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Grenfell, P; Platt, L; Stevenson, L (2018) Examining and Challenging the Everyday Power Relations of Sex Workers' Health. In: Realising Justice for Sex Workers: An Agenda for Change. Rowman & Littlefield International, London, UK. ISBN 9781786603951

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Examining and Challenging the Everyday Power Relations Affecting Sex Workers' Health

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Amid the polarised feminist politics surrounding sex work, public health is often framed as a pragmatic middle ground (Tucker and Tuminez 2011). As alliances have developed between sex workers, academics and practitioners in the fight against HIV, and concern with the social determinants of health has grown (Marmot 2005), public health professionals are increasingly focusing on the social, political and economic conditions that shape sex workers' health (Shannon et al. 2015). This has drawn their/our much-needed attention to the negative health consequences of sex work criminalisation, police enforcement, stigma and related structural injustices – concerns long voiced by sex worker rights movements (Decker et al. 2015; Crago 2008). It has also led to greater involvement of sex workers in shaping health programmes, research and policies (NSWP 2014) and of public health professionals in advocacy for legal reform and sex workers' rights (Wolffers and van Beelen 2003; Shannon et al. 2015). However, much research and practice pays insufficient attention to sex workers' health needs beyond HIV and neglects their agency in negotiating threats to their well-being. Efforts to involve sex workers do not always challenge power relations between public health professionals and people who sell sex, or reflect the diversity of sex worker communities (Busza 2004; Cornish and Campbell 2009). Furthermore, some (public) health professionals appear reluctant to engage in debates surrounding sex work laws amid threats to funding and conflation of sex work and trafficking (Forbes 2010), while others support policies that are likely to compromise sex workers' safety, health and rights (FitzGerald and McGarry 2016).

Drawing on our multiple perspectives across social science, epidemiology and sex worker rights activism, we examine shifts in public health research, practice and policy and discuss the

implications for our understandings of, and possibilities to challenge, the power relations that shape sex workers' health. We believe that achieving social justice requires a fundamental shift in the power relations that institutionalise, legitimise and normalise suffering and inequalities (Bourgeois 2001; Krusi et al. 2016) and we therefore propose an agenda for change in three key ways. First, we call for 'person-centred' (Onyango, Schatz and Lazarus 2017) approaches to service provision, research and policy making, situating sex workers' health and decision making relative to broader structural contexts while recognising their individual and collective agency in negotiating health, safety and well-being. Second, we urge collaboration with sex workers over funding, design, implementation and evaluation of health services, research and policies (NSWP 2014) with critical reflection on contingent power relations. Third, we encourage (public) health professionals to support advocacy for sex work laws and social policies that protect sex workers' safety and health – efforts that would recognise the intricate links between the health harms and injustices that sex workers face (Overs and Hawkins 2011). Although we focus on what public health practitioners, researchers and policy makers can do to support sex workers' social justice efforts, our proposals are also relevant to broader medical and health-care communities.

Power, Agency and Social Justice

In this chapter, we discuss critically the power relations between people who sell sex, (public) health professionals and other institutional actors, and their implications for social justice. Following Fraser (2009), we understand social justice to mean that all people are entitled to participate equally in social life, and that this requires appropriate distribution of resources; recognition of communities marginalised on the basis of race, ethnicity, class, gender and/or sexuality; and their representation in political spaces. Foucault (1991) argued that power is exercised through all social relations, norms and techniques rather than solely through state

institutions, laws and rights. He drew attention to self-disciplining in the face of social norms, and how apparently ‘neutral’ institutions exert control, or ‘biopower’, over (women’s) bodies and lives, and target populations via invasive systems of regulation (Foucault 1998). While sceptical about its transformative potential, he recognises that power necessarily gives rise to resistance (Foucault 1998).

