

British Association for Sexual Health and HIV
Response to Paying the Price, Home Office Consultation on Prostitution
Helen Ward and Angela Robinson, November 2004

Who we are

The British Association for Sexual Health and HIV (BASHH) is a professional organisation for doctors and allied health workers in the UK who deliver specialist sexual health services. (see www.bashh.org)

Members of BASHH have regular contact with prostitutes and clients through their use of our generic sexual health services. In addition, a large number of clinics provide, directly or through collaboration with other agencies, health care and health promotion services for sex workers. Through this service work, together with in depth research carried out by a number of members, we have a picture of sex workers and clients in the UK, including a clear impression of their sexual health needs.

Response to *Paying the Price* – introductory remarks

We welcome this consultation paper on prostitution, since it is clear that the current regulatory framework is unfair, criminalising women and men working in the sex industry and compounding the social and financial problems of the most vulnerable people involved in sex work. We support any policies that would shift the focus from policing and criminalisation towards harm minimisation and support. We also support any policies that help to reduce the exploitation, violence and abuse that is associated with sex work for many, but not all, of the individuals involved.

However, we are concerned that *Paying the Price* is overly focused on street prostitution, drug using sex workers and under-age/ coerced sex workers, and as such does not provide an accurate picture of the sex industry in the UK today. The overwhelming presentation of sex workers as victims who are coerced, addicted, underage or trafficked does not accord with the experience of many health care workers who are in regular contact with sex workers. Our experience is of a far more varied group of people, and this will inform our responses on the specific areas of the consultation outlined below.

We focus on three areas in our response: first, the epidemiology of sexually transmitted infectious in relation to prostitution; secondly the delivery of sexual health services for sex workers and others involved in commercial sex; thirdly our recommendations on the legal and policy framework for prostitution.

The epidemiology of sexually transmitted infectious in relation to prostitution

Paying the Price is unclear on whether sexually transmitted infections and HIV (STI/HIV) are a particular risk for sex workers. In some sections the relatively low level of STI/HIV in sex workers is cited while in others it is suggested that sex workers and men who pay for sex are a factor in the recent increases in STI/HIV in the UK. Evidence from detailed research in London, for example, has shown that women sex workers are at a slightly increased risk of STI and HIV when compared with population rates, but are generally at lower risk of STI/HIV than other women attending genitourinary medicine clinics.^{1 2} These women report extremely high rates of condom use in commercial exchanges, much higher than the general population, There is a reported increase in use of condoms with non-commercial partners as well, and this had led to a sharp decline in the risk of STI in sex workers at a time when population rates have been rising. Similar results have been reported for many other parts of the country. However, there are clear exceptions to this general pattern. A small number of recent

¹ Ward H, Day S, Weber JN. Risky business: health and safety in the sex industry over a nine year period. *Sexually Transmitted Infections* 1999;75(5):340-343

² Ward H, Day S, Green A, Cooper K, Weber J. Declining prevalence of STI in the London sex industry, 1985 to 2002. *Sex Transm Inf* 2004;80:374-379

outbreaks of syphilis, and more recently hepatitis B, have included female sex workers who work on the streets and may be using drugs such as crack cocaine. More detailed investigation of these outbreaks is required to assess the reasons why these sections of the population are at increased risk – poor access to treatment services due to the current crisis in sexual health service provision, associated with multiple reasons of deprivation of these individuals and communities, are likely to be key factors rather than prostitution per se.

There is less evidence on the level of STI/HIV in men who pay for sex, although a recent presentation at the International AIDS Conference in Bangkok showed that the numbers of men in the UK who report paying women for sex has increased, and that they are more likely to have had an STI in the previous five years. However, whether this increased risk is related to the sex work contacts is unclear, since these men report much higher numbers of sexual partners overall, most of whom are non-commercial.³

There has been some research on risks of STI/HIV among men who sell sex, and they appear to be at higher risk than women workers. However, they too report high levels of condom use in commercial sex, and risks are associated with non-commercial partnerships.⁴

We believe that it is essential that the notion of sex workers “spreading” disease is strongly countered. As this brief outline suggests, there is no evidence for this pattern in the UK. Rather there is strong evidence that most commercial sex is safer than non-commercial sex due to high levels of condom use and avoidance of the most risky exposures. The image of prostitutes as sources of disease has been dominant for centuries, and has led in the past to inappropriate and damaging policies, such as the Contagious Diseases Acts in the nineteenth century which led to the forced examination and detention of poor women. In addition to being ineffective in controlling venereal disease, these laws led to widespread human rights abuses.⁵

Delivery of sexual health services for people involved in commercial sex

Paying the Price poses the following questions related to sexual health services:

11 How are services (for example, sexual health services) best tailored to meet the specific needs of children and adolescents involved in prostitution?

