Prohibitory Prostitution Laws and the Human Right to Health

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Candidate Declaration

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submitted for the degree of:	LLM in International Human Rights Law

is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

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List of Abbreviations

ACHPR	African Charter on Human and Peoples' Rights
AIDS	Acquired Immune Deficiency Syndrome
ASWA	African Sex Workers' Alliance
CEEHRN	Central and Eastern European Harm Reduction Network
CESCR	Committee on Economic, Social and Cultural Rights
ECHR	European Convention on Human Rights
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IPU	Inter-Parliamentary Union
PLRC	Prostitution Law Review Committee (New Zealand)
SOOBs	Small Owner-Operated Brothels
STI	Sexually-Transmitted Infection
SWAN	Sex Workers' Rights Advocacy Network
UDHR	Universal Declaration of Human Rights
UKNSWP	United Kingdom Network of Sex Work Projects
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCHR	United Nations Commission on Human Rights
WHO	World Health Organization

Abstract

This paper demonstrated that laws that criminalise sex work or aspects thereof are associated with negative outcomes for sex workers' right to health under international law. It also showed that the right to health is an underused mechanism in judicial challenges to these laws.

The objective was to analyse, at practical and judicial levels, the relationship between prohibitory prostitution laws and the right to health. International treaties were examined to establish the relevant content of the right. Studies of the health-related effects of these laws, in various jurisdictions, were reviewed. Existing research into the effects of legalising prostitution under specified circumstances, and the effects of decriminalisation, was also examined. Case law was reviewed of judicial challenges to prostitution laws, and health-related aspects of relevant cases were discussed. The reasons that each court did or did not reach a decision protecting sex workers' right to health were also considered.

The dissertation found that prohibitory laws lead to negative consequences for sex workers' health by increasing their risk of violence and sexually-transmitted infections; adversely affecting their mental health, through these risks and through stigmatisation; denying them occupational health and safety; and excluding them from the process by which health-affecting decisions are made. It found positive health outcomes from removal of these laws, although excessive regulation of legal prostitution can have negative effects. It also found insufficient justification for health-based arguments in favour of prohibitory laws.

It showed that only a small number of challenges to these laws have highlighted their relationship to health, and the basis of these challenges has not been the right to health itself, although a breach of a derivative right has sometimes been asserted. Health has also, at times, served as a defence to these laws.

It concluded that sex workers' right to health can best be protected through a legal framework that decriminalises consensual commercial sex and explicitly protects their occupational health and safety rights. This must be accompanied by efforts to ameliorate stigmatisation. Judicial action can play a role, although it may require the assertion of a derivative right rather than the right to health itself.

Chapter I – Introduction to the Research

1. INTRODUCTION

At first glance, prostitution[1] may seem curiously absent from the rapid expansion of international human rights law that has taken place over recent decades. No treaty or convention explicitly recognises the right to be free from abuses – other than coercion and trafficking – when engaging in what is often called the world's oldest profession.[2] Nonetheless, it should be possible to accommodate sex workers within the existing framework of human rights provisions that are generally applicable, or that apply to all persons within categories into which sex workers fall. This paper will focus specifically on the right to health.

As will be shown, health is widely recognised as an essential socio-economic right. The health of sex workers can be significantly affected by the legal environment in which they operate. Yet the impact of prostitution laws on health is rarely considered in a human rights context – and even less frequently in judicial challenges to these laws. This gap may have significant implications for sex workers' right to health. The aim of this paper is to contribute to filling that gap by analysing, at both practical and judicial levels, the relationship between prohibitory prostitution laws and the human right to health.

2. STRUCTURE

Chapter I will introduce the proposal and give a brief overview of the purpose of the research and the questions it seeks to answer. It will also set out the frameworks, definitions and methodology used.

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[1] There is no universally-accepted definition of 'prostitution'. Attempts to establish one have been problematic for a variety of reasons, ranging from simple practical differences over how to draw lines through grey areas, to whether or how to exclude phenomena (such as pornography, 'lap dancing' or under certain conditions, marriage) that might fall within a literal interpretation but do not fit within most legal or popular ideas of 'prostitution', to bitter ideological disputes. An attempt to construct a 'one size fits all' definition would not be appropriate in a paper dealing with existing laws, from various jurisdictions, which do not themselves contain a uniform definition. It can be generally assumed, however, that the laws in question relate to the performance of sexual services for remuneration other than in the contexts listed parenthetically above.

[2] K Kempadoo and J Doezema (eds), *Global Sex Workers: Rights, Resistance and Redefinition* (Routledge, New York 1998) 30.

Chapter II will examine the right to health as outlined in various international instruments, highlighting the dimensions of this right that have particular relevance to sex workers.

Chapter III will then look specifically at how the right to health, as set out in the previous chapter, is affected by laws that criminalise sex work (or aspects thereof). It will do this by reviewing the available literature on the health risks faced by sex workers under full or partial criminalisation. Where available, evidence will also be presented from jurisdictions in which sex work is not criminalised. In countries that have made changes to their prostitution laws in recent decades, any differences in the evidence from before and after the reform will also be discussed. It will finally be considered whether the right to health can *justify* prohibitory laws.

Chapter IV will explore the limited case law that has developed in this area, to show how different countries have interpreted the health aspects of prostitution law and policy. This review will include cases from jurisdictions that do not specifically recognise a human right to health but where health issues were nonetheless considered in proceedings, as well as cases from jurisdictions where a right to health is recognised (whether or not it is deemed to give rise to any rights to engage in commercial sex).

Chapter V will conclude with a summary of the findings of the research. It will also make recommendations for future studies that could be carried out in this area, in order to improve our understanding of the relationship between prostitution law and the international human right to health.

3. FRAMEWORKS AND DEFINITIONS

3.1 Policy approaches to prostitution

Policy approaches to prostitution can be distinguished by regulatory framework. In much of the literature this involves a three-category division, typically labelled as criminalisation/prohibition, legalisation/regulation and decriminalisation. In this classification, ‘criminalisation’ outlaws the purchase and sale of sex and/or associated activities; ‘legalisation’ permits commercial sex under specified conditions; and

'decriminalisation' does not regulate it at all, at least in respect of consensual sex between adults.[3] More recently, the advent of the so-called Swedish model – in which selling sex is decriminalised while buying sex remains illegal – has given rise to a fourth category, often labelled 'partial (de)criminalisation'.[4]

A problem with this method of classifying policy approaches is that it inadequately reflects the objectives and ideologies behind the different frameworks, nor does it clearly show the relationships between them. This is a significant weakness, as the categories inevitably involve some amount of generalisation and, in practice, tend toward some degree of overlap.[5]

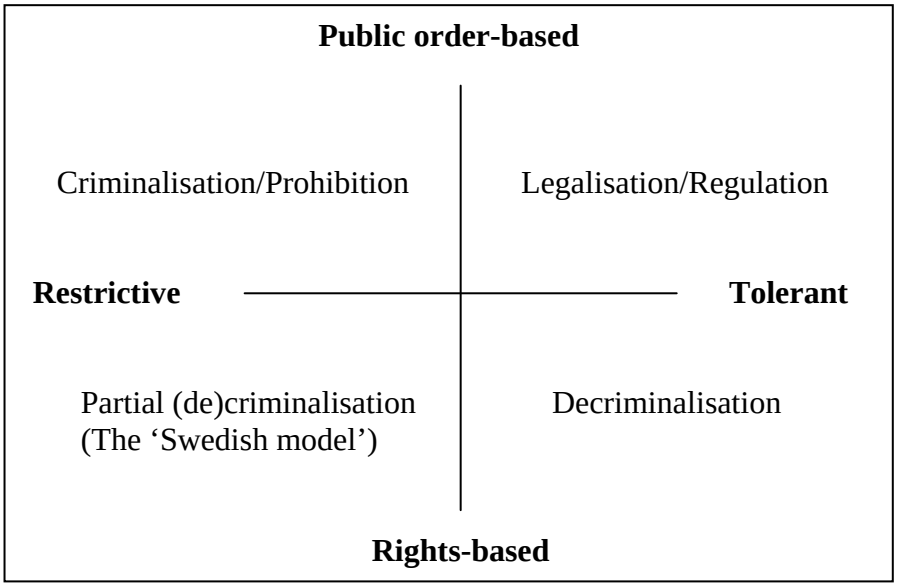
This paper accepts the four-category division as both the clearest and the most widely accepted classification scheme. However, to reach a genuine understanding of the regulatory frameworks, they must be seen as the outcome of different objectives and attitudes toward sex work. The objectives can be broadly described as either *public order-based* or *rights-based*. A public order-based approach is one aimed primarily at curtailing the negative societal effects of prostitution, while a rights-based approach focuses on the human rights of persons involved in prostitution. Each approach may be grounded in either a *restrictive* or a *tolerant* attitude toward sex work, with a restrictive attitude seeking to deter prostitution while a tolerant attitude accepts its existence – at least to the extent that the objective is achieved. The following chart shows how these factors intersect to give rise to different policy approaches:

[3] See eg E Mossman, *International Approaches to Decriminalising or Legalising Prostitution* (Ministry of Justice of New Zealand, Wellington 2007) 11-12. Some writers, however, use different terminology or methods of distinguishing the various frameworks. For an extensive review of the different types of classification, see C Overs, '17 Different Frameworks of Sex Work Law and Still Counting' (2010) <http://www.plri.org/sites/plri.org/files/Examples%20of%20different%20frameworks.doc> accessed 29 July 2011.

[4] eg, ML Richter and others, 'Sex Work and the 2010 FIFA World Cup: Time for Public Health Imperatives to Prevail' (2010) 6 Globalization and Health 1 <http://www.globalizationandhealth.com/content/6/1/1> accessed 17 June 2011.

[5] Mossman (n 3) 6; Columbia University School of Public Health Law and Policy Project, 'A provisional framework for analyzing laws and policies that affect sex workers' (2005) <http://www.soros.org/initiatives/health/focus/sharp/articles_publications/publications/compendium_20070319/comparative/provisional_20070402.pdf> accessed 17 June 2011.

Figure 1: Policy approaches to prostitution



While this diagram is, like all classification methods, an oversimplification, it helps to demonstrate the importance of viewing prostitution law within its underlying policy context. This is illustrated by the fact that it may be possible (at least theoretically) to sell sex legally under any of the four categories: in Canada, Britain and Ireland, which take a 'criminalisation' approach by prohibiting most acts associated with sex work, although not the actual exchange of sex for money;[6] in Sweden, where only *buying* sex is criminalised; and of course in legalisation and decriminalisation states.[7] Classifying policy approaches as either 'tolerant' or 'restrictive' helps to distinguish those jurisdictions in which the law is aimed at deterring (or 'sending a message about') prostitution from those in which the primary legislative concern is the manner in which it takes place.

Several objections to this schema are possible. It might be argued that public order and human rights do not inevitably have the oppositional relationship depicted. The rights of

[6] Such acts may include advertising or soliciting for sex, providing commercial sex on an ongoing basis from the same location, or sharing an indoor venue with another sex worker or assistant. Not all associated acts are illegal in every jurisdiction that takes this approach – see ch III.

[7] Notable examples of 'legalisation' states include the Netherlands, Germany, the US state of Nevada and the Australian states of Queensland and Victoria. By contrast, New South Wales, Australia and New Zealand are widely regarded as 'decriminalisation' states due to their general tolerant/non-regulatory environment, although both in fact have elements of other policy frameworks. For example, New South Wales restricts the locations where street soliciting can take place, while New Zealand requires licensing of larger and managed brothels.

sex workers often do figure, at least to some degree, in the arguments for legalisation. The Swedish model, which is primarily concerned with women in prostitution,[8] has been described as privileging the rights of women as a class over those of sex workers individually; in that respect it may be seen as closer to a public order objective (in which the perceived 'common good' is also placed above the individual). However, the diagram broadly reflects the available evidence, which suggests that measures imposed to safeguard public order often conflict with the rights of sex workers;[9] that legalisation regimes tend to prioritise the former;[10] and that the Swedish model was developed with the aim of restricting prostitution in a way that safeguards the rights of those engaged in it.[11]

3.2 Ideological frameworks

The ideological framework underlying these approaches is also important. Public order-based policies may be grounded in religious or other traditional morality, in which sexuality itself is seen as a matter for societal control; in class privilege, where prostitution poses a threat to the bourgeois family;[12] or simply in the desire to contain what is often seen as prostitution's associated crime and nuisance.

[8] Although the ban on purchasing sexual services is framed in gender-neutral terms, it was adopted as part of a broader Violence against Women Act ('Kvinnofrid') as a result of intensive lobbying by the Swedish feminist movement. G Ekberg, 'The Swedish Law that Prohibits the Purchase of Sexual Services' (2004) 10 Violence against Women 1187, 1191-92.

[9] See ch III.

[10] The prioritisation of public order over rights in legalised regimes can be seen in, for example, the 'objects' of Victoria, Australia's Prostitution Control Act 1994 s 4 in which 'the protection of prostitutes' ranks below community amenity and control of criminality; the stated aims of the German legalisation scheme, as cited in B Kavemann, H Rabe and C Fischer, 'The Act Regulating the Legal Situation of Prostitutes: Implementation, Impact, Current Developments – Findings of a Study on the Impact of the German Prostitution Act' (2007) <http://www.cahrv.uni-osnabrueck.de/reddot/BroschuereProstGenglisch.pdf> accessed 25 June 2011, 37, which place regulation of legal prostitution and curbing illegal prostitution above protecting the rights of sex workers; and the decisions by Dutch and Scottish authorities to close tolerance zones (see ch III) despite their demonstrated health and safety benefits (M van Doorninck and R Campbell, 'Zoning Street Sex Work: The Way Forward?' in R Campbell and M O'Neill (eds), *Sex Work Now* (Willan, Cullompton 2006) 74; T Sanders and R Campbell, 'Designing Out Vulnerability, Building in Respect: Violence, Safety and Sex Work Policy' (2007) 58 British Journal of Sociology 1, 4). Further discussion of this aspect of legalisation is found in G Abel, 'Decriminalisation: A Harm Minimisation and Human Rights Approach to Regulating Sex Work' (DPhil thesis, University of Otago 2010) 25.

[11] Ekberg (n 8) 1188-92. Ch III will demonstrate, however, that this has not necessarily been the consequence of the Swedish law – nor indeed it is still clearly the aim of those who support it.

[12] LM Agustín, *Sex at the Margins: Migration, Labour Markets and the Rescue Industry* (Zed, London 2007) 102-05.

There are two leading rights-based frameworks. The first, which underpins the 'restrictive' attitude found among adherents of the Swedish model, is the violence against women framework.[13] This argues that prostitution is incompatible with women's human rights: it violates the rights of the women involved in it, by reducing them to objects to be bought and sold, and violates the rights of women as a class by perpetuating a male-dominant, female-subservient social order. A contrasting framework sees sex work as a type of labour and argues that ordinary employment rights should apply. Adherence to this view does not necessarily imply approval of commercialised sex; socialist feminists, for example, may see it as a lamentable outgrowth of capitalism and patriarchy.[14] However, it rejects what it sees as futile attempts to eradicate it through prohibitory measures, and instead seeks to protect sex workers' rights through a tolerant legal regime which allows them to operate in conditions of relative safety.

This paper is grounded in a sex work as labour framework, which will, it is hoped, be demonstrated as the framework most compatible with the international right to health. It therefore also accepts decriminalisation as the optimal policy approach. The health-based counter-arguments of other frameworks will also be presented; however, opposing claims grounded solely in 'competing' rights and objectives are beyond the present scope.[15]

[13] Gendered language is nearly always used when this view is expressed, notwithstanding the fact that not all sex workers are women. An example comes from S Jeffreys, *The Idea of Prostitution* (Spinifex, Melbourne 1997) 242: 'I suggest that prostitution constitutes a variety of *male* sexual violence towards women.' (emphasis in original).

[14] —, *The Radical Women Manifesto: Socialist Feminist Theory, Program and Organizational Structure* (Red Letter Press, Seattle 2001) 67-68.

[15] For example, violence against women theorists such as Jeffreys (n 13) see prostitution primarily as an issue of equality, and on that basis may oppose decriminalisation even if it is shown to result in better health outcomes. By the same token, those who approach the issue from a religious perspective may feel that preserving souls is more important than preserving corporeal health. These positions are important, not least because they are held by many with power or influence in jurisdictions throughout the world. They are not, however, the subject of this paper.

3.3 General terminology

3.3.1 *'Prostitute' or 'sex worker'?*

In a generally controversial field, one of the biggest sources of disagreement is the terminology that should be used for buying and selling sex – and for persons who sell it. The traditional terms of 'prostitution' and especially 'prostitute' are rejected as stigmatising by many of those engaged in the practice.[16] The terms 'sex work' and 'sex worker', although preferred by some whom they describe, are objected to by those who see the practice as immoral or demeaning (or both) and refuse to conceptualise it as a form of work. Feminists who seek its abolition often use the adjective 'prostituted', as they believe this more accurately reflects the position of those in the sex trade, whom they consider to be largely passive victims of the exploitative acts of others.[17]

This paper addresses the issue in the context of the international right to health. A significant body of literature from global health actors has been reviewed, and it is evident that 'sex work' and 'sex workers' are the standard terms in that sector.[18] Those are therefore the primary terms used in this document. For stylistic reasons 'commercial sex', 'transactional sex' and 'prostitution' are all used on occasion. However, 'prostitute' has been largely avoided outside of direct quotations, as its use would be inconsistent with the focus on health (which, as will be seen, can be affected by stigmatisation).

3.3.2 *Who is a sex worker?*

The definition of a 'sex worker' in this paper may be considered as 'consenting female, male, and transgender adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally'.[19] While certain

[16] T Sanders, M O'Neill and J Pitcher, *Prostitution: Sex Work, Policy and Politics* (Sage, Los Angeles 2009) 9.
[17] Jeffreys (n 13) 330.
[18] Indeed, even abolitionist Sweden acknowledges this in its 2010 report to the United Nations General Assembly Special Session on AIDS: Government of Sweden, 'UNGASS Country Progress Report 2010' <http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/sweden_2010_country_progress_report_en.pdf > (UNGASS Report) accessed 25 June 2011, 63.
[19] AIDS Accountability International, 'Language and Glossary of Terms' <http://aidsaccountability.org/?page_id=4751> accessed 25 June 2011. While 'sex work' can also be used

aspects of this report may be relevant to persons under 18 or to those involved in the sex trade against their will, other human rights implications arise in their cases which may render the report's conclusions inappropriate. It should therefore be assumed that the sex workers discussed herein are all consenting adults over the age of 18.[20]

On the basis of the data reviewed, it has not been possible to distinguish the effects of criminalisation in terms of sex workers' gender. Most of the research has been carried out solely on female, and apparently cisgender,[21] sex workers; the minority that examines male and/or transgender sex workers does not seem to indicate a *substantive* difference in the risks posed to them by prohibitory laws, although it does find some differences in degree.[22]

Finally, migrant sex workers who do not have full health care or employment rights have not been addressed. This is a regrettable omission, necessitated by space constraints. In brief, they are frequently excluded from the right to work in legal sex industries,[23] often excluded from the health services available to other sex workers, and risk not only arrest but deportation if found to be engaged in prostitution. It can be generally assumed, therefore, that the problems faced by national and resident sex workers, as outlined in this paper, are magnified for this particularly marginalised subcategory.

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more broadly to include work in pornography, nude dancing and other forms of sexually-oriented entertainment, those aspects of the sex industry are not considered here.

[20] It is sometimes claimed, particularly among violence against women theorists, that there is no such thing as 'consent' in the sex trade: all those involved were forced into it, either by another actor or by their personal circumstances. This is an ideological view which rejects testimony to the contrary from sex workers who do not consider themselves 'forced', as well as comparisons to other low-status industries which are equally unlikely to be the first choice of someone with a wide range of options. It is also evidently rejected by the Joint United Nations Programme on HIV/AIDS (UNAIDS), which states: 'All adult sex workers have the right to determine whether to remain in or leave sex work' ('UNAIDS Guidance Note on HIV and Sex Work' (2009) UNAIDS/09.xxE / JC1696E, 17). For the sake of absolute clarity, it may be said that this paper's distinction is between persons who were forced into prostitution by another actor, and persons who were not so forced; and only the latter are considered herein.

[21] The term 'cisgender' describes persons whose gender identity matches the biological sex assigned to them at birth. E Shapiro, *Gender Circuits: Bodies and Identities in a Technological Age* (Routledge, New York 2010) 58.

[22] For example, transgender sex workers may be particularly at risk of assault by police: Sex Workers' Rights Advocacy Network (SWAN), 'Arrest the Violence: Human Rights Abuses against Sex Workers in Central and Eastern Europe and Central Asia' (2009) <http://www.unhcr.org/refworld/docid/4cbfdf332.html> accessed 8 July 2011, 29.

[23] This is the case in, for example, Finland (Aliens Act [301/2004] s 148) and New Zealand (Prostitution Reform Act 2003 s 19).

3.3.3 ***'Criminalisation'***

The term 'criminalisation' is used throughout this document to refer to punitive measures imposed on sex workers or their clients for engaging in prostitution (whether *per se* or in violation of the conditions of legalised regimes), or for unlawful associated activities. However, some jurisdictions may in fact address prostitution through their administrative rather than criminal codes.[24] The difference is not significant in this context, as fines and/or detention for administrative breaches are unlikely to be any more desirable from the point of view of the offender.

4. METHODOLOGY

The research data included in Chapter III have been drawn from a wide variety of sources, in numerous jurisdictions. They include quantitative and qualitative studies from a mixture of academic journals, newspapers, official and non-governmental reports, books, advocacy materials and post-graduate research. It is recognised that the objectivity of some of these sources may be called into question; indeed, some of them represent the lived experience of persons involved in the sex industry and make no claim to objectivity. There are also certain limitations inherent to sex work research,[25] and as a Canadian Supreme Court Justice has noted:

> predictions respecting the ramifications of legal rules upon the social and economic order are not matters capable of precise measurement, and are often 'the product of a mix of conjecture, fragmentary knowledge, general experience and knowledge of the needs, aspirations and resources of society, and other components'.[26]

Simply put, direct causal links between laws and adverse health outcomes are often impossible to prove – and by no means have rigorous attempts been made in respect of all the relationships suggested in this paper. Inevitably, there has been some reliance on anecdote. Anecdotal evidence, however, can be useful in conveying the reality of lived

[24] SWAN (n 22) 55.
[25] FM Shaver, 'Sex Work Research: Methodological and Ethical Challenges' (2005) 20 Journal of Interpersonal Violence 296 identifies these as the difficulty in finding a representative sample of such a 'hidden' category of people; the reluctance of stigmatised and criminalised individuals to be forthcoming in their responses; and the failure of many researchers to recognise the wide diversity that exists within sex working populations (tending, for example, to focus on the more visible street-based sector and to overlook the often larger – and often demographically distinct – indoor sector).
[26] *RJR-MacDonald v Canada* (1995) 3 SCR 199 [67] (La Forest J).

experiences – particularly when it reinforces the more formal types of evidence available.[27]

Much of the evidence presented has also been backed up by multiple citations from different jurisdictions. This is intended in the first instance to demonstrate the consistency of findings in the material that has been surveyed. The varied socio-cultural contexts in which similar effects have been found can also serve as a kind of control factor, implicating the prohibition itself in the adverse health outcome reported. Where feasible, such reports merit a more scientific method of study – but in the meantime they deserve to be taken seriously as, at the very least, indications of a possible causal association.

