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Prostitution: Exploitation, Persecution, Repression,
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Sexual Exploitation and HIV/AIDS

In June 1981, the Center for Disease Control and Prevention published a report of morbidity and mortality based on 5 victims of a rare pulmonary infection contracted by perfectly healthy homosexual individuals. The study showed that these 5 men had immunodeficiency problems. These cases of HIV/AIDS were later noted as the first to be identified in the United States. During the following decade the epidemic reached its peak, with more than 3.5 million cases around the world in 1997 (*Arnegard*, December 16th, 2012). At this time the virus was a mystery, treatment was a failure and the mortality rate was ever-increasing.

Thirty years later, more than 35 million people all over the world were living with HIV/AIDS. Thanks to improved treatments and a considerable investment towards fighting the virus, the UN estimates 18.9 billion US$ (17.45 billion €) in 2012 (*UNAIDS (a),* 2013), the number of deaths caused by HIV/AIDS decreased by 30% between 2005 and 2012 (1.6 million). The total of new reported cases of HIV/AIDS has also dropped – by 33% in the world in 2001, and even by 50% in some countries (*The Henry J. Kaiser Family Foundation,* November 30th, 2015).

That being said, approximately 2.3 million new cases were reported in 2012 and significant disparities exist between the prevalence in different countries. Although the prevalence in the world is approximately 0.8, certain countries, often those with a lower average annual income, suffer from a much greater prevalence of HIV/AIDS. Swaziland, where the most significant HIV/AIDS epidemic rages, has a prevalence of 26.5%.

Prevalence is determined by economic, political, cultural and demographic factors. These factors vary from country to country, which explains the significant differences in the presence of HIV/AIDS around the world. If we set aside these differences, we are left with a few hard facts: four categories of populations are the most vulnerable to HIV/AIDS.

The probability of contracting the virus is 14 times greater for prostituted women than for other women, 19 times greater for homosexual men than for the rest of the male population; nearly 50 times greater for transgendered women than for other adults, and 50 times greater for intraveinous drug users than for the rest of the population (*OMS,* July 11th, 2014). Sex exchanged for money has had a profound impact on the transmission of HIV/AIDS.

In West Africa, we estimate that 10 to 32% of recent infections are spread through the sex trafficking. In Uganda, Swaziland and Zambia, 7 to 11% of recent infections are linked with prostituted persons, their clients and their personal partners (*UNAIDS (c),* 2013). This reality means that the fight against HIV/AIDS has been not only a fight against the epidemic, but also a question of human rights and gender equality.

Prostitution and the increased risk of HIV/AIDS infection

According to the UNAIDS world report, the average rate prevalence of HIV/AIDS in prostituted persons is 14% (according to statistics from documents published by 24 countries since 2006). However, inquiries are too infrequent to draw any definitive conclusions. Moreover, there are significant differences between countries and regions. The average rate of prostituted persons infected with HIV/AIDS is 22% in Southern and Eastern Africa (8 countries), 17% in Central and Western Africa (17 countries), and less than 5% in all other regions. Of the 62 countries that shared these statistics, the prevalence of prostituted persons infected with HIV/AIDS varied from 1% in 14 countries to 70% in Swaziland (according to a survey of 323 prostituted persons) (*UNAIDS (c)*, 2013).

Contrary to popular belief, all prostituted persons do not fit the same profile. Prostituted persons come from all social classes and do not represent a single profile. Because of this diversity, it is difficult to discuss prostituted persons as a single, homogenous group. The particular situation of each prostituted person has an important influence on their risk of being infected with HIV/AIDS. Factors such as their status (whether or not they are also a victim of human trafficking), their gender (male, female or transgendered), their working place (working behind closed doors or on the street), the accessibility of social services, and their level of education all play a role in their risk of being infected.

Even within the same country, these factors can vary greatly and can turn out a different rate of prevalence from one city to another. For instance, in India, the prevalence for prostituted persons in Mumbai is 4.6% compared to the numbers recorded in certain neighbourhoods in Maharashtra, where 24% of prostituted persons work on the street and 29% work in brothels (*WHO*, 2011). These differences aside, the nature of their activity often exposes prostituted persons to situations and behaviours with similar risks.

