UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF NEW YORK

ALLIANCE FOR OPEN SOCIETY INTERNATIONAL, INC., OPEN SOCIETY INSTITUTE, and PATHFINDER INTERNATIONAL,

Plaintiffs,

-against-

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT *et al.*,

Defendants.

DECLARATION OF NILS DAULAIRE

05-Civ.-8209 (VM)

I, NILS DAULAIRE, hereby declare as follows:

1. I am the President and Chief Executive Officer of the Global Health Council ("GHC"). I have held that position since 1998.

2. I make this declaration in support of Plaintiffs' motion seeking leave to amend the Complaint and GHC's motion for a preliminary injunction.

The Global Health Council

3. GHC is a private, not-for-profit, membership alliance incorporated in Delaware and enjoying tax-exempt status under Section 501(c)(3) of the Internal Revenue Code. GHC's executive office is located at 15 Railroad Row, White River Junction, VT 05001. It has a second office dedicated to global health policy at 1111 19th Street, NW – Suite 1120, Washington, D.C. 20036.

4. GHC was founded in 1972 under the name "National Council of International Health" as a U.S.-based, nonprofit membership organization with the purpose of identifying priority world health problems and reporting on them to the U.S. public, legislators, international and domestic government agencies, academic institutions and the world health community.

5. GHC's member organizations operate in at least 116 countries. GHC member organizations include many prominent U.S. non-profit and academic organizations working to alleviate the burden of disease and disability in the middle- and low-income countries. Individually and collectively, these organizations work to strengthen the ability of developing nations to address the critical problems of HIV/AIDS, child health, women's health, reproductive health, and infectious disease. Many GHC members are heavily engaged in HIV/AIDS prevention, treatment and care in the effort to save lives, relieve suffering, empower communities and build local health capacity.

6. GHC has 485 members that are organizations, of which approximately 259 are based in the United States. Of those, approximately 228 are non-profits (including associations, foundations, and non-governmental organizations); 24 are for-profits; and 21 are colleges and universities. GHC also has one U.S.-based governmental entity as a member, the John E. Fogarty International Center. In addition, GHC has 4,564 individual members, who include practitioners in health professions and students studying to become professionals, of which 3,904 are based in the United States.

7. GHC's mission is to ensure that all who strive for improvement and equity in global health have the information and resources they need to succeed. Essential to

fulfilling the GHC's mission as a professional association is our ability to create a safe and inviting space in which GHC members can opine on and debate important issues of public health, especially issues that are controversial. To that end, the GHC holds, on an almost weekly basis, conferences, forums, briefings, dinners and other events at which GHC members and guests share information, experiences and opinions. As a science-based professional association, GHC's most basic responsibility is to protect the ability of its members to carry out robust debate in the forums provided by GHC. Laws and policies that chill the ability of GHC members to bring evidence and opinion to bear on public health issues therefore inherently vitiate the fundamental rationale for GHC's existence.

8. GHC further realizes its mission by serving as a convener and host for member coalitions focused on specific issues. These coalitions include the Global AIDS Roundtable, the HIV/AIDS Implementers Work Group, the Neglected Tropical Diseases Coalition, the Malaria Roundtable and the Tuberculosis Working Group. GHC also plays an important role in other coalitions, such as the International Family Planning Coalition, the U.S. Child Survival Coalition and the Stop TB Coalition. HIV/AIDS is a prominent topic in most of these coalitions, since its impact is felt in many domains, including opportunistic infections, pediatric AIDS and reproductive health. These forums provide a vehicle for sharing information and coordinating evidence-based advocacy in favor of health policies that will most advance desired health outcomes. The free flow of information within the coalitions is essential to evolving policy recommendations that reflect the field experience and research of the members. GHC and its members engage in dialogue and advocacy with Congress and government agencies, such as Defendant

United States Agency for International Development ("USAID"), to inform the government about pressing international health problems and to share evidence as to what policies help or hinder improved health. As the world's largest membership alliance dedicated to improving health throughout the world, GHC has over 30 years of experience informing the public and the government about critical health issues in the developing world and advocating for effective U.S. foreign assistance for health.

9. As a membership organization, GHC provides a means through which members can collectively express concerns about U.S. policy. GHC members are often reluctant to publicly criticize the policies of the U.S. government or government agencies from which they receive funding. Through their membership in GHC, member organizations can collectively express objections to government policies and make recommendations for new or revised policies, without being publicly identified. As explained below, these fears are warranted, because GHC members have, in the past, been subjected to criticism by members of Congress and other public officials for their policy positions, particularly in regards to prostitution and other controversial issues.

10. GHC has the responsibility of advocating for the needs and views of its members. GHC's primary advocacy priority areas are HIV/AIDS, children's health, women's health, infectious disease, health systems and health equity. GHC is in constant consultation with its members individually and through the roundtables and coalitions described above. GHC reaches its policy positions through these consultations and its review of the relevant evidence. On a daily basis, GHC is engaged in dialogue with authorizing and appropriations committees in Congress on issues of global health. GHC also engages in advocacy with multilateral organizations such as UNAIDS, the Global

Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, and other UN agencies. GHC advocates for sufficient investment in health, policies based on scientific evidence, increased access to essential services by populations that are most under-served, and effective management of health programs.

11. Many of GHC's U.S.-based members administer programs or provide health care services to people with HIV/AIDS or at high risk of contracting the virus, and more intend to administer such programs in the future. Some of these programs expressly target sex workers or include sex workers within their general scope. Many of the members' programs targeting sex workers have a proven track record in reducing HIV infection and providing treatment to those with the virus and have led to significant advances in understanding the physical, cultural, and socioeconomic underpinnings of the AIDS epidemic. Many of the members administering these programs receive funding to carry out HIV/AIDS work both from defendants and from other, private sources. Some examples of U.S.-based member organizations that receive both government and private funds are: EngenderHealth, *see* Declaration of Maurice Middleberg dated August 12, 2005, ¶ 4; plaintiff Pathfinder International, *see* Declaration of Daniel E. Pellegrom dated February 7, 2008, ¶ 7; CARE, *see* Declaration of Helene Gayle dated February 6, 2008, ¶¶ 3, 8; and IntraHealth, *see* Declaration of Pape Gaye dated January 25, 2008, ¶ 7.

The Global AIDS Act Restrictions

12. GHC members, including many based in the U.S., execute a number of programs funded by Defendants USAID and HHS, including programs funded by the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 ("Global AIDS Act").

13. The Global AIDS Act contains a "government funds restriction" which prevents funds made available under the act from being spent on activities that "promote or advocate the legalization or practice of prostitution and sex trafficking," although it allows for the provision of health care and related services to prostitutes. 22 U.S.C. § 7631(e). GHC does not herein challenge the government funds restriction.

14. The Global AIDS Act also contains a "policy requirement" providing, in pertinent part, that "no funds made available to carry out this Act . . . may be used to provide assistance to any group or organization that does not have a policy explicitly opposing prostitution and sex trafficking." 22 U.S.C. § 7631(f).

15. USAID did not enforce the policy requirement against U.S. NGO grantees until 2005. However, starting in 2003, U.S. NGO's have been required to include a clause in all subagreements with foreign organizations stating that, as a condition of entering the subagreement, the foreign organization has "a policy explicitly opposing, in its activities outside of the United States, prostitution and sex trafficking." Upon information and belief, HHS also did not enforce the policy requirement against U.S.-based non-governmental grantees for at least some of the period between the enactment of the Global AIDS Act and May 2005.

16. Then, in June 2005, USAID applied the policy requirement to U.S. NGOs by issuing USAID Acquisition & Assistance Policy Directive 05-04 dated June 9, 2005 ("AAPD 05-04"). Neither in this policy directive, nor in any other written document, does USAID either define "explicitly opposing prostitution" or provide clear guidance on what privately funded activities are permissible and impermissible under the policy requirement.

17. Similarly, beginning on or about May 2005, HHS began applying the policy requirement to U.S. NGOs. HHS has not defined the term "explicitly opposing prostitution" nor has it issued guidance to the public explaining which types of activities are permissible and impermissible under this restriction.

18. HHS and CDC have required all recipients of Global AIDS Act funding to "agree that HHS may, at any reasonable time, inspect the documents and materials maintained or prepared by the recipient in the usual course of its operations that relate to the organization's compliance [with the policy requirement]." *See, e.g.,* "Expansion and Support of HIV/AIDS/STI/TB Information, Education, Communication and Behavioral Change Communication Activities in Ethiopia – Amendment," 70 Fed. Reg. 29759, 29759-29760 (May 24, 2005), annexed to the Declaration of Daniel E. Pellegrom dated December 7, 2005 as Exhibit A.