Data have also been presented that might be seen as contradicting the relationship between certain prohibitory laws and ill-health. These are frequently found in states that have legalised prostitution through measures aimed at minimising perceived associated threats to public order, rather than through rights-based measures concerned with sex workers' health and safety. This often takes the form of 'over-regulation', in which the stringent conditions imposed on the legal sector make *illegal* operation more attractive, and in which the legal sector is kept smaller than the number of sex workers wishing to operate within it – creating competition for legal prostitution jobs which undermines the ability of workers in that sector to assert their rights. From a right to health perspective, this demonstrates a flaw in public order-based legalisation, rather than in legal prostitution *per se*.

In nearly all other cases, the 'contrary' reports do not suggest a link between prohibitory laws and health *improvements*, but rather that they have had little impact one way or the other – in contrast to other studies in this paper which find adverse outcomes under similar laws in other jurisdictions. While this may indicate that negative effects are not inevitable, it does not render the entire association untenable. The link between a law and a health outcome is rarely a direct one and some variation in the findings should not be unexpected. It may, for example, be the case that cultural or other factors can mitigate any potential health risks that arise as a consequence of a law. Furthermore, sex

[27] E Bell, *Research for Health Policy* (OUP, Oxford 2010) 161.

workers do not all operate under the same circumstances even in the same jurisdictions, and some will find it easier than others to ‘compensate’ for negative effects. The critical question is whether the law can amount to an unnecessary obstacle between sex workers and their right to health – and if it can, that right is no less breached just because some sex workers are able to overcome a similar obstacle.

Having set out the approach that will be taken in analysing the link between prohibitory prostitution laws and the right to health, this paper will now turn to an exploration of how sex workers’ rights could be protected under the international human right to health.

Chapter II – The Right to Health in International Law

1. INTRODUCTION

While the precise content of any right is subject to debate, conceptually the 'right to health' lends itself to particular ambiguity. 'Health' is not something that can be provided in tangible form like food or water, or even in abstract form like education (unless it is read as merely a right to health *care* – a very narrow definition of the right[28]). Nor, clearly, is it something that a government with the best intentions – and resources to match – could positively ensure to everyone within its territory, as long as there are illnesses for which there is no known prophylactic or cure. Human rights treaties are by their nature somewhat aspirational, but they are not meant to be fantastic and to promise things no government is capable of delivering.

It is therefore not surprising that the international agreements which set out the 'right to health' do not frame it precisely in those words. However, the terms that are used can vary significantly from one treaty to another. This Chapter will review the key international human rights documents and summarise those elements of the right which have particular relevance for sex workers.

2. THE ORIGINAL PRINCIPLES OF THE RIGHT TO HEALTH

2.1 Foundational documents: The WHO Constitution and UDHR

The Constitution of the World Health Organization (WHO), a specialised agency of the United Nations, describes the right as the 'enjoyment of the highest attainable standard of health… without distinction of race, religion, political belief, economic or social condition'; 'health' is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[29] In this formulation, the right to health is the right to be as healthy as one can possibly be. The Constitution is vague,

[28] The United Nations Committee on Economic, Social and Cultural Rights (CESCR) makes clear that the right to health 'is not confined to the right to health care'. CESCR, 'General Comment 14' in 'Note by the Secretariat, Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies' (2008) UN Doc HRI/GEN/1/Rev.9 (Human Rights General Documents) [4].

[29] Constitution of the World Health Organization (adopted 22 July 1946, entered into force 7 April 1948) 14 UNTS 185 (WHO Constitution) preamble.

however, on the obligations this imposes on states, declaring only that governments 'have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures'.[30]

The contemporaneous Universal Declaration on Human Rights (UDHR) takes a different approach. In Article 25(1), it proclaims:

> Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age of other lack of livelihood in circumstances beyond his control.[31]

Here, the right to health becomes essentially a part of the right to social security.[32] While this formulation has the advantage of greater clarity as to the nature of state obligations, it also risks excluding those elements of health protection and promotion which do not derive from the kind of positive duties listed in the Article – such as a right not to be subjected to criminal laws that create conditions that could endanger one's health.

2.2 The International Covenant on Economic, Social and Cultural Rights

Formally, neither the WHO Constitution nor the UDHR impose any binding legal obligations:[33] an authoritative statement on the international right to health can only be found in the human rights treaties by which the world's nations have agreed to be bound. Of these, the most important is the International Covenant on Economic, Social and Cultural Rights (ICESCR), which provides in Article 12:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

[30] WHO Constitution (n 29) preamble.
[31] Universal Declaration of Human Rights (adopted 10 December 1948 UNGA Res 217A(III) (UDHR) art 25(1).
[32] The evolution of the drafting process is chronicled in J Morsink, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (University of Pennsylvania Press, Philadelphia 1999) 191-210.
[33] Some commentators believe, however, that the UDHR has become binding as part of customary international law: see eg MG Kaladharan Nayar, 'Human Rights: The United Nations and United States Foreign Policy: Introduction' (1978) 19 Harvard International Law Journal 813, 816-17.

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[34]

The right is thus framed in essentially the same terms as in the WHO Constitution (although its definition of 'health' was omitted). The UN Commission on Human Rights, which drafted the Covenant, accepted a suggestion by the WHO Director General for 'an undertaking by Governments that adequate health and social measures should be taken' to achieve the right, although the list that ultimately appeared in Article 12(2) differed somewhat from his proposal.[35] One of the rejected items is mirrored in Article 7(b) in the final document, which sets out a right to 'safe and healthy working conditions'.[36]

In its General Comment 14 on the Right to Health the ICESCR's monitoring body, the Committee on Economic, Social and Cultural Rights (CESCR), interprets Article 12.1 as not 'a right to be *healthy*'[37] (emphasis in original) but rather 'an inclusive right extending…to the underlying determinants of health', including, *inter alia*, 'healthy occupational and environmental conditions'.[38] It goes on to set out a list of states' negative obligations, which include

> refraining from denying or limiting equal access for all persons…to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs….In addition, States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health.[39]

Among the positive duties, according to the CESCR, are obligations 'to adopt measures against environmental and occupational health hazards' and to develop 'a coherent

[34] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) UNTS 993 (ICESCR) art 12.
[35] UN Commission on Human Rights (UNCHR), Seventh Session 16 April-19 May 1951 'Draft International Covenant on Human Rights and Measures of Implementation: Suggestions submitted by the Director-General of the World Health Organization' (18 April 1951) UN Doc E/CN.4/544.
[36] ICESCR (n 34) art 7(b).
[37] ibid art 8.
[38] CESCR (n 28) [11].
[39] ibid [34].

national policy to minimize the risk of occupational accidents and diseases'.[40] Furthermore, states must 'undertake actions that create, maintain and restore the health of the population', including 'supporting people in making informed choices about their health'.[41] A list of core obligations is also set out, including 'to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups', ' to take measures to prevent, treat and control epidemic and endemic diseases', and 'to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them'.[42]

While the Covenant allows for limitations to all its protected rights, these must be 'compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society'.[43] States may not impose greater limits than the Covenant allows for.[44] The CESCR has interpreted these clauses to mean that limitations to fundamental rights in the interest of public health must be 'strictly necessary for the promotion of the general welfare', must be 'the least restrictive alternative' available and should be 'of limited duration and subject to review'.[45]

3. KEY CONCEPTS IN THE INTERNATIONAL RIGHT TO HEALTH

3.1 Equality and non-discrimination

Other human rights documents explicitly ground the right to health in a right to equal treatment and non-discrimination – a particularly important protection for marginalised and vulnerable groups. The Convention on the Elimination of All Forms of Discrimination against Women recognises health as one of a number of rights guaranteed 'on a basis of equality of men and women',[46] including within it the equal 'right to protection of health and to safety in working conditions, including the

[40] ibid [36].
[41] ibid [37].
[42] ibid [43].
[43] ICESCR (n 34) art 4.
[44] ibid art 5(1).
[45] CESCR (n 28) [28]-[29].
[46] Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979, entered into force 3 September 1981) 1249 UNTS 13 art 11(1).

safeguarding of the function of reproduction'[47] and the equal right to access health care services.[48]

The Declaration and Programme of Action arising from the World Conference on Human Rights in Vienna in 2003 speaks of the special onus on states to 'create and maintain adequate measures at the national level, in particular in the fields of education, health and social support, for the promotion and protection of the rights of persons in vulnerable sectors of their populations'.[49] Resolution 1989/11 of the Commission on Human Rights takes perhaps the broadest equality-based approach of all, stating that 'non-discrimination in the field of health should apply to all people and in all circumstances'.[50]

3.2 Freedom from violence

The right to freedom from violence also has health implications. The CESCR makes this link explicitly, noting that the definition of 'health' 'takes into account such socially-related concerns as violence'.[51] It finds within the ICESCR a specific state obligation to 'take measures to protect all vulnerable or marginalized groups of society…in the light of gender-based expressions of violence'.[52] It further states that the obligation to protect the right to health is violated by 'the failure to protect women against violence or to prosecute perpetrators'.[53]

The right to be free from violence most commonly takes the form of a prohibition on torture and inhuman or degrading treatment, generally at the hands (or with the complicity) of the state. A broader protection could perhaps be found in the right to security of person. This is guaranteed in both the UDHR[54] and the International Covenant on Civil and Political Rights[55] alongside the right to liberty, suggesting a

[47] ibid art 11(1)(f).
[48] ibid art 12(1).
[49] UN General Assembly 'Vienna Declaration and Programme of Action' (12 July 1993) UN Doc A/CONF.157/23 [24].
[50] UNCHR Res 11 (1989) UN Doc E/CN.4/RES/1989/11.
[51] CESCR (n28) [10].
[52] ibid [35].
[53] ibid [51].
[54] UDHR (n 31) art 3.
[55] International Covenant on Civil and Political Rights (adopted 16 December 1966, entered into force 23 March 1976) 999 UNTS 171 art 9(1).

narrow interpretation relating only to issues of detention. The International Convention on the Elimination of All Forms of Racial Discrimination, however, links it to 'protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual, group or institution'.[56] The Declaration on the Elimination of Violence Against Women calls for 'due diligence to prevent, investigate and, in accordance with national legislation, punish acts of violence against women, whether those acts are perpetrated by the State or by private persons'.[57]

3.3 Occupational health and safety

A number of agreements of the International Labour Organization, another UN specialised agency, pertain to workplace health and safety issues. The Occupational Safety and Health Convention 1981 requires states to implement policy to

> prevent accidents and injury to health arising out of, linked with or occurring in the course of work, by minimising, so far as is reasonably practicable, the causes of hazards inherent in the working environment.[58]

This 'applies to all branches of economic activity' and 'to all workers', defined as 'all employed persons'.[59] The definition of health 'includes the physical and mental elements affecting health which are directly related to safety and hygiene at work'.[60]

3.4 The right and duty of participation

The protection of health is not solely a matter for the states. As the CESCR notes, 'the adoption of unhealthy or risky lifestyles may play an important role with respect to any individual's health'.[61] Thus, a certain element of personal responsibility is inherent in the right to health. This is reflected in the Declaration of Alma-Ata, which speaks of the

[56] International Convention on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965, entered into force 4 January 1969) 660 UNTS 195 art 5(b).
[57] Declaration on the Elimination of Violence against Women, UNGA Res 48/104 (23 February 1994) (adopted without vote) art 4(c).
[58] Convention Concerning Occupational Safety and Health and the Working Environment (adopted 22 June 1981, entered into force 11 August 1983) ILC 155 art 4(2).
[59] ibid arts 1-3.
[60] ibid art 3(e).
[61] CESCR (n28) [9].

peoples' 'right and duty to participate individually and collectively in the planning and implementation of their health care'.[62]

'Informed opinion and active co-operation on the part of the public' are deemed essential in the WHO Constitution,[63] a linkage that highlights the importance of knowledge in individuals' ability to effectively play their own part in exercising their right to health. The CESCR also emphasises this in stressing 'the right to seek, receive and impart information and ideas concerning health issues'.[64]

This right to information, and the active individual role that it envisages in health protection, implies certain corollary rights. One set out by the CESCR is 'the right to participation of the population in all health-related decision-making at the community, national and international levels'[65] Also suggested is a right to autonomy in health decisions. This is acknowledged in the Declaration of the Fourth World Conference on Women, which refers to 'the right of all women to control all aspects of their health'.[66]

4. REGIONAL TREATIES

4.1 Europe

The European Convention on Human Rights (ECHR) contains no reference to health, although it does include a prohibition on inhuman and degrading treatment and a detention-related right to security of person.[67] The Twelfth Protocol also provides that 'enjoyment of any right set forth by law shall be secured without discrimination on any ground';[68] thus, any domestically-guaranteed right to health must be available to everyone on an equal basis.

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[62] 'Declaration of Alma-Ata' International Conference on Primary Health Care (Alma-Ata 6-12 September 1978) [IV].
[63] WHO Constitution (n 29) preamble.
[64] CESCR (n28) [12][b] (footnote omitted).
[65] ibid [11].
[66] 'Beijing Declaration and Platform for Action' in 'Report of the Fourth World Conference on Women' (Beijing 4-15 September 1995) (1996) UN Doc A/CONF.177/20/Rev.1 [17].
[67] Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (ECHR) arts 3 and 5.
[68] ibid protocol 12.

In the European Social Charter, by contrast, numerous statements on the right to health can be found. Article 11 requires states

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.[69]

Occupational health and safety is also comprehensively guaranteed. Under Article 2, states parties must undertake 'to eliminate risks in inherently dangerous or unhealthy occupations'.[70] Article 3, titled 'The right to safe and healthy working conditions', requires states to

> undertake, in consultation with employers' and workers' organisations:
>
> 1. to formulate, implement and periodically review a coherent national policy on occupational safety, occupational health and the working environment. The primary aim of this policy shall be to improve occupational safety and health and to prevent accidents and injury to health arising out of, linked with or occurring in the course of work, particularly by minimising the causes of hazards inherent in the working environment;
> 2. to issue safety and health regulations;
> 3. to provide for the enforcement of such regulations by measures of supervision;
> 4. to promote the progressive development of occupational health services for all workers with essentially preventive and advisory functions.[71]

The European Union's Charter of Fundamental Rights recognises the

> right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.[72]

Article 31 also guarantees every worker 'the right to working conditions which respect his or her health, safety and dignity',[73] while the right to security of person is protected by Article 6 – albeit linked solely to the right to liberty.[74]

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[69] Council of Europe, European Social Charter (revised) (3 May 1996) ETS 163 art 11.
[70] ibid art 2(4).
[71] ibid art 3.
[72] European Union, 'Charter of Fundamental Rights of the European Union' (7 December 2000) 2000/C 364/01 art 35.
[73] ibid art 31(1).
[74] ibid art 6.

4.2 The Americas

In the Americas, a right to health is first set out in the 1948 American Declaration of the Rights and Duties of Man. Article XI, titled 'Right to the preservation of health and to well-being', states:

> Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.[75]

The American Convention on Human Rights contains only the same tenuous health protections as the ECHR;[76] it is again the companion charter in which the right is more fully developed. The Protocol of San Salvador makes an expansive statement on the right to health:

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.
2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:
    a. Primary health care, that is, essential health care made available to all individuals and families in the community;
    b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction;
    c. Universal immunization against the principal infectious diseases;
    d. Prevention and treatment of endemic, occupational and other diseases;
    e. Education of the population on the prevention and treatment of health problems, and
    f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.[77]

Additionally, Article 7 sets out a right to 'Safety and hygiene at work'.[78]

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[75] American Declaration of the Rights and Duties of Man, OAS Res XXX adopted by the Ninth International Conference of American States (1948) reprinted in reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System OAS/Ser.L/V/I.4 Rev. 9 at 19 (2003) art XI.

[76] American Convention on Human Rights (Pact of San Jose) (entered into force 18 July 1978) OAS Treaty Series No 36 (1969) reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System OAS/Ser.L/V/I.4 Rev. 9 at 29 (2003). Art 5(2) prohibits cruel, inhuman or degrading treatment; art 7 guarantees the right to 'personal liberty and security' in a detention context and art 24 sets out a right 'without discrimination, to equal protection of the law'.

[77] Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (entered into force 16 November 1999) OAS Treaty Series No 69 (1988) reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System OAS/Ser.L/V/I.4 Rev. 9 at 29 (2003) art 10.

[78] ibid art 7(e).

A separate Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women provides additional protections, setting out a 'right to be free from violence in both the public and private spheres'.[79] It includes 'physical, sexual and psychological violence' occurring at the hands of any person and including violence 'condoned by the state'.[80]

4.3 Africa

Article 16 of the African Charter on Human and Peoples' Rights (ACHPR) states that:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.[81]

The Charter's Protocol on the Rights of Women in Africa (the Maputo Protocol) contains a broader statement on the right to health, including reproductive and sexual health. Article 14 sets out the rights to 'choose any method of contraception'[82] and to 'self protection and to be protected against sexually transmitted infections',[83] and obliges states parties to 'provide adequate, affordable and accessible health services, including information, education and communication programmes to women'.[84]

Interestingly, the Maputo Protocol is the only regional charter to make the link between freedom from violence and the right to security of person. Subsection 1 of Article 4 sets out the entitlement for respect to life, integrity and security and contains the standard prohibitions against inhuman and degrading treatment, while Subsection 2 requires states parties to 'take appropriate and effective measures' to address a wide range of aspects of violence against women.[85] 'Violence against women' is elsewhere defined as

[79] Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (entered into force 5 March 1995) OAS Treaty Series A 61 (1994) reprinted in OAS/Ser.L/V/I.4 Rev. 9 at 117 (2003) art 3.
[80] ibid art 2.
[81] African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58 (ACHPR) art 16.
[82] Protocol to ACHPR on the Rights of Women in Africa (Maputo Protocol) (adopted 11 July 2003, entered into force 25 November 2005) OAU Doc CAB/LEG/66.6 art 14(1)(c).
[83] ibid art 14(1)(d).
[84] ibid art 14(2)(a).
[85] ibid art 4.

'all acts perpetrated against women which cause or could cause them physical, sexual, psychological and economic harm', including threats.[86]

5. CONCLUSION

As this survey of international and regional human rights treaties and declarations shows, there is no single universal conceptualisation of the right to health. However, a number of patterns exist from which conclusions can be drawn.

First, the right to health is not a right simply to medical care, although that is an element of it. It imposes both positive and negative duties on states to help individuals avoid damage to their health – which includes their physical, mental, reproductive and sexual health. These duties are owed to all persons without discrimination, but special consideration must be given to the concerns of particularly vulnerable people, a category into which sex workers fall.[87]

Although the right to freedom from violence is an autonomous right, it is also a component of the right to health. Violence against women is a particular concern in this regard. States are obliged to prevent and penalise gender-based violence – a risk for female and transgender sex workers, as well as men who sell sex to men[88] – whether at the hands of its agents or of third parties.

Occupational health and safety are also critical elements of the right to health. States have a duty to ensure safe and healthy working conditions in all employment sectors. States are also obliged to take steps to prevent and control the spread of infectious and endemic diseases, both within and outside the employment sphere.

The right to health also includes a right to participate in the process by which health-affecting decisions are made. By definition, this includes criminal laws that may have

[86] ibid art 1(j).
[87] Sex workers are specifically identified as a 'vulnerable group' in UNCHR 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (2004) UN Doc E/CN.4/2004/49 [39].
[88] Gender-based violence may be defined as violence 'directed against a person on the basis of gender or sex'. Human Rights Watch, *Criminalizing Identities: Rights Abuses in Cameroon Based on Sexual Orientation and Gender Identity* (Human Rights Watch, New York 2010) 61.

consequences for one's health. Access to information is essential for the effective exercise of this right.

Finally, although criminal laws and other rights-limiting measures may be allowed in the public interest – including for the protection of public health – these must be no greater than necessary, time-limited and subject to review.

It is within this context that the effect of prohibitory prostitution laws on the right to health of sex workers must be examined.

Chapter III – The Links between Criminalisation and the Right to Health

1. INTRODUCTION

Having set out the elements of the right to health with particular relevance to sex workers, this paper will now turn to laws that may give rise to breaches of that right. It will first consider the commonly-reported adverse effects of criminalisation, and will then examine the health outcomes that have been demonstrated in countries with legalised or decriminalised prostitution. Before concluding, it will ask whether the right to health can be used to justify prohibitory laws.

2. THE ADVERSE EFFECTS OF CRIMINALISATION

2.1 The risk of violence

There is probably no health risk to sex workers more widely reported than the risk arising from violence. The link between this risk and laws that criminalise sex work is discussed extensively in the literature, with a number of explanations put forward.

2.1.1 *Consequences of reporting violence in a criminalised environment*

A regular claim is that sex workers are reluctant to report assaults for fear of themselves being charged with prostitution-related offences. In interviews conducted in Ireland after a law was enacted prohibiting solicitation of prostitution,[89] nearly all those who say that they would not go to police if attacked cite this risk as a reason.[90] Furthermore, it is suggested that clients and persons who pose as clients[91] knowingly take advantage

[89] Criminal Law (Sexual Offences) Act, 1993, s 7.

[90] AM O'Connor, 'Women Working in Prostitution: Towards a Healthier Future' (1996) <http://www.drugsandalcohol.ie/5616/1/2030-023Women.pdf> accessed 29 July 2011, 18.