Erratic condom use

In the UNAIDS 2013 world report, countries indicated that “condom use in commercial sex is high and improving; 44 countries reported higher median condom use in 2012 than in 2009: 85% compared to 78%” (*UNAIDS (c*), 2013). In 2010, in 26 of 86 countries that provided statistics, more than 90% of prostituted persons confirmed having used a condom in their last sexual encounter with a client. Thirteen other countries announced a condom use of 80 to 90% (*UNAIDS (c*), 2013). Although these numbers seem encouraging, 47 countries, more than half the countries who shared their statistics, indicated that the rate of condom use was less than 80% and 17 where the use was less than 60% (*UNAIDS (c*), 2010). These numbers are based on several factors. Firstly, condom access, which can be very difficult in some countries: “A review of sex workers’ experiences of public health facilities in four countries in Eastern and Southern Africa identified insufficient access to condoms and lubricants among their unmet health needs” (*UNAIDS (c*), 2013). Another factor is the amount of time spent in prostitution industry. According to a study based on the rate of prevalence in prostituted persons working behind closed doors in Cambodia, between 1998 and 2007, the use of condoms almost doubled to attain 100% condom use in less than 9 years. The prevalence of HIV/AIDS in prostituted persons has consequently decreased by at least 30%.

However, the study also shows that the rate of prevalence of HIV/AIDS also increases based on the amount of time one is prostituted, which leads us to believe that the use of condoms varies depending on how long a person has been prostituted and on how many partners. There could be multiple explanations for inconsistent condom use: difficulty to access condoms, being offered more money for sex without a condom, intimidation and violence on the part of the client to force unprotected sex.

Inequalities – gender and violence

Theoretical and psychological inequalities between men and women lead to physical violence founded on gender, marginalisation and an imbalance of power. “In addition to the greater physiological vulnerability of women to HIV, gender inequalities include vulnerability to rape, sex with older men, and unequal access to education and economic opportunities. These make HIV-related risks especially acute for girls and young women” (*UNAIDS (c*), 2013). In certain regions of the world (nearly all sub-Saharan countries and certain Caribbean countries), women are far more exposed to the risk of infection than men. The majority of people infected are women aged 15 to 24 (*UNAIDS (c*), 2013). Sexist violence has increased the risk of contracting HIV/AIDS. Two recent studies, one in Uganda takes a look at women aged 15 to 49 and the other in South Africa studies women aged 15 to 26, revealed that women with violent partners were 50% more likely than other women to contract HIV/AIDS (*UNAIDS (c*), 2013). The risk is increased for prostituted women particularly exposed to violence. In Adama (Ethiopia), 60% of prostituted women indicated that they have come across violence in their prostitution activities. In Mombasa (Kenya), 79% have faced the same type of violence (*UNAIDS (c*), July 2014).

More broadly speaking, half of the people infected with HIV/AIDS in the world are women and 76% of these infected women live in Sub-Saharan Africa. This high number reflects the influence of institutional factors, infrastructure and sociocultural factors: the lack of sex education, the absence of care (prevention and treatment), stigmatization and the apologia for certain ‘male’ behaviours. Thus, the risk of infection for women is increased, while men continue to be encouraged to have multiple sexual partners (and often partners of both sexes). A recent study revealed that 90% of women infected with HIV/AIDS in India were contaminated over the course of a long-term relationship. At the same time, a number of homosexuals married women to avoid being stigmatized or discriminated against. These men continued to have sexual intercourse with other homosexual men, thereby exposing their wives to the virus.

Human Trafficking

Gender inequality is directly linked to human trafficking. In fact, each year, the majority of victims of human trafficking are women and young girls (75% of recorded victims). Of the 2.4 million victims of human trafficking in the world, 79% are trafficked for the purposes of sexual exploitation (*UNODC*, June 2010). The majority of these young girls are tricked or trapped into being trafficked; often being promised well paid work, they are then sold and prostituted. Human trafficking is a phenomenon that, like HIV/AIDS, affects every country in

the world. Country of origin, transit or destination - they all play a part in human trafficking. Given that most of these women or girls were forced into prostitution in the first place, negotiating the use of protection is made even more difficult. Victims are also more vulnerable to sickness in general. One study of the brothels of Mumbai looking at victims of human trafficking showed that nearly 25% of women and girls were HIV positive (*Avert*, May 1st, 2015). Even in countries where there is a low prevalence of HIV/AIDS, prostituted persons are more exposed to the transmission of the virus through unprotected sex. Therefore, a country like France, where the majority of prostituted persons are foreign and victims of human trafficking, is charged with the difficult task of answering all the questions that prostitution raises, including the HIV/AIDS problem.

