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Incarceration of female sex workers in China and STI/HIV. Programmes that are not rights-based are doomed to fail

M D E Goodyear

Tucker and Ren (see page 34) describe the plight of female sex workers incarcerated in China's female re-education through labor (RTL) centres for moral education and vocational training, and in particular those with sexually transmitted infections (STIs) and HIV/AIDS.¹

This raises several major issues about public health, ethics and human rights. From the earliest times, public and social policy on sex work has been based on social exclusion and the control of "loose women".^{2,3} Part of the moral panic driving these policies has centred around a medical model in which sex workers are seen not only as reservoirs of contagion but also as women in need of mandatory rehabilitation. One of the most notorious manifestations of these gender and class structural inequalities was the mid-nineteenth century Contagious Diseases Acts in the UK and UK colonies. However, they are never far from the surface, as has been evident in the recent Home Office Co-ordinated Strategy on Prostitution and the proposals contained in the current Criminal Justice and Immigration Bill for compulsory rehabilitation orders. East and West are perhaps more convergent in their thinking than might appear *prima facie*. This essentialist conception of women who sell sex contradicts that of cultural citizenship—the right to visibility and presence rather than marginalisation.⁴

Probably one of the most significant factors shaping policy on sex work has been the emergence of HIV/AIDs in the late twentieth century as one of the most threatening pandemics of modern times and certainly the most threatening of those associated with sexuality. This tragedy has generated global strategies and the devotion of considerable resources to its control. Not surprisingly, since these target potentially high-risk sexual behaviour, sex workers

found themselves at the centre of attention, particularly those using intravenous drugs, which increased risk still further.

The 1986 Ottawa Charter describes health promotion as "the process of enabling people to increase control over, and to improve, their health" and obliged signatories to identify and remove obstacles to the achievement of health. This formed the philosophical underpinning of New Zealand's decriminalisation legislation in 2003. Similar thinking has also led to international agencies such as Oxfam, the International Labour Organization and the World Health Organization calling for the removal of criminal sanctions,⁵ arguing that programmes cannot be adequately implemented in a penalised context. In reality, concerns about STI/HIV are only part of the complex health and social problems that sex workers in Asia and elsewhere have to deal with.^{6,7} Although targeting sex workers is inappropriate discrimination, recognising that they have a role to play in STI/HIV control is not. Outreach services to marginalised groups are unlikely to be successful unless they are peer-group driven,⁸ which is why sex workers are treated as partners in New Zealand and Australia.⁹ Since the appearance of HIV, sexual health knowledge and practice amongst sex workers has changed considerably to the point where they have been seen more appropriately as educators,¹⁰ and have transformed themselves from high to low risk designation. Sex workers, who have the most to gain, are now front line leaders in global AIDS control.

Despite these considerations, international policies still remain ambivalent at best.^{11,12} Although these have provided useful resources and made strong statements about stigma and inclusiveness in the past, recent policy development has been criticised for lack of a sex worker centred approach,¹³ while moralistic US policies continue to undermine efforts everywhere.¹⁴

Profound political and social changes in China have been accompanied by both

increases in STI/HIV and expansion and change within the sex industry,¹⁵ placing sex workers at increased risk and creating a greater need for comprehensive services. Obtaining accurate, particularly politically inconvenient, data in China can be challenging.¹⁶ Although this is especially difficult in association with illegal activities, the balance of evidence¹⁷ points to a significant prevalence of infection within the sex work community, which is likely to worsen the stigma attached to this group as the alleged source of the nation's problems. Stigma in turn leads to violence and denial of rights, including access to health and social services.^{7,12} Furthermore, targeting sex workers ignores the structural factors, including the role of the State, which create and facilitate high risk behaviour.¹⁸

See related article by Tucker and Ren (page 34) and commentary by Teng (page 36)

Coercive treatment is not only unacceptable from a human rights perspective but is not likely to be effective. Exclusionary policies reinforce existing stigma and vulnerability heightening the potential for disease transmission. Tucker and Ren estimate there may be up to 300 000 sex workers currently incarcerated—approximately 8% of the total sex workers population of about 4 million (0.03% of the total population) although the US State Department estimate is 10 million.¹⁷ Even if effective programmes were adequately delivered within RTLs, and even if we assume that this is an enriched population both for risk and prevalence of STI/HIV, the immediate effect is likely to be small and the long term effect even less. Against any ameliorative efforts must be weighed other coercive factors, such as police harassment of women in possession of condoms.

Around the world, sex workers have demonstrated that, given the appropriate resources and support, they can organise and become effective transformational agents in improvement in sexual health and the control of infection. However, sexual health is structured by many factors other than the individual sex worker's motivation, knowledge and practice—for instance, clients, managers, the work environment and the availability of condoms. Sex workers are also at risk from intimate partners and drug use. Overemphasising the role of sex workers in disease transmission

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Editorial

is likely to ignore equally high risk practice in the general population, including the bridging vector role of clients, and undermines the overall strategy.

Empowerment of sex workers increases health practice negotiating abilities. Unless sex workers are engaged and empowered as partners, the structures within which they work arranged to maximise their self-determination, comprehensive programmes put in place to provide peer education and support¹² tailored to the specific needs of the highly sectorised industry,¹⁷ and the structural inequalities that shape the vulnerability of both women and sex workers addressed, then China's STI/HIV control strategies¹⁹ will fail. Despite the authors' optimism it is unlikely that significant progress in the welfare of China's sex workers will be made without radical re-organisation and a comprehensive national strategy that includes the removal of criminal sanctions, tackling social stigma and the provision of services that are both centred on and driven by sex workers as Teng notes (see page 36), policy and implementation can be different in China.²⁰

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