[91] In its ordinary usage, the term 'client' refers to a person who pays for goods or services. It may thus be inappropriate in relation to a person who uses the pretence of seeking paid sex to attack a sex worker whom he has no intention of paying. However, this distinction is generally blurred in the literature – including in statistical measurements of the extent of violence against sex workers. An exception is H Kinnell, *Violence and Sex Work in Britain* (Willan, Cullompton 2008), who notes at 62 that 'most "client" attacks are committed by men who only pretend to be clients until they have manoeuvred the sex worker into a position of vulnerability'. For the sake of convenience and due to the lack of sufficient disaggregating data, 'client' is reluctantly used in this paper to describe both those who intend to pay and those who do not.

of their reluctance: 'it has always been dangerous, but it has increased. Clients are aware, the law has changed and are aware that the women don't want to go to the police.'[92]

In Canada, where it is an offence to communicate in public for the purpose of prostitution,[93] sex workers also cite the fear of losing custody of their children as a reason not to report assaults.[94] General mistrust of police and the 'criminal' label are also factors: 'the majority of prostitutes do not report assaults against them for fear of not being taken seriously, of being judged or treated as criminals';[95] 'the police are seen as an adversary rather than an ally due to criminalization'.[96] The law is viewed by many sex workers as conflating 'victim' with 'criminal' status in police eyes; this makes them doubt that police will protect them.[97]

It must be noted that even where prostitution is legal, many sex workers express reluctance to report attacks, citing such factors as suspicion of the value of doing so,[98] fear of alerting police to their illegal drug use,[99] and fear of their occupation being exposed.[100] However, this reluctance is not necessarily limited to sex workers: a recent survey in New Zealand finds that only 32% of general-population assault victims reported the offence.[101] While removal of criminal penalties is clearly not sufficient in

[92] Female sex worker quoted in O'Connor (n 90) 12.
[93] Criminal Code, RSC 1985, c C-46 (Canadian Criminal Code) s 213(1)(c).
[94] House of Commons Canada Subcommittee on Solicitation Laws of the Standing Committee on Justice and Human Rights (Canadian Subcommittee), 'The Challenge of Change: A Study of Canada's Criminal Prostitution Laws' (2006) <http://www.parl.gc.ca/Content/HOC/committee/391/just/reports/rp2599932/justrp06/sslrrp06-e.pdf> accessed 29 July 2011, 67.
[95] ibid 21.
[96] ibid 67.
[97] Testimony of expert witnesses in *Bedford v Canada* 2010 ONSC 4264 [125].
[98] Prostitution Law Review Committee (PLRC), *Report of the Prostitution Law Review Committee on the Operation of the Prostitution Reform Act 2003* (Ministry of Justice of New Zealand, Wellington 2008) 58.
[99] E Mossman and P Mayhew, *Key Informant Interviews: Review of the Prostitution Reform Act 2003* (Ministry of Justice of New Zealand, Wellington 2007) 40.
[100] A Arnot, 'Legalisation of the Sex Industry in the State of Victoria, Australia: The Impact of Prostitution Law Reform on the Working and Private Lives of Women in the Legal Victorian Sex Industry' (MA thesis, University of Melbourne 2002) 62-63; G Abel, L Fitzgerald and C Brunton, *The Impact of the Prostitution Reform Act on the Health and Safety Practices of Sex Workers: Report to the Prostitution Law Review Committee* (University of Otago, Christchurch 2007) 120.
[101] Ministry of Justice, *The New Zealand Crime and Safety Survey: 2009 Main Findings Report* (Ministry of Justice, Wellington 2010) 44. This figure is identical to the percentage in another study of New Zealand 'private indoor' sex workers who have reported an assault by a client, although reporting rates for the street and 'managed indoor' sectors are significantly lower: Abel, Fitzgerald and Brunton (n 100) 120.

itself to address this risk to health, criminalisation evidently creates a further motivation to not report an attack.

2.1.2 ***Risks taken to avoid arrest***

Violence may also result from actions taken by sex workers in order to avoid arrest. A common example involves street workers moving from a location patrolled by police to one where they are less likely to be detected – often, an industrial or otherwise isolated area. A substantial body of evidence demonstrates that enforcement of the 'communication' law in Canada has this dispersal effect, which is often followed by an increase in violent crime against sex workers (although a causal link has not been definitively established).[102] Even if the new area is not particularly isolated, a heightened risk may exist due to less familiarity with their surroundings, or needing to work later at night when detection is less likely.[103] Displacement may also have the effect of isolating sex workers from each other, thus preventing them sharing information on dangerous clients.[104]

Acquisition of a regular clientele can be an important safety mechanism.[105] The logic of this is simple: a sex worker who can earn sufficient income from trusted clients will not need to take chances with clients whose propensity for violence is unknown. A regular clientele also reduces the risk of arrest.[106] However, displacement measures can put sex workers at greater risk by altering their client base.[107] Additionally, a sex worker in an unfamiliar location will have no experience of the local clients and may not recognise the 'dangerous' ones.

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[102] *Bedford* (n 97) citing testimony of expert witness Dr John Lowman, Professor at the School of Criminology at Simon Fraser University [130], House of Commons Special Committee on Pornography and Prostitution, 'Pornography and Prostitution in Canada: Vols 1 & 2' (1985) (Fraser Report) [145] and the Department of Justice, 'Street Prostitution: Assessing the Impact of the Law: Synthesis Report' (1989) [151], [154]; Canadian Subcommittee (n 94) 62; Federal/Provincial Territorial Working Group on Prostitution, 'Report and Recommendations in Respect of Legislation, Policy and Practices Concerning Prostitution Related Activities' (1998) <http://www.walnet.org/csis/reports/consult.doc> accessed 18 June 2011, 9, 59.

[103] Central and Eastern European Harm Reduction Network, *Sex Work, HIV/AIDS, and Human Rights in Central and Eastern Europe and Central Asia* (CEEHRN, Vilnius 2005) 44.

[104] Canadian Subcommittee (n 94) 63-64.

[105] C Benoit and A Millar, 'Dispelling Myths and Understanding Realities: Working Conditions, Health Status and Exiting Experiences of Sex Workers' (2001) <http://www.hawaii.edu/hivandaids/Working%20Conditions,%20Health%20Status%20and%20Exiting%20Experience%20of%20Sex%20Workers.pdf> accessed 11 July 2011, 52.

[106] A Lutnick, 'Survey Says: Job Satisfaction?' (2007) 3:1 Spread 44, 47.

[107] CEEHRN (n 103) 44.

The client's fear of arrest may also divert prostitution into isolated areas. Describing the effect of police crackdowns, a New England sex worker says: 'We still gotta work. It's not like that stops…you might do it in a more secluded place, like go into the park or something. 'Cause *he* don't want to get caught'[108] (emphasis added). This has implications for the safety of sex workers under partial (de)criminalisation regimes, where only purchasing sex is illegal. A 2007 report by the Swedish National Board of Health and Welfare cites a sex worker's view

> that there may be fear among clients that makes it harder to use safe meeting places. Instead, the meeting places have become more out of the way, such as wooded areas, isolated stairwells and office premises, where clients do not risk discovery.[109]

Some reports from Norway, which criminalised the purchase of sex in 2009,[110] indicate a similar effect: shortly after the law's enactment, one sex worker stated that whereas transactions used to take place near the busy Oslo harbour, now 'the men drive us out of town to find an empty space with no one in sight'.[111] It appears, however, that no research has yet been carried out into the effects of the Norwegian law.

2.1.3 ***Criminalisation of safety measures***

While sex work is often considered an inherently dangerous occupation,[112] sex workers can and do take precautions to enhance their safety. Criminal laws, however, may hinder these efforts by rendering those very precautions illegal.

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[108] KM Blankenship and S Koester, 'Criminal Law, Policing Policy and HIV Risk in Female Street Sex Workers and Injection Drug Users' (2002) 30 Journal of Law, Medicine and Ethics 548, 550.

[109] Socialstyrelsen (National Board of Health and Welfare of Sweden), *Prostitution in Sweden 2007* (Socialstyrelsen 2008) 48.

[110] General Civil Penal Code s 202a.

[111] G Fouché, 'Sex Ban Puts Us at Greater Risk' *Guardian* (London 27 May 2009) <http://www.guardian.co.uk/society/2009/may/27/prostitution-norway> accessed 18 June 2011.

[112] ML Rekart, 'Sex-Work Harm Reduction' (2005) 366 The Lancet 2123. However, some sex workers and researchers dispute this, suggesting that most occupational risks could be eliminated by careful operation within a proper legal framework: see for example R Thomas, 'Where's the Harm in Sex Work?' (discussing presentation by Swedish sex worker activist Pye Jakobsson at the International Harm Reduction Association conference, Beirut, April 2011) <http://blog.soros.org/2011/04/wheres-the-harm-in-sex-work/> accessed 18 June 2011; T O'Doherty, 'Criminalization and Off-Street Sex Work in Canada' (2011) 53 Canadian Journal of Criminology and Criminal Justice 217 (O'Doherty 2011) 218, noting that off-street workers comprise the large majority of sex workers, and that two-thirds in her study say they have never experienced violence; hence 'it is apparent that many people engage in prostitution without experiencing violence. We can no longer simply assume that violence is an inherent part of prostitution'; L Cusick, 'Widening the Harm Reduction Agenda: From Drug Use to Sex Work' (2006) 17 International Journal of Drug Policy 3, 6, 'the harms that are introduced by sex work depend on sex work taking place in conditions of vulnerability'.

2.1.3.1 *'Brothel-keeping' laws*

Brothel-keeping is prohibited in England[113] and Ireland[114] under the common law definition of 'brothel', which refers to a place used for prostitution by more than one person.[115] Thus, a sex worker operating alone will not face a charge of brothel-keeping, but two or more who work together may. Such charges have been brought in both jurisdictions in recent years,[116] and may serve to deter sex workers from taking the safety precaution of working in pairs. Although there does not appear to be any research into the *actual* deterrent effects of this law, the British Home Office recognised in 2006 that it runs 'counter to advice that women should not work alone in the interest of safety', and proposed to amend it to allow two or three-person brothels.[117] This proposal has not been realised.

Canadian law defines a brothel, or 'bawdy-house', as any place 'kept or occupied' by even one person for prostitution,[118] and renders bawdy house-keeping an indictable offence.[119] This criminalises most indoor sex work, which has been found in a number of studies to pose less risk of violence than street-level sex work.[120] However, the actual deterrent effect of this law is questionable, as at least 80% of prostitution in Canada is

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[113] Sexual Offences Act 1956 s 33(a).
[114] Criminal Law (Sexual Offences) Act 2003 s 11.
[115] *Gorman v Standen, Palace Clarke v Standen* [1964] 1 QB 294 (DC).
[116] *R v Finch* (Luton Crown Court 29 April 2010) (acquitted); —, 'Women Fined for Brothel-Keeping' *Irish Times* (Dublin 8 June 2011) <http://www.irishtimes.com/newspaper/ireland/2011/0608/1224298573781.html> accessed 19 June 2011 (pled guilty).
[117] Home Office, 'A Coordinated Prostitution Strategy and a Summary of Responses to Paying the Price' (Report) (2006) <http://www.surreycc.gov.uk/sccwebsite/sccwspublications.nsf/f2d920e015d1183d80256c670041a50b/ae416f8239f800bc802572f3005561c5/$FILE/SSCB%20Prostitution%20Strategy.pdf> accessed 29 July 2011.
[118] Canadian Criminal Code (n 93) s 197(1).
[119] ibid s 210(1).
[120] T O'Doherty, 'Off-Street Commercial Sex: An Exploratory Study' (MA thesis, Simon Fraser University 2007) (study of off-street workers in Vancouver, British Columbia, Canada); L Plumridge and G Abel, 'A "Segmented" Sex Industry in New Zealand: Sexual and Personal Safety of Female Sex Workers' (2001) 25 Australian and New Zealand Journal of Public Health 78; P Pyett and D Warr, 'Women at Risk in Sex Work: Strategies for Survival' (1999) 35 Journal of Sociology 183 (comparing brothel and street sex workers in Victoria, Australia); D Whittaker and G Hart, 'Research Note: Managing Risks: The Social Organisation of Indoor Sex Work' (1996) 18 Sociology of Health and Illness 399 (study of flat-based sex workers in London); BG Brents and K Hausbeck, 'Violence and Legalized Brothel Prostitution: Examining Safety, Risk and Prostitution Policy' (2005) 20 Journal of Interpersonal Violence 270, 293 (study of legal brothel workers in Nevada, USA); JM Wojcicki and J Malala, 'Condom Use, Power and HIV/AIDS Risk: Sex-Workers Bargain for Survival in Hillbrow/Joubert Park/Berea, Johannesburg' (2001) 53 Social Science and Medicine 99, 106.

said to take place indoors.[121] Furthermore, bawdy-house prosecutions are rare, due to a police practice of reactive enforcement triggered mainly by complaints.[122] The greater danger of the law may be that it deters indoor workers from reporting assaults for fear of arrest, but the precise relationship between these two violence risk factors does not appear to have been studied.

The problem of criminal safety measures can arise even with legalised prostitution, since in such regimes sex work remains criminal to the extent that it breaches the specifically sanctioned conditions. In Queensland, Australia, it is legal only when practiced in licensed brothels or by sole operators.[123] Sole operators were initially prohibited from working in pairs or indeed with anyone other than a licensed security guard – a provision that led a sex workers' organisation to describe them as 'sitting ducks'.[124] A 2004 review of the law's operation found sole operators to be at heightened risk of physical and sexual violence.[125] Amending legislation has been introduced to allow sole operators hire a driver or message-taker, but those persons may not be sex workers themselves and may not work for any other sex worker[126] – limitations that may render the 'reform' financially unviable and therefore meaningless in practice.[127]

In New South Wales, Australia, brothels are generally allowed only in industrial or commercial areas, a rule frequently ignored by one- or two-person brothels for safety reasons.[128] Two-person brothels are also required to obtain development consent, through a public process which many prefer to avoid lest they become targets of abuse and violence.[129]

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[121] Canadian Subcommittee (n 94) 5. Some Canadian sex workers, however, do assert that they have personally been deterred by the law: *Bedford* (n 97) [31], [36], [43]. Furthermore, not all indoor prostitution is illegal; 'outcalls' to hotels or clients' homes will not, in general, breach the 'bawdy-house' provision of the Code.
[122] Canadian Subcommittee (n 94) 55.
[123] Prostitution Act 1999 (Qld).
[124] Crime and Misconduct Commission, *Regulating Prostitution: An Evaluation of the Prostitution Act 1999 (Qld)* (Crime and Misconduct Commission, Brisbane 2004) 11.
[125] ibid 68-70.
[126] Prostitution and Other Acts Amendment Act 2010 (Qld) s 16(9)-(10).
[127] Respect Inc 'Submission to the Crime and Misconduct Review of the Prostitution Act' (2011) <http://www.cmc.qld.gov.au/asp/index.asp?pgid=10911&cid=5575&id=827> accessed 15 July 2011, 8.
[128] Brothels Task Force, *Report of the Brothels Task Force* (Government of New South Wales 2001) 9-11. Brothel location in New South Wales is dealt with under planning rather than criminal law. It is, however, included here as an example of the consequences of over-regulation.
[129] ibid 13.

2.1.3.2 *'Living off the proceeds' laws*

In many jurisdictions, it is also an offence for a third person to live off the proceeds of prostitution. The reasoning behind this law is clear: it is aimed at criminalising those who exploit and profit from others' sexual services (commonly described as 'pimps'). However, the broad terms in which these laws are drafted often cast the net far wider.

In Canada, a sentence of ten years' imprisonment is possible for living 'wholly or in part on the avails of' another person's prostitution.[130] The courts have interpreted this to apply to a security guard, a driver, or a person who answers the telephone to screen clients.[131] These, too, are potential safety mechanisms which cannot be legally utilised. In testimony before a House of Commons Subcommittee, many sex workers stated that they considered this law to put them at risk,[132] although there is an absence of documentary evidence on its actual effects.[133]

Furthermore, there may be undesirable consequences for sex workers even when this law reaches its target. A report by a European Commission-funded non-governmental organisation working with sex workers states that the use of a similar law to close down hotels and apartments in a Paris red light district had a displacement effect similar to that faced by street workers at times of crackdown.[134]

2.1.3.3 *Interference with effective screening mechanisms*

Criminal laws may also inhibit sex workers' ability to 'screen out' potentially dangerous clients. Canada's 'communication' provision, which *is* heavily enforced,[135] is widely criticised as pressurising sex workers to move into private locations quickly and

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[130] Canadian Criminal Code (n 93) s 212(1)(j).
[131] *Bedford* (n 97) [379].
[132] Canadian Subcommittee (n 94) 58.
[133] While actual prosecutions under this provision are rare, this appears to be due to a difficulty establishing evidence rather than selective enforcement (ibid citing Fraser Report (n 102) 390, 417-18). It has not been established to what extent, if any, the disincentivising effect of the law is countered by the low prosecution rate.
[134] European Network for HIV/STD Prevention in Prostitution (Europap/Tampep 4), 'Policies on Sex Work and Health' (1999) <http://www.who.int/hiv/topics/vct/sw_toolkit/policies_sw_health.pdf> accessed 25 June 2011.
[135] Accounting for more than 90% of reported prostitution-related offences: Testimony of Roy Jones, Director, Canadian Centre for Justice Statistics, in Canadian Subcommittee (n 94) 52.

perhaps before they have had sufficient time to evaluate the client – for such factors as whether he appears to be drunk or unstable or has been reported by other sex workers as a 'bad date'.[136] This may also be a factor in the recorded increase in crimes against sex workers since enactment of this provision,[137] although the same uncertainty about causation applies.

Irish sex workers, discussing the solicitation law,[138] similarly complain that they must make more hasty decisions: 'you used to look out for clients, now you're looking out for the police as well. You'll jump into the first car that stops. You can't concentrate on two things at once.'[139]

Similar effects have been noted where only clients are criminalised. The 'kerb-crawling' provision in English law[140] is alleged to cause pressure on sex workers to get into clients' cars more quickly.[141] In Sweden, it is reported that sex work now involves a 'lightning decision' in which street-based workers simply get into the first car that stops for them.[142]

These measures are promoted by supporters of the Swedish model on the premise that they will reduce prostitution by reducing the essential 'demand' element. However, it is suggested to be mainly the non-violent clients that these measures deter; they are said to have little effect on the dangerous ones.[143] This could be because people with violent

[136] ibid 64; *Bedford* (n 97) [128].
[137] As previously cited (n 102).
[138] Criminal Law Act (n 89).
[139] O'Connor (n 90) 18.
[140] Sexual Offences Act 1985 s 1. 'Kerb-crawling' is defined therein as a man soliciting a woman from a motor vehicle 'persistently or in such manner or in such circumstances as to be likely to cause annoyance to the woman (or any of the women) solicited, or nuisance to other persons in the neighbourhood'.
[141] United Kingdom Network of Sex Work Projects, 'Response to "Paying the Price"' (2004) <http://www.uknswp.org/UKNSWP_Paying_the_Price_response.pdf> accessed 25 June 2011, 13; T Sanders, 'The Risks of Street Prostitution: Punters, Police and Protestors' (2004) 41 Urban Studies 1703, 1713.
[142] Ministry of Justice and the Police of Norway, 'Purchasing Sexual Services in Sweden and the Netherlands: Legal Regulation and Experiences' (2004) <http://www.regjeringen.no/upload/kilde/jd/rap/2004/0034/ddd/pdfv/232216-purchasing_sexual_services_in_sweden_and_the_nederlands.pdf> accessed 29 July 2011, 13, 19; also P Östergren, 'Sexworkers critique of Swedish Prostitution policy' (2004) <http://www.petraostergren.com/pages.aspx?r_id=40716> accessed 19 June 2011.
[143] J Eriksson, 'What's Wrong with the Swedish Model?' (2006) 2:1 Spread 40, 41; M Hester and N Westmarland, *Tackling Street Prostitution: Toward an Holistic Approach* (Home Office Research, Development and Statistics Directorate, London 2004) 24; Ministry of Justice and the Police of Norway (n 142) 12-13; R Campbell and M Storr, 'Challenging the Kerb Crawler Rehabilitation Programme'

tendencies are generally less risk-averse than others,[144] making the threat of arrest less likely to influence their behaviour. A person who is willing to take chances with the serious penalties for bodily harm offences may also have little concern for the possibility of arrest on a lesser prostitution charge. However, there is an absence of research into the personal and psychological qualities that distinguish clients who respond to deterrence strategies from those who do not.

Such measures, therefore, may inadvertently put sex workers at greater risk by decreasing the proportion of 'safe' clients relative to violent clients – and thus increasing the likelihood that any given client will turn out to be dangerous. This effect has serious implications for the health and safety rights of sex workers under criminal laws that aim to reduce demand by targeting clients.

2.1.3.4 *Interference with client negotiations*

Another common safety measure is negotiating prices and services at the start of an interaction with a client. Having 'set prices' is a common strategy by which sex workers assert control over a potential transaction.[145] However, fear of arrest under 'soliciting' or 'communicating' laws may lead them to omit this vital step,[146] and allow the client to name the service he wants and the price he is willing to pay for it. Such circumstances increase the likelihood of a client overstepping the sex worker's comfort boundaries,[147] and may result in violence if a dispute arises over price or services.[148]

(2001) 67 Feminist Review 94, 102 citing S Wilcock, *The Lifeline Sexwork Project Report: Occupational Health and Safety Issues and Drug Using Patterns of Current Sexworker: Survey Findings* (Lifeline, Manchester 1998); W McElroy, 'Prostitutes, Feminists and the Economic Associates of Whores' in J Elias, *Prostitution: On Whores, Hustlers and Johns* (Prometheus, New York 1998) 338.

[144] A Mawson, 'Reinterpreting Physical Violence: Outcome of Intense Stimulation-seeking Behavior' (1999) 6 Academic Emergency Medicine 863.

[145] G Cox and T Whitaker, *Drug Use, Sex Work and the Risk Environment in Dublin* (National Advisory Committee on Drugs, Dublin 2009) 127.

[146] Arnot (n 100) 61; Canadian Subcommittee (n 94) 65.

[147] Lutnick (n 106) 45.

[148] J Lowman, 'Violence and the Outlaw Status of (Street) Prostitution in Canada' (2000) 6 Violence Against Women 987, 19; O'Doherty 2011 (n 112) 227.

