. Depression and anxiety perhaps may be easier mental health indicators for Australian scholars to observe or question in their samples due to the fact that there might be less stigma around them and therefore sex workers are more comfortable discussing their symptoms, or perhaps because it is easier to treat than PTSD. Doctors can prescribe medication for depression and anxiety and a sex worker's lifestyle or living situation may not interfere with her treatment and symptom management; whereas PTSD treatment typically requires therapy that sex workers might not be able to afford or consistently attend.

An examination of sex workers health in relation to the three health indicators demonstrates that for at least two of them, HIV and IDU, the occupational frame of sex work has influenced health outcomes. I draw this conclusion based on three features/elements of the NSW decriminalization approach. First, their framing of sex work as an occupation has led to the regulation of brothels, which has subsequently allowed women to work in indoor environments (and with others) where they have increased agency to control safe sex practices. Secondly, the laws on sex work create occupational health and safety standards in order for brothels to continue operating and for sex workers to be permitted to work in them. Third, and what I would argue is one of the most important components of this system, is the onus and incentive of responsibility for health and HIV prevention created by the Public Health Act 1991. I have presented the case of NSW's decriminalization of sex work to provide a polar contrast to Canada's approach. Furthermore, I have also highlighted some aspects that I will argue should be considered for best practice recommendations, and will elaborate on their potential for positive

health outcomes later in the final chapter. In the following chapter, I will present the last case study, Sweden's neo-abolitionist model.

CHAPTER 3: SWEDEN

SEX WORK LEGISLATION IN SWEDEN

In 1998, Sweden passed legislation that criminalized the purchase of sexual services. The addition of these laws came after nearly two decades of debate on the issues of prostitution and sex work in Sweden. The Swedish approach to prostitution was first criticized as being soft in a 1976 report on club culture (Hubbard, Matthews, & Scoularc, 2008). Subsequently, this ignited a public policy debate on the issue and resulted in three inquiries being commissioned between 1977 and 1995. The first inquiry in 1977 provided the most extensive investigation of prostitution to date and such scope has not been replicated since; the 1993 inquiry brought about a recommendation to criminalize the purchase and sale of sexual services (Department of Justice, 2010). This recommendation led to the eventual development of the Act Prohibiting the Purchase of Sexual Services 1998. The Act was passed as part of a larger omnibus bill, the Violence Against Women Act 1998, which is intended to address gender inequality and violence towards women (Barnett, Casavant, Nicol, 2011, Neilson, 2011). The Act states that a person who obtains a sexual relationship in exchange for payment will be punished with fines or imprisonment (up to six months), and includes all sexual services in all locations (escort agency, brothel, hotel, bar, home, etc) (Hubbard, Matthews, & Scoularc, 2008, Neilson, 2011). Payment does not necessarily need to be monetary and can include drugs, alcohol or another agreed upon type of compensation (Canadian HIV/AIDS Legal Network, 2005, Dodillet & Ostergren, 2011).

According to Dodillet and Ostergren (2011) the law targets three components of prostitution: pandering, property and the actual purchase of sexual services. The pandering portion of the Act addresses pimping, procuring (coercion) and the promotion or financial exploitation of a person participating in sex work. It carries a fine or up to four years imprisonment or eight years for serious offences. Another portion of the Act prohibits renting apartments and rooms for prostitution; landlords (or tenants) must terminate a lease or tenancy if the premise was utilized for prostitution. Effectively, these provisions prevent sex workers from working in brothels or their operation, conducting services in hotels or living with family/friends/partners because they may be seen as exploiting or promoting sex work (Dodillet & Ostergren, 2011, Canadian HIV/AIDS Legal Network, 2013).

The Swedish government has framed prostitution and sex work as forms of gender inequality and violence against women, and men are identified as the predominant group

perpetuating violence towards women through their demand for sexual services (Barnett, Casavant, Nicol, 2011, National Board of Health and Welfare, 2008, Kulick, 2003, Levy, 2011). The government's rationale posits that if demand is reduced, or altogether eliminated, prostitution and sex work will end: no demand, no incentive to sell services (Levy, 2011, Swedish Institute for Communicable Disease Control, 2010). Directly tied to this idea, that demand causes prostitution or is the reason why women are prostituted, is the belief that sex workers lack agency, are weak victims and are of false consciousness and could not objectively choose to engage in sex work (Levy, 2011, World AIDS Campaign, n.d., Dodillet & Ostergren, 2011).

The Swedish government's position was, in part, influenced by a strong women's movement and centre/left politicians who persistently vocalized their concerns and lobbied the government during the decades-long debate (Levy, 2011, McDonald, 2004, Dodillet & Ostergren, 2011). Feminists successfully argued that sex work is a form of oppressive violence, that no women would voluntarily sell sex and that prostitution must be eliminated in order to achieve gender equality (Levy, 2011, Dodillet & Ostergren, 2011). In his review of the social and political context surrounding the formation of the Act, Don Kulick (2003) also points out that Sweden's entrance into the European Union also influenced the framing of the issue. According to Kulick's (2003) research, in the two years preceding Sweden's 1994 referendum on EU membership Swedish media was "filled with reports warning that Eastern European women were poised to invade the country" for sex work (Kulick, 2003, p. 200). Furthermore, sex work was also connected to organized crime, drugs and the threat of increased HIV infections; Kulick (2003) argues that the combination of these factors shaped a fear of prostitution in Swedish society.

