The Sexual and Reproductive Health Needs and Rights of Female Sex Workers

Just like women within the general population, female sex workers (FSWs) have a range of comprehensive sexual and reproductive health (SRH) needs and rights.1 Due to restrictive norms, laws, and policies that fuel ongoing stigma, discrimination, and marginalization, however, they are at particular risk of their sexual and reproductive health and rights (SRHR) not being realized.2 Accessing this care is a part of their human right to the highest attainable standard of health.3

Unintended pregnancy and abortion

- Unintended pregnancy is a risk among many women, however for FSWs, sexual violence and limited ability to negotiate condom-use with intimate partners and clients are additional risk factors.4
- FSWs commonly experience unsafe abortions due to the criminalization of sex work and abortion in many settings.5 This leads to a heightened risk of mortality due to unsafe abortions.6
- Among FSWs, the lifetime prevalence of abortion in Asia and Africa ranges between 22 and 86 percent. This prevalence includes both safe and unsafe abortions.7

Family planning and contraceptives

- FSWs’ family planning and contraceptive needs are impacted by the fact that they may have divergent goals with different partners: while FSWs may want to prevent pregnancy with clients, they may also have pregnancy intentions with their intimate partners.8
- Data suggests that FSWs often have a greater unmet need for family planning than the general population, and FSWs with intimate or non-paying partners may be at higher risk of unintended pregnancy and sexually transmitted infections (STIs).9

For the purposes of this fact sheet, FSWs primarily means cisgender women sex workers. However, it is crucial to recognize the unmet sexual and reproductive health needs and extreme rights violations faced by transgender women engaged in sex work. There remains a tremendous research gap on the distinctive needs of transgender women sex workers—the limited data available demonstrate high levels of stigma, discrimination, violence, and elevated risk for HIV. For example, a 2008 systematic review and meta-analysis examining sex work and HIV status among transgender women found that as many as one in four transgender women sex workers is living with HIV (note that this review primarily included studies conducted in high- and middle-income countries). To the extent that transgender people and sex workers constitute distinctive key populations, transgender women sex workers may be understood to experience intersectional forms of risk and vulnerability which require committed research, investment, and response.10
• FSWs often report limited access to, or knowledge of, available contraceptive methods, especially younger and/or migrant/refugee FSWs.11

• Reliance on condoms alone is common, however FSWs also use long-acting reversible contraception methods (LARCs), including injectable methods, the intrauterine device, subdermal implants, and sterilization when accessible.12

• FSWs face barriers to correct and consistent condom usage including client violence and refusal, as well as financial incentives for unprotected sex.13

Safe pregnancy and maternal health

• For FSWs who have pregnancy intentions, there is a need and demand for antenatal care.14

• FSWs risk the denial of delivery and antenatal care services. If provided, FSWs also risk disrespect and abuse during delivery and antenatal care due to discrimination.15

• FSWs experience higher than average risk of maternal mortality due to HIV, complications from abortion and unintended pregnancies, and lack or respectful maternal care.16

• FSWs report pregnancy related suicides, antenatal and post-partum depression.17

• FSWs report stillbirths and health problems among their children, including: neonatal deaths, low birthweight, prematurity, neonatal abstinence syndrome, and emotional problems.18

• Many FSWs who have pregnancy intentions and are HIV-positive remain unaware of their status due to low engagement in HIV prevention and care due to inaccessibility. This threatens their health due to lack of engagement with HIV treatment, but also creates the risk of HIV transmission to both partners and children.19

HIV and STI prevention and treatment

• HIV risk is high among FSWs due to low condom use, rape, client condom refusal, and coercive police interaction. HIV risk among FSWs is also associated with high levels of alcohol use.20

• Among FSWs in lower-to-middle income countries there is an HIV prevalence of 11.8 percent, and a pooled odds ratio of HIV infection of 13.5 compared with the general population of women of reproductive age.21
SRHR and Female Sex Workers