2.1.4 ***Diminished independence***

Contrary to the intention of 'living on the avails' laws, criminalisation provisions may actually *increase* sex workers' reliance on pimps. This could be because self-protection is made more difficult,[149] 'bail and protection money' is needed,[150] direct contact between buyers and sellers is inhibited,[151] or someone is needed to look out for police.[152] This effect is also noted in Sweden, where it is claimed that

> prostitutes' dependence on pimps has increased because street prostitutes cannot work as openly as before. The police informed us that it is more difficult to investigate cases of pimping and Trafficking in Human beings because prostitution does not take place so openly on the streets any more.[153]

In relation to indoor prostitution, the same report states:

> Someone is needed in the background to arrange transport and new flats so that the women's activity is more difficult to discover and so that it will not attract the attention of the police.[154]

Official reports also acknowledge claims that the number of pimps has increased, which some attribute to the greater difficulty of contact between sex worker and client,[155] and that 'clients no longer provide tip-offs about pimps, for fear of being arrested themselves'.[156]

These anecdotal reports do not necessarily indicate an increase in violence against sex workers at the hands of pimps. The pimp-prostitute relationship is not inevitably a violent one.[157] However, the use of 'dependence' terminology by those who have observed this alleged effect strongly suggests a potential for abuse and exploitation. Further research in this area is clearly warranted.

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[149] Federal/Provincial Territorial Working Group on Prostitution (n 102) 65, A Brannigan, 'Victimization of Prostitutes in Calgary and Winnipeg' (Report) (1994) Department of Justice of Canada TR1996-15e, ix.
[150] M Keogh and J Harrington, *Survivor: Memoirs of a Prostitute* (Maverick House, Ashbourne 2003) 166 cites this as the reason that 'pimps came back in droves' after the introduction of the soliciting law (n 89).
[151] Socialstyrelsen (n 109) 47-48.
[152] CEEHRN (n 103) 37.
[153] Ministry of Justice and the Police of Norway (n 142) 52 (capitalisation as in original).
[154] ibid 53.
[155] Socialstyrelsen (n 109) 47-48.
[156] Ministry of Justice and the Police of Norway (n 142) 19.
[157] '…according to official crime statistics, serious violent assaults and homicides against prostitutes are more frequently perpetrated by customers than pimps. Certain prostitutes, particularly in British Columbia, endorsed the view of customers as the major source of danger, and noted that pimps often serve as protectors.' Federal/Provincial Territorial Working Group on Prostitution (n 102) 47-48.

2.1.5 ***State violence***

Perhaps the clearest and most alarming link between criminalisation and violence is that sex workers are often victimised *by the police themselves* as a consequence of their illicit status. High rates of police violence against sex workers have been reported in many countries where prostitution is unlawful.[158] Often, this takes the form of police demanding sexual favours in exchange for avoiding arrest or detention.[159] This abuse of the state's coercive powers clearly infringes the victims' right to security of person – under almost any definition – as well as the autonomy component of their right to sexual health. State violence can also occur when police use excessive force against sex workers during 'crackdowns' on prostitution.[160] Sex workers who generally refrain from reporting attacks due to fear of arrest can hardly be expected to point the finger at attackers in police uniform.

Such violence may have longer-term effects on sex workers' health. A recent study from British Columbia, Canada finds a significant correlation between assault by police and subsequent gender-based violence, which may be explained by a reluctance to

[158] WHO Department of Gender, Women and Health, Global Coalition on Women and AIDS, 'Violence against Sex Workers and HIV Prevention: Information Sheet' (January 2005) <http://www.who.int/entity/gender/documents/sexworkers.pdf> accessed 18 June 2011 citing Sangram, Point of View and VAMP 'Turning a Blind Eye' (2002) 1(3) Of Veshyas, Vamps, Whores and Women: Challenging Preconceived Notions of Prostitution and Sex Work' (study of Indian sex workers showing that 70% have sustained beatings at the hands of police); J Thural and A Murphy, 'Sex Workers and Police in New York City' (2005) 8 Research for Sex Work 16 (14%); CEEHRN (n 103) 22 (18% of Moscow sex workers have been raped by police), 43 (Novgorod, Russia, 21%, brutality; Georgia, 26%, sexual or physical violence; Lithuania, 66%, physical violence); SWAN (n 22) 21 (Kyrgyzstan, 89.5% of the 19 sex workers interviewed allege sexual assault by police within the previous year).

[159] CEEHRN (n 103) 22, 43; J Bindman, 'Redefining Prostitution as Sex Work on the International Agenda' (1997) <http://www.walnet.org/csis/papers/redefining.html> accessed 18 June 2011; NJ Almodovar, 'The Consequences of Arbitrary and Selective Enforcement of Prostitution Laws' 2010 8 Wagadu Journal of Transnational Women's and Gender Studies 241, 251; T Rhodes and others, 'Police Violence and Sexual Risk among Female and Transvestite Sex Workers in Serbia: Qualitative Study' (2008) 337 British Medical Journal 811; African Sex Worker Alliance (ASWA), '"I Expect to be Abused and I Have Fear": Sex Workers' Experiences of Human Rights Violations and Barriers to Accessing Healthcare in Four African Countries' (2011) <http://www.plri.org/sites/plri.org/files/ASWA_Report_HR_Violations_and_Healthcare_Barriers_14_April_2011.pdf> accessed 29 July 2011, 17, 33, 50; P Saunders, 'Capital Punishment: DC Activists Fight Prostitution Free Zones' (2009) 5(1) Spread 34, 36.

[160] K Shannon and others, 'Prevalence and Structural Correlates of Gender Based Violence among a Prospective Cohort of Female Sex Workers (2009) 339 British Medical Journal b2939 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2725271/> accessed 18 June 2011; Human Rights Watch, *Off the Streets: Arbitrary Detention and Other Abuses Against Sex Workers in Cambodia* (Human Rights Watch, New York 2010) 25, 35-36.

access police services after such an event, even where needed for safety.[161] Acts short of violence may also pose a threat: in a study from Central and Eastern Europe, informants in all 27 countries identify police harassment as 'one of the most significant factors contributing to sex workers' vulnerability to violence and health risks'.[162]

2.2 Sexually-transmitted infections

Sex workers engage for a living in an activity by which disease, including HIV/AIDS, can be transmitted. It might therefore be thought that sexually-transmitted infection (STI) is merely an occupational hazard, irrespective of the legal status of prostitution. However, a significant body of evidence supports the proposition that the illegality of sex work 'may itself be an HIV risk factor',[163] with similar implications for other STIs. This evidence will now be presented.

2.2.1 *Violence and STIs*

The heightened risk of violence for illegal sex workers may make them more susceptible to infection: violence against sex workers is associated with an increased likelihood of HIV and STI acquisition.[164] This is unsurprising, as rape rarely takes place with a condom,[165] and can cause injuries that facilitate STI and HIV transmission.[166]

[161] Shannon and others (n 160) 5. The study was conducted on 237 drug-using female sex workers on the streets of Vancouver.
[162] CEEHRN (n 103) 41.
[163] Blankenship and Koester (n 108) 549.
[164] Shannon and others (n 160) 1.
[165] N van Beelen and A Rakhmetova, 'Addressing violence against sex workers' (2010) 12 Research for Sex Work 1, 1; ASWA (n 159) 38.
[166] TSH Beattie and others, 'Violence against Female Sex Workers in Karnataka State, South India: Impact on Health, and Reductions in Violence Following an Intervention Program' (2010) 10 BioMed Central Public Health 476; E Pisani, *The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS* (Granta, London 2008) 129.

2.2.2 ***Obstacles to accessing health services***

Outreach to persons in high-risk categories is regarded as an essential element of HIV prevention,[167] and is also important in addressing other aspects of sex workers' health. However, sex workers can be difficult to reach where their status is illegal:

> Police harassment is clearly a greater threat to sex workers in Belarus, a situation that greatly impeded HIV/STI prevention and care efforts among them and thus limits their right to health. Respondents from Belarus noted that due to the illegal status of commercial sex work and police crackdowns, this group is extremely difficult to reach with prevention messages and condoms.[168]

The Joint United Nations Programme on HIV/AIDS (UNAIDS) states that where sex work is illegal and punishable, the secrecy with which it takes place makes HIV and STI prevention and treatment programmes 'nearly impossible to implement'.[169] It describes criminalisation as creating a risk of alienating sex workers from the services available and deterring them from seeking information and education on safer sex.[170] Criminalisation also leaves sex workers vulnerable to blackmail, which may be used against them when seeking treatment.[171]

In Canada, social workers describe the 'communication' provision as making it harder to reach street-level sex workers to offer them condoms and other health services – or indeed to warn them about violent clients.[172] Police may also seize the opportunity presented by sex worker-targeted health services to make arrests.[173] In other

[167] WHO, *Priority Interventions: HIV/AIDS Prevention, Treatment and Care in the Health Sector* (2nd edn World Health Organization, Geneva 2010) 4.
[168] CEEHRN (n 103) 36, and see also 14.
[169] UNAIDS, 'Sex Work and HIV/AIDS: UNAIDS Technical Update' (2002) <http://data.unaids.org/publications/IRC-pub02/jc705-sexwork-tu_en.pdf> accessed 25 June 2011, 8.
[170] ibid 8.
[171] ASWA (n 159) 52.
[172] Canadian Subcommittee (n 94) 64.
[173] I Wolffers and N van Beelen, 'Public Health and the Human Rights of Sex Workers' (2003) 361 The Lancet 1981, 1981; M Ditmore, 'Report from the USA: Do Prohibitory Laws Promote Risk?' (2001) 4 Research for Sex Work 13, 13.

jurisdictions, outreach groups are reportedly threatened by police with closure[174] or charges of 'controlling prostitution'.[175]

Peer outreach – in which members of the target community deliver information and advice – is particularly important with marginalised groups. Peers are often seen as more credible and trustworthy than outsiders.[176] A peer outreach programme introduced in Sonagachi, Calcutta led to an increase in the proportion of sex workers who 'often' or 'always' use condoms from 2.7% in 1992 to 90.5% in 1998.[177] Where anti-prostitution operations include the use of informants, however, this can compromise peer outreach programmes by undermining sex workers' trust in each other.[178]

Outreach can also be hindered under legalisation regimes where funding is provided only for services aimed at the legal industry. This is found to be the case in a recent Australian study, which shows that nearly all brothels were reached by health services in decriminalised New South Wales, while in heavily-regulated Victoria funding was available only for the minority of brothels operating under licence.[179]

2.2.3 ***Deterrents to condom use***

The prophylactic sheath, or condom, is recognised by the WHO as having 'an 80% or greater protective effect against the sexual transmission of HIV and other STIs'.[180] It is therefore an essential tool for protecting the sexual health of men and women in prostitution. Criminal laws may, however, create barriers or disincentives to their use.

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[174] E Maron and B Ramakant, 'HIV, Sex-Workers and Injecting Drug Users: Developing a Rights-Based Approach in Central Asia and Eastern Europe' (2011) <http://www.aidsportal.org/atomicDocuments/AIDSPortalDocuments/20110614114026-HIV,%20sex-workers%20and%20injecting%20drug%20users%20developing%20a%20rights-based%20approach%20in%20Central%20Asia%20and%20Eastern%20Europe.pdf> accessed 8 July 2011, 2.

[175] UKNSWP (n 141) 71.

[176] UN Office on Drugs and Crime, *Substance Abuse Treatment and Care for Women: Case Studies and Lessons Learned* (United Nations, New York 2004) 41.

[177] C Jenkins, 'Female Sex Worker HIV Prevention Projects: Lessons Learnt from Papua New Guinea, India and Bangladesh' (2000) UNAIDS/00.45E, 81.

[178] Blankenship and Koester (n 108) 552.

[179] C Harcourt and others, 'The Decriminalisation of Prostitution is Associated with Better Coverage of Health Promotion Programs for Sex Workers' (2010) 34 Australian and New Zealand Journal of Public Health 482, 485-86.

[180] WHO, 'Condoms for HIV Prevention' (undated) <http://www.who.int/hiv/topics/condoms/en/> accessed 25 July 2011.

2.2.3.1 *Condoms as evidence of prostitution*

The practice of treating condom possession as evidence of prostitution appears in the literature with alarming frequency. In Washington DC, carrying multiple condoms is a ground for being declared a suspected sex worker and expelled (under threat of arrest) from *ad hoc* 'prostitution-free zones'.[181] In New York,[182] Britain[183] and South Australia[184] condoms are treated as evidence of illegal activities. In Finland, which denies the right of entry to foreign national suspected sex workers,[185] 'huge amounts of condoms' is one way that this status is determined.[186] Even in Sweden, where sex workers themselves cannot be prosecuted, police seeking to avert prostitution or arrest clients 'look for condoms as evidence of sex. This gives sex workers a strong *incentive not to carry condoms*'[187] (emphasis in original).

2.2.3.2 *Barriers to condom negotiation*

Many researchers have also looked at the relationship between criminality and sex workers' capacity to refuse unsafe sex. Where sex work itself is illegal, the worker's bargaining power over a client reluctant to use condoms may be reduced.[188] UNAIDS recognises this in its most recent Guidance Note on HIV and Sex Work, stating:

> Where sex workers are able to assert control over their working environments and insist on safer sex, evidence indicates that HIV risk and vulnerability can be sharply reduced.[189]

Criminal measures targeting clients may also lead to an increase in sex workers' willingness to engage in unsafe sex. This is attributed to a decrease in clients, with a

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[181] A Forbes, 'Sex Work, Criminalization and HIV: Lessons from Advocacy History' (2010) 22 BETA, the Bulletin of Experimental Treatments for AIDS 20, 26-27.
[182] ibid 27. A bill to prohibit this practice is presently under consideration by the state legislature.
[183] UKNSWP (n 141) 71.
[184] L Banach and S Metzanrath, 'Principles for Model Sex Industry Legislation' (2000) <http://www.bayswan.org/Resources_For_Prost_Law/Model_Prost_Laws/model-principles_swdecrim.pdf> accessed 29 June 2011, 21.
[185] Aliens Act (301/2004) s 148.
[186] M Jyrkinen, 'The Organisation of Policy Meets the Commercialisation of Sex: Global Linkages, Policies, technologies' (DPhil thesis, Swedish School of Economics and Business Administration 2005) 195-96. What constitutes 'huge' is not explained.
[187] J Eriksson, 'The "Swedish model": Arguments, Consequences: Presentation to Green Ladies' Lunch, Prostitution in Europe – Berlin' (2005) <http://www.glow-boell.de/media/de/txt_rubrik_2/160305LLVortrag_Eriksson.pdf> accessed 19 June 2011 [5].
[188] Blankenship and Koester (n 108) 549-50.
[189] UNAIDS Guidance Note (n 20), 4.

consequent loss of income (which makes requests for unsafe sex more difficult to refuse)[190] and increased competition among workers.[191] Health authorities in one Swedish city express 'a fear of a dramatic development in a negative direction for the health of the prostitutes and the spread of venereal diseases' since the enactment of the sex purchase ban.[192]

It is unclear whether these fears have been realised, as the Swedish government has not established a proper surveillance system for sex workers and 'no clear overall understanding exists' of their risk-taking.[193] A recent report includes the alarming statistic that only 18.5% of sex workers used a condom with their most recent client, and that *none* in the under-24 age group had. The sample is small and comprises mostly male substance abusers,[194] and so cannot be assumed to be representative of Swedish sex workers generally. It is further noted that none in this sample tested positive for HIV.[195] Nonetheless, the low rate of condom usage is clearly a cause for concern and for further study.

2.2.3.3 *Political opposition to condom distribution*

Efforts to promote condom use by sex workers and their clients may meet resistance on the basis that they encourage illegal commercial sex. In a parallel with the controversies over needle exchange programmes for injecting drug users, distribution of condoms to sex workers are opposed in Sweden on the basis that it is incompatible with a 'zero

[190] Eriksson (n 187) [5]; Ministry of Justice and the Police of Norway (n 142) 12 citing Socialstyrelsen, Kännedom om Prostitution 2003 (National Board of Health and Welfare, Stockholm 2004); Östergren (n 142); Blankenship and Koester (n 108) 550; Campbell and Storr citing Wilcock (n 143) 63-64; S Stuteville and A Stonehill, 'Sex in the City of Joy: White House Morality Threatens Kolkata's Sex Workers' (2006) 2:2 Spread 37, 40.
[191] Ministry of Justice and the Police of Norway (n 142) 13; G Betteridge, *Sex, Work, Rights: Reforming Canadian Criminal Laws on Prostitution* (Canadian HIV/AIDS Legal Network, Toronto 2005) 42; UKNSWP (n 141) 13.
[192] Ministry of Justice and the Police of Norway (n 142) citing Polismyndigheten i Skåne 'Rapport – Lag (1998:408) Om Förbud Mot Köp av Sexuella Tjänster' (2001) ALM 429-1044/99.
[193] Government of Sweden (n 18) 65.
[194] Government of Sweden (n 18) 107. The survey involves 20 male and seven female sex workers, of whom only five – four men and one women, all in the 24-49 age group – used a condom with their most recent client. This is significantly lower than the figures reported by most of the 86 other countries that answered this question in their 2010 reports: UNAIDS, 'Global Report: UNAIDS Report on the Global AIDS Epidemic 2010' (2010) UNAIDS/10.11E (UNAIDS 2010) 346-49. However, great caution must be taken in drawing comparisons, as methodology is not consistent across countries.
[195] Government of Sweden (n 18) 26.

tolerance' approach to prostitution.[196] Prohibitory laws are also implicated in the cancellation of client-targeted HIV prevention measures.[197] These attitudes might explain the low rate of condom usage cited in the paragraph above, although no impact assessments could be found.

2.2.4 ***Displacement into riskier work environments***

An Ecuadorean study[198] finds enforcement of prohibitory laws against indoor prostitution to increase STI rates by shifting sex workers onto the street, where clients are more likely to demand unprotected sex. By the same token, however, enforcement against street prostitution shifts sex workers into the less risky brothels, resulting in a significant reduction in STI transmission.

The latter is the only positive health outcome of criminal enforcement to appear in any of the research, and it will need to be replicated in other countries before conclusions can be drawn as to its general applicability. Notably, however, the study addresses only STI transmission, and not the relationship between law enforcement and other negative health outcomes. If, for example, enforcement in the street sector reduces the STI rate but increases the risk of violence, then a rights-based approach would suggest that STI reduction should be pursued in a different manner.

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[196] Riksförbundet för Gomosexuellas, Bisexuellas och Transpersoners Rättigheter (Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights) (RFSL), 'Förbud mot köp av sexuell tjänst. En utvärdering 1999-2008, SOU 2010:49.' (2010) <http://app.rfsl.se/apa/19/public_files/ry_101025_kop_av_sexuell_tjanst.pdf> accessed 4 July 2011, 8.

[197] ibid 2. These claims mirror reports from across the developing world that HIV prevention measures have been hampered by the US policy of denying aid to any organisation working with sex workers that does not sign up to an 'anti-prostitution pledge'. It is claimed that agencies have had to stop offering condoms and education classes (including sexual health and peer education) because under the regulations they may do this only if they set up fully separate facilities, which they do not have the resources to do. In a survey of staff at agencies in receipt of these funds, more than 60% admit to self-censorship due to the pledge. A drop-in programme for sex workers in Bangladesh which had been recognised as a UNAIDS 'best practices' model lost most of its centres after its funder signed the pledge. See Forbes (n 181) 25-26. In July 2011 a US court ruled this requirement an unconstitutional violation of the recipients' freedom of speech rights, although this judgment is applicable only to US-registered organisations: *Alliance for Open Society International v US Agency for International Development* Docket No 08-4917-cv (Court of Appeals for the Second Circuit).

The US government had previously been accused of interfering with publicly-funded research into HIV prevention among sex workers on the grounds that it ran counter to the George W Bush administration's anti-trafficking policies: J Kaiser, 'Studies of Gay Men, Prostitutes Come under Scrutiny' (2003) 300 Science 403.

[198] P Gertler and M Shah, 'Sex Work and Infection: What's Law Enforcement Got to Do With It?' (2009) Unpublished manuscript <http://scid.stanford.edu/system/files/shared/Gertler_Shah_3-17-09.pdf> accessed 23 July 2011.

2.2.5 ***Compulsory HIV/STI prevention measures under legalisation***

Even where commercial sex is legal, sex workers may be penalised for failing to adhere to certain measures aimed at preventing transmission. The two most common are mandatory condom usage and mandatory screening requirements.

2.2.5.1 *Mandatory condom use*

A number of jurisdictions that permit sex work require the use of condoms. In Nevada, USA, brothel workers must 'require each patron to wear and use a latex prophylactic' in any sexual activity.[199] In Queensland, Australia, it is an offence to offer paid sex without a condom, and brothel owners must take 'reasonable steps' to encourage their use.[200] A mandatory condom law also applies in New Zealand.[201]

Sex worker organisations often oppose these laws. In Queensland, where only a portion of the industry is legalised, it is argued that the law may penalise illegal workers, who might have been difficult for health services to reach or who may have had information and condoms withheld from them.[202] Police are alleged to seek to 'entrap' sex workers by offering extra money for unprotected sex.[203] In New Zealand, fears were initially expressed that sex workers could be targeted under the law in disputes with clients, whose word might be deemed more credible.[204]

It is also argued that sex workers do not need a law to tell them they should look after their sexual health. There may be truth to that in many jurisdictions. In Victoria, Australia, the increase in condom use that followed legalisation is widely believed to be due primarily to the spread of HIV/AIDS, as this increase occurred in both legal and

[199] Nevada Administrative Code ch 441A.805.
[200] Prostitution Act 1999 (as amended), s 77(a).
[201] Prostitution Reform Act 2003, ss 8-9.
[202] Crime and Misconduct Commission (n 124) 67.
[203] Respect Inc (n 127) 6; Scarlet Alliance, 'Submission to the Crime and Misconduct Review of the Prostitution Act' (2011) <http://www.cmc.qld.gov.au/data/portal/00000005/content/22015001304485357479.PDF> accessed 20 July 2011.
[204] Abel (n 10) 49.

illegal sectors.[205] Condom use is also high in other Australian states where prostitution is mostly illegal.[206]

Others, however, point to the law's persuasive influence on *clients* as its important element. A study of New Zealand sex workers finds that 62.5% have cited the law in order to deter clients who request sex without a condom.[207] The ability to 'point to the legislation' is seen as particularly important for younger and less experienced sex workers, who might be less confident in their client negotiations.[208]

It is difficult to justify entrapment measures, particularly where sex workers' HIV/STI rate is low and the threat posed to public health is negligible. However, it is not clear that mandatory condom laws have any other negative consequences, and some benefits are suggested. It is possible that a more narrowly-tailored law – or a prohibition on entrapment – could protect sex workers from undue client pressure without putting them at risk of unjust arrest. However, further study in this area is needed.

