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Review of clinical and health promotion services for sex workers in Western Australia

Prepared for the Communicable Disease Control Directorate,
Western Australian Department of Health



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This report was prepared for the
Communicable Disease Control Directorate,
Western Australian Department of Health

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Acronyms

BBV	Blood Borne Virus
CALD	Culturally And Linguistically Diverse
DH	Department of Health
FPWA	Family Planning Association of Western Australia
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use/r
MSM	Men who have Sex with Men
PAG	Project Advisory Group
SHBBVP	Sexual Health and Blood Borne Viruses Program
STI	Sexually Transmissible Infection
SWOPWA	Sex Worker Outreach Program Western Australia
UAI	Unprotected Anal Intercourse
WA	Western Australia

Executive Summary

Background

The Western Australian Department of Health's public health response to HIV/AIDS and other sexually transmitted infections (STI) in Western Australia (WA), as well as national HIV and STI strategies, include sex workers as a target population for clinical services and health promotion. Strategies, actions and programs for prevention work in this population are outlined in the WA STI Model of Care Implementation Plan 2010-2014 and the WA HIV Model of Care Implementation Plan 2010-2014 documents.

The Sexual Health and Blood Borne Viruses Program (SHBBVP) in the Department of Health has overall responsibility for the Implementation Plans and contracted the Burnet Institute to conduct a review of public health programs and services outlined in these plans and aimed at the prevention and control of HIV and other STI among sex workers in WA.

The objectives of this review are to:

1. Describe the sex industry in WA and describe trends of HIV/STI among sex workers using available data sources;
2. Identify the determinants of health care seeking behaviour among sex workers in WA and identify gaps in service provision and barriers to implementation of STI and BBV prevention and control initiatives;
3. Assess the extent to which recommended actions and guiding principles have been implemented and adopted, specifically with relation to sex workers and BBV and STI prevention within WA's strategies and plans, and assess their appropriateness to the current context; and
4. Make recommendations on delivering preventive services to sex workers in urban and rural settings.

Methods

This evaluation was guided by an Advisory Group and used a method which involved a situation analysis and a document and literature review relying on available sources as well as the collection of novel data through in-depth interviews of provider and consumer group stakeholders and a self-completed sex worker survey. A thematic analysis based on the synthesis of responses from these data collections was conducted to inform a critical analysis of clinical and health promotion programs for sex workers in WA.

Results

The sex industry in WA: The sex industry in WA is relatively small when compared to those in the Eastern states of Australia. However, there are particular barriers to service delivery in WA stemming from both the small industry and the diversity within it. The sex industry in WA spans a much larger geographical region by comparison to most other states and this presents unique challenges to reaching sex workers when considering the transiency of workers and the criminalised setting of the industry. The size of the industry is difficult to estimate because of the many illegal aspects that compel many sex workers to be discrete about

their profession. Further, many sex industry businesses and escort services will change their name, address and contact details to avoid police surveillance.

HIV and STI in sex worker populations: It is largely accepted in Australia that the rates of HIV infection and other STI among female sex workers are low compared to the general sexually active community, and this is true of WA. There are however, sub groups of sex workers that are likely to be more at risk and for which little is documented in terms of sexual health (e.g. male and transgender sex workers, CALD sex workers, street workers).

The determinants of health care seeking: The barriers to sex workers accessing clinical and health promotion services that were identified in this review through both the stakeholder interviews and consumer surveys were categorised in broad themes that include the diversity of sex workers in the industry and their mobility as individuals. These present challenges in estimating the size and location of sex worker communities which lead on to issues of reach and accessibility for sex worker services. Also identified was the criminalised and stigmatised environment that sex workers are working in and how this impacts on their ability to disclose their sex work and hence access comprehensive health care.

The gaps in service provision: The gaps in service provision from sex worker services also impacts on the overall health and wellbeing of the sex worker communities and those identified were: the turnover of program staff; inadequate hours of operation; lack of peer education; lack of sex worker involvement in program planning and delivery; the low profile of the programs themselves and the acknowledgement that some sex workers in WA are hard to reach and require targeted approaches.

The extent to which recommended actions have been implemented: The extent to which Magenta and/or SWOPWA have implemented the actions outlined for them in the WA STI Model of Care Implementation Plan 2010-2014 and the WA HIV Model of Care Implementation Plan 2010-2014 was also assessed.

The clinical and health promotion services offered by Magenta and SWOPWA programs address many of the actions outlined in the these Implementation Plans however just as many gaps in service implementation have also been identified which could be impacting on the reach and coverage of services to sex workers in WA as well as the continued engagement of sex workers with the programs. It was also identified that some of the outcomes outlined in the strategies are compromised by the limited level of a peer based approach within the Magenta and SWOPWA programs.

These gaps can be summarised in the broad areas of staffing and resourcing, lack of peer education and other input from sex workers and the need for improved collaborations and methods of service delivery; alongside these is the need for continued and enhanced data collection. The following recommendations were made.

Recommendation 1: Explore staff incentives and ways of retaining corporate knowledge

FPWA should explore and provide meaningful benefits for retaining valuable staff, for example career development opportunities.

To enhance follow up and continuity of service, Magenta and SWOPWA should create a culture where knowledge is shared and consistently recorded in order to minimise disruption in service delivery.

SHBBVP should consider options to facilitate full-time employment of staff to address multiple needs such as retaining staff, increasing service coverage and hours of operation.

Recommendation 2: Develop processes to support the employment and retention of peer workers at Magenta and SWOPWA.

FPWA should promote and facilitate the employment of sex workers or those with previous sex work experience as peers for the delivery of Magenta and SWOPWA services. This should include sex workers from the targeted language groups.

FPWA should explore models of peer-worker involvement and training that have been implemented with other relevant risk populations (e.g. people who inject drugs and men who have sex with men) and other sex worker programs (e.g. Sex Industry Network, South Australia) in order to inform similar approaches to sex worker services in WA.

Recommendation 3: Involve and engage sex workers in all aspects of health service planning, policy and service delivery.

Sex workers representing the diverse sex worker communities should be invited to consult on decisions made around new initiatives at the program level. Potentially useful approaches would be through the invitation of sex workers to internal meetings or by running consultation focus groups and planning days and methods to incentivise participation (e.g. payments for volunteering time) should be explored.

Consideration should be given to establishing advisory structures for peers to represent the various subgroups of sex workers. Such structures could potentially sit within the current governance and/or management structure of Magenta and SWOPWA (FPWA) and used to inform strategic direction and provide feedback to management and government.

To allow effective peer involvement and meaningful contribution, suitable sex worker representatives should be selected and supported in their role by providing appropriate training to build knowledge and skill around working as a consultant in the chosen structure (AIVL, 2006).

Recommendation 4: The programs should continue their existing collaborations and continue to identify partnership opportunities, particularly in rural and remote areas and in clinical settings.

Magenta and SWOPWA should continue to consult with major stakeholders such as local police and WASUA and continue to identify partnership opportunities like these that can mutually enhance the capacity of organisations to service sex workers. These partnerships could be formalised with documented project plans that include timelines, resources, outcomes, objectives and outcome measures.

Magenta clinic staff should facilitate the integration of sex workers into mainstream clinical services by using such methods as written referrals to the new doctor which has shown to be effective in enhancing the relationship between the patient and new doctor and reducing loss to follow up. A similar method should be used when referring sex workers to services in rural/remote WA.

Magenta outreach staff should investigate ways for their services in remote and rural areas in WA to be promoted and facilitated by those local services. Consider the possibilities for sexual health nurses to accompany them on outreach and/or community and peer educators from the area to continue outreach in the periods between Magenta visits with Magenta's guidance and resources.

Recommendation 5: Build on current responses to HIV and STI prevention in sex worker communities, enhance capacity for these activities to ensure adequate reach and coverage and implement evidence based approaches.

Develop a regular and consistent approach to providing health promotion, such as peer education and extended hours of outreach, to continue to support and educate this mobile and diverse group. Supplement these approaches by utilising as many forms of media as possible to improve the profile and visibility of Magenta and SWOPWA programs in sex worker communities.

Magenta and SWOPWA programs should monitor, document and report the impact of legislation and policy on sex workers' health and safety in WA. Information, trends and issues identified should be used and reported to inform the basis of advocacy around the legal and policy impacts on sex workers and service delivery.

Further to Section 4.4.2, opportunities should be sought to involve suitably skilled and experienced sex workers in the education and guidance of sex workers new to the industry.

Build on recommendations outlined in 4.4.3 to use collaborations to efficiently deliver health promotion and services. Explore ways to provide coordination of provision of health promotion and clinical services to sex workers in regional and remote areas and enhance partnerships between regional and remote hospitals, sexual health services and public health units.

Recommendation 6: Extend data collection

Evaluation, surveillance and research activities should be embedded into the work of many programs and services. The identification of appropriate measures for the assessment of the effectiveness of the programs should be developed. Consideration of the capacity of programs to collect and interpret such data should be taken when devising such data collection processes and capacity building, skills training and/or out-sourcing of some surveillance and evaluation activities should occur.

Research methods for collecting data from sex worker subpopulations where knowledge is lacking (e.g., male sex workers, CALD sex workers, private workers and regional and remote workers) should be developed and considered.

The SHBBVP should consider establishing sentinel surveillance for clinics that are known to routinely see sex workers to better capture the testing behaviour, outcomes and risks associated with sex work in WA.

Preface

Background to review

The Western Australian Department of Health has a long-term and on-going commitment to funding health promotion and clinical services for sex workers as part of the national response to the prevention and control of HIV/AIDS and other sexually transmissible infections (STI) within Western Australia (WA). Services that exist for sex workers have been provided through public health units and state-funded clinical services as well as community-based non-government organisations. The principal community-based non-government organisation providing health promotion and clinical services to sex workers in WA is Family Planning WA through two programs: Magenta (sex worker support service) & Sex Worker Outreach Project WA (SWOPWA).

In May 2008, the Kirby Institute (formerly the National Centre for HIV Epidemiology and Clinical Research) at the University of New South Wales provided a report for the WA Department of Health to inform policy considerations for legislation of the sex industry in WA. This work was a continuation of the Law and Sex Worker Health (LASH) project funded by the National Health and Medical Research Council to investigate the various legislative approaches across Australian jurisdictions and their association with health and welfare outcomes for sex workers. The report compiled by the LASH team recommended that the WA Department of Health “commission an independent review of clinical and health promotion services available to sex workers” [1]. Following this recommendation, the Burnet Institute was contracted by the WA Department of Health to conduct a review of public health services aimed at the prevention and control of HIV and other STI among sex workers.

Objectives of the review

The objectives of this review are to:

1. Describe the sex industry in WA and describe trends of HIV/STI among sex workers using available data sources;
2. Identify the determinants of health care seeking behaviour among sex workers in WA and identify gaps in service provision and barriers to implementation of STI and BBV prevention and control initiatives;
3. Assess the extent to which recommended actions and guiding principles have been implemented and adopted, specifically with relation to sex workers and BBV and STI prevention within WA’s strategies and action plans, and assess their appropriateness to the current context; and
4. Make recommendations on delivering preventive services to sex workers in urban and rural settings.

Project Advisory Group

A Project Advisory Group (PAG) was established to guide the implementation of this review.

The PAG comprised of representatives from government, community service organisations, service providers, and consumer representatives in WA. Members included:

- Lisa Bastian, Western Australian Department of Health;
- Steve Blackwell, CEO FPWA;
- Janelle Fawkes, CEO Scarlet Alliance, Australian Sex Workers Association;
- David Lee, Melbourne Sexual Health Centre;
- Donna Mak, Western Australian Department of Health;
- Lewis Marshall, Sexual Health Physician;
- Meg Marshall, Scarlet Alliance WA Representative, Australian Sex Workers Association;
- Stephen Plecas, Manager Magenta FPWA; and
- Suzanne Wallis, Melbourne Sexual Health Centre.

The role of the PAG was to:

- Provide informed comment on the proposed method developed to undertake this project;
- Contribute to identification and linkages with organisations and services that provide clinical or health promotion services to sex workers in WA;
- Provide appropriate guidance and/or referrals for sex workers who participate in this project and who require health services and/or counselling after participation;
- Provide insight and expertise during the data collection phase of the review relating to clinical or health promotion services to sex workers in WA; and
- Review and comment on the final report produced for the WA Department of Health.

Structure of this report

Section 1: Sex work in Australia and public health responses

Section 1 provides a background to the sex industry in Australia and includes a description of the types of sex work, legislative approaches to sex work and clinical and health promotion programs targeting sex workers around Australia. This section also provides a summary of the national strategies for reducing transmission of HIV and STI in the sex worker population.

Section 2: Situation analysis of the sex industry in WA

Section 2 provides an overview of the sex industry in WA, describing the size, location, clinical and health promotion services available and the health status of sex workers in both metropolitan and regional/remote areas.

This section responds directly to Objective 1, described above.

Section 3: Critical analysis of clinical and health promotion programs in WA

Section 3 presents the findings from consultations with key informants in synthesis with results from the self-completed survey for sex workers with the aim of identifying barriers to implementation of clinical and health promotion services. This section also assesses the extent to which strategies identified in state-level action plans relating to HIV and other STI prevention in the sex worker population have been implemented and their appropriateness to the current context.

This section responds directly to Objectives 2-3, described above.

Section 4: Discussion and recommendations

Section 4 summarises the findings of the review and describe recommendations for future planning.

This section responds directly to Objective 4, described above.

Methods

The methods used for specific sections of the report are described according to the report structure. Some data collection-specific participant/sample characteristics are reported here, with findings reported thematically in the following sections.

Section 1: Sex Work in Australia and public health responses

A comprehensive review and collation of information specific to programs targeting sex workers was conducted to provide a background to sex work in Australia as well as health promotion and clinical service provision from a public health perspective. The document review included peer-reviewed manuscripts, government documents and grey literature.

A range of methods were used to collate literature, academic database searches, internet searches, and a review of reference lists in relevant published manuscripts and reports. Further information on public health responses was obtained through attendance at a sex work and health symposium as well as direct contact and in-depth interviews with key informants from relevant services outside WA to obtain supplementary information.

Section 2: Description of the sex industry in Western Australia: A situation analysis

A combination of internet searches, document reviews and leads from the PAG and other informants were used to identify available data sources to inform the situation analysis.

Internet-based review

We conducted an internet-based review to compile a description of the characteristics of the sex industry across WA. This included Google searches, online directories with adult services, brothels or escort agency listings, and online WA newspaper classifieds. Search terms such as “full service”, “full body massage”, and “top service” were considered indicative of sex work. Previously published reports were also used to supplement the description of the sex industry.

Document review

In addition to published research papers, to inform the situation analysis we reviewed several reports, policy and legislature documents, and government strategies to reduce HIV and other STI among sex workers which contained information specific to WA. These documents also included Magenta and SWOPWA service reports and contracts with the WA Department of Health as well as WA surveillance reports.

In-depth stakeholder consultations

Information gathered from the in-depth stakeholder consultations were used to add knowledge and context to the situation analysis. Within these consultations, verbal reports relating to local research conducted around the sexual health of sex workers in varying types of sex work was included. The method used in the in-depth stakeholder consultations is described under Section 3.

HIV and STI surveillance data analysis

To assess the sexual health of WA sex workers, HIV and STI surveillance data for the period 2001-2010 were analysed. These were provided by the Communicable Disease Control Directorate, Public Health Division at the WA Department of Health. Surveillance data on STI diagnoses in WA included, where complete, the occupation of the person at the time of their diagnosis. Cases where sex work was reported as the individual's occupation were compared to all other cases notified. Where possible, a statistical test of proportions was used to determine any significant differences between the two groups ($p < 0.05$). In addition to this, STI diagnosis data provided by one metropolitan sexual health service for the period 2006-2010 were examined.

Section 3: Critical analysis of clinical and health promotion services for sex workers in WA

In-depth stakeholder consultations

Stakeholders selected for participation in this review were drawn from two groups:

1. Provider representatives from government and non-government organisations that have key responsibility for implementing health interventions. Identification of relevant stakeholders was informed by input from the PAG, the document review and the situation analysis. Interviewed stakeholders also identified further stakeholders as suitable informants.
2. Consumer representatives from the sex industry. Sex workers were invited by referring staff from Magenta who could identify sex workers with sufficient experience to provide informed comment. Sex workers who consented to have their contact details passed on to the interviewer were contacted to arrange an appointment for an interview. Semi-structured in-depth interviews were designed to ascertain views of stakeholders regarding the features of existing health services, barriers and enablers to providing services, strengths and weaknesses of existing services, emerging issues in the sex industry and suggestions for future planning.

Telephone interviews were offered where face-to-face interviews could not be arranged (either because of timing of interviews or geographic barriers to participation). All interviews were documented through detailed notes and, where consented and logistically possible, by audio-recording.

A total of 28 key stakeholders from the provider group participated in an interview. The face-to-face interviews with key stakeholders took place during a two-week period which commenced 28th March 2011, after which all interviews were conducted by telephone. Key stakeholders located across WA, including Perth, Fremantle, Kalgoorlie and Port Hedland, were interviewed. Stakeholders included clinical representation, health promotion, education and support services, public health officials, outreach educators and nurses as well as Department of Health representatives.