How the Policy Requirement Harms GHC and its Members

19. From the moment of its adoption to the present, GHC and its members have been concerned about the policy requirement. GHC has followed the progress of the plaintiffs' lawsuit from its inception. GHC initially hoped that our direct involvement in the lawsuit would not be necessary because the plaintiffs had brought a facial challenge to the policy requirement. Had that challenge been successful, GHC members would have benefited from it. However, when the Court ruled solely on the plaintiffs' as-applied challenge and Defendants continued to enforce the policy requirement against all GHC members other than Pathfinder, GHC realized that it was necessary for us to participate in the lawsuit in order to obtain relief for our members.

20. In the summer of 2006, GHC sought permission from the Court to file a motion to join this case and obtain relief for its members. At the Court's request, GHC surveyed its members in the fall of 2006 to determine how many desired relief from the policy requirement. Twenty-eight members both received funding subject to the policy requirement and desired to receive that funding without being subject to the policy requirement. Eighteen of those 28 members wished to remain anonymous. Some members were afraid to respond to the survey and/or seek relief in the context of this lawsuit for fear that their identities would be exposed and that they would face retaliation from the Defendants, upon whom they rely for substantial funding.

21. Those members were warranted in their fears, because the policy requirement has subjected U.S.-based GHC members to intense scrutiny from members of Congress, who read the policy requirement extremely broadly and are quick to claim our members are violating it. For example, in a letter dated July 15, 2005 to the Hon. Andrew Natsios, then-Administrator of USAID; Representative Mark Souder (R-IN); and 27 other members of Congress accused GHC member CARE, which is based in the U.S., of violating the policy requirement by promoting a "rights-based" approach to prostitution, which the signatories incorrectly equate with advocacy for the legalization of prostitution and its cultural acceptance as a legitimate form of employment. In the same letter, the members of Congress also accused GHC member International Center for Research on Women, which is also based in the U.S., of holding a "pro-prostitution" stance.

22. In a subsequent letter dated December 7, 2005 to the Hon. Andrew Natsios, Rep. Souder again accused GHC member CARE of violating the policy

requirement by providing funding to an Indian organization that he said advocates for the decriminalization of adult sex work. In June 2006, USAID officials made inquiries to CARE about its association with this organization, to which CARE provides private funding in connection with a tuberculosis prevention program. *See* Declaration of Helene Gayle dated February 6, 2008, ¶¶ 20-21.

23. GHC and its members are harmed by the policy requirement in several ways, each of which is discussed in greater detail in the following paragraphs: 1) The policy requirement chills debate in GHC-sponsored meetings and publications and therefore fundamentally undermines GHC's role as a professional association; 2) the policy requirement restricts the use of private funds by GHC's members; 3) the policy requirement compels members to adopt a policy and forces them to speak; and 4) the policy requirement is vague, and as such does not provide sufficient guidance for members to comply.

1. Chilling Debate in GHC-Sponsored Forums

24. GHC does not receive funds from the United States government, including the Global AIDS Act. Yet GHC is grievously harmed by the Act. The Act's deliberate chilling of free speech by our member organizations vitiates our core mission as a scientific and professional organization that promotes the free exchange of evidence, experience, analysis and opinion among our members. The harm to GHC exemplifies the wide-reaching, pernicious consequences of restricting the marketplace of ideas. The government has a hypothesis that criminalization of sex work assists in HIV prevention. The government then adopts the position that contrary evidence or experience gained by

organizations actually implementing the Leadership Act may not be communicated in scientific forums organized by their professional association –GHC – or in any other forum even using non-federal funds. Though the GHC is not party to any agreement with the US government, GHC members receiving Global AIDS Act funds cannot freely communicate their experience, evidence or views to GHC staff. Nor, using non-federal funds, can they communicate freely with fellow GHC members at forums organized by the GHC. Restrictions on speech are dangerous because they deprive the listener as the well as the speaker of the benefit of diverse views. In this instance, GHC is precluded from receiving the honest expression of the field experience of our members, though the GHC receives no funds from the US government.

25. The policy requirement chills and precludes the scientific and policy debate essential to the functioning of the GHC as a professional association. The position of the U.S. government that sex work should be criminalized is hotly contested in the global health profession. There is substantial contrary evidence in the professional literature (*see*, for example, M. L. Reckart, "Sex-Work Harm Reduction," *The Lancet* Vol. 366 (December 17/24/31, 2005): pp. 2123-2134.). The policy requirement also stands in opposition to the views expressed by multilateral organizations, including UNAIDS. Many of our members disagree, as a public health matter, with the view that sex work should be criminalized. Other members do not wish to take a public position on the legal status of sex work. However, the policy requirement bars from federal funding any member organization that fails to support the U.S. government position or presents evidence or experience at a GHC forum that contradicts the U.S. government position. GHC members who, on the basis of evidence and experience, do not agree with the U.S.

government position but wish to access U.S. government funds are not permitted to express that view or share relevant evidence at GHC scientific meetings or with GHC staff. This is a fundamental harm to the GHC, which depends on the free flow of evidence and opinion among its members to carry out its mission. This harm can only be redressed by protecting all our members from fear of retaliation for expressing their views at GHC scientific meetings and other forums.

26. The GHC manages multiple electronic and print publications, including a weekly newsletter, monthly newsletter, a magazine (Global HealthLink) and a newspaper (AIDSLink, which is devoted exclusively to HIV/AIDS). These publications are principally intended as an outlet for expression of member news, experience and opinion. The policy requirement precludes members from expressing a point of view contradicting that of the U.S. government in GHC publications for fear of being barred from federal HIV/AIDS funds. The chilling effect of the policy requirement on the expression of member viewpoints on AIDS policy in GHC publications is a direct harm to GHC. Redress of this harm requires that all our members be granted immunity against being disbarred from U.S. government funds as a result of expressing opinion in GHC publications.

2. Restricting the Use of Members' Private Funds

27. The policy requirement vitiates members' freedom to utilize private funds in the way they believe best advances public health. The Defendants' ban on the use of the non-U.S. government funds possessed by GHC members to do work that Defendants construe as being insufficiently opposed to prostitution restricts members from engaging

in speech and HIV-prevention activities with their private funds. The vagueness of the policy requirement, and Defendants' refusal to clarify what private activities grantees must abstain from, forces GHC's members to refrain from engaging in any activities that could possibly be construed as insufficiently opposed to prostitution. For this reason, U.S.-based GHC members have reported to GHC a pattern of self-censorship and reluctance to discuss programs for sex workers in public or for attribution.

28. GHC does not support the U.S. government's view that sex work must be criminalized. It is possible that the policy requirement could be construed as barring GHC members from making privately funded contributions to GHC in order to avoid indirectly subsidizing our viewpoint.

29. As a result of the policy requirement, U.S.-based GHC member IntraHealth International has been forced to refrain from developing new, privately funded initiatives to remove barriers to health care for sex workers, for fear that such projects could risk defunding of their USAID- and CDC-funded projects. *See* Declaration of Pape Gaye dated January 25, 2008, ¶ 30.

30. Were GHC member and plaintiff Pathfinder International not protected by the preliminary injunction this Court issued in 2006, it would be significantly chilled in its groundbreaking, highly successful work organizing sex workers in India to further HIV/AIDS prevention. This work is described in greater detail in the declaration by Daniel Pellegrom accompanying this motion.

3. Compelling Speech

31. The third way in which GHC and its members are harmed by the policy requirement is that it forces the members to espouse the U.S. government's policy

position on a sensitive political issue. While the U.S. government clearly believes that criminalizing prostitution is the best and only way to protect women and sexual health, as a public health matter that point of view is disputed by many in the global health profession.

32. Many of GHC's U.S.-based members believe that prostitution causes serious health, psychological and physical risks for women, and they work to address those risks and assist women in finding alternatives. However, they also believe that by forcing the members to explicitly oppose prostitution, the policy requirement stigmatizes one of the very groups whose trust they must earn to conduct effective HIV/AIDS prevention and forces them to approach those engaged in prostitution in a judgmental manner. As a public health matter, they believe that this interferes with their HIV/AIDS prevention work.

