

Submission to World Health Organization open call for feedback to develop a population-representative sexual health survey instrument

Prepared for Triple-X Workers' Solidarity Association of British Columbia

By Andrew Sorfleet
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Summary

Research conclusions often ultimately define sex workers as “having exchanged goods or money for sex.” The lack of distinction between formal and informal contexts for transactional sex has been a flaw for more than 30 years that has been recognized all along. The development of a WHO global sexual health survey instrument is an opportunity to finally address this inadequacy in surveys identifying commercial sex in order to assess risk for STBBI transmission.

Domain

**Priority socio-demographic relevant for sexual health survey instruments:
Sex Workers**

Survey Instruments

Questions regarding involvement in commercial sex

Definitions of sex work that make no distinctions regarding the context of transactional sex fail to capture the nuance and broad variance between sex services performed in workplace settings, and sex traded for commodities and money in informal contexts. The differences in possible risk for STBBI transmission between these two settings can be extreme. Sex traded where need and circumstances are driving factors and where communications are often less clear, including but not limited to coercion, exploitation, extortion and threats, drug or alcohol dependency is more likely to involve activities at higher risk for STI and HIV transmission. On the other hand, sex services for hourly rates and fees in professional workplace settings, where sexual health and safety measures and practices—including consistent condom use—are engrained in professional sex industry practices, present nominal risk for STBBI transmission.

These studies are also then absorbed into meta-analysis for regional prevalence rate averages, degrading the relevance of the statistical analysis in settings where STBBI epidemics are focussed, within broader national low sero-prevalence settings. In Canada, this is the case with both HIV and syphilis.

For example:

According to the Ontario HIV Treatment Network (OHTN), in a July 2012 brief titled "Sex Worker HIV Risk:"

"Establishing the prevalence of HIV among sex workers is challenging because they are a hard-to-reach population. Estimates range from 1% to 60%."

Of 11 studies reviewed, only two addressed women working in indoor settings. Four studies assessed street youth specifically ("involved in survival sex"), three included only female drug users, one recruited Aboriginal women. The OHTN *Rapid Response* brief postulates:

"There are three main categories of risk for HIV infection among commercial sex workers in Canada: high risk sex or sex with high risk partners, illicit drug use, and unstable living and working environments. Other risk factors include young age, tattooing or body piercing, and a history of sexual abuse."

The OHTN "Sex Worker HIV Risk" brief then states:

"Little is known about these issues in Canada and other high-income countries. In the Canadian context, injection drug use among sex workers and heterosexual transmission to clients and then to their sexual networks is contributing to the HIV epidemic."

According to B.C. Centre for Disease Control (BCCDC), Estimation of Key Population Size: Final Report (2016), selling sex could not be isolated as the sole risk factor in HIV sero-conversions where sex work was reported:

"In fact, a sex worker study conducted in Victoria (n=201 adult sex workers aged ≥ 18 years, including 160 female, 36 male and 5 transgender individuals) has shown that condom use with clients

among sex workers exceeds 90%, indicating that professional sexual services are performed safely in an occupational setting.”

“However, there are individuals engaging in survival sex work or transactional sex in informal settings who may not identify as sex workers. These individuals may be faced with other issues such as poverty, violence (including intimate partner violence) and drug addiction that increase their risk for HIV/HCV acquisition. Therefore, for the purpose of HIV/HCV programming, a clear definition of a priority population based on behaviour and context that impose risk, rather than a general identification with a group, is needed.”

Implications: Lack of nuance in research results in flawed policies

National and regional public health policies regarding STBBI prevention are derived from meta-analysis of research that typically does not differentiate between “sex work” and “survival sex.” Broad policy definitions of sex work shape the resourcing and delivery of prevention programming.

For example:

In the *Sexually Transmitted and Blood-borne Infections (STBBI) Framework for Action* from the Public Health Agency of Canada “people engaged in the sale, trade, or the purchase of sex” are listed as populations “disproportionately affected by STBBI.”

In a letter exchange between Triple-X and the Public Health Agency of Canada dated April 3, 2019, the Chief Public Health Officer, Dr. Theresa Tam states:

“The Pan-Canadian STBBI Framework for Action aims to acknowledge STBBI transmission risks associated with the spectrum of sex workers, including individuals engaged in survival sex work and transactional sex in informal settings.”

The Public Health Agency of Canada and the STBBI Pan-Canadian Framework for Action make no distinction to acknowledge the very low STBBI transmission risks associated with professional sexual services provided in workplace settings with occupational health and safety practices.