Semi-structured in-depth interviews were also conducted with key consumer representatives selected by Magenta senior staff. Of the eight sex worker contacts provided, six sex workers were successfully followed up and interviewed. One interview was conducted face-to-face in Perth, the remaining five were telephone interviews.

Self-completed sex worker survey

A self-completed paper-based survey (also made available online) was distributed for sex workers to complete. The design of the survey and methods of recruitment was informed in consultation with the PAG, and staff of Magenta and Scarlet Alliance (Appendix 1). The survey consisted of a combination of closed and open-ended questions (Appendix 2) around involvement and awareness of the relevant services, health and welfare needs, and health seeking behaviour, perceived or actual barriers to health service uptake and the appropriateness of existing services to consumers.

Note: Multiple strategies were advised and adopted during the course of the review to recruit sex workers for both interview and survey participation. A detailed description of these can be found in the Appendix. Ethics approval for the recruitment of sex workers to participate in the in-depth interviews or the survey was obtained from the Alfred Hospital Human Research Ethics Committee, Melbourne.

A total of 100 survey responses were received; 14 hardcopy and 86 online. Among the online surveys, 53 were considered complete (that is, respondents went on to Section 3 of the survey). These surveys, together with the 14 hardcopy surveys, were included in the analysis (N=67). Table 1, below shows how sex workers who completed the questionnaire heard about the survey (where data were available).

Table 1 Completed surveys; where respondents heard about the survey

Recruited through:	n	%
Word of mouth - educator or nurse*	17	42.5
Magenta website	7	17.5
The West Australian personals	6	15.0
Word of mouth - other sex worker	3	7.5
Scarlet Alliance website	3	7.5
FPWA website	2	5.0
Received a text message	1	2.5
Other newspaper	1	2.5
Total	40	

**includes the completed hardcopy surveys.*

Note: this question was added 2 weeks after commencement of the online survey.

Section 1 Sex Work in Australia and Public Health Responses

The types of sex work in Australia and internationally vary by location or setting, recruitment of clients, remuneration, services provided and visibility. Similarly, sex workers are diverse in terms of their gender, sexual orientation, cultural backgrounds, and motivations or reasons for entering the sex industry. This heterogeneity should therefore be taken into account when reflecting on strategic policy directions, research and practice in relation to the provision of health and support services to sex workers.

1.1. Types of sex work in Australia

In Australia, the sex industry can be described as constituting four overarching but interlinked types of sex work; these are street based, brothel based, escort and private work. Sex workers may have worked in more than one type, either consecutively or concurrently.

1.1.1. Street-based sex work

Street-based sex work involves the solicitation of clients for sexual services in public or semi-public locations such as the street, parks or other public places, and the servicing of clients in these location or inside cars or short-stay premises [2]. It is estimated that street-based sex workers comprise between 1-2% of all sex workers in Australia, however globally street-based sex work is probably the most widespread type of sex work [2].

1.1.2. Brothels (legal and illegal)

Brothels are premises that are used explicitly for the purpose of providing sexual services by more than two sex workers [3]. In Australia they may be decriminalised and regulated by councils or legal or illegal and regulated by legislation or a licensing authority depending on the legislation in the state or territory; however it is important to note that illegal brothels still operate in states where sex work is legalised. There is anecdotal evidence that massage parlours also offer sexual services – or ‘extras’ – for financial return [4] particularly when the operation of brothels is illegal.

1.1.3. Escort work

Escort work involves a sex worker visiting a client at their home or hotel. Escort is arranged by the client directly with independent escort workers or through an escort agency (personal communication, Scarlet Alliance).

1.1.4. Private sex work

Private sex work involves the provision of sexual services in a private location, usually involving sole-operators. Private sex work may take place in a location sourced by the sex worker or from their home. Private sex work is typically advertised in the classified section of newspapers [5, 6]; anecdotal evidence

suggests that the internet is becoming a more frequent mode of advertising in recent years, particularly by urban-based sex workers. Due to the nature of their client recruitment, private sex workers are less visible.

1.2. Sexual health and wellbeing of sex workers

1.2.1. Prevalence of sexually transmitted infections

Sex workers in Australia generally have very low rates of STI compared to the broader sexually-active population. The national HIV prevalence among women reporting sex work as their occupation remained low at <0.1% since 2003, and this included those reporting injecting drug use (IDU) [7]. National sentinel surveillance of chlamydia showed that in 2010, in a network of sexual health clinics, the proportion of chlamydia tests returning a positive result among young heterosexual men and women was 16.3% and 15.6%, respectively compared to 5.6% among female sex workers [7, 8]. Further, a review of patient records at the Melbourne Sexual Health Centre between 2005 and 2008 found that while female sex workers accounted for 15.1% of total consultation time, only 3.2% of STI detected in this period were among female sex workers. Separate analyses of data collected by the Melbourne Sexual Health Centre have also found that sex workers are 10 times less likely than non-sex workers to contract an STI [9].

There has been a steady decline in STI among sex workers and their clients over the past decade, acknowledged to be a result of the consistent use of condoms by sex workers [1, 3, 10]. It is noted, however, that there is limited recent evidence on the prevalence of STI among various sex workers populations in WA (e.g., brothel-based, street-based and private sex workers). A summary of estimates of STI incidence and prevalence among sex workers in Australia is presented in Table 2 below.

Table 2 Incidence or prevalence estimates of STI among sex workers in Australia

Authors (year)	Location	Sex work description	Gender	Measurement	Estimate	Sample size	Source
Lee et al (2005)	Victoria (MSHC clients)	Brothel-based (requiring certificate of attendance)	Female	Incidence of any STI	Any STI 1.66/100 person months	388	[11]
Rowe (2011)	Melbourne	Street-based	Female (75), Male (7), Transgender (7)	Prevalence of HIV	1%	100 – 11 from Footscray, unknown gender	[4]
Estcourt et al (2000)	Sydney	Sex worker (not further described)	Males	Prevalence of one or more STI	31.9%	94 male	[12]
Estcourt et al (2000)	Sydney	Sex worker (not further described)	Females	Prevalence of one or more STI	15.6%	1671 female	[12]
Samaranayake et al (2009)	Victoria (MSHC clients)	Sex worker (not further described)	Female	Prevalence of one or more STI	1.9%	13440 consultations	[13]
Samaranayake et al (2009)	Victoria (MSHC clients)	Sex worker (not further described)	Male	Prevalence of one or more STI	8.4%	20471 consultations	[13]
Morton et al (2002)	Victoria (MSHC clients)	Brothel-based sex workers	Female	Prevalence of chlamydia	2.4%	3616 consultations	[14]

1.2.2. Sex workers with specific health and welfare needs

Much of the published evidence on the health status of sex workers, context of sex work and identification of higher-risk practices and settings for sex work in Australia have been focused in south-eastern Australia, specifically Melbourne and Sydney. There is limited evidence in both peer-reviewed and non-peer reviewed publications regarding sex work in WA. As such, the following discussion regarding sex workers with specific health and welfare needs are generalised and may not be representative of the sex industry or of sex worker communities in WA.

1.2.2.1. *Street based sex workers*

Street-based sex workers comprise the most vulnerable part of the sex industry [1, 15]. Street-based sex work is criminalised, and as such street-based sex workers are more susceptible to police interrogation, denigration by the public and violence and sexual assault than other types of sex workers [4, 16]; as a result, many sex workers regard street-based sex work as undesirable [2]. IDU is prevalent among street workers, and it is hypothesised that the financial burden of drug use can influence the ability to negotiate safe sex [4]. This, alongside anecdotal evidence that the demand for unprotected sex has increased in recent years [4], the risk of HIV and STI could be increasing in this group.

1.2.2.2. *Sex workers who inject drugs*

As referred to above, a meaningful proportion of street-based sex workers are reported to be IDU, with Harcourt et al reporting over 80% of a sample of street-based sex workers in Sydney reported ever injecting drugs [17]. IDU are at increased risk for exposure to hepatitis C (HCV) as well as a range of additional adverse mental and physical health outcomes [18]. Sex workers who are IDU are more likely to be homeless or at risk of homelessness, and less likely to have supportive relationships than other sex workers [18].

1.2.2.3. *Culturally and linguistically diverse sex workers*

Whilst acknowledging that culturally and linguistically diverse (CALD) sex workers are a diverse group, CALD sex workers are likely to experience more pronounced barriers to maintaining health and wellbeing when compared to sex workers from non-CALD backgrounds. Sex workers from CALD backgrounds are more likely to face socio-cultural and political barriers such as language difficulties, unfamiliarity with the Australian health care system, ineligibility for public health services, and difficulties interpreting legislation relating to sex work (Brewer, 2009). Further, CALD sex workers that are working illegally may be in breach of visa conditions, leaving them vulnerable to arrest, detention and deportation [4]. Anecdotal evidence from service providers suggests that the cultural backgrounds of CALD sex workers have changed over time. Over the past ten years, cultural backgrounds have shifted from being largely Thai to Chinese and Korean.

Sex workers from CALD backgrounds are disproportionately affected by hepatitis B virus (HBV), given the majority of CALD sex workers in Australia are from countries with high rates of chronic HBV [19]. Sex workers from CALD backgrounds may also experience significant barriers to access testing and treatment for chronic HBV due to both socio-cultural and political barriers.

1.2.2.4. *Transgendered sex workers*

The word "transgender" incorporates both transsexuals and transvestites. In many countries, including Australia, transgender sex workers are a significant part of the sex industry. Similarly, sex work is a significant

part of the transgender community. A study of 146 transgender people in Sydney revealed that 45% had spent some time working in the sex industry and 70% of these had worked on the street [17]. It is noted that transgendered people are motivated to work in the sex industry for several reasons, including earning an income, discrimination in employment, rejection by families and communities, mobility, tradition, and psychological factors [20]. Whilst acknowledging that transgendered sex workers, as with all sex workers, have had different experiences of the industry [20], there is evidence that transgendered sex workers are more likely to have been sexually assaulted than those that have not engaged in sex work [21].

1.2.2.5. *Male sex workers*

The client base of male sex workers is predominantly male [2]. The prevalence of STI in male sex worker populations has been reported to be higher than that among female sex workers [12, 13] and contrary to female sex worker populations, there is also evidence that STI are increasing among male sex worker networks [22]. A recent study of Victorian sentinel surveillance data found the incidence of chlamydia among male sex workers to be higher than that among other men who have sex with men (MSM); 14.8 per 100 PY compared to 9 per 100 PY (Wilkinson, 2011 in review). It is suggested that sexual risk practices among male sex workers most commonly occur in their private lives and may be associated with increased prevalence of drug use and 'sexual adventurism' compared to other men who have sex with men; making sex work an indicator of increased STI transmission, but not a direct cause [11, 23].

1.2.2.6. *HIV positive sex workers*

Sex workers who are HIV positive experience discrimination on many levels, including discrimination from the community as well as being commonly criminalised for sex work in settings where sex work is decriminalised [24]. Many states and territories across Australia criminalise sex work when sex workers are knowingly infected with an STI. As a result, sex workers who are HIV positive are unable to work in the regulated market and are not adequately reached or supported by health promotion programs or clinical services [24].

1.2.2.7. *Sex workers working in a criminalised environment*

Health promotion and other public health activities are more effectively implemented in settings where the target groups are not clandestine, and proponents of a legislation and registration framework argue that a legislation and registration framework can have a key role in facilitating the effective delivery of such activities [15]. In addition, sex workers working in illegal brothels or in states where sex work is criminalised are more susceptible to a number of negative factors, including poor access from outreach activities provided by health and welfare services [1, 4]. These issues are addressed in greater detail below.

1.3. Legislative responses to sex work in Australia

Legislative responses to sex work in Australia is the responsibility of individual states and territories. There are three legislative frameworks that exist in Australia: decriminalisation, licensing and registration, and criminalisation [16, 25]. The legislative approaches to sex work across Australia (as at August 2011) are presented in Table 3.

Table 3 Legislative approaches to sex work around Australia

State or Territory	Legislative framework
Australian Capital Territory	Licensing and registration of brothels
New South Wales	Decriminalised
Northern Territory	Licensing of escorts employed by escort agencies; Private sex work legal; Brothels illegal,
Queensland	Licensing of brothels; Private sex work legal
South Australia	Criminalised (Commercial sex is not illegal, but being on premises frequented by prostitutes and receiving money in respect of prostitution are illegal)
Tasmania	Criminalisation of brothels: one or two private sex workers legal
Victoria	Licensing and registration of individual sex workers and brothels
Western Australia	Criminalised (private work is legal however street work is illegal, as are brothels), with proposed changes to the licensing and registration model in 2011

Source: Scarlet Alliance [26]

1.3.1. Decriminalisation

Decriminalisation of the sex industry involves the removal of the criminal sanctions overseeing sex work, and enables regulation through other occupational means such as workplace occupational health and safety and public health practices [25]. Decriminalisation does not infer that sex work is unregulated; rather, it infers that regulation is not applied through the criminal law [15]. The establishment of brothels under a decriminalised framework become subject to planning laws, administered by local governments. In Australia, New South Wales is the only state to have decriminalised all forms of sex work [26].

1.3.2. Licensing and registration

The licensing and registration model of the sex industry involves the removal of criminal sanctions however it imposes a number of requirements via licensing restrictions or registration requirements. Licensing of the sex industry is determined by individual states and territories, and may involve establishments or individuals applying for and securing a license to operate, or a range of additional stipulations attached to the licence, such as the requirements for sex workers to undergo regular sexual health examinations and provide proof of such in order to work in licensed premises [14, 15]. A licensing and registration model is the most common legislative approach to sex work in Australia, with various models of implementation relating to who is required to be licensed and/or registered [14, 15].

1.3.3. Criminalisation

The criminalisation approach to sex work is where selling sex and/or buying sex is a criminal act, regardless of the type of sex work (e.g. brothel-based, street-based or private work). The legal status of sex work in

states and territories where sex work is criminalised may differ, and sex work itself may be legal whilst activities relating to sex work is illegal, such as promotion of employment for staff to work in sex work establishments, seeking someone to be a client of a sex worker, inducing someone to act as a sex worker or keeping premises for the purposes of sex work [13, 25].

1.4. Impact of legislation on public health

1.4.1. Decriminalised sex work

It is widely acknowledged that an environment where sex work is decriminalised results in better public health outcomes for sex workers and the broader community [6, 11, 27]. The health of sex workers is improved in environments where sex workers have control over their work choices, are able to effectively negotiate condom use, able to earn a reasonable income, and be supported by both health services and community based organisations [2, 28, 29]. Decriminalised sex work environments encourage such outcomes. In addition, when criminal sanctions are removed from sex work, regular labour and occupational health and safety laws apply, thus improving working conditions and standards for sex workers [28].

It is argued that New South Wales, with decriminalisation of sex work, has one of the most effective and successful models to minimise public sexual health risks posed by sex work [1, 24, 27, 28]. Evaluation of the New South Wales decriminalised and unregulated model has found no evidence that decriminalised and unregulated sex work have increased demand for commercial sex; rather, it is asserted that the decriminalised environment allows for collaborative partnerships between government and sex worker organisations and programs, as well as achieving high condom usage rates and low transmission rates of HIV/STI [1, 28, 30].

1.4.2. Licensing and registration of sex work

In legal brothels in states where sex work is underpinned by a licensing and registration framework (such as Victoria) a range of stipulations may be attached to the licence. For example, in Victoria brothels are required to sight evidence that sex workers working in their establishments have undergone sexual health screening [11]. In some states, individual sex workers and brothels are required to obtain a licence from government departments in order to practice legally (refer to Table 3). Such stipulations are argued to be counterproductive to improving the public health of sex workers. They are argued to be both stigmatising and act as a disincentive to register, potentially pushing sex workers further underground and increasing the number of sex workers working in the unregulated market; thus increasing their potential exposure to violence and exploitation and reducing their access to services [11].

In a report to the WA Government, Donovan et al asserted that “*licensing represents a potential threat to public health*”, and that a legislative framework “*should not be regarded as a viable legislative response*” [1]. In settings where individual sex workers are required to be registered, it is argued by The Scarlet Alliance that licensing and registration of individual sex workers requires workers to decide between “*abiding by the law and putting their own safety at risk*” [31]. For example, outreach activities may only be delivered to brothel-based sex workers identified via a register of approved brothel licenses. This approach highlights a major public health issue with such systems, whereby outreach activities are confined to licensed brothels and do not reach illegal brothels that potentially employ more vulnerable sex workers. For example, the

service agreement for the Victorian Government-funded RhED program only allows provision of outreach services to licensed brothels [1, 15].

Harcourt et al and others argue that one of the concerns relating to licensing systems is the administrative costs to maintain such systems and unnecessary health screens which diverts important resources from more productive health programmes [15, 32]. For example, sex workers in Victoria are currently required to undergo regular screening for a range of STI. The argument for routine STI screening among sex workers under a regulated framework is that sex workers are at increased risk of STI given their increased exposure to ‘risk events’. There is, however, little evidence to support this, with evidence to the contrary suggesting that sex workers in Victoria do not have higher rates of STI when compared with non-sex workers [3]. In fact, a number of studies have found that sex workers have lower rates of STI than non-sex workers [13]. Given the lack of evidence supporting the need for routine screening of sex workers, there have been calls for Victoria to reduce the frequency of STI screening for sex workers [9, 13, 32]. Advocates for reduced frequency of STI screening highlight the great strain placed on public and private sexual health services to provide such services; for example, Melbourne Sexual Health Centre reported that monthly screening of sex workers consumed 15% of clinical hours despite the rate of STI detection being one-third that of other clients attending the clinic [13]. Advocates for reduced frequency of screening also suggest that such requirements may constitute insensitive or inhumane treatment of sex workers, poor-quality examinations and breaches of confidentiality [2, 27]. Regulatory frameworks are criticised as they “*enforce invasive sexual health screens on sex workers, regardless of the worker’s symptoms, work practices and consent*” [15]. The Victorian Sex Work Act 1994 has been recently amended to include a change from monthly STI testing to a time period gazetted by the Minister for Health however, to date, the required frequency has not changed.

