HIV Ireland Report

Potential impact of the Swedish model on rates of HIV/AIDS among sex workers and their access to healthcare

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Introduction

Currently in Ireland it is not illegal to be a sex worker per se. Under the Criminal (Sexual offences) Act 1993, it is an offence to solicit in a street or public place for the purpose of prostitution. This law can be applied to both buyers and sellers. In recent years there was a call for the Nordic model (criminalising the purchaser) cumulating in the setting up of the *Turn Off the Red Light* campaign. Government have been very supportive of the Nordic model. In June 2013, the Oireachtas Justice Committee came out in favor of developing legislation for the Nordic model.

In November of 2014 Justice Minister Frances Fitzgerald published the draft heads of the Criminal (Sexual Offences) Bill 2014 which includes legislative plans to criminalise the purchase of sex in Ireland. It subsequently went out to consultation and the Department of Justice have been receiving feedback on the draft to date.

HIV Ireland (herein HIVI) is seeking to establish the facts on the potential of more adverse outcomes for sex workers and their clients if Ireland criminalises the purchase of sex. Specifically will it negatively impact the rates of HIV/AIDS and negatively impact access to treatment (screening and treatment once diagnosed).

Consequentially HIVI commissioned a weeks worth of research time to examine and report on the evidence from other early-adopters of criminalising the purchasers of sex - Sweden, Norway, Iceland, UK, and Canada - to see if there is any evidence that this change led to worse outcomes in (a) health outcomes of rates of HIV/Aids and Sexually Transmitted Infections and (b) access to services for HIV/Aids. HIV Ireland also requested information on the New Zealand and Dutch models.

In this report Section one outlines the theory on which the Swedish model was developed and where it has been adopted in other developed economies. Section two briefly defines and describes the sex worker population and provides an estimate of the baseline rate of HIV/AIDs in Ireland. Section three examines the effect of the Swedish model on HIV/AIDS rates and outlines factors identified in the literature which are associated with an effect on the rates of HIV/AIDS in the adopter countries. It finally discusses other knock on effects to the health and wellbeing of sex workers experienced in these countries. Section four discusses the impact on access to services for the diagnosis and treatment of HIV/AIDS and outlines factors affecting access.

This report was limited by three features (1) the limited body of literature looking at the issues of HIV/AIDS among sex workers in developed countries, specifically the countries we focussed on, (2) the timeframes for examining the legislative change which in most cases were really very recent so the data are not available but more importantly the real impact may not be identified until much later into this social experiment and (3) the social and cultural context within which this legislative change is made varies siginificantly. The impact of cultural norms and wider social attitudes must be considered.

Section One: The Swedish Model

Background

"Laws, policies, and practices can help or harm sex workers in their efforts to stay healthy while selling sex."(Das and Horton, 2015)

An interview[1] with Gunilla Ekberg (2004) a long time Swedish radical feminist and lawyer documents succinctly the political and philosophical backdrop to the development of the 'Swedish Model'. Gunilla Ekberg describes how

> "*The cultural shift in Sweden was that we went from seeing prostitution as separate from other forms of male violence to naming it as a serious form of male violence against women. And if prostitution is male violence against women, then it is a crime and consequently, there is a perpetrator.*"

She went on to outline how philosophically this issue is about gender equality.

> *"In Sweden, it is understood that any society that claims to defend principles of legal, political, economic, and social equality for women and girls must reject the idea that women and children, mostly girls, are commodities which can be bought, sold and sexually exploited by men. To do otherwise is to allow that a separate class of female human beings, especially women and girls who are economically and racially marginalised, is excluded from these measures."*

This interpretation is consistent with how the Global Commission on HIV and the Law (2013) describes the Swedish model "Based on the premise that women in sex work need protection, it regards the sex worker as the 'victim' and the client as the 'exploiter'.

Sometimes called the Nordic Model, because of its adoption, or partial adoption in Norway, Finland and Iceland, the Swedish model of regulation of sex work became law in Sweden in 1999 and proposes that all sex work is violence against women. While Norway adopted the law verbatim, there are variations in the laws in each remaining country in the Nordic region. Finland has only criminalised the clients of trafficking victims, while Iceland has banned everything, including strip-tease. This is very different from the law in Sweden. Denmark, also a Nordic country, has refused to criminalise clients (Jakobsson, 2013). It is therefore not possible to call the laws in Sweden a 'Nordic Model', as there are differences in the laws between the Nordic Countries.

The wording of the law in Swedish is (translated):

> "Anyone who for remuneration procures a temporary sexual relationship will be guilty if their action is not punishable by some other offense according to the penal code of purchasing sexual services, and will be sentenced to fines or prison or not more than six months."

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[1] "Abolishing Prostitution: The Swedish solution"

It is important to remember that the situation in Sweden is radically different from most other European countries, let alone Ireland. As Don Kulick (2003) states: “Sweden has some of the harshest sex laws in the world. It is the only European country, for example, where during the early years of the AIDS epidemic, a national law was passed abolishing existing gay bathhouses and prohibiting the establishment of new ones. It is also one of the few countries in the world where persons with HIV can still be forcibly incarcerated without a criminal trial, simply because doctors believe that they will not follow instructions to inform their sexual partners that they are HIV+. Sweden is also one of the few countries in Europe perhaps the only one where it is impossible to remain anonymous as a person with HIV: if you test positive at any state funded or private clinic, your physician is legally obliged to report your identity to the health authorities, and you are then legally obliged to report to a doctor regularly with information about your sexual encounters and relationships.” (Don Kulick, 2003).

Furthermore, Kulick continues: “Law dealing with what in Swedish is referred to as ‘procuring’ (koppleri) is very harsh, and can result in prison for up to four years. It is illegal to profit in any way from sexual services performed by anyone else. This is positive in the sense that it makes the exploitation of sex workers and others by unscrupulous profiteers illegal. But it also makes it illegal for sex workers to rent apartments or commercial spaces for work it makes it illegal for them to hire anyone to book their appointments, it makes it illegal to openly advertise their services in newspapers and magazines, and it even makes it difficult for them to live with anybody, since their lover, roommate or friend could be seen as profiting from the sex worker’s income, in cases where they share expenses or have joint bank accounts.” (Don Kulick, 2003). Therefore, although sex workers are “decriminalised”, there are still very harsh laws surrounding them, that treat them as second class citizens, and which increase negative social perceptions of sex workers thus increasing societal stigma.

It should be noted that the Swedish courts have stated that “remuneration” includes not only payment of money, but also gifts including alcohol or clothing (BRÅ, 2000). This means that the person who gives someone a drink in a bar, or takes someone to dinner, or other gives a person gifts, and then sex takes place, would be in breach of this law, whether or not the person receiving the gift is a sex worker or not. The person receiving the drink, the dinner, or the gift, would be treated as someone who needs rescuing, whether or not they needed rescuing.

The Swedish model in other countries

Table 1 below provides an overview of legislative approaches on prostitution in a number of countries, which in the majority have historically taken similar approaches to prostitution, though some have diverged in the last decade.

Table 1: High income countries legal models of prostitution

Country	Current Legal Model on Prostitution	Year of Legislation change	Outcomes
Sweden	Not Criminalised Selling of sexual services Prohibited Purchasing sexual services Pimping Operating a brothel	1999	A reduction in visible street prostitution (Ekberg 2004; Skarhead 2010) No overall increase in prostitution (Skarhead 2010) Lack of hard evidence as to the laws impact and declines followed by increased activity through internet and mobile phones (Socialstyrelsen 2004) Negative impacts have been reported in health and welfare service supports to off-street sex workers (Hindel 2008) Evidence suggests strong disincentives for sex workers to carry condoms as police routinely confiscate belongings as evidence (Ku Hon Chu and Glass, 2013) After the introduction of the model HIV prevention projects aimed at clients of sex workers ceased (Ku Hon Chu and Glass, 2013)
Iceland	Not Criminalised Selling of sexual services Prohibited Purchasing sexual services Pimping Operating a brothel Advertising sexual services Striptease	2009	Large public support for banning the purchase of sex Police have stated they lack the resources to enforce the law and despite the law prostitution is thriving
Norway	Not Criminalised Selling of sexual services Prohibited Purchasing sexual services Pimping Operating a brothel	2008	Initial drop in street prostitution but later reports suggesting a return to previous levels (Expatica 2009; NRK 2013) Considerable criticism within Norway of the law and its effects, however evaluating the law has proved difficult, due to problems isolating the law from other social factors (Brunovskis and Skibrei 2012) Consistent harassment of sex workers from police has been reported (Visser 2013)
The Netherlands	Not criminalised Buying and selling of sexual services Brothels Prohibited Coerced prostitution Exploitation of sex worker	2000	Abuse towards sex workers has not ended with legalisation and Dutch and other EU women are still trafficked into the country (Outshoorn 2012) Those in the unregulated sector are more vulnerable to violence and may not be receiving health and safety services (Hindle 2008)
UK	Not Criminalised Selling sexual services Prohibited	2009	Emphasis is primarily on reducing street prostitution (Kelly 2009) Policy driven largely by visibility of prostitution and sex workers and residents have expressed dissatisfaction (Hubbard, Mathews and Scoular, 2007)

	Paying for sex with someone who has been forced Owning/managing a brothel		Proposed adoption of sex-purchase ban 2014
Canada	Not criminalised Selling sexual services Criminalised Selling sexual services near where a person under 18 may be present Owning or managing brothels Advertising sexual services	2014	Model aims to limit prostitution as far as possible New bill has divided the nation as 12 months earlier the Justices of the Supreme Court of Canada identified that criminalising sex workers and their clients contributes to a lack of safety for sex workers Laws inconsistent with sex workers rights groups who argue for decriminalisation based on the rights and safety of sex workers (Bedford challenge 2013) "The restrictions on advertising and communication limit sex workers ability to screen clients and negotiate transactions which ofcourse can lead to violence and reduce health and health access" (Alison Clancey, Executive Director, Supporting Womens Alternatives Network (SWAN), correspondence on March 6th 2015)
New Zealand	Not criminalised All aspects of unforced sex work Prohibited Forcing a person to exchange sexual services Unsafe sexual practices	2003	No reported impact on the numbers of sex workers as a result of the law (Abel 2007) Had a 'marked effect' on supporting sex workers in refusing particular clients and improved conditions for sex workers (New Zealand Ministry of Justice 2008) Models goals are to reduce discrimination and support rights and welfare of sex workers rather than endorse prostitution (Kelly 2009) Sex workers report their client negotiation powers, general safely and relationships with the legal system are all enhanced by the law (Abel 2007) Decriminalisation of prostitution is associated with better coverage of health promotion programs for sex workers (Harcourt 2010)
Scotland	Not Criminalised Selling sexual services Prohibited Owning/managing brothels Pimping	2007	4 proposals to criminalise the purchase of sex have failed to achieve a majority within Scottish parliament Law seeks to eradicate street prostitution entirely but no evaluation of the 2007 law exists

Section Two: HIV/AIDS among sex workers

The sex worker population

Definition of sex work: In this study the term sex worker refers to

"*A woman or man who exchanges or trades sexual acts for money over a sustained period of time...sex workers may start and stop opportunistically, or engage in sex work in response to fluctuating circumstances or lifestyles*." (National Advisory Committee on Drugs 2009).