Both the Swedish government and researchers have been evaluating the impact and effectiveness of the "Swedish model". The most recent reports from the government were published in 2008 and 2010. The 2008 report, published by the Socialstyrelsen (herein, National Board of Health and Welfare), reviewed the state of prostitution as of 2007 and admitted that the figures around prostitution and sex work since the new legislation are very uncertain. Police and public authorities can only estimate the extent of street prostitution due to a lack of any empirical or systematic monitoring of prostitution on the part of police or government. In the report, authorities estimated there were approximately 200 street sex workers in Stockholm, 70 in

Malmö and 30 in Göteborg (National Board of Health and Welfare, 2008). The report concluded that after the law came into force, there was an initial immediate drop in street prostitution –it virtually disappeared off the streets. However, this was short lived and street prostitution gradually returned (about two-thirds); data for Stockholm suggests that in 2005 there were 150 street sex workers and in 2006 that number rose to 200 (National Board of Health and Welfare, 2008). Regardless of the uncertainty in the figures presented, the government asserts that street prostitution has been halved since the prohibition on purchasing sexual services (National Board of Health and Welfare, 2008, Department of Justice, 2010). Another significant finding from the latest Swedish reports is the expanded use of online methods to search for and sell sexual services (forums, chat rooms, dating sites) and mobile phones; in fact, the clients who provided information for the 2008 review stated that these were the most influential technologies in purchasing services (National Board of Health and Welfare, 2008). The 2010 report, which reviewed the years 1999-2008, also echoed the noticeable growth of internet and mobile use to purchase services, but go on to make a contradictory claim that there is no indication that internet prostitution has not increased (Department of Justice, 2010). It is difficult to understand how the report draws this conclusion when it acknowledges that it is difficult to assess indoor and internet prostitution nor does it present empirical data. Finally, the 2010 report from the Department of Justice indicated that more than 85% of clients prosecuted under the Act received 50 “day fines”; a Canadian background paper from the Library of Parliament stated that 2010, 650 individuals were convicted under the law (Barnett, Casavant, Nicol, 2011).

Critics of the Swedish reports and monitoring methods argue that the law has not led to a decrease in prostitution but rather has moved it to different areas and reorganized the industry. Social workers claim street prostitutes have moved into more remote streets and cover more area of the city (Dodillet & Ostergren, 2011). Other researchers (Barnett, Casavant, Nicol, 2011, Canadian HIV/AIDS Legal Network, 2013, Danna, 2012) argue that prostitution has simply moved indoors due to increased police surveillance and the trend towards internet/mobile purchases. In their paper documenting the successes and documented effects of the law, Dodillet & Ostergren (2011) shed doubt on the effectiveness of the law in their outline of a 2009 experiment conducted by Swedish National Radio. The Swedish National Radio had 19 local radio stations place fake advertisements for sexual services on the internet, claiming to be a local woman to be contacted via email or mobile phone. In less than a week, the ads received 1000

individual replies. When the radio stations contacted some of them men to question whether the law influenced their behaviour, all of the men stated that the law did not deter them from purchasing services. Many compared it to speeding, it is illegal and they may receive a fine, but it was still worth doing; that is, the risk might be increased but it's not enough to prevent them from doing it.

From my review of the Sweden's government publications discussing the purchasing law and its effectiveness, it is quite apparent that the government's reviews and surveys predominantly, if not exclusively, focus on clients. That is, when measuring or documenting what impact the law is having, the government relies on the experiences of clients and how it affects them and them alone. Even with government's lack of focus on sex workers, other researchers and non-governmental organizations have reported the main concerns of sex workers. Sex workers report feel hunted and harassed since the new law came into effect (Dodillet & Ostergren, 2011), there is greater competition for fewer clients, good, safe clients are gone; prices for services have dropped and they have less time and capacity to negotiate services and safe sex practices with client (Canadian HIV/AIDS Legal Network, 2013, Hubbard, Matthews, & Scoularc, 2008). Furthermore, clients will no longer testify or come forward if they witness a sex worker being exploited or abused because doing so would implicate them in purchasing and could lead to their arrest (Kulick, 2003, Dodillet & Ostergren, 2011). Sex workers also report that the social stigma they experience has intensified (Dodillet & Ostergren, 2011, Swedish Institute for Communicable Disease Control, 2010).

Sweden's feminist movement and lobbies heavily influenced the framing of sex work as a form of violence against women and gender inequality. In fact, the gender inequality portion of this framing is very important to understanding the Swedish approach. When there is an inequality in society, often time the remedy is thought to be removing or modifying that which causes the inequality. In Sweden's case, the solution to ameliorate the inequality stemming from sex work is to remove sex work from society entirely via laws targeting clients. However, the literature summarized at the end of the section suggests that at the very least, the laws are not achieving their objectives to the extent the Sweden government asserts they are. A feminist influence on sex work issues has the potential to draw attention to health needs of these women; however, the Swedish governments lack of scope of sex work in the country is also found in relation to the health indicators.