This conceptualisation of power is pertinent to feminist sex work politics, social justice goals and the position of public health relative to each. A ‘radical feminist’ position – claimed by many who advocate the abolition of the sex industry – typically identifies the main cause of women’s oppression as male power and denies ‘prostituted women’ any agency (see the introduction by McGarry and FitzGerald in this volume). A ‘liberal feminist’ position framing sex work as, primarily, a matter of individual choice – a view often misattributed to sex worker rights activists and academics supporting decriminalisation – evokes the neoliberal notion that people act free of structural constraints (*ibid.*). These positions, simplified here for brevity, reinforce the highly critiqued structure/agency dichotomy. Giddens’s (1984) ‘structuration theory’ offers an alternative by recognising their interdependence: social systems are (re)produced by individuals and collectives, but through reflexivity, agents can resist or rework them. Coupled with relational understandings of power (Foucault 1991) and everyday resistance (Johansson and Vinthagen 2014), this enables a focus on how sex workers experience, negotiate and resist threats to their well-being, within and against the constraints of structural forces. Most sex worker rights activists adopt such an approach, considering how injustices at the intersections of race, gender, sexuality, class and immigration status (re)produce sex workers’ mistreatment and how sex workers resist and rework these structural forces (ICRSE 2016).

Power is central to broader issues of social justice. Concepts of structural, symbolic and everyday violence hold that mistreatment, stigma, exclusion and ill health are often manifestations of inequalities – in relation to gender, race, class and sexuality – institutionalised through dominant power relations, legitimised as the intrinsic social order, normalised and rendered invisible (Bourgois 2001). Here it is useful to view stigma as a relational and structural process saturated with power, produced both through interpersonal interactions and institutional practices, policies and discourses (Parker and Aggleton 2003). Notions that sex workers are either ‘risky’ or ‘at risk’ (Krusi et al. 2016) or inherently vulnerable (Brown and Sanders 2017), for example, reproduce their stigmatisation and hinder recognition of their diverse needs (see the chapter by Dodsworth in this volume). Achieving social justice requires a disruption of the power relations between people who sell sex and the institutions and societies that function to govern their work, health and lives – centring sex workers as agents and citizens.

Foucault (1998) argued that dominant power relations dictate which discourses are suppressed and which are considered credible – legitimacy which, in turn, reproduces their power. These knowledge–power relations are particularly relevant to sex workers, whose construction as too unrepresentative or vulnerable to speak for their community has justified their exclusion from policy debates (Price 2012). Public health arguments are often framed as apolitical, despite their embeddedness in social, political and economic systems (Caceres, Cueto and Palomino 2008). Yet (public) health professionals have influence over health agendas and the terms on which we collaborate with sex workers. The misconception of public health as ‘neutral’ territory also means that such evidence and agendas are often centred in policy debates – at times, more so than other social justice issues (Caceres, Cueto and Palomino 2008). This infuses the relationship between sex workers and public health professionals with power. We must reflect, then, on how we

reproduce and can actively rework these power relations, through the methods we employ, approaches we advocate, funding we seek and collaborations we forge.

Structural Interventions, People-Centred Approaches

Public health work in relation to sex work has long prioritised HIV and sexually transmitted infections among cisgender (cis) female sex workers, often out of concern for the wider ‘public’ rather than sex workers’ own health (Prüss-Ustün et al. 2013). Although violence and reproductive and mental health are receiving growing attention, this is often in the context of HIV prevention (Maciotti, Grenfell and Platt 2017; Deering et al. 2014), reflecting many public health professionals’ area of expertise and interest (Wolffers and van Beelen 2003), and funders’ priorities (Mama Cash, Red Umbrella Fund and Open Society Foundations 2014). Paradoxically, cis men and transgender (trans) women who sell sex – who are at particularly high risk of HIV – have received far less attention (Minichiello, Scott and Callander 2015; ICRSE 2015). An HIV-centred approach may be more justifiable in contexts of high prevalence, but sex workers across settings stress violence and police harassment as their most pressing concerns – harms that also restrict their access to HIV-related and other health care (Rhodes et al. 2008; Crago 2009; Decker et al. 2015). Public health work must expand to address these and other health concerns in an integrated way, in the context of sex workers’ occupational and broader life pressures and in direct collaboration with sex workers. Tailored to individuals’ needs and priorities, sex worker health and support services should offer sexual, physical and mental health care, drug and alcohol treatment, partner- and workplace violence support, transgender-specific health care, and access to wider social supports (see below) (NSWP 2014). Such approaches would recognise sex workers as citizens with a right to health in the same way as other members of the public.