Gaining an accurate estimation of the number of workers in the sex industry is a difficult task, in part because they constitute a marginalised population. Sex work is also a transitory occupation, with sex workers transiting in and out of the industry, some remaining for only a short period of time and others entering and exiting the industry a number of times over a long period. It is, however, important that best estimates are made as to effectively deliver services to this section of the population and cater for their varying needs. As has been well documented, the sex worker population is not homogenous and there are issues which are more pertinent to certain sectors than others (O'Connor et al., 1996; Plumridge & Abel, 2001). Much attention has been focussed by researchers, public commentators, politicians and others on the street sector, as it represents the most visible proportion of the sex industry, yet in most countries it represents only around a tenth of the industry (Hubbard, 2004; Scambler, 1997; Weitzer, 2005).

The sex worker population in Ireland

Currently there are no precise figures of the number of women or men working in prostitution in Ireland, but estimates from various agencies providing services to women engaged in prostitution nationally range between 600 in 2003 (Bindel and Kelly, 2003), 700 in 2006 (Valiulis, Redmond, Bacik 2006), to 1000 in 2012 (Ruhama 2013). While these figures are only estimates, thirteen agencies delivering services to sex workers in Ireland provided detailed figures to the Irish Rights Commission Report in 2006 which indicted between 551-571 women were in contact with these agencies in 2005 (Valiulis, Redmond, Bacik 2006). The report found prostitution to be 'an issue throughout Ireland, everywhere, every town and city'[2]. Large numbers of foreign nationals were identified as having contact with these agencies with Albania, Brazil, China, Croatia, Czech Republic, 'Eastern Europe', Ghana, Italy, Jamaica, Latvia, Lithuania, Moldova, Mongolia, Nigeria, Poland, Romania, Russia, Slovakia, South Africa, Spain, Ukraine, Venezuela and Zambia reported to be countries of origin for many of the women. This is in line with more recent data from the case statistics of Ruhama of sex workers who identified to the agency for support came from all over the world (Ruhama Annual Report, 2013). The 136 women seeking support through Ruhama came from 29 countries; the majority coming from Ireland (57) followed by Brazil, Nigeria, Spain, Colombia and Romania.

[2] Athlone, Carlow, Cork, Dublin (city centre and suburbs), Galway, Kerry, Kilkenny, Laois, Louth, Limerick, 'The Midlands', Sligo, Waterford, Wexford, were all identified as places where prostitution exists

Has the Swedish model reduced the size of the sex worker population?

Sweden

Prior to the law coming into effect, no count of the number of sex workers was completed. An estimate based on a 1996 survey of 2810 people, with 187 responses stating they had paid for sex at one time or another, equating to 12.7% of the male respondents. The Swedish government then made claims based on this figure that over four hundred thousand men, over 18 years of age, had, at some point in their lives, paid for sex (Kulick, 2005). In 2008, a similar estimate was completed, and 2,500 surveys were sent out, but only 45.5% of them were returned. Although the study showed that 8% of male respondents had paid for sex during their lifetime, and the Swedish government claimed this represented a decrease in the number of clients, the author of the report stated that because the survey was not representative of men, in particular young men were underrepresented, and the large number of non-returns, no valid conclusion could be drawn. The author also indicates that perhaps men who were clients were unwilling to admit being so because of the criminal act it had become (Dodilett & Östergren, 2011: 15-16). It is therefore not possible to extrapolate from a non-representative survey to the entire Swedish male population, and nor is it possible to state that the number of clients reduced.

After the law came into effect, using the records of social workers and Police, an estimate of the number of street based sex workers was completed. Maj Britt Theorin (2001) states "street prostitution has decreased by 50 per cent and the Swedish police maintain that the majority of these women have not moved into hidden forms of prostitution." However, "… about 1/3 of all prostitution consists of street prostitution, and that 2/3 takes place in concealed form". … The survey confirms the results of previous studies - that prostitution in Sweden consists of much more than the visible street prostitution" (Socialstyrelsen, 2000). It can therefore be seen that the claimed 50% reduction in street prostitution (the only kind visible to the authorities) in Sweden that occurred when the law was first introduced, is really only a possible decline of 1/6th of the total amount of prostitution in Sweden[3].

It should also be noted that "In 2009, the National Bureau of Investigation estimated that there were about 90 Thai massage parlours in Stockholm and vicinity, most of which were judged to be offering sexual services for sale. At the turn of 2011/2012, the number of Thai massage parlours in the Stockholm area was estimated to be about 250 and throughout the country about 450" (Swedish National Police Board, 2012).

Furthermore, "The increase in the number of foreign women selling sex, cases of trafficking and persons advertising on the Internet, has also resulted in a situation where police and social authorities have trouble monitoring the scope of these activities" (Holmström & Skilbrei, 2009).

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[3] This is similar to what we see in Ireland where the National Advisory Committee on Drugs (2009) found that any agencies providing services to women engaged in sex work have reported that prostitution has becomes less visible due to a number of factors, including technological advancement and the use of mobile phones and the internet by sex workers. In Dublin the regeneration and gentrification of parts of the city, has disrupted long-established sex markets. Consequently, it is harder for outreach workers to locate and engage with this client group.

Norway

An evaluation of the law was commissioned by the Justice Ministry and published in August 2014 and stated that the ban on purchasing sexual services had reduced the demand for sex and thus the extent of prostitution in Norway (Rasmussen, Strøm, Sverdrup, Hansen, 2014). However it cannot be sure what the reason for any assumed decrease in the number of sex workers may be. As the Norwegian Working Group (2004) found "It is impossible to say whether a reduction on the streets is due to legislation or to other factors. Mobile telephones and the Internet are probably of great significance for women selling sex elsewhere than on the streets". The report also found that it has become much more difficult to be a sex worker in Norway, given reduced economic conditions but states that this effect is in line with the intended consequences of the law. The report also found no evidence of more violence against sex workers after the ban. The report however has been severely criticised, with its conclusions in conflict with other studies (Eriksson, 2006; Dodillet and Östergren 2011; Levy, 2011; Levy, 2014).

The current situation of HIV/AIDS among sex workers in Europe

According to global data reported between 2007 and 2011, HIV infections among sex workers were highest in sub-Saharan Africa, where more than a third (37%) of female sex workers were HIV-positive, followed by Eastern Europe (11%), and around half that number in Latin America and the Caribbean (6%) and Asia (5%). The lowest rate, 2%, was reported in the Middle East and North Africa (WHO Surveillance data).

UNAIDS epidemiological surveilance data in Europe over the past deacade on the rates of HIV infection have revealed declines in new infection rates of up to 25% (UNAIDS report on the global AIDS epidemic, 2010), signifying advancements in the global fight against the disease. However HIV infection continues to be a source of public health risk within Europe with a total of 136,265 new HIV diagnoses in 51 of 53 countries in 2013 (HIV/AIDS Surveillance in Europe, 2013). New HIV infections are expanding within certain populations that are most at risk. In western Europe the highest proportion comes from men having sex with men, followed by people originating from countries with generalised epidemics[4].

In many high-income countries and regions, such as Canada, the USA, and Europe, HIV epidemics that initially escalated in people who inject drugs in the mid-1990s shifted to female sex workers (Shannon, 2014). Female sex workers also bare a disporportioanly large risk and burden of HIV as evidenced in a recent systematic review and meta-analysis of sex workers in low and middle income countries (Baral 2010). Female sex workers were found to have a 13.5 times greater chance of HIV infection than women in the general population (Baral, 2010).

Data on HIV rates in sex workers in Western Europe is scare, due in the main part to the difficulty in reaching this group (ECDC, 2012). Several European countries do not track HIV prevalence in sex workers (TAMPEP, 2009) and most European countries that report prevalence data for female sex estimate based on urban centers and therefore are not representative of the country as a whole

[4] A generalized HIV epidemic is where greater than 1% of the population is HIV positive

(ECDC, 2012). The research available shows that HIV prevalence among male and transgender sex workers typically exceeds that of female sex workers (UNAIDS, 2012). Similarly, statistics on HIV prevalence among sex workers in the United States are few in number, but HIV infections among those who inject drugs tend to be significantly higher than among those who do not (Centre for AIDS Prevention Studies, 2008).

Although evidence in Europe shows that sex workers are not driving the HIV epidemic in the region, prevalence among sex workers exceeds 1% in 22 countries and 5% in 6 (mainly Eastern Europe) (ECDC, 2012). And given that sex work in Europe is still largely performed by women (who constitue 87% of the sex worker population) female sex workers in Europe are still a high risk group for contracting HIV. In Vancouver, estimates put HIV prevalence at 20% in female sex workers working in informal indoor venues (eg, bars or hotels), 12% on the street, and 3% in formal sex work establishments (eg, in-call venues) (Deering, 2013)[5].