According to the Chief Public Health Officer, “This population, along with others, was identified as disproportionately affected by STBBI, as there is

greater potential for other associated high-risk behaviours such as condomless sexual activity or injection drug use.”

For example:

The 2017 B.C. Centre for Disease Control (BCCDC) guidelines for Medical Health Officers explicitly states that “exchanging goods or money for sex” is considered a setting and context for high risk of HIV transmission. According to the BCCDC Guidelines for Medical Health Officers, physicians who learn or suspect that a patient may be engaging in behaviour considered high risk have reason to report that this person may pose a risk of HIV transmission to others. Based on these reports, a Medical Health Officer can compel individuals to be tested for HIV.

Mandatory testing compelled by medical health authorities simply for being a sex worker is considered a violation of sex workers’ labour rights. In addition, sex workers appear as the only example of persons who may have HIV who may “pose a risk to the larger community,” and thus non-compliant sex workers are vulnerable to having their name, a description and HIV status published in the media by public health authorities, police and courts as has happened in the past.

Implications of flawed public health policy

When there is no distinction between commercial sex in formal workplace settings and transactional sex in informal contexts, two problems result: First, HIV prevention resources and programming including HIV PrEP delivery needlessly targets sex workers who are not at risk of STBBI infection. Those resources could be diverted to communities and social networks with high HIV sero-prevalence and high-risk behaviours where they are needed most. Second, the assertion, based on scant evidence, that sex workers generally are high risk for STBBI transmission perpetuates prejudice and stigma within the public health and health care sectors as well as the general public—including clients.

Prejudicial assumptions about providing sexual services are barriers to public health goals for STI and HIV prevention and could discourage sex workers from accessing sexual health services. The 2014 Working Paper by Celia Benoit *et al.* from the Canadian Institutes for Health Research reported that 40% of sex workers said their health-care needs were not met in the prior year compared with about 12% of the general population. In addition, 29% of sex workers feared being judged by doctors. Is it possible that public health statements that centre sexual services as a vector for HIV transmission contribute to this?

There is no research that concludes that British Columbia sex workers overall are more likely to be HIV-positive or transmit HIV. In fact, according to the BCCDC's Estimation of Key Population Size report:

“Historically, it has been assumed that sex work plays an important role in the heterosexual and same-sex transmission of HIV ...the project team requested the BCCDC Surveillance Team to perform an analysis on new HIV diagnoses among men and women in B.C. from 2006-2015 to determine what proportion of these cases reported sex work as a potential risk factor. We found that the number of women diagnosed with HIV and who reported sex work declined from 22 and 26 individuals in 2006 and 2007 to only two and one individual in 2014 and 2015. Injection drug use was also reported by 33%–100% of these women [who also reported sex work] over the same period.”

These conclusions are echoed in some of the earliest HIV sex work research in the United States. Dr. Judith Cohen, Priscilla Alexander and Constance Wofsy in “Prostitutes and AIDS: Public Policy Issues,” *AIDS & Public Policy Journal*, 1988, define prostitution as “the exchange of sexual services for money.”

“Prostitutes have always been cautious about STDs, out of concern for their own health and their ability to work. Therefore, they have tended to be more responsible about preventing transmission in order to protect themselves as well as others. They learn to recognize symptoms in men and refuse to have sexual contact with those they believe to be infected. Most have made use of whatever preventive measures were available, including soap and water, condoms and spermicides. This caution has increased with their awareness of AIDS.”

“Prostitutes in the U.S. are not and have not been significant vectors for the transmission of STDs, including AIDS. To the extent that prostitutes have become infected, their rate of infection has paralleled the rate among IVDUs in their communities, and almost all prostitutes who have tested positive in sero-prevalence studies or who have been diagnosed with AIDS have had a history of intravenous drug use.”

“Furthermore, the closing of brothels and other prostitution businesses has often been accompanied by a local rise, not a reduction, in the incidence of STDs.”

Even early publications for the World Health Organization have recognized the difference in the contexts for transactional sex. “The Role of Prostitution in the Spread of Venereal Disease,” *U.N. International Review of Criminal Policy* (Willcox, 1957):

“The proportion of venereal disease in the general population which was caught from prostitutes in a number of Asian countries is contrasted with the situation in France, the United Kingdom, and the United States of America. In Asia most venereal infections are contracted from prostitutes whereas in the countries listed, this is not so, the professional prostitute having been largely replaced by the ‘good-time girl’.”