1.4.3. Criminalisation of sex work

Sex workers working in settings where sex work is criminalised have been shown to be more vulnerable to STI, violence and exploitation [4, 15, 27]. Sex workers working in settings where sex work is criminalised are more likely to experience sexual assault when compared to other sex workers [29, 33] as well as having reduced access to health promotion and public health activities [1, 27]. For example, Donovan et al’s report to the WA Department of Health noted that Magenta, the organisation charged with delivering health promotion services to the WA sex industry, had limited access to most brothels due to the illegal status of the industry [1]. Similarly, in Victoria, RhED receives government funding limited to providing outreach services to registered brothels only (personal communication, RhED, 2011). An exception to this is the Hustling to Health Programme run by RhED to support street-based sex workers.

The frequently stated objective of criminalisation of sex work is to reduce the size of the industry, however there is no evidence that criminalisation of sex work has decreased the size of the commercial sex industry [15]. Rather, the effect of such an approach has resulted in reduced access of sex workers to health promotion and public health activities including a range of legal, welfare and other support services. Similarly, Harcourt notes that law enforcement directed primarily at visible prostitution, i.e. street-workers is not productive as it does not address the underlying causes of social harms, and it may increase coercion and exploitation by encouraging street-based sex workers to seek protection from pimps and other criminals [15].

1.5. Policy approaches to promoting the health of sex workers

1.5.1. National strategies to reduce HIV and STI transmission

The Australian Government Department of Health and Ageing, as well as individual state and territory governments, have prepared framework documents outlining the national strategy and state and territory level strategies or implementation plans, to reduce the transmission of, and the morbidity, mortality and personal and social impacts associated with, STI and HIV. These have been developed to guide governmental policy and funding, and have been developed with significant input from community organisations, researchers, clinicians and health sector workforce organisations. Key prevention initiatives and action items are suggested in each document, which, in the context of funding arrangements, should be progressed through the relevant organisations to achieve the desired outcomes.

At a national level, the Sixth National HIV Strategy (2010-2013) guides Australia's response to HIV and identifies sex workers as a priority population due to their *"significantly higher number of sexual encounters than other community members leading to an increased potential for transmission of HIV if safe practices are not adopted"* [34]. The National HIV Strategy states that support should be provided for community based sex worker organisations to provide peer education and outreach and to ensure sex workers are able to maintain safe sex practices. The Strategy identifies high priority subpopulations that require specifically tailored and targeted interventions, including transgender sex workers, street based sex workers, Aboriginal and Torres Strait Islander sex workers, CALD sex workers, sex workers who inject drugs, and male sex workers [34].

The Second National Sexually Transmissible Infections Strategy (2010-2013) also identifies sex workers as a priority population for action in the prevention and management of STI [35]. It also notes the importance of organisations and programs to provide education and outreach to sex workers. Emphasis is placed on ensuring safe sex practices are implemented and maintained to reduce the transmission of HIV and STI and the morbidity and mortality caused by these infections. The National STI strategy also suggests monitoring policy and legislation affecting sex workers, as well as ensuring a strong partnership exists between government and community-based organisations to achieve its aims. The strategies and plans are very broad, allowing for flexibility as new issues emerge. The National STI Strategy further notes that voluntary testing is recognised as a successful approach to detecting STI, and refers to the cost-benefit analysis findings that reported mandatory testing of sex workers as unnecessarily frequent and excessively expensive [32].

The National Hepatitis B Strategy (2010-2013) identify people from CALD backgrounds as a population prioritised for prevention of HBV transmission and unvaccinated sex workers as a population of interest. The Strategy notes that peer education has a role in increasing awareness on availability of vaccination to all sex workers [19].

1.5.2. Government funded sex worker health promotion programs

In each state and territory a community based sex worker organisation or program is resourced to implement health promotion work including HIV and STI prevention. The latest National HIV and STI Strategies include the support for community-based sex worker organisations to provide peer education as a priority action. This builds on Australia's successful response to HIV which was based on a partnership approach between Government and communities affected by HIV and STI. The involvement of the sex worker community in Australia's response to HIV and STI is generally recognised as contributing to the success of community-driven health promotion and peer based interventions [34, 35]. Such organisations have been the drivers behind *"the establishment of safe-sex as a norm, the availability of safe-sex equipment, and community-driven health promotion and peer based interventions"* [35].

At the time of writing, in all states and territories, with the exception of Tasmania, governments have allocated funding to non-government organisations to provide health promotion for sex workers. Such health promotion services are provided via an organisation or program that specifically targets sex workers. A small number of the programs also partner with clinics to provide clinical services. These health promotion programs are generally state or territory-wide however they are commonly located in capital cities; the majority employing sex workers to deliver peer education. Program delivery is typically via a shopfront service which provides a range of on-site facilities as well as telephone, online and outreach services [27]. A number of key services are provided in all programs, such as outreach, however there is variation of the provision of other services such as clinical services or injection equipment. An overview of government funded sex worker health promotion programs across Australia is presented in Table 4.

The following is a description of services commonly available through sex worker health promotion programs across Australia.

Outreach programs

Outreach is delivered in a variety of settings including the street, brothels or via off-site clinics and is particularly useful for delivering services to sex workers living in regional or remote settings. Outreach is considered a key component of all public health programs targeting sex workers across Australia. Outreach is generally viewed as an appropriate strategy because it reaches sex workers at locations that may be confidential or generally inaccessible. Outreach services are also commonly provided after regular business hours to be made more accessible to sex workers.

Peer education

Peer education is based on the understanding that individuals are best supported and motivated by their peers. It differs from peer based organisations in that peer education models may exist within broader health or community programs or be government funded. Peer education is a two-way exchange of information, knowledge sharing and strategy development and is recognised within the National HIV and STI Strategies as a successful approach to prevention.

Peer education has generally been implemented in Australia via the employment of current or former sex workers (self-identified) to engage with other sex workers, provide outreach as well as health and legal

information. Peer educators engage with sex workers, provide outreach and provide health and legal information and generally do not require formal qualifications or training.

Sexual health clinical services

Several programs in Australia currently provide sexual health clinical services through their shopfront. Clinical services may be provided by the state-wide sexual health clinic as part of their outreach program or by the umbrella organisation. Sexual health clinical services may include providing sexual health screening, sexual health screening certificates (if required) and a range of other sexual and reproductive health services.

Legal information

A number of sex worker public health programs in Australia currently provide information on the legal status of sex work as part of their program. Provision of legal information to sex workers is seen as an important component of public health services to sex workers, given the influence of legislation on their safe work practices, health and welfare.

Industry exit support

A limited number of programs in Australia provide support services for sex workers who wish to leave the industry. These programs may be case managed and include a range of support services such as housing, health and welfare, counselling, legal, financial, education and training, employment and social and recreational support.

“Ugly Mugs”

Several sex worker organisations and programs throughout Australia maintain an Ugly Mugs report which is a documented list of the details of violent, threatening or abusive clients and incidents reported by sex workers. The Ugly Mugs report is used as a safety tool to warn sex workers on potentially dangerous clients and situations and is made available to sex workers through the shopfront, outreach and mailing lists.

Information, education and communication materials

All sex worker public health programs across Australia provide a range of resources for sex workers that include information, education and communication (IEC) materials. IEC materials are generally peer developed and peer tested. IEC materials may be developed locally, or provided by The Scarlet Alliance or other sex worker organisations.

CALD services

All sex worker organisations across Australia provide translated materials, mostly in Asian languages such as Mandarin, Cantonese and Thai. Online information is also translated. Some sex worker programs provide interpreter services or CALD outreach workers or peer educators to support those who do not speak English.

Regional and remote services

A limited number of sex worker programs around Australia provide outreach workers or regional branches to provide services to remote communities which include sex worker information packs safe sex supplies and referrals. For example, Respect Inc (Queensland) sends workers to different communities across the state as needed, while SWOP NSW has two regional branches and partners with remote clinics and health centres to provide sexual health services to sex workers in remote regions.

Table 4 Government funded sex worker public health programs

State	Program	Funding structure	Equivalent full-time positions^	Peer involvement	Services offered	CALD/ regional and remote services
New South Wales	SWOP NSW	A project of the AIDS Council of NSW	Approx 10 in Sydney, 1 regional	Employs peer workers Peer volunteers Peer reference group consulted at various times	Outreach; Peer education; IEC materials; Condoms and other safe sex equipment; Legal information; STI clinic; Other health services; Remote services	4 CALD workers (Thai, Chinese); translated resources; website information in other languages Outreach workers based at the ACON branches in the Hunter and Illawarra; and partnerships with local clinics and health centres; and website information
Queensland	Respect Inc	Service agreement held with Queensland Health	Approximately 3.6	Peer based	Outreach; Peer education; Drop-in; Resources; Information; Referrals; Condoms and other safe sex equipment; Education/training	CALD resources and packs translated to different languages. One part time bilingual peer educator (Asian languages) Outreach to communities all across QLD with packs, supplies, resources, information, referrals
Western Australia	Magenta - Sex Worker Support Project & SWOP WA	Programs of FPWA Sexual Health Services	7.16	Not peer based	Outreach; Drop-in/telephone; Condoms and other safe sex equipment; Education; Sexual Health Clinic; Referrals; Legal information; Other Information	CALD resources, information packs; website information in other languages Outreach to communities in Kalgoorlie with packs, supplies, resources, information, referrals
Australian Capital Territory	SWOP ACT	A program of the AIDS Action Council of the ACT	*1	Peer based Employs peer workers	Outreach; Peer education; Condoms and other safe sex equipment; Referrals; Information/Resources; STI prevention/education; Legal information; Sexual Health Clinic; Multicultural Project	Education and support to CALD workers; developed culturally appropriate resources in a number of languages; website information in other languages

State	Program	Funding structure	Equivalent full-time positions [^]	Peer involvement	Services offered	CALD/ regional and remote services
Victoria	Resourcing Health & Education (RhED)	A program of Inner South Community Health Services	Approximately 8	Employs peer workers, has a peer reference group	Outreach; Peer education; Drop-in/telephone; Counselling; Information, referral and advocacy; Sexual health screening, allied health services and health information; Condoms and other safe sex equipment; Supply of needles and syringes; OH&S education/support; Interpreter	Interpreter services; translated educational materials; website information in other languages; in the past have had a CALD worker employed, this is vacant at the moment as they do a needs analysis for the CALD community Conduct rural visits for sex workers in regional towns
South Australia	South Australian Sex Industry Network (SIN)	A program of the AIDS Council of South Australia	Approximately 5	Peer based; Employs peer workers	Outreach; Peer education; Drop-in; Condoms and other safe sex equipment; Referrals; Information/Resources; Specific projects – male, multicultural, trans or gender diverse, street work, Hep C	A multicultural project for migrant sex workers with Thai and Chinese speaking support and translated material No regional brothels; most workers who would go regional are based in the city so access services there; no specific regional/remote services
Tasmania	Scarlet Tasmania	A program of Scarlet Alliance	1	Peer based	Outreach; peer education; training; legal information	
Northern Territory	SWOP NT	A program of the Northern Territory AIDS and Hepatitis Council	2	Peer based	Outreach; Peer education, Information/resources; Education/training; OH&S; education/support; Sexual Health information	Some translated materials No regional/remote services

[^] For further information on staffing levels, refer to Appendix 3.

* Could not be contacted

1.5.2.1. *National sex workers association*

The Australian national sex workers association, Scarlet Alliance, is a community-based organisation with a membership of current and active sex workers, organisations and projects, with representatives in each state and territory. Scarlet Alliance plays an important role in the delivery of health promotion and clinical services to sex workers through several activities including advocacy, development of information, training of peer educators, education and communication materials, research, policy and legislature review [36]. Further description of Scarlet Alliance’s work can be found at: <http://www.scarletalliance.org.au/>.

Section 2 Description of the sex industry in WA: Situation Analysis

2.1. Legislation regarding sex work in WA

2.1.1. Current legislation and policing

Currently, sex work in WA is largely criminalised and overseen by the Prostitution Control Act (2000). Whilst private work is legal, the seeking of a sex worker or client in public view is illegal, as are all forms of organised sex work (i.e. brothels).

Under the current legislation, police have powers to:

- Issue a 'move on' notice to people loitering that they believe intend to or are committing an offence relating to sex work in or in view of a public place;
- Search and detain anyone (without a warrant) they think may be committing an offence or carrying anything that could be used as evidence if charged with an offence;
- Enter at any time (without a warrant) any place or business where it is suspected that sex work is being carried out; and
- Work undercover for the purpose of detecting the act of an offence [37, 38].

2.1.2. Proposed changes to legislation

The Liberal-National Government in WA announced plans to regulate brothels in 2009; since that time there has been considerable debate regarding the legislative status of sex work in WA. Draft legislation (known as a Green Bill) outlining the proposed changes to the prostitution laws in operation in WA was released for public comment in June 2011 [39].

In the proposed Bill, street based sex work will continue to be prohibited. Sex work will only be legal when it is conducted in premises that have obtained a license from a licensing authority. Sex workers may be able to work as sole-operators after obtaining a council approval which must be displayed on their wall or by entering into a contract of service with a specified sex work business (i.e. brothel) and then obtain a license from the licensing authority. Licenses for sex work will not be given to anyone or any business operating in a residential area and thus operating from home will not be legal [39].

2.2. Description of sex industry

Despite the criminalisation of brothel operation and street based sex work in WA, a thriving sex work industry exists in metropolitan, regional and remote areas.

2.2.1. Size and type of industry

A recent study of brothel-based sex workers estimated of the size of the sex industry in WA recorded to include approximately 520 brothel-based workers in any one year in Perth, as well as 50 private workers, 50

women providing escort services, around 25 female street-based workers and a small number of male and transgendered street-based sex workers [1]. It is also documented that the sex industry in Perth is smaller in comparison to Sydney and Melbourne [27].

It should be noted that it was beyond the scope of this review to measure the size of the industry or the number of sex workers. Nonetheless, our internet review to identify sex worker establishments and services state-wide identified 145 listings of brothels, escort agencies, massage parlours, and private workers in online directories and classifieds based in Perth and in regional and remote areas of WA. Magenta reviewed and validated this list, and noted that there were at least eighteen duplicates of services operating in the same venue. Magenta also identified an additional eleven brothels, escort agencies and massage parlours that were not identified in our review.

In the early 2000s the number of sex workers in WA was estimated at between 3000 and 3500 individuals [40] however with increased economic development in WA and population growth, as well as the technology available for online advertising it is likely to have grown since then.

2.2.2. Location of industry

Our review identified that the majority of brothels, escort agencies and massage parlours that advertise online are located in Perth, of which the highest proportion of identified establishments were in the Perth CBD, Victoria Park, and Burswood; this is consistent with previous research [1]. The majority of brothels, escort agencies and massage parlours were located within a 10km radius of central Perth. A number of sites were located around Rockingham, Naval Base, and Kwinana (approximately 30-40 km south of Perth) and Mandurah (approximately 60km south). Further remote from Perth, we identified brothels and escort services located in Kalgoorlie (approximately 650km east of Perth) and in the Pilbara Region (Port Hedland and Karratha, approximately 1550km north of Perth).

Information gathered from stakeholders provided data on the location and type of sex industry in regional and remote locations outside of Perth. It was reported that there were one or two brothels operating in Port Hedland with a small number of private workers who advertise locally. There have been reports of a regular mobile service from Port Hedland travels to Newman, working out of a hotel for a few days per week at a time. Karratha was reported to have one brothel with a small number of private workers advertising locally. In Kalgoorlie, three types of sex workers were described, local resident sex workers, migrant Asian brothel workers and other sex workers who probably work privately and very little is known about them. There is one large brothel and a number of very small brothels that usually have only two people working in them and the rest are private workers. It was also reported that there were a number of “fly in, fly out” sex workers operating in mining towns such as Port Hedland; that is sex workers who work in regional areas short term to make money and are usually working and living in metropolitan areas where they get their clinical care and support.

2.3. Inclusion of sex workers in the HIV and STI Model of Care Implementation Plans

In WA, implementation of HIV and STI strategies are guided by the WA STI Model of Care Implementation Plan and the WA HIV Model of Care Implementation Plan (2010-2014), prepared by the Sexual Health and

Blood-borne Virus Program in August 2010 [41]. These Implementation Plans replaced the previous WA HIV/AIDS, Sexually Transmitted Infections and Hepatitis C Action Plans (2006-2008).

The Implementation Plans identify primary prevention via a range of community-based and peer based actions for prevention and awareness among priority populations. Priority populations identified in the Implementation Plans include gay men and other men who have sex with men, people living with HIV, people who inject drugs, people in custodial settings, as well as sex workers (note that not all the priority populations are listed here) [42]. The plans categorise activities into primary prevention (limiting spread of HIV and STI in the population) and secondary prevention (early detection of HIV and STI).