33. Moreover, many U.S.-based members are aware that Defendants have construed the policy requirement as prohibiting advocacy for the elimination of criminal penalties against women engaged in prostitution. Because GHC members operate under a variety of legal regimes around the world, many members are loathe to adopt a policy that directly contradicts the policy of some of the countries in which they work.

34. Were it not for the policy requirement, many of GHC's U.S.-based member organizations would not have adopted policies explicitly opposing prostitution. These include the organizations that stated in response to our member survey that they oppose the policy requirement. It is common practice in the field of international development to refrain from taking policy positions unless those positions flow naturally from the experience of providing services. For GHC's members, the adoption of a

government-mandated, organization-wide policy infringes on the independence that is fundamental to their operation as non-governmental organizations.

35. For example, U.S.-based GHC member EngenderHealth has articulated a concern that being forced to adopt the government's policy may jeopardize its work in Brazil. *See* Declaration of Maurice Middleberg dated August 12, 2005, ¶ 15. Because the area of reproductive health is so sensitive, EngenderHealth risks alienating some funders or partners in its work by taking any policy position on the issue of prostitution, which in turn risks threatening the effectiveness of their HIV/AIDS prevention work.

4. Vagueness

36. The final way in which GHC and its members are harmed is that the policy requirement is confusing and vague and therefore imposes extra administrative costs. Many U.S.-based members are unsure of what activities and speech they may and may not engage in with private funds. Members have reported that USAID missions have been inconsistent in applying the language of the policy requirement. Some members have reported that local USAID missions in countries in which they operate have demanded to see an organization's policy opposing prostitution while others have reported that missions did not demand to see the policy. Some members have reported that, in the absence of guidance from the Defendants, primary recipients of U.S. government funds have inserted their own language in subcontracts about what constitutes compliance with the policy requirement.

37. One U.S.-based GHC member had to spend months of scarce staff time and resources in discussion with USAID to reinstate a grant after it had been withdrawn

under pressure from U.S. legislators. Because the requirements of the policy are vague, USAID was able to withdraw and reinstate the grant according to political pressure, forcing our members to commit scarce resources to allay the political fears of USAID.

38. Another U.S.-based GHC member was forced by the local USAID mission to commit scarce resources to training local service providers to comply with the policy requirement.

The Affiliate Guidelines Do Not Remedy the Harm to GHC And Its Members

39. USAID and HHS have issued guidelines with regard to the establishment of "affiliated" organizations that could express an opinion on sex work different from the U.S. government-mandated opinion. Such affiliated organizations must be legally, physically, and financially separate. Factors used in determining whether the affiliate is separate from the entity receiving Leadership Act funds include the existence of separate personnel, management, and governance; separate accounts, accounting records, and timekeeping records; separate facilities, equipment and supplies; distinct signs and other forms of identification which distinguish the Recipient from the affiliated organization; and "protecting" the U.S. Government and the project name from public association with the affiliated organization. The guidelines caution that meeting these conditions would not necessarily constitute compliance with the Leadership Act, but that each instance would be considered on case by case basis.

40. These guidelines were issued without opportunity for comment. GHC would have issued strong objections to these guidelines had an effort been made by the government to solicit informed views.

41. The guidelines were issued without any accompanying analysis as to the burden placed on organizations receiving funds under the Leadership Act. No estimate of any kind is provided as to the likely costs and barriers to meeting the conditions.

42. No effort was made to inquire of the affected organizations as to whether the guidelines would create a realistic opportunity to express positions differing from the government mandated opinion.

43. The guidelines do not provide clear criteria for the creation of an affiliated organization. They quite clearly caution that an organization meeting all the criteria and factors could still be considered out of compliance and fail to meet some unstated "case by case" test. The guidelines also fail to explain how much weight will be given to each factor in the analysis of whether an affiliate is in compliance. Most importantly, the guidelines fail to achieve their essential purpose; they make no effort to clarify the vague prohibition from the original law and, in fact, only make the contours of that prohibition more unclear.

44. Significantly, the guidelines appear to bar GHC's members from controlling any organization that uses private funds to engage in speech barred by the policy requirement. One of the five criteria to be taken into account in determining whether enough separation exists is "[t]he existence of separate personnel, management, and governance." This criterion appears to bar our members from using their private money to engage in the forbidden speech through another organization. In this way, the guidelines fail to provide our members with an avenue for constitutionally protected speech.

45. Even if a GHC member were able to transfer its private funds to an affiliate, and to use those funds to speak through that affiliate, doing so would be logistically and financially difficult, and perhaps impossible. In order for a GHC member to speak freely with its private funds, it would have to create an affiliate organization in every country in which it operates. Creating affiliates that will maintain the legal, financial, and physical separation from the parent organizations that the guidelines require will present very heavy burdens on GHC's member organizations. Even if GHC members were to limit their creation of affiliates just to those countries in which they might express an opinion differing from the U.S. government view on sex work, the requirements would still be heavily burdensome. These burdens virtually preclude any member from actually developing an affiliate as demanded by the government.

46. The legal separation mandated by the guidelines imposes heavy costs on GHC's member organizations in terms of time, effort, and money. In many of the developing countries where GHC's member organizations operate, starting a new NGO is a complex and arduous process. The NGO must secure the approval of the local government to register, which typically involves complex negotiations with multiple ministries. That process takes a great deal of time by the NGO's employees and requires the help of attorneys, whose fees the NGO must pay. Moreover, it is far from a foregone conclusion that the governments of developing countries will approve the registration of affiliates whose only purpose is to satisfy a US government requirement for expressing a point of view.

47. Even if the registration of the affiliate is approved, it is likely to be very difficult to staff the new entity with the separate personnel required by the guidelines. If

the new affiliate tries to hire citizens of the United States or of a third country, it will have difficulty securing visas and work permits. The governments of developing countries grant such authorization to secure essential expertise, not to import persons whose job is necessitated by restrictions on the advocacy functions of existing organizations. Local employees are hard to find in many countries either because the requisite skills will not be available or because national staff feel vulnerable to political and other pressures if they espouse unpopular points of view.

48. Our members will also incur enormous costs recruiting and employing a second, redundant set of employees. It is extremely expensive for our members to hire expatriates or third country nationals to staff their offices. In the case of expatriate employees, members generally pay for such expenses as each employee's moving and housing costs, their children's education, and bringing the family home for visits.

49. Establishing and operating a physically separate office will also be extremely expensive for our members, who must pay for security, office equipment, furnishings and other items for each office. Additionally, in some developing countries where GHC members operate, technological equipment such as computers, printers, satellites, and networking supplies must be imported. This is not only expensive, but requires the members to work through detailed local customs laws for a second time. It also requires paying for computer set-up and operation (often including installing the necessary wiring and satellite dishes) in a second office.

50. Another difficulty created by the guidelines is the requirement that the board of directors of the parent NGO be entirely separate from the board of the affiliate. Boards of Directors are the final authority over and control GHC member organizations.

The affiliates, then, would also be controlled by their separate and independent boards. If the premise behind the creation of the affiliate is to create a way for the parent to speak its intended message through another source, this requirement runs counter to the achievement of that ostensible goal. The affiliate having a separate board will make it impossible for the parent NGO to have control over the affiliate and thus control over the message coming from that affiliate. This requirement, then, could again leave the parent NGO with no outlet for its intended message.

51. The financial separation mandated by the guidelines is equally onerous for members. Since no commingling of funds is allowed between the parent organization and the affiliate, the affiliate would be required to raise all its own funds, starting from nothing. This is a difficult and time consuming process. Fund raising is already extremely challenging for GHC members. The new affiliates would have to allocate valuable man-power and resources towards fund raising and away from achieving the organizations' objectives. The affiliates would have to convince potential donors to give money before the organization has a track record of work to showcase to potential donors. To raise requisite funds, it is very likely that the affiliate will need to draw on the pre-existing donor pool of the parent NGO. Since there is only a finite amount of money donors are willing to give to NGOs, this will deprive the parent organization of much needed funds.

52. The legal, governance, and financial challenges pose an insuperable burden for our members. The practical consequence will be to bar GHC members from expressing a point of view through any organizational vehicle. The Government proposes that a non-profit organization divert scarce resources from their primary mission of

addressing the HIV/AIDS pandemic and other critical health and poverty alleviation programs to rent or buy facilities, hire a separate staff, create an independent Board, develop separate accounting systems, and create a new, distinct identity *so that it may express an opinion on an issue of public policy*. Even undertaking all these actions may not suffice given the ambiguity of the case-by-case test in the guidelines. The government has created an extremely high and unreasonable hurdle for organizations to surmount.