2.2.5.2 *Mandatory HIV/STI screening*

Many countries also require sex workers to be screened or tested for HIV/AIDS, and often for other infections. This is problematic for a number of reasons.

First, compulsory testing can generate negative perceptions of the public health services on the part of sex workers.[209] This is particularly the case where they have been brought to clinics by the police, and may lead them to avoid public health services entirely.[210]

Mandatory testing may also reduce clients' incentive to use condoms, by inducing a belief that the sex worker must be 'clean' if he or she is allowed to work.[211] This

[205] Arnot (n 100) 59.
[206] ibid 104.
[207] Abel, Fitzgerald and Brunton (n 100) 124.
[208] Mossman and Mayhew (n 99) 33-34.
[209] CEEHRN (n 103) 44.
[210] ibid 47-49.
[211] UKNSWP (n 141) 72; P Kelly, 'Zona Galactica: A Look Inside Mexico's State-Run Brothel' (2008) 4:2 Spread 44, 46. This is an unsafe assumption even immediately after a test, as sexually-transmitted HIV can be passed on even before it would show up in the results: Pisani (n 166) 133.

sometimes leads clients – whose concern may be only for their own infection risk – to pressurise sex workers to forego the condom.[212]

Mandatory screening requirements may also deter sex workers from registering in those jurisdictions where registration is required to avail of the benefits of legalisation. It is believed, for example, that this is the main reason for the very low registration rate in Greece.[213]

In fact, the perception of sex workers as a 'high risk' group for HIV/AIDS and STI is often belied by statistics showing very low prevalence rates (particularly for non-drug injecting sex workers) in Britain,[214] Australia,[215] New Zealand,[216] Central and Eastern Europe,[217] and even in some countries in the developing world.[218] This is often also the case where prostitution is illegal, suggesting that the risks of criminalisation outlined earlier can be countered through alternate health-promoting measures. Low prevalence rates also suggest that sex workers pose a low public health risk, thus undermining the justification for intrusive mandatory measures.

Where the HIV/STI prevalence rate is higher, the logic of mandatory testing might seem clearer. Yet male-to-female transmission is significantly more efficient than vice versa.[219] Arguably, then, it would make more sense to require screening of men who buy sex than women who sell it. Yet no registration or screening system for clients appears to exist in any jurisdiction – an indication of how 'legalisation' is often

[212] Legal Assistance Centre, *'Whose Body Is It?': Commercial Sex Work and the Law in Namibia* (Legal Assistance Centre, Windhoek 2002) 217.
[213] Crime and Misconduct Commission (n 124) 31.
[214] P Boynton and L Cusick, 'Sex Workers to Pay the Price' (2006) 332 British Medical Journal 190, 191.
[215] Commonwealth of Australia Department of Health and Ageing, *National HIV/AIDS Strategy: Revitalising Australia's Response 2005-2008* (Commonwealth of Australia, Canberra 2005) 4; Commonwealth of Australia Department of Health and Ageing, *National Sexually Transmissible Infections Strategy 2005-2008* (Commonwealth of Australia, Canberra 2005) 28.
[216] PLRC (n 98) 50.
[217] KL Dehne, 'The HIV Epidemic in Central and Eastern Europe: Update' (1999) <http://www.who.int/hiv/strategic/en/e_eur99.pdf> accessed 25 June 2011, 9.
[218] UNAIDS 2010 (n 194) 193, 200, 207. The rates for transgender workers may be significantly higher than the average, although research in this area is limited. See M Friedman, 'Epidemic of Neglect: Trans Women Sex Workers and HIV' (2006) 2:1 Spread 22.
[219] NS Padian and others, 'Heterosexual Transmission of Human Immunodeficiency Virus (HIV) in Northern California: Results from a Ten-year Study' (1997) 146 American Journal of Epidemiology 350.

constructed with a view toward protecting the public from sex workers, rather than the perhaps more logical reverse.[220]

Finally, there is little evidence that the spread of HIV is actually curtailed by mandatory testing. Such policies yield little benefit in return for their significant cost.[221] They do, however, divert funds that could be put to better use in preventive measures.[222] It is therefore unsurprising that UNAIDS flatly declares that there is 'no public health justification' for mandatory HIV testing of sex workers.[223] Voluntary testing is also endorsed by the WHO[224] and the UN Special Rapporteur on the Right to Health.[225]

2.3 Mental ill-health

A number of factors may contribute to mental ill-health among sex workers. These can include experiences before, in and outside prostitution; adverse interactions with the law; feelings about their involvement in the sex industry; genuine occupational hazards; and risks posed or heightened by the illegal status of their work. It is often difficult to separate these factors, and many studies on the subject fail to even try.[226] Nevertheless, there are a number of ways in which criminalisation appears to play some role.

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[220] The perception of sex workers as vectors of disease has been used to justify both criminalisation and legalisation of prostitution. See Brents and Hausbeck (n 120) 274-75; S Day and H Ward, 'Sex Workers and the Control of Sexually Transmitted Disease' (1997) 73 Genitourin Med 161, 161.

[221] Day and Ward (n 220) 164; WK Mariner, 'Legal Issues in HIV/AIDS Prevention and Treatment in the Russion Federation' (2001) <http://dcc2.bumc.bu.edu/RussianLegalHealthReform/ProjectDocuments/n1000.IIIA4.Analysis.pdf> accessed 7 July 2011 (spelling as in original).

[222] Mariner (n 221).

[223] UNAIDS, 'International Guidelines on HIV/AIDS and Human Rights: 2006 Consolidated Version' (2006) HR/PUB/06/9 (UNAIDS 2006), 96.

[224] WHO (Resolution of the World Health Assembly) 'Global Strategy for the Prevention and Control of AIDS' (14 May 1992) 45.35: 'there is no public health rationale for any measures that limit the rights of the individual, notably measures establishing mandatory screening'.

[225] UNCHR 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (2010) UN Doc A/HRC/14/20 (UNCHR 2010) [39].

[226] For example, one widely-cited study finds that 68% of sex workers exhibit signs of Post-Traumatic Stress Disorder (PTSD). However, the study also reveals very high levels of childhood trauma and 'current or past homelessness', and fails to consider the possible contribution of these factors to the PTSD levels recorded. M Farley and others, 'Prostitution and Trafficking in Nine Countries: An Update on Violence and Posttraumatic Stress Disorder' (2004) 2 Journal of Trauma Practice 33.

2.3.1 ***Ill-health effects from other adverse consequences of criminalisation***

The adverse consequences described elsewhere in this Chapter may have knock-on effects for sex workers' mental health. For example, a clear association has been found between violence against sex workers and mental ill-health.[227] The ongoing risk of exposure to HIV/STI may also have adverse consequences for mental health.[228] Logically, therefore, it is likely that any law that increases the risk of violence or infection will also increase the risk of mental ill-health. By the same token, a link has been found between violence and an increase in risky behaviour, STI and reduced access to health services, possibly as a result of mental health effects of violence.[229]

Poor working conditions, which may be associated with a lack of employment rights, can also have adverse mental health impacts. A Canadian study which finds significantly higher rates of depression among sex workers notes that many interviewees 'associated their psychological state of health with the working conditions they experienced in the sex industry'.[230]

2.3.2 ***Stigmatisation***

The perception of selling sex as a deviant behaviour creates a powerful stigma against sex workers. Goffman defines stigma as 'an undesired differentness'[231] in a person, by which the person is 'reduced in our minds from a whole and usual person to a tainted, discounted one'.[232] It is described as the single biggest issue facing sex workers – even those who operate legally.[233]

The Canadian study cited above finds a clear link between criminalisation, stigmatisation and mental ill-health. It states that

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[227] W Rössler and others, 'The Mental Health of Female Sex Workers' (2010) 122(2) Acta Psychiatrica Scandinavica 143.
[228] Brents and Hausbeck (n 120) 293.
[229] Beattie (n 166).
[230] Benoit and Millar (n 105) 68-69.
[231] E Goffman, *Stigma: Notes on the Management of Spoiled Identity* (Touchstone, New York 1986) 5.
[232] ibid 15.
[233] S Pickering, JM Maher and A Gerard, 'Working in Victorian Brothels: An Independent Report Commissioned by Consumer Affairs Victoria into the Victorian Brothel Sector' (2009) <http://www.consumer.vic.gov.au/CA256902000FE154/Lookup/CAV_Publications_Reports_and_Guidelines_2/$file/CAV_Monash_Report_Brothels.pdf> accessed 29 July 2011, 17.

> a large part of their relatively poor mental health had to do with the negative manner in which the sex trade is depicted in our society. The illegalities of the sex trade and its dishonourable public reputation tended to negatively affect how workers feel about themselves and what they did for a living.[234]

Stigmatisation's adverse effects may not be limited to mental health. It is implicated in violence against sex workers, by suggesting their lives are less valuable and that they are appropriate targets for abuse.[235] 'Anti-prostitution' rhetoric by media, politicians and community activists may lead to an increase in violent or harassing behaviour against sex workers.[236] It may also encourage a view on the part of police that attacks on sex workers do not merit investigation, as they 'cannot be raped'[237] or are otherwise not worth protecting. Sex workers themselves may then come to accept the view that violence is 'just part of the job'.[238] This too mirrors Goffman, who writes that when the stigmatised person is denied respect by others, 'he echoes this denial by finding that some of his own attributes warrant it'.[239]

Reluctance to report violent attacks is an obvious consequence of this denial. It can also 'lead to a sense of hopelessness and reduce their desire to take care of themselves, including protecting against HIV'.[240] Judgmental attitudes on the part of health care providers can create a barrier to access to health care services, which may lead sex workers to withhold important lifestyle information from their health care provider, or simply not return.[241]

In her study of sex workers in Victoria, Arnot notes stigmatisation to be an ongoing problem even among the majority who believe they have benefited from the legalised regime. She points out that destigmatisation was never one of legalisation's aims – to the contrary, the government took pains to emphasise its *moral* opposition to

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[234] Benoit and Millar (n 105) 70.
[235] Canadian Subcommittee (n 94) 20.
[236] Lowman (n 148) 1004; European Network for HIV/STD Prevention in Prostitution and Justice for Women, 'Violence against Sex Workers' (2000) <http://www.walnet.org/csis/groups/nswp/europap-violence.html> accessed 15 July 2011; ASWA (n 159) 64.
[237] CEEHRN (n 103) 45; ASWA (n 159) 62.
[238] A Quadara, 'Sex Workers and Sexual Assault in Australia: Prevalence, Risk and Safety' (2008) 8 Australian Centre for the Study of Sexual Assault Issues 1, 22.
[239] Goffman (n 231) 5.
[240] Blankenship and Koester (n 108) 554.
[241] Sex Trade Advocacy and Research, 'Safety, Security and the Well-Being of Sex Workers: A Report Submitted to the House of Commons Subcommittee on Solicitation Laws' (2006) <http://web2.uwindsor.ca/courses/sociology/maticka/star/pdfs/safety_and_security_report_final_version.pdf> accessed 2 July 2011, 28-29; ASWA (n 159) 55.

prostitution.[242] Studies from other jurisdictions note that legal sex work is often treated as 'not work' in certain respects. For example, Dutch brothels cannot advertise for workers in employment offices.[243] This may perpetuate a stigmatising view of sex work, which is likely in turn to further stigmatise sex workers.

Undoubtedly, this reflects a deep-seated unease on the part of many in society: they may recognise the inevitability of commercial sex, at least under current social and economic conditions, but they do not want to condone it. As understandable as this view is, it must be asked whether it contributes to the very negative outcomes that underlie it – creating a vicious cycle in which stigmatisation leads to greater sex work-related harms; those harms increase negative views about sex work; and sex workers are further stigmatised by those views.

It is clear, then, that criminalisation alone does not cause stigma, but it does appear to exacerbate it. While it may not be entirely within the state's power to remove the label of 'undesirably different', it is within its power to remove the label of 'criminal', and this would seem to be an essential first step toward destigmatisation.

2.4 Occupational health and safety

This Chapter has demonstrated that sex workers operating outside the law face conditions inconsistent with the right to occupational health and safety. These include risks of violence which the state may be directly liable for, through its law enforcement agents, or may facilitate through acts or omissions which heighten that risk. It also includes risks of infectious disease or mental ill-health which, while to some extent an occupational hazard, can evidently be exacerbated by policies that increase sex workers' vulnerability to those risks. Where prostitution itself is criminalised, sex workers who expose these threats to their health may only place themselves at risk of arrest. Laws

[242] Arnot (n 100) 112.
[243] V Hayes, 'Prostitution Policies and Sex Trafficking: Assessing the Use of Prostitution-Based Policies as Tools for Combating Sex Trafficking' (2008) <http://www.kentlaw.edu/perritt/courses/seminar/VHayes-final-IRPaper.pdf> accessed 29 June 2011, 35-36.

that prohibit working indoors, or with additional persons for security, also deny them access to a safe working environment.[244]

Despite the principle that health and safety rights apply to all sectors and without discrimination, it may be arguable that a state that does not recognise an occupation as 'work' has no duty to treat those involved as 'workers' by protecting their occupational health.[245] The logic behind that argument is much more difficult to sustain in jurisdictions such as Canada, Ireland and Sweden where providing sex for money is not, in itself, a crime. If a state has, albeit perhaps with reluctance and discouragement, accepted that one can legally earn income from sexual services, is it not then obliged to protect the health and safety of those who do? Similarly, where the state accepts 'prostitution' as an occupation, then even when it strictly limits the conditions in which it can take place (as in Australia and the Netherlands), can it justifiably deny occupational health and safety protections to those who sell sex under other circumstances?

These questions raise wider labour rights issues beyond the scope of this paper, and it is not proposed to resolve them here. It must be concluded, however, that laws which prevent sex workers from practicing their trade under occupational health and safety conditions pose a significant obstacle – if not an outright barrier – to their ability to exercise this aspect of their right to health under international law.[246]

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[244] Inner South Community Health Service, 'Shantusi: Surveying HIV and Need in the Unregulated Sex Industry – Call to Action' (2011) 7.

[245] A similar issue arose in a recent South African case which considered a sex worker's right to compensation for unfair dismissal in light of the illegality of selling sex in the jurisdiction. Her claim was initially rejected but subsequently upheld on appeal, on the basis that the constitutional protection against unfair labour practices trumps the common law rule against enforcement of illegal contracts: *Kylie v Commission for Conciliation, Mediation and Arbitration* 2010 (4) SA 383 (LAC). However, the Court was careful to emphasise that its decision did not mean that sex workers have the full range of employment rights. For a strong criticism of this ruling see K Selala, 'The Enforceability of Illegal Employment Contracts According to the Labour Appeal Court: Comments on *Kylie v CCMA* 2010 4 SA 383 (LAC)' (2011) 14 Potchefstroom Electronic Law Journal 207 <http://www.saflii.mobi/za/journals/PER/2011/17.pdf> accessed 29 July 2011. A comparison might also be drawn to undocumented immigrants, who are also often excluded from occupational protection because of their 'illegal' status. See R Guthrie and M Quinlan, 'The Occupational Safety and Health Rights and Workers' Compensation Entitlements of Illegal Immigrants: An Emerging Challenge' (2005) 3 Policy and Practice in Health and Safety 41. Sex workers, of course, are often undocumented migrants as well.

[246] Even where prostitution is legal, the occupational health and safety rights of sex workers may be limited where they are deemed to be 'independent contractors' rather than employees. This is the case in, for example, New Zealand, where protections under the Health and Safety in Employment Act 1992 are greater for employees than for independent contractors: PLRC (n 98) 155-56. However, it may be that the

2.5 Exclusion of sex workers from the decision making process

As noted in Chapter II, the right to health includes a right to participate in the process by which health-affecting decisions are made. Yet a constant feature of both criminalisation and legalisation processes is that the very persons around whose lives are most affected by prostitution law – sex workers themselves – are given a minimal input role, or excluded entirely.

This has been seen in a number of jurisdictions. Writing about the reforms that took place in Australia in the late 20th century, Banach notes that sex workers were seen as just one of a number of 'key stake holders', whose views were sought only to the degree that they could justify the type of reforms thought necessary to fight organised crime and police corruption (the driving forces behind legalisation in the country).[247] This, she argues, explains why occupational health and safety concerns were virtually dismissed in the reform process.[248] Sex workers have also had little say in either the Dutch legalisation process[249] or the Swedish criminalisation of clients.[250] When the Rhode Island, USA, Senate Judiciary Committee conducted hearings into whether indoor prostitution should be criminalised, six of the ten committee members – including the Chair – left before the sex workers' turn to speak.[251]

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wider the range of employment options available to persons wishing to work in the sex industry, the easier it is for them to negotiate the conditions under which they will accept work (PLRC 156). Furthermore, the distinction between an employee and an independent contractor for occupational health and safety purposes is neither consistent across jurisdictions, nor indeed is it inevitable: an Ontario, Canada court in January 2011 interpreted the reference to 'regularly employed' workers in the provincial Occupational Health and Safety Act to include certain independent contractors. *Ontario (Ministry of Labour) v United Independent Operators* 2011 ONCA 33.

[247] L Banach, 'Sex Work and the Official Neglect of Occupational Health and Safety: The Queensland Experience' (1999) 18 Social Alternatives 17, 18.

[248] Banach (n 247) 20, citing Criminal Justice Commission, 'Review of Prostitution Related Laws in Queensland' (1991) NCJ 129933 which dismisses occupational health and safety risks as merely part of a sex worker's job. Quadara (n 238) similarly notes at 31 that Australia's laws reflect its policy makers' focus on preventing disease, even though sex workers themselves identify stigma, violence and stress as the most dangerous aspects of their job.

[249] H Wagenaar, 'Democracy and Prostitution: Deliberating the Legalization of Brothels in the Netherlands' (2006) 38 Administration and Society 198, 227; M Wijers, 'Prostitution Policies in the Netherlands' (2008) <http://lastradainternational.org/lsidocs/Wijers_M_Pros_policies_NL_2008%5B1%5D%5B1%5D.pdf> accessed 29 July 2011, 11.

[250] Socialstyrelsen (n 109) 49; A Gould, 'The Criminalisation of Buying Sex: The Politics of Prostitution in Sweden' (2001) 30 Journal of Social Policy 437, 447, 452.

[251] L Arditi, 'Sex workers testify at Senate hearing on prostitution bill' *Journal* (Providence, Rhode Island 17 September 2009) <http://www.projo.com/news/content/PROSTITUTION_BILL_06-19-09_UIEPAKU_v59.3cd847f.html> accessed 16 July 2011. The bill to outlaw indoor prostitution was subsequently passed.

This is not only a breach of the participatory element of their right to health, but has a more practical drawback: the less the regime reflects sex workers' operational needs, the less likely they are to comply with it.[252] Denying sex workers' input into the policy process may also contribute to their disempowerment and increase their stigmatisation, and could lead to more adverse impacts on health promotion and HIV prevention.[253]

3. THE EFFECTS OF REMOVING CRIMINAL PENALTIES

This Chapter has outlined many potential adverse effects of laws that criminalise aspects of prostitution. It will now turn to the evidence showing that sex workers' health and safety rights are indeed better protected where those laws are absent.

While some caution is necessary in evaluating this evidence, three conclusions can reasonably be drawn. Firstly, sex workers who are able to operate without risk of arrest to themselves or their clients appear to consider this beneficial to their health and safety. Second, where evidence exists to substantiate or disprove this belief, the weight of it points toward substantiation. Finally, where evidence exists to contradict this belief, it is nearly always due to designs in the legalisation scheme that provide inadequate protection for sex workers.

The grounds for these conclusions are summarised below.

3.1 Where legal and illegal prostitution exist side-by-side, sex workers in the legalised industry tend to report better health and safety outcomes.

Research into the outworking of Queensland's Prostitution Act 1999 finds that sex workers in the legal sector 'appear to have good occupational health and are safer from violence, harassment and intimidation'.[254] 77% of sex workers surveyed for an official evaluation consider legal brothels the safest place to work.[255] Another Queensland study

[252] Arnot (n 100) 110.
[253] Diskrimineringsombudsmannen (Discrimination Ombudsman of Sweden), 'Yttrande över "Förbud mot köp av sexuell tjänst. En utvärdering 1999-2008" (SOU 2010:49)' <http://www.do.se/sv/Om-DO/Remissvar/2010/Yttrande-over-Forbud-mot-kop-av-sexuell-tjanst-En-utvardering-1999-2008-SOU-201049/> accessed 4 July 2011.
[254] C Woodward and others, *Selling Sex in Queensland 2003: A Study of Prostitution in Queensland* (Prostitution Licensing Authority, Brisbane 2004) 8.
[255] Crime and Misconduct Commission (n 124) 71.

comparing legal and illegal workers finds the latter significantly more likely to have been raped or assaulted by a client or a police officer, far less likely to feel 'safe' on an average day, and less likely to report attacks.[256] Mental health outcomes are also found to be better for Queensland workers in the legal sector.[257]

In Victoria, sex workers in licensed brothels report greater security and safer working conditions than those in unlicensed brothels.[258] In New South Wales, illegal home-based brothel workers are 'less likely to access occupational health and safety programs'[259] than their legal counterparts.

3.2 Sex workers feel empowered by laws that grant them legal rights.

Many sex workers who experience the transition from illegal to legal prostitution detect a noticeable improvement in their sense of security. This is attributed to not only their own but also the clients' awareness of their legal status – in particular, that the police can now be contacted if anything untoward occurs.[260] The ability to openly negotiate services upfront without fear of arrest on soliciting charges increases their feeling of control.[261]

The extension of occupational health and safety protections to sex workers is also described as an empowering factor: a Victoria brothel worker states that following legalisation, 'the girls did have a lot more power with occupational health and safety and the likes'.[262] One study finds that 93.8% of New Zealand sex workers feel they have health and safety rights under the law,[263] and most believe reform has brought about actual health and safety improvements.[264]

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[256] C Woodward, 'Regulating the World's Oldest Profession: Queensland's Experience with a Regulated Sex Industry' (2005) 8 Research for Sex Work 16, 17.
[257] C Seib, J Fischer and JM Najman, 'The Health of Female Sex Workers from Three Industry Sectors in Queensland, Australia' (2009) 68 Social Science and Medicine 473.
[258] Pickering, Maher and Gerard (n 233) 3 citing Groves, et al, 'Sex Workers Working within a Legalised Industry: Their Side of the Story' (2008) 84 Sexually Transmitted Infections 393.
[259] Brothels Task Force (n 128) 14.
[260] Arnot (n 100) 60-61, 62, 76; Abel, Fitzgerald and Brunton (n 100) 139.
[261] Arnot (n 100) 61-62, 76.
[262] ibid 72.
[263] Abel, Fitzgerald and Brunton (n 100) 164.
[264] ibid 157.