Intraveinous drug use

Prostituted persons are not only exposed to the HIV/AIDS virus through their sexual exploits. Needle injected drugs increase the risk of contamination dramatically. Prostituted persons are often users of injectable drugs. In China for example, a study showed that, 12 to 49% of prostituted persons, who were also needle injected drug users, contracted HIV/AIDS (*WHO,* 2011). The correlation between prostitution and drug use is immensely complex. Certain people enter into prostitution to finance their addiction, while others fall into an addiction after prostituting themselves. It is not unheard of that procurers would force their prostituted persons to consume drugs until they become addicted. This strategy enables them to control them more easily. Whatever their level of dependency, prostituted persons run a double risk of becoming infected with HIV/AIDS.

Legal complications

Beyond the legislative debates regarding whether or not prostitution should be legalized, all countries in the world are confronted with the challenge of fighting HIV/AIDS. The criminalization of sex trafficking (or at least of certain aspects of the sex trafficking) constitutes an important obstacle for prostituted persons. Statistics do not show a direct correlation between legislation and the prevalence of HIV/AIDS. It is nonetheless acknowledged that in countries where prostitution is criminalized, prostituted persons do not benefit from health care services or HIV/AIDS prevention, which leaves them even more vulnerable to infection. For example, several countries consider the possession of condoms as proof of being a prostituted person. Prostituted persons in Kenya, Zimbabwe, the Russian Federation, Namibia or the United States, report that the police confiscate and systematically destroy condoms found on the prostituted persons and then arrest them (*UNAIDS*, July 2014). Therefore, they find themselves forced to have unprotected sex with their clients. This raises a contamination issue, which is paradoxically linked to having a lack of access to protection. Numerous governmental organizations and nongovernmental organization distribute condoms to prostituted persons and organize sexual health themed seminars, led by other prostituted persons. It is clear that legalization is the problem. In the words of Maria, a prostituted women in Los Angeles (California), interviewed by Human Rights Watch (HRW): “Why does the

city provide me with condoms if I cannot have them on my person without being sent to jail?" (*Avert*, May 1st, 2015).

This is but one example of the way that legislation prevents prostituted persons from having the access they need to safe sex. Some laws restrict prostituted persons' access to health care services, while other laws are downright discriminatory. For example, 76 countries and territories have criminalized sex between two same-gendered people (*UNAIDS* (b), 2013). According to the 2013 UNAIDS Report, studies have proven that punitive laws have negative consequences on access to health care. Over the last two decades, the number of laws criminalizing the transmission of HIV/AIDS and/or the fact of not revealing one's infection to a partner, has increased. These laws increase discrimination and stigmatization of the vulnerable persons that suffer from HIV/AIDS, which can have an effect of isolating these people from society, and in turn, increase their risk of contaminating others. Fear of discrimination makes it more difficult for infected persons to access proper health care and protection. Payal, an 18-year-old prostitute in Nepal explains: "When I went to a VCT (Voluntary Counselling and Testing) clinic, the health workers immediately asked if I was a sex worker. One of the doctors even asked: 'Are you HIV positive?' This dissuaded me from returning to a hospital." (*Avert*, May 1st, 2015).