53. Even if the legal, governance and financial hurdles could be surmounted, the creation of an affiliate divorced from the rest of the existing organization's program implementation undercuts its utility as an advocate of a point of view. To the extent that groups would have to cordon off sex work advocacy from other programs it would force NGOs to have an artificial separation between advocating policy positions and the practical experience of implementing programs from which their policy positions derive. The utility of NGOs in the policy arena stems largely from their unique vantage point. The positions they advocate come from experience gained on the ground and from their understanding of the true consequences of policies formulated in far away capitals. A forced dichotomy between the NGOs that implement and those that advocate undermines the utility of our members as bridges between policy makers and the complex realities encountered while implementing programs.

54. More fundamentally, the affiliate guidelines in no way alleviate the central harm to the Global Health Council. As stated above, the very rationale for the existence of the GHC as a professional organization is to create forums at which our members may come and freely share opinions based on the evidence and experience derived from their

work. We emphasize that this means the work of the organizations actually implementing the HIV/AIDS programs, not some arms-length affiliate that does not have the same governance, management, staff, expertise or evidence as those actually implementing programs. GHC is, above all, a place at which organizations that implement programs share the reality that they encounter in the field, including how public policy affects program implementation. The anti-prostitution policy requirement prevents those implementing the HIV/AIDS Leadership Act from providing informed comment to each other and to the GHC as to the assumptions and impacts of the Act. For example, GHC is soon hosting its annual conference. There, Pathfinder will have a poster session – a booth with information and a staffer to speak with - called "Condoms and Health Care: Sex Workers Need More." Pathfinder can speak freely at the event because they have the protection of the injunction, but other conference attendees would not be able to have poster sessions that engage interested parties in a free and open exchange of ideas on sex work for fear of violating the policy requirement. The GHC is therefore robbed of its ability to encourage informed dialogue among its members. The GHC is prohibited from hearing the views of the members implementing the Global AIDS Act if those views differ from the government-approved opinion. Any member receiving Global AIDS Act funds risks losing those funds by communicating a dissenting opinion to the GHC or at a GHC-sponsored forum. This means that the GHC cannot offer Congress or the executive branch an accurate rendering of the experience and evidence derived from its members if they differ from government-sanctioned opinion. The creation of "affiliates" does not address these fundamental damages to the GHC since we are still barred from hearing the untrammeled views of our members.

55. For all the above reasons, the anti-prostitution policy requirement constitutes a grievous and irremediable harm to the Global Health Council and our members. We therefore ask the intercession of the Court to prevent application of the policy requirement to GHC's members.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on February 6, 2008
Washington, District of Columbia

Nils Daulaire

Sex-work harm reduction

Michael L Rekart

Sex work is an extremely dangerous profession. The use of harm-reduction principles can help to safeguard sex workers' lives in the same way that drug users have benefited from drug-use harm reduction. Sex workers are exposed to serious harms: drug use, disease, violence, discrimination, debt, criminalisation, and exploitation (child prostitution, trafficking for sex work, and exploitation of migrants). Successful and promising harm-reduction strategies are available: education, empowerment, prevention, care, occupational health and safety, decriminalisation of sex workers, and human-rights-based approaches. Successful interventions include peer education, training in condom-negotiating skills, safety tips for street-based sex workers, male and female condoms, the prevention-care synergy, occupational health and safety guidelines for brothels, self-help organisations, and community-based child protection networks. Straightforward and achievable steps are available to improve the day-to-day lives of sex workers while they continue to work. Conceptualising and debating sex-work harm reduction as a new paradigm can hasten this process.

Lancet 2005; 366: 2123–34

Published online December 1, 2005
DOI:10.1016/S0140-6736(05)67732-X

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Sex work and injection drug use are among the most perilous activities worldwide. Harm reduction has stimulated global debate about drug use, and the application of harm-reduction principles to interventions such as needle exchange has reduced HIV spread and improved the lives of drug users.[1] Since drug users might participate in sex work to pay for drugs, drug-user harm reduction includes condom promotion, and sex workers could use drugs to cope with psychological, emotional, and physical stress.[2–5] Safe-sex campaigns and social marketing of condoms are based on harm-reduction principles. The process of harm reduction is not new to the study of sex work. Harm-reduction and risk-reduction strategies have been adopted by health authorities, sex worker organisations, and sex workers themselves. This Review aims to (1) examine studies of sex work, by concentrating on peer-reviewed publications, and classify harms and harm-reduction strategies into overall themes; and (2) focus on simple, available strategies to improve sex workers' lives. Male and trans-sexual sex workers face harms and can benefit from harm-reduction strategies; however, this Review will not focus on these topics or the specific issues of clients outside of the general theme of sex-work harm reduction.

Sex-work harm reduction has been proposed by the International Harm Reduction Development (IHRD) programme as a framework for discussion, action and research.[6] Sex-work harm reduction has also been conceptualised in newsletters, booklets, reports and conference abstracts.[7–12]

Sex-work harms

Differences in social context need to be considered for sex-work harms to be meaningful. In some societies, sex work is legal or decriminalised; sex workers have access to health and social services; and they are not heavily stigmatised or economically destitute.[13] Alternatively, sex work could be a survival tactic during severe societal disruption when no services are available and life necessities are scarce.[14] Most societies exist between these extremes and sex-work harms thus vary from place to place.[2] Poverty, war, globalisation, and neocolonialism are important causes of the international sex-work trade[2] but these issues are beyond the realm of harm reduction.

Drug use

Injection drug use is common in sex workers in many locations.[2–5,15–17] Sex workers who inject drugs might use condoms less consistently and, for more money, they might agree to unprotected sex or anal sex.[3,4,16,18,19] Individuals who share needles, syringes, and drug injection paraphernalia are at risk of HIV, hepatitis B and C, and syphilis.[20,21] Female sex workers could be in relationships with male injectors who mix the drug and inject the women, increasing their HIV risk.[22] Physical and sexual abuse by customers has been associated with drug use in sex workers.[15,23] Injection drug use can cause

Search strategy and selection criteria

For peer-reviewed publications, I searched MEDLINE (from 1966) and EMBASE (from 1980) using the MeSH terms "prostitution" and "risk reduction". UN, UNAIDS, and WHO publications were searched online with "sex work", "sex worker", "sex trade", "prostitution", "prostitute", "survival sex", "transactional sex", "harm reduction", "risk reduction", "trafficking", "decriminalization", and "human rights". The same terms were used to search psychological, social sciences, and social work publications (from 2000) from PsychInfo, Social Work Abstracts, Social Science Abstracts, and the Web of Science. EMBASE, MEDLINE, and a comprehensive social scientific and psychological review on sex work (1990–2000) were also used. Reference lists from selected articles and widely used textbooks on sexually transmitted disease were also reviewed. With the same key words, I searched non-peer-reviewed work using an online search engine (Google), abstracts from International AIDS Conferences (1996–2004); UN, UNAIDS, and WHO websites and publications; and information from non-governmental organisations. Peer-reviewed work and UN publications were reviewed to establish overall themes. All harms and harm-reduction strategies were listed and grouped under general headings. Selected articles best represented specific themes according to the following hierarchy: analytical studies, descriptive studies, UN publications, and commentaries or editorials. Randomised, controlled, or large studies were preferred. The Journal Citation Reports database was used to select high-impact journals. Non-peer-reviewed work was searched for additional issues.

skin infections, thrombosis, sepsis, endocarditis, overdoses, and other serious illnesses.[20]

Sex workers could use non-injection drugs such as cocaine, crack, and crystal methamfetamine,[5,16,17,19,24–27] leading to poor judgment, unsafe sex, immune suppression, cardiovascular and neurological disease, overdose, and addiction.[16–20] In Guyanese sex workers, cocaine was significantly associated with inconsistent condom use.[17] Alcohol, probably the most important drug in the sex-work industry,[3,5,16,26–28] has been associated with violence, abuse, unsafe sex, HIV infection, and liver damage.[5,16,20,29]

Disease

Sex workers have an increased risk of sexually transmitted infections (STIs), including HIV.[2,16,17,30–36] Condom use varies among sex workers,[2–4,15,16,28,32] and the decision to use condoms is often controlled by the customer or brothel owner.[2,16,18,24,28,37] Descriptive and analytical studies show that sex workers commonly use condoms less often with regular partners, spouses, and non-paying customers.[2,16,17,19,24,32,38–40]