Data on HIV among sex workers in Ireland

In 2013, 344 people were newly diagnosed with HIV in Ireland, giving a rate of 7.5 per 100,000 population. Since 2010, the annual rate of new HIV diagnoses has been relatively stable in Ireland, ranging from 7.0 to 7.5 per 100,000 population (O'Donnell, Moran, Igoe, 2014). This compares to 5,846 new HIV diagnoses in England (9.4 per 100,000), 287 in Scotland, 125 in Wales, 95 in Northern Ireland (Public Health England 2013). In 2013, 131 (35%) newly diagnosed cases in Ireland were heterosexually acquired, a similar number to 2012 (133 cases). Since 2010, the number of new diagnoses among heterosexuals in ireland has remained stable between 127 and 133 cases (O'Donnell, Moran, Igoe, 2014).

Heterosexual contact was the second most commonly reported mode of transmission, accounting for 38% of new diagnoses in 2013 (39% in 2012). Among heterosexual cases, over half (57%) were among individuals originating from countries with generalised epidemics (O'Donnell, Moran, Igoe, 2014).

Table 2 below provides an overview of new HIV diagnoses per 100,000 in several western European countries between 2004 and 2013. Irelands rates, while higher than Nordic countries , are close to the western European average (UNAIDS, 2013).

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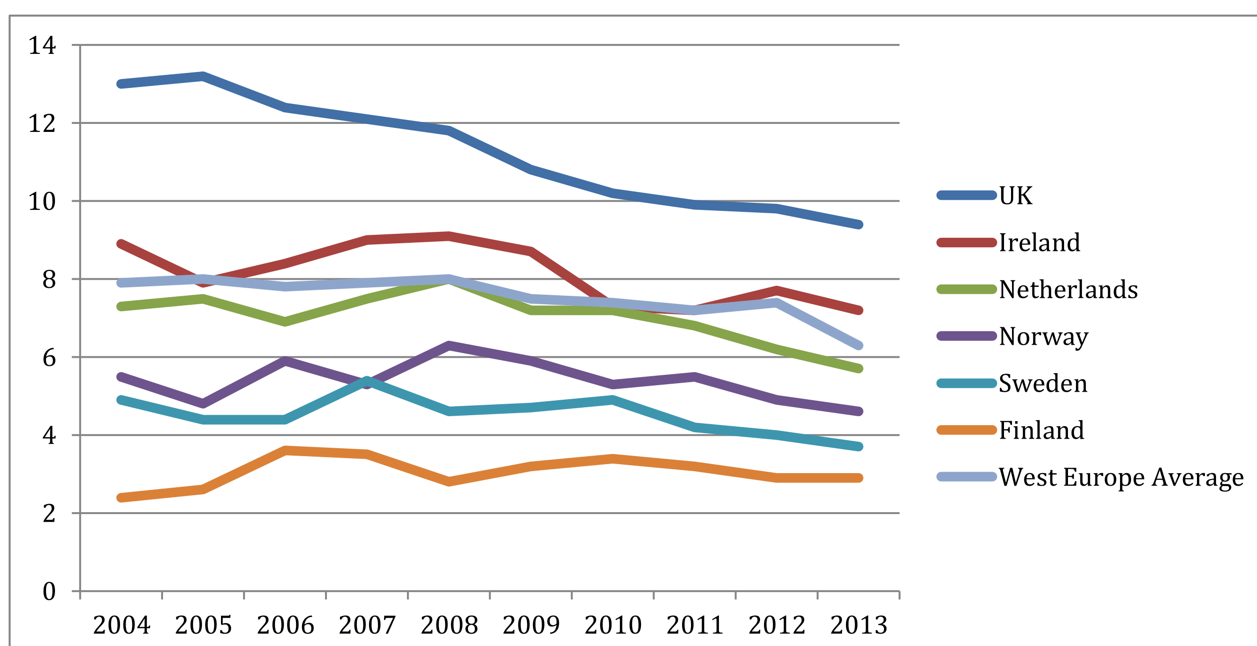
[5] Modeling predicts that interventions to promote access to safer work environments for female sex workers could avert 37% (95% UI 16–61) of HIV infections among female sex workers and their clients in Vancouver in the next decade through the combined effect on reduced violence, police harassment, and non-condom use (Deering, 2013).

Table 2: HIV diagnoses and rates per 100,000 population in Western Europe (2004–2013)



Ireland, like the UK and Luxembourg does not track HIV prevalence in sex workers at a national level (ECDC, 2012). Several authors have noted that even in those countries that do provide prevalence data on HIV in sex workers, these estimates tend to be based on numbers coming from urban centers (ECDC, 2012) while others would call the methods of sampling and data collection into question:

> *"All the statistics on HIV prevalence among SWs in Europe can be found in the ECDC thematic report on sex work in 2012. I would be quite suspicious of this data though, since it is being collected in sometimes very unreliable ways (e.g. the Swedish case: of 979 clients interviewed by the Swedish Prison Project in 2006/07, 46 reported they had sold sex of whom 45 were test for HIV and 1 female (2.2%) was confirmed as HIV positive) And this is how they determined the prevalence among female SWs in Sweden is 2.2%..."* (Advocacy and Policy Officer with the International Committee on the Rights of Sex Workers in Europe).

One study conducted in 1998 in Dublin which examined the health profile of 150 new sex workers who attended a drop-in clinic in the city between 1991-1997 revealed that among those tested 2.5% were HIV positive, 5% were hepatitis B positive, 8% were hepatitis C positive and 25% had an STD. Almost 8% were injecting drug users (IDU) with higher prevalence of HIV, hepatitis B and C compared with non-IDU (McDonnell, 1998). In 2009 a study with drug using sex workers found the levels of reported contact with health services amoung this group were high (64%), but so too were levels of self-reported Hepatitis C Virus (HCV) (78%) and Human Immuno-deficiency Virus (HIV) (21%) infection among the men and women interviewed (Whitaker, 2011).

Section Three: Increase/decrease in rates of HIV/AIDS

Shannon and colleagues in their review of the factors associated with HIV among female sex workers argue;

> "*an increasing number of reports show how punitive laws and policies governing sex work, including criminalisation of some or all aspects of sex work, incarceration, demolition of red-light districts and legal restrictions on where sex workers operate elevate HIV acquisition and transmission risks*" (Shannon et al 2015).

Where female sex workers have constrained rights and access to resources due to their status as sex workers and women, gender-based violence and sex trafficking have been consistently linked to increased odds of HIV infection and condom non-use. By contrast, gender empowerment and higher education and literacy continue to mitigate HIV risk among female sex workers (Shannon et al, 2015).

Evidence of change

We did not find any study which examined the rates of HIV/AIDS before/after the implementation of the Swedish model. However, the literature, most notably in the Lancet special issue on sex workers and HIV/AIDS, contains many expert opinions that a model of criminalisation has a negative effect in that is increases sex workers risk of HIV/AIDS:

Enforcement-based approaches and policing within criminalised frameworks have consistently been linked to elevated risks for violence, and reduced ability to negotiate safer sex transactions, including prevention of HIV and other STIs (Krusi et al, 2014).

Additionally, Catherine Healy, a sex worker advocate and National Director of the New Zealand Prostitutes Collective made the point in the context of New Zealand which has a model of decriminalisation that:

> "*The rates of HIV among sex workers in New Zealand remain low, although they have always been low, even prior to decriminalisation. Sex workers occupational safety and health has been enhanced by decriminalisation, in a context where sex workers, clients, and third parties are allowed to operate consensual commercial sex services.*" (Catherine Healy; correspondence on March 12th 2015)

Catherine also gave us information of how sex work is regulated in New Zealand and how sex workers have a workplace safety/occupational health guidance which states condoms use are a regulatory requirement in the delivery of sex work. This again relates to the wider context of delivery of a model of decriminalisation.

The Crime and Justice Research Centre's (CJRC) key informants were not aware of any substantial change in the use of safer sex practices by sex workers as a result of the enactment of the Prostituion Reform Act 2003 (PRA). It was generally felt that most sex workers had already adopted such practices as a result of the effective HIV/AIDS prevention campaign that ran in the late 1980s. Many informants said that it was in sex workers' own best interests to look after their health (Contracting a

sexually transmitted infection (STI) meant they had to take time off work.) Sex workers in brothels seemed to actively monitor this admonishing any sex worker who has provided sexual services without using a condom.

Despite no great change in safer sex practices, there were several positive effects reported as a result of the PRA. Both the CJRC and the Christchurch School of Medicine (CSOM) reports cite numerous examples of sex workers being able to negotiate safer sex by stating that it is against the law for them not to practice it.

> *"I now say, "I don't want your germs, do you want mine? I could be fined and go to jail, and if you take it off, then I could send you to jail"* (SOOB, CJRC, 2007) (Ministry of Justice 2008)

1. Condom handouts not as successful

Condom use within commercial sex transactions has typically been framed as the responsibility of sex workers, with research overwhelmingly aimed toward identifying sex workers at high risk of condom non-use and implementing behavioural interventions to increase condom use (Deering et al, 2013). However, male condoms decrease the per-contact probability of male-to-female transmission of HIV by about 95% (Deering et al, 2013). But interventions to encourage condom use are successful; a 30-minute, single-session behavioural intervention promoting condom use negotiation skills among female sex workers in Mexico successfully reduced HIV and STIs incidence by more than a half (Strathdee et al, 2015). Shannon et al (2015) make the point that in any model of sex work; condom coverage must include *condom access* (eg free or subsidised condoms at the workplace, the ability to carry condoms while working and contact with peer condom distribution), availability and affordability, linked to reduced HIV acquisition and transmission among female sex workers (Shannon et al, 2015). This issue of condom access has been highlighted in the literature on the Swedish model.

Sweden

Levy (2013: 4) notes that "Harm reduction efforts to reduce the harm that may be experienced during sex work – is seen as incompatible with Sweden's abolitionism, with efforts to eliminate prostitution". This means that, while sex works and clients are seen as target groups for the reduction of HIV/AIDS, the "provision of condoms to sex workers is not seen to be the Stockholm Unit's or the state's responsibility. Social workers at the Unit oppose condom distribution" (Levy, 2013).