November 2018

- FSWs experience barriers to accessing voluntary, confidential testing and adhering to antiretroviral therapy (ART) following a diagnosis of HIV. These barriers include negative attitudes among some providers and the effects of criminalization.  
- Provider stigma, discrimination, and coercive testing are barriers to FSWs accessing HIV testing and counseling.  
- Pre-exposure Prophylaxis (PrEP) is effective for preventing HIV, however uptake and access among FSWs is limited by stigma, fear of disclosure, fear of the authorities, and absent support and mobility.  
- Post-exposure Prophylaxis (PEP) is the use of antiretroviral medicines after potential exposure to HIV to prevent infection.  
- While PEP can be effective for prevention, FSWs experience barriers to uptake, including perceived side effects of antiretroviral medications, lack of knowledge about PEP, and stigma.  
- Microbicides (i.e., topical gel, vaginal ring, etc.) can be effective women-controlled methods for HIV prevention among FSWs.

Gender-based violence

- FSWs are at greater risk of rape and/or sexual violence than the general population.  
- Violence against FSWs is pervasive and committed by police, clients, and intimate partners.  
- Studies document levels of GBV against FSWs by intimate, non-paying partners exceeding 50 percent.  
- GBV is associated with a range of poor health outcomes for FSWs, including HIV, other STIs, and poor maternal health.  
- FSWs are less likely to report GBV due to a “normalizing” environment of tolerance promoted by criminalization.

Barriers to access: Structural and political impediments to SRH services

The criminalization and marginalization of sex work through legislation and policy impact the health of women involved in the sex industry. Below are key barriers to the health and wellbeing of FSW.
Criminalization

- Criminalization, a legal framework that prohibits sex work, providing money or goods in exchange for sex (i.e., being a client); and/or operationalizing sex work (i.e., being a “madam” in a brothel), causes policing, persecution, and violence against FSW by law enforcement. Usually, these legal frameworks stem from colonial penal codes in places like India and Uganda.\(^{34}\)
- Criminalization generates stigma from law enforcement, society, and health service providers.\(^{35}\)
- Risk of violence is amplified among sex workers due to criminalization-related experiences, such as violent or coercive policing practices whereby the police take advantage of FSWs’ criminal status and violent acts by clients, and can make reporting GBV to authorities more difficult.\(^{36}\)
- Criminalization is also associated with client violence, police harassment, unsafe work environments, reduced condom use, and increased risk of HIV.\(^{37}\)

The Nordic Model/End-Demand Laws

- The Nordic Model decriminalizes the selling of sex, but makes the purchasing and operational activities of commercial sex a crime.\(^{38}\)
- A 2015 study by Amnesty International that interviewed FSWs in Norway following the adoption of the Nordic Model found that by aiming to end the demand that drives sex work, the approach negates FSW ability to exercise consent and agency.\(^{39}\)
- According to the Amnesty International study, policies aimed to penalize clients result in sex workers having to incur greater personal safety risks and be further marginalized. In interviews, the FSWs recounted having to visit clients’ homes or more private and more risky places, experiencing heightened violence by clients and harmful stereotyping, being wrongfully evicted by landlords, and having a reduced ability to use condoms.\(^{40}\)
- End demand laws (laws that prohibit the purchase of sex through criminalization or fines as a way to end demand for sex work) negatively impact FSWs’ access to HIV services and contraception, and safety.\(^{41}\)
- Criminalizing operational activities related to sex work further marginalizes sex workers and undermines efforts to combat trafficking.\(^{42}\)
Decriminalization: A Pathway to SRHR for FSWs

- Decriminalization is when criminal penalties for sex work are removed, and sex workers receive the same protections and recognition as workers in any other occupation.\(^{43}\)

- Decriminalization is identified as an effective way for governments to fulfill the rights of sex workers, and has improved access to HIV and sexual health services through occupational health and safety standards within the industry in New Zealand and New South Wales where it has been implemented.\(^{44}\)

- A Lancet study using predictive mathematical modeling found that decriminalization of sex work would have the greatest impact of all structural interventions to prevent HIV among FSWs, across all study countries and in both concentrated and generalized epidemics.\(^{45}\)

- Decriminalization can positively affect FSW HIV risk and treatment; it helps ensure FSWs’ equitable access to ART, and if accompanied by community empowerment, it can avert 33–46 percent of HIV infections among FSWs within 10 years.\(^{46}\)

- Decriminalization enables a safe environment for reporting violence to the police.\(^{47}\)

- In New Zealand, following decriminalization, research shows that FSW are more likely to have a personal doctor and to disclose that they are sex workers, and there are now Occupational Safety and Health Guidelines that establish workplace safety obligations for FSW and brothel owners.\(^{48}\)
SRHR and Female Sex Workers

November 2018


2Id.