STI complications are common in sex workers, including pelvic inflammatory disease and ectopic pregnancy.[16,30,38] STIs are cofactors in HIV transmission,[30,38,41] and frequent intercourse can cause genital trauma, greatly increasing HIV risk.[16,42,43] Sex workers sometimes douche, or use drying or astringent substances that remove the lubricating vaginal fluid to increase a sense of tightness or induce "dry sex". These practices have been associated with an increased risk of STIs or HIV infection.[2,44–46] Sex workers could also acquire hepatitis A or herpes through anal-oral contact.[47]

Violence

Violence[2–5,15,16,18,23,27,48–50] against sex workers is an important issue in many communities. Violence includes physical, verbal, and sexual abuse; gang rape; traumatic intercourse; emotional trauma; robbery; confinement; and murder. Street-based sex workers have an increased risk of violence.[48] Violence results in morbidity, disability, emotional scarring, psychological stress, and low self-esteem. Significantly raised overall mortality and homicide mortality have been shown in active and former sex workers.[49] Violence by an intimate partner has also been associated with an increased risk of HIV infection.[51]

Discrimination

Sex workers are easy targets for discrimination, the overtly expressed corollary of stigmatisation.[2,16,38,52–55] These individuals are devalued in many societies and often blamed for the breakdown of the traditional family, epidemics of STIs and HIV/AIDS, escalating crime, and the subversion of youth.[3,16,28,52,53] Stigmatisation can lead to abuse, violence, criminalisation, denial of services, and low self-esteem, which affects sex workers' health.[2,3,16,38] Sex workers with HIV/AIDS could be doubly stigmatised.[16]

Debt

Young people sometimes enter sex work to support their families but soon acquire personal debts for transportation, accommodation, clothes, cosmetics, condoms, food, medical care, drugs, and fines.[2–4,16,24,56–58] Risk-taking in sex workers has been statistically correlated with financial need.[59] Brothels can hold sex workers in debt bondage, allowing them to keep a small proportion of their earnings.[16,24] As debts accumulate, the likelihood of individuals leaving sex work falls.[3]

Criminalisation

Prostitution, or some aspect of it such as soliciting, is illegal in many countries, but the law is an ineffective means of eliminating its negative aspects, often resulting in the criminalisation of sex workers.[2,10,16,38,53,60] Even if prostitution is not illegal, sex workers can be treated as criminals.[2,18,53] Criminalisation leads to violence; police harassment; increased HIV and STI risk; reduced access to services; psychological disease; drug use; poor self-esteem; loss of family and friends; work-related mortality; and restrictions on travel, employment, housing, and parenting.[10,16,18,24,38,61–65]

	Estimated yearly occurence
Adverse health effects in prostituted children*	
Infectious disease	
STDs	2 000 000
HIV infection	300 000
HPV infection	4 500 000
HBV infection	500 000
Pregnancy	
Maternal deaths	4752
Spontaneous abortions	900 000
Induced abortions	1 224 000
Abortion-related complications	367 200
Abortion-related deaths	710
Mental illness	
PTSD	6 700 000
Attempted suicide	1 640 000
Substance abuse	
All substances	9 000 000
Violence	
Physical assault	2 500 000
Rape	2 500 000
Murder	6900
Malnutrition	Unable to estimate
Adverse health effects in infants born to prostituted children†	
Infant deaths	190 080
Complication of STDs	237 000
HIV infection	249 480
Deaths from HIV infection	54 886
HBV infection	8316

STD=sexually transmitted disease. HPV=human papillomavirus. HBV=hepatitis B virus. PTSD=post-traumatic stress disorder. *Based on an estimated 9 million girls and 1 million boys prostituted per year. †Based on an estimated 2 376 000 infants born to prostituted children per year. Table reproduced from reference 67, with permission from Elsevier.

Table 1: **Estimated yearly occurrence of adverse health effects of child prostitution**

Exploitation

Child prostitution, human trafficking for sex work, and the abuse of migrant sex workers are important examples of exploitation.[16,24] UNICEF has estimated that 1 million children enter the sex trade every year.[66] Children can be sold or led into prostitution by their families.[3,16,67] Customers frequently prefer young girls, especially virgins, believing that there is less risk of diseases such as HIV/AIDS or that sex with virgins will enhance their sexual potency, cure disease, or extend their lifespan.[16,24,67,68] Children brought into prostitution have little power to negotiate condom use[16,67] and the immature vagina and cervix are more susceptible to STIs.[30] Child prostitutes are at high risk of HIV and STIs, violence, sexual abuse, rape, substance use, mental illness, tuberculosis, hepatitis, malnutrition, suicide, and death (table 1).[16,23,34,67,69] Pregnant adolescent sex workers are at increased risk of pregnancy complications, maternal morbidity and mortality, and the complications from safe and unsafe abortions.[67]

The UN defines human trafficking as "recruitment, transportation, transfer, harboring or receipt of persons, by coercion for the purpose of exploitation including prostitution".[70] Although trafficking and sex work raise different issues, trafficking for sex work is associated with HIV infection, STIs, discrimination, illegal immigration status, reduced access to medical and legal assistance, violence, and drug use.[16,71–75] Once trafficked, girls might be reluctant to return home.[72] Human trafficking is the fastest growing international trafficking business.[70,76]

A migrant is an individual who is engaged in a remunerated activity in a state where he or she is not a national. Migrants can be at risk of discrimination, violence, HIV and STIs, criminalisation, poor medical care, and drug use.[4,16,40,52,57,58,77–81] Female economic migrants are targeted by sex work recruiters.[82,52] Migrant sex workers have become a bridge population in the global spread of HIV/AIDS,[82,83,84] and their mobility causes problems for the establishment of support networks and ongoing medical care.[30,48,80,85] An Australian study showed a higher risk of STIs and lower condom use for international sex workers than for local sex workers.[86]

Strategies for sex-work harm reduction (table 2)

For centuries, sex workers have faced the harms of sex work. They have developed strategies for understanding their options, modifying their risks, and coping with their situations. Social science publications, especially the autobiographical writings of sex workers, show the logic and power they use in their day-to-day lives.[2,5,18,54,55,57,80,87,88]

Sex workers' coping strategies are based on personal knowledge, tradition and culture, experience, and future plans. Although intended to reduce risk, some strategies could worsen the situation or have no effect (panel 1). Harm-reduction initiatives for sex workers should build on their own strategies, value their distinctive differences, not conflict with their culture and traditions, and increase their options for self-determination, autonomy, and control.[2,18,54,57,59,87,88] The social, behavioural, and professional heterogeneity of sex worker subgroups often needs different individual and structural interventions.[93,94] WHO's Sex Work Toolkit[82] delineates the key principles and issues for HIV prevention, care, and empowerment, and the best practices against the inherent challenges in interventions for sex-work harm reductions (panel 2).

	Initiatives	Harms reduced
Education	Peer education, outreach programmes, accessible and appropriate materials, sex worker involvement	Drug use, disease, violence, debt, exploitation
Empowerment	Self-esteem, individual control, safe sex, solidarity, personal safety, negotiating skills, refusal to clients, service access, acceptance by society	Drug use, disease, violence, debt, discrimination, exploitation
Prevention	Male and female condoms, lubricant, vaccines, behavioural change, voluntary HIV counselling and testing, participation in research	Drug use, disease
Care	Accessible, acceptable, high-quality, integrated care; prevention-care synergy; prophylaxis; STIs, HIV/AIDS, and psychological care; social support	Drug use, disease, violence, exploitation
Occupational health and safety	Control exposures and hazards, treatment for injuries and diseases, employer duties, worker rights	Drug use, disease, violence, debt, exploitation
Decriminalisation of sex workers	Sex worker organisations, sex work projects, non-governmental organisations	Criminalisation, discrimination, violence
Rights-based approach	Education, telephone hotlines, training targeted and user-friendly services, government action, media, PREVENT,* refugee package, community development	Exploitation (ie, child prostitution, human trafficking, exploitation of mobile populations)

*PREVENT=psychological counselling, reproductive health services, education, vaccinations, early detection, nutrition, treatment.