> *"If they make so much money maybe they should buy their own condoms."* (Interview, 2009, National Coordinator Against trafficking and Prostitution cited in Levy 2011)

As a result, "Where the Stockholm Prostitution Unit fails to provide condoms on the street, sex worker respondents reported having to provide one another with condoms, with additional reports of shoplifting for condoms around Stockholm's street sex work area" (Levy, 2013).

Levy notes an interview with a Swedish politicians who was a proposer of the Swedish model who argued in regards to the provision of condoms and harm reduction information

> *“since it’s illegal, you can’t, it becomes very strange if you are informing of something that not legal in Sweden, it would be the same thing as (if) you would inform of buying and selling drugs’ (Levy 2013).*

Nevertheless, the Swedish Discrimination Ombudsman (2010) seeks “*to emphasize that zero tolerance towards buying sex should not constitute a barrier to harm reduction work that is aimed at people who sell sex.*” Despite this, “Sweden perceive harm reduction measures as something that facilitate criminal activities such as pimping and trafficking”. To quote the Swedish governmental inquirer Anna Skarheds public statement: ‘*We do not work with harm reduction in Sweden. Because that is not the way Sweden looks upon this. We see it as a ban on prostitution: there should be no prostitution*’” (Thing, Jakobsson, & Renland, 2011).

When arresting a client with a street based sex worker, police strip search the sex work and confiscate condoms to use in evidence. This means street based sex workers are less willing to carry condoms (Eriksson, 2006: 98;). The Malmo Prostitution Units attempt to hand out 8 condoms to buyers of sex in 2010 met with national outcry amongst politicians and in the Swedish media. In addition to condom provision, this Unit handed out a harm reduction pack containing, amongst other things, a safer sex selling guide, a rape alarm, condoms, and lubricant. With the purchase of sex criminalised, providing information vis-à-vis how to safely sell sex is still seen as ‘very strange’; with additional concern that safer sex selling guides may even encourage non-sex workers to begin to sell sex (Levy, 2011).

Canada

> *“While it is still early days, the laws have already negatively affected our ability to do out HIV prevention and outreach work with sex workers. There is much confusion and fear around the new laws. In turn the women and the managers of the massage parlours are much more hesitant to accept condoms and in some cases, they have refused accepting condoms altogether for fear that condoms will be used as evidence of sex work occurring on the premises.”* (Alison Clancey, Executive Director, Supporting Womens Alternatives Network (SWAN), correspondence on March 6th 2015).

New Zealand

By contrast, the situation in New Zealand is of a model of care which actively encourages safe sex among the sex worker population.

> “*I've got a really good doctor… he's just fabulous. He's, like I get my condoms off him a lot of the time… I get – I even just ring up his nurse, so I don't even have to pay… They just give me a script, give me a script at the counter, yeah, and he gives that to me, and he's really good. And like, um, any check ups I need, I go to him, and he always asks me, you know, "How's work going? Are you still escorting?" He really pushes for me to, um, better myself. Like, he's really proud of me… he just wants, um, better, like a parent would… he knows I travel too, and me and him have spoken and he's faxed me scripts to*

other places for condoms. He's really good." (Sex Worker cited in Fitzgerald and Brunton, 2007).

The majority of survey participants reported having their own doctor. However, only half of the participants who reported having a doctor indicated that they told him/her that they were sex workers. Street-based workers were the most likely sector to report their occupation to their doctors with managed workers the least likely. Most participants indicated that they accessed their GP for their general health needs as well as their sexual health needs (Fitzgerald and Brunton 2007).

However it was noted that not all would go to their GP

"I'm getting more and more comfortable about telling them that I am, and they freak out, (Laugh) and it's like… Well at the PC (NZPC[6]), I mean you can tell them anything. You can tell them you did 10 men standing on your head, they're not going to bat an eye. But things like Student Health, um, they're really uncomfortable I'm a prostitute. They're so uncomfortable hearing that." (Sex Worker cited in Fitzgerald and Brunton 2007)

Therefore stigma still exists even within a country which has decriminalised the act. In 2007, the AIDS Epidemiology Group reported to the Ministry of Health on HIV prevalence amongst 9,439 people who attended sexual health clinics in 2005 and 2006 (AIDS Epidemiology group, 2007). The report notes that none of the 343 self-identified sex workers were found to be infected with HIV. This compared to an HIV prevalence of about 4.4% among homosexual and bisexual men, 0.1% of heterosexual women, and 0.1% of heterosexual men. It should be noted that the sample (people attending sexual health clinics) are a higher risk group than the general population. Therefore, these figures probably overstate the HIV prevalence in the community.

Potential effect in Ireland?

This could have huge implications in Ireland where the National Advisory Committee on Drugs report found condom use was the standard method participants had used to reduce their risks of contracting and transmitting STIs and the risk of unplanned pregnancy.

"The participants spoke about always using condoms for protection, not only during sexual intercourse but also for orogenital and/or manual relief. Most were aware that they needed different types of condoms for different acts. Some used condoms as barriers to conception and some used condoms as barriers to intimacy. Most of the women availed of the relevant health services for STI screening and check-ups." (National Advisory Committee on Drugs 2009).

[66] New Zealand Prostitutes Collective

2. Increased violence and physical risk

Within criminalised environments, physical and sexual violence in the workplace, whether by clients, police, managers, pimps or predators posing as clients are among the most ubiquitous and influential determinants of HIV acquisition and transmission risk among female sex workers, linked with inconsistent condom use, client condom refusal, condom use failure and breakage and HIV infection (Shannon et al, 2015).

Sweden

Increased competition for clients among street workers results in harsher conditions for sex workers. To compensate for fewer clients, street workers are engaging in risker sexual services: to compensate for fewer clients workers often take drunk clients, report more aggressive clients that are not deterred by law and who refuse condom use (Krusi et al 2014). These factors expose street workers to a great risk of violence and infectious diseases. Criminalisation and policing force sex workers to rush or forgo screening prospective clients or negotiating the terms of sexual transactions before entering a vehicle, placing sex workers at increased risk of physical violence, rape and HIV/STIs (Krusi et al 2014).

Indoor sex workers have reported more apprehension about seeking help if they have a violent client as they fear all their clients will be targeted given they now have a specific work location. There is also a reduction in clients willing to 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 (Kuilck, 2003; Dodillet and Ostergen, 2011).

Socialstyrelsen, the Swedish Board of Health and Welfare, reports (2003) that "We cannot state with certainty whether there has been an increase of violence affecting prostitutes since our previous report or during the last few years. Some informants speak of greater risks for prostitutes, but few have observed an actual increase in violence". They further state (2003) "Police who have studied the occurrence of violence have not found any evidence of an increase. They also feel that the women have enough trust in the police to report any incidents of violence to which they are subjected."

From 2001 until the most recent research reports, Swedish sex workers have been reporting an increase in violence against them (Sambo, 2001; Eriksson, 2006; Dodillet & Östergren, 2011, Levy, 2013), though this appears to be ignored in the official Swedish evaluation, was downplayed, or blamed on sex workers (Skarhed, 2008). Jordan, (2010: 9-10) states: "The Skarhed Report notes that a 2003 government report spoke about more risk because of greater competition among women for fewer clients. However, it dismisses the information and blames women themselves for the violence. It relies on a few statements from the police and some women who left prostitution to assert that the real cause is more heroin (Skarhed 2010, 33). Thus, the government contemptuously tries to avoid any responsibility for violence caused by the law by shifting the blame for violence to the women themselves. Its claim of 'clean hands' is not surprising because the report has to reject any concerns or evidence that might support calls to abolish the law. " (Jordan, 2010).

Kulick (2003) notes "Social workers and street prostitutes say that the quality of clients has declined, and a recent report commissioned by the National Board of Police has concluded that women are now forced to accept not only more clients (since prices have dropped), but also more unstable and dangerous clients than they would have accepted before the law, when there were more clients and, hence, more choice (Nord and Rosenberg, 2001).

New Zealand

Fitzgerald and Brunton (2007) note the fact that the activities associated with sex work were no longer criminalised and that participants were aware they now had legal rights, made them more empowered in their negotiations with clients:

> *"Um, well, it definitely makes me feel like, if anything were to go wrong, then I'm, then it's much more easier for me to get my voice heard. And um (.) I also, I also feel like it's, um, some kind of hope that, um, there's slowly going to be more tolerance perhaps of, um (.) you know, what it is to be a sex worker. And it affects my work, I think, because when I'm in a room with a client, I feel like, um (.) like I'm, like I feel like I am deserving of more respect because I'm not doing something that's illegal. So um, I guess it gives me a lot more confidence with a client because, you know, I'm doing something that's legal, and there's no way that they can, you know, dispute that. And um, you know, I feel like if I'm in a room with a client, then it's safer, because, you know, maybe if it wasn't legal, then, you know, he could use that against me or threaten me with something, or you know. But now that it's legal, they can't do that.*" (Sex Worker cited in Fitzgerald and Brunton 2007).

The CSOM study found that over 90% of survey participants were aware that they had increased occupational safety and health, and legal rights under the PRA. The majority of participants in the CSOM qualitative interviews reported having knowledge of their employment rights under the PRA, particularly 'in terms of safer sex and occupational health and safety', which makes them feel 'legitimate'. (Ministry of Justice, 2008)

According to Abel and Fitzgerald (2010), the occupational safety and health manual that guides the health and safety of sex work in New Zealand's decriminalised environment is a powerful weapon, as sex workers have legal backing to demand that clients use condoms; and there is also no fear of carrying condoms on your person, as sex work has been decriminalised (cited in Roguski 2013)

3. Police harassment

In addition to police abuse as a human rights violation, law enforcement strategies and local policing of sex work, including arrests and incarceration, raids, displacement, and confiscation of condoms or syringes, are key barriers to HIV prevention efforts among female sex workers worldwide, which reduces or eliminates the ability to negotiate male condom use and increases HIV prevalence and incidence (Shannon et al, 2015).