Recently, there has been a marked shift towards structural approaches in public health (Marmot 2005). In the context of HIV, Rhodes's (2009) 'risk environment' framework resists blaming individuals and communities and 'shifts responsibility for harm' to related social, political and economic institutions. Sex work researchers have combined this with concepts of structural, symbolic and everyday violence to draw attention to macrostructural, community and work environment influences on sex workers' health (Shannon et al. 2015; Shannon et al. 2008). This work highlights how sex workers' safety and health are compromised by criminalisation and policing (Shannon et al. 2015; Krusi et al. 2014), denial of access to justice (Krusi et al. 2016), 'raid and rescue' initiatives (Maher et al. 2015), and unsafe or exploitative workplaces (Goldenberg, Duff and Krusi 2015; ICRSE 2016) – and how decriminalisation can alleviate these harms (Shannon et al. 2015; see also the chapter by Abel in this volume). Yet legal reform alone is insufficient. Sex workers' safety and health are also threatened by poverty, homelessness, limited access to drug treatment, peer-led and specialist health services (Deering et al. 2014, Grenfell et al. 2016), urban 'redevelopment' (Bandewar et al. 2016), restrictive immigration policies (Goldenberg et al. 2014), stigma, transphobia and racism (Rhodes et al. 2008) – directly and in interaction with criminalisation (Platt et al. Forthcoming). Indeed, sex workers who work in street-based environments, use drugs, are migrants, are racially marginalised, are trans or are living with HIV face the greatest threats of policing, violence and discrimination and may be least connected with sex worker organisations and health and support services (e.g., Rhodes et al. 2008; Crago 2009; ICRSE 2016). Such violence, stigma and inequalities therefore becomes institutionalised along economic, sociocultural and political lines. Sex worker rights activists have long voiced these matters of recognition and social justice (Crago 2008; Overs 2002) which must

be central to inclusive public health interventions, policies and research (Overs and Hawkins 2011).

Ensuring access to appropriate and respectful services, tackling structural inequalities, dismantling institutional cultures of stigma and supporting sex-worker-led organisations are vital dimensions of social justice work. Sex workers across diverse settings report derogatory, humiliating and dismissive treatment in criminal justice sectors, directly restricting their access and perceived entitlement to protection and justice (Scorgie, Vasey, et al. 2013b; Crago 2009; Krusi et al. 2016). Relationships with police have improved in contexts of decriminalisation (see the chapter by Abel in this volume) and where sex workers and practitioners have worked to challenge police mistreatment (Biradavolu et al. 2009). Yet sex worker organisations and community reporting systems remain vital sources of information on avoiding violent offenders and gaining access to justice. In mainstream health services, sex workers across diverse settings report experiences of abusive, blaming and shaming treatment and broken confidentiality – concerns that make many reluctant to disclose their work (Maciotti, Grenfell and Platt 2017; NSW 2014; Scorgie, Vasey, et al. 2013a). Sex-worker-led and specialist health projects, by contrast, offer spaces where sex workers can seek and share advice without judgement (NSW 2014). Yet their funding is restricted by shifts towards ‘exiting’-focused services, austerity agendas (Grenfell et al. 2016) and a lack of resources allocated to sex-worker led projects (Mama Cash, Red Umbrella Fund and Open Society Foundations 2014). Such projects also often work with specific groups of sex workers (e.g., cis women, street- or venue-based workers), although some are working to reach cis male and trans sex workers, migrants and people who work independently (NSW 2014). It is vital that such services, and related funding, are inclusive of the diverse modes of working, identities, needs and realities of people who sell sex – for example, employing interpreters,

providing transgender-specific health care, using community and online outreach, offering harm-reduction supplies and ensuring clinic spaces and times are accessible (NSWP 2014). Evidence reflecting this diversity (Minichiello, Scott and Callander 2015; Weitzer 2009; ICRSE 2015) and best practice guidelines (NSWP 2014) can inform service development and training for (public) health professionals, with input from a diverse range of sex workers.