14 What needs to be done to raise the awareness of sexual health among those involved in prostitution, including those who buy sex?

33 Is there a case for designating managed areas at a local level? What would be the resource implications of such a move; what regulatory and health requirements should be placed on those operating in a managed zone; and how would such areas be identified?

35 Would registration help safeguard public health?

First we should point out there are already a large number of services providing sexual health and other services for people involved in sex work as providers or users. These include routine genitourinary medicine clinics as well as targeted specialist services.^{6 7} There are a number of different models that can and have been applied to such services, depending on local circumstances. An expert collaboration in Europe has produced detailed guidelines on health services for sex workers, based in the best available evidence, and these are currently

³ Johnson AM, Mercer C, Ward H, et al. Increasing prevalence of female commercial sex contacts among men in Britain: Implications for HIV transmission. Paper presented at the XV International AIDS Conference, Bangkok, Thailand, 11-16 July 2004.

⁴ Sethi G, Holden B, Gaffney J, Greene L, Ward H. HIV, sexually transmitted infections and risk behaviour in male sex workers in London over a 10 year period. Paper presented at the *Joint conference of the British Association for Sexual Health and HIV and the American Sexually Transmitted Disease Association*, Bath, UK, 19-21 May 2004

⁵ Walkowitz JR. *Prostitution and Victorian society: Women, class, and the state*. Cambridge: Cambridge University Press (1980).

⁶ Donegan C, Ward H, Day S. Services for female prostitutes in genitourinary medicine clinics in the UK. *Genitourin Med* 1996;72:450-451.

⁷ See www.europap.net under countries, see UK listings

being reviewed in relation to producing a specific set of guidelines for the UK.⁸ In addition there are two manuals detailing best practice in providing services promoting health for sex workers,^{9 10} plus a recently produced online toolkit from the World Health Organisation.¹¹

To briefly summarise, services for sex workers need to be inclusive and relate to the needs of all sex workers. They should be based on the principles of harm minimisation, and therefore be non-judgemental about sex work; there is a tendency in *Paying the Price* to link services to the aim of helping people to exit prostitution. This is not appropriate for the delivery of sexual health services. The network of Genitourinary medicine clinics (GUM) in the UK results from a bold step taken in the early 20th century to provide free and confidential services for people with venereal disease in which “morality” was put to one side and a pragmatic response made possible. The same principles apply to services for sex workers and their clients: We should provide services that meet their needs, provide screening and treatment, vaccinations, health promotion and access to other support, including support for violence, abuse and ways to leave prostitution if appropriate. We fear that if the emphasis is reversed, with most services framed around support for exiting sex work, this will put off the majority of workers who are not looking to leave prostitution at that time. Delivery of services to young people involved in prostitution should be based on the same principles, with the additional responsibilities of child protection. Close working relationships with local child protection teams are essential, as are guidelines for identifying vulnerable young people and supporting them appropriately.

Interventions to improve the awareness of safer sex has have proved effective where there are integrated clinical, outreach and support services for sex workers. We recommend that such models be applied more widely. Many GUM clinics cannot provide such services due to lack of resources, but we think such initiatives could help reduce the risks of further outbreaks of STI that include sex workers, and bring existing outbreaks under control.

Improving awareness for men who pay for sex is more difficult, since they are not a clearly defined group. It is likely that many men using GUM services will not disclose participating in commercial sex and therefore will not be targeted with specific advice. Reaching these men therefore has to form part of general population campaigns about safer sex, in all settings. Part of the difficulty relates to the laws surrounding prostitution, and the increasing criminalisation of these men. This will make men even less likely to disclose commercial sex. Having a more open sex industry would allow “customers” to be provided directly with sexual health advice, including recommendations on screening and safety, and for the workers and businesses involved to define safer working conditions.