HEALTH SERVICES FOR SEX WORKERS IN SWEDEN

Within Sweden, there are (only) three cities which have social and health service agencies that provide services dedicated to sex workers: the Prostitution Unit (Stockholm); the Prostitution Group (Goteburg) and the Prostitution Knowledge Centre (Malmo) (Dodillet & Ostergren, 2011, Levy, 2011). Dodillet and Ostergren (2011) indicate that there are no national guidelines for these centre or their services and therefore diverging approaches to which services are available; the Unit in Stockholm concentrates its efforts on getting sex workers to quit selling sexual services, whereas the Knowledge Center in Malmo is focused on harm reduction. In general, these municipal-level groups have adopted the task of monitoring changes in prostitution in there are, prostitution reduction, disseminating information and providing training to social assistance providers and the community (Ekberg, 2012). In a localized study focusing on Stockholm in particular, Daniela Danna (2012) found that within the city there are four publicly funded and two private (which were also public funded) social service groups that provide services to both clients and sex workers (especially those who are homeless or addicted to drugs). When she looked at Stockholm's Prostitution Unit, the Unit reported seeing approximately 500 people annually and that between 2000-03, 130 sex workers were treated at the Unit; 60% of the 130 would come to leave the sex trade entirely (Danna, 2012). She also notes that the National Union for Sexual Education will offer services to sex workers and clients as well. The Union stated that they had accepted 25 sex workers for therapy services and 30 clients who had an addiction to prostitution (Danna, 2012). In her overview of the Swedish law, Ekberg (2012) details the Spiral Project in Stockholm. The project began in 1978 and has a clinic where sex workers can obtain free health services such as seeing a psychologist, counselor or gynecologist. Ekberg (2012) also outlines two programs in Malmo (in addition to the Knowledge Centre). The first is Navet, which offers outpatient treatment and counseling for women who were IDUs and who are selling (or have) sexual services. Secondly, Malmo has the FAST program (a Swedish abbreviation for sale of sexual services) which focuses on off-street sex work.

Despite all these various units and programs, researchers, sex workers and government reports indicate that the law itself, and the perceptions that accompany it, has become a barrier to accessing health and social services. The effects to healthcare access come in the form of reduced services, loss of negotiating power during transactions and stigma. In a research paper

presented the to British Society of Criminology, John Levy (2011) summarizes three examples where the law has had negative consequences for sex workers and health services regarding harm reduction. Several authors have drawn attention to the fact that harm reduction efforts, despite being legal, are seen as legitimizing or encouraging sex work and drug use –subsequently this attitude influences condom distribution (Levy, 2011, Dodillet & Ostergren, 2011). Levy (2011) points to the fact that condom distribution is not part of the Stockholm Prostitution Unit’s outreach efforts, and in fact, withholding condoms is used as a means to attract sex workers to come to the Unit. Moreover, sex workers have reported receiving conditional assistance; that is, receiving assistance would be conditional on the women agreeing to stop selling sexual services for a period of time (e.g., three months)(Levy, 2011). As previously mentioned, the Knowledge Centre in Malmo focuses on harm reduction, but when the Centre attempted to distribute condoms to clients in 2012 they received national criticism and had to cease distribution (Levy, 2011). In addition to harm reduction efforts, funding for health projects has also been compromised and reduced by the new law; funding is only those projects which focus on getting women to leave sex work (Global Network of Sex Work Projects, n.d.). Social workers have also reported that, despite receiving funding for outreach, it has become more difficult to stay connected with sex workers and offer them services (Barnett, Casavant, Nicol, 2011, Dodillet & Ostergren, 2011). Some research suggests this is due to police harassment and surveillance forcing women to change areas often and work in more hidden locations –further away from health services (Barnett, Casavant, Nicol, 2011, Global Network of Sex Work Projects, n.d.).

I will now once more return to the issues of condom use and sex workers. Since the new law came into effect, sex workers’ capacity to negotiate safe sex practices with clients has diminished. The law has deter clients from purchasing services from street sex workers (not necessarily from indoors markets), and the ripple effect of a reduction in clients has led to lower prices for sexual services, an increase in competition among women still working the streets, anxious clients who want faster transactions and clients who refuse condom use because evidence of condoms is used in prosecutions (Canadian HIV/AIDS Legal Network, 2013, Department of Justice, 2010). Increased competition and lower prices has meant that sex workers can no longer afford to refuse clients, including those who refuse condom use; therefore, the clients who refuse condom use increase the risk of HIV transmission for sex workers (Canadian HIV/AIDS Legal Network, 2013). The Norwegian National Police Board points out what

essentially becomes a cycle: women experience a loss in wages and compensate for it by participating in riskier sexual services to keep an income going (Global Network of Sex Work Projects, n.d).

Several authors and reports also discuss the social stigma that Swedish sex workers experience after the new law. In its 2008 review, the Swedish government acknowledged that sex workers did not trust authorities in the police/legal system or government (National Board of Health and Welfare, 2008). For that report, the National Board sought to contact women who had experience in sex work and noted the high level of distrust and apprehension among the women. A report by the World AIDS Campaign (n.d.) found sex workers felt their experience were belittled and ignored, and that they were treated as if they lacked agency to choose sex work for themselves. The stigma sex workers feel also prevent them from seeking out assistance and health services (Dodillet & Ostergren, 2011, National Board of Health and Welfare, 2008). When they do attend to health services, such as HIV and STI testing, they not disclose their work stigma and the fear of discrimination (Canadian HIV/AIDS Legal Network, 2013).