In the same New Zealand study, an important factor is the explicit provision for the right of workers to refuse a client or service.[265] 64% say they feel 'more able to refuse to do a client' since the law change.[266] The percentage of Christchurch-based sex workers who 'felt that they had to accept a client when they didn't want to' has also dropped significantly since law reform.[267]

New Zealand has also seen a reverse of the 'dispersal' effect discussed earlier, with street-level sex workers now able to take the protective measures of operating in the daytime and in well-lit areas.[268] While this can cause conflicts with local communities, the state has thus far insisted on prioritising sex workers' safety[269] – a demonstration of the rights-based, rather than public order-based, objective of its prostitution laws.

Positive mental health outcomes have also been noted. New Zealand sex workers and non-governmental organisations in the sector both describe decriminalisation as helping sex workers 'feel better about themselves'.[270] One respondent in the same study, a nurse, feels that a better working environment contributes to this improved self-image.[271] In another study, New Zealand sex workers say they considered their new rights 'mentally enabling, allowing them to feel supported and safe'.[272]

While stigmatisation remains an issue, there are some indications that this is lessened where criminal sanctions are removed. Many New Zealand sex workers say they feel more 'legitimate' under the law[273] and feel that relations with police have improved.[274]

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[265] Prostitution Reform Act 2003 s 17. The same right is also provided for under Victoria, Australia's Prostitution Control Regulations 2006 reg 7(1).
[266] Abel, Fitzgerald and Brunton (n 100) 116.
[267] ibid 117: percentages dropped from 53% to 44% in the street sector, 58% to 45% in the managed sector and 63% to 38% among private workers.
[268] PLRC (n 98) 119, 121.
[269] In 2009 one city council, complaining of anti-social behaviour in areas frequented by street-based sex workers, sought amendments to the law to outlaw street prostitution or to allow local authorities ban it from particular areas. The New Zealand government declined to take these steps, on the basis that they could have the effect of 'driving street prostitution further underground, further impairing the health and safety of street-based workers, reducing access for support services to assist sex workers and displacing the activity to other potentially more problematic locations'. Ministry of Justice of New Zealand, 'Review of Street-Based Prostitution in Manukau City' (2009) <http://www.justice.govt.nz/policy/commercial-property-and-regulatory/prostitution/prostitution-review-manukau> accessed 30 July 2011 [63].
[270] Mossman and Mayhew (n 99) 35.
[271] ibid.
[272] Abel, Fitzgerald and Brunton (n 100) 13.
[273] ibid 139-40.
[274] ibid 164.

Another study finds that violence is more likely to be reported, and appears to be taken more seriously, since decriminalisation.[275] A Queensland-based sex workers' organisation has stated in 2011 that 'we feel that recognition of our legitimacy is slightly better than it was ten years ago and in the preceding years since the laws were changed'.[276] It therefore seems that eliminating the criminal penalties associated with higher levels of stigmatisation is a crucial element in sex workers achieving their highest attainable standard of health.

3.3 Negative outcomes from legalisation are usually linked to measures that fail to prioritise sex workers' rights.

Although legalised prostitution has the capacity to alleviate the negative outcomes discussed in this Chapter, it can paradoxically also worsen the position of some workers – where their human rights are not prioritised over other considerations. Examples of this effect are listed below.

3.3.1 *'Over-regulation' of indoor work*

Some jurisdictions have seen the illegal sector rewarded by 'over-regulation' of indoor work. In Victoria, sole operators must obtain planning permission but lose their anonymity in the process; this leads to many sex workers operating illegally, a fact not lost on their clients.[277]

Victorian brothels, meanwhile, are subject to a licensing regime so onerous that many of those already existing under prior legislation closed down 'overnight' when stronger regulation was brought in.[278] In many cases the smaller, owner-operated brothels were the ones that could not make the transition; this led to a reduction in sex workers' control over their own working environment.[279] Another effect was initially to increase competition among workers for jobs in the vastly shrunk legal sector (which also reduced their bargaining power over their working conditions),[280] and eventually to lead

[275] Mossman and Mayhew (n 99) 10.
[276] Respect Inc (n 127) 17.
[277] Arnot (n 100) 71.
[278] ibid 65.
[279] ibid 16, 65.
[280] ibid 16.

to the growth of an illegal brothel industry, where the many health and safety requirements in legal brothels[281] may not be strictly adhered to. It is for this reason that the UNAIDS/Inter-Parliamentary Union Handbook for Legislators warns that 'controls on owners/operators should not be so onerous to comply with that a second illegal industry is created'.[282]

New Zealand, by contrast, exempts small owner-operated brothels (SOOBs) from the regulatory regime applying to 'managed' brothels; a number of the latter closed within a few years of decriminalisation, citing competition from sole operators and SOOBs.[283] The wider range of legal choices available to New Zealand sex workers puts those who opt for the managed sector in a stronger negotiating position relative to brothel management, a factor that promotes better working conditions.[284]

3.3.2 ***Displacement into 'tolerance zones'***

A number of jurisdictions allow commercial sex – particularly at street level – to take place only within specifically-defined areas, which are often described as 'tolerance zones'. Such measures are perhaps the clearest example of legalisation's public order objective: their aim is not so much to channel prostitution *into* particular areas as to channel it *out* of others –usually those that have powerful residential or business lobbies. They are intended primarily to reduce the nuisance factor caused by prostitution.

Where tolerance zones are designed with a view to safeguarding the rights of sex workers, evidence suggests they can be very effective in terms of safety and health promotion,[285] and on that basis are supported by some sex workers and representative

[281] For example, brothel rooms must have an accessible and functioning 'panic button', sufficient lighting to enable the sex worker check for signs of STI, and prominent signs indicating through words and imagery that condom use is required: Prostitution Control Regulations 2006 reg 7(3).
[282] UNAIDS/Inter-Parliamentary Union (IPU), 'Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact' (1999) UNAIDS/99.48E, 56.
[283] PLRC (n 98) 38, 93.
[284] Abel (n 10) 243, 320.
[285] Ministry of Justice and the Police of Norway (n 142) 25; van Doorninck and Campbell (n 10) 68-70, 78 citing AV Kerschl, 'The Dislocation Process of the Illegal Street Prostitution Scene in Cologne: Results of the Scientific Evaluation of the Pilot Project – Paper Presented at 'Drugs and Mobility in Europe AMOC Conference', Prague, 3-5 June 2004; Sanders and Campbell (n 10) 4.

organisations.[286] Zones that take community rather than sex workers' needs into account, however, can have the opposite effect. Displacement to more remote or less visible areas can make sex workers targets for violence;[287] zones that are too small to accommodate their population can create competition amongst workers.[288] As noted above, sex workers often rely on each other for crucial safety information, and a policy that leads to tensions among them risks damaging that important relationship. It may also undermine sex workers' negotiating power in their interactions with clients and result in more risky behaviour, as discussed earlier in this Chapter.

3.3.3 ***The adverse effects of a 'two-tier' system***

Where sex work is made legal under specified conditions, enforcement may be increased against other forms of prostitution in order to justify the creation of a legal sector.[289] The negative effects of criminalisation thus continue to exist, and may even be compounded, for those outside the legal sector. De Rode Draad, a sex workers' advocacy organisation in the Netherlands, believes that conditions in the legal sector have improved as a result of legalisation, but have worsened for those without employment permission whose activity is no longer tolerated.[290]

3.3.4 ***Exclusion of safe operating methods from the legalised system***

If sex workers are forced to choose between obeying the law and their own safety, the risks of choosing the former may outweigh the benefits of legalisation. In a Queensland study, nearly half of those sex workers who feel competent to judge the impact of legalisation believe it made the industry more dangerous, overwhelmingly citing the requirement that non-brothel workers operate alone.[291]

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[286] N McKeganey, 'Street Prostitution in Scotland: The Views of Working Women' (2006) 13 Drugs: Education, Prevention and Policy 151, 159; UKNSWP (n 141) 24. For a contrary view, see Banach and Metzanrath (n 184) 29.
[287] Kavemann, Rabe and Fischer (n 10) 8.
[288] van Doorninck and Campbell (n 10) 70.
[289] R Perkins, *Working Girls: Prostitutes, Their Lives and Social Control* (Australian Institute of Criminology, Canberra 1991).
[290] Ministry of Justice and the Police of Norway (n 142) 34.
[291] Banach (n 247) 18.

4. CAN THE RIGHT TO HEALTH JUSTIFY PROHIBITORY LAWS?

This section will address the arguments that, despite the foregoing evidence, prohibitory prostitution laws can nonetheless be justified on the basis of the right to health. Two such arguments regularly appear in the literature.

4.1 'Prostitution and health are incompatible'

The first argument rejects the underlying premise of this paper: that sex workers' right to health can be promoted through the appropriate application (or non-application) of the criminal law. This argument itself takes two forms.

4.1.1 *Prostitution as an inherent risk*

Supporters of prohibitory laws argue that most of the risks outlined in this Chapter exist regardless of the legal framework: violence, HIV/STI and mental ill-health affect sex workers in legal as well as illegal sectors.

Even accounting for the inadequacies of many legalisation schemes, the evidence suggests this is true. Violence, for example, has not been eradicated in any of the New Zealand sectors, and some sex industry operators appear to doubt that it ever could be: 'Clients getting stroppy will always happen. This was the case before the Act and after it.'[292] As has been noted, legal sex workers can still suffer from the ill-health effects of stigmatisation, which cannot be eradicated through abolition of criminal laws alone.

However, this argument appears to view sex work in isolation from all other occupations. Fatalities are high in the construction sector; agricultural workers risk non-fatal injury; work-related illness (including mental ill-health) is common among social care workers.[293] Any one of these jobs could be deemed intrinsically hazardous. Their social value relative to prostitution might be a matter for debate, but that is not relevant to their status as high-risk occupations. Yet it is almost inconceivable that measures

[292] Mossman and Mayhew (n 99) 38, quoting a brothel operator.
[293] Government of the United Kingdom, Health and Safety Executive, 'The Health and Safety Executive Statistics (HSSH) 2009/10' <http://www.hse.gov.uk/statistics/overall/hssh0910.pdf> accessed 30 July 2011.

aimed at minimising health and safety risks to those workers would be rejected because of the inherent dangers they face.

More fundamentally, this argument misapprehends the nature of the right to health itself. As it is not a 'right to be healthy', it is not unfulfillable merely because a worker might suffer ill-health irrespective of any preventive measures taken. The right to the highest attainable standard of health 'presupposes a reasonable, not an absolute, standard';[294] it is contextual by definition, and applies to those in risky occupations no less than to others.

4.1.2 ***Prostitution as violence against women***

The 'violence against women' ideology, discussed in Chapter I, provides a feminist slant to this argument. It sees sex work as inherently hazardous irrespective of any *quantifiable* risks – prostitution itself is the danger, with invariable harms for those involved in it:

> Let me be clear. I am talking to you about prostitution per se, without more violence, without extra violence, without a woman being hit, without a woman being pushed. Prostitution in and of itself is an abuse of a woman's body.[295]

In this view, a woman is harmed simply by the act of trading sex for money. The damage is inseparable from the act itself, and is not dependent on any physiological consequences or even her own awareness of the harm. Sex workers who claim to have escaped such negative effects (or at least any that cannot be linked to the illicit status of their work) are essentially said to be suffering from false consciousness, the Marxist concept of exploited groups accepting the societal framework in which their exploitation is justified.[296]

This view rejects sex workers' right to take the steps they consider necessary to improve their occupational health within the sex industry, seeking instead to impose its own idea of what sex workers need to improve their health (which usually amounts to no less than

[294] V Leary, 'The Right to Health in International Human Rights Law' (1994) 1 Health and Human Rights 25, 33.
[295] A Dworkin, 'Prostitution and Male Supremacy' (1993) 1 Michigan Journal of Gender and Law 1, 3.
[296] Jeffreys (n 13) 128-160 exemplifies this approach.

exiting the sex trade entirely).[297] In doing so, it denies their right to autonomy in health decisions – and does so on essentially ideological grounds. Although adherents point to research data on the extent of ill-health in the sex industry, the underlying premise is that these data reflect certain manifestations of harm rather than the harm intrinsic to prostitution itself. But if no physical injury or infection has been sustained, and psychological damage cannot be detected, how can the harm be proven? In denying sex workers legal measures which could avert demonstrable harms on the basis of *theorised* harms, this approach also sets a precedent which ideologues from a non-feminist tradition might be only too happy to exploit.[298]

Furthermore, the violence against women framework may itself contribute to the harms that sex workers face. It defines all 'prostituted women' as victims, an imposed status of weakness which clearly has the power to stigmatise them (including those who do not see themselves in that light). In doing so, it may also contribute to the perception of sex workers as easy targets for abuse – and encourage those inclined to commit more tangible forms of violence. The portrayal of sex workers as, for example, unable to reject client demands[299] may give succour to those clients who believe that once they have paid their money they are entitled to demand what they want.[300] Sex workers' negotiating position relative to clients and brothel owners may also be diminished when they are perceived to be the weaker party to the transaction.[301] Theorists from this

[297] This point is well illustrated by the ongoing *Bedford* case (n 97), which will be discussed in detail in ch IV: notable violence against women theorists testified for the Crown against removing sections of the Criminal Code which do not outlaw prostitution *per se* but, as described above, put sex workers at heightened risk of violence.

[298] For example, conservative groups opposed to a wide range of reproductive and sexual freedoms – not merely abortion, but often contraception and sex education – have begun to use the rhetoric of 'protecting' women from the purported harms of these practices. See RB Siegel, 'The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument' (2007-2008) 57 Duke Law Journal 1641.

[299] Dworkin (n 295) 6: 'He can do anything he wants'.

[300] This attitude on the part of some, although not all, paying clients is widely reported. See for example Quadara (n 238) 11; ASWA (n 159) 36. It is not a new idea that certain feminist constructions of gender-based violence may, by conveying to men a sense of their power and strength over women, inadvertently make women more vulnerable to attack: this is suggested (albeit in relation to rape rather than prostitution) in S Marcus, 'Fighting Bodies, Fighting Words: A Theory and Politics of Rape Prevention' in J Butler and JW Scott (eds), *Feminists Theorize the Political* (Routledge, New York 1992). Marcus notes also the link between rape and a male conceptualisation of women's sexuality as men's property, referring to L Clark and D Lewis, *Rape: The Price of Coercive Sexuality* (The Women's Press, Toronto 1977). This link may underlie the reason that the exchange of money creates a sense of entitlement on the part of some clients, as paying for something may reinforce a belief that it 'belongs' to the payer.

[301] B Sullivan, 'Rethinking Prostitution' in B Caine and R Pringle (eds), *Transitions: New Australian Feminisms* (Allen & Unwin, Sydney 1995).

perspective also frequently oppose harm reduction[302] measures aimed at sex workers and their clients, on the basis that they encourage or facilitate prostitution.[303] Finally, the stigmatisation exacerbated by this framework may also make it more difficult for sex workers to leave the trade, due to the risk of negative reactions on the part of others who learn of their past.[304]

4.2 'Public health through prohibition'

The second health-based argument justifies prohibitory laws on the grounds that they will lead to better *public* health outcomes by reducing the overall amount of prostitution.[305] This is problematic for several reasons. First, it has not been demonstrated that any form of criminalisation has this effect. A number of studies have reached the conclusion that 'criminal sanctions do not eradicate or reduce the extent of prostitution'.[306] Others note a reduction in the amount of *street* prostitution as a

[302] The term 'harm reduction' was developed in the context of mainly intravenous drug use to describe measures aimed primarily at alleviating negative outcomes for continuing users, as opposed to measures aimed primarily at reducing or deterring use. In the sex work context it may refer to, for example, promotion of greater condom use, 'ugly mugs' schemes which facilitate sex workers' sharing of information about dangerous clients, or, according to some views, decriminalisation itself. See Cusick (n 112); P Saunders, 'Harm Reduction, Health and Human Rights, and Sex Work' (2006) Open Society Institute <http://www.soros.org/initiatives/health/focus/sharp/articles_publications/articles/harmreduct_20060601/approaches_20060601.pdf> accessed 23 July 2011.

[303] eg, D Hughes, 'Aiding and Abetting the Slave Trade' *Wall Street Journal* (New York 27 February 2003) <http://www.uri.edu/artsci/wms/hughes/abetting_slave_trade.pdf> accessed 15 July 2011; see also s 2.2.3.3 above on the rejection of condom-promoting measures in Sweden.

[304] UNAIDS/IPU (n 282) 56.

[305] J Bindel and L Kelly, 'A Critical Examination of Responses to Prostitution in Four Countries: Victoria, Australia; Ireland; the Netherlands; and Sweden' (2003) <http://www.glasgow.gov.uk/NR/rdonlyres/C19E010B-1A4F-4918-97BD-F96AF7D7F150/0/mainreport.pdf> accessed 30 July 2011, 26.

[306] M Neave, 'Prostitution Laws in Australia: Past History and Current Trends' in R Perkins and others (eds), *Sex Work and Sex Workers in Australia* (University of New South Wales Press, Sydney 1994) citing K Daniels, 'St Kilda Voices' in *So Much Hard Work: Women and Prostitution in Australian History* (Fontana/Collins, Sydney 1984) 335. See also Federal/Provincial Territorial Working Group on Prostitution (n 102) 62; A Collins and G Judge, 'Differential Enforcement Across Police Jurisdictions and Client Demand in Paid Sex Markets' (2010) 29 European Journal of Law and Economics 43; M Della Giusta, 'Simulating the Impact of Regulation Changes on the Market for Prostitution Services' (2010) 29 European Journal of Law and Economics 1; J Lowman and C Atchison: 'Men Who Buy Sex: A Survey in the Greater Vancouver Regional District' (2006) 43 Canadian Review of Sociology and Anthropology 281; P Hubbard, 'Community Action and the Displacement of Street Prostitution: Evidence from British Cities' (1998) 29 Geoforum 269, 283-84.

Only one study has been found which concludes that criminalisation deters sex-sellers: S Jenkins, 'Beyond Gender: An Examination of Exploitation in Sex Work' (DPhil thesis, Keele University 2009) 237-39. However, this conclusion appears to be reached on the basis of comments offered by a number of respondents who either choose to work within rather than outside the law, or say that they would not sell sex at all if they could not do so legally. The 'deterrent effect' attributed to the first category amounts to a preference between three available options (legal prostitution, illegal prostitution,

consequence of criminalisation and enforcement, but suggest that the 'missing' sex work may have merely moved indoors.[307]

The suggestion that criminalisation improves public health is also undermined firstly by the evidence of the risk of adverse health effects as outlined in this Chapter, and second by the broad support for decriminalisation within the global health sector: the removal of laws that prohibit consensual commercial sex is advocated by the WHO[308] and UNAIDS,[309] as well as the Special Rapporteur on the Right to Health,[310] for many of the reasons stated herein.

Finally, in view of the risks of criminalisation cited in this Chapter, such a policy would have the effect of pursuing public health goals at the expense of the individual sex worker's right to health. This would run contrary to established principles of human rights law. While, as noted in Chapter II, public health is an objective *capable* of justifying limitations on individual rights, those limitations are subject to a necessity

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or other work), and does not necessarily indicate which of the latter two options would be chosen if the first were eliminated; while the 'deterrent effect' for the second category is merely speculative, as none of the respondents have actually been faced with that decision. The author's further reference to 'few' respondents being willing to breach the law (246) is hard to reconcile with the fact that approximately one-quarter of all respondents are based in jurisdictions where their work itself is illegal (292).

In any event, most of the subjects of this study, who are drawn entirely from the indoor 'escort' sector, record positive responses to health-related questions (289). Thus, even if criminalisation does act as a deterrent in this particular sector of the sex industry, there does not seem to be a *public health* justification for it.

There are some studies suggesting that *arrest* may help to deter sex-buyers, at least within the street sector: D Brewer and others, 'A Large Specific Deterrent Effect of Arrest for Patronizing a Prostitute' (2006) 1:1 Public Library of Science One 1 <http://dx.plos.org/10.1371/journal.pone.0000060> accessed 19 July 2011; M Monto and S Garcia, 'Recidivism among the Customers of Female Street Prostitutes: Do Intervention Programs Help?' (2001) 3(2) Western Criminology Review 1. These conclusions are reached on the basis of low rates of rearrest. Monto and Garcia caution, however, that the figures might simply reflect the number of clients who have not yet learned how to avoid arrest. Furthermore, neither study suggests a drop in the overall amount of prostitution. While there is no discussion of this, possible reasons include a constant supply of 'new' clients to replace those deterred by arrest; the effect, discussed above in s 2.1.3.3, of sex workers continuing to ply their trade but with clients they would have previously refused; and displacement of clients into more hidden sectors where detection and arrest are less likely.

[307] Ministry of Justice and the Police of Norway (n 142) 53; Socialstyrelsen (n 109) 63; RFSL (n 196) 9; M Neave, 'The Failure of Prostitution Law Reform' (1988) 21 Australian and New Zealand Journal of Criminology 202, 205; S Cameron and A Collins, 'Estimates of a Model of Male Participation in the Market for Female Heterosexual Prostitution Services' (2003) 16 European Journal of Law and Economics 271, 273. The Swedish government accepts that street prostitution is 'only a fraction of total prostitution', the full extent of which is difficult to estimate due to its hidden nature: Government of Sweden (n 18) 63.

[308] K Ahmad, 'Call for Decriminalisation of Prostitution in Asia' (2001) 358 Lancet 643, 643 quoting G Poumerol, WHO Western Pacific Regional Adviser on HIV/AIDS and STI.

[309] UNAIDS 2006 (n 223) 29-30.

[310] UNCHR 2010 (n 225) [76(b)].

and proportionality requirement. Thus, the public health-promotion measures must minimally infringe the health rights of individual sex workers; they must *actually* further the objective sought, and a time limitation and review requirement apply.

What this suggests is that a state must aim to ameliorate the adverse public health impacts of prostitution in a manner that also promotes the health of those it cannot deter from sex work. If doing both proves impossible, and there are compelling grounds for the state to prioritise public health over individual rights, then – and only then – can it do so.[311] However, it must do so through means that *genuinely* advance the public health, and must aim to remove the infringement on individual rights as soon as the public health objective is achieved.