On the specific proposal of managed zones, there are many different opinions among health care workers, including those in BASHH. Many believe that these would be a step forward, preferable to the current lottery whereby sex workers may be tolerated in the streets for months or years, and then suddenly face a police “crackdown” in which they are repeatedly arrested and face possible imprisonment for breach of an Anti-Social Behaviour Order (Asbo). This causes them to disperse to other areas where they are frequently more vulnerable to violence and less able to look out for each other. In addition, the levying of fines gives women no option but to return to the streets even when they would prefer not to. Against this background, the notion of an area where sex work is permitted appears preferable to some, and health services could be made available, assuming these are given appropriate resources. There are many other health care workers who consider that the creation of managed zones will just reinforce the stigma of prostitution, perpetuating the idea that this is an inherently wrong activity and can only be allowed out-of-site in some industrial estate. Like any “managed” system, and as has been found in many countries, it is likely that only a minority of sex workers would choose to work there, and others, including those with problem

⁸ Practical Guidelines for Delivering Health Services to Sex Workers EUROPAP (2003), EUROPAP, European Commission DVG. These guidelines are available at www.europap.net under services, and from Europap (europap@imperial.ac.uk)

⁹ Hustling for Health: developing services for sex workers in Europe, European Network for HIV/STD Prevention in Prostitution (EUROPAP) (1998), available at www.europap.net

¹⁰ Making Sex Work Safe AHRTAG (1997), London, ARHTAG/Network of Sex Work Projects, available at www.nswp.org

¹¹ WHO toolkit who.arvkit.net/sw/en/index.jsp

drug use or in coercive relationships, would continue to work outside these zones with even worse access to support.

On the final question - *would registration help safeguard public health?*- the answer is clear: no. Evidence from the past in the UK (Contagious Diseases Acts) and from other parts of Europe where such schemes exist (Greece, Austria) shows that registration of sex workers in which they are required to undergo regular screening is counter-productive for a number of reasons:

1. Only a minority of sex workers will sign up for the scheme since it effectively limits their rights by making screening mandatory, and means that state agencies could limit them in other ways as a result of their presence on the register (sex workers fear restrictions on their rights to family life, and to future employment or travel).
2. Where registration is linked to screening, services for non-registered sex workers (the majority) will suffer; they may avoid contact with health care services who are seen as part of this state regulation, and the forced screening (mostly unnecessary) will be a massive drain on health care resources.
3. Where sex workers are registered and screened, but clients are not, there is less incentive for men to adopt safer sex practices – they may believe that the state is providing a “safe” supply of prostitutes and this absolves them of the need to take care of their own health.
4. Certificates stating that someone is free from infection cannot be valid, which is why GUM clinics discourage their use, even when requested by patients. This is because if someone screens negative for an infection one day, by the time they come back to pick up their certificate they may have contracted an infection.
5. Colleagues in countries where registration still exists report that some sex workers go to great lengths to ensure they will have a negative screen, particularly when they think they may have an infection, using disinfectants and antibiotics that will interfere with the accuracy of the test. In this way registration could increase the transmission of STI.

We consider that people should be provided with the information, support and services to take responsibility for their own sexual health. The role of government in this is to ensure that sexual health services, including health promotion, are adequately funded to help people achieve this. We do not think it is appropriate for government to regulate sex workers on the grounds, which we believe are spurious, of protecting sexual health.

Legal and policy framework

Overall, we think that our job of improving sexual health would be best served by a policy framework that reduces the stigma associated with sex work, and allows consenting adults to have sex as they choose. We are very concerned that protecting children, reducing violence against sex workers and helping people who have been coerced into sex work are all made more difficult by laws that criminalise prostitution.

We support calls from sex workers themselves, and from many of those who work closely with sex workers, for the decriminalisation of prostitution. This would allow sex workers to develop ways of working more safely, including working more closely with the police and other agencies in identifying violence, exploitation and abuse, including of children.

We urge the Home Office to work closely with other government departments to ensure the full funding of sexual health services to help reduce the problems associated with sex work. We feel this is preferable to going further along the track of trying to abolish prostitution. The latter aim is, we think, unlikely to work for something that, whether you like it or not, is regarded as one of the oldest professions in the world.

Helen Ward & Angela Robinson on behalf on BASHH