HIV IN SWEDEN AND SWEDEN'S SEX WORKERS

Sweden's most recent HIV prevention policy is outlined in the National Strategy to Combat HIV/AIDS and Certain Other Communicable Diseases, a bill passed in Parliament in 2006 and covers the years 2006-2016 (Swedish Institute for Communicable Diseases, 2012, Swedish Institute for Communicable Disease Control, 2010). The Strategy was formed using a rights-based perspective and emphasizes individual sexual rights to choose with whom and when to have sexual relations (Swedish Institute for Communicable Diseases,2012). The overarching objective is to “restrict the spread of HIV infections and other sexually transmitted and blood borne infections and to limit the consequences of these infections for the individual and for society” (Swedish Institute for Communicable Disease Control, 2010, p). This is to be achieved by halving the rate in HIV infection by 2016, providing testing for asylum seekers and those who have traveled to countries with high HIV endemics and improving the knowledge about HIV and living with HIV in the public Swedish Institute for Communicable Disease Control, 2010). Sweden began to monitor HIV and AIDS in 1985, and even then the National Commission on AIDS 1985 listed prostitutes as a high risk groups (Bredstrom, 2009). The CDPCA also makes HIV testing free, and individuals can only be compelled to take a test without consent if they

exhibit a history of risky sexual behaviour or if their partner has been identified as a new infection (Bredstrom, 2009, Swedish Institute for Communicable Disease Control, 2010). In addition, physicians and laboratories are required to note newly detected infections in an electronic system, SmiNet (Government of Sweden 2010). As of 2011, the Swedish Institute for Communicable Diseases (2012) reported that there were 5,800 individuals living with HIV in Sweden.

Sex workers have been identified by Swedish authorities as one of the major at risk groups for HIV transmission due to their large number of sexual interactions (Waltman, 2011 Vallgarda, 2007); however, men who have sex with men (MSM) and IDUs are a more significant concern for prevention policy (Swedish Institute for Communicable Disease Control, 2012, 2010,). The most recent data that Sweden has provided on sex workers and HIV was in its UNGASS Country Progress Report for 2010, prepared by the Swedish Institute for Communicable Disease Control (2010). According to the sex worker indicators in the report, HIV prevention programmes reached 43.2% of sex workers; 78.4% received an HIV test and knew their status with the previous 12 months; 71.4% could correctly identify means of preventing HIV transmission and rejected major misconceptions about transmission, and zero sex workers tested positive for HIV. There are two interesting details that should be noted. The first is that this information comes from 2010, and in its recent 2012, Sweden could provide information on these sex worker indicators because it did not monitor them. Second, the statistics are not representative of sex workers, HIV and health care services. The sex workers who were surveyed for this 2010 report were identified through the survey of IDU for the report. Out of the 259 IDUs that were identified and questioned for the report, 37 sex workers were identified (Swedish Institute for Communicable Disease Control,2010). The statistics published on sex workers comes from this subpopulation identified in the IDU group. The Swedish government states that accessing the sex worker population is difficult and that no comprehensive national system to collect data on them currently exists; furthermore, the subpopulation of sex workers is amalgamated into the heterosexual and the MSM groups and treated as separate. I'm sure some would argue that some statistics are better than none at all, which would be the silver lining here. However, this approach is problematic for several reasons. Most obviously, it is a small and non-representative sample of sex workers who IDUs and non-drug users. Secondly, IDU sex workers are known to have different health and sexual behaviours compared to non-drug using sex

workers. The IDU subgroup of sex workers is more likely to engage in risky sexual behaviour (non-condom intercourse) and more likely to exchange used syringes, and therefore have a higher risk for HIV transmission. In using this subgroup for the report, an incomplete and inaccurate picture of sex workers health status and needs in regards to HIV is likely to emerge.

Overall, Sweden's approach to HIV prevention in sex workers is contradictory. It also exhibits a lack of consistency and application of existing measures/technologies that could be used to better understand sex workers health and needs where HIV is concerned. The lack of empirical evidence or focus on the HIV risks, needs and demographics of sex workers suggests that the feminist/gender equality framing has not influenced an implementation of policy initiatives that attempt to improve or understand the health outcomes of these women. It is unclear to me as to whether this is due to ignorance on the part of the Swedish health and public officials or part of the social mentality that fears condoning/supporting any aspect of sex work.

INTRAVENOUS DRUG USE AND POST-TRAUMATIC STRESS DISORDER IN SWEDEN'S SEX WORKERS

Until recently, Sweden only had two needle and syringe exchange programs (NSEP) in the entire country, one in Malmo and the other in Goteburg. In the 1980s, the government granted permission for two experimental NSEPs to be carried in only these two cities (Vallgarda, 2007). The government moved to regulate NSEPs in 2006 and made them legal, nationally, through the Needle Exchange Act 2006 (Swedish Institute for Communicable Disease Control, 2010). The law permits country councils to run NSEPs if they receive authorization for the National Board of Health and Welfare. The NSEPs will offer HIV, Hepatitis B and C testing for free, in addition to encouraging individuals to seek addiction therapy and exchanging clean needles and syringes for used ones (Swedish Institute for Communicable Disease Control, 2010, Vallgarda, 2007).