The criminal laws discussed in this Chapter seem very unlikely to meet that high threshold of permissibility. Many were introduced with little if any consideration of their impact on individual rights, or of whether less restrictive methods were available. The 'least restrictive' argument is undermined by the fact that public health-promoting measures, including non-coercive means to deter sex work,[312] are already in place in many jurisdictions. Finally, the public health benefits of criminalisation are in any case highly speculative given the evidential gap noted above.[313]

Of course, to even debate this question is to overlook one very simple fact: 'the public' is made up of individuals. Thus, any policy with adverse consequences for individual health will have some – even if slight – negative impact on public health.[314] While there may be times that a choice must be made, treating the two as complementary and

[311] L Gostin and JM Mann, 'Towards the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies' (1994) 1 Health and Human Rights 59, 74, outlining the conditions for a human rights-compliant limitation on individual rights in the interest of public health, state as follows: 'To determine the least restrictive alternative, non-coercive approaches should first be considered; if noncoercive approaches are insufficient, gradual exploration of more intrusive measures are permissible where clearly necessary.'

[312] Programmes to assist sex workers who wish to 'exit' prostitution are explicitly promoted and funded by many governments, irrespective of its legal status. See P Mayhew and E Mossman, *Exiting Prostitution: Models of Best Practice* (Ministry of Justice of New Zealand, Wellington 2007).

[313] As Gostin and Mann (n 311) 77 stress: 'The risk to the public must be *probable*, not merely speculative or remote.' (emphasis in original)

[314] This point is made by BM Meier and LM Mori, 'The Highest Attainable Standard: Advancing a Collective Human Right to Public Health' (2005-2006) 37 Columbia Human Rights Law Review 101: while at 121 the authors define public health as referring 'to the obligations of a government to fulfill the collective rights of its peoples to health. Rather than focusing on the health of individuals, public health focuses on the health of societies', at 137 they note that 'the individual and public components of health rights are not mutually exclusive but rather are interdependent'.

interrelated is surely the preferable approach from a health-based as well as rights-based perspective. This is recognised by UNAIDS, which states that

> public health objectives can best be accomplished by promoting health for all, with special emphasis on those who are vulnerable to threats to their physical, mental or social well-being. Thus, health and human rights complement and mutually reinforce each other in any context.[315]

5. CONCLUSION

This section has demonstrated the potential of prohibitory prostitution laws to adversely affect the health of sex workers by putting them at greater risk of violence – at the hands of police, clients or pimps. The possibility of arrest is clearly a barrier to seeking police assistance where it is needed. It may also lead sex workers to omit certain safety mechanisms that could reduce the likelihood of suffering violence, or may influence them to engage in riskier behaviour (or with riskier people). Clients' fear of arrest may also lead to increased pressure on sex workers to take unadvisable chances with their safety. Finally, illegality enables unscrupulous police to blackmail sex workers into trading sexual services for freedom, and may create a climate of impunity for those who assault sex workers, increasing the likelihood of such attacks taking place and of longer-term risks to sex workers' health. In this way, the laws breach the right of sex workers to be free from state and (in the case of women) gender-based violence; the right to effective state protection from the risk of third-party violence; and the right to take the steps they deem necessary to protect their health from the risks of violence, including steps to create a safe working environment.

Criminalisation can also interfere with sex workers' right to health by increasing their risk of HIV/STI infection. It does this by subjecting them to a greater risk of sexual assault, by impeding their access to health services and the ability of health workers to reach them (with further implications for other aspects of sex workers' health), and by undermining critical peer outreach programmes. It may also create an environment in which unsafe sex is more likely, through legal disincentives to carry condoms, diminution of sex workers' power to negotiate condom use, and disputes over the legality or propriety of condom distribution schemes. Such laws thus violate states' duty to act as necessary to prevent, treat and control disease. They further breach sex

[315] UNAIDS 2006 (n 223) 77.

workers' right to health by impeding their right of access to sexual, reproductive and other health services – including information about those services – and their right to protection against disease.

Strict control of sex workers' sexual health in a legalised environment may also violate their rights. While mandatory condom use may offer some advantages during negotiations with clients, screening requirements appear to serve little purpose but to offer clients (and the public) unreliable assurances about the sexual health of sex workers – assurances which might rebound negatively on the workers by encouraging clients to demand unsafe sex. They may deter sex workers from complying with registration requirements or engaging with the health services at all. These laws therefore also impede sex workers' right of access to health care services and interfere with their right to maintain their own sexual health. These breaches are amplified by the particularly vulnerable and marginalised status of the category involved.

Prohibitory laws can also lead to mental ill-health outcomes: firstly, by increasing the other risks outlined in this chapter, with knock-on effects for mental health, and additionally by creating or exacerbating a stigma against sex workers which can negatively affect their mental health. This stigma can be self-reinforcing, and can in turn lead to further breaches of their right to health by encouraging violence against them or denial of health care services. In this way, the laws can amount to a breach of the state's duty to safeguard both mental and physical health.

Criminalisation also creates risks for sex workers by making occupational health and safety rules almost impossible to enforce. This interferes with their right to safe working conditions and breaches the state's duty to protect against occupational hazards.

The right to health has been breached in the making of these laws, too, as sex workers have been regularly excluded from the lawmaking process. This breaches their right of participation in decisions that affect their health and their right to take the steps necessary to protect their health, including the right to autonomy over their sexual health. Although legalisation measures appear to generally have better health outcomes, these too can involve rights breaches where do they not sufficiently take into account

the views of sex workers themselves and their acquired knowledge of the safest ways for them to operate.

While health issues are often cited in support of prohibitory laws, these arguments tend to rest on assumptions that are either unproven (that criminalisation deters prostitution) or unprovable (that prostitution is itself an act of violence – at least when a woman is involved). These are insufficient bases for denial of sex workers' right to health. Furthermore, where anti-prostitution laws are adopted in the interest of public health, with no consideration of alternatives and without regular effectiveness reviews, the requirement is breached that limitations on individual rights be strictly (and verifiably) necessary, proportionate and of a limited duration.

Prohibitory prostitution laws can therefore violate the right to health of sex workers in a multitude of ways. They may, in and of themselves, amount to infringements of specific element of the right to health, or may operate in such a way as to give rise indirectly to specific breaches. In either case they additionally breach the right in a broader sense – by obstructing sex workers' ability to achieve their overarching right to the highest attainable standard of health. With these conclusions in mind, the next Chapter will examine how the right to health has been, and could be, used in judicial challenges to prostitution laws.

Chapter IV – Judicial Approaches to Health and Prostitution Laws

1. INTRODUCTION

Prostitution, and laws that prohibit it, are found across the world. These laws have been challenged on many occasions. Surprisingly, in view of the factors detailed in the previous chapter, the negative health impacts of criminalisation seem to have rarely featured in these challenges – with other rights such as the right to a livelihood,[316] to freedom of expression,[317] to privacy[318] and to equality[319] serving as the focus instead. While this may be explained in some cases by the absence of any statutory or constitutional grounds for a health-based challenge, even where this option is available it has not often been used.[320]

This Chapter will examine the small number of cases in which health issues have featured prominently in challenges to prohibitory prostitution laws. Although this cannot claim to be an exhaustive list, it does represent the full extent of relevant case law that could be identified through a number of different research methods – internet search engines, case law databases, journal and newspaper references and direct enquiries to sex worker advocacy organisations. The findings demonstrate the underused potential of the right to health for those seeking an end to criminalisation, but also show the risks of failure to adequately counter health-based arguments in favour of the status quo.

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[316] eg, *Bangladesh Society for the Enforcement of Human Rights v Bangladesh* (2000) 29 CLC (High Court Division).
[317] *R v Skinner* (1990) 1 SCR 1235 (Supreme Court of Canada).
[318] *Jackson v Texas* 2011 WL 2320819 (Court of Appeals of Texas).
[319] Interpretation 666 of Social Order Maintenance Act Art 80 s 1(1), 20 November 2009 (Constitutional Court of Taiwan) <http://www.judicial.gov.tw/constitutionalcourt/en/p03_01_printpage.asp?expno=666> accessed 26 July 2011.
[320] For example, *Hendricks v Namibia* 2002 NAHC 4, a wide-ranging challenge invoking the rights of equality, privacy, freedom of association and freedom of choice in occupation, could have referred to the Namibian Constitution's non-binding Principles of State Policy, which direct the enactment of measures to 'ensure that the health and strength of the workers…are not abused' and to 'improve public health': Constitution of the Republic of Namibia (amended 1998) ch 11 art 95. It could also have pointed out that Namibia is a party to ICESCR (n 34) and ACHPR (n 81) and has a monist system in which ratified international instruments become part of its domestic law: Legal Assistance Centre, 'Right to Health' (undated) <http://www.lac.org.na/projects/alu/Pdf/right-to-health.pdf> accessed 10 July 2011, 13-14. See also the Indian and South African cases discussed below.

2. HEALTH AS A DEFENCE TO PROHIBITORY LAWS: INDIA

The right to health is not explicitly guaranteed in the Indian Constitution, although it contains a number of relevant non-justiciable provisions. Article 39 directs the state to seek to ensure 'that the health and strength of workers, men and women, and the tender age of children are not abused'.[321] Article 42 declares that the state 'shall make provision for securing just and humane conditions of work',[322] while Article 47 deems 'the improvement of public health' to be one of the state's 'primary duties'.[323] The Supreme Court has, nonetheless, deemed health to be a fundamental human right, by reading these provisions in conjunction with both international law and Article 21 of the Indian Constitution ('No person shall be deprived of his life or personal liberty except according to procedure established by law').[324]

Where the courts have considered health in the context of prostitution laws, however, they have tended to apply it against sex workers. In *PN Swamy, Labour Liberation Front, Mahaboobnagar v Station House Officer, Hyderabad*[325] a brothel was raided and the female sex workers 'rescued' from it were subjected, by court order, to medical examinations. A number of them were found to be HIV positive and so were kept in detention, to be transferred to a 'protective home' for counselling. The women challenged their detention under Article 21 and the freedom of movement provisions of Article 19.[326]

The Andhra Pradesh High Court read the binding provisions of Articles 19 and 21 in conjunction with the directive principles of Articles 39(e) and 47 (but not, interestingly, of Article 42). It held that the state must protect public health and, consequently, must 'provide all facilities including medical treatment for the upliftment and rehabilitation of fallen women'.[327] It stressed that the rights of society – in this case, to be protected from the spread of infectious disease – took precedence over the rights of the

[321] Constitution of India, 1950 (Indian Constitution) art 39(e).
[322] ibid art 42.
[323] ibid art 47.
[324] The right to health was first read into this provision in *CESC Ltd v Subhash Chandra Bose* 1992 AIR SC 573, 585.
[325] 1998 (1) ALD 755.
[326] ibid [8].
[327] ibid [18].

individual.[328] Thus, it ordered the women infected with HIV to be sent into the home for a period of two years.[329]

In *Sahyog Mahila Mandal v Gujarat*[330] a challenge was brought to statutory provisions restricting the locations in which prostitution can take place, and allowing warrantless search and arrest where a breach was suspected.[331] The petitioner, a local sex workers' organisation, based their Article 21 argument on the rights to privacy and livelihood rather than health.[332] In rejecting their claim, however, the High Court touched on health issues, adopting a violence against women approach in declaring that 'all prostitution causes harm to women'[333] and additionally linking sex work to the spread of HIV/AIDS and to 'assault, rape and even murder'.[334]

These cases indicate a judicial view of prostitution entirely at odds with the human rights-based approach outlined in the two previous chapters: one in which the rights of individual sex workers – who are simultaneously pitied as victims of abuse and pilloried as vectors of disease – are subjugated to the larger 'public interest'. While it cannot be said that the right to health was entirely ignored in these rulings, it was not the right to health of sex workers that the courts were concerned with. The Indian Supreme Court has, however, recently announced that it may set out 'conditions' to protect sex workers' right to carry out their trade with dignity[335] – another right that has been read into Article 21, and which the Court has linked to the right to health.[336] It remains to be seen whether this will mark a new direction in the judiciary's approach to health rights in the context of sex work.[337]

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[328] ibid [29], [31], [33].
[329] ibid [38].
[330] (2004) 2 GLR 1764.
[331] Immoral Traffic (Prevention) Act 1956 ss 7, 14-15.
[332] *Sahyog Mahila Mandal* (n 330) [2.1], [10].
[333] ibid [8.5]
[334] ibid [10.1]
[335] G Singh, 'Supreme Court Considers Regulating Prostitution' *India Today* (New Delhi 20 July 2011) <http://indiatoday.intoday.in/site/story/supreme-court-prostitution/1/145521.html> accessed 23 July 2011.
[336] *Bandhua Mukti Morcha v Union of India* 1984 SC 802.
[337] An interesting contrast may be drawn between these cases and *Naz Foundation v Government of NCT of Delhi* (2009) 160 Delhi Law Times 277. This involved a challenge to the application of s 377 of the Indian Penal Code of 1860, which prohibits 'carnal intercourse against the order of nature', to consensual sexual acts between adult males. While the law was defended as an HIV-controlling measure, the petitioner argued that the law contributed to the spread of HIV by driving male homosexuality underground, and subjected men who have sex with men to increased stigma and police abuse. These claims were supported by the National AIDS Control Organisation, a specialised agency of India's Ministry of Health and Family Welfare. The Delhi High Court cited art 12 ICESCR (n 34), as well as the

3. HEALTH AS A DOUBLE-EDGED SWORD: SOUTH AFRICA

The South African Constitution safeguards a right of access to 'health care services, including reproductive health care'.[338] Under the header 'Freedom and Security of the Person', Section 12 also provides in subsection 1 for a right 'to be free from all forms of violence from either public or private sources',[339] and goes on to declare in subsection 2:

> Everyone has the right to bodily and psychological integrity, which includes the right
> (a) to make decisions concerning reproduction;
> (b) to security in and control over their body; and
> (c) not to be subjected to medical or scientific experiments without their informed consent.[340]

The Constitution also requires the courts, when interpreting the Bill of Rights, to 'consider international law'[341] and further states that

> When interpreting any legislation, every court must prefer any reasonable interpretation of the legislation that is consistent with international law over any alternative interpretation that is inconsistent with international law.[342]

This suggests that when hearing cases that involve potential adverse effects on the right to health, South Africa's courts should consider those effects in light of a broader definition of that right than merely that within its Constitution.

This opportunity arose in the prostitution context in *State v Jordan*,[343] a challenge to provisions of the Sexual Offences Act that prohibited selling sex and brothel-keeping.[344] Although the applicants brought the case primarily on privacy, equality and livelihood grounds, health issues were also raised and featured prominently in the *amicus* briefs

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Indian Supreme Court's previous acknowledgement (n 336) of health as an essential element of the right to life under art 21 of the Indian Constitution (n 321), in accepting the petitioner's argument that the law involved a breach of the right to health. It further stated that 'popular morality or public disapproval of certain acts is not a valid justification for restriction of the fundamental rights under Article 21'. [71]

[338] Constitution of the Republic of South Africa, 1996 (South African Constitution) s 27(1)(a).

[339] ibid s 12(1)(c).

[340] ibid s 12(2).

[341] ibid s 39(b).

[342] ibid s 233.

[343] 2002 (6) SA 642.

[344] Sexual Offences Act 23 of 1957 s 20(1)(aA) and ss 2, 3(b) and 3(c) respectively. These prohibitions remain in force, although the sale of sex is now governed by s20(1)(Aa) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. Purchasing sex is now also criminalised under s 11 of the latter act.

and affidavits submitted by researchers, doctors, sex workers and non-governmental organisations. It was argued that criminalisation heightened sex workers' risk of violence – because of the threat of prosecution if they reported attacks against them,[345] by making them more vulnerable to exploitative pimps[346] and abusive police,[347] and because they were prohibited from operating in a safer indoor environment.[348] The risks from criminalisation of increased HIV/STI transmission were also noted, with reference to the difficulty of detecting infections among a hidden population,[349] sex workers' fear of exposing themselves to arrest by accessing health services,[350] and the reduced ability to negotiate condom use.[351] It was also argued that criminalisation generally impeded the development of coherent policy and practice in the promotion of sex workers' health.[352]

The absence of occupational health and safety protections in a criminalised environment was also highlighted,[353] with the suggestion that safer sex could be better promoted within regulated brothels.[354] Negative consequences of stigmatisation were also identified, such as adversely affecting sex workers' dignity and self-esteem,[355] encouraging physical and verbal assaults against them,[356] legitimising discrimination against them by public and social services[357] and hindering attempts to exit the industry.[358] Finally, it was noted that the State had made no attempt to find 'less invasive alternatives'.[359]

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[345] Sex Workers Education and Advocacy Task Force, Centre for Applied Legal Studies and the Reproductive Health Research Unit (SWEAT, CALS and RHRU), Submissions in *State v Jordan* Case No CCT31/01 [1.14], [6.55], [6.58], [6.60], [6.72].
[346] ibid [6.63]; CR Jansen and N Janse van Nieuwenhuizen, Appellants' Heads of Argument in *Jordan* [56], [176]; TW Leggett, Supporting Answering Affidavit in *Jordan* [32].
[347] Jansen and Janse van Nieuwenhuizen (n 346) [48], [180]; SWEAT, CALS and RHRU (n 345) [6.61]; Leggett (n 346) [35], [58].
[348] Jansen and Janse van Nieuwenhuizen (n 346) [96], [121], [176], [200]; SWEAT, CALS and RHRU (n 345) [6.58], [13.5]; Commission for Gender Equality (CGE), Submissions in *Jordan* [126]; CD da Silva, Affidavit in *Jordan* [7].
[349] CGE (n 348) [33.2.10.3.1].
[350] SWEAT, CALS and RHRU (n 345) [6.55], [6.74].
[351] ibid [14.38.2].
[352] Jansen and Janse van Nieuwenhuizen (n 346) [46]-[47], [173], [185], [187].
[353] ibid [161]; SWEAT, CALS and RHRU (n 345) [3.3], [6.63], [6.66].
[354] Jansen and Janse van Nieuwenhuizen (n 346) [97], [197]-[198].
[355] ibid [52]-[54]; CGE (n 348) [96]. The right to dignity is also guaranteed by s 10 of the South African Constitution (n 338).
[356] SWEAT, CALS and RHRU (n 345) [3.2], [6.72].
[357] ibid [3.3], [6.74].
[358] ibid [6.55], [6.84].
[359] Jansen and Janse van Nieuwenhuizen (n 346) [69].

The State's response also dealt with health issues, describing prostitution as inherently harmful to women's self-esteem[360] and carrying an inevitable risk of violence. Although it accepted that regulation could reduce the danger to sex workers at an individual level, it insisted that violence would increase 'in absolute terms' through a resulting expansion of the sex industry.[361] It referred to sex workers as 'conduits for the spread of sexually transmitted disease',[362] and insisted that this too would increase at an overall level in a legalised environment, even though the risk to individual sex workers might be reduced.[363]

Submissions in favour of the State's position additionally asserted the limited usefulness of condoms in preventing what they described as an inherent link between commercial sex and HIV,[364] and claimed that the removal of criminal penalties would either have no effect on[365] or would increase[366] unsafe sexual practices. The State and one of its supporters, the president of an organisation called Doctors for Life, also cited the views of violence against women theorists on the intrinsically harmful nature of prostitution.[367]

Confronted with such extensive claims and counter-claims about the health impacts of prostitution and prostitution law, the Court took the simplest approach available to it: it simply ignored them. Ngcobo J's majority judgment, which upheld the law as a justifiable response to prostitution's 'social ills',[368] made no reference whatsoever to health issues – with the exception of stigmatisation, which he described as

> a social attitude and not the result of the law…prostitutes knowingly accept the risk of lowering their standing in the eyes of the community, thus undermining their status and becoming vulnerable.[369]

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[360] Government of South Africa, Submissions in *Jordan* (n 345) [8].
[361] ibid [33]. The State justified its predictions for a post-legalisation expansion of the industry by reference to the experience of several Australian states; however, it was noted by SWEAT, CALS and RHRU (n345) [14.8.2] that this evidence was derived from statements by Australian politicians and media rather than empirical research.
[362] Government of South Africa (n 360) [21].
[363] ibid [34].
[364] A van Eeden, Supporting Affidavit in *Jordan* (n 345) [17]; AP de Vries, Supporting Affidavit in *Jordan* [12.1].
[365] de Vries (n 364) [93.1].
[366] van Eeden (n 364) [28].
[367] ibid [33], [41]; Government of South Africa (n 360) [11].
[368] *Jordan* (n 343) [25] (Ngcobo J).
[369] ibid [16].

The partial dissent[370] of O'Regan and Sachs JJ, meanwhile, made reference to the health claims of both sides but deemed them 'disputes' for the legislature to determine.[371] It further agreed with the majority that sex workers' vulnerability was 'due in some part to their own conduct',[372] without considering to what degree the law itself played a role.

Both opinions thus rejected the Court's responsibility to determine whether criminalisation affects sex workers' health in a manner that breaches their constitutional rights. The issue was ignored by the majority, and deemed by the minority to be one for the legislature alone. That the decision already made by the legislature might have been the wrong one, in terms of the state's obligations toward its citizens, was not one that the Court was prepared to consider; the burden of safeguarding sex workers' health would be placed on sex workers alone.

While responsibility for this avoidance of duty rests primarily with the justices themselves, it might be noted that no coherent approach was taken to the legal basis for the health-related challenges. Two submissions cited the Section 12 right to security of the person; however, the Appellants referred to the subsection concerning freedom from violence,[373] while *amici* argued under the bodily integrity subsection[374] (emphasising the right of all people to 'control over their body', which they compared to the right not to undergo a medical procedure without consent).[375] The founding affidavit on behalf of these *amici* had also claimed an infringement of the constitutional right of access to health care services,[376] but this was omitted from their substantive submissions – while the appellants' submission described 'access to health care' as a right indirectly breached by criminalisation, but curiously described this only as 'not acceptable', with

[370] Their dissent was to the part of the judgment that upheld the criminalisation of selling sex, which these justices considered an equality breach because it disproportionately targeted women. They concurred with the majority opinion insofar as it upheld the prohibition on brothels.
[371] *Jordan* (n 368) [86]-[89], [119] (O'Regan and Sachs JJ).
[372] ibid [66].
[373] Jansen and Janse van Nieuwenhuizen (n 346) [48].
[374] SWEAT, CALS and RHRU (n 345) [1.17.2], additionally citing the right to freedom and security of the person in the Constitution of the Republic of South Africa, Act 200 of 1993 (Interim Constitution) s 11. A question as to which Constitution applied was decided in favour of the Interim Constitution, due to the fact that the acts that gave rise to the challenge took place when that Constitution was in force. These *amici* agreed [4.2] that there were 'no material differences' between the two documents – a perhaps unfortunate position, given that there is no equivalent to s 27 (n 338) in the Interim Constitution.
[375] SWEAT, CALS and RHRU (n345) [5.5] citing South African Constitution (n 338) s 12(2)(b).
[376] J Arnott, Founding Affidavit in the application to be admitted as *amici curiae of* SWEAT, CALS and RHRU in *State v Jordan* (n 345) [21.5] citing South African Constitution (n 338) s 27(1)(a).

no specific reference to the constitutional right.[377] Another *amicus* took an essentially defensive approach, arguing that protection of public health was never the intent of the law.[378] It bears considering whether the Court would have found it so easy to disregard the health issues if the challengers had agreed amongst themselves as to precisely how a constitutional breach arose from them.