Sweden

Due to the increased policing as a result of sexkopslagen, increasing numbers of sex workers who remain on the streets have been arrested and deported for illegal immigration, many before prosecutors were able to charge clients as they were deported before their statements were recorded (Kulick, 2003).

Reports have shown sex workers also experience more harassment due to the policing of clients and police often film sex workers engaging in sex acts in order to gain evidence against clients, this often results in sex workers being subjected to invasive searches (Kulick, 2003).

In relation to the initial drop in the number of street based sex workers, Kulick (2003) notes:

> "*Immediately after the law began to be enforced, police noted a drop in the numbers of street prostitutes . This may have something to do with the fact that policemen, who had been allotted 7 million Swedish kronor (US$650,000) to enforce the new law, immediately began making their presence on the streets where sex workers worked very visiblely. Armed with video cameras, which they ostentatiously pointed at any car that slowed down near a sex worker, they effectively frightened away clients, thus driving the sex workers off the streets"* (Kulick, 2003).

As the police have been warning "the owners of the apartment/facilities/hotel where prostitution activity is discovered that they will be prosecuted for pimping if the tenancy agreement is not terminated". This police action has "lead to many who sell sexual services being evicted from facilities/apartments/hotel rooms where they have sold sexual service in/from. In some cases they have been evicted immediately by the landlord and lost the deposit they paid for the apartment/facility" (Bjørndahl, 2012). As a result of this, sex workers now feel "that they have been criminalized", and that "the police is no longer perceived by the women as allies they can turn to when they have been subjected to something illegal, because they fear that they will be investigated when they contact the police" (Bjørndahl, 2012).

Levy (2011) found evidence of police harassment of sex work or of unprofessional police conduct which were 'fairly commonplace during fieldwork. These included stories of harassment of sex workers in the street, the police announcing a sex workers name from a patrol carr and a sex worker being raped in a police van. The same author also found that sex workers additionally experience difficulties when attempting to report violent crime and rape in the context of their sex work, to the police.

"*We hear horrible stories all the time…they (the police) still have this old thing like you know 'whores can't be raped'*"(Interview, 2011 with Pye Jakobsson, Founder of the Rose Alliance cited in Levy, 2011).

Canada

Surprisingly this turning of the polices' attention to the activity of sex work has not yet happened in Vancouver, Canada. This support of sex workers is attributed to a development and publication of the Sex Work Enforcement Guidelines by the Vancouver Police Department which were broadly welcomed at the time:

"In an interesting turn of events however, most police departments across the country have not enforced the new laws as the police themselves realise the new laws will bring greater harm to sex workers. That said, there have been a few instances where they are starting to be enforced which is quite worrisome and we are watching quite closely. The Vancouver Police Department has directed its members to follow the Sex Work Enforcement Guidelines which were passed prior to the new federal laws that focus on safety, and state consensual sex work between adults is not an enforcement priority" (Alison Clancey, Executive Director, Supporting Womens Alternatives Network (SWAN), correspondence on March 6th. 2015)

In a recent qualitative study among 26 cisgender and 5 transgender women who were street-based sex workers; researchers wanted to understand if the criminalisation and policing of sex buyers rather than sex workers shaped sex workers working conditions and sexual transactions including risk of violence and HIV/sexually transmitted diseases. They found that while police sustained a high level of visibility, they eased charging or arresting sex workers and showed increased concern for their safety (Krusi et al, 2014).

"*Every time they pull you over its strictly to ask you how you're doing, how things are. If there's any bad dates you want to report*"(Fiona, cisgender woman sex worker). (Krusi et al, 2014).

However, a striking feature of many sex workers accounts in this study was that police inquiring about their safety was perceived as a nuisance at best, and a form of police harassment at worst. Conversations between sex workers and police were viewed as having a destabilising effect as any police interactions may scare away clients and have the potential to raise suspicions that a sex worker might be an undercover police officer. The ongoing police focus has profoundly impacted the safety strategies sex workers employed. Sex workers continued to mistrust police, had to rush screening clients and were displaced to outlying areas with increased risks of violence, including being forced to engage in unprotected sex (Krusi et al, 2014). This could have implications in Ireland where the National Advisory Committee on Drugs found that most of the men and women interviewed were of the opinion that the Gardaí played an important role in reducing the risks associated with street-based sex work. Many actively engaged the Gardaí in their protection and also complied with Garda requests to leave the street (National Advisory Committee on Drugs, 2009).

Section Four: Access to care

"Illegality of sex work created barriers to sex workers seeking HIV prevention and care due to fear of authorities and concerns about confidentiality. (However) Services specifically designed for sex workers and with sex workers can overcome some of these concerns. Several successful interventions with strengthened community-led support and cohesive environments are associated with sex workers willingness to engage in HIV prevention and care." (Strathdee et al, 2015).

Research and programmes in the past decade suggest that behavioural and biomedical interventions among female sex workers alone have had only modest effects on the reduction of HIV at the population level, which has led for calls for combination HIV prevention that includes structural interventions. For example, efforts to roll-out antiretroviral therapy (ART) or distribute condoms to female sex workers in settings where criminalisation and stigma deter access to condoms or health services continue to hamper HIV prevention, treatment and care efforts (Shannon, 2015).

Evidence of change

Laws criminalising clients act as a barrier to sex workers accessing health services and drive workers underground and away from health services and increase their risk of HIV. A study by UNAIDs found that the biggest barrier to outreach workers in terms of HIV/AIDS prevention is the invisibility of sex workers. "The role of community organisations in the reduction of HIV risk through increased condom use and lower HIV prevalence among female sex workers at the population level is increasingly important. Gaps in data for community empowerment up to now can be attributed in a large part to scarcity of resources to assess efforts but also macrostructural constraints of criminalization and stigma that restrict the ability of female sex workers to organize" (Shannon et al, 2015).

Sweden

> "*There are substantial barriers in terms of sex workers accessing service and healthcare provison in Sweden. It's also important to remember that Sweden's broader opposition to harm reduction etc has come to impact people who use drugs and drive strikingly high hepatitis C prevalence and incidence, as well as considerable levels of overdose deaths (amongst the highest in Europe)"* (Dr Jay Levy , Policy and Advocacy Officer with the International Network of People who use Drugs, correspondence on March 4th 2015).

Levy (2011) documents how one female sex worker was told by social services at a Prostitution Unit that they would not correspond with her doctor in helping her to get a sick note unless she ceased her sex selling for three months. The sex workers stated

> *"If you are stopping prostitution for three months….So I was angry, because if you are not working in sex work, what (how) am I going (to do) get the money*?" (Lisa, Interview, 2009, cited in Levy 2011).

Conditionality of service provision for sex workers does not appear to be limited to Prostitution Units. One respondent was told that she would be eligible for social welfare only on condition that she ceased her work as a stripper. Having refused to do so, she was refused assistance, and as a result had to give up custody of her son who she could no longer afford to support. The Stockholms Units reputation results in some sex workers being reluctant to visit the Unit in the first place, and indeed may act as a deterrent to seek any form of service provision or assistance (Levy, 2011).

Dodillet and Ostergren, citing a study carried out by the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights (RFSL) explained that sex workers with whom the RFSL had been in contact with had reported that stigma prevented them from talking about their prostitution experiences when testing for HIV/STI which lessens the chances to reach these people to conduct harm reduction measures" (cited in Ka Hon Chu and Glass 2013).

Canada

A Canadian organisation supporting sex workers cites problems for their out-reach work which is targeted to sex workers. Signing up to the service means acknowledging you're partaking in illegal activity so people are no longer open to the service.

> *"We have been shut out entirely and refused entry to indoor sex work sites in that accepting our support services is again perceived to be an admission that sex work is taking place. This outcome has been extremely disheartening for us as an organisation. Gaining access and building relationships with the very hard to reach population of im/migrant sex workers has been 10 years of very hard work and t be shut out literally overnight has been detrimental to continued community health access and information for women we support"* (Alison Clancey, Executive Director, Supporting Womens Alternatives Network (SWAN), correspondence on March 6th 2015)

1. Stigma

In criminalised and quasi-criminalised sex work environments, access to non-judgemental, adequate health services has been identified by UNAIDS (2009) as one of the fundamental pillars in ensuring HIV prevention in the sex industry and remains key to effective harm reduction strategies in the sex industry (Rekart 2005 cited in Lazarus et al, 2012).

A growing number of research studies globally have postulated that stigma may act as a barrier to health access for sex workers. Goffman (1963) defined stigma as an "attribute that is deeply discrediting" with the stigmatised individual possessing an "undesirable difference" and a "spoiled identity". Enacted stigma can result in shunning, avoidance or physical and emotional abuse. Felt stigma is the act of internalising the stigmatising label creating a negative self-identity. (Goffman 1963 cited in Lazarus et al 2012). Additionally "whore stigma" has been conceptualised to predominantly characterise street-based sex work and same women for transgressing gender norms (Lazarus et al, 2012).

Sweden

Jordan, (2012) states in Sweden the "The law adopts traditional patriarchal images of innocent, sexually pure women in need of rescue and protection and bad women - social deviants who sell sex - who do not deserve society's protection. The government and its supporters hope that, by using negative images to increase stigma of sex workers and their customers, public pressure will force them to conform (at least superficially) to the views of the majority." (Jordan, 2012)

Dodillet and Östergren (2011: 22) reports similar, while Florin (2012: 273) noted that "The [Skarhed] commission recognized that there are complaints about increased social stigma, the sensation of being haunted by the police, and the perceived insult of legally being declared incompetent." Being legally declared incompetent has other effects. Sambo (2001) reported that sex workers were having their children taken off them, with Socialstyrelsen (2004: 10) noting "Some of the women have children, but they have generally been placed in care". Levy, (2013: 1) reports: "though the sexköpslagen has been portrayed as legislation that protects sex workers from legal repercussion, sex workers report losing child custody due to their sex work, domestic harassments by police and social services, and difficulties with tax and immigration authorities. These all serve to reduce the likelihood of sex workers seeking state-sponsored assistance. In addition to all of these harms, legislation and discourse serving to redefine Swedish norms have distracted from the sexköpslagen's failure to achieve its ambition" (Levy, 2013).