The plans endorse a partnership between the WA Department of Health, other state and local government organisations, community-based organisations, primary health providers and research sectors, in order to reduce the transmission of and morbidity and mortality caused by STI and HIV. Sex Worker Support Project (known as Magenta) and Sex Worker Outreach Project WA (known as SWOPWA), two programs of Family Planning Western Australia, are identified as stakeholders responsible for the implementation of community and peer based prevention interventions. Interventions identified in both the STI Implementation Plan and HIV Implementation Plan that identify Magenta and SWOPWA as stakeholders include:

- STI education and social marketing;
- Strategies to reinforce consistent condom use;
- Continued and increased access to health hardware and harm minimisation programs;
- Improved links and interaction between sexual health and STI services;
- Provision of a peer based education program;
- Monitoring of the impact of legislation and local government policy on sex workers; and
- Support for enactment and or reform of sex worker legislation in WA.

The extent to which these strategies and actions have been implemented by Magenta and SWOPWA will be addressed in Section 3.

2.4. Description of health promotion and clinical services for sex workers in WA

2.4.1. Government funded programs: Magenta and SWOPWA

Magenta and SWOPWA are government funded programs provided through Family Planning Association of Western Australia (FPWA) Sexual Health Services. In line with the National Strategies and state Implementation Plans for HIV and STI prevention, FPWA has acknowledged sex workers as one of their priority populations in their 2009-2012 Strategic Plan and define aims and outcomes for their services and programs that include areas such as evaluation, research, the development of strategic alliances, participation of community networks and employment [43].

2.4.1.1. *Description of activities and programs*

Magenta provides outreach and in-house services to sex workers and small owner operated businesses whilst SWOPWA is a separate program that is primarily outreach based with services focused on street based sex workers mainly in the Northbridge and Highgate areas.

Magenta

Magenta aims to provide reliable, accurate and unbiased sexual health education and health promotion to sex workers. Its services include outreach, low cost supplies, walk-in and telephone information and debriefing opportunities. Referrals are often given, for example to women's health services, sexual assault services, housing and other sex worker friendly services. The Magenta shopfront located in Northbridge at the time of this review, is open four days a week during regular business hours, and Magenta outreach activities operate within these times (9:30am to 4pm).

Magenta offers a sexual health clinic that operates half a day a week (Wed 10am-1pm). Given the limited time, sex workers are taught about sexual health checks and encouraged to find another health care provider and offered referrals to sex worker friendly doctors. Magenta provides training to doctors through FPWA doctor's training program, in which they deliver 15-minute education sessions to GPs on providing health services to sex workers.

Magenta also compiles and distributes an Ugly Mugs list by collecting reports from sex workers who have experienced violence or mistreatment from a client. They will also contact police on behalf of sex workers to report an incident, with the sex workers consent. They also develop newsletters and beginner packs to educate sex workers who are new to the industry.

Magenta also provides information and advice on the implications of legislation in terms of occupational health and safety. This information is listed in a pamphlet, distributed by Magenta staff and in the shopfront and available for download.

SWOPWA

SWOPWA provides outreach three evenings per week (Tuesday, Wednesday and Thursdays from 4pm-7pm), as well as Friday and Saturday evenings (4pm to 7pm) on a rotating basis.

The majority of education and support work is done by phone and outreach but there is also a walk-in option to the Magenta shopfront for sex workers giving them an opportunity to discuss work related issues away from work in a private environment for sex workers who prefer to relate face-to-face.

SWOPWA also engage with a WA Police Department liaison officer by meeting with them on a quarterly basis (approximately). The main function of the liaison officer is to educate other members of the police force on issues around sex work and the context and climate of sex work in WA.

At the time his report was being prepared, staffing of Magenta and SWOPWA was at full capacity with 7.16 full time equivalent staff.

2.4.1.2. Reported service levels

In accordance with the contract for service, Magenta and SWOPWA provide six monthly activity and financial reports to the SHBBVP, WA Department of Health [44] and Magenta also conducts an annual survey/feedback exercise that is documented in activity reports.

According to the Magenta Service Report for July-December 2010, Magenta reported a total of 3120 contacts with sex workers, distribution of 142,515 condoms and provision of 2103 educational materials via internet download [44]. Approximately half (49%) of contacts reported were via telephone or SMS contact.

Of the 1001 one-to-one outreach interactions reported, the majority (95%) were in metropolitan areas. Of those interactions that occurred in metropolitan areas, only 10% of contacts were with males or transgendered sex workers [44]. There were 211 contacts with sex workers from CALD backgrounds in metropolitan areas, and six in regional areas.

Magenta reported contact with 32 small owner operated businesses and 28 manager or operator controlled businesses. Of the 760 sex workers accessed via these in-house interactions, over 85% were females.

During the six month reporting period covered in the last report, 13 clinics were held (approximately fortnightly), with 77 booked and 56 attending clients; all clients were female. Over one third (39%) were from a CALD background, and an interpreter was used with 22 of these clients [44].

2.4.2. Other health promotion and clinical services

2.4.2.1. Other FPWA services

Sex workers also have the opportunity to access mainstream services provided through FPWA which offers two clinical services; FPWA Sexual Health Services and Quarry Health Centre for under 25s. Clinical staff at FPWA is required to complete certificate courses in sexual and reproductive health in addition to minimum levels of professional qualifications and relevant registrations. This training is provided in-house for professional development and includes education around providing health care to sex workers.

2.4.2.2. Hospital-based STI education, screening and outreach

Sexual health education and screening is available at the Fremantle Hospital Sexual Health Clinic (known as the B2 Sexual Health Clinic) and the Royal Perth Hospital Sexual Health Clinic. Both provide free services and allow sex workers to use pseudonyms. Sexual health nurses from the B2 Sexual Health Clinic offer a periodic outreach service to two brothels in Fremantle (one of which has closed since the start of this review). This outreach service is funded by the WA Sexual Health Blood-Borne Virus Program (SHBBVP). Due to logistical difficulties, outreach visits do not involve a physical examination however sex workers can provide self-collected samples for testing. Sex workers are also encouraged to attend the clinic for a full sexual health consultation.

2.4.2.3. Regional public health units

In Kalgoorlie there is a sexual health clinic funded by the public health unit that offers free testing for sex workers, however it is not anonymous. The Kalgoorlie sexual health clinic also provides a regular clinical outreach service to one large brothel in the area. There is also a women's health care centre in the region.

In the Pilbara, a full time sexual health clinic operates in South Hedland staffed with sexual health nurses. A public health physician to whom nurses can make referrals is available at this clinic once a week. Community health nurses also work in drop in centres in the region that mainly target youth and people from Aboriginal background, but these services are not advertised as widely as the clinic.

2.4.2.4. General practitioners

Four of the six sex workers who participated in the interviews indicated they used a private GP service for their sexual health checks. Two large city GP clinics in Perth were also mentioned as preferred clinics for sex workers.

2.5. Sexual health of sex workers in WA

2.5.1. Review of HIV and STI surveillance data

The following is a summary of HIV and STI epidemiology among sex workers in WA based on HIV and STI cases notified to the WA Department of Health and obtained from the Epidemiology and Surveillance Program. Refer to Appendix 4 for the detailed WA Department of Health surveillance report.

Note: Differences in the proportions between notifications among sex workers and others were investigated using a two-sample test of proportion.

Of the 60,966 chlamydia infections notified to the WA Department of Health between 2001 and 2010, 36 reported sex work as their occupation; 98% of these were female compared with 58% of all other notifications ($P<.001$). A larger proportion of sex workers diagnosed with chlamydia were born overseas; 44% compared to 10% of all other notifications ($P<.001$). A larger proportion of chlamydia notifications among sex workers was detected through asymptomatic screening; 86% compared with 36% of other notifications ($p<.001$).

Of the 15,012 notifications of gonorrhoea, 23 were among individuals reporting sex work; two of which were in male sex workers. In WA, 72% of gonorrhoea is diagnosed among Aboriginal people, with a female to male ratio of 1.3:1, however sex workers diagnosed with gonorrhoea were mainly non-Aboriginal female and living in metropolitan WA ($p<.001$). Diagnosed sex workers were generally older and their infections were predominantly identified through asymptomatic screening (65%) compared to the other cases (24%) where the majority presented with symptoms ($p<.001$).

Of the 21 gonorrhoea infections among female sex workers, 19 reported acquiring the infection from a partner of the opposite sex and two did not have the sex of their partner recorded. Of the 21 infections among female sex workers, seven were identified through throat swabs, indicating transmission through oral sex. It is important to note that many of these cases had more than one specimen site recorded and could therefore be a combination of oral and genital infections. Of the two gonorrhoea infections among male sex workers, one was identified solely through a rectal swab and one was identified solely through a urine sample.

Of the 690 individuals diagnosed with HIV between 2001 and 2010, seven reported sex work as their occupation; 5 males and 2 females. Approximately 50% of HIV infections in WA are diagnosed in individuals from overseas, whereas the majority ($n=6$, 86%) of HIV diagnoses among sex workers were overseas born ($p=.068$). Four of these HIV diagnosed sex workers (three male, 1 female) tested negative for HIV within the six months prior to their diagnosis suggesting regular HIV screening and incident infections. Four of the five male sex workers with HIV were exposed through male-to-male sex, the other acquired HIV from a female injecting drug user. No information on likely source partners for the male-to-male sex workers was captured through surveillance.

Comment

These surveillance data show much lower numbers of STI diagnosed among sex workers when compared to the rest of the WA population. Higher numbers of STI have been diagnosed among female sex workers compared to male sex workers. This is not surprising after interview informants indicated that the male sex

industry in WA is much smaller than the female industry. The surveillance data also suggests that sex workers take up regular screening, showing a much greater proportion of asymptomatic presentation when compared to other cases diagnosed in WA. This early detection of STI is important for the sexual health of individuals as well as for limiting the onward transmission of STI to any partners.

Although numbers of STI are low among sex workers, the surveillance data are limited and cannot be used to inform the risk practices of sex workers and others. For example, there were many anecdotal reports by sex worker informants in this review of lower condom use for oral sex compared to vaginal or anal sex, which could explain the oral gonorrhoea; however it is unclear whether the likely source partner is a private partner or client. Also, the 6 HIV infected sex workers born overseas could indicate a particular vulnerable group. The majority of HIV infected sex workers are male sex workers who generally have higher rates of STI than female sex workers but comparable rates to other homosexually active men (Wilkinson, 2011 in review). It is unclear using surveillance data alone, whether the exposure to HIV came from particular risk practices in the private or working lives of sex workers.

More data are needed in this area to further understand the risk of exposure to STI for sex workers in WA.

2.5.2. Sub-groups of sex workers with additional needs

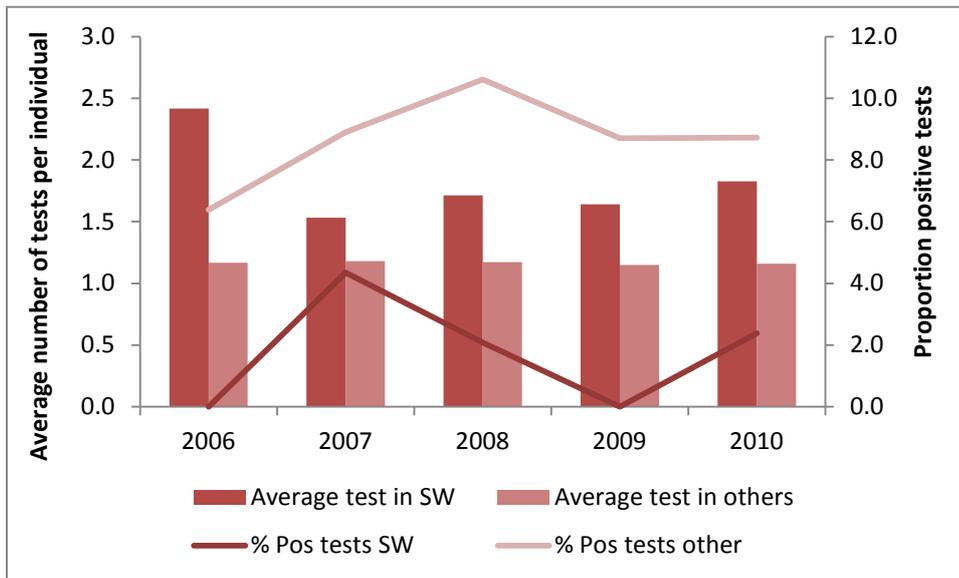
It is well documented that prevalence of STI are low compared to other sexually active populations in Australia [9, 13], however some subgroups of sex workers may be more vulnerable to HIV and STI transmission as well as other blood borne viruses such as HBV and HCV for a range of reasons discussed in Section 1. However, due to several reasons including data incompleteness as well as issues relating to documentation of occupational status or other exposure categories (such as male-to-male sex and injecting drug use) there is an absence of data to monitor the sexual health of sex workers who are members of more exposed sub-groups. As a result it is not possible to monitor changes in behaviours or prevalence of HIV, STI, HCV and HBV among sub-groups such as male sex workers, sex workers who inject drugs and sex workers from CALD backgrounds. Given the overlap between some of these risk populations and behaviours, it is difficult to also determine the relative risk of sex work in contributing to STI risk in comparison with other risk behaviours.

2.5.3. Review of data from other sources

Fremantle Sexual Health Clinic provided chlamydia screening data over a five year period, 2006-2010. Overall female sex workers were screened for STI more frequently than other females attending the clinic, yet the positivity rate among the sex workers tested was less than half that of the other females (Figure 1). HIV, gonorrhoea and syphilis results are not shown, as no sex workers have screened positive at Fremantle Sexual Health Clinic for any of these in the five year period.

Royal Perth Hospital sexual health clinic staff reported a small number of sex worker clients that regularly attended for testing. The rate of diagnosis of STI among these women was very low. Clinic staff also reported that Asian sex workers who attended were a mostly transient group, however they seem to be tested regularly and receiving HBV vaccinations elsewhere; they reported not seeing any increased rate of infection among these sex workers.

Figure 1 Chlamydia testing and positivity among female patients at Fremantle Hospital SHC, by sex work status (SW), 2006-2010



Magenta sexual health clinic data from Jan-Jun 2010 showed no positive chlamydia or gonorrhoea results in the 122 tests requested. Similarly in the second half of 2010, 112 chlamydia and gonorrhoea PCR tests and 32 syphilis tests were requested with no positive results. There were other sexual health issues reported however such as abnormal Pap smear results and Bacterial Vaginosis.

Kalgoorlie sexual health clinic staff reported very low rates of STI among sex workers they see for testing. Internal documentation of STI in the sex workers tested found that rates of STI were low in local, resident sex workers. In late 2010, outreach screening visits were conducted with many of the Asian brothels and no chlamydia or gonorrhoea was found, one case of syphilis (however this was not a recent infection) and one case of HBV was diagnosed. There were some sex workers who were travelling between Sydney, Perth and Kalgoorlie who were also screened and one case of chlamydia was diagnosed, however the sex worker was sure she was infected by her boyfriend.

According to a former sexual health nurse working in Hedland, STI are also low in the region however other sexual health issues for sex workers were not uncommon.

“Numbers were small, rates of STI were very low but a number of other non-sexual health issues arose as they are not a group that readily accesses health care.”

2.5.4. Findings from the LASH study on the health of sex workers in Perth

In 2006, the National Health and Medical Research Council funded the Law and Sex Worker Health (LASH) study to describe the various legislative approaches across Australian jurisdictions and their association with different health and welfare approaches across Australia. Following on from this study, the Western Australian Department of Health contracted the LASH team to compile a report to inform WA policy considerations with regard to the review of legislative approaches to sex work in WA. The key findings of the investigation, led by Donovan et al (2010) included:

- Coverage of services for sex workers in WA was limited and focused primarily on Perth;
- SWOPWA services focused on street-based sex workers mainly in the Northbridge and Highgate areas and only a minority of brothels allowed outreach access from Magenta;
- Perth brothels had lower access to education and support services compared to Melbourne and Sydney;
- The prevalence of chlamydia and gonorrhoea in Perth-based female sex workers was at least as low as the general population and similar to the rates in sex workers in Melbourne and Sydney;
- The majority of sex workers surveyed reported having regular sexual health check-ups, typically at least every six months. Just over half of respondents reported going to their local general practitioner for their sexual health checks; and
- There was a priority need for health promotion staff with Asian-language skills to service the considerable proportion of sex workers in Perth from Asia, with one in five reporting fair or poor English language skills [1].

Section 3 Critical analysis of clinical and health promotion programs in WA

This section describes the gaps in service provision and barriers to uptake of services as identified through the in-depth interviews and survey responses (refer to Methods). It also explores the extent to which actions included in the Western Australian HIV and STI implementation plans have been applied by the sex worker program.