Intravenous drug users have been identified as a high-risk population and are examined where HIV is concerned, however my literature review has not yielded any studies that examine IDU in the sex work population, their needs, health status or access to treatment. In the previous section I mentioned that 37 (14.2%) out of 259 IDUs surveyed for an HIV report were identified as sex workers, but that is essentially the extent of cross-population data or analysis on the part of the Swedish government. In reviewing the 2008 report (National Board of Health and

Welfare, 2008) on the law prohibiting the purchase of sexual services it is apparent that it is not uncommon for sex workers to be identified through the IDU population and addiction services, as opposed to be specifically sought out and interviewed/questioned for reporting. Several municipalities and city districts reported that service providers often become aware of an individual's status as a sex worker in conjunction with addiction care; subsequently, this leads service providers to believe addiction is common among sex workers (National Board of Health and Welfare, 2008). Unfortunately, there is no data with actual numbers of IDU sex workers provided. Due to the lack of systematic evaluation or monitoring of sex works in the IDU group, or vice versa, it is difficult to say anything meaningful or with certainty about sex workers who are IDUs, mainly because we do not know if the data is representative of street and indoor workers or whether it is stable/changing.

Sweden's anti-harm reduction approach has also had a negative impact on drug users, and therefore sex workers who are IDUs. Street sex workers report a high prevalence of intravenous amphetamine and heroin use among those working on the street, and due to the lack of harm reduction programs and NSEPs, they must participate in risky drug behaviour such as purchasing needles from drug dealers, take used needles from friends or buy on the needle black market that has developed in Sweden (Levy, 2011). Where harm reduction therapy programs do exist, it can take up to a year to receive drugs for opioid (e.g., methadone) substance therapy (Danna, 2012). Since Sweden now has a new law in place to regulate and authorize NSEPs across the entire country, there is still a possibility that with evaluation and time these programs will improve and multiple so as to improve access and availability of treatment for sex workers who are IDUs.

Research focusing on the mental health of sex workers is even scarcer than that on HIV and IDU in this group. In discussing the impacts of the Swedish law on purchasing, Max Waltman (2010) from Stockholm University notes that there is a lack of rigorous clinical assessments of post-traumatic stress disorder in sex workers in Sweden. Nonetheless, he states that professionals who work with and treat psychological trauma in recovering sex workers report observing PTSD or PTSD associated symptoms/reactions in all the women they worked with (Waltman, 2010). The 1995 Swedish government inquiry on prostitution found that social safety nets had numerous gaps when it came to outreach and support for sex workers with mental health and drug issues (Waltman, 2010). The report stated that it was difficult to provide these women with care because neither psychiatric nor addiction programs were willing to take

responsibility for their care; as a result, sex workers with mental health issues would have a more difficult, if not impossible, time being reintegrated into the community (Waltman, 2010). Again, it is unclear to me why the mental health of sex workers, let alone their experience with PTSD, is not a significant issue for the Swedish government in light of the inquiry findings and reports of treatment professionals. Their lack of consideration or assessment of PTSD or mental health status in sex workers may be due to the fact that there is a low prevalence in the general population and therefore it does not warrant attention. Moreover, the lack of evaluation and study of PTSD could also be part of the larger, general approach of consistently avoiding humanizing sex workers. Unfortunately, due to the lack of insight in the literature I can only speculate.

Where HIV and IDU are concerned, I believe it is important to draw attention to the Swedish government's framing of harm reduction. To the government and to public authorities, harm reduction is seen as a means of condoning drug use or sex work and therefore, up until recently, harm reduction strategies were discouraged. As the literature demonstrates, this approach has increased and maintained health risks among sex workers who do not have access to safe injection or sex supplies. Furthermore, I would argue that if these risks remain it will eventually lead to sustained poor health outcomes for the women who do not eventually gain access to safe supplies. In relation to IDU and PTSD we see again a similar approach to one regarding HIV. There is a lack of data and understanding about sex workers who are IDU or their mental health in general. When the research on all three health indicators is considered as a whole, then a trend of neglect in the research on sex workers and their health outcomes emerges.

CHAPTER 4: ANALYSIS AND BEST PRACTICES

ANALYSIS

In the introductory chapter I outlined my hypothesis on the framing of sex work and prostitution and access to healthcare. My major research paper posits that how a government frames sex work and prostitution in policy (i.e., an occupation, crime, gender inequality, etc.) will affect sex workers' access to healthcare services. By extension of this hypothesis, the thesis I sought to prove argued that if framing can affect access to healthcare services, it therefore could create barriers and impact health outcomes of sex workers. More specifically, I would argue that how we frame an issue in policy will influence what we believe to be appropriate measures to regulate or address the issue. In all three case studies, there was a legislative component to addressing sex work and for that reason this MRP has focused on examining the consequences of these laws/regulations on health. For each chapter, I have provided a summary of the socio-political context that influenced the formation of policies and laws on sex work in each country. Further on, I then provided an overview of statistics and research regarding the three health indicators, HIV, intravenous drug use and post-traumatic stress disorder, to demonstrate how the sex work frame impacted sex workers accessing services and ultimately their health outcomes.

In this chapter I will briefly summarize the different frames applied in each case study as well as what sorts of barriers these frames have created for positive health outcomes. Secondly, I will present my policy recommendations in the best practices section at the end.

Both Canada and Sweden have used a “violence against women” frame to rationalize and justify their respective laws on prostitution. Both countries have also legislated laws that restrict the activities of sex worker in similar ways, such as laws regarding common body houses or the use of apartment for sex services. Sweden's approach incorporates gender inequality in the framing of sex work as well. In doing so, its legislation has focused on criminalizing the clients because they are perceived to be the members of society who are perpetuating violence and gender inequality towards women. It has been difficult to determine what kinds of barriers the Swedish approach creates for sex workers because most of the research on their model focuses on whether it deters clients or not. That being said, I was able to identify a resistance to support harm reduction policies, by way of condom distribution or needle exchange, because of a fear

that such policies will be perceived as condoning sex work. Additionally, sex workers in Sweden have reported to feel an increase in social stigma in some studies; this social stigma prevents them from fully disclosing their occupation and receiving the healthcare they require when they attend health services.