Public health professionals can also support sex workers' access to wider social support, including justice, housing, welfare, immigration, legal advice and, for those who desire it, support to leave sex work and access alternative employment – through referrals and working partnerships with sex worker organisations, police, social services and NGOs. Such partnerships offer opportunities to tackle cultures of stigma, through institutional policies, routine practices and everyday interactions, reflecting on and challenging our and others' role(s) in reproducing dominant discourses relating to sex work. We urge closer, interdisciplinary attention to anti-stigma work that considers and seeks to disrupt the intersecting gendered, racialised, postcolonial and economic power relations of sex work stigma.

Recognising sex workers' agency is vital to challenging stigmatising discourses (Brown and Sander 2017) and ensuring that their needs are centred in practice, policy and research – an issue that has received insufficient attention in public health. Conscious of such critiques, Rhodes (2009) urges close consideration of how individuals interact with, navigate and shape their environments, and authors employing relational understandings of power provide useful examples. In Vancouver, Shannon et al. (2008) demonstrate how cis and trans women engaged in street-based survival sex exercised agency over screening and setting prices, and peer-based safety strategies, within the constraints of repressive policing, violence, a lack of safe and legal workplaces, drug withdrawals, economic insecurity and the long-standing oppression of

Indigenous communities. In Johannesburg, Wojcicki and Malala (2001) argue that cis female sex workers' practices – including those conceptualised as 'risky' – should be understood not solely as the acts of powerless women suffering sexism, racism and poverty but as their 'active participation in power struggles', as they seek to 'maximize possibilities and potentials in an inhospitable and difficult environment'. The authors implore researchers not to frame sex workers as 'powerless' but to explore their agency and decision making, with a view to resisting stigma and informing practitioners about why individual behavioural interventions are unsuccessful. These analyses help to reframe sex workers as active risk managers in risk environments, however constrained. In the following section, we consider how collective organising in the context of public health programmes is working to transform these environments and the related challenges.

We call for person-centred approaches that address sex workers' diverse health needs in the contexts of their lives, developed in collaboration with sex workers (Onyango, Schatz and Lazarus 2017). Such approaches must acknowledge, and seek to challenge, the criminalisation, stigma, transphobia, racism and poverty that sex workers experience, rather than blaming or shaming them for their practices. Yet they must also recognise sex workers' individual and collective agency in negotiating and resisting threats to their safety, health and well-being. This requires us to understand the diverse identities, realities and aspirations of people who sell sex, treat them with dignity and respect, and remain sensitive to the needs of marginalised sex workers without assuming inherent vulnerability. Public health researchers often talk about doing research 'on' rather than 'with' particular communities. Many continue to frame sex workers' health in relation to the wider population and the HIV epidemic, and fail to challenge discourses that perpetuate stereotypes of sex workers as 'risky' or 'at risk'. While these efforts may help to garner mainstream funding and attention, and there is undoubtedly a need for sustained HIV-related

research and programming, we call for a fundamental shift, in language and action, towards the broader safety, health and rights of people who sell sex, as citizens.

Collaborative Approaches to Research and Practice

Since the emergence of HIV, there has been a proliferation of interventions providing sex workers with information, tools and services to protect their sexual health, including through ‘community mobilisation’ and ‘peer’ approaches (Kerrigan et al. 2015) – raising questions of who constitute communities and peers, and how such approaches engage with the politics of sex workers’ health. Some initiatives have (re)oriented towards sex workers’ priorities, expanding to address previously neglected issues of violence, police mistreatment and economic insecurity, with sex workers taking ownership of programmes and exerting influence over research, practice and policy (Leite, Murray and Lenz 2015; Biradavolu et al. 2009; NSW 2014). Yet such approaches have not always addressed structural and community influences on health, involved sex workers in decision making or taken account of power relations between sex workers (Cornish and Campbell 2009). Funding is heavily HIV-oriented (Mama Cash, Red Umbrella Fund and Open Society Foundations 2014), often tied to globalised management and monitoring expectations (Cornish et al. 2012) and subject to ideological shifts (Ditmore and Allman 2013), and reliance on quantitative evaluation limits our understanding of how such approaches may (or may not) work. There is a particular lack of documented examples of such approaches from Europe and North America, despite strong and politically-active sex worker rights movements in these regions.