3.1. Barriers to sex workers accessing clinical and health promotion services

3.1.1. Diversity of sex industry

It is well known that sex workers in Australia are a diverse group and as expected, sex workers in WA reported coming from varied backgrounds and localities and having a variety of needs (see Appendix 5 and Appendix 6 for survey responses). The survey conducted to inform this report was completed by a small sample of sex workers (N=67), but captured some of the diversity present in the industry; 36% of respondents were overseas born and 16% typically resided outside metropolitan WA, including interstate and overseas. Also, a third of respondents reported less than one years experience and one fifth reported 6-10 years experience in sex work (Table 5). This presents a variety of issues and considerations for service provision such as language and cultural barriers, unfamiliarity with local industry climate, geographical reach, and the need for specific approaches and information to keep sex workers engaged with services.

Table 5 Demographic characteristics of sex worker survey respondents

Gender	n	%
Female	47	70.2
Male	13	19.4
Transexual	2	3.0
Missing	5	7.5
Age group	n	%
18-24	17	25.4
25-29	9	13.4
30-34	20	29.9
35-39	9	13.4
40-44	3	4.5
45+	9	13.4
Country of birth	n	%
Australia	43	64.2
Other	24	35.8

Place usually lives	n	%
Perth	36	53.7
Fremantle	5	7.5
Other metro	15	22.4
Other	11	16.4
Length in industry	n	%
< 1 year	22	32.8
1-2 years	12	17.9
3-5 years	12	17.9
6-10 years	15	22.4
11+ years	6	9.0

3.1.2. Transiency of sex workers

Both service providers and sex workers described the sex industry in WA as transient. There were multiple examples of transience given and these included: sex workers moving in and out of the industry during the course of their career; moving geographically between metropolitan and rural regions within WA; moving seasonally between WA and other Australian states; and moving between the types of sex work within the industry.

Table 6 shows 30% of sex workers who responded to the survey have moved between at least two types of sex work and almost 50% reported working outside of Perth.

Table 6 Characteristics of the work of sex worker survey respondents

Type of sex work	n	%	Place usually works	n	%
Listed 1 type	47	70.2	Perth	33	49.3
Brothel only	12	25.5	Fremantle	5	7.5
Street only	3	6.4	Perth and Fremantle	7	10.4
Private only	22	46.8	Other metro	14	20.9
Escort only	6	12.8	Bunbury	4	6
No sex only	4	8.5	Overseas	3	4.5
Listed 2 types	12	17.9	Missing	1	1.5
Brothel and other	7	58.3			
Private and other	5	41.7			
Listed 3 types	4	5.97			
Listed 4 types	4	5.97			

Outreach workers from health promotion and clinical services in both metropolitan and remote locations have reported a high turnover of brothel based sex workers at the brothels they visit, affecting their reach, long term engagement with sex workers, and potentially the frequency with which outreach needs to occur to maintain engagement.

“In the past we have approached the brothels ... offered screening and education but apart from the odd drop in for an STI screen we really have had minimal contact. Not sure if this is because they really don’t want to use us or with their high staff turnover they are just not aware we are here.”

Additional challenges occur for service providers to keep abreast of emerging trends and shifts in the industry profile over time. Service providers have reported a change in the makeup of Asian born workers over a very short period of time, for example.

“There has been a gradual increase in migrant sex workers over the last 5 years that has gone from approximately 12-15% to about 20-25%....from mainly Thai and Vietnamese to over 50% of migrant workers being of Chinese origin”.

3.1.3. Criminalisation, stigma and discrimination

Community stigma and the criminalised nature of the industry in WA impacts on sex workers’ ability to disclose their work when they are in contact with services or seek advice or protection when needed;

affecting the health and wellbeing of sex workers. Many of the provider informants from the sex worker programs gave examples situations where sex workers who had experienced violent or threatening incidents while working did not go on to report these to the police, even after offering to assist them in doing so. This is particularly an issue for CALD workers who may fear disclosing their work because of a lack of understanding of their rights and the perceived cultural shame associated with the work they do. One CALD sex worker revealed that stigma was the main reason she did not go to the police when her property was damaged by a client and it also stopped her from socialising with people in her community.

“I am embarrassed to tell them what I do for work”.

Similarly, sex workers who worked in establishments also expressed discomfort about seeking help.

“If I’m in trouble and need help I don’t feel I can ask for it without being scrutinised”

Informants also reported instances where street workers feared talking to the outreach educators because of the chance they may be identified as a sex worker and penalised as a result, creating additional barriers for the delivery and uptake of services.

The survey revealed that perceived stigma resulted in sex workers not feeling able to disclose their sex work to health practitioners, while 55% reported feeling very comfortable discussing their health needs, only 31% reported routinely disclosing their sex work to practitioners (Figure 2 and Figure 3). These data suggest that perceived stigma may result in missed opportunities for targeted health care and STI screening based on accurate sexual history taking, potentially limiting the provision of comprehensive health care.

Figure 2 Levels of comfort reported by sex workers when discussing sexual health needs with practitioners

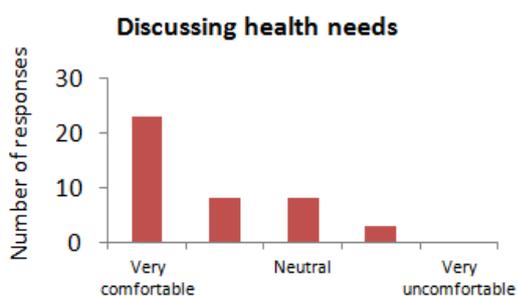
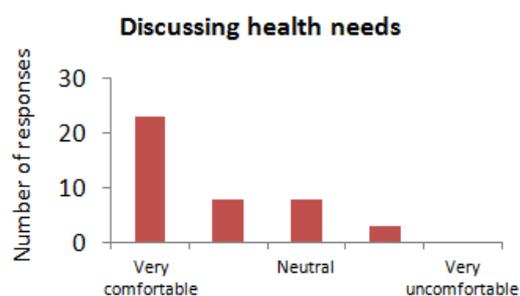


Figure 3 Disclosure of sex work to practitioner at last check-up



3.1.4. Turnover of program staff and human resources

Magenta and SWOPWA experience a high turnover of skilled educators. For example, in the previous six months Magenta has seen a manager and peer educator leave for other work opportunities and SWOPWA has also lost their program manager. This creates “down time” while roles are filled, loss of corporate memory and human resources become more limited. These restrictions limit continuity of program delivery which affects the long term engagement of sex workers. Reported examples of the discontinuity or inconsistency in service provision have been expressed by sex workers seeking specific program services.

“There is often no-one available to give info or do outreach or drop off supplies. I have...been told I will get a call back and haven’t.”

This issue is not uncommon in health programs servicing the community, especially those providing service to the specific populations that require particular skill sets and experience and when opportunities for higher remuneration are often available. This factor creates challenges for the success of the sex worker programs in WA and was well recognised by the providers interviewed.

“Continuity of staff and ensuring the skill set and experience exists for the work to be done well has been a challenge.”

3.1.5. Inadequate hours of operation

Both provider and consumer respondents reported inflexible and unsuitable hours of operation of clinical services for sex workers. The opening hours of clinics are usually regular business hours and very few clinical services offered appointments outside of these hours. Sex workers also reported long wait periods for appointments.

“[Regular sexual health check-up] does not fit into my schedule; I have a normal full time office job and then sex work so time frame is very difficult”

The hours of health promotion services were also not optimal for their target group. Sex workers reported dissatisfaction with the hours of operation of Magenta and SWOPWA services, including outreach programs.

“SWOPWA hours are outside the best hours for street workers”

“Make outreach services more suited to our work hours and ...open their office 5 or 6 days per week”.

3.1.6. Lack of peer involvement

Peer education

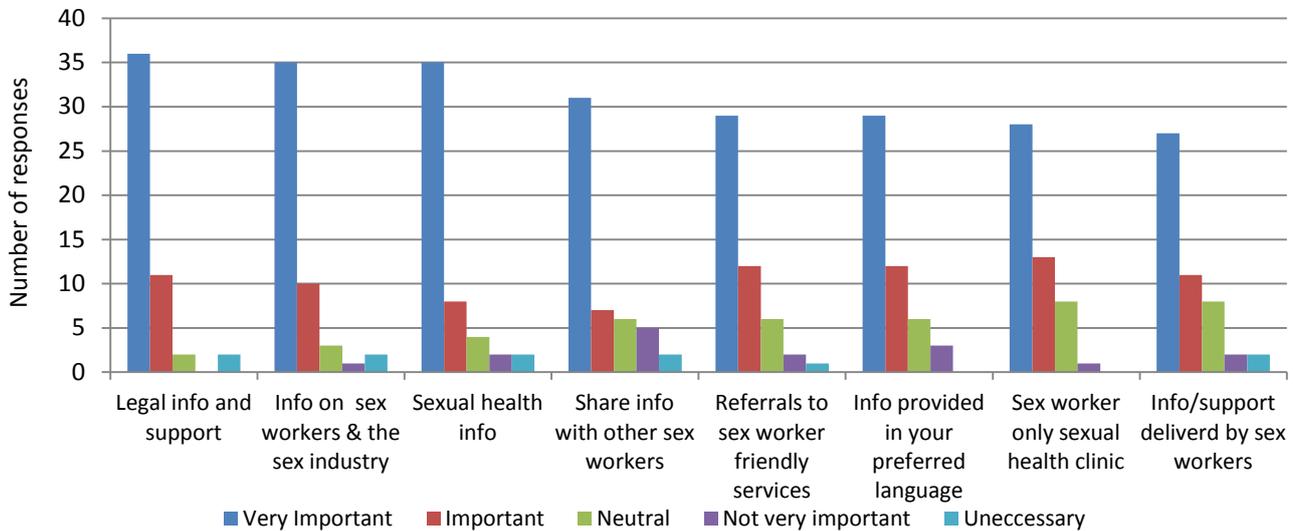
Peer education is regarded as a key component to the delivery of health promotion and outreach services to sex workers and is identified as a priority in the National Strategies for HIV and STI prevention. At the time of writing this report, FPWA did not employ current sex workers as peer educators nor did it specify current or previous sex work as criteria in job descriptions.

The sex workers who participated in the in-depth interviews all noted that they would prefer someone with sex work experience when accessing services at Magenta, and in any case it is essential to be able to speak to experienced, non-judgemental and knowledgeable staff when they needed to debrief or gain information. These sex workers also expressed dissatisfaction with having to talk to students or inexperienced staff when someone more experienced was unavailable.

Survey respondents were asked to rate the importance of different types of information as well as how the information was delivered. The full range of support and service types identified in the survey (Appendix 2) was rated as very important by the majority of sex workers who responded (Figure 7); 76% indicated a strong preference for information and support delivered by sex workers. In their responses to the open ended questions, sex workers suggested the employment and delivery of sex workers in order to engage new workers, experienced workers and CALD workers. The following quote is an example of the gap felt by sex workers in relation to peer education.

“... the ability to pick up the phone or drop into the service and to know that the person I am speaking to has firsthand knowledge of the industry and is able to talk to me like a colleague.”

Figure 7 Sex workers rated the importance of specific aspects of services in WA (n=52)



Program planning and direction

Aside from a small number of peers employed at Magenta and SWOPWA there is very little involvement of sex workers in the planning and direction of the sex worker program. Magenta conducts regular customer satisfaction surveys to gauge the success of their services and acquire feedback and suggestions for improvement; however beyond this we did not find evidence of consumer representation, participation or consultation in the governance of the programs.

A number of stakeholders discussed the history of sex worker programs in WA and recalled historical issues which may be influencing the current level of consumer involvement in Magenta and SWOPWA, and included tensions arising from the lack of clarity in roles, community pressures based on misinformation which may have led to necessary restrictions in governance and issues for accountability. One stakeholder stated:

“Community perceptions can influence government in a negative way...resulting in the shutdown of Phoenix”

This residual concern may have contributed to the limited involvement of sex workers in program planning at Magenta and SWOPWA.

3.1.7. Low profile of health promotion programs

With new workers and people moving in and out of the industry or between locations, regular outreach and comprehensive and sustained reach for health promotion is essential. Many sex workers interviewed and surveyed reported that sex worker programs in WA did not have enough of a public profile and many suggested more advertising in newspaper classifieds and GP waiting rooms. Sex workers reported that not enough new workers knew about Magenta and they had originally learned about the service through word

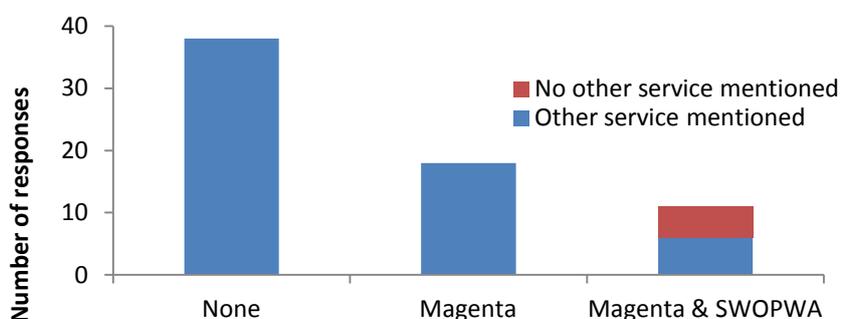
of mouth and wished they'd heard about it sooner. Some sex workers interviewed who were regular clients of Magenta were not aware of the full range of information and services available.

"I haven't used the ugly mugs service. Didn't know about it"

"Some [sex workers] think Magenta just sells condoms"

The low profile of the sex worker programs was demonstrated through responses to the survey question asking sex workers where they accessed support, information or education services. For 57% of records (n=38) there was no indication of Magenta, SWOPWA or other services being accessed (Figure 4). These respondents were: 68% female, 68% Australian born and 34% aged 18-24 years. Almost two-thirds of these respondents had been working in the sex industry for less than two years (37% for <1 year and 26% between 1 and 2 years). One possible explanation is that these sex workers are accessing Magenta and/or SWOPWA for the purchase of hardware but not necessarily gaining other resources or support that could be of benefit to them, especially early on in their career.

Figure 4 Access of support, information or education services by sex worker respondents



3.1.8. Hard to reach sex worker populations

During the course of the consultation the majority of service providers interviewed mentioned sex workers who fall outside their service and an existence of sex workers who may not be linked in with health promotion or clinical services. Not knowing the profile and geographical location of sex workers in order to reach and engage with means that some sex workers from many sub groups and regions can be “slipping through the net”.

While there are sex workers who proactively seek information and use services available to them, there are groups of sex workers that are considered hard to reach for demographic reasons (e.g. rural or CALD sex workers), practical reasons (e.g. schedule conflicts) or attitudinal reasons (e.g. think they are not cared about).

There are also some sex workers who will not want to be contacted for fear of exposure. The following examples have been given by stakeholders planning services for sex workers.

"...difficulty estimating the number of sex workers in and around Perth, for example sex workers and brothels can use more than one phone number."

"Some establishments deny sex work for example massage businesses and strip clubs and so it's much harder to gain access."

3.2. Extent to which strategies and action plans have been implemented in Western Australia by Magenta and SWOPWA

Tabulated below (Table 8 and Table 9) are the four strategies listed in the WA STI Model of Care Implementation Plan 2010-2014 and the three from the WA HIV Model of Care Implementation Plan 2010-2014 that include actions for Magenta and/or SWOPWA [38, 39]. Each of the planned actions within the specific strategies was assessed using information gathered from consultation with key informants from both service provider and sex worker groups. The needs expressed by the sex worker group in interview and survey responses are presented in Appendix 5 and Appendix 6.

Table 8 STI prevention strategies, planned actions for Magenta/SWOPWA and the extent to which actions have been implemented.

Strategy 1. Promote general STI awareness			
Outcome	Actions	Extent to which action has been implemented	Gaps as identified by stakeholders
Continue and enhance state-wide community and peer based primary prevention interventions for each identified priority population	Develop and undertake appropriate and targeted STI education and social marketing aimed at people at risk of acquiring STI, emerging at-risk groups and the general community in WA	Magenta has developed many STI education materials that include brochures, newsletters, translated information and a starter pack for new workers. These are available as hardcopy and some information is online. They have a website, advertise in newspapers biannually, contact advertising sex workers via SMS and employ educators on the ground.	Limited use of available media, for example email and classified advertising. Materials on the website do not include full range of publications. Low profile of programs and lack of engagement with and knowledge of program services by new sex workers.
	Develop and implement strategies to reinforce consistent condom use and uptake of regular STI testing	Magenta and SWOPWA provide an outreach education service and supply condoms and educational materials. There is a drop in centre where sex workers can access information, education and supplies. A sexual health clinic operating half day a week provides opportunities for one-on-one education.	Many known establishments are not consistently accessed for condom distribution and education of sex workers. Inconsistency in service availability and delivery. Unsuitable hours of operation.
	Continue to provide and increase access to health hardware, such as condoms and dental dams, and harm	Magenta and SWOPWA provide free or low cost safe sex supplies to sex workers. These are also delivered to brothels and private workers on request.	There can be delays in the delivery of hardware and issues with hours of operation. The possible lack of knowledge about availability of cheap hardware

	minimisation programs using best-practice and innovation models	Stock and prices can be viewed online and ordered by phone.	without advertising.
	Improve links and interactions between sexual health and STI services where required	All providers interviewed were aware of Magenta and referred their clients and patients. Magenta also made referrals to sex worker friendly main stream STI services. Some STI services carried Magenta's STI education materials as well.	Some of the hardcopy materials made available at the other services were out dated and translated versions were not available. Remote and rural access to program resources relies heavily on physical delivery. Many sex workers return to Magenta's clinic despite being referred to other GPs.
	Provide peer based education and/or skill building to maintain/improve a safe sex culture as well as regular STI testing	Magenta and SWOPWA employ both peer and non-peer educators and offer skill based workshops at the Magenta premises for sex workers. There is also a sexual health helpline operated by FPWA, Monday to Friday 8.30am to 5pm and Saturday 9am to 5pm for country callers.	The help line is not staffed by Magenta potentially effecting consistent follow-up and continuity of care. Limited involvement from current and former sex workers in service delivery and program planning. Limited levels of peer education.