Finally, the Swedish model prevents sex workers from accessing the same labour and other rights that Sweden promotes and ensures for other people who have a legal right to work. While they are required to pay taxes, they cannot do so as a sex worker as the tax office does not accept sex work as a business. If they do not pay taxes, they cannot participate in the social security benefits that are available to other workers. Sex workers have no labour rights and are not permitted to take actions to make their work safer or easier (Jordan, 2012).

Canada

In a multivariate analysis of a sex worker survey in Vancouver, Canada even before the criminalisation of clients, Lazaraus et al found even adjusting for socio-demographic, interpersonal and work environmental risks, occupational sex work stigma remained independently associated with an elevated likelihood of experiencing barriers to health access.

Within their sample of 252 women, close to half (49.6%) experienced barriers to accessing health care services in the previous 6 months. The authors conclude "Study findings indicate the critical need for policy and societal shifts in views of sex work as a legitimate occupation, combined with improved access to innovative, accessible and non-judgemental health care delivery models for street based sex workers that include the direct involvement of sex workers in develooment and implementation" (Lazarauset al 2012).

UK

The view of one London sex workers support service who wished to remain anonymous is

> "*Proposals to further criminalise generic Clients of Sex workers and indeed oppose any increased legislation as this can have a negative impact on sex workers safety and access to healthcare. As a face to face service provider it is our experience that increased legislation renders sex workers more hidden and reticent to engage in healthcare. The reality of this is that laws that are proposed to protect sex workers actually render them more vulnerable as they take more and more risks to work in a hidden way"* (Project Manager, a London Sex workers Support Service, correspondence on the 15th March 2015).

She went on to give an example of home visits:

> *"When specialist sex worker health teams go to visit women in their working flats to offer healthcare and advice on safety. As each delivery of increased legislation takes place many sex workers withdraw from that relationship/ contact as they are scared of recrimination. This has been our particular experience in Westminster, Kensington and Chelsea and Hammersmith and Fulham where we deliver outreach to working flats and saunas. Health service outreach teams are often the only mainstream contact for most women, men and Transgender sex workers and if there is a vulnerable individual we are best placed to recognise a problem and to support that individual. How can we do that when they no longer want to let us in? Routinely our clients report to us that they are increasingly suspicious and mistrustful of services after intense periods of legislation and police raids"* (Project Manager, a London Sex workers Support Service, correspondence on the 15th March 2015).

She then referred to a particular policy change which she felt was similar to what might be experienced if the criminalisation of clients was introduced.

> *"Preceding the Operation Pentameter raids between 2006-2009 that were delivered to identify and rescue victims of trafficking we had established outreach services to approx 40 flats in the Westminster and Kensington and Chelsea area. Subsequently to those police raids we lost the majority of those premises because women actually moved, went underground or refused us access saying that they no longer trusted us. We had taken about ten years to build up relationships in these premises and it took about 3 years to re- establish contact, repair the relationship and find the new premises. The subsequent enquiry into Operation Pentameter found there were virtually no victims of trafficking found after approx.800 premises were raided across the UK and a significant number of women were actually charged under immigration offences".* (Project Manager, a London Sex workers Support Service, correspondence on the 15th March 2015)

In Ireland the National Advisory Committee on Drugs noted that sex workers often experience discrimination and stigmatisation; drug-using sex workers are doubly stigmatised. This stigma and shame increases the risks of drug-using sex workers not reporting violent crime to the Gardaí, and was often reinforced by some guard's prejudiced and judgemental attitudes. The stigma/shame also prevented some of the men and women from appearing in court because of their fear that it would be reported in the newspapers (National Advisory Committee on Drugs, 2009).

2. Sex work and other risk factors in accessing services

In thinking about sex workers accessing services it's really important to remember the heterogeneous identities among the sex worker population and how different personal identities and social situations can further alienate sex workers from the services they need to access and utilise.

Sex workers are a culturally diverse group that include women, men and transgender people. The Lancet series on HIV and sex work highlighted both the commonalities of sex work (such as exposure to violence) but also the unique risk factors that require specific priorities for each group (Das and Horton, 2015). Sex workers work in a wide array of contexts- some in safety- and some in difficult and dangerous settings (Beyrer et al, 2015).

Migrant workers

Roguski (2013) reporting on migrant sex workers in New Zealand identified two unique needs, creating a degree of vulnerability, were identified as language where they possess no, or a limited, command of English was identified as potentially placing migrant workers in a vulnerable position and health considerations in terms of primary health care, health professionals related concern that, due to a fear that they may be required to disclose their immigration status, migrant workers often avoid seeking clinical intervention through a general practitioner (Roguski 2013).

Brockett and Murray (1994), in discussing the health of Thai sex workers in Autralia, noted firstly Thai sex workers face prejudice not only from an Australian community, who do not readily condone the sale of sex for a living, but also from the Thai community due to the moral teachings of Buddhism, which dictates that sex work is one of the five businesses that should not be undertaken. Next, a lack of English often leads to many workers risking their sexual health by not using a condom with clients, with many being pressured by the establishment managers and their agents. They also commented that knowledge surrounding AIDS and HIV was poor. A third isolating issue identified by Brockett and Murray (1994) is that Thai sex workers on contract were reported to be seen as being on the lowest rung of the sex industry ladder. Thus, they were vulnerable to having their rights violated, experiencing prejudice and client abuse (cited in Roguski, 2013).

Research on Chinese migrant sex workers in Hong Kong (Zi Teng (2006)) indicated that the occupational health and safety of Chinese migrant sex workers was not adequate. Due to cost and lack of knowledge of where to access medical help, many migrant workers did not seek medical assistance when they, through self-diagnosis, believed they had contracted an STI. Rather, workers reported purchasing medication themselves, or waiting until they returned to China (cited in Roguski 2013).

A study examining the relationship between migration and sex workers in the United Kingdom (UK), through discussions with 100 migrants who came to work in the sex industry (Mai, 2009) found that there were a number of factors which contributed to the standard of working conditions experienced by migrants working in the sex industry. Their knowledge of English, their right to work legally in the UK, and their personal and occupational connections all impacted on the experience they had working in sex industry. A number of participants expressed that discrimination against sex workers and their absence of immigration papers left them exposed to exploitation and injustices (Mai, 2009). When questioned about the laws surrounding the sex industry in the UK, the majority of migrants postulated that the criminalisation of clients would not stop them working but it would make the life of a migrant sex worker more difficult and result in a black market sex industry that disempowers sex workers (Mai, 2009 cited in Roguski, 2013).

However Shannon and colleagues systematic review of HIV among female sex workers found that “migration and mobility have particularly complex and non-linear effects on HIV risk pathways among female sex workers both mitigating and conferring HIV risk”. Internal domestic and circular migration and mobility (eg intraurban or intradistrict mobility, and short term travel to sex-work hotspots) have been associated with enhanced HIV vulnerability, whereas long durations of mobility and international migration from non-endemic settings have been linked to high rates of condom use and low HIV prevalances (Shannon et al, 2015).

Drug using sex workers

Deering et al (2013) looking at the factors associated with not using condoms during sexual practices among street sex workers in Vancouver found that sex workers with more frequent drug use was strongly associated with being offered or accepting more money for sex without a condom. Deering and colleagues stated that these findings were consistent with other studies they had looked at which also found clients looking for unprotected sex may seek out sex workers who are particularly vulnerable to coercion, including women who are experiencing acute withdrawal and immediate need to use drugs. Similarly Rusakova et al (2015) note how drug-using sex workers are more likely to engage in behaviours with high risk of HIV infection through their work but also how their intimate partners and clients often engage in behaviours with high risk of HIV infection also (eg. syringe sharing). Rusakova and colleagues also note how in some cases the sex work preceded the drug use; where drug use is involuntary because pimps or managers coerce sex workers into drug use as a means of control.

Currently, there are no reliable estimates on the number of problem drug-using street sex workers in Dublin given that both activities are illegal, highly stigmatised and consequently these groups represent hidden populations in Ireland. However findings from the ROSIE study (Research Outcomes Study in Ireland) (Comiskey and Cox, 2007) reveal that 9 per cent of opiate users starting a new treatment episode reported having ever solicited/ sold sex and 4 per cent reported recent (last 90 days) involvement in sex work. Among the female study participants, self-reported involvement in sex work was substantially higher; 23 per cent of the women reported having ever sold sex and 14 per cent reported recent involvement in sex work.

Additionally a survey of female street sex workers in Dublin found that the vast majority (83%) were injecting drug users (O'Neill and O'Connor, 1999). The literature suggests that sex workers who are problem drug users (in particular injecting drug users) have higher rates of HIV and HCV infection, are more likely to be homeless, have poorer safety outcomes of the sex encounter, have high levels of depressive health symptoms, are at greater risk of violence, and have more contact with the criminal justice system than sex workers who are not problematic drug users. Interventions aimed at reducing the harms associated with problem drug use (and sex work) tend to focus on individual risk behaviour change and individually orientated models of change, often failing to recognise how risks and their perceptions are context laden (National Advisory Committee on Drugs, 2009).

A qualitative interview study of drug-using sex workers in Dublin in 2011 (n=35) found that most of the men and women grew up in inner-city working-class communities in Dublin in the 1970s and 1980s, which were characterised by high rates of intergenerational unemployment, low levels of educational attainment, social deprivation and economic marginalisation (Whitaker 2011). It was within these marginalised communities that the circulation and economics of heroin were heavily centred. In addition, the majority of participants had adverse life experiences in their childhood and early adolescence, relating to one or more of the following areas: family conflict, chaotic home environment, parental and/or sibling substance use, child physical and/or sexual abuse, experience of being in care and/or youth homelessness, early school leaving, bereavement, and traumatic life event(s)(National Advisory Committee on Drugs, 2009).