Table 2: **Interventions for sex-work harm reduction**

Education

Education for sex workers can improve healthy behaviour by delivering the basic facts about disease,

***Panel 1:* Personal coping strategies of sex workers**

- Keep working and personal lives separate[88]
- Prioritise positive roles, such as motherhood[87]
- Dissociate emotionally and physically from work and clients (eg, douching, condom use, drug use)[5,19]
- Use degrees of intimacy to distinguish between work and non-work sex (eg, no kissing at work, no condom use with regular partners)[18,37,87,88]
- Undertake self-programming, internal dialogue, and meticulous management of time and space[2]
- Maintain a positive and professional attitude towards work[2]
- Acknowledge that they are sex workers, making condom use easier to negotiate with clients[55]
- Practise good genital hygiene[18,40]
- Undertake self-assessment for STIs, and assess STI risk in clients[18]
- Use antibiotics before and after sex[85,89,90]
- Use two or three condoms at the same time,[91] extra lubricant,[92] or both
- Switch to non-vaginal sex practices[2]

***Panel 2*: Principles and issues for effective HIV interventions in diverse sex work settings**

Key principles

- Adopt non-judgmental attitude
- Ensure that interventions do no harm
- Respect sex workers' rights to privacy, confidentiality, and anonymity
- Respect sex workers' human rights and accord them basic dignity
- Respect sex workers' views, knowledge, and life experiences
- Include sex workers, and, if appropriate, other community members in all stages of the development and implementation of interventions
- Recognise that sex workers are usually highly motivated to improve their health and wellbeing, and that sex workers are part of the solution
- Build capacities and leadership among sex workers to facilitate effective participation and community ownership
- Recognise the role of clients and third parties in HIV transmission—ie, targeting the whole sex work setting, including clients and third parties, rather than only sex workers
- Recognise and adapt to the diversity of sex work settings and of participating individuals

Key issues

- Assessment: follow ethical guidelines and good research practice
- Planning: build local support, identify potential partners
- Prevention outcomes: safer sex and increased condom use, increased sex worker participation and control over working and social conditions, reduced STI burden
- STI treatment: at a minimum, provide management of symptomatic STIs and either screening for asymptomatic STIs or presumptive treatment for STIs if accurate screening is not feasible
- HIV testing and counselling: training to provide a sensitive, non-judgmental service; strict confidentiality; pre-test and post-test counselling and informed consent; referral to psychological support and clinical care if possible
- HIV care: counselling and peer support; if possible, establish self-help groups and improve access to treatment, care, support, home care, and antiretroviral treatment
- Harm reduction for sex workers: discourage injection, needle-sharing, and overall use of drugs
- Management: mentoring and support to adopt organisational transparency and open communication, community participation, clear policies, flexible and adaptable structure
- Training: schedule training so that sex workers can attend, develop policies on incentives and payment for attendance, write reports for future use
- Monitoring and assessment: use feedback information from stakeholder groups to change, develop, and expand projects; use assessment results to lobby for funding, replication, expansion, or social or policy changes

Panel adapted from information in reference 82, with permission.

dispelling myths, and offering healthy lifestyle and work options.[82] Education can effectively reduce drug use, disease, violence, debt, and exploitation.[2,16,32,86,95–100]

Peer education has resulted in substantial increases in STI and HIV knowledge, condom use, and safer sex practices, and reduced incidence of HIV and STIs.[2,16,96–101] Peer educators need training, support, protection, and standards of conduct. Experienced sex workers can counsel other, often younger, sex workers about how to live safely. Peer education of sex workers in Chad was shown to be the most cost-effective option for the prevention of HIV/AIDS at under US$100 per infection prevented.[102] Outreach programmes delivered by educators, social workers, nurses, and respected community members have also had success.[2,16,95,103]

Many groups associated with sex work can benefit from education.[16,60,95,96,100,104] Successful materials are simple, clear, consistent, non-judgmental, attractive, and culturally sensitive.[16,71,95] Positive reinforcement can deal with prevailing practices, values, and beliefs.[105] Challenges include mobility, brothel manager control, criminalisation, language, culture, and traditions.[16,71,78,95,97,106]

Empowerment

Sex work harms can be mitigated by empowerment—ie, provision of the means and opportunity for self-assertion.[2,16,37,95,107] Personal empowerment is the awareness and strengthening of personal skills and options to control and improve sex workers' lives. Community empowerment strengthens the community's ability to participate in positive changes. Social empowerment enables sex workers to fight for their rights and acceptance in society.[16,95]

The aim of empowerment is to reduce vulnerability. Sex workers could be vulnerable because of poor self-esteem, lack of education and skills, negative societal attitudes, poverty, family responsibilities, poor health, mobility, and cultural and legal restrictions.[2,16,40,57,85,108–111] This vulnerability can result in difficulties for sex workers accessing and using condoms, negotiating safe sex, refusing clients, seeking redress, organising, parenting, using contraception, having abortions, and accessing public services.[9,16,85,95,111–116] The sex-worker community could be vulnerable because of invisibility and internal competition.[3,18,54]

Successful initiatives have resulted in enhanced self-esteem; improved negotiating skills; ability to refuse clients; access and use of condoms; training to recognise, avoid, and escape violence; STI and HIV preventive services; safe houses; drop-in centres; and STI treatment through pharmacies.[2,9,16,95,107,115,117] Civil society organisations have promoted practical safety tips to empower street-based sex workers (panel 3).

There are structural examples of how policy and law can empower sex workers. In Santo Domingo, Dominican Republic, sex establishment support for condom use and HIV or STI prevention was a significant predictor of consistent condom use (odds ratio 2·16; 95% CI 1·18–3·97).[37] Thailand's 100% condom campaign increased condom use in commercial sex from 14% to 94% by making condoms freely available, sanctioning against non-compliant brothels, and advising men through the media to use condoms with prostitutes.[119] A report of significant decline in condom use by brothel-based female sex workers in Thailand underscores the need for interventions to be sustained.[120]

Community development has been successful in the promotion of safe sex, identification of injustice,

provision of child care, support for HIV-infected workers, enhancement of self-esteem, co-operation with police and controllers, provision of legal and financial training, initiation of alternative income-generation schemes, and support for migrants and human rights.[16,95,107,114,115,121,122] In Johannesburg, South Africa, hotel-based sex workers have united to reduce risk and to educate newcomers.[54] When dealing with authorities, the community development model could be more effective and safer than actions by individual sex workers.[16,107,114,121]

Prevention

Male condoms reduce HIV and STI transmission in sex workers[32,41,98,119] and prevent STI complications such as pelvic inflammatory disease.[123] A reliable and accessible supply of good-quality condoms is essential.[16,99,124] Condom promotion, distribution, and social marketing result in increased condom use and reduced STI and HIV infection rates, especially in female sex workers.[99] Local culture, language, and traditions should also be considered.[125]

Female condoms have successfully prevented pregnancy and reduced STI transmission in analytical studies,[126–128] and there is in-vitro evidence and biological plausibility for HIV prevention.[127] Female condoms empower women by enabling them to negotiate safe sex, by promoting healthy behaviour, and by increasing self-effectiveness and sexual confidence.[129] A simulation model in South Africa concluded that a well-designed female condom programme for sex workers would be highly cost effective.[130] Female condoms do not need an erect penis, are reusable, and can be inserted ahead of time and left in after sex. Since they are made of polyurethane, female condoms can be used with water-based or oil-based lubricants. Female condoms are accepted by sex workers[127,131] but major difficulties include cost and poor availability.