Strategy 2. Policy and legislation

Outcome	Actions	Extent to which action has been implemented	Gaps as identified by stakeholders
Support efforts to ensure a supportive regulatory environment which supports the health and safety needs of sex workers	Monitor the impact of legislation and local government policy on sex workers	Magenta has materials available to update sex workers on the legislation affecting their work practices and links to other sources of information relevant to sex workers.	Absence of documentation monitoring the impact of legislation and policy on sex workers' health and wellbeing.
	Support for enactment and/or reform of the following legislation will help to address STI prevention education and health promotion as well as treatment: New Public Health Act, Prostitution Control legislation and Sex Industry Code of Practice, and the Poisons Act	Representatives from Magenta have been involved in addressing local government policy. SWOPWA liaise with local police to improve relationships with and treatment of street workers.	Lack of clarity around Magenta and SWOPWA's role and expectation in advocacy activities. Gap in reported activity toward reform of legislation ensuring a regulatory framework supportive of the occupational health and safety needs of sex workers.

Strategy 3. STI Testing

Outcome	Actions	Extent to which action has been implemented	Gaps as identified by stakeholders
Remove barriers	Continue to educate at-	Magenta and SWOPWA offer	Many known establishments are

to STI testing	risk groups about the importance of STI testing and how to access STI services	STI testing information and education both on the premises and on outreach programs.	not consistently accessed for education of sex workers. Low profile of programs could be limiting sex worker knowledge of resources available to them.
	Improve access to and availability of STI testing services (e.g. outreach services) for all groups	Magenta operate a sexual health clinic half a day a week on their premises and refer to sex worker friendly GPs.	Long waiting periods for clinic appointments. No availability for STI testing as part of outreach program.
Strategy 4. Epidemiological, social and clinical research and surveillance			
Outcome	Actions	Extent to which action has been implemented	Gaps as identified by stakeholders
Continue to build the evidence base	Continue to monitor epidemiology, social and clinical research findings focusing on STI and at-risk priority populations	Magenta and SWOPWA analyse consumer feedback and collect data on service contacts and clinic visits.	Data lacking to answer questions about the size and makeup of the industry, the relative risks associated with specific sex worker groups.

Table 9 HIV prevention strategies, planned actions for Magenta/SWOPWA and the extent to which actions have been implemented.

Strategy 1. Target priority populations			
Outcome	Actions	Extent to which action has been implemented	Gaps as identified by stakeholders
Continue to enhance state wide community and peer based prevention interventions	Develop and undertake appropriate and targeted HIV education and social marketing aimed at people at risk of acquiring HIV, emerging at-risk groups and the general community throughout WA: sex workers including CALD workers	Magenta provides health education materials and workshops on safe sex practices and HIV prevention. Free safe sex and injecting equipment available through SWOPWA. Education is carried on through outreach programs as well. Provide translated materials on Magenta website. Magenta has access to some CALD brothels.	No safe injecting information available on the website or in new worker packs. Lack of clear strategy and benchmarking to effectively target CALD communities. Limited involvement with current sex workers in strategic planning results in barriers to timely identification of emerging issues. Limited peer education.
	Provide peer based education and/or skill building to maintain/improve a safe sex culture as well as regular HIV/BBV and STI testing	Magenta and SWOPWA employ both peer and non-peer educators and offer skill based workshops at the Magenta premises for sex workers. There is also a sexual health helpline, Monday to Friday 8.30am to 5pm and Saturday 9am to 5pm operated by FPWA for country callers.	The help line is not staffed by Magenta potentially effecting follow up and continuity of care. Limited involvement from current and former sex workers in service delivery and program planning.
	Develop and implement strategies to reinforce consistent condom use	Magenta and SWOPWA provide an outreach education service and supply condoms and	Many known establishments are not consistently accessed for education of sex workers. Low

	and uptake of regular STI testing and availability of NPEP to high-risk groups	educational materials. There is a drop in centre where sex workers can access information, education and supplies. A sexual health clinic operating half day a week provides opportunities for one-on-one education.	profile of the program could possibly be limiting consumer knowledge of the resources available to sex workers.
	Continue to provide and increase access to health hardware, such as condoms and dental dams, and NSP using best-practice and innovation models	Magenta and SWOPWA provide free or low cost safe sex supplies to sex workers. These are also delivered to parlours and private workers on request. Stock and prices can be viewed online and ordered by phone.	There can be delays in the delivery of hardware. The possible lack of knowledge about availability of cheap hardware without advertising.
	Improve links and interactions between sexual health and HIV services where required	Magenta and SWOPWA provide support and assistance for sex workers by negotiating with other community agencies such as the Police, Ministry of Justice and WA Substance Users Association.	Collaborations with clinical services in rural areas are lacking.
Strategy 2. HIV and STI Testing			
Outcome	Actions	Extent to which action has been implemented	Gaps as identified by stakeholders
Remove barriers to HIV and STI testing	Continue to educate at-risk groups about the importance of testing and how to access services	Magenta and SWOPWA offer STI testing information and education both on the premises and on outreach programs.	Many known establishments are not consistently accessed for education of sex workers.
	Improve access to and availability of HIV/BBV and STI testing services (e.g. outreach services) for all priority groups	Magenta operate a sexual health clinic half a day a week on their premises and refer to sex worker friendly GPs.	Long waiting periods for clinic appointments. No availability for STI testing as part of outreach program. Remote and rural access to program resources relies heavily on physical delivery.
	Ensure regular and opportunistic testing for STI is available for all priority groups	Magenta operate a sexual health clinic half a day a week on their premises and refer to sex worker friendly GPs.	The clinic is in high demand and many sex workers return to Magenta's clinic despite being given referrals to other GPs
Strategy 3. Epidemiological, social and clinical research and surveillance			
Outcome	Actions	Extent to which action has been implemented	Gaps as identified by stakeholders
Continue to build the evidence base	Continue to monitor epidemiology and social research findings with at-risk groups	Magenta and SWOPWA analyse consumer feedback and collect data on service contacts and clinic visits.	Data lacking to answer questions about size and makeup of the industry, risks associated with specific sex workers groups.

Reach and coverage of affected communities are the principle aims for all community based programs and achieving this can be affected or influenced by multiple aspects of service delivery. For Magenta and SWOPWA a variety of factors have been identified that could impact on their accessibility to sex workers in WA. For example, in this review sex workers have said they need a service that is open at least five days a week so they can access hardware and support. Street workers as well as educators have indicated that the hours of outreach for street workers are not in line with the times that they are working and their needs for the service. Sex workers have also said that they are not aware of the range of resources and services that Magenta and SWOPWA offer and would like them to advertise more because they are conscious of the demand for Magenta's services, especially for sex workers who are new to the industry or new to WA. Increasing the program's profile and extending shopfront and outreach hours are areas where resourcing and/or work safety issues come into consideration however it would directly increase access to safe sex hardware as well as continued education and support for sex worker groups as outlined in the strategies above.

This review has also identified a lack of participatory input from sex workers in the planning and implementation of the actions. The WA Implementation Plans have clear actions for Magenta and SWOPWA to develop and undertake appropriate and targeted HIV education and social marketing aimed at sex workers including CALD workers and make mention of identifying emerging groups at risk of HIV and other STI. Peer education is successful in reaching people who may not be reached by other means[45] and strategies to access and engage some hard to reach sex worker groups could be informed by closer sex worker consultation. When asked how sex worker programs can engage CALD workers for example, many responses supported the involvement of multilingual peer workers who also have cultural knowledge to reach this community. Also, the continued communication and liaison with sex worker representatives is likely to assist in uncovering emerging issues which can then be investigated and/or addressed in a timely way. Such peer participation will also provide an understanding of the historical, cultural and social contexts of the sex worker community.

The Implementation Plans also recommend peer based education and/or skill building to maintain and improve a safe sex culture as well as regular HIV/BBV and STI testing. Continued assessment of the impact of peer education has confirmed its utility, especially in the areas of HIV, hepatitis C, and sexual health education[46]. Allowing sex workers to participate in their own health care will create a responsive, effective, equitable and inclusive program that is operating in the best interest of the whole community. It has been well documented for many years that effective HIV and STI health promotion lies in the active participation of affected communities, through peer education and community ownership [47] and in this review, the provision of services by people with sex work experience was identified as very important by many of the sex workers surveyed.

Strategies for the prevention of HIV and other STI recognise the benefit of routine and asymptomatic screening in the control of transmission. The WA Implementation Plans specify that Magenta and SWOPWA develop and implement strategies to encourage the uptake of regular STI testing and improve access to testing and Magenta's sexual health clinic is one way the program does this. The clinic is run one morning a week alongside other health promotion initiatives and its success is demonstrated by the high demand for appointments and the repeat business from sex workers. One-on-one sexual health education is provided to sex workers waiting for their appointment and an interpreter is on site which has meant that more Asian workers visit the clinic for their routine screening. Magenta staff also encourages sex workers to use

mainstream services and provide lists of sex worker friendly doctors to their clients, most of whom have undertaken training at FPWA that includes education around service provision to sex workers.

Magenta and SWOPWA programs have good working relationships with government and funders and liaise with community organisations to benefit sex workers that they have access to. These programs have a familiarity and knowledge of services that they can refer sex workers to however reach and efficiencies for the sexual health services can be enhanced particularly in rural and remote parts of WA and especially given its geographical size. Magenta and SWOPWA programs are based in Perth and expectedly operate Perth-centric services most of the time. To extend their reach, information and education is disseminated via telephone, email, online and via outreach to rural towns around WA that are known to be populated with sex workers (namely Kalgoorlie and Hedland). Working in a more integrated way with clinical services in rural towns could make these services more accessible to sex workers local to the towns, as well as mobile sex workers who come in to the towns for work.

Advocacy at multiple government, service and community levels is essential for reducing barriers to health care among sex workers especially in the context of criminalisation and heightened stigma. Magenta and SWOPWA programs describe advocating on behalf of sex workers as a service provided to sex workers, for example assisting with police contact when sex workers have experienced a violent incident and representatives of the program have also been involved in the development of government strategies for HIV/STI prevention. There appears to be a lack of clarity around the positioning of the Magenta and SWOPWA programs in the advocacy of sex workers. Magenta and SWOPWA are identified in the Implementation Plans to both monitor the impact of legislation and local government policy on sex workers and to support enactment or reform of legislation however this is not reflected in their service agreements nor has any documentation as such been developed by Magenta or SWOPWA.

The ongoing evaluation to measure performance against aims of the actions outlined in HIV/STI prevention strategies is crucial for the continued development of these strategies and for building the evidence base to allow the assessment of the effectiveness of these actions. This review has also revealed an absence of data and documentation that could be used to evaluate the success of the programs that provide health promotion to sex workers, monitor the impact of legislation and policy on sex workers' health and wellbeing, measure the size and makeup of the industry and identify characteristics of the subgroups not reached.

Section 4 Conclusion and recommendations

This section is a response, specific to each of the review objectives using a synthesis of the literature, secondary and novel data presented earlier.

4.1. Describe the sex industry in WA and the trends of HIV/STI among sex workers using available data sources

The sex industry in WA is relatively small when compared to those in the Eastern states of Australia. However, there are particular barriers to service delivery in WA stemming from both the small industry and the diversity within it. The sex industry in WA spans a much larger geographical region by comparison to most other states and this presents unique challenges to reaching sex workers when considering the transiency of workers and the criminalised setting of the industry. The size of the industry is difficult to estimate because of the many illegal aspects and stigma that compel many sex workers to be discrete about their profession. Further, many parlours and escort services will change their name, address and contact details to protect their privacy and avoid police surveillance. For this reason many sex worker populations can be difficult to reach.

The situation analysis revealed gaps in knowledge about some sub groups of sex workers and highlighted the difficulties health and service providers have in accessing some brothels and sex workers directly. For example, the extent to which CALD sex workers were reached was unknown and the needs of fly-in-fly-out sex workers in regional and remote areas were not well understood.

Overall the sexual health of sex workers appeared to be comparable to that of the rest of the population however the data are limited to those seeking health care and possibly limited by an under reporting of sex work at health services. Although it is largely accepted in Australia that the rates of HIV infection and other STI among female sex workers are low compared to the general sexually active community, there are sub groups of sex workers that are likely to be more at risk and for which little is documented in terms of sexual health (e.g. male and transgender sex workers, CALD sex workers, sex workers who inject drugs). Particular groups of sex workers, for example those from CALD backgrounds or street-based workers are of particular interest in relation to other infections such as HBV and HCV. As noted above, improved data is needed to further understand trends of infections and behaviours among these groups.

4.2. Identify the determinants of health care seeking behaviour among sex workers in WA, gaps in service provision and barriers to implementation of STI and BBV prevention and control initiatives

Many barriers to sex workers accessing clinical and health promotion services were identified in the review. Some of these made it difficult for service providers to reach and engage sex workers such as the transiency of the industry, turnover of staff at brothels and certain sex worker populations probably not wanting to be contacted and continually changing their contact details.

Many of the factors identified in Section 3.1 play a role in deterring sex workers from accessing services even when they can see the benefits of these services. For example, discomfort in disclosing their work to doctors or police, lack of continuity in staff or programs and inconvenient hours of availability. These factors can have varied impacts for different communities of sex workers that of course have varying priorities and challenges. Sex worker programs, when considering regional and remote sex workers, for example also have geographic and logistic considerations that stretch their resources and physical reach and considerations relating to the specific needs of this group where the community is smaller and sex workers might have reduced options to maintain their anonymity.

Understanding the specific needs of sex worker communities and adapting targeted projects to meet these needs can be improved by the involvement of sex workers in the gathering of data, engagement in the community and the dissemination of health promotion resources.

4.3. Assess extent to which recommended actions and guiding principles have been implemented and adopted, specifically in relation to sex workers and BBV/STI prevention within WA's Strategies and Action Plans, and assess their appropriateness to the current context

The interviews with providers and consumers revealed that sex workers feel positively about sexual health education and promotion, understand the benefits and welcome the information. The need for continued sexual health promotion was strongly felt by all key stakeholders, confirming the prominence of health promotion in the strategies and actions documented in the WA HIV and STI Model of Care Implementation Plans.

The clinical and health promotion services offered by Magenta and SWOPWA programs address many of the actions outlined in the these Implementation Plans however just as many gaps in service implementation have also been identified which could be impacting on the reach and coverage of services to sex workers in WA as well as the continued engagement of sex workers with the programs.

These gaps can be summarised in the broad areas of staffing and resourcing, lack of peer education and other input from sex workers and the need for improved collaborations and methods of service delivery; alongside these is the need for continued and enhanced data collection. These have been expanded upon below along with recommendations made.

4.4. Make recommendations on delivering preventive services to sex workers in urban and rural settings

4.4.1. Staffing and resources at Magenta and SWOPWA

Sex worker programs, Magenta and SWOPWA have experienced a high turnover of staff creating gaps in service delivery, corporate memory and availability of resources. All positions at Magenta and SWOPWA are part time, which means the attractive opportunities elsewhere (e.g. remuneration) could pose challenges in retaining staff.

Recommendation 1: Explore staff incentives and ways of retaining corporate knowledge

FPWA should explore and provide meaningful benefits for retaining valuable staff, for example career development opportunities.

To enhance follow up and continuity of service, Magenta and SWOPWA should create a culture where knowledge is shared and consistently recorded in order to minimise disruption in service delivery.

SHBBVP should consider options to facilitate full-time employment of staff to address multiple needs such as retaining staff, increasing service coverage and hours of operation.

4.4.2. Participatory input from sex workers

Aside from a small number of peer educators working at Magenta and SWOPWA there is little involvement of sex workers in the planning and implementation of the actions outlined in the HIV/STI prevention plans. Peer education is recognised as a two-way exchange of information, knowledge sharing and strategy development and is identified in the National HIV and STI Strategies as a successful approach to prevention.

Involving and working more collaboratively with sex workers will strengthen information networks, bring additional perspectives to decision making and potentially provide links with hard to reach groups.

Recommendation 2: Develop processes to support the employment and retention of peer workers at Magenta and SWOPWA.

FPWA should promote and facilitate the employment of sex workers or those with previous sex work experience as peers for the delivery of Magenta and SWOPWA services. This should include sex workers from the targeted language groups.

FPWA should explore models of peer-worker involvement and training that have been implemented with other relevant risk populations (e.g. people who inject drugs and men who have sex with men) and other sex worker programs (e.g. Sex Industry Network, South Australia) in order to inform similar approaches to sex worker services in WA.

Recommendation 3: Involve and engage sex workers in all aspects of health service planning, policy and service delivery.

Sex workers representing the diverse sex worker communities should be invited to consult on decisions made around new initiatives at the program level. Potentially useful approaches would be through the invitation of sex workers to internal meetings or by running consultation focus groups and planning days and methods to incentivise participation (e.g. payments for volunteering time) should be explored.