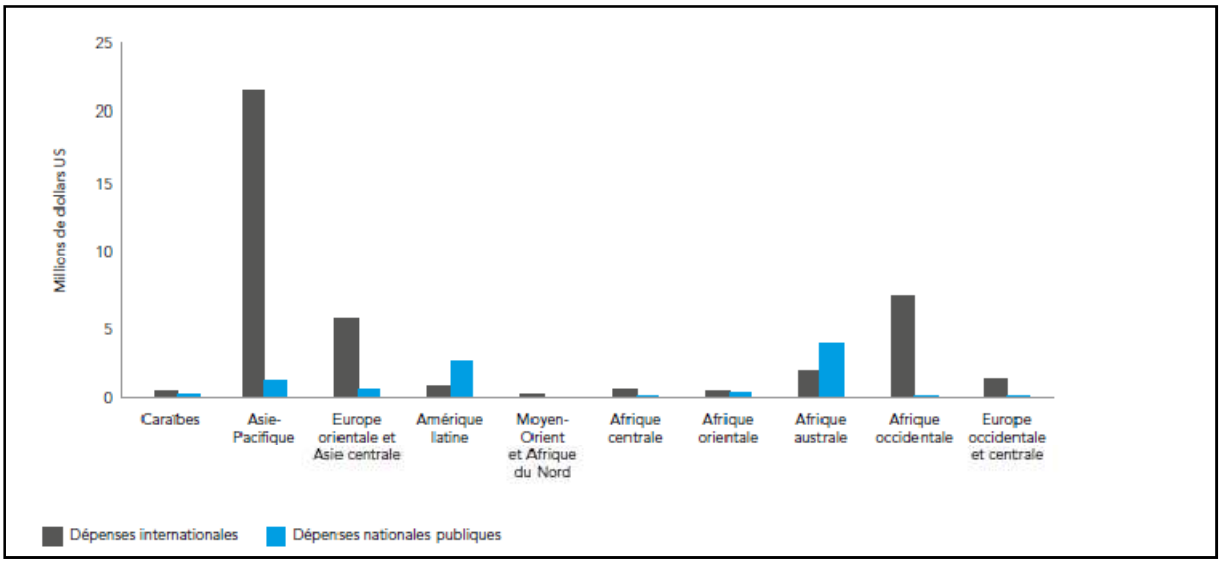
Another legislative obstacle to the prevention and treatment of HIV/AIDS is the criminalization of homosexuality. In Sub-Saharan Africa, numerous men and transgendered persons engage in prostitution for economic reasons. Nevertheless, because homosexuality is strictly forbidden and criminalized, prostituted persons are even more socially isolated, which makes their access to proper health care even more difficult. In 2010, 106 countries (62%) had laws and regulations in place to protect carriers or people exposed to HIV/AIDS. However, statistics are insufficient to show that these regulations actually had a positive impact (UNAIDS, 2010). Nearly a third of countries still have not adopted legal protection. Furthermore, only 56% of countries blessed with these laws are actually able to register, document and take action on discrimination cases against persons infected or exposed to HIV/AIDS (UNAIDS, 2010). In other words, despite the existence of protective legislation, an insufficient application of these laws and a continuous stigmatization mean that prostituted persons are the most vulnerable to becoming infected with the virus.

Intervention programs geared towards prostituted persons

Since the explosion of the HIV/AIDS epidemic, the international community has searched for a solution, not only to finance research for a cure, but also to launch prevention and treatment programs. Thousands of projects to fight the virus have already been put into place all over the world, by governmental organisations and nongovernmental organisations alike. Some programs aimed at at-risk groups have on the other hand, proven their effectiveness. In India for example, Avahan was put in place by the Bill & Melinda Gates Foundation in 2003. This program focuses on empowerment, with programs that promote condoms, sexually transmitted infection (STI) and HIV/AIDS testing... These programs are geared towards prostituted persons, men who engage in sexual relationships with other men and injected drug users in 6 states in Southern India. According to a survey taken in 2013, the program may have prevented 600, 000 infections in 10 years. Even so, at-risk groups, more

specifically prostituted persons, are rarely the main focus of these programs. According to the Gap Report 2014 from UNAIDS, only a third of respondent countries are fortunate to have programs that help reduce the risk for prostituted persons. The lack of financing for prevention programs aimed at prostituted persons is one of the main reasons why these programs do not exist. Despite the increased risk of infection for prostituted persons, the prevention programs that are geared towards prostituted persons represent a small portion of the prevention on a global scale.

National and international public spending on programs aimed at supporting prostituted persons in low and medium wage nations (Statistics from 2013)



Source : Global Report. Global report UNAIDS on the global AIDS epidemic 2013, pg.23.

2014 AIDS Conference in Melbourne

The 20th international conference on HIV/AIDS was centered on human rights. Ahead of this biannual conference, the Declaration of Melbourne (*AIDS 2014*, May 2014) already denounced multiple cases of discrimination and repressive legislation around the world that continued to affect people living with HIV/AIDS as well as the most vulnerable people in the face of the virus: prostituted persons, drug users and gay men. Criminalizing these practices constrains the fight against HIV/AIDS and studies have shown that repressive and discriminatory policies fuel the epidemic. Over the course of the conference, many voices demanded the general decriminalization of the activities of vulnerable persons, particularly the decriminalization of sex trafficking, as was recommended by the World Health Organization (WHO) as well as by the famous scientific review The Lancet, which published a special issue containing seven different studies on “HIV and Sex Workers”. During the conference, researches continually pointed out the barriers preventing prostituted persons from accessing prevention and health care. Moreover, they denounced stigmatization, discrimination and criminalization of prostitution, which is at the root of the problem. They suggested decriminalization as a viable alternative, which according to them could reduce the

number of HIV/AIDS infections by between 33 and 46% among heterosexuals in the next ten years.