All the men and women interviewed were dependent heroin users prior to engaging in sex work; a significant minority were minors at the time. There were a variety of entry routes into sex work; the dominant route being through peer or friendship networks. This often happened when the person had financial problems and their friend/acquaintance paved the way for them to become involved in sex work. For a significant minority of participants this introduction happened while homeless and/or staying in emergency accommodation. For most of the participants the primary rationale for engaging in sex work was economic; to 'make ends meet' and/or 'for the sake of me habit'. Sex work provided a source of income and hence financial independence. Moreover, it was often considered less risky than alternative sources of income, such as drug-dealing and shop-lifting. The interface between participants' drug use and their sex work was complex. The men and women interviewed needed a continual source of funds to maintain their (often multiple) drug dependency. For most, sex work proved very lucrative in this regard. However, the increased income obtained from sex work invariably contributed to an escalation in drug use (National Advisory Committee on Drugs, 2009).

In a study looking at the stigma experienced by drug-using sex workers accessing support services in Dublin found that the majority (n=26) of study participants reported being HCV positive, seven were HIV positive and five were HIV/HCV co-infected. However, they are at risk of not receiving (and/or complying with) the appropriate treatment regimes for these blood-borne viral infections. Only one of the study participants reported receiving the combination interferon and ribavirin HCV treatment; three of the participants were receiving HIV triple therapy treatment (Whitaker, 2011).

Additionally, on top of issues with access services for HIV/AIDS, most participants had other very complex needs. Most of the men and women interviewed had experienced periods of prolonged homelessness, and the majority could be considered homeless at the time of interview (by virtue of their unstable accommodation). For many, their lifestyle hindered them getting appropriate accommodation and/or contributed to them being excluded from emergency accommodation. The precarious and impoverished existence brought on by homelessness places them at further risk of poverty, social isolation, and inadequate access to healthcare and other services. Moreover, homelessness increases the risk of engaging in unhygienic and risky injecting practices. Study participants when homeless were required to inject in public or semi-public places (Whitaker, 2011).

The men and women identified a number of barriers to their attempts to reduce the risk of harm in their daily lives. These include difficulties navigating their way around the complexity and bureaucracy of the social care and drug treatment systems, inflexible access criteria within services, lengthy drug treatment waiting lists and limited service options (Whitaker, 2011).

Sexual minority sex workers

Deering et al (2013) also reported how sexual minority sex workers may be particularly vulnerable to HIV/STIs by experiencing additional and unique forms of stigma and marginalisation, including homophobia and transphobia.

What different aspects of sex workers mean?

In the Swedish context, Levy and Jakobsson (2014) argue those who have been left selling sex on the street following 1999, those who are most vulnerable and resource poor and have been unable to establish themselves off-street, those who now face greater competition, depreciated prices due to fewer clients buying sex publicly, shorter negotiating times and increasingly anxious clients, are thus in great need of assistance and service provision.

Discussion

There are many ways of looking at the impact of the Swedish model and of criminalisation more widely:

> "Risk environments are crucially important for sex workers, since they constantly intersect with police and the law. Where sex work is legal, the focus of policing is on reducing violence, protecting sex workers, and supporting effective HIV programming. Such an enlightened response reduces sex workers vulnerability and risk to HIV, and should be followed elsewhere. This (Lancet) series calls on governments to decriminalise sex work. There is no alternative if we wish to reduce the environment of risk faced by women, men and transgender people worldwide" (Das and Horton, 2015).

"There is great optimism regarding HIV prevention. Breakthroughs in HIV treatment, prevention science, programme implementation, and human rights realisation have led to assertions that an AIDS free generation is possible…However without a rights-based framework for HIV interventions and participation, engagement and empowerment of sex workers, HIV control will remain elusive…Decriminalisation of sex work could avert the largest percentage of HIV infections in sex workers and clients during the next decade, through iterative effects on violence, police harassment, safer work environments and HIV transmission pathways." (Beyrer et al 2015).

As Beyrer and colleagues acknowledge; occupational health approaches, which recognise sex work as work, that many people will continue to sell sex, and that a reduction in HIV risks and exposures is a key goal.

On the other hand, there is the viewpoint that sex work is not a free choice and sex workers are experiencing really quite traumatic effects of the industry;

> "You have to talk about the historical power differences between men and women which lead to men oppressing women and putting women and girls in a subordinate position. If you don't have that analysis, you will never understand prostitution. Those who are pro-prostitution ofcourse ignore power differences between men and women. They boil prostitution down to individual choice. If you analyse choice you recognise that choice is only possible if you chose from equal alternatives. You have to distinguish between making a decision and having a genuine choice." (Ekberg, 2008).

The backdrop to the Swedish model has been an equality agenda. The wish to tackle the pathways to sex work which were widely known to be associated to social disadvantage, deprivation, poverty and social exclusion.

Conclusion

The evidence outlined above indicates that the Swedish model is leading to a more adverse environment for sex workers in terms of their ability to protect themselves against the risk of exposure to HIV/AIDS. The Swedish model in the context of the Swedish system of care delivery appears to limit sex workers ability to access the services they need. The evidence from Canada and the UK show access to outreach preventative health services are being weakened, which is again a related but different issue regarding access to services following client criminalisation. However there is strong evidence that we can reject the assumption that client criminalisation leads to better public health outcomes by decreasing sex worker rates. Estimates of the numbers of sex workers in Sweden vary considerably and are difficult to confirm, given the hidden nature of the practice and that initiaton takes place primarily by telephone or over the internet. With no available data on the indoor sector, claims of reducing sex work rates based on this legislation are difficult to confirm.

While overall the evidence is limited, it suggests that client criminalisation, which is often presented as a human rights-based approach concerned with women in the sex industry, may encourage conditions which violate the right to occupational health and safetly and can promote adverse health outcomes for sex workers. Client criminalisation may be ‘a’ or ‘the’ push factor to disperse sex workers to more isolated locations and reduce access to safe work environments which in turn has been shown to increase violence against sex workers which is associated with a greater likelihood of acquiring HIV. However, the evidence base consists of largely small scale qualitative studies and we do not yet have the quantitative data which would show the direct size of any legistlative change effects on health status and also account for other factors which might confound this relationship.

In conclusion; sex work is clearly a complex social phenomenon. Any legislative change will impact sex workers and it will impact different sex workers differently. One thing that remains constant is the fact that the design of the legislative environment of sex work is led by non-sex workers. A harm reduction model of sex work might justifiably encourage the participation of a wide range of sex workers in the Irish industry in advising what supports would help them to reduce rates of HIV/AIDS and encourage the use of available services.

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The authors would like to acknowledge the support and assistance they received following an email campaign to many of the leading organisations supporting sex workers in the countries we investigated. The time they gave to us and the help they offered in steering us through the often complex social and legislative landscapes of sex work in their country was really gratefully received. We believe they provided a unique and important voice to this report. All organisations are open to being contacted by HIV Ireland in the future. See details of the organisations and contact names/email addresses in the appendix.

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Appendices

1. Methods

A scoping review defined as “mapping rapidly the key concepts underpinning a research area and the main sources and types of evidence available; and can be undertaken as stand-alone projects in their own right; especially where an area is complex or has not been reviewed comprehensively before” (Mays, Roberts et al. 2001). The scoping review methodology was chosen because firstly it is not common to have experimental designs in this literature such as randomised control trialls and a scoping review allowed the inclusion of many different study designs. Secondly the scoping review is attractive because it doesn’t place strict limitations on search terms, identification of relevant studies or study selection at the outset. Thirdly a scoping review allows for a very iterative process where researchers can redefine the search terms and undertake more sensitive searches of the literature in the process. Finally a scoping review is well suited to producing in-depth and broad results which would develop understanding and new questions in the research area. These are all the strengths of the methodology as identified by Arksey and O’Malley (2005).

The manner in which it is operationalised is discussed next using the scoping review framework developed by (Arksey and O'Malley 2005).

Step One: Identifying the research question.

Worked with HIVI to define the research requirements and specify the review outcomes.

- *Sex workers*: Our understanding is to include male and female workers, sex workers of all nationalities and all types of sex workers.
- *Intervention*: The criminalisation of the purchase of sex.
- O*utcomes*: An increase or decrease in the incidence/prevalence of HIV/AIDS & increased or decreased access[7] to treatment for HIV/AIDs

Step Two: Identifying relevant studies.

<u>Inclusion criteria</u>: We preferentially are looking for studies that have reported on or evaluated the effectiveness of criminalizing the purchase of sex on health outcomes for sex workers and clients of sex workers. Specifically effects on HIV/AIDS rates and access to HIV/AIDS related health services. To this end all study types will be included and no restrictions will put in place for demographics (e.g. age, marital status, monthly income, residency).

<u>Search Strategy</u>:

- Electronic databases: Including the Cochrane Central Register of Controlled Trials, Prospero (a database of systematic reviews), PubMed, EMBASE, the Social Sciences Index, Social Services Abstracts, Web of Knowlege and JSTOR.
- Manual search of the Internet and Google Scholar.
- Traditional non-electronic methods including looking in the reference lists of articles and books.
- Hand searching of high-yield journals.
- Directly contacting existing networks/ relevant organisations

Step Three: Study selection.

Documenting those articles which fit the study aims and inclusion criteria. Abstracts will be reviewed and those accepted will be managed using the reference library, Endnote. Endnote will keep track of articles and produce lists of references for the final report in the word processing package. Copies of the full articles will be obtained for analysis, for those studies that best fit with the research question.

Step Four: Charting the data.

We plan to synthesis and interpret the data by sifting, charting and sorting material according to the research question.

Step Five: Collating, summarising and reporting the results.

A report will be written for the Board of HIV Ireland by the end of March 2015.

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[7] Access measured by aggregate figures of diagnosis and treatment; 'realised access' only. This does not capture unmet need which is only measured in population based cross sectional surveys which focus on sex work only.

2. Template of Letter to NGOs

Dear *Insert Name*

I am contacting you as independent researcher commissioned by HIV Ireland, a voluntary organisation who work to improve conditions for people living with or affected by HIV and AIDS in Dublin, Ireland.