Consideration should be given to establishing advisory structures for peers to represent the various subgroups of sex workers. Such structures could potentially sit within the current governance and/or management structure of Magenta and SWOPWA (FPWA) and used to inform strategic direction and provide feedback to management and government.

To allow effective peer involvement and meaningful contribution, suitable sex worker representatives should be selected and supported in their role by providing appropriate training to build knowledge and skill around working as a consultant in the chosen structure (AIVL, 2006).

4.4.3. Strengthening collaborations

There are many effective relationships between FPWA, Magenta and SWOPWA and other key organisations (e.g. government, other community services and clinics), for example, SWOPWA is working towards collaboration with WA Substance Users Association (WASUA) to deliver targeted education to street workers. Working as a partnership allows organisations to share information, responsibility and resources toward the same goal of improving the health and wellbeing of their target community.

Magenta would benefit from extending their collaborations with clinical services and strengthening others with organisations servicing sex workers in rural and remote WA. For example, working in an integrated way with mainstream practitioners may alleviate some of the demands on Magenta and FPWA's clinic resources; make more clinic and one-on-one education opportunities available for new workers. Working collaboratively with regional/remote services already accessing sex workers will provide valuable information about the sex industry in those areas and allow more targeted approaches to be developed which those regional/remote services could help to implement.

Recommendation 4: The programs should continue their existing collaborations and continue to identify partnership opportunities, particularly in rural and remote areas and in clinical settings.

Magenta and SWOPWA should continue to consult with major stakeholders such as local police and WASUA and continue to identify partnership opportunities like these that can mutually enhance the capacity of organisations to service sex workers. These partnerships could be formalised with documented project plans that include timelines, resources, outcomes, objectives and outcome measures.

Magenta clinic staff should facilitate the integration of sex workers into mainstream clinical services by using such methods as written referrals to the new doctor which has shown to be effective in enhancing the relationship between the patient and new doctor and reducing loss to follow up. A similar method should be used when referring sex workers to services in rural/remote WA.

Magenta outreach staff should investigate ways for their services in remote and rural areas in WA to be promoted and facilitated by those local services. Consider the possibilities for sexual health nurses to

accompany them on outreach and/or community and peer educators from the area to continue outreach in the periods between Magenta visits with Magenta's guidance and resources.

4.4.4. Delivery of health promotion and advocacy

Effective health promotion requires consideration of broader structural and social determinants of health beyond that of access to services and health education. It is important for SWOPWA and Magenta programs to create structures that enable sex workers to be in control of their own health. It is also important that FPWA builds in policies to advocate for the health and wellbeing of sex workers including those regarding employment in order to assist with the reduction of stigma and discrimination and hence the potential impact on sex worker health.

Access to sex workers by peer educators along with well defined advocacy actions will help underpin the success of the WA sex worker programs.

Recommendation 5: Build on current responses to HIV and STI prevention in sex worker communities, enhance capacity for these activities to ensure adequate reach and coverage and implement evidence based approaches.

Develop a regular and consistent approach to providing health promotion, such as peer education and extended hours of outreach, to continue to support and educate this mobile and diverse group. Supplement these approaches by utilising as many forms of media as possible to improve the profile and visibility of Magenta and SWOPWA programs in sex worker communities.

Magenta and SWOPWA programs should monitor, document and report the impact of legislation and policy on sex workers' health and safety in WA. Information, trends and issues identified should be used and reported to inform the basis of advocacy around the legal and policy impacts on sex workers and service delivery.

Further to Section 4.4.2, opportunities should be sought to involve suitably skilled and experienced sex workers in the education and guidance of sex workers new to the industry.

Build on recommendations outlined in 4.4.3 to use collaborations to efficiently deliver health promotion and services. Explore ways to provide coordination of provision of health promotion and clinical services to sex workers in regional and remote areas and enhance partnerships between regional and remote hospitals, sexual health services and public health units.

4.4.5. Data collection and improving the evidence base

The lack of data and benchmarking to effectively measure the reach and effectiveness of health promotion to sex workers and the effectiveness of service delivery limits the ability of the programs to appropriately target at-risk groups and limits the capacity for evaluating current initiatives and strategies. However, evaluation outcomes need to be carefully determined based on the nature of initiatives. For example, in relation to short and medium term initiatives, population-level outcomes such as behaviour change and changes to disease incidence are unlikely to be realised. While such outcomes are ultimately of key importance, they are best monitored over an extended period of time and interpreted on the basis of overarching strategies and a suite of initiatives rather than in attribution to specific programs.

Recommendation 6: Extend data collection

Evaluation, surveillance and research activities should be embedded into the work of many programs and services. The identification of appropriate measures for the assessment of the effectiveness of the programs should be developed. Consideration of the capacity of programs to collect and interpret such data should be taken when devising such data collection processes and capacity building, skills training and/or out-sourcing of some surveillance and evaluation activities should occur.

Research methods for collecting data from sex worker subpopulations where knowledge is lacking (e.g., male sex workers, CALD sex workers, private workers and regional and remote workers) should be developed and considered.

The SHBBVP should consider establishing sentinel surveillance for clinics that are known to routinely see sex workers to better capture the testing behaviour, outcomes and risks associated with sex work in WA.

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Appendix

Appendix 1. Recruitment strategies

Revised Sex Worker Recruitment Strategies

In-depth interviews

1. Staff facilitation of interview appointments by Magenta, Scarlet Alliance and Fremantle Sexual Health Service (educators and nurses)

- Staff to identify appropriate consumer representatives to participate in a telephone interview and inform them of the project
- If sex worker agrees then educator or nurse either passes the sex worker's phone number Burnet (Carol El-Hayek) or asks sex worker to contact Burnet directly via SMS, phone or email
- Where possible assist by setting up time and phone for interview (for example sex worker could go in to Magenta and use their space for the telephone interview)

2. SMS by Magenta

- Contingent on ethics approval, an SMS will be sent to sex workers on the Magenta database inviting people to participate in an in-depth interview. Wording of the SMS will be developed in consultation with Magenta staff

3. Promotion at sex worker establishments by Scarlet Alliance

- Scarlet Alliance to fax/email establishments and other appropriate contacts in their network to inform them of the project and request support in promoting telephone interviews via flyer
- This flyer has been translated into 3 Asian languages in an attempt to identify CALD sex workers for an interview as well
- Text: "Have a say in how services are delivered to sex workers in WA! The Burnet Institute is working with the WAn Department of Health to identify ways to improve health services for sex workers in WA. The Burnet Institute is a non-Government organisation based in Melbourne, Victoria. We would like to interview you via telephone about your experience with health services in WA, with a focus on sexual health services and wider programs that provide support to sex workers. **What's involved??** Participation is completely voluntary and will not affect your access to services 30 to 40 minute telephone interview by a female researcher from the Burnet Institute. A telephone interpreter can be provided. With your permission, we will record the interview and take notes. We will not record your name at any time. We will not ask you to sign anything. Your privacy and confidentiality will be protected. After the interview, when notes are complete,

the recording will be erased. Interviews will be scheduled at a time convenient to you. **Contact** If you would like to take part in an interview please either text BURNET to 0487 282 337 OR email carol@burnet.edu.au”

4. Invitation via on-line survey

- The last page of the survey asks respondents who have completed the on-line survey if they would like to participate in a telephone interview
- Text: “We are also conducting interviews with sex workers as part of this project. Would you be willing to also participate in a telephone interview to discuss your experiences and views about health services for sex workers in WA in more detail? If you would like to take part in an interview please either: Text BURNET to 0487 282 337 or email: carol@burnet.edu.au. Carol El-Hayek will call you to arrange a time for the interview. Thank you!”

Surveys

1. Staff distribution of paper based surveys

- Distribution of paper-based surveys to sex workers by Magenta outreach educators and Fremantle Sexual Health Service outreach nurses
- Sex workers can send the survey directly to Burnet in the stamped self-addressed envelopes provided

2. Promotional card

- Distribution of a business card sized card to sex workers by Magenta educators and Fremantle Sexual Health Service nurses to invite sex workers to complete the on-line survey
- Text: “Have your say! If you are a sex worker in WA and aged over 18 years, please complete a brief survey about how health services are and should be provided to sex workers in WA. The survey can be completed during April-May 2011. The website can be found at: www.burnet.edu.au/WAsurvey. Thank you! “

3. Classified section in newspapers

- Advertisement in the classified section of urban and regional newspapers in WA has been purchased to run until the end of May 2011.
- Text: “*FOR SEX WORKERS: Working in WA, aged 18+. Please complete an anonymous on-line survey on health services provided to sex workers. The survey is open April-May 2011 at www.burnet.edu.au/WAsurvey”*

4. SMS by Magenta

- SMS sent to sex workers on the Magenta database inviting people to participate in the on-line survey
- Wording of the SMS will be developed in consultation with Magenta staff

5. Promotion of survey via FPWA, Magenta and Scarlet Alliance website

- Links to the on-line survey posted on the website of FPWA, Magenta and the Scarlet Alliance
- Text: *“Have your say on how services are delivered to sex workers in WA. The Burnet Institute (an NGO based in Melbourne) is working with the WAn Department of Health to identify ways to improve health services for sex workers in WA. If you are a current or former sex worker in WA and aged over 18 years, we would like to know about your experiences of accessing services and how you think these can be improved. Please complete this brief and anonymous on-line survey between April and May 2011. www.burnet.edu.au/WAsurvey”*

Appendix 2. Self-administered consumer survey

This is a voluntary and confidential survey. This survey should be completed by past and current sex workers only.

SECTION ONE - ABOUT YOU

Where do you usually live? Perth Fremantle Other metro Regional/rural _____

What is your gender? _____

Age group: 18-24 25-29 30-34 35-39 40-44 45+

Country of birth: Australia Other: _____

If you were born outside of Australia, what year did you arrive in Australia? _____

What language do you prefer to speak at home? English Other: _____

Are you of aboriginal or Torres Strait Islander background? No Yes, Aboriginal
 Yes, TSI

What is your highest level of education?

Year 10 or earlier Year 11 Year 12 Diploma/trade certificate

University or similar

SECTION TWO - YOUR WORK

How long have you worked in the sex industry? (If you have not worked continuously in the sex industry, please indicate how long you have worked in the sex industry in total)

< 1 year 1-2 years 3-5 years 6-10 years 11+ years

What kind of sex-work do you usually do? (Tick all that apply)

Street-based Brothel-based Escort agency Private / Sole operator

No sex (massage only, BDSM) Other (please describe: _____)

Is sex work your sole source of income? Yes No

Where do you usually work: Perth Fremantle Other metro Regional/rural

SECTION THREE – SEX WORKER SUPPORT, INFORMATION & EDUCATION SERVICE

Have you accessed sex worker support, information or education services from: (tick all that apply)

Magenta Yes No

Street Worker Outreach Project (SWOPWA) Yes No

Other _____

What sex worker support, information or education did you require from these services?

Did you receive the support, information or education you needed? Yes No

Provide some information on whether you had a positive or negative experience when you accessed the service and why _____

Please rate the importance of having the following aspects of education and support available to sex workers in WA: (tick appropriate box)

	Very important	Important	Neutral	Not very import	Unnecessary
Information on working as a sex worker and the sex industry in WA					
Legal information and support					
Sexual health information					
The opportunity to share information with other sex workers					
Referrals to other sex worker friendly services					
Sex worker only sexual health clinic					
The information is provided in your preferred language					
The information and support is delivered to you by current or former sex workers					

What other support, information or education services do you need as a sex worker in WA?

What are the gaps (if any) you have identified between the services available to sex workers and the needs of sex workers in WA?

How do you think support, information and education services can be improved to better meet the needs of sex workers? _____

SECTION FOUR - SEXUAL HEALTH CHECKUPS

Have you ever had a sexual health check up? Yes No

If yes, when was your last sexual health check up?

In the past 6 months 6-12 months ago 1-2 years ago More than 2 years ago

How frequently do you attend for a sexual health check up?

Once a year Twice a year More than twice a year (specify: _____)
 Every other year Other (Please describe: _____)

Where did you go for your last sexual health check up?

FPWA Sexual Health Services (Northbridge) B2 Sexual Health Clinic Fremantle Hospital
 Sexual Health Clinic Royal Perth Hospital Magenta clinic
 Quarry Health Centre for under 25s (Fremantle) Local GP GP in another area
 Had it at work (outreach nurse) Other _____

Why did you go for your last sexual health check up? (Tick all that apply)

Symptoms Regular STI screen Regular Pap test Risk of STI Contraception
 Treatment Certificate / work requirement Immunisation Other sexual health advice

How comfortable did you feel discussing your sexual health needs with the practitioner?

Very comfortable Comfortable Neutral Uncomfortable Very uncomfortable

At your last sexual health check up, did you disclose your sex work to the practitioner?

Yes No Can't remember

What were the main factors that impacted on your decision to disclose or not disclose?

What issues, if any make attending for regular sexual health checkups difficult?

How do you think clinical services can be improved to better meet the needs of sex workers? (Sexual health and STI testing services from a clinic or GP)

IN GENERAL

What are the main reasons why you use or prefer some sex worker services over others? (*Tick as many that apply*)

- | | |
|---|--|
| <input type="radio"/> Low cost or free | <input type="radio"/> Provides safe sex information |
| <input type="radio"/> Close to home or work and easy to get to | <input type="radio"/> Provides information specific to sex workers |
| <input type="radio"/> Far away from home or work so my privacy is protected | <input type="radio"/> Not a sex-worker specific service |
| <input type="radio"/> The range of services provided | <input type="radio"/> Provides services and/or information in languages other than English |
| <input type="radio"/> Friendly and approachable service | <input type="radio"/> Other: _____ |
| <input type="radio"/> Staffed by current and former sex workers | _____ |
| <input type="radio"/> Provides free or low cost condoms | |

What should services in WA do to ensure ongoing involvement and engagement with sex workers?

New sex workers _____

More experienced sex workers _____

Sex workers from non English speaking backgrounds _____

Sex workers in regional and remote areas _____

Appendix 3. Government funded sex worker programs staffing levels

Table 10 Description of staffing levels at government funded sex worker programs across Australia

State	Program	Description of positions	Equivalent full-time positions
New South Wales	SWOP NSW	17 staff in Sydney (5 x FT; 10 x PT (1-4 days/week); 2 x casual) + volunteers; 3 staff at regional branches (1 x FT; 2 x PT)	Approximately 10 in Sydney, 1 regional
Queensland	Respect Inc	2 x 30hours 3 x 20hours 1 x 16hours 3 x casual	Approximately 3.6
WA	Magenta - Sex Worker Support Project & SWOP WA	Several part-time positions	Approximately 7.16 FTE
Australian Capital Territory	SWOP ACT	*	*
Victoria	Resourcing Health & Education (RhED)	Core RhED service = 4.8 EFT Arrest referral = 0.8 EFT Hustling Health = 0.2 EFT Pathways to exit = 2.1 EFT	Approximately 8
South Australia	South Australian Sex Industry Network (SIN)	1 x FT 8 x PT during the week 3 x casual outreach workers	Approximately 5
Tasmania	No government funded program		Nil
Northern Territory	SWOP NT	1 EFT (1 x 4days a week in Darwin; 1 x 1 day a week in Alice Springs)	2

*Could not be contacted

Appendix 4. WA STI surveillance data

Table 11 Number of chlamydia notifications by occupation and demographic characteristic, WA, 2001 to 2010

Demographic characteristic		Occupation					
		Sex worker		Other/unspecified		Total	
		(n = 36)		(n = 60,930)		(n = 60,966)	
		Number	%	Number	%	Number	%
Sex	Male	3	8.3%	25,525	41.9%	25,528	41.9%
	Female	33	91.7%	35,398	58.1%	35,431	58.1%
	Unknown	0	0.0%	7	0.0%	7	0.0%
Aboriginality	Aboriginal	0	0.0%	11,060	18.2%	11,060	18.1%
	non-Aboriginal	29	80.6%	30,757	50.5%	30,786	50.5%
	Unknown	7	19.4%	19,113	31.4%	19,120	31.4%
Age (Years)	Age range	18 - 59	N/A	1 - 90	N/A	1 - 90	N/A
	Median age	26.0	N/A	22.0	N/A	22.0	N/A
Region of residence	Metro	29	80.6%	42,092	69.1%	42,121	69.1%
	Rural	2	5.6%	7,275	11.9%	7,277	11.9%
	Remote	4	11.1%	11,034	18.1%	11,038	18.1%
	Interstate/overseas	1	2.8%	434	0.7%	435	0.7%
	Unknown	0	0.0%	95	0.2%	95	0.2%
Region of birth	Australia	15	41.7%	38,805	63.7%	38,820	63.7%
	Overseas	16	44.4%	6,245	10.2%	6,261	10.3%
	Unknown	5	13.9%	15,880	26.1%	15,885	26.1%
Where infection acquired	WA	29	80.6%	42,187	69.2%	42,216	69.2%
	Interstate	0	0.0%	629	1.0%	629	1.0%
	Overseas	3	8.3%	2,288	3.8%	2,291	3.8%
	Unknown	4	11.1%	15,826	26.0%	15,830	26.0%
How case identified	Clinical presentation	4	11.1%	16,664	27.3%	16,668	27.3%
	Contact tracing/epi investigation	0	0.0%	6,715	11.0%	6,715	11.0%
	Screening	31	86.1%	21,932	36.0%	21,963	36.0%
	Unknown	1	2.8%	15,619	25.6%	15,620	25.6%