The public health literature documents impressive impacts of community-based ‘empowerment’ interventions in terms of reducing violence and HIV and improving access to services, particularly in India (Kerrigan et al. 2015). However, diversity in interventions across settings, insufficiently rigorous study designs and a lack of theoretical basis limit the potential of

quantitative evaluations to establish how they have achieved these effects (Kerrigan et al. 2015). Ethnographic studies illuminate why such projects are successful in parts of India but do not always translate well elsewhere. The Sonagachi Project in Kolkata's main red-light district began as an externally run HIV prevention programme but soon adapted to address sex workers' most pressing concerns, including police raids, violence and economic insecurity, and later became sex worker-led (Cornish and Ghosh 2007). In a context of entrenched poverty and stigma, and where third parties dictated working conditions, some men's social clubs resisted project activities as they realised their control over sex workers was reducing, but this in itself was seen to indicate a shift in power relations (Cornish and Ghosh 2007). Although madams did, at times, place their own economic concerns above sex workers' well-being, the project capitalised on their strong ethos of rules, insisting on good working conditions to continue providing project support. Cornish and Campbell (2009) compare the Sonagachi Project to a programme in a mining town in South Africa to understand why the former was far more successful in preventing HIV. Sonagachi was long-term, built on strong community organising and adopted an integrated social model of health, with sex workers taking on increasing decision-making responsibilities. By contrast, the shorter-term programme in South Africa, in the context of a more transient and less hierarchical sex industry, adopted a narrower biomedical approach, did not involve sex workers extensively in project management, and sex workers became resentful of those selected and paid as peer educators. These examples highlight the importance of local contextual knowledge, decision making with and by sex workers, and a broad, social view of health, as well as an understanding of the complex power relations within local sex industries that may affect programmes' success (Cornish and Ghosh 2007).

In the context of such interventions, sex workers have worked to shift power relations with police, and other political and social actors, to tackle violence and stigma and increase their representation. In Kolkata, sex workers used ‘persuasion’, ‘protest’ and favour exchange to gain support from police, politicians and local social organisations – work that required skills in ‘political thinking and strategic negotiation’, and commensurate time, resources and training (Cornish, Shukla and Banerji 2010). In Karnataka, southern India, a community-based crisis management system was set up to address extensive police violence, whereby a small number of sex workers were trained to provide immediate support to peers reporting violence and, through a network of civil society, legal and government actors, encourage them to take their cases to court (Biradavolu et al. 2009). However, economic worries and lengthy processes left some sex workers unwilling to pursue their cases and peer workers suffered stress and heavy workloads. While the most extreme police violence declined, raids and bribes continued. In the same project, sex workers used the infrastructure of a stigmatising and misinformed government HIV prevention programme to disseminate information on their own activities, provide accurate HIV information and challenge sex work stigma, reframing themselves as health educators (Blankenship et al. 2010). Yet even guest speakers reproduced harmful discourses that sex workers were not always willing to challenge. Broader anti-stigma efforts were successful to the extent that peer educators were willing to publicly identify as sex workers and encourage others to attend clinics, but women concerned about disclosure avoided services so as not to be seen with known sex workers. This work highlights some of the complexities of community mobilisation approaches and related efforts to challenge violence and stigma.

Despite these promising examples, asymmetrical power relations remain evident in many programmes, reflected in top-down approaches that privilege public health agendas over sex

workers' own concerns, and programmes that reinforce existing hierarchies within sex worker communities (Leite, Murray and Lenz 2015; Cornish and Campbell 2009). Leite, Murray and Lenz (2015) argue that even the concept of peer education may threaten principles of unity and solidarity, as sex workers become 'non-peers' imparting (state) knowledge to 'unknowing' sex workers. We must therefore approach critically the governance and implementation of programme activities (Leite, Murray and Lenz 2015) but also the notion of whose knowledge counts. Participatory, multi-method research can help to document how sex workers are addressing their communities' health needs and support advocacy for sex-worker-led services, and funding, in relation to and beyond HIV.