HIV Ireland work with sex workers through a human rights perspective & harm reduction approach and are keen to understand the effect that the criminalisation of the purchase of sex, or 'the Swedish Model', might potentially have on sex workers in Ireland. This is particularly timely as in Ireland, a draft Heads of Bill was published last year by the Irish Department of Justice with the view to publish the *Criminal Law (Sexual Offences) Bill* in Parliament later this year to introduce the Swedish Model in Ireland.

You have been identified as an organisation who advocate for the human rights of sex workers on the Global Network of Sex Work Projects. HIV Ireland are asking for your help to reflect on your experience of the Swedish model in *insert country*. This would really help them make informed decision on whether to support or oppose this legislation in Ireland.

HIV Ireland are particularly interested in two aspects which might be affected after the implementation of the Swedish model:

1. The rates of HIV/AIDS among sex workers.
2. The access of sex workers to diagnostic services, treatments and care for AIDS/HIV.

We are kindly asking you to share your experiences and perspectives on these two issues in your country. Your feedback can come in any format you prefer, it could be your own personal thoughts, anonymised case studies which might illustrate issues you see, or national reports or evidence from your country. The more evidence and experience you can share the better placed we are to understand.

We strongly believe that donating your time to us in this manner will benefit sex workers and those who advocate for their human rights in Ireland. Your comments will be treated with utmost confidentiality and in keeping with best practice in qualitative research we can guarantee that neither you, nor your organisation will be identified in our report if you do not wish to be named.

We would be really grateful if you could reply to us with any comments or materials by Friday March 13th.

With thanks for your time and best wishes from Dublin,

Researchers Name,
Researchers Contact Details

3. List of NGOs contacted and contact people in those NGOs

Country	Organisation	Email	Name of contact
International	Global network of sex work projects	rights@nswp.org	
	International Union of Sex workers	Branch_secretary@iusw.org	
	International Committee on the Rights of Sex Workers in Europe	Luca.stevenson.icrse@gmail.com Agata_dziuban@gazeta.pl info@sexworkeurope.org	Luca Stevenson Agata Dziuban (Policy Officer)
	International Network of people who use drugs	jaylevy@inpud.net	Jay Levy Advocacy and policy officer
	Sex Workers rights advocacy network	swansecretariat@swannet.org	
	TAMPEP	Info@tampep.eu	
Sweden	Rose Alliance	Info@rosealliance.se	Pye Jacobson
Norway	Sex workers interest organisation in Norwaty	pion@pion-norge.no	
Iceland	Human trafficking centre, Iceland	Info@humantraffickingkingcentre.org	Jenni Hankel
UK	UK network of sex work projects	Admin@uknswp.org.uk	
	Streetreach Project	streetreach@doncaster.gov.uk	Marilyn Haughton
	Womens Breakout	http://www.womensbreakout.org.uk/contact-us/	
	Sex worker open university	contact@swou.org	Toni
UK (England)	English Collective of Prostitutes	ecp@prostitutescollective.net	
	Working mens project	Gregory.king@imperial .nhs.uk	
	X:talk	Xtalk.classes@googlemail.com	
	English collective of prostitutes	ecp@allwomencount.net	
	MASH	Helenc@mash.org.uk	Helen Clayton
	Bradford working womens project	diane.woodhead@bdct.nhs.uk	Michelle Khan or Diane Woodhead
UK (Scotland)	SCOT-PEP	voice@scot-pep.org.uk	
	Streetwork	jan@streetwork.org.uk	Jan Williamson Head of Services
	SACRO	lking@lothianscjs.sacro.org.uk	Louise King
	THT Highland	Info_highland@tht.org.uk	
	THT Scotland	Info.scotland@tht.org.uk	
	ROAM	enquiries@roam_outreach.com	
	Drugs Action Quay Services	Info@drugsaction.co.uk	Senga Macdonald
Northern Ireland	The Rainbow Project	info@rainbow-project.org	
Netherlands	SOA Aids Netherlands	Info@prostitute.nl	
New Zealand	New Zealand Prostitutes Collective	info@nzpc.org.nz	Catherine Healy[8]
Canada	Maggies	Maggiescoord@gmail.com	
	Gender & Sexual Health Initiative: AESHA [9]	info@cfenet.ubc.ca	

[8] Wrote: *Taking the Crime Out of Sex Work: New Zealand Sex Workers' Fight for Decriminalisation*.

[9] AESHA is the longest standing project of GSHI. Building on community-based research partnerships since 2004, AESHA extended in 2010 to a longitudinal evaluation of the physical, social and policy environment shaping sexual health, HIV vulnerability and access to care in the street and hidden off-street sex industry. To date, we have interviewed close to 1000 sex workers who work in street/public place-based settings, venue-based settings such as micro-brothels, massage parlours and health enhancement centres, independently off-street, through self-advertising and/or online, and in informal out-call venues, such as bars, saunas and hotels.The AESHA Project is monitored by a Community Advisory Board of more than 15 agencies representing sex work, women, youth and sexual health organizations. AESHA findings have been published in dozens of peer-reviewed papers, cited in international policy recommendations (including the Global Commission on HIV and the Law) and presented at multiple community, academic, and public policy events, including expert witness testimony and legal interventions in challenges to Canada's criminalized prostitution laws and the BC Missing Women's Inquiry. The AESHA cohort serves as a platform to monitor and evaluate ongoing policies, interventions and community initiatives and their impact on the health and safety of street and hidden off-street sex workers.

	The SHAWNA Project (Sexual Health and HIV/AIDS: Women's Longitudinal Needs Assessment)		
	The coalition of the rights of sex workers	Lacoalition2000@yahoo.com	
	FIRST/ SHAW	joycearthur@shaw.ca	Joyce arthur
	Aidslaw : Canadian hiv/aids legal network	sclaivaz@aidslaw.ca	Stephanie Claivaz-Loranger
	POWER	powerottawa@gmail.com	
	Sex workers action group	Swagkingston@gmail.com	
	SWAN Vancouever	Info@swanvancouver.ca	Alison Clancey Executive Director
	Sex Professional of Canada	welcome@spoc.ca	
	Sida-Voe Laval (venus project)	Venus_svl@hotmail.com	
	Stella	Stellaliaison@videotron.com	
	PACE	Pace-admin@telus.net	
USA	Helping individual prostitutes survive	hips@hips.org	
	Swaay; Sex Work Activists, Allies, and You	swaay@swaay.org	
	HOOK	hawkkinkaid@gmail.com	
	PERSIST Health project	sarah@persisthealthproject.org	
	Prostitutes of New York	Pony@panix.com	
	Red Umbrella Project	info@redumbrellaproject.org	
	Sex workers outreach project	Board@swopusa.org	
	Women with vision	Info@wwav_no.org	
South Africa	Sex Workers Education and Advocacy Taskforce (SWEAT)	http://www.sweat.org.za/contact-us/	
	South African National Aids Council	connie @sanac.org.za	Dr Constance Kganakga,
Australia		bdonovan@kirby.unsw.edu.au	Prof Donovan

4. Database search strategy

Electronic databases Including the Cochrane Central Register of Controlled Trials, Prospero (a database of systematic reviews), PubMed, EMBASE, the Social Sciences Index, Social Services Abstracts, Web of Knowlege and JSTOR.

Manual search of the Internet and Google Scholar.

Database	Search terms*	Returned items	Full texts	Relevant
PubMed	‘sex worker’ [mesh terms include ‘prostitute/prostitutes/prostitution’] AND ‘HIV’ [mesh terms including ‘Acquired Immunodeficiency Syndrome Virus, AIDS Virus, AIDS Viruses, AIDS Human Immunodeficiency Viruses, Human Immunodeficiency Acquired Immune]	76 articles screened by title and abstract review	6 articles read in full	4 articles relevant to the review- references within these articles were hand searched for additional relevant literature
Social Science Index	‘sex worker’ OR ‘prostitute’ OR ‘prostitution’ AND ‘HIV’	23 articles screened by title and abstract	9 articles read in full	5 articles relevant to the review- references within these articles were hand searched for additional relevant literature
Web of Science	‘sex worker’ OR ‘prostitute’ OR ‘prostitution’ AND ‘HIV’ AND ‘purchase of sex’	33 articles screened by title and abstract	4 articles read in full	3 articles relevant to the review- references within these articles were hand searched for additional relevant literature
Embase (13/03)	‘sex worker’ OR ‘prostitute’ OR ‘prostitution’ AND ‘HIV’			4 articles relevant to the review- references within these articles were hand searched for additional relevant literature
Cochrane library Prospero	‘sex worker’ OR ‘prostitute’ OR ‘prostitution’ AND ‘HIV’ AND ‘purchase of sex’ OR ‘client criminalisation’ OR ‘prohibition of purchase of sex’	No clinical trials or systematic reviews relating to sex workers, HIV rates and legal models on prostitution were registered with Cochrane of Prospero		
Jstor	‘sex worker’ OR ‘prostitute’ OR ‘prostitution’ AND ‘HIV’	104 articles screened by title and abstract		No relevant articles returned

* Refining the search terms to include ‘client criminalisation/criminalization AND/OR prohibition of purchase of sex/ purchase of sex’ (except in the case of web of science) returned no results in the database searches therefore searches were kept broad in order to increase the likelihood of capturing relevant literature

Returned articles

The majority of articles returned during the database searches were not relevant, given that the bulk of research relating to sex workers and HIV were focused on sex trafficking; interventions in community setting to reduce HIV spread; men who have sex with men; or sex workers in sub-Saharan Africa, Asia and South America where the HIV epidemic is significantly different to Western Europe. Studies included in the review focused on female sex workers working in high income/ developed countries (Canada, New Zealand, Europe, USA). The search did not return articles that focused specifically on client criminalisation and the impact on sex workers HIV rates however the included studies that examined legal models of prostitution (decriminalisation/illegalisation/client criminalisation) and the impact on sex workers, of which health and HIV rates made up some of the discussion.

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