Notes: Number = Number of notifications reported to the DoH

Overseas acquired:

- Sex workers: Oceania region (1/3; 33%), North-East Asia (1/3; 33%), the Americas (1/3; 33%)
- Other/unspecified occupation: South-East Asia (1,108/2,288; 48%)

Source: Communicable Disease Control Directorate, Public Health Division, Department of Health, Western Australia

Table 12 Number of gonorrhoea notifications by occupation and demographic characteristic, WA, 2001 to 2010

Demographic characteristic		Occupation					
		Sex worker		Other/unspecified		Total	
		(n = 23)		(n = 14,989)		(n = 15,012)	
		Number	%	Number	%	Number	%
Sex	Male	2	8.7%	6,406	42.7%	6,408	42.7%
	Female	21	91.3%	8,581	57.2%	8,602	57.3%
	Unknown	0	0.0%	2	0.0%	2	0.0%
Aboriginality	Aboriginal	2	8.7%	10,821	72.2%	10,823	72.1%
	non-Aboriginal	21	91.3%	3,829	25.5%	3,850	25.6%
	Unknown	0	0.0%	339	2.3%	339	2.3%
Age (Years)	Age range	17 - 44	N/A	1 - 88	N/A	1 - 88	N/A
	Median age	34.0	N/A	23.0	N/A	23.0	N/A
Region of residence	Metro	19	82.6%	4,285	28.6%	4,304	28.7%
	Rural	1	4.3%	995	6.6%	996	6.6%
	Remote	2	8.7%	9,585	63.9%	9,587	63.9%
	Interstate/overseas	1	4.3%	122	0.8%	123	0.8%
	Unknown	0	0.0%	2	0.0%	2	0.0%
Region of birth	Australia	19	82.6%	13,389	89.3%	13,408	89.3%
	Overseas	2	8.7%	1,090	7.3%	1,092	7.3%
	Unknown	2	8.7%	510	3.4%	512	3.4%
Where infection acquired	WA	22	95.7%	12,552	83.7%	12,574	83.8%
	Interstate	0	0.0%	203	1.4%	203	1.4%
	Overseas	1	4.3%	838	5.6%	839	5.6%
	Unknown	0	0.0%	1,396	9.3%	1,396	9.3%
How case identified	Clinical presentation	4	17.4%	6,139	41.0%	6,143	40.9%
	Contact tracing/epi investigation	1	4.3%	1,227	8.2%	1,228	8.2%
	Screening	15	65.2%	3,575	23.9%	3,590	23.9%
	Unknown	3	13.0%	4,048	27.0%	4,051	27.0%

Notes: Number = Number of notifications reported to the DoH

Overseas acquired: Sex workers: North-East Asia (1/1; 100%), Other/unspecified occupation: South-East Asia (635/838; 76%)

Source: Communicable Disease Control Directorate, Public Health Division, Department of Health, Western Australia

Table 13 Number of HIV notifications by occupation and demographic characteristic, WA, 2001 to 2010

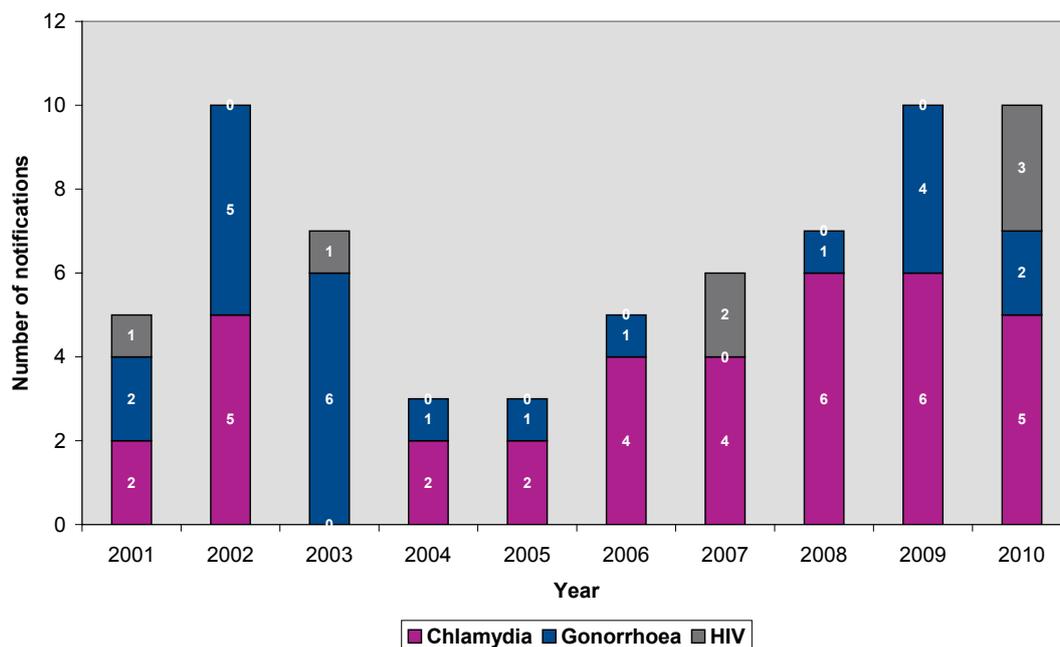
Demographic characteristic		Occupation					
		Sex worker		Other/unspecified		Total	
		(n = 7)		(n = 683)		(n = 690)	
		Number	%	Number	%	Number	%
Sex	Male	5	71.4%	514	75.3%	519	75.2%
	Female	2	28.6%	168	24.6%	170	24.6%
	Unknown	0	0.0%	1	0.1%	1	0.1%
Aboriginality	Aboriginal	0	0.0%	46	6.7%	46	6.7%
	non-Aboriginal	7	100.0%	637	93.3%	644	93.3%
	Unknown	0	0.0%	0	0.0%	0	0.0%
Age (Years)	Age range	22 - 59	N/A	1 - 74	N/A	1 - 74	N/A
	Median age	38.0	N/A	37.0	N/A	37.0	N/A
Region of residence	Metro	6	85.7%	593	86.8%	599	86.8%
	Rural	0	0.0%	43	6.3%	43	6.2%
	Remote	1	14.3%	45	6.6%	46	6.7%
	Interstate/overseas	0	0.0%	0	0.0%	0	0.0%
	Unknown	0	0.0%	2	0.3%	2	0.3%
Region of birth	Australia	1	14.3%	336	49.2%	337	48.8%
	Overseas	6	85.7%	345	50.5%	351	50.9%
	Unknown	0	0.0%	4	0.6%	4	0.6%
Where infection acquired	Australia	5	71.4%	349	51.1%	354	51.3%
	Overseas	2	28.6%	322	47.1%	324	47.0%
	Unknown	0	0.0%	12	1.8%	12	1.7%
How case identified	Clinical presentation	1	14.3%	73	10.7%	74	10.7%
	Contact tracing/epi investigation	0	0.0%	113	16.5%	113	16.4%
	Screening	5	71.4%	486	71.2%	491	71.2%
	Unknown	1	14.3%	11	1.6%	12	1.7%

Notes: Number = Number of notifications reported to the DoH

Overseas acquired: Sex workers: North-West Europe (1/2; 50%), South-East Asia (1/2; 50%), Other/unspecified occupation: South-East Asia (134/322; 42%), Sub-Saharan Africa (122/322; 38%)

Source: Communicable Disease Control Directorate, Public Health Division, Department of Health, Western Australia

Figure 14 Number of chlamydia, gonorrhoea and HIV notifications among sex workers, WA, 2001 to 2010



Notes: One gonorrhoea re-infection in 2002; one gonorrhoea re-infection in 2003
 One chlamydia/gonorrhoea co-infection in 2002; one chlamydia/HIV co-infection in 2010

Appendix 5. Services and information sought by sex workers

One of the objectives of this review included identifying the determinants of health care seeking behaviour. As part of the process to identify these determinants, we consulted sex workers through in-depth interviews and the survey to capture what sex workers sought from health care services and what the barriers were to obtaining these services from their perspective.

Three key areas were drawn from the question asking what sex workers sought from the services they accessed: information; support; products and services.

Specific responses shown in Table 11 demonstrate that sex workers want very specific sex industry information. For example, new sex workers are requesting information on what to expect coming in to a new industry, experienced workers who are considering moving into a different area have asked for lists of businesses with good work practices and sex workers from out of town sought information on local laws and policing practices.

Table 11 What sex worker support, information or education did you require from these services?

Information	Support	Products and services
Work prospects and resources	Housing	Free or affordable safe sex supplies
How to deal with problematic clients	Family issues	Clinical services
WA legislation	Drug addiction	A register of problematic clients
Recognising STI	Peer support	Medical check up
Safe sex information	Counselling/debriefing	STI testing
Sexual health and testing information	Providing resources	Information booklets
Potential risks/threats while working	After a physical attack/threat	Introductory booklets for new workers

At all stages of their career, sex workers indicated they want to be aware of information and services relevant and available to them and be able to access these as the need arises.

“If we need help we will reach out for it... it should always be there for when we do need it.”

Sex workers also expressed a need for a skills-based understanding of certain areas of their work; for example strategies for maintaining their safety and handling difficult clients or introducing safe sex practices to their work and recognising an STI. They reported a need to speak openly about their experiences and issues one-on-one for debriefing and support but also in forums to gain information and insight from other sex workers about work practices.

Very important to sex workers accessing services was the delivery and timing of services. Unanimously, sex workers want information that is current, accurate and shared in a mature, non-judgemental and friendly way by peer workers or experienced non peer workers at a time that is relevant to their needs.

Appendix 6. Gaps and suggested improvements

The following are summarised (paraphrased) responses to the open ended question in the survey. They are not listed in any order and similar responses have been grouped.

Reasons given for dissatisfaction with the service sought

The information sought was not available

There were no sex workers available to talk to (conversation was hypothetical rather than practical)

There was nowhere private to talk

The service was overcrowded

The worker appeared to know nothing about sex worker issues

Positive experiences with the service

Staff were pleasant, helpful, positive, friendly, non-judgemental and/or easy to talk to

The service provides a supportive, friendly, consistent and/or confidential environment

The services offered are useful

Testing and protection are made accessible and affordable

The information about sexual health was useful

Gratitude for the work that is done

Services and information generally sought by sex workers

A forum for listing problem clients

Assistance with problem managers

A place to get off the streets for a few minutes

To talk with someone for debriefing

Gain support from peer educators and talk with someone as a colleague

Clinical services out of office hours and one where no identification is required

Needle and syringe disposal, wet wipes, water and small touch lights for working at night

Health information and education

Financial education

Education around retraining if desired

Housing information and education

Give new workers a realistic expectation of the industry, including work safety

Guidance on how to maintain privacy and

Advice on dealing with problematic clients

Gain knowledge of the laws associated with sex work

Support and assistance to engage with police

Information on advertising as a sex worker

Access to a service after hours

Brothel ratings in relation to work practices

Local knowledge for workers from interstate or overseas

As much support and information as possible made available to all sex workers

Gaps in services as identified by sex workers

There is a need for greater conformity of legislation, currently different areas of Australia operate differently
Discrimination towards sex workers
Limited resources, there is often no-one available to give information or drop off supplies
Long waits for access to doctors
Peer education and support by and for sex workers
SWOPWA hours are outside the best hours for street workers
Magenta is closed on Fridays
Lack of interest or support around the mental issues associated with sex work
The lack of authority over brothel owners and managers who are mistreating their workers
Inability to turn to the police

Suggested improvements as identified by sex workers

A safe place to talk, for example a SWOPWA vehicle to sit in “to get off the streets to talk or just take some time out”
A safe place to work from, for example away from police
A safe, clean place to needle inject
The need for posted areas for pickup and drop off
A clinical outreach service, supporting SWOPWA for example
Proactive and consistent communication to advertising sex workers
Community education to reduce social stigma around sex work
Provide more free condoms
Make information more easily obtained by new workers
Make immediate medical support available to sex workers
The availability of a sex worker support group
Longer hours or night visits to inform and provide tools that promote safe sex
More outreach and visits to parlours
More people with experience in sex work working as educators
Advocacy on behalf of the sex workers
More information on problem clients, for example more ugly mugs lists
Raise awareness of support organisations such as Magenta
More funding for support organisations to reach more workers
More rights given to support organisations to legally enter premises and talk to sex workers
One coordinating body that is autonomous, self run and self governed by sex workers
Increase sex worker access to information on their rights and how to protect their sexual health
Education of other skills would also be useful, for example managing money, child care etc.

Factors impacting on decision to disclose sex work

Those who did not disclose reported the following reasons:

Embarrassment, wanting to keep it private, felt judged, it's personal
It was not important or necessary information for the GP
Have had previous negative experiences disclosing sex work to health professionals
Protecting identity in a small community
It does not matter

The health department and the media vilify sex workers who contract infections

Those who did disclose reported the following reasons:

To be honest or open, “nothing to be ashamed of”

Felt very comfortable, health practitioner was accepting, no judgement and trust

To normalise sex work

Felt it was necessary for the screening or to get the certificate

Thought it would be useful/helpful information for GP, so that they can better understand my needs and provide thorough risk management

It’s a sex worker friendly clinic

No problem disclosing due to absence of mandatory testing or enforced registration in WA.

Issues reported by sex workers making regular sexual health check-ups difficult

Appointment times usually end at 5pm and not enough appointments are offered resulting in long waiting periods for appointments

Being judged or some degree of embarrassment at presenting to a clinic

The costs involved of having it done privately, for example, “I’m not an Australian citizen or PR”

Confidentiality; having sex work recorded on medical records

Travel and location is inconvenient

The need to sacrifice the time it takes when risk of infection is low

Over-testing creates more stigma, shame and discrimination for sex workers by ignoring that sex workers have lower rates of STI and HIV than the general population

Improvements that could be made to clinical services

STI pathology requests issued from a GP at sex worker's request without him/her having to see a GP

Sex worker clinic available 5 days a week, creating more available appointment times and allow more time with each patient

Make it a free service

Have a doctor work with SWOPWA outreach workers at least one night per week

Come to my brothel to do check-ups

More clinic locations

More sex worker friendly doctors with more staff trained on the issues of sex work

Ensure WA does not introduce mandatory regular STI testing

Have mandatory sexual health testing

Privacy needs to be of importance

Introduce remote or self-testing

Send reminders for upcoming appointments

Suggested ways to keep sex workers engaged in a service

To engage new workers:

Consultation; no program planning without input from sex workers

More health services with sex worker friendly nursing and medical staff

Advertise

Become independent and autonomous, have a sex worker board...and be run only by sex workers
Change the laws to be more supportive and inclusive of a worker's right to earn money as a sex worker may help break down the barriers
Allow advertising for jobs in the paper again giving girls more choice about where they go to work
Newspapers with a personals section should be required to include an ad for Magenta and their services in every issue to increase their visibility to new and current workers
Workers need to be trained and educated on what to expect before entering sex work
Have a new workers kit providing information on the following: state legislation; safety in the work place; sex worker courses available; tax; operating as a sole trader; tips and ugly mug reports
Have current or past sex workers as staff
Have information on hand in brothels and massage parlours
Make outreach services more suited to our work hours
Provide mobile clinical services
Extend Magenta's hours of operation to 5 or 6 days per week
Monitor papers and websites and contact sex workers in a friendly way to inform them of the services available
More sexual health information
Outreach to sex services premises by current and former sex workers only
Workshops

To engage experienced workers

Advertise, a suggestion: every edition of the paper which has a personals section could include an ad to make workers aware of the services available to them
Be accountable and transparent
Better monitoring and collection of information
Communication via phones and text
Access experienced workers through Magenta and through their madams
Have forums like the sister girls do in Cairns every second year
Run and advertise workshops. Examples of topics given: ways to keep clients coming back; how to do BDSM safely; rope tying and other services; money management; laws
Some way we can all network and share information and skills
Provide a support group
Have current or past sex workers as staff and do not employ people who have no understanding of the industry
More experienced workers have valuable knowledge, involve them and allow them to co-ordinate peer based education programs and support systems
Randomly call sex workers who regularly advertise in the paper and ask them for their involvement in health promotion programs
Provide information on retirement from the industry
Provide updates of changes to legislation
Increase word of mouth advertising
Improve the reliability and consistency of staff returning calls

To engage CALD workers

Advertise

Make available interpreters who have an accepting attitude

Provide more information, for example simple, easy guidelines of expectations and WA law in their language

Ensuring funding is available for correct and consistent translation of resources

Outreach by current and former sex workers from non-English speaking backgrounds in priority language groups

Consider forming a steering committee of sex workers from non-English speaking backgrounds to engage and inform services and ensure the services are and continue to be relevant

More native speakers to help women out who have poor English

To engage regional and remote workers:

Fund a mobile sexual health clinic

Ensure they are informed them of their legal rights

Monitor ads in papers and websites and contact them to advise of services available

More outreach work in regional areas and more support, for example information and resources can be mailed out to regional areas

Provide online support and online information packs and remote self-testing by mail

Outreach trips by peer educators to regional centres

Promotional information in those areas and visit those areas more often

Have a better website