Contrary to the Swedish approach, Canada's legislation criminalizes the activities associated with prostitution. However, from the prosecution and charging statistics available for Canada it is clear that although prostitution is not illegal, sex workers are the ones who are criminalized. The Canadian frame that emerges sees prostitution as violence against women, and yet also makes sex workers the centre of criminalization and enforcement; this paradoxical frame is reflected in the laws. We do not want to make prostitution explicitly illegal, because that would be equivalent to blaming the victim, but society or the government deems it unacceptable/criminal on some level and therefore makes the acts that facilitate sex work illegal. As a consequence of these laws, sex workers have been pushed into more isolated areas and further from health or social services, have lost control over their work environment and their capacity to negotiate safe sex practices effectively. Furthermore, there is also a lack of support for harm reduction strategies despite the high prevalence of IDU seen among sex workers; I would argue this lack of support is due to not wanting to condone sex work in any way, much like Sweden.

The Australian regulatory model has been internationally recognized as being a successful means to regulate sex work, and the state I specifically focused on, NSW, has been praised for being the best place for sex workers. The most pertinent questions are why? And what makes NSW different? The Australian/NSW debate on sex work recognized that there were negative consequences that stemmed from illegal sex work, such as public nuisance, illegal criminal activity and increase risk of HIV infection. The solution for NSW was to position sex work as an occupation and regulate it through laws and policies as such. Since sex work became an occupation, labour and health authorities also created occupation health and safety guidelines for brothels. The Australian/NSW approach asserts that if the goal is to mitigate an undesirable outcome/effect of street sex work on society, then it should be regulated so it can be controlled and decreased. In addition to being concerned with police corruption and illegal criminal activity, the governments were also concerned about the health risks to sex workers; particularly the rise of HIV infections and the risk of transmission between workers and clients. In response

to recognizing this elevated risk of infection via sexual services and IDU, the Australian government implemented targeted health initiatives for sex workers in the 1980s. By framing sex work as an occupation with risks and negative impacts to be mitigated, the NSW government created policy options that allowed it to regulate sex work and health consequences through laws, health strategies and occupational standards.

BEST PRACTICES

Out of the three models presented in the case studies, I will be drawing on the regulatory framework of New South Wales to provide best practices recommendations for Canadian policy. For the purpose of this paper, NSW's regulation is the superior framework as the evidence in the literature has shown it to both improve health outcomes of sex workers, and to sustain these outcomes. This section will highlight one component of Australia's health policy and two components of the NSW regulatory system as best practices which could be adopted by Canada in the future: 1) a national HIV strategy that includes objectives for sex workers' HIV health (Australia); 2) harm reductions strategies utilizing peer outreach and harm reduction supplies; and 3) increased control work environment and/or settings.

National HIV Strategy

One feature of Australia's federal approach to HIV health that distinguishes it from the other two case studies is the fact that its national policy plan includes a focus on sex workers' risk of HIV infection. Australia's Sixth National HIV Strategy 2010-2013 explicitly acknowledges that sex workers experience an elevated risk of being infected with HIV due to the nature of their occupation. In order to mitigate the risk and decrease the rate of infection in the sex worker demographic, the National Strategy outlines the objectives, priorities and prevention strategies for this at-risk group. The government's aim is to continue promoting safe sex as a norm and make safe sex materials accessible; utilizing peer outreach and education for HIV prevention; and community-based health promotion strategies. The priorities established in the National Strategy include investing in prevention programs and in evaluations so that evidence-based policy can be developed; tapping into the expertise of community agencies; surveying the group in order to generate more data on sex workers and monitor research on innovative technologies.

There are two elements to the Australian approach that make it a best practice worth adopting. First is the recognition of the higher risk of HIV infection that sex workers face. The Australian government frames the risk of infection as an occupational health and safety hazard. I am not suggesting that Canada do the same thing in its HIV prevention policy (it will likely take quite awhile for that to occur should all the prostitution laws be struck down by the Supreme Court), but what I am suggesting is that recognition would validate that the risk does exist for sex workers in Canada and also validate their health needs. To neglect the increased risk and unique health needs of sex workers is to deny that their health outcomes are equally important to that of general population and to those groups who are acknowledged in policies/priorities. Sex work itself is not illegal in Canada and so it is difficult to make sense of why the Canadian government has not taken initiative on this issue; one possible explanation could be based on the government's position that sex work is socially and morally degrading and a resulting reluctance to support investing in policy and prevention for this group. That being said, the Ministry of Health and other related agencies should not preclude sex workers from targeted preventions, especially given that the Canadian frame suggests these women to be vulnerable, and that data indicates that the rate of HIV prevalence can be as much as 6 times the national average for this group. I would argue that sex work, which increases the risk of HIV transmission for this group, is not illegal and therefore it is not reasonable to exclude sex workers from a national prevention policy. I make this argument based on the fact that the government has a strong anti-sex work position and yet, monitors the rates of HIV among other groups whose behaviour is deemed illegal, such as IDU. Therefore, this suggests that it is not the "illegal" nature of sex work that renders it excluded from national surveillance but perhaps the government's resistance to support sex workers in any way.