"Governments and politics can no longer ignore the evidence," said Kate Shannon of the University of British Colombia, and one of the authors featured in The Lancet. Many have taken the opportunity to widen the debate and criticize the penalization of the clients of prostitution, like the Swedish model. "We say that the Swedish model is the worst model, as bad as countries who hyper criminalize sex trafficking. But they yield approximately the same results," says Dr. Réjan Thomas, a prominent figure in the fight against HIV/AIDS in Canada (*Radio-Canada*, July 22nd, 2014). The Dutch and New Zealand models are also cited. In the wake of the Melbourne conference, world medias seemed to have a united voice: to end HIV/AIDS, we need to start by decriminalizing prostitution!

Decriminalising would mean freeing the sex industry. We can ask ourselves if such a speech does not ideologize the debate rather than enables us to come up with viable solutions. It is the client, more than the prostituted person, that is the carrier of HIV/AIDS and that transmits the disease from one woman to another, prostituted or not. "Punishing clients is not recognized as a factor of the risk of infection of HIV: no studies have been conducted that show that banning paying for sex has health risks," highlighted a collective of doctors in 2013 (*Le Monde*, November 12th, 2013). The rate of prevalence of HIV/AIDS is not higher in countries where the client is penalized, on the contrary: 0.10% in Sweden versus 0.40% in France or Spain in 2013. Normalizing prostitution will also not further protect prostituted persons: in countries where prostitution is regulated like in Germany, certain establishments advertise unprotected sex to draw clients!

If decriminalizing prostituted persons is a necessary step to promote the fight against HIV/AIDS, punishing the client is also essential.

Sources

- « Aids 2014. Melbourne Declaration: Nobody left behind me », *AIDS 2014*, May 2014
- « Ce sont les acheteurs de sexe qu'il faut pénaliser », *Le Monde*, November 12th, 2013.
- « HIV and Sex Workers », *The Lancet*, July 23th, 2014.
- « Les personnes les plus exposées au risque d'infection à VIH ne bénéficient pas des services de santé dont elles ont besoin », *Communiqué de presse - Organisation Mondiale de la Santé (OMS)*, July 11th, 2014.
- « Sex workers and HIV/AIDS », *Avert*, May 1st, 2015.
- « The Global HIV/AIDS Epidemic: Overview », *Factsheet - The Henry J. Kaiser Family Foundation*, November 30th, 2015.
- Arnegard M.E., *Multi-assay algorithm for monitoring the HIV pandemic's leading edge*, Fred Hutchinson Cancer Research Center, December 16th, 2012.
- CRIDES/Fondation Scelles, *Revue de l'actualité internationale de la prostitution*, 2013.
- CRIDES/Fondation Scelles, *Revue de l'actualité internationale de la prostitution*, 2014.
- Pickles M., Boily M.-C., Vickerman P., et al., « Assessment of the population-level effectiveness of the Avahan HIV-prevention programme in South India : a preplanned, causal-pathway-based modelling analysis », *The Lancet Global Health*, Vol.1, no.5, September 20th, 2013.

- Rochon M., « La criminalisation de la prostitution augmente les cas de sida, selon une étude », *Radio-Canada*, July 22th, 2014.
- UNAIDS, *Global Report: UNAIDS report on the global AIDS epidemic 2010*,, ONUSIDA/10.12E, 2010.
- UNAIDS (a), *2013 Global Fact Sheet*, 2013.
- UNAIDS (b), *AIDS by numbers 2013*, JC2571/1/E, 2013.
- UNAIDS (c), *Global Report : UNAIDS report on the global AIDS epidemic 2013*, JC2502/1/E, 2013.
- UNAIDS, *The Gap Report 2014*, JC2656, July 2014.
- UNODC, *UNODC Factsheet on Human Trafficking*, June 2010.
- WHO (World Health Organization), *La riposte mondiale au VIH/sida. Le point sur l'épidémie et sur les progrès du secteur de santé vers un accès universel. Rapport de situation 2011*, World Health Organization (WHO), UNAIDS, UNICEF, 2011.
- WHO (World Health Organization), *Implementing Comprehensive HIV/STI Programs with Sex Workers – Practical approaches from collaborative interventions*, World Health Organization (WHO), United Nations Population Fund (UNFP), Joint United Nations Programme on HIV/AIDS (UNAIDS), Global Network of Sex Work Projects (NSWP), The World Bank, United Nations Development Programme (PNUD), 2015.