3Global Network of Sex Work Projects supra note 1.


8Center for Health and Gender Equity (CHANGE), Women, All Rights, Sex Workers Included: U.S. Foreign Assistance And The Sexual And Reproductive Health And Rights Of Female Sex Workers (2016) available at http://www.genderhealth.org/files/uploads/All_Women_All_Rights_Sex_Workers_Included_Report.pdf

9Tricia Petruney et al., Meeting the contraceptive needs of key populations affected by HIV in Asia: an unfinished agenda, 2 AIDS Res. & Treatment (2012); Eileen Yam et al., Use of Dual Protection Among Female Sex Workers in Suzailand, 39 Int’l. Persp. on Sexual & Reprod. Health 69-75 (2013).


12Borna Nyaoko, Contraceptive preference among female sex workers in the street study in Nairobi, Kenya, 93 Sex Transm Infect. (2017); Michele Decker et al., Induced abortion, contraceptive use, and dual protection among female sex workers in Moscow, Russia, 120 Int’l. J. Gynecology & Obstetrics (2013); Schwartz S. et. al., supra note 5.


15Id.


Sonali Wayalet al., Contraceptive practices, sexual and reproductive health needs of HIV-positive and negative female sex workers in Goa, India, 87 SEX TRANSM Infect. (2011); Sheree Schwartz et. al., Safer Conception Needs for HIV Prevention among Female Sex Workers in Burkina Faso and Togo, 5 Infectious Diseases in Obstetrics & Gynecology (2014).


Tara Beattie, Personal, interpersonal and structural challenges to accessing HIV testing, treatment and care services among female sex workers, men who have sex with men and transgenders in Kanyakurna state, South India, 66 J. EPIDEMIOLOGY & COMMUNITY HEALTH 42, 46-47 (2012).


Odhiambo Otieno et. al., Correlates of prevalent sexually transmitted infections among participants screened for an HIV incidence cohort study in Kisumu, Kenya, 26 INT J STD AIDS (2015); Robert Smith et. al., Evaluating the potential impact of vaginal microicides to reduce the risk of acquiring HIV in female sex workers, 19 AIDS (2005); Lut Van Damme et. al., Effectiveness of COL-1492, a nonoxynol-9 vaginal gel, on HIV-1 transmission in female sex workers: a randomised controlled trial. 360 THE LANCET (2002).


Jennifer Toller Emausquin, Police-related experiences and HIV risk among female sex workers in Andhra Pradesh, India, 1 J Infect Dis.(2011); Schwitters et. al., supra note 29.


Schwitters et. al., supra note 29; Xu-Dong Zhang et. al., Prevalence and correlates of sexual and gender-based violence against Chinese adolescent women who are involved in commercial sex: a cross-sectional study, 6 BMJ OPEN (2016).


SRHR and Female Sex Workers

November 2018


36Karen Deering et. al., supra note 24; Schwitters et. al., supra note 29; T. Rhodes et. al., supra note 35; Stephanie Church et. al., Violence by clients towards female prostitutes in different work settings: questionnaire survey, 322 BMJ, 524 – 525 (2001).

37Kate Shannon et. al., supra note 21.


42Amnesty International, supra note 40.


45Kate Shannon et. al., supra note 21.
SRHR and Female Sex Workers

Shannon K. et. al., *supra* note 21; Ian Grubb et al., *Maximizing the benefits of antiretroviral therapy for key populations*, 17 J. Int'l AIDS Soc'y 1, 6 (2014).