The second element of importance is the strategy in and of itself. A national HIV prevention policy similar to that of Australia's would serve as a blueprint and platform based on which other departments, ministries, agencies and stakeholders could work from; furthermore, it could encourage cost-effective intergovernmental and research collaboration. A prevention policy focused on sex workers would create objectives and priorities to guide the functions of provincial or regional agencies, clinics and outreach organizations because it would give them clearly defined objectives to work towards. An important part of the policy cycle is to evaluate policy as well, which would give the government the opportunity to expand and implement

policies or to alter them to improve outcomes; moreover, it would offer an opportunity for Canada to create its own base of evidence-based policy and research where HIV in sex workers is concerned¹. By extension of the policy evaluation that would take place, efficiencies and cost-effective measures could be identified so that community services could be streamlined and improved. More importantly, I would argue that forming a sex worker targeted component in a national strategy would generate information and data on sex workers that Canada is presently lacking –therefore closing a knowledge gap we have. If we accept that good policy needs to be based on relevant data, this is problematic.

Harm Reduction

The NSW government utilizes harm reduction strategies in relation to both HIV transmission and sex workers who are IDU. NSW health policies mainly target HIV infection through safe sex practices and needle exchange programs. Donovan et al. (2012) found that peer education and prevention programs led to an increase in condom use with clients among sex workers (reported at 99%). Moreover, occupational health and safety standards for brothels mandate that personal hygiene equipment, such as condoms, be available on the premise for workers for their safety and HIV harm reduction (NSW WorkCover, 2001). In conjunction, NSW has also implemented harm reduction for HIV and IDU through needle/syringe exchange programs (which are also a component of the National Strategy on HIV). NSW health services began to provide clean injection equipment because of the high rates of IDU among street sex workers (and to a much lesser extent, indoor sex workers) and the associated health risks. In addition to the negative side effects drug use has, IDU also creates a higher risk of HIV transmission among sex workers from shared needles and a decrease in safe sex behaviour.

¹ Here I would argue that health policy cannot be solely guided by ideology because it is concerned with more than the principles, priorities or objectives we establish for public health, but it is also largely concerned with the distribution of health services and resources. Research and evidence-based approaches in health care allow for the evaluation and monitoring of how health policy and priorities are implemented. That is, by using research and evidence we can seek to determine whether the objectives of health policies are being achieved in reality through our system. This is particularly significant in a system like Canada's, which places significant importance on universal access to services. Poor health is not ideologically based, and utilizing research helps the policymakers become informed about how to deliver health care more efficiently and effectively (cost and otherwise) and to improve health outcomes of the general population and those who have more specific needs and risks, such as sex workers. Moreover, given that the system is publicly funded, research-based approaches to developing policy can also foster a means of accountability for services, costs and health outcomes.

Lastly, I would also argue that the Public Health Act 1991 is a means of harm reduction in NSW. The Public Health Act 1991 places an onus on both sex workers and clients to disclose HIV status, as well as other STIs, when transactions for sexual services occur. By criminalizing withholding a positive HIV diagnosis, the Act creates an incentive for both involved parties to inquire about HIV and to avoid prosecution for knowingly infecting another. Moreover, the Act also contains health certificates that can be requested by employers and public health orders for sex workers who have been identified as not using safe sex and disclosing practices. It should be noted that aside from the Public Health Act 1991, the two other harm reduction strategies in NSW stem from the federal National Strategy for HIV since the 1980s and 1990s; further providing support to the previous best practice of formulating a national strategy that addresses sex workers.

Harm reduction policies should be considered for Canada because (similarly to Australia and NSW) sex workers in Canada present high rates of IDU. As mentioned in the chapter on Australia, approximately 77% of street sex workers (or more) report IDU. In Canada, the numbers are lower, approximately 56-57%, but the risk of HIV transmission from needle sharing and compromised safe sex practices are found to be the same. At present, there is only one needle exchange program in Canada, INSITE, in the city of Vancouver. A report that has been completed by the Urban Research Health Initiative (2013) (at the British Columbia Centre for Excellence in HIV/AIDS) found that over the last 15 years injection drug use has declined (to 6.9% from 38.1%). Additionally, the researchers found that syringe sharing (down to 1.7%) and HIV transmission has also decline; meanwhile, there has been an increase in access to drug treatment and drug cessation programs. According to their research, the authors concluded that these positive health outcomes are a result of Vancouver's innovative harm reduction program established through INSITE. Although the report did not provide information as to what proportion of those who use INSITE are sex workers, the high rate of IDU and HIV among IDU sex workers was noted. The latest research on INSITE suggests that it is an effective means of reducing harmful and risky drug use. It would therefore be reasonable to expect that sex workers across the country would benefit from needle exchange programs similar to INSITE if they implemented and over the long run, would also exhibit improvements in IDU and HIV health.

Workplace Environment Control

The Canadian law that prohibits common bawdy houses (brothels) prevents sex workers from working together or working alone in a private space. As a result, sex workers lack control over their work environment and settings. The situation sex workers face would not be entirely hopeless if they had the capacity to properly screen clients and establish expectations (e.g., condom usage) before transactions. However, this too is prohibited in Canadian law as it is illegal to publicly communicate for the purpose of prostitution. Combined, these two laws leave few options for sex workers because they remove their ability to exercise agency and control in their work environments; it also prevents them from controlling their own health standards in a safe space.