4. HEALTH AS A STATUTORY RIGHT: NEW ZEALAND

There is no specific guarantee of a right to health in New Zealand's Bill of Rights, although it does contains provisions against torture, involuntary scientific experimentation and non-consensual medical treatment, all under the header of 'Life and Security of the Person'.[379] A number of statutory provisions safeguard health – including Section 3 of the Prostitution Reform Act, which identifies the law's purpose as to

> create a framework that—
> (a) safeguards the human rights of sex workers and protects them from exploitation;
> (b) promotes the welfare and occupational health and safety of sex workers;
> (c) is conducive to public health;…[380]

Several prostitution-related cases have been heard in the New Zealand courts since decriminalisation, involving challenges to by-laws enacted by local councils for the purpose of restricting the locations where brothels can operate. The courts' record in deciding these challenges has been mixed, and concerns about sex workers' health and safety featured prominently in only one judgment: *JB International v Auckland City Council*,[381] which struck down the by-law due, *inter alia*, to its potential adverse impact on these rights. In another case, *Conley v Hamilton City Council*,[382] the by-law was upheld on the basis that it was unlikely to have the negative effects alleged by the applicants. Health and safety breaches were one such alleged effect but this was not a major element of the decision.

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[377] Jansen and Janse van Nieuwenhuizen (n 346) [46]-[47].
[378] CGE (n 348) [33]-[33.2.10.3.2].
[379] New Zealand Bill of Rights Act 1990 ss 9-11.
[380] Prostitution Reform Act 2003 s 3.
[381] 2006 NZHC 221, holding at [95] that the by-law might force brothels to operate in less safe locations and would likely encourage the establishment of illegal brothels.
[382] 2007 NZCA 543. The essence of the Court's decision was that the by-law did not amount to a prohibition on brothels in the designated area; there was therefore little risk of the negative consequences that might flow from such a ban.

It is clear, in any event, that prostitution operates within a legal framework in New Zealand in which sex workers' health must be a primary consideration. Given the statutory protections, it seems unlikely that any law or by-law could pass scrutiny if it was found to be incompatible with this right.

5. HEALTH AS A DERIVATIVE RIGHT: CANADA

Ironically, the most comprehensive health-based challenge to criminal laws against prostitution has occurred in a jurisdiction which does not clearly recognise a right to health: the right is not textually guaranteed in the Canadian Charter of Rights and Freedoms, nor have the Courts read it explicitly into any textual rights.[383] Canada has ratified ICESCR and a number of other of the instruments discussed in Chapter II[384] but has not incorporated them into domestic law, and although Canadian courts have accepted a general obligation to reflect these instruments' values,[385] they have not been sympathetic to pleadings that rely on unincorporated international law.[386]

The Canadian judiciary has, however, accepted a link between security of the person[387] and certain rights that fall within the parameters of the right to health as outlined in Chapter II. In *R v Morgentaler* Dickson CJ found that security of the person encompassed both bodily and psychological integrity, and could be breached in the context of criminal law by state interference and 'serious state-imposed' stress.[388] It was subsequently accepted that security of person 'extends beyond the criminal law'.[389]

In *Bedford v Canada*,[390] the applicants have relied on these precedents to argue that the right to security of person is breached by provisions of the Criminal Code which

[383] See R Ferguson, 'The Right to Health in Canada' (2011) <https://compartnetwork-righttohealth.pbworks.com/f/Canada(1).pdf> accessed 15 July 2011.
[384] ibid 2-3.
[385] *Baker v Canada (Minister of Citizenship and Immigration)* (1999) 2 SCR 817 [70].
[386] *Toussaint v Canada* 2010 FC 810 [70].
[387] Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK) 1982, c 11 s 7.
[388] *R v Morgentaler* (1988) 1 SCR 30 [56].
[389] *New Brunswick (Minister of Health and Community Services) v G(J)* 1999 3 SCR 46 [58].
[390] 2010 ONSC 4264.

'materially contribute to the violence faced by prostitutes'.[391] While the case has not reached its conclusion, the indications thus far are that the courts agree.

The case was brought in the Superior Court of Ontario by three current or former sex workers who argued that the provisions discussed in Chapter III prevented them from engaging in sex work (which is not itself illegal in Canada) in a safe environment.[392] The applicants called for the bawdy-house provision to be struck down, because 'the evidence demonstrates that violence is significantly reduced or eliminated in most indoor settings'; argued that the rule against living on the avails of prostitution makes it illegal to hire people whose assistance can 'reduce or eliminate the incidence of violence faced by prostitutes' such as managers, drivers and security; and claimed that the prohibition on communication for the purpose of prostitution forces street workers to make quick decisions without time to evaluate potential clients who might pose a danger to them.[393]

The Crown's response was also health-based, but rooted in a violence against women framework. The Attorney General argued that risk and harm are inherent to sex work and exist irrespective of how it is practised, whether it takes place indoors or outdoors and what laws govern it; and that prostitution is also associated with other harmful activities such as physical violence, drugs and human trafficking.[394] It was further argued that the communication provision could deter prostitution and, at least indirectly, lead to sex workers exiting the industry.[395] The Crown's position was supported by a

[391] ibid [10]. This Charter right had featured in a previous challenge to anti-prostitution laws, *Reference re ss. 193 & 195.1(1)(c) of Criminal Code (Man.)* (1990) 1 SCR 1123. However, a different approach was taken to the 'security of the person' clause: the applicants claimed that the Code breached this right by impeding their exercise of their chosen profession, thereby interfering with their ability to provide for themselves. In this way the clause was linked to the right to work and right to a livelihood. The Court rejected this argument, finding that s 7 was primarily concerned with rights in detention and in any case did not confer a right to a particular profession. It is curious that no health and safety-based s 7 argument was introduced, as the Supreme Court had by the time of the hearing already accepted such an interpretation, in relation to the harms caused to women by restrictive abortion laws: *Morgentaler* (n 388).
[392] *Bedford* (n 390) [8].
[393] ibid [11], citing Canadian Criminal Code (n 93) ss 210(1), 212(1)(j) and 213(1)(c) respectively. The definition of a person 'living on the avails', now found in s 213(3) of the Code, had been challenged in *R v Downey* (1992) 2 SCR 10 on the basis that it created a presumption of guilt. It was upheld as reasonable and proportionate; however, the dissent of McLachlin J found it overbroad due to the wide range of innocent relationships that could be affected by it, and the potential for it to compel sex workers to live and operate alone, at risk to their safety. Although her judgment referred only to the presumption created by the provision, and not to the 'living against the avails' rule generally, the reasoning she employed was strikingly similar to the arguments used throughout *Bedford* in opposition to the rule.
[394] *Bedford* (n 390) [17].
[395] ibid [497].

number of feminist academics who conceptualise prostitution as a form of male violence against women.[396]

Himel J's decision, issued in September 2010, struck down all three provisions of the Code. Citing a number of the researchers and reports discussed in Chapter III, she found sufficient evidence to conclude 'on a balance of probabilities, that the impugned provisions sufficiently contribute to a deprivation of' the applicants' security of the person.[397] Rejecting the respondent's claim that the harms arose simply from the act of engaging in sex work – in part because she found that one of its own witnesses' evidence suggested otherwise[398] – she held that

> there are ways of conducting prostitution that may reduce the risk of violence towards prostitutes, and that the impugned provisions make many of these 'safety-enhancing' methods or techniques illegal. The two factors that appear to impact the level of violence against prostitutes are the location or venue in which the prostitution occurs and individual working conditions of the prostitute.[399]

She accepted the applicants' specific arguments against each of the impugned provisions, concluding that under them

> Prostitutes are faced with deciding between their liberty and their security of the person. Thus, while it is ultimately the client who inflicts violence upon a prostitute, in my view the law plays a sufficient contributory role in preventing a prostitute from taking steps that could reduce the risk of such violence.[400]

The question of public health benefits of the law was also considered. This was done through an analysis based on Section 1 of the Charter, under which any limitations to fundamental rights must be justified on essentially the same principles as those required under Articles 4-5 ICESCR[401] – that is, they must be proportionate and necessary to advance an important purpose.[402] In this respect, too, the provisions failed, as the Court held that 'putting prostitutes at greater risk of violence cannot be said to be consistent

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[396] Testimony was given on behalf of the Crown by J Raymond and ML Sullivan of the Coalition Against Trafficking in Women, whose website <http://www.catwinternational.org/about/index.php> accessed 30 July 2011 states 'All prostitution exploits women, regardless of women's consent', and by M Farley (see n 226).
[397] *Bedford* (n 390) [359].
[398] ibid [353], noting that 'Dr. Farley's unqualified assertion in her affidavit that prostitution is inherently violent appears to contradict her own findings that prostitutes who work from indoor locations generally experience less violence'.
[399] ibid [360].
[400] ibid [362].
[401] See ch II s 2.2.
[402] *Bedford* (n 390) [446]

with the goal of protecting public health or safety'.[403] Evidence that the communication provision did not deter prostitution was also cited in support of a finding that it did not eliminate, but merely displaced, the public nuisance element that it was intended to address.[404] Although no specific conclusion was reached as to whether the law deterred prostitution generally, this appears to be a tacit rejection of that claim.

The decision was appealed and oral arguments were heard before the Supreme Court of Ontario in June 2011. While reasserting its view of sex work as inherently dangerous, the Crown argued further that the state is not obliged to protect those who enter the trade. The basis of this position was that prostitution is not a constitutionally-protected right.[405] This would seem to run contrary to international law, which imposes no such qualification on the state's general duty to protect the health of its citizens. It could in fact be argued that the obligation is even greater in relation to sex workers – whose occupation, it should be reiterated, is not itself illegal in Canada – given states' particular duty to safeguard the health interests of especially marginalised categories.

While the appellate decision is still awaited, trial reports indicate a great deal of scepticism from the bench about the Crown's position, several judges seeming to accept the right of sex workers to safe conditions and the Code's adverse impact on that right.[406] Whatever the ruling, a further appeal to the federal Supreme Court is likely. Thus, Canadian sex workers – and those following the case from elsewhere, some of whom are no doubt considering similar challenges – may have to wait some years before it is finally determined whether laws that criminalise many aspects of sex work breach the health rights derived from the right to security of person under Canada's laws.[407]

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[403] ibid [385]
[404] ibid [494], [498].
[405] K Makin, 'Prostitution "not a constitutionally-protected right," Crown argues in landmark case' *Globe and Mail* (Toronto 13 June 2011) <http://www.theglobeandmail.com/news/national/ontario-court-to-hear-arguments-in-landmark-prostitution-case/article2058348> accessed 10 July 2011.
[406] K Makin, 'With pointed questions, judges probe inequities in prostitution law' *Globe and Mail* (Toronto 13 June 2011) <http://www.theglobeandmail.com/news/national/with-pointed-questions-judges-probe-inequities-in-prostitution-law/article2059569/> accessed 10 July 2011.
[407] Another harm-based s 7 challenge to the Code's prostitution provisions, *Downtown Eastside Sex Workers United Against Violence Society v Canada* 2008 BCSC 1726, is also pending. The Supreme Court of British Columbia initially dismissed the case on the basis that the applicants, an advocacy organisation and a former sex worker, had no standing to bring the action. This decision was overturned by the provincial Court of Appeal, whose grant of *locus standi* has in turn been appealed to the federal Supreme Court. A hearing on the matter will likely take place in late 2011. N Hall, 'Supreme Court of Canada Grants Prostitution Law Appeal' *Sun* (Vancouver 31 March 2011)

6. CONCLUSION

As has been seen, the right to health is an underused mechanism for challenging anti-prostitution measures. This may not be surprising, as it appears to be an underused mechanism in litigation generally: a study of national judicial decisions between 2000-2005 found that the right to health was considered in only five countries (and in fewer than ten cases in total), despite being recognised in the domestic law of 63 countries.[408] Neither, seemingly, has the *international* right to health featured in any prostitution law challenge, although 160 countries have agreed to be bound by the ICESCR to date.[409] While health issues have been a significant element in a small number of challenges, there appear to be no cases in which a breach of the right to health *per se* formed the basis of the challenge.

It is difficult to draw firm conclusions from this survey of health-based challenges to prohibitory prostitution laws. There are relatively few of them; they arose from different circumstances in different jurisdictions; different arguments and analyses were made, and different outcomes resulted. Extreme caution is needed in deriving any sort of pattern.

With that caveat in mind, the available evidence suggests the following. First, it seems that *some form of* a right to health may have the potential to override prohibitory prostitution laws, where there is a definite legal basis for it and sufficient evidence of the laws' interference with that right. However, the State is also likely to invoke a health-based defence of those laws, such as by stressing the 'inherent' links between sex work and violence or focusing on the need to contain HIV/AIDS. It is therefore essential that any such challenge is grounded not merely in the abstract health right, but on clear evidence of precisely how it is incompatible with the impugned laws. Where the State makes a public health argument, the challengers must be able to demonstrate, firstly, that public health is *not* in fact protected by the law – but that in the event the Court finds that it is, the law nonetheless disproportionately interferes with sex workers' individual right to health. This may be particularly difficult in jurisdictions, such as

<http://www.vancouversun.com/news/court+allows+Attorney+General+appeal+Downtown+Eastside+Workers+ruling/4537173/story.html> accessed 10 July 2011.

[408] G Backman and others, 'Health Systems and the Right to Health: An Assessment of 194 Counties' (2008) 372 The Lancet 2047, 2075.

[409] Ratification status as of 30th July 2011, obtained from UN Treaty Collection at <http://treaties.un.org/Pages/ViewDetails.aspx?chapter=4&lang=en&mtdsg_no=IV-3&src=TREATY>.

India, where the courts seemingly do not accept the principle that public health rarely justifies the suppression of individual rights. The negative views of sex workers expressed in some of these judgments suggest also a need for greater emphasis on the adverse effects of stigmatisation.

Of course, even if the case for a right to health infringement proves unassailable, the challenge could still fail. The Court could find that another right or interest trumps sex workers' right to health, or it could, as in South Africa, simply defer to the legislature. No outcome is ever inevitable. It is probably safe to predict, however, that if the Canadian Supreme Court ultimately rules in favour of the *Bedford* applicants, jurisdictions across the world will see similar health-based challenges – and that in any event, health issues are likely to take on increasing significance in both legislative and judicial attempts to overturn prohibitory prostitution laws.

Chapter V – Conclusions and Recommendations

1. SUMMARY OF THE RESEARCH

This research has demonstrated that the right to health, as set out in international law, encompasses a number of elements relevant to sex workers. It places positive and negative obligations on states to protect individuals from risks to their physical, mental, reproductive and sexual health – without discrimination, and with special consideration given to particularly vulnerable people. It obliges states to prevent and penalise gender-based violence, whether by public or private actors. It imposes on states a duty to ensure safe and healthy working conditions. It requires state action to prevent and control the spread of infectious and occupational diseases. It includes a right to health information and a right to participate in the process by which health-affecting decisions are made. All these factors are part of the right to the highest attainable standard of health, which applies to sex workers no less than to any other category of people.

Prohibitory prostitution laws can breach this right in a number of ways. They heighten the danger of violence for sex workers, including state and gender-based violence. They hinder HIV/STI prevention efforts, limit access to health care and create an environment in which sex workers may be placed at greater risk. They make it all but impossible for sex workers to enforce occupational health and safety rules. These factors can also have negative consequences for sex workers' mental health, which is further affected by the stigma that a criminalised system imposes or exacerbates.

Many of these risks are present, at least to some degree, even where sex work is legalised. However, where legalisation is implemented with the objective of safeguarding sex workers' human rights rather than controlling the public order aspects of prostitution, better health outcomes are reported. The inclusion of sex workers in the policy-making process is essential, both to protect the participatory element of their right to health and to ensure the laws adopted reflect their health and safety needs.

Certain arguments in favour of criminalisation also invoke issues of health. However, accepting these arguments would require subjugating sex workers' right to health to an ideology which they may not share, to a deterrent effect that has not been shown to

exist, or to a breach of international principles on acceptable 'public health' limitations to individual rights.

The evidence of adverse impacts on sex workers' health has rarely featured in legal challenges to prohibitory prostitution laws, despite the substantial number of jurisdictions that recognise some form of a right to health. Furthermore, where health issues have been raised, this has not been in the context of the 'right to health' *per se* but rather in other, related aspects of the domestic law. In those jurisdictions that explicitly recognise a right to health, this may represent a missed opportunity. Health issues have also been cited in defence of prohibitory laws, reflecting the violence against women framework and depicting sex workers as conduits of infectious disease. The Canadian experience, at least to date, suggests that these laws can be successfully challenged on health-related grounds – even in the absence of an explicit domestic right to health. New Zealand case law also demonstrates the usefulness of statutory occupational health and safety rights, at least where sex work is a recognised occupation. However, the South African judgment highlights the need for a clear legal basis for a health-based challenge, while the Indian cases suggest that there may be a presumption on the part of some judges that the health risk lies in prostitution itself, and that applicants should be prepared to rebut this presumption even if their challenge rests on different grounds. Firmer conclusions will have to wait until the case law is more fully developed.

2. FUTURE RESEARCH DIRECTIONS

Some of the methodological challenges highlighted in Chapter I may be inevitable in sex work research. However, within these limitations, a number of improvements could be made. Firstly, where prostitution laws are reformed, attempts should be made to collect data prior to (or, if necessary, as soon as possible after) the new legislation taking effect, to give future research a comparative basis within the same jurisdiction. While many studies do attempt to make historical comparisons, if data must be collected after the fact the accuracy might be compromised by fading memories and the difficulty in controlling for variables retrospectively. New Zealand's survey of its sex

industry a short time after enactment of its Reform Act[410] has proven useful at demonstrating the improvements brought on by decriminalisation, and at countering predictions that it would lead to a growth of the industry.

While it may never be possible to prove a causal link between criminalisation and the adverse health effects discussed in this paper, a more scientific approach to research could often be employed. The anecdotal nature of evidence does not disprove its validity but may undermine its credibility, particularly in the face of competing claims by criminalisation's supporters. There is an especially acute need for scientific research on the effects of the Swedish policy of criminalising only the purchase of sex, since this law was adopted with the stated objective of improving the position of women in prostitution and in the undoubtedly sincere belief that it would do so. If it is in fact having the opposite effect, its supporters are unlikely to shed that belief on the basis of anecdotal evidence alone.

Certain health issues were left out of this paper entirely, despite appearing with some frequency in the literature on prostitution. Substance abuse, in particular, is clearly an issue that affects a significant number of sex workers and merits examination in this context. Any link between the criminalisation of sex work and the propensity for substance abuse may be complicated by the fact of many abused substances also being illegal. It would therefore need very thorough analysis, which was not found in the research reviewed for this paper. Mental health issues also deserve to be more comprehensively explored than they have been here. Non-sexually transmitted illnesses (such as glandular fever) and non-violent occupational injuries are other sex work-related health risks that have been identified but have not been adequately researched.

Finally, there is a need for greater study of criminalisation's effects on different categories of sex worker. If it is the case that women, for example, are particularly at risk of certain adverse consequences, then knowing this and understanding why could help to address those consequences even in jurisdictions that are not prepared to remove their criminal laws. The effects of criminalisation on categories that have not been

[410] Prostitution Law Review Committee, *The Nature and Extent of the Sex Industry in New Zealand: An Estimation* (Ministry of Justice of New Zealand, Wellington 2005).

considered here at all – undocumented migrants, minors and persons forced into prostitution – should also be analysed specifically, as they have particular needs that cannot necessarily be addressed in the same way as those whom this paper has considered.

3. CONCLUSION

Research alone will not, of course, resolve the controversy over sex work and the appropriate policy response. Ideology, morality and public order concerns – to say nothing of political self-interest – will always influence the debate and may, in some jurisdictions, be impossible for even irrefutable evidence to overcome. Yet the breaches of the right to health associated with criminalisation are too significant for human rights advocates to accept the deferential approach of the South African Constitutional Court. Until society finds an *effective* way to eradicate prostitution – if it ever does – sex workers must be recognised as being as entitled to the highest attainable standard of physical, mental, sexual, reproductive and occupational health as any other category of person would be.

The legal framework most likely to achieve this objective is decriminalisation of consensual commercial sex, combined with explicit protection of sex workers' occupational health and safety rights. Such a policy would remove those threats to sex workers' health that arise from their (or their clients') fear of arrest, enable them to take the safety precautions necessary to minimise risks, and allow them to assert their right to a safe and healthy working environment. Legalisation provides these benefits only to those sex workers working within the regulated sector, leaving those outside it still subject to the risks posed by criminalisation; while partial (de)criminalisation such as that operating in Sweden offers sex workers little advantage over full criminalisation. Sex workers themselves, however, must play a central role in any decision as to which precise measures to adopt.

While legal reform is essential for the attainment of sex workers' right to health, it is not sufficient. Stigmatisation underlies many of the risks discussed in this paper and cannot be alleviated merely by a change in the laws. The negative attitudes that foster abuse against sex workers, and that can deter them from seeking needed police and health care

services, must also be addressed. Ultimately, this may require a ‘normalisation’ of sex work that even those with a tolerant attitude may find difficult to accept. The significant adverse impact of stigma, however, suggests that this challenge simply must be confronted as part of any viable strategy to promote sex workers’ health.

Finally, judicial action may play a useful role in achieving sex workers’ right to health. Depending on the laws of the jurisdiction, this action could be based on the right to health itself or on a related right from which a right to health could be derived. There is clearly no single formula to how it could be approached, and no guarantee of success in any case. It is hoped, however, that there is now a clearer picture of how and why such action would be justified in the interest of sex workers’ human rights, and of how it might be able to succeed.

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