Data have shown significantly reduced breakage rates without added slippage when more than one male condom was used.[91] When both male and female condoms were available to brothel-based sex workers in Thailand, unprotected sex fell by 17% (p=0·16) and STI incidence by 24% (p=0·18).[126] Lubrication is especially important for female condoms.[127,92] Dental dams and condoms that are cut lengthwise are plausible barriers during cunnilingus, but controlled trials are scarce. The availability of an effective and safe microbicide will be an important advance in sex-worker safety.[132,133]

Sex workers could benefit from the early use of an HIV vaccine.[134] Vaccine-feasibility studies in Thai and Kenyan sex workers have shown ongoing high rates of HIV incidence, substantial interest, and good compliance.[135,136] Hepatitis B vaccination programmes for sex workers can be effective, especially in the outreach setting and when the interval between the second and third dose is shortened.[47,85,111,137] However, coverage rates could be low because of little perceived risk and inappropriate delivery systems.[138]

Meta-analysis has shown that behaviour change interventions effectively reduce HIV transmission for sex workers.[99] Douching, dry sex, kissing, and unprotected oral-genital contact should be discouraged.[44,45,139] Nonoxynol-9-containing products offer no additional protection to latex condoms and could predispose to HIV acquisition.[140,141]

Voluntary HIV counselling and testing has been associated with increased condom use, reduced number of partners, and decreased HIV and in sex workers and clients.[99] This effect results from behaviour change

***Panel 3:* Safety tips for sex workers**

Appearance	Wear shoes that you can run in
	Avoid scarves, necklaces, and bags that can be used to hold or choke you
	Wear clothing that can be left on during sex in case you have to run away
Negotiations	Stick to a price list and time limit
	Pick your own parking spot or hotel
	Have a supply of condoms and lubricant
	Get money up front
	Use the same stroll
The car	Approach from the driver's side
	Arrange service and location while outside car
	Circle the car looking for other passengers
	Take down the licence plate (or pretend to)
	Do not fasten the seatbelt
	Wave goodbye to someone and shout the time of your return (or pretend to)
Oral sex	Learn to put on condom with your mouth
	At ejaculation, keep pressure on condom with your lips to prevent leakage
	Gargle with mouthwash or liquor afterwards, but do not brush your teeth
Vaginal sex	Use birth control
	Keep genital area well lubricated with water-soluble lubricant
	Do not douche or use vaginal-drying substances
	Position yourself on top, facing customer
	Keep hand on base of penis to keep it hard and to avoid spillage
	After ejaculation, remove penis from vagina immediately
Anal sex	Try to negotiate out of it
	Charge too much for the customer to afford
	Use extra lubricant
	Use female condoms
Self-defence	Do not carry weapons
	Use your voice and speed (eg, scream, hit car horn)
	Attack body areas that are easily injured (eg, throat, eyes, testicles)
	Run away against traffic, towards lights and people
	Work with friends
	Tell workmates about bad customers

Panel adapted from information in references 8, 12, and 118, with permission.

subsequent to education, support, and the knowledge of one's HIV status. Care programmes and participation in research can have a similar effect.[99,142] Integration of STI and HIV services into family planning has been espoused,[16,124,143] but there is little published evidence of effectiveness.[144] Additional success factors include links to community agencies, financial incentives, and support for childcare, transportation, and meals.[145]

Care

Sex workers need accessible, acceptable, and good-quality medical care. Prevention and care are most successful if delivered together, which is referred to as the prevention-care synergy.[16,71,107] Integrated services are important because sex workers could be exposed to many health risks, and follow-up is difficult.[16,85,146] Referral to specialised services such as those for safe abortion and drug treatment is essential.[85,146] Meta-analysis shows that STI treatment is highly effective in the reduction of disease transmission.[98,99,147]

Accessibility, acceptability, and quality care for sex workers are challenging issues in both developed and developing countries because of mobility, discrimination, criminalisation, poverty, vulnerability, illegal status, lack of health insurance, and unfamiliarity with the local language and culture.[2,16,114] Sex workers should participate in decision-making about service location and opening hours of operation.[107,114] Innovative access strategies include mobile delivery, hotel-room and home-based clinics, roadside clinics at police checkpoints, drop-in centres, and general clinics in sex-work areas.[16,103,112,148,149]

Acceptability often depends on staff attitudes,[2,16,112] which can be improved through sensitivity training.[16,107,112] Childcare and the opportunity to rest, bathe, and talk with other sex workers enhance acceptability.[95,107,112] Waiting times and clinic distance are also important. Sex workers will choose clinics that are welcoming with appropriate testing and treatment.[16,95,107] In Managua, Nicaragua, vouchers redeemable at private, public, or non-governmental organisation clinics were positively received by sex workers and clinics.[10] Communication can be addressed by cultural mediators and information in different languages.[16,57,107,150]

Care and support for sex workers with HIV/AIDS is important. The UNAIDS (Joint UN Programme on HIV/AIDS) basic package for HIV and AIDS includes: voluntary HIV counselling and testing, psychological support, palliative care, treatment (for pneumonia, oral thrush, vaginal candidiasis, and pulmonary tuberculosis), prophylaxis with co-trimoxazole, and facilitating community activities that reduce the HIV effect.[71,124] Antiretroviral prophylaxis during pregnancy, chest radiographs, Mantoux PPD skin tests for tuberculosis, and Pap smears should be available to sex workers.[124,151,152] Since HIV viral load relates to HIV transmission, HIV-infected sex workers should be offered highly active retroviral therapy (HAART) when possible,[153] or be given viable options for leaving sex work.

Panel 4: Australian health and safety guidelines for brothels and the sex work industry

Employer duties

- Assess and control risks: screen, examine, and refuse clients; provide panic buttons, good lighting, safe equipment, and good hygiene; ensure safe handling of cleaning substances and ensure safe-sex practices
- Consult with employees, identify hazards, comply with fire laws, adhere to electrical safety
- Allow employees to access support organisations, join unions, have staff amenities, and receive health services

Working conditions

- Track hours and days worked; allow adequate breaks, vacation, and leave; provide safe and comfortable clothing
- Ensure no coercion and no inducement to practise unsafe sex; proper and consistent use of barriers
- Keep risks to a minimum for pregnant employees; ensure no smoking, or smoking only outside
- Handle waste, and prepare food and drink safely (handwashing, refrigeration, cleaning)

Protection and prevention

- Provision of accessible, properly stored, good-quality condoms, dams, and gloves, with their safe disposal
- Provide water-based lubricants, clean towels and linens; clean up body fluid spills
- Provide training to avoid condom breakage and slippage, and inform what to do if condom breaks
- Ensure regular, voluntary staff-health monitoring and employer-paid education; ergonomically designed furniture and supplies
- Identify high-risk procedures and areas, and develop control strategies to combat violence
- Provide regular maintenance of spas, sex aids, and (lightweight) bondage and discipline equipment

Care and support

- First-aid kits and trained personnel, alcohol and drug treatment programmes, safety for escorts
- Provide workers' compensation: accident reporting, injury management, return-to-work programmes, employer-paid insurance, access to occupational-health clinics and services

Panel adapted from information in references 159–161, with permission.

Sex workers and clients sometimes use antibiotics before or after sexual contact to prevent STIs and HIV.[3,67,85,89,90] Pre-exposure antibiotic prophylaxis warrants investigation,[85] especially for individuals heavily exposed for short periods such as seafarers on shore leave and part-time sex workers. However, prophylactic antibiotic use by sex workers has been linked to unsafe sex and presumptive periodic treatment of STIs in female sex workers has shown only transient success.[90,154] Sexually assaulted sex workers should be offered postexposure prophylaxis.

Occupational health and safety

Occupational health and safety refers to workplace issues that can affect employees. These principles are rarely applied to sex work, despite many occupational exposures, hazards, injuries, and diseases, including: harassment, violence, musculoskeletal injuries, bladder problems, stress, depression, alcohol and drug use, respiratory infections, latex allergy, the removal of children, and death.[2,48,75,155–157] Occupational health and safety standards are justifiable only if participation in sex work is voluntary and does not allow the participation of children.[158] Health and safety guidelines for brothels and the sex industry have been developed in Australia (panel 4).

Where prostitution is legal, progress of occupational health and safety could be hampered by owner or manager disinterest and the so-called one-hazard approach, focusing exclusively on STIs and HIV/AIDS. Employers argue that sex workers are independent contractors or casual employees responsible for their own health insurance, social security, pension, and benefits. However, workplace safety can be improved, if sound policies and standards are in place and if sex workers are allowed to organise and lobby.[37,114,156,162] Environmental and structural support for condom use and STI prevention has been shown as an important predictor of consistent condom use in female sex workers.[40] Forced brothel closures and treatment of sex workers as political scapegoats make the workplace more dangerous.[163]

Decriminalisation of sex workers

Decriminalisation refers to the removal of criminal laws. The UN, UNAIDS, and WHO support decriminalisation of adult sex work if no victimisation is involved;[16,63] however, no consensus exists among sex workers, non-governmental organisations, and advocates.[164] Drug-use harm reduction focuses on decriminalisation of drug users rather than the illicit drug industry. Sex workers should not be treated as criminals. Sex-worker organisations, non-governmental organisations, and research projects have been effective in decriminalising sex workers, by protecting their legal rights, lobbying for rational legislation, and working at the grass roots to protect them.[95,107]

Police are often blamed for criminalising prostitutes, but education, training, and lobbying can improve relations so that sex workers view the police as supportive and protective.[16,61,107] The courts should assess sex worker testimonies objectively and sex workers need the opportunity to seek redress for rights violations.[165] Courts can interpret the law to improve the lives of sex workers. In 2000, the High Court of Bangladesh declared that sex work was not illegal and that sex workers had the right to earn a living.[95] The Court censured state agencies for closing brothels.