Participatory approaches seek to centre community members as co-producers of knowledge and practice to achieve social change (O'Neill, Woods and Webster 2004). They aim to challenge the power relations that dictate what and who is considered 'evidence' and 'expert' (Foucault 1998) with the potential to offer sex workers greater 'voice' in relation to policies, services and research that affect them (O'Neill, Woods and Webster 2004). They can redress sex workers' longstanding exclusion from political and academic spaces (Price 2012), develop more in-depth understanding of their needs and reorient research and practice towards communities' priorities and action (O'Neill, Woods and Webster 2004). However, they require commitment of time, resources and training and sex workers' willingness and availability to participate, and risk reinforcing hierarchies within sex worker communities (O'Neill, Woods and Webster 2004; Nencel 2017). There are challenges over developing shared language that is precise but not unnecessarily technical, and sensitive but not stigmatising or presumptuous; agreeing on shared agendas, timescales and decision-making processes; and ensuring that sex working researchers do not have to be 'out' to participate, while retaining methodological transparency and integrity.

Participatory approaches demand particular reflexivity over positionality and power. We must consider whose voices get to reflect the ‘community’ and how willing community researchers are to consider different perspectives (Nencel 2017), working to involve a diverse range of sex workers, including those who sell sex but do not identify as sex workers (Nencel 2017; ICRSE 2015, 2016). We must also ask ourselves as public health professionals how willing we are to reflect on and challenge our practices, preconceptions, privileges and participation in reproducing dominant discourses (Skilbrei 2017), including the influence of our ‘public health’ lens. We urge a collectively reflexive approach, in which sex-working and non-sex-working colleagues encourage each other to reflect on our positionality, power and assumptions relative to one another and to wider communities of sex workers.

Participatory public health research has helped to draw attention to injustices faced by sex workers across diverse settings, including for example studies across Kenya, Zimbabwe, Uganda and South Africa (e.g., Scorgie, Nakato, et al. 2013) and longitudinal research in Canada (Shannon et al. 2008). A number of authors also provide detailed and critical methodological accounts. In the context of a long-standing partnership in Karnataka, Blanchard et al. (2017) highlight the value of establishing a sex worker committee that jointly owns the research and has specific responsibilities for management and community-based analysis. In Pakistan, Collumbien et al. (2009) reflect on how ‘peer ethnography’ helped them to better understand male and trans sex workers’ identities, relationships and lives, contributing to diversifying knowledge and service provision in this setting. In Svay Pay, Cambodia, Busza (2004) notes how NGO-run ‘participatory research and action’ workshops with Vietnamese cis female sex workers proved a popular space for women to meet and contrast work experiences, and allowed them to critique the programme’s funder-driven, biomedically focused monitoring. Yet they were unable to sustain sex workers’

involvement and hand over programme management, largely due to women's high mobility and brothel managers' restrictions on their participation.

There are other well-documented accounts of collaborative sex work research in public health (Weeks et al. 2010) and of the negative implications of studies that have failed to consult adequately with sex workers (Nencel 2017). Yet accounts of participatory research often mention sex workers' involvement only briefly, with little discussion of implications for knowledge (co)production. This may relate to scientific writing conventions, but it may also reflect a lack of reflection on the power relations that such approaches involve and seek to address. In our research in London, UK we have moved from working with community fieldworkers¹ whose role was limited to data collection (Platt et al. 2011) to a fuller collaborative approach, as we have gained experience in participatory research methodologies and developed relationships with activists and researchers in other disciplines. In our current project, evaluating how removing sex-work-related police enforcement could affect sex workers' safety, health and access to services in East London, co-researchers are central members of the team, involved in design, implementation, analysis and dissemination. Yet, while our funders support community involvement (National Institute for Health Research 2012) and we strive to reflect critically and collectively on positionality and power, the grant is held by public health academics. In future we hope to co-develop grant proposals, which will require both pre-award funds and a funding structure that accommodates shared community-academic ownership and responsibility.