Research on the NSW sex industry, presented in the relevant chapter, demonstrates that permitting transactions and services to occur indoors has contributed to improving safety and health outcomes for sex workers. In addition to creating occupational health and safety standards through WorkCover, NSW also places an onus on brothel operators and sex workers to ensure standards are implemented. If they are not, then authorities such as WorkCover can enforce sanctions, much like those seen in other forms of employment, which can result in the loss of wages or profits. Therefore, health and safety standards provide incentives for owners/workers to be responsible for their work environment. Permitting indoor space for the purpose of sex work to be established, even if in limited numbers, would offer sex workers on the streets alternatives to being exposed outside and also give them the agency to deny clients who refuse condom use or expect drug use. Working for an establishment would provide a more sustainable or reliable flow of clients, therefore diminishing the fear of lost wages should a worker refuse a client. Essentially, this means that sex workers would not be forced to take health risks. The quantity of brothels and their locations could be regulated by using local councils and planning committees, as is the case in NSW. More importantly, by finding a means to concentrate sex work within a city allows health officials to better collect research data on the health of these workers and also provides better access to this demographic group for targeted health promotion/prevention. Finally, sex workers would also become more accessible for organizations that provide social assistance/support to exist sex work.

When these best practices are considered together, it becomes apparent that for Australia and NSW there was a policy evolution as a result of its decriminalization-regulatory trajectory. After decriminalizing sex work and moving the majority of it indoors, the risks of sex work surfaced over time. In response, the governments made sex work part of HIV prevention and harm reduction strategies, and created legal obligations for both brothel operators and sex workers to preserve the health of workers and clients. I would therefore further argue at this point that in addition to making sex work an occupation, the governments in Australia have also come to treat sex work as a health issues, both for sex workers and the wider communities they are in. Herein might lay the reason for Australia's and NSW's success in improving and maintaining positive health outcomes.

Additionally, it is important to note the potential Canada has for best practices to improve health outcomes. Research on Vancouver's INSITE provides evidence that harm reduction policies are not only effective, but also effective in the Canadian setting. In having such a program that has been operating for as long as INSITE has, Canadian health officials are already equipped with research, training and a model from which they can draw on and pilot in other cities.

CONCLUSION

With *Bedford v. Canada* going before the Supreme Court of Canada to contest the constitutionality of Canadian prostitution laws, a significant legal and policy change may be imminent for Canada. Research on Canada's laws has shown that the series of provisions that criminalize the activities associated with sex work have jeopardized sex workers' capacity to exercise agency over their work environment, and increased their vulnerability to violence and poor health. The issue of sex workers' health outcomes is particularly important not only because it can affect public health, but also because they are not engaging in an illegal activity and yet, are neglected in health policies in Canada. The goal of my major research paper has been to examine the health outcomes of sex workers on three indicators (HIV, IDU and PTSD) in order to support my hypothesis that how sex work is framed influences which barriers to healthcare exist, and subsequently influences healthcare outcomes.

The literature review on sex workers and the three health indicators for each country has demonstrated that sex workers experience barriers to accessing health services and to positive health outcomes to some degree regardless of the regulatory approach or frame applied by the government. However, what the regulatory approach and framing of sex work appears to do is influence what kind of barriers are experienced and perhaps to what extent. For example, in the Canadian case, the criminalization frame has led to legislation that forces sex workers out of public spaces and into more remote areas; second, sex workers reported poor location of health services to be a barrier for them. Furthermore, Sweden's anti-harm reduction position, a component of its neo-abolitionist frame, makes it difficult for sex workers to simply acquire condoms. Even in the Australian approach, where sex work has been decriminalized and framed as an occupation, women report stigmatization as a barrier to fully disclosing their employment; in turn this prevents them from receiving the proper care they require when they attend services. Social stigma was identified as a common barrier in all three countries, but the fact that sex workers in Australia discussed it as a barrier suggests that even under the most ideal regulatory system, a government's framework will only achieve so much in influencing how society as a whole perceives and treats sex workers.

With the exception of harm reduction, each of the best practice recommendations was derived from the Australia/NSW model. Their policy approach to sex work first recognized it as

a type of employment, and then developed the public and sex worker health dimensions of the occupation. The framing of the issue is a key component of their system because it guides their approach, effects which issues are identified and considered, as well as the policies, programs and priorities developed. In addition to illustrating how framing sex work as an occupation can facilitate or complement health policies for better access and outcomes, I have argued that the Australian/NSW case also indicates how critical it is to have targeted programs and strategies for sex workers' health. Strategies often require data, research and monitoring of a group to evaluate polices and alter them for best outcomes; research therefore can facilitate closing the knowledge gap on sex workers' health that Canada presently has. It would be worthwhile to explore whether enhancing current health policies to include more targeted strategies and prevention programs using outreach could be enough to improve health outcomes in the event that the Supreme Court of Canada does not strike down the prostitution laws before it.

There are several next steps that could be pursued in researching and formulating policy recommendations on health outcomes of sex workers, such as: examining how NSW HIV prevention strategies can be adopted to the Canadian context; how sex work can be re-framed as a health issue; how health outcomes can improved using best practices in the event that some or none of the laws are struck down by the Supreme Court and how the sense of social stigma can be reduced among sex workers in order to improve disclosure to health professionals.

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