Incarceration and a criminal record can interfere with housing, social assistance, travel, employment, education, food aid, and parenting.[61,165] Illegal immigration status drives sex workers underground, which results in poor access to health services, discrimination, violence, STI or HIV acquisition, and exploitation.[2,16,58,61,75,79,114] Decriminalisation of migrant sex workers would help them access services, seek redress for rights violations, and protect themselves and their customers from disease.

The health-care system can treat sex workers like criminals, which affects access to services and health education and leads to raised rates of HIV, STIs, hepatitis, disability, and death.[61,62,165] Mandatory HIV testing is an example.[65] Educational and training efforts can be successful.[61,107,165] The media can shape public attitudes to support either criminalisation or compassion.[3,107,166] Society disapproval of sex workers could promote low self-esteem, risk-taking, drug dependency, and hopelessness. Literacy, education, empowerment, and unity can reverse this downward spiral.[107]

Human-rights-based approaches

UNAIDS has adopted a human-rights-based approach to HIV/AIDS.[167,168] Extension of this approach to sex work and STIs would allow a supportive environment enabling sex workers to participate in, contribute to, and enjoy economic, social, cultural, and political development.[168,169] Child prostitution, human trafficking for sex work, and exploitation of migrant and mobile sex workers are serious abuses of human rights.

Peer education, outreach programmes, and appropriate educational materials have effectively improved the lives of women trafficked for sex work, child prostitutes, and migrant sex workers.[16,95,104,150,170,171] *Siren's story*,[8,171] which depicts a Filipina sex worker in Australia who manages her private and working life successfully, is a popular booklet containing information on health, management of money, and negotiation for safe sex. The media can also raise public awareness. *Meninas da noite* (Little girls of the night),[172] a collection of investigative reports by Gilberto Dimenstein, exposes child trafficking for sexual exploitation in the Amazon region and northwest Brazil.[173] Dimenstein exposes sexual abuses of girls as young as 9 years and as small as 15 kg.

***Panel 5:* Harm-reduction strategies best suited to government action**

- Enact and enforce sex tourism laws
- Establish national databases of child sexual offenders
- Share information across jurisdictions and foster international collaboration
- Provide legal migration opportunities
- Increase and enforce penalties for exploitation
- Provide legal visa options for victims of trafficking
- Enact and enforce child pornography laws, including on the internet
- Monitor employment agencies
- Facilitate photoshop reporting of pornographic pictures, especially of children
- Provide witness protection for victims willing to testify against their exploiters
- Outlaw methods used to circumvent the illegality of trafficking (eg, fake marriages, temporary wives, serial sponsorship, and the bride trade)
- Require government agencies to report on the status of human trafficking and child prostitution
- Link international aid with progress against child prostitution, human trafficking, and exploitation
- Support a UN-sponsored international campaign to prevent child prostitution

Telephone hotlines provide confidential access to information for potential or actual victims of exploitation and for family members and friends.[170,174] Education and training are important for agencies, individuals, and officials that interact with victims including youth-serving agencies, health-care workers, police, politicians, taxi drivers, hotel staff, and tour guides.[67,95,104,174] Sex work customers can be educated through the media, information at airports and travel clinics, and John School (educational classes for sex-work customers, focusing on STIs, HIV, and sex workers' rights), where former victims educate offenders to reduce recidivism.[104]

User-friendly drop-in clinics, open-door counselling centres, camps, and shelters have been successful.[121,170,171] Services at high mobility sites such as transit stations and border crossings and in high-risk zones such as markets, harbours, truck stops, and bus and train stations can reach migrant sex workers.[150,175] A global moratorium should be undertaken on mandatory HIV testing, which increases the risk of discrimination, violence, exploitation, and disease, and promotes a false sense of security among clients, controllers, and governments.[14,176]

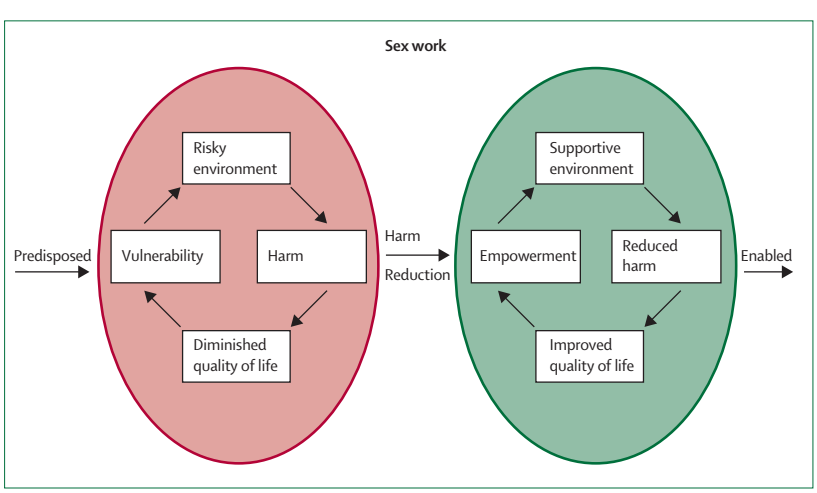

Figure: **Conceptual framework of sex-work harm reduction**

Non-governmental and sex-work organisations and their projects are at the forefront of the fight against exploitation.[107,121,171,173] CARAM Asia (Coordination of Action Research on AIDS and Mobility) produces educational information, advocates local and national issues, and develops interventions throughout the migration process.[171] TAMPEP (Transnational AIDS/STI Prevention among Migrant Prostitutes in Europe Project) supports women, transvestites, and transexuals from eastern Europe, Latin America, Africa, and southeast Asia working as sex workers in Europe.[171] The Maiti Project in Nepal provides safe spaces for returned trafficked women and educates the so-called sending communities to prevent other girls from being trafficked.[170] In rural Cambodia, 52 villages have established a community-based child protection network that educates the community about trafficking and intervenes for children at risk.[177] The health needs of children coerced into prostitution is summarised as PREVENT—psychological counselling, reproductive health services, education, vaccinations, early detection, nutrition, and treatment.[67]

Sex work is a common survival tactic for refugees and displaced people to earn money for food.[14] Women and children refugees are highly vulnerable to sexual violence, rape, and trafficking. Refugee sex workers need condoms, protection, access to household bleach and needle exchange, and basic HIV/AIDS and STI information in the language of the refugee and host community.[14] Radio is an important medium for communication. Governments are in the best position to implement specific strategies (panel 5).

Conclusions

The figure shows a conceptual framework for sex-work harm reduction. Poor determinants of health[178] are often predisposing factors for individuals entering sex work. Sex workers' personal vulnerability might then act synergistically with a risky environment, exposing them to harms that lead to a reduced quality of life.[179] Vulnerability, a risky environment, sex work harms, and diminished quality of life often amplify each other in an ongoing cycle. An objective of harm reduction might be to enable sex workers to move into a more positive cycle of empowerment, supportive environment, harm prevention and mitigation, and improved quality of life. This cycle could enable sex workers to eventually leave prostitution.

This summary of peer-reviewed, scientific work substantiates the many serious harms of sex work and presents simple, safe, and inexpensive strategies to avoid

risk, mitigate harm, and save lives. Sex-work harm reduction should be viewed as a new paradigm to improve the lives of sex workers through debate, discussion, and action, in the same way that drug users' lives have been improved by drug-use harm reduction.

The sex-work industry should not be condoned, especially if it participates in victimisation. However, the global focus on the sex work industry could result in individual sex workers becoming the unintended targets of elimination and control efforts. Civil society, especially sex work organisations, is deeply involved in improving the day-to-day lives of sex workers, and the scientific community can take an active role by using evidence-based research to pilot innovative initiatives, assess existing strategies, and develop a database of proven interventions. The participation of sex workers in this effort will ensure its success.

Conflict of interest statement

I declare that I have no conflict of interest.

Acknowledgments

No external funding was given for the writing of this Review. I acknowledge the assistance and support of Jacqueline Barnett, Gina Ogilvie, James Frankish, Josephine Rekart, Edward Rekart, Emma Rekart, Ellen Leung, Joanne Soh, and the sex workers in southern Vietnam who shared their time and their lives.

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