Academic-community collaborations with sex workers require careful planning and implementation, clear mechanisms and responsibilities for decision making, and time and resources for collective reflexivity and knowledge exchange. These approaches require our willingness to share power and to reflect critically upon and challenge institutional policies,

discourses and practices that govern knowledge production – including our participation in them. We can encourage funders and ethics committees to invite sex workers onto panels to evaluate the importance and appropriateness of sex-work-related projects. There is also a need for recognition that the value of collaborative approaches in achieving social change may not be solely, or best, reflected via peer-reviewed publications (Nyden 2003) and narrow, biomedical health outcomes such as HIV prevalence, condom use and clinic attendance (Cornish and Campbell 2009) – however important these issues are. There is considerable research expertise within the sex worker rights movement, but there is scope for appropriately resourced peer reviewing and mentoring schemes, whereby academics support sex workers who want help with (health-)related publishing and sex workers act as (paid) reviewers and contributors to academic publications of relevance and interest to them.

Collaborative approaches remain highly contingent upon funding environments. A number of funds are led by or involve sex workers in decision making, but a minority of funding for sex workers' health goes to sex-worker-led organisations (Mama Cash, Red Umbrella Fund and Open Society Foundations 2014) and major governmental donors retain considerable influence. Since 2002, all recipients of funding from the U.S. Presidents' Emergency Relief Fund for AIDS have been required to state their opposition to prostitution and barred from any activities supporting decriminalisation – with a subsequent legal challenge exempting U.S.-based, but not overseas, organisations (Ditmore and Allman 2013). This has forced many sex work projects internationally to seek funding elsewhere, compromise their activities or close down (Ditmore and Allman 2013; Busza 2004). The requirements of international funders can also pose barriers to sex workers' meaningful involvement even in programmes aimed at community mobilisation. In Kolkata, Cornish et al. (2012) demonstrate how sex worker organisations have had to adapt to funders'

‘impenetrable ... policies and administrative procedures’, including globalised monitoring standards, which threaten to undermine the grassroots approaches they seek to support.

We urge (public) health professionals to collaborate with diverse sex worker stakeholders, over the funding, design, implementation and evaluation of health programmes and research. Such efforts must seek to set agendas and generate knowledge that reflect the diverse needs, identities and realities of people who sell sex. This requires our openness to share control, learn from sex workers and reflect critically on our practices and assumptions; a commitment to incorporating such learning into training programmes, service delivery and research; and willingness to challenge linked bureaucratic and political barriers. We must also support sex workers’ efforts to gain access to political and educational spaces from which they may have been excluded (e.g., local and national government, universities, funding boardrooms).

Advocating for Laws and Policies That Protect Sex Workers’ Safety, Health and Rights

Historically, public health professionals advocated the regulation of prostitution, obliging women who sold sex to undergo mandatory venereal disease screening (Drinot 2006). This approach, still in place in a number of countries, constructs sex workers as ‘vectors of disease’ (Foucault 1998), while recent laws mandating annual psychological consultations reproduce notions that sex work is inherently damaging (Macioti, Grenfell and Platt 2017). Sex worker activists have been outspoken in their condemnation of such approaches, but public health and medical professionals have often remained silent. The more common contemporary terrain of harm reduction is founded on the principle of minimizing exposure to HIV and wider harms such as violence, discrimination, debt, criminalisation and exploitation, while seeking to avoid moral judgement over sex work – reflecting important advances in service provision (Rekart 2005). Yet even these approaches can

inadvertently contribute to framing sex workers as either risk producers or passive recipients of risk (Krusi et al. 2016).

Internationally, sex worker rights activists have been instrumental in developing policy positions and HIV guidelines that advocate sex-worker-led interventions, decriminalisation and recognition of labour rights (Overs 2002; WHO et al. 2013; Ahmed 2011; also see the chapter by Abel in this volume). Public health and medical professionals are joining calls for the decriminalisation of sex work, including of clients and third parties, coupled with sex-worker-led interventions that challenge stigma and structural injustices (Grenfell et al. 2016; ICRSE 2014; Shannon et al. 2015; WHO et al. 2013). Nevertheless, some appear reluctant to engage in such debates (Forbes 2010). This may, in part, reflect positivist notions that health ‘evidence’ and ‘experts’ are separable from their political context. Yet paradoxically, it also stems from the influence of abolitionist campaigning in spite of extensive literature demonstrating the harms of the approaches they advocate, such as criminalising clients (Krusi et al. 2016). Forbes (2010) attributes the U.S. medical community’s silence over the harms of criminalisation to their emphasis on responding to trafficking and a lack of training on sex workers’ health. Last year, the British Medical Association voted not to pass a motion supporting decriminalisation following heavy campaigning by an organisation advocating the ‘Nordic model’ (Nordic Model Now 2017). Other practitioners specifically advocate the criminalisation of clients, ignoring or disregarding as ‘biased’ (Byng, Story and Callaghan 2016) evidence of this legal model’s harmful effects – the Irish Medical Organisation’s representation to the government making no reference to critical studies (FitzGerald and McGarry 2016). Abolitionist groups have also suggested that Amnesty International’s support of decriminalisation was grounded in a singular focus on HIV, privileging clients’ health over women’s lives and not accounting for ‘the intersectionality of race, gender and