Historical prevalence of ambiguity in longitudinal research

Definitions of commercial sex that lack distinction between formal and informal settings become more and more entrenched over time due to the necessity of consistent markers in ongoing longitudinal studies.

For example:

In February 1995, as coordinator of the Sex Workers Alliance of Vancouver, I was invited to sit on the advisory panel for the Vanguard Project, British Columbia Centre for Excellence in HIV Research (BCCfE) in Vancouver. For the purposes of the study, “paid sex” included “sex exchanged for money, drugs, goods, clothing, shelter or protection.” The survey instrument asked respondents if “ever in their life-time” had exchanged sex. I lodged a complaint:

“Having a section on paid sex might have been able to determine that people are more likely to practice safer sex when a commercial transaction is involved... [However,] Section I: ‘Paid Sex’ is unable to accomplish even this because it doesn’t distinguish between people who self-identify as sex workers and those who have had casual commercial sex encounters.”

Recruitment for the Vanguard Project longitudinal cohort ran from 1995-2002. Research papers from the Vanguard Project were published in peer-reviewed

journals and presented at HIV conferences from 1996 until 2010, and are still listed as part of the new Momentum Study out of the BCCfE. The project also engages in “population modelling” that projects estimates of HIV incidence in local and provincial as well as global settings.

In 2001, the Vanguard Project reported that male sex workers are seven times more likely to contract HIV compared with the other gay and bisexual men in the Vanguard cohort.

In an editorial in the same issue of *International Journal of Epidemiology*, Alex Carballo-Diéguez and Ezra Susser made this critique:

“The trading of sex plays a central role in the HIV pandemic and we should examine it with the utmost rigour as well as sensitivity. ‘Sex trade’ is one of those concepts that seem clear only until the moment we try to define it. The apparently dispassionate ‘sex trade’ nomenclature is in fact extremely difficult to operationalize. Weber *et al.* define sex trade as ‘exchange of money, drugs, goods, clothing, shelter, or protection for sex within one year prior to enrolment.’ Although this broad definition of sex trade may be appropriate to get an initial impression of the proportion of people in a sample who engage in these behaviours, a finer distinction is needed if we want to gain any deep understanding of this experience and its connections to other observable variables. A number of dimensions need to be considered, for example: Intentionality; Types of goods exchanged; Frequency; Number of partners; History; Roles; Choice and; Cultural milieu.”

Perhaps the most important distinction that is missing, however, is whether or not survey respondents consider themselves sex workers and, provide sexual services in an occupational capacity in workplace settings.

Conclusion

Research conclusions often ultimately define sex workers as “having exchanged goods or money for sex.” The lack of distinction between formal and informal contexts for transactional sex has been a flaw for more than 30 years that has been recognized all along. The development of a WHO global sexual health survey instrument is an opportunity to finally address this inadequacy in surveys identifying commercial sex in order to assess risk for STBBI transmission.

About Triple-X

Founded in 2012, Triple-X is Canada's first registered Triple-X Workers' labour organization reserving membership exclusively for persons who have agreed to the direct exchange of sexual stimulation for financial compensation. Triple-X also organizes and co-sponsors Vancouver's Red Umbrella March for Sex Work Solidarity, held annually since 2013. As of June 2018, the Triple-X certification mark was registered with Innovation, Science and Economic Development Canada, Section 4 of the Defined Standard for accredited workers ensures:

“... that they are qualified to: a) assess risks for sexually transmitted infections (STIs); and b) ensure best practices in STI prevention are followed appropriate for the service provided according to B.C. Centre for Disease Control guidelines.”

In our role to provide education regarding sexual health and safety, Triple-X examines and analyzes federal and provincial public health policies for potential implications on the sex industry.

About the Author

Andrew Sorfleet has worked in the sex industry for over a decade and has been a sex workers' rights activist since 1990. He was education coordinator and outreach worker at Maggie's – The Toronto Prostitutes' Community Service Project (1991-1994), founding regional representative (1992) of the Global Network of Sex Work Projects (NSWP), NSWP Internet coordinator (1996-2006), and coordinator of the Sex Workers Alliance of Vancouver (1995-2005). He is author of *\$WE&R! The Sex Workers' Workbook* produced for the Law Commission of Canada (2005), and was the official rapporteur for the European Conference on Sex Work, Human Rights, Labour and Migration (Brussels 2005). Currently, Sorfleet is president of the board of Triple-X Workers' Solidarity Association of British Columbia.

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