inequality’ (Coalition Against Trafficking in Women 2015) – a misrepresentation of both Amnesty’s policy and harm-reduction efforts (Rekart 2005). Public health work has undoubtedly centred on HIV, at times with a greater focus on population health than that of sex workers. Yet support for decriminalisation reflects a departure from these shortcomings, in response to extensive evidence of how criminalisation compromises the safety, health and service access of people who sell sex, particularly those who are marginalised based on their gender (identity), race, immigration status, poverty and/or drug use (Crago 2009; Platt et al. Forthcoming).

We consider decriminalisation a vital step towards redressing the injustices that sex workers experience, but this must be accompanied by inclusive health, education, welfare, employment and immigration policies, and funding for integrated, specialist and sex-worker-led services. In the UK, where we are witnessing major cuts to public health funding, restrictive immigration and austerity agendas, and where sex work is increasingly framed as an issue of ‘community safety’ and violence against women (Grenfell et al. 2016), there is a pressing need for (public) health professionals to speak out. We urge our colleagues here and internationally to join advocacy for sex work laws, health and social policies that protect sex workers’ safety, health and access to services. This includes calling out policies and practices that stigmatise sex workers, whether by mandating HIV testing and psychological assessments or by constructing sex workers as deviant, risky, or powerless victims. We can do so by engaging in policy consultations and calls for evidence, but also by supporting sex workers’ reactive campaigns to counter the use of flawed research and arguments.

Conclusion

Public health occupies a unique position in relation to the governance and study of sex work that, far from being disconnected from related politics and power relations, is implicated intricately.

Through the sustained efforts of sex worker rights activists and allies, (public) health has become a platform for collaboration, reflected in the funding of services for and by sex workers, sex workers' involvement in health policy fora and public health professionals' participation in advocacy for legal reform. However, some (public) health policies, practices and discourses related to sex work continue to reproduce shame, blame and exclusion, and it is vital that we reflect critically on our own roles in reproducing and reworking underlying power relations. We call for a broadening of the public health agenda, to reflect sex workers' diverse professional and personal health needs, with expanded attention to criminalisation, stigma and other macrostructural, community and work environment influences, as well as sex workers' individual and collective agency. This will require close attention to the everyday gendered, racialised, postcolonial and economic power relations that work to limit, or through their resistance offer, possibilities for sex workers to organise, protect their health and safety, and access health, social care and justice. Recalling the concept of the risk environment, such efforts may help us to reimagine relations of power and risk with a view to the production of safe, healthy and transformative environments by and for sex workers. We encourage critically reflective, collaborative and interdisciplinary approaches that operate in full partnership with sex workers, reflective of their diverse identities and lived experiences; that challenge the power afforded public health academics, agencies and policy makers; and that recognise the knowledge, skills and experience that sex-working and non-sex-working researchers bring to such collaborations. Finally, we urge (public) health professionals to speak out in debates over sex work laws, antitrafficking policies and related austerity and anti-immigration agendas, that threaten sex workers' safety, health and rights. Such efforts would recognise that goals of addressing health inequalities must align with those seeking social justice for, by and with people who sell sex.

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¹Community fieldworkers and co-researchers include people who have experience of sex work themselves or of working closely with sex workers in sex worker organisations or outreach programmes; we do not differentiate between sex-working and non-sex-working researchers, so that sex workers can participate in research teams without having to disclose their sex